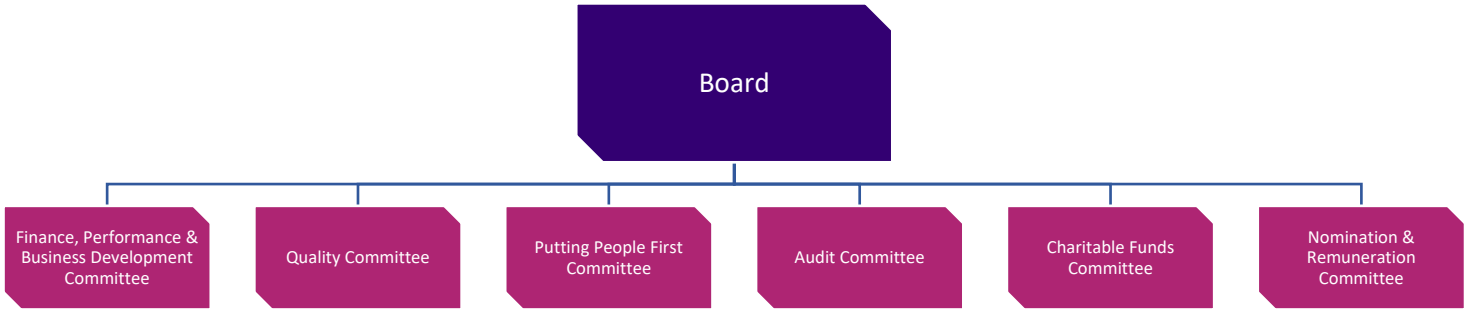
Liverpool Women's NHS Foundation Trust

Trust Board

5 May 2022, 10.00am

Blair Bell Lecture Theatre & Virtual, via Teams



NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

Location	Blair Bell Lecture Theatre & Virtual via Teams
Date	5 May 2022
Time	10am

Item no. 22/23/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
		PRELIMINARY BUSINESS			
030	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	1000 (5 mins)
031	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
032	Minutes of the previous meeting held on 7 April 2022	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
033	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
034	Service Outline – Still Births	To receive service outline	Presentation	Medical Director	1005 (10 mins)
035	Patient Story	To receive a patient story	Presentation	Deputy Chief Nurse & Midwife	1015 (15 mins)
036	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	1030 (5 mins)
037	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	1035 (10 mins)
		MATERNITY			
038a	Ockenden Final Report	For assurance	Written	Deputy Chief Nurse & Midwife	1045 (20 mins)
038b	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	For assurance	Written	Deputy Chief Nurse & Midwife	1105 (10 mins)
		QUALITY & OPERATIONAL PERFORMANCE			
039a	Chair's Report from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1105 (30 mins)
039b	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	

039c	Operational Plan 2022/23	For information	Presentation	Chief Operating Officer	
BREAK – 10 mins					
Board Thank You – 5 mins					
PEOPLE					
040a	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Deputy Director of Workforce	1150 (30 mins)
040b	National Staff Survey Results 2021	For assurance	Written	Deputy Director of Workforce	
FINANCE & FINANCIAL PERFORMANCE					
041a	Chair's Report from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1220 (40 mins)
041b	Finance Performance Review Month 12 2021/22	For assurance - To note the current status of the Trust's financial position	Written	Chief Finance Officer	
041c	Digital Annual Review	For assurance	Written	Chief Information Officer	
BOARD GOVERNANCE					
042a	Proposed Corporate Objectives 2022/23	For approval	Written	Chief Executive	1300 (20 mins)
042b	Revised Risk Management Strategy for 2022-23	For approval	Written	Trust Secretary	
042c	Board Assurance Framework	For assurance	Written	Trust Secretary	
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
043	Emergency Preparedness, Resilience and Response Annual Report	To note	Written	Chief Operating Officer	Consent
CONCLUDING BUSINESS					
044	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1320 (5 mins)
045	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
046	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
047	Jargon Buster	For reference	Written	Chair	

Date of Next Meeting: 7 July 2022

1325 - 1335	*Questions raised by members of the public*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Liverpool Women's NHS Foundation Trust

Meeting attendees' guidance

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

Before the meeting

- Consider the most appropriate format for your meeting i.e. physical, virtual or hybrid. There are advantages and disadvantages to each format, and some lend themselves to particular meetings better than others. Please seek guidance from the Corporate Governance Team if you are unsure.

General considerations:

- Submit any reports scheduled for consideration at least 8 days before the meeting to the meeting administrator. Remember to try and answer the 'so what' question and avoid unnecessary description. It is also important to ensure that items/papers being taken to the meeting are clear and provide a proposal/recommendation to reduce unnecessary discussion time at the meeting.
- Ensure your apologies are sent if you are unable to attend and *arrange for a suitable deputy to attend in your absence
- Prepare for the meeting in good time by reviewing all reports
- 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 this is permitted.

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

- For the Chair / Administrators:
  - Ensure that there is a clear agenda with breaks scheduled if necessary
  - Make sure you have a list of all those due to attend the meeting and when they will arrive and leave.
  - Have a paper copy of the agenda to hand, particularly if you are having to host/control the call and refer to the rest of the meeting pack online.
  - If you are the host or leader for the call, open the call 10-15 minutes before the start time to allow everyone to join in an orderly way, in case there are any issues.
  - At the start of the call, welcome everyone and run a roll call/introduction - or ask the meeting administrator to do this. This allows everyone to be aware of who is present.
  - Be clear at the beginning about how long you expect the meeting to last and how you would like participants to communicate with you if they need to leave the meeting at any point before the end.

- General Participants
  - Arrive in good time to set up your laptop/tablet for the virtual meeting
  - Switch mobile phone to silent
  - Mute your screen unless you need to speak to prevent background noise
  - Only the Chair and the person(s) presenting the paper should be unmuted
  - Remember to unmute when you wish to speak

- Use headphones if preferred
- Use multi electronic devices to support teams.
- You might find using both mobile and laptops is useful. One for Microsoft teams and one for viewing papers

At the meeting

General Considerations:

- For the Chair:
  - The chair will assume that all members come prepared to discuss agenda items having read through supporting papers, this obviates the need for leads to take up valuable time presenting their papers.
  - The chair will allow a free ranging debate and steer discussions to keep members on track whilst at the same time not being seen to overly influence the outcome of the debate.
  - The chair will provide a brief summary following presentation and discussion of the paper, confirming any key risks and / or assurances identified and whether there are any matters for the Chair's log.
  - The chair will question leads when reports have not been submitted within the Trust's standard template or within the required timeframe.
  - Ensure that correct people are in the room to 'form the meeting' with other attendees invited to attend only when presenting their item.

- General Participants:
  - Focus on the meeting at hand and not the next activity
  - Actively and constructively participate in the discussion
  - 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)
  - Consent agenda items, taken as read by members and the minutes will reflect recommendations from the paper. Comments can still be made on the papers if required but should be flagged to the Chair at the beginning of the meeting.

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

- For the Chair:
  - Make sure everyone has had a chance to speak, by checking at the end of each item if anyone has any final points. If someone has not said anything you might ask them by name, to ensure they have not dropped off the call or assist them if they have not had a chance to speak. In hybrid meetings, it can be useful to ask the 'virtual' participants to speak first.

    - Remember to thank anyone who has presented to the meeting and indicate that they can leave the meeting. It can be easy to forget this if you can't see them.

- General Participants:
    - Show conversation: open this at start of the meeting.
        - This function should be used to communicate with the Chair and flag if you wish to make comment
    - Screen sharing
        - If you wish to share a live document from your desktop click on share and identify which open document you would like others to view

Attendance

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

After the meeting

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

Standards & Obligations

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

13. Towards the end of the meeting, agendas should carry a standing item that requires members to collectively identify new risks to the organisation – it is the responsibility of the chair of the committee to ensure, follow agreement from the committee members, these risks are documented on the relevant risk register and scored appropriately

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

Page 129 Handbook to the NHS Constitution 26th March 2013

Liverpool Women's
NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held in the Blair Bell Lecture Theatre and Virtually via Teams at 09.30am on 7 April 2022

PRESENT

Robert Clarke	Chair
Kathryn Thomson	Chief Executive
Eva Horgan	Chief Finance Officer
Gary Price	Chief Operating Officer
Louise Martin	Non-Executive Director
Dr Susan Milner	Non-Executive Director / SID
Tracy Ellery	Non-Executive Director / Vice-Chair
Gloria Hyatt MBE	Non-Executive Director
Zia Chaudhry MBE	Non-Executive Director
Jackie Bird	Non-Executive Director
Tony Okotie	Non-Executive Director
Sarah Walker	Non-Executive Director
Marie Forshaw	Chief Nurse & Midwife
Michelle Turner	Chief People Officer / Deputy Chief Executive

IN ATTENDANCE

Matt Connor	Chief Information Officer
Dianne Brown	Interim Associate Director
Gillian Walker	Patient Experience Matron (item 006 only)
Dr Anna Paweletz	Consultant Neonatologist (item 005 only)
Joanne Berry	Tissue Viability Nurse (item 006 only)
Nashaba Ellahi	Deputy Director of Nursing and Midwifery (item 009e only)
D/Sgt Bev Ainsworth	Observer
Jim Deacon	NHS England, Head of Emergency Planning for Merseyside and Cheshire (item 009b only)
Lesley Mahmood	Member of the public
Felicity Dowling	Member of the public
Denise Richardson	Member of the public
Niki Sandman	Appointed Governor
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Prof. Louise Kenny CBE	Non-Executive Director
Dr Lynn Greenhalgh	Medical Director

Core members	**May 21**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr 22**
Robert Clarke - Chair	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓
Kathryn Thomson - Chief Executive	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓
Dr Susan Milner - Non-Executive Director / SID	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓

Tracy Ellery - Non-Executive Director / Vice-Chair	✓	✓	A		✓		A	✓	✓	✓	✓	✓
Louise Martin - Non-Executive Director	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓
Tony Okotie - Non-Executive Director	✓	✓	✓		✓		✓	A	✓	✓	✓	✓
Prof Louise Kenny - Non-Executive Director		✓	✓		A		✓	A	✓	A	A	A
Eva Horgan – Chief Finance Officer	Non-member						✓	✓	✓	✓	✓	✓
Marie Forshaw – Chief Nurse & Midwife	A	✓	✓		✓		✓	✓	✓	✓	✓	✓
Gary Price - Chief Operating Officer	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓
Michelle Turner - Chief People Officer	A	✓	✓		✓		✓	✓	A	✓	✓	✓
Dr Lynn Greenhalgh - Medical Director	✓	✓	✓		✓		✓	✓	✓	✓	A	A
Zia Chaudhry – Non-Executive Director	Non-member							✓	✓	✓	✓	✓
Gloria Hyatt – Non-Executive Director	Non-member							✓	✓	✓	✓	✓
Sarah Walker – Non-Executive Director	Non-member							✓	✓	✓	✓	✓
Jackie Bird – Non-Executive Director	Non-member											✓

22/23/	
001	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. No declarations of interest were made, and apologies were noted as above. It was noted that Item 016 'Revised Risk Management Strategy for 2022-23' would be removed from the consent agenda.
002	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
003	**Minutes of the previous meetings held on 3 March 2022** The minutes of the Board of Directors meeting held on 3 March 2022 were agreed as a true and accurate record.
004	**Action Log and matters arising** The Action Log was noted.
005	**Service Outline** Dr Anna Paweletz attended to outline the Trust's response to support maternity and neonatal services in Ukraine. It was noted that in partnership with Trust Executives and Medical Aid UK, equipment no longer used by the Trust had been identified. This had been packaged and was being delivered to a hospital in Lviv, Western Ukraine. Dr Paweletz continued to note that there were plans to explore the 'twinning' of the two hospitals to establish a close relationship and the transfer of knowledge and experience. The Chair commended all involved in the initiative stating that it would make a real and pragmatic difference to patients in Lviv. The Chief Executive added that this was a demonstration of effective leadership and noted support for the principle of twinning, noting a precedent in Uganda.

	The service outline was noted.
006	**Patient Story** Gillian Walker, Patient Experience Matron and Joanne Berry, Tissue Viability Nurse attended alongside a patient and her new-born son. The Tissue Viability Nurse introduced the story explaining that the following an emergency C-Section, observations became unstable, and the patient was bleeding internally, leading to a return to theatre and an emergency laparotomy was undertaken. The patient recovered well and after several days was discharged from Liverpool Women's Hospital (LWH). She later returned to Aintree University Hospital (AUH) with the wound opening. The patient was left with an open wound and was transferred back to LWH for management of the wound. An assessment at AUH had indicated a six-month period for healing, however, LWH had acquired a Renasys Touch System device which enabled the use of negative pressure wound therapy. After five weeks, the wound healed completely, and the patient was discharged. The Chair asked the patient what could have improved their experience. The patient explained that transferring between hospital sites had been a frightening experience and had meant that she had been kept apart from her baby for long periods. The lack of maternity awareness and experience at other hospital sites had also been apparent in the treatment received. It was noted that throughout the whole experience, medical terminology had been used to explain the situation where the use of plain English would have supported the patient's understanding and reduced anxiety. On behalf of the Board, the Chair thanked the patient for her bravery in telling her story and noted that there were key lessons that would need to taken forward, particularly relating to the transfer of the patient between various hospital sites and the challenged this had presented. This underlined the importance of the Trust's Future Generations Strategy and provided a clear example of the risk to patient safety and experience of the Trust being on a standalone site. The Board noted the patient story. *Gillian Walker and Joanne Berry left the meeting*
007	**Chair's announcements** The Chair welcomed Jackie Bird to the Board. Jackie had been appointed as a Non-Executive Director, commencing with the Trust from 1 April 2022. Detective Sergeant Bev Ainsworth was also welcomed to the meeting. Detective Sergeant Ainsworth was on a month-long programme with the Trust to observe NHS practice and support knowledge exchange. The Chair noted that a Council of Governors meeting had been held on the 10 February 2022. This had provided an opportunity for governors to contribute to the Trust's 2022/23 objective setting process and the development of the updated Research and Development Strategy. The Chair reminded the Board that the period (previously known as 'purdah') leading up to the 2022 local government elections had begun and asked that members continue to be mindful of the requirement to maintain political impartiality in carrying out public duties. The Board noted the Chair's update.
008	**Chief Executive's report** The Chief Executive presented the report which detailed local, regional and national developments. The following key points were highlighted:

	• The Trust had become a British Society of Gynaecological Endoscopy Accredited Centre. Thanks were extended to the team involved in achieving this success and the continuing ambition in developing and expanding the service to make it one of the best in the country was acknowledged. • The Women of the Year Luncheon & Awards had presented a special accolade to the Women of the NHS at this year's ceremony, which took place on Friday 1 April 2022 in Birmingham. Representatives from the Trust's neonatal service had been nominated to collect the award. • There had been several key appointments made across the local health system. Of note was the appointment of Raj Jain as the new Chair-designate of the NHS Cheshire and Merseyside Integrated Care Board (ICB), ready to take up the post from July 2022 should Parliament confirm the current plans. • That there had been one use of the Trust Seal during 2021/22 The Chief Information Officer drew attention to the LWH Maternity Digital Journey 2021/22 infographic and highlighted the strong leadership being provided by the Trust's Digital Midwives in progressing with this work. The Chief People Officer noted that the 2021 Workforce Race Equality Standard (WRES) report had recently been published. This had shown that the Trust was the top performing Trust in the country for two out of the nine indicators and in the top ten for another two indicators. This was demonstrative of progress in this area, but it was stated that the Trust could not be complacent and there was room for continued improvement. The Chief Nurse and Midwife referred to the recent publication of the final Ockenden Report. Firstly, thanks were extended to everyone involved in enabling the final report to be published, including Donna Ockenden for leading the review but most importantly the families who showed extreme bravery in sharing their experiences and whose contribution would help improve the safety of maternity services in the future. The Chief Nurse and Midwife outlined the immediate actions that the Trust was taking in response to the report. Non-Executive Director, Tony Okotie, queried if there were any significant areas of additional focus beyond the themes identified in the interim report. The Chief Nurse & Midwife highlighted that the final report had identified the importance of multi-disciplinary training and of actively listening and responding to the patient voice. There had also been indications of relying less on Birth Rate Plus as an indication of safe midwifery staffing and instead utilising local intelligence which incorporated sickness rates. The Chief Executive added that the importance of centralised CTG monitoring had also been highlighted, an issue which the Trust had recently sought assurance on through the Quality Committee. Other issues identified by Board members as key features of the report were as follows: • The importance of having robust serious incident management practices • Ensuring effective communication with patients • The potential need for additional funding for maternity units to meet the recommendations The Chief Executive noted that a more extensive report on the Trust's response would be received at the May 2022 Board. The Board of Directors: • noted the Chief Executive update.
009a	Quality & Operational Performance Report The Board considered the Quality and Operational Performance Report. The Chief Operating Officer informed the Committee that the format of the performance report and dashboard had been updated. There would be further amendments to the metrics over the coming

	months to ensure that there was alignment with the System Oversight Framework and other regulatory requirements. The Chief Operating Officer outlined the Trust's cancer performance noting that there had been a deterioration in the 2 week wait metric during January 2022, mainly as a result of the Omicron variant on staffing and patient availability. An improvement had been seen during February 2022. There had been a significant number of attendances to the Gynaecology Emergency Department during February 2022 and had negatively impacted the 4-hour performance target. This continued to be closely monitored by the Gynaecology Division. There had been an improvement in the reporting period on diagnostic performance. The Chief Nurse & Midwife reported that the Trust had seen a recent increase in Serious Incidents, particularly in maternity services. There had also been a Never Event reported in the period. The underpinning issues were being explored and a detailed paper was scheduled for consideration at the Quality Committee. Non-Executive Director, Louise Martin, noted that the Maternity Led Unit (MLU) had been closed in the period due to staffing and stated that this did not provide assurance that agency usage for midwives would reduce during 2022/23. The Chief Finance Officer noted that there had been significant investment into the maternity service in recent years and the expectation was that services would be delivered within the available budget. The Chief Nurse and Midwife confirmed that there was a strong commitment to reduce agency staffing as much as possible. The Chief People Officer queried if the Family Health Division was monitoring the impact on patient experience due to the closure of the MLU. Action: To explore the impact on the patient experience due to the closure of the MLU. The Chair highlighted the deterioration in VTE performance, and it was agreed that this would be reviewed in detail at the Quality Committee. Chair's Log: Quality Committee to review the deterioration in VTE performance. The Board of Directors: • Received and noted the Quality & Operational Performance Report. *Jim Deacon joined the meeting*
009b	Major Incident Update The Interim Associate Director reported that following the Major Incident in November 2021 the Trust had completed the local and regional debrief process. She continued to outline the governance proposals in order to ensure the learning from the incident was embedded within the Trust. The Head of Emergency Planning for Merseyside and Cheshire (NHS England) attended to provide the themes from the multi-agency debrief. Issues noted included: • The permissions for signing off communications not rapid enough • Link between NWAS Regional Operational Co-ordinating Centre (ROCC) and NHS England out of protocol • The on-site presence of NHS England in the hospital control team would have been helpful • Reliance on IT solution had been problematic In summary, the response from the various partners had been effective and feedback from all had identified that hospital staff had responded excellently. There were lessons to be learned that would form an action plan for the wider system.

	The Board discussed the recommendations to enhance security arrangements on the Crown Street site and acknowledged that there would be a balance to be achieved between better security whilst remaining open and accessible to the public. The Board noted the assurances provided by the report. *Jim Deacon left the meeting.*
009c	Learning from Deaths Quarter 3, 2021/22 The Board received the report which presented the mortality data for quarter three and the learning from deaths information for quarter two. In Quarter three there were the following deaths: • Adult deaths – 0 • Stillbirths 10 (rate 5.1/1000) • Neonatal deaths 11 inborn (rate 5.7/1000 inborn births) + 5 deaths from postnatal transfers All Quarter two deaths had been reviewed using the appropriate review tools and methodology. The review of stillbirths and neonatal deaths were subject to a multidisciplinary review panel meeting with external professionals utilising the Perinatal Mortality Review Tool (PMRT). All cases invited parents to be involved in the review by submitting comments and questions for discussion. The stillbirth rate had increased since 2019/20. It was unknown if this was a pattern replicated in the UK with ONS data for 2021 awaited. There had been no increase in care issues identified from reviews of stillbirths. A thematic review of stillbirths would be conducted with full year data for 2021/22. Common themes from recent learning from deaths reviews included: 1. Importance of integrating the electronic growth chart into the maternity electronic patient record 2. Importance of sending placentas for analysis Non-Executive Director, Louise Martin, commended the quality of report but noted a concern regarding the still birth trend. There was a national ask to reduce the stillbirth rate to 2.6/1000 by 2025 and it was asked how the Trust planned to move towards this target. Non-Executive Director, Sarah Walker, added that it would be useful for the Board to understand a breakdown of the stillbirth figures i.e., how many were due to birthing complications, to potentially identify opportunities to improved interventions and care. Non-Executive Director, Dr Susan Milner, noted caution about the interpretation of stillbirth rates, highlighting that it would be important to analyse them in the context of acuity and socio-economic factors. On this latter point, the Chair identified a potential research project and noted that this issue would be useful to escalate to the Integrated care System, once in place. It was suggested that a specific report on the Trust's stillbirth rate be received at the Board for further scrutiny. Action: For the Board to receive a report on the Trust's stillbirth rate. The Board of Directors: • took assurance that there was an adequate process against the requirements laid out by the National Quality Board and that there were effective processes in place to assure the Board regarding governance arrangements in place to drive quality and learning from the deaths of adults in receipt of care at the Trust. • Noted the number of deaths in our care • Noted the number of deaths subject to case record review • Noted the number of deaths investigated under the Serious Incident framework

	• Noted the number of deaths that were reviewed/investigated and as a result considered due to problems in care • Noted the themes and issues identified from review and investigation • Noted the actions taken in response, actions planned and an assessment of the impact of actions taken. • Noted that the monitoring and review of the stillbirth rate continued by the Family Health Division, with a thematic review to be conducted with Q4 data. Issues identified at the reviews and recommendations made would now be tracked through the Maternity Clinical Meeting • the monitoring and review of the neonatal mortality rate continued with an external review of mortality for extremely preterm infants to be available in Q1 2022-23
009d	Integrated Governance Report The Board received the report which covered Quarter 3 of 2021/22 and formed part of the regular reporting schedule of the Trust to ensure that there was oversight and assurance monitoring of Integrated Governance across the Trust. Non-Executive Director, Louise Martin, noted that the issue relating to blood sampling labelling had again been identified as a key risk in the report. It was queried when there would be progress on making improvements to this area. Non-Executive Director, Tony Okotie, noted that a detailed report had been received recently by the Quality Committee and it had been explained that the reasons for incorrect labelling were multifactorial, with some taking time to improve e.g., the implementation of an IT solution for printing labels. Issues relating to human error were being monitored and the Chief Operating Officer noted that the Pathology Steering Group had awareness of areas with high volumes of errors and challenges were made during performance reviews. The Board noted the assurances provided by the report. *Nashaba Ellahi joined the meeting*
009e	Bi-annual staffing paper, July-December 2021 (Q2 & Q3) The Board received the report which set out the Trust position in the context of the National Nursing, Midwifery and AHP workforce challenges. The report was previously presented at Putting People First Committee (PPF) on 21st March 2022. The PPF Committee were assured with the triangulation of information presented that provided a Trust wide overview. The Committee commented on the available detail at a divisional level, noted in several appendices, which were discussed, supported, and demonstrated divisional actions being taken to address and improve safe staffing. Non-Executive Director, Jackie Bird, drew attention to the red flag events listed in the report and queried if there had been unintended consequences from this process. The Deputy Director of Nursing & Midwifery explained the process for managing red flag events and confirmed that there had been no unintended consequences. Non-Executive Director, Louise Martin, noted the quality of the report but noted that it could be further improved if mandatory training compliance trajectories were included. Action: To include mandatory training compliance trajectories in future bi-annual staffing papers. The Board of Directors: • Noted the contents of the paper and; • Took assurance from the actions undertaken to effectively manage and provide safe staffing within Nursing, Midwifery and AHP to support the delivery of safe care.

	Nashaba Ellahi left the meeting
009f	**Maternity Incentive Scheme (CNST) Year 4 - Assurance** The Board received the report which outlined the scheme requirements for compliance required to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year 4. A risk relating to Safety Action 1 was highlighted (use of the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard). It was explained that the current 'pause' in reporting was complicating the data, as the MBRRACE-UK reporting system had started to record the deaths of babies, in this pause period as not applicable. If the data of perinatal mortality cases reported in the pause was disregarded, the current compliance rate would sit at 84% (target 95%). Assurance was provided against the Safety Action 6 in relation to Carbon Monoxide monitoring – an issue that had previously been reported as a risk to the Board. Attention was drawn to the following appendices: • Neonatal Nursing Workforce (Appendix A) • Neonatal Medical Workforce (Appendix B) • Perinatal Surveillance Dashboard Update (Appendix C) The Board of Directors: • Received and noted assurance regarding CNST compliance • Noted the specific updates in relation to: o Neonatal Nursing Workforce o Neonatal Medical Workforce o Perinatal Surveillance Dashboard Update
009g	**Chair's Reports from the Quality Committee** The Board considered the Chair's Reports from the Quality Committee meetings held on 21 February 2022 and 28 March 2022. It was noted that there had been some mixed responses from the Committee effectiveness survey, and this would be interrogated further with the current Chair and Committee members to understand the reasons behind this and to identify improvements to practice. The Committee had approved and updated Statement of Purpose subject to the addition of reference to the Community Diagnostic Centre and its alignment with Trust services. The Statement of Purpose would be submitted to the Care Quality Commission once finalised. The document had been included as an appendix to the report in order for the Board to provide its approval. The Board of Directors: • Received and noted the Chair's Reports from the Quality Committee meetings held 21 February 2022 and 28 March 2022. • Approved the updated Statement of Purpose subject to the addition of reference to the Community Diagnostic Centre and its alignment with Trust services and its submission to the Care Quality Commission.
	Board Thank you *Rob Williams (Head of Procurement and Contracts) joined the meeting.* The Chief Finance Officer presented a 'thank you' to Rob Williams who whilst being on secondment to the Trust as Head of Procurement and Contracts had been instrumental in the Trust's recent successful delivery of a highly challenging capital expenditure programme ahead of year-end.

	The Chief Operating Officer presented a thank you to Francine Sergison, Dr Lema Imam and Dr Tamilselvi Ramnathan who had been identified in patient feedback for providing excellent and safe care to a patient in theatres.
010a	Workforce Performance Report The Board received the Workforce Performance Report. The Chief People Officer noted that the following key issues had been discussed in other items on the agenda: • Sickness rates • Mandatory training compliance • Staffing requirements emerging from the Ockenden Report recommendations. The Board of Directors: • Noted the Workforce Report.
010b	Equality, Diversity and Inclusion Annual Report The Board received the Equality, Diversity and Inclusion Annual Report for 2021/2022. The Chief People Officer explained that the report provided the required information as stipulated in the Quality Contract with the CCG, whilst also providing a summary and overview of some of the key developments and successes in ED&I over the last 12 months. The report would be uploaded onto the public-facing section of the Trust website. Non-Executive Director, Louise Martin, commented that there was a significant focus in the report on staff and suggested that there should be a re-balance to ensure that priority was also given to the activities in place to support patients and the local community. The Chief People Officer acknowledged that there was a 'split' in the reporting of ED&I activity (staff in the 'People' agenda and patients in the 'Quality' agenda) and there was a recognition that there needed to be improvements in how these workstreams aligned. The Putting People First Committee had requested that a bespoke ED&I Strategy be developed to support further improvements in this area. The Chief People Officer suggested that the Board utilise a future development session to provide views on this strategy. Action: Board development session to be utilised to support the drafting of an ED&I Strategy Non-Executive Director, Zia Chaudhry, drew attention to the chart illustrating the Trust's patient profile in terms of identified religion, noting that the terms 'Muslim' and 'Moslem' had been used as synonyms. To support cultural literacy, it was suggested that the Trust should be keeping the terms as separate to ensure that how patients wanted to be seen was reflected in the data capture. Non-Executive Director, Gloria Hyatt, asked if the bullying and harassment definition was well understood in the Trust. The Chief People Officer confirmed that clarity on definitions was provided in mandatory training and induction and the Trust's 'Be Kind' messaging was supporting this. The Chair suggested that the report could be improved if there was enhanced clarity around if the Trust was achieving its intended aims in this area and that evidence could be provided for this. The Chief People Officer confirmed that realistic objectives would be set for 2022/23 and this would enable the Trust to better track progress. The Board of Directors received the report.
010c	Chair's Report from the Putting People First Committee

	The Board considered the Chair's Report from the Putting People First Committee meeting held on 21 March 2022. Non-Executive Director, Susan Milner chaired the meeting and highlighted the following issues: • The Committee noted risks and cost pressures from the medical workforce plans which would need to be more robustly understood • The Committee had received feedback from the Freedom to Speak Up (FTSU) temperature check surveys undertaken in December 2021, noting negative perception of FTSU process by the junior doctor workforce. Remitted to the Medical Staff Committee to discuss preventative factors with the medical workforce and noted work to be undertaken by the newly appointed FTSU Guardian Srinivasarao Babarao, Neonatal Consultant. • Considered the proposal to increase the frequency of PPF Committee meetings. An additional four meetings would be added to the workplan 2022/23 for focussed meetings, and not for standard agenda reports, to allow sufficient time to discuss identified risks during an increasingly challenging period within the Trust. The Chief People Officer noted that the Committee had been sighted on the disappointing results of the (at the time) embargoed Staff Survey 2021. Trend data was being collated and a formal report would be presented at the next meeting. The Board of Directors: • Received and noted the Chair's Report from the Putting People First Committee meeting held on 21 March 2022. • Supported the recommendation to increase the frequency of Committee meetings to 10 per year.
011a	Finance Performance Review Month 11 2021/22 The Chief Finance Officer presented the Month 11 2021/22 finance performance report which detailed the Trust's financial position as of 28 February 2022. At Month 11, the Trust was reporting a £1.5m deficit Year to Date (YTD) against a £0.1m deficit plan, and a breakeven forecast in line with the revised Board approved plan. The YTD trust wide position had improved in month due to non-recurrent benefits, such as the maternity incentive scheme additional funding distribution, offsetting ongoing pressures in agency staffing and gas and electricity prices. Work continued through the Financial Recovery Board and other forums to ensure that all pressures are being managed effectively. Financial performance remained a concern for the Family Health and Gynaecology divisions in particular with continued pay pressures across services. Elective Recovery Fund (ERF) income was significantly behind plan, with the year-to-date position reflecting the risk relating to Cheshire & Merseyside (C&M) delivery. However, there had been recent confirmation that the Termination of Pregnancy baseline adjustment had been agreed. The impact of this would be assessed and amended as necessary in Month 12. There had been improvement in the Cost Improvement Programme (CIP) performance and the cash position in month. This was mainly due to the additional rebate provided from CNST year three compliance. Positive progress had been made with the delivery of the Capital Expenditure programme and there had been a recent decision to write off debt between the Trust and One to One midwives as all possible avenues of recovery had been exhausted. Non-Executive Director, Tracy Ellery, stated that the 2021/22 financial year had been a significant challenge and commended the work of the finance and operational teams in delivering a projected breakeven position. The Board also acknowledged the significant progress made to deliver the Community Diagnostic Centre. The Board of Directors: • Noted and received the Month 11 2021/22 Finance Performance Review

011b	**Revenue and Capital Budgets 2022/23** The Chief Finance Officer introduced the draft budget for approval, noting that they were currently proposed as: • An I&E deficit plan of £10.57m after a CIP programme of £4.2m and funding cost pressures of £7.7m against the original 2021/22 budget, less a vacancy factor of £1.4m. This included Elective Recovery Fund (ERF) target income of £2.7m (which could have upside or downside), and system funding of £13.6m. • A capital programme of £8.5m- £5m business as usual and £3.5m for the Community Diagnostic Centre. • Cash support was assumed although this would only be drawn down if ultimately required after a final plan was agreed. Interim cash arrangements were in place in the meantime. The Board was asked to approve this plan, noting the scrutiny and recommendation for approval from the Finance, Performance and Business Development Committee, and recognising that they reflected a draft position in line with national deadlines. The deadline for final submission was 28 April 2022. Charity budgets had been reviewed by the Charitable Funds Committee who had recommended Board approval. These represented expected incoming and outgoing resources of £425k, an increase on 2021/22. Non-Executive Director, Jackie Bird, queried if there was potential for the CIP programme to become more challenging should schemes not progress past the Quality Impact Assessment (QIA) stage. The Chief Finance Officer noted that there was no concern regarding some of the more significant projects and added that there might be additional projects that could be utilised should others not meet the QIA criteria. Non-Executive Director, Tracy Ellery, accepted that there needed to be an opening budget position for the Trust to operate against as it started the 2022/23 financial year. However, it was stated that it would be difficult for the Board to accept a c.£10m at the end of the month without additional scrutiny. There was agreement from the Board that the final sign off of the 2022/23 budget would require Board level sign off and that it would not be appropriate to delegate this authority. The Board of Directors: • Approved the draft budget 2022/23 • Agreed to convene an additional meeting to provide approval on the final budget ahead of the 28 April deadline • Approved the Charity Budget 2022/23
011c	**Chair's Reports from Finance, Performance and Business Development Committee** The Board considered the Chair's Reports from the Finance, Performance & Business Development Committee meetings held on held 21 February 2022 and 28 March 2022. Committee Chair and Non-Executive Director, Louise Martin, noted that the significant issues noted at the Committee had been discussed during other items in the Board meeting. The Board of Directors: • Received and noted the Chair's Reports from the FPBD Committee meetings held on held 21 February 2022 and 28 March 2022.
011d	**Chair's Report from the Audit Committee** The Board considered the Chair's Report from the Audit Committee meeting held on 24 March 2022. Committee Chair and Non-Executive Director, Tracy Ellery, highlighted the following key issues: • Whilst robust assurance was provided on the Trust's data quality processes, the on-going challenge to data quality relating to the multiple clinical systems was highlighted. Noted that the implementation of Meditech expanse would significantly mitigate this risk.

	• The Committee received an outline of the developing ICS governance landscape and the potential implications on good governance and accountability for the Trust as a sovereign organisation. The challenges of maintaining good governance between organisations was discussed and the Committee agreed to maintain a watching brief on the emerging models of accountability to support the Board in responding effectively. • Three internal audit reports were received 1) Assurance Framework (meets requirements) 2) Never Events and Serious Incidents (Substantial Assurance) and 3) Quality Spot Checks (Medicine Management) (Substantial Assurance). • A draft Head of Internal Audit Opinion was noted. This provided a draft substantial assurance opinion. The Board of Directors: • Received and noted the Chair's Report from the Audit Committee meeting held on 24 March 2022.
011e	Chair's Report from the Charitable Funds Committee The Board considered the Chair's Report from the Charitable Funds Committee meeting held on 21 March 2022. Committee Chair and Non-Executive Director, Tracy Ellery, highlighted the following key issues: • The Committee received positive assurance of fundraising against the targeted charity appeals including, big Tiny Steps, and Mona Lisa Laser. • The Committee noted that a number of operational issues had been escalated from the Fundraising Update, including difficulties to deliver projects to completion and digital issues to utilise the onsite fundraising pay terminals. It was recommended that an escalation process should be utilised by the fundraising team to address issues. • The Committee received an annual review of the Investment Portfolio. A detailed discussion was held to consider whether further exclusions should be applied to align with the Green environmental aims of the Trust whilst not destabilising the investment portfolio of the Charity. The Committee did not support the proposal to maintain the current position and requested proposals for a suggested timescale for the Charity to disinvest in oil, gas and fuel. It was agreed that this would be received at the next formal meeting in June 2022. • The Committee discussed the creditors owing to the Trust, noting an estimate of £100 - 110k interdebtedness between the Charity and the Trust at year-end. Reduction of the level of debt had been delayed due to the impact of Covid-19 on fundraising activity. The Committee requested a trajectory to complete payment. It was noted that a plan would be provided to the next meeting and would include repayment of the interdebtedness. The Board of Directors: • Received and noted the Chair's Report from the Charitable Funds Committee meeting held on 21 March 2022.
012a	Corporate Objectives 2021/22: Final Outturn Review The Board received the final outturn review against the 2021/22 Corporate Objectives, noting that the detail had been considered at the aligned Committees. The Board of Directors: • Received the report, and; • Noted the performance / progress to date against the 2021/22 Corporate Objectives.
012b	Proposed Risk Appetite Statement for 2022-23 The Board considered the proposed Risk Appetite Statement for 2022-23, noting that following scrutiny at the aligned Committees, there was a recommendation that it remain unchanged from the 2021-2022 statement.

	The Board of Directors: • Received the recommendations of its committees regarding risk appetite and risk tolerance levels for 2022-23, and; • Approved the Risk Appetite Statement for 2022-23.
012c	**A new approach to non-executive director champion roles** The Trust Secretary explained that over the last few years within the NHS, there had been an increasing focus on the designation of Board Champions and nominated leads designed to engender board level commitment and focus around key areas of service development or delivery. In response to this issue, NHS England had worked with stakeholders to review the issues the roles were originally established to address, to consider the most effective means of making progress now. There remained a small number that were statutory requirements and some that still required an individual to drive change or fulfil a functional role. Other functions were suggested to be aligned with the responsibilities of Board Committees. Following consultation with the Board, it was proposed that the following NED champion roles be retained: • Freedom to Speak up • Safeguarding • Board Maternity Safety Champion • Wellbeing The following roles were proposed to be removed with assurances being reported via relevant Committees: • Termination of Pregnancy • Mortality • End of Life Care The Board of Directors: • Agreed the proposed changes to the Trust's NED Champion roles *The following items were received under the 'Consent Agenda'*
013	**Board Assurance Framework** The Board of Directors received the Board Assurance Framework.
014	**Trust Board Terms of Reference** The Board of Directors approved the Board Terms of Reference.
015	**Board Committee Annual Reports, 2022/23 cycles of business and Terms of Reference** The Board of Directors approved the following documents: • Committee Annual Reports for the Quality, Finance, Performance & Business Development, Putting People First and Charitable Funds Committees • Committee Business Cycles for 2022/23 for the Quality, Finance, Performance & Business Development, Putting People First, Audit and Charitable Funds Committees • Committee Terms of Reference for the Quality, Finance, Performance & Business Development, Putting People First, Audit and Charitable Funds Committees *The following item was removed from the consent agenda*
016	**Revised Risk Management Strategy for 2022-23** The Board received the draft Risk management Strategy for 2022/23 and it was noted that it had undergone a number of amendments and additions (most significantly in 2021) to reflect

	developments in the Trust's approach to assessment, management and mitigation of risk. The most significant of these was listed as follows: • Reviewed statement of intent from the Chief Executive (subject to finalisation by the Chief Executive) • Updated wording regarding the underpinning of the BAF by Key Strategic Threats • Risk team profile (and key contacts) including divisional governance management structure Non-Executive Director, Louise Martin, stated that there had been issues during 2021/22 with the identification of risks relating to the Trust's statutory compliance obligations and asserted that this issue should be acknowledged with an amendment to the Strategy. This amendment would provide additional clarity on the roles, responsibilities, and escalation routes for statutory compliance risks. There was agreement that the Strategy should be amended to reflect these comments ahead of being approved by the Board. The Board of Directors agreed to defer the approval of the 2022/23 Risk Management Strategy until the suggested amendments had been finalised.
017	**Review of risk impacts of items discussed** The Chair identified the following risk items and positive assurances: Risks: • The need to capture the lessons learned from the patient story, particularly the issues relating to Future Generations • Increase in the Serious Incident rate • Increase in the stillbirth rate trend • Continued workforce pressures • The Trust's financial position and long-term sustainability Positive assurances • WRES report outcomes • Endometriosis service accreditation
018	**Chair's Log** The following Chair's Logs were noted: • Quality Committee to review the deterioration in VTE performance.
019	**Any other business & Review of meeting** None noted. **Review of meeting** No comments noted.
020	**Jargon Buster** Noted.

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
5 May 2022

Key	Complete	On track	Risks identified but on track	Off Track

Meeting Date	Ref	Agenda Item	Action Point	Owner	Action Deadline	RAG Open/Closed	Comments / Update
7 April 2022	22/23/010b	Equality, Diversity and Inclusion Annual Report	Board development session to utilised to support the drafting of an ED&I Strategy	Chief People Officer	June 22	On track	
7 April 2022	22/23/009e	Bi-annual staffing paper, July-December 2021 (Q2 & Q3)	To include mandatory training compliance trajectories in future bi-annual staffing papers.	Chief Nurse & Midwife	Nov 22	On track	
7 April 2022	22/23/009c	Learning from Deaths Quarter 3, 2021/22	For the Board to receive a report on the Trust's stillbirth rate	Medical Director	July 22	On track	
7 April 2022	22/23/009a	Quality & Operational Performance Report	To explore the impact on the patient experience due to the closure of the MLU.	Chief Nurse & Midwife	July 22	On track	
3 March 2022	21/22/173	Ockenden – One Year On	For a Board Development Session to be held on how best to utilise available ED&I data to identify areas of focus for improvement.	Chief People Officer & Chief Operating Officer	June 22	Complete	To be included within action 22/23/010b
3 February 2022	21/22/163c	Board Assurance Framework	For Executives to review and update the actions contained within their aligned BAF risks.	All Execs	May 22	Complete	Updated BAF on agenda – see item 42c
2 December 2021	21/22/118	Patient Story	For the Board to receive an overview of the work being	Chief Nurse & Midwife	July 22	On track	

			undertaken by the Patient Experience Matron in April 2022.				
4 November 2021	21/22/86c	Cheshire & Merseyside Women's Health & Maternity Services Programme Update	For the April 2022 Board to receive an update on the work undertaken by the Women's Health & Maternity Services Programme to reduce health inequalities.	Chief Operating Officer	~~Apr 22~~ July 22	On track	Owing to length of April's agenda, this item has been deferred to July 2022.

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	07.04.2022	To review the deterioration in VTE performance Lead Officer: CN&M	Quality	May 2022	On track	
Received	24.03.22	To receive a proposed method of assessing the maturity of Divisional Governance arrangements to support the Audit Committee in undertaking reviews. Lead Officer: TS	Audit	July 2022	On track	
Delegated	03.02.22	To review the development of a business case for an expanded endometriosis service. Lead Officer: CFO	FPBD	October 2022	On track	To be progressed through the Divisional Operational Planning process with an update provided to the FPBD Committee as part of the six month review of progress.
Delegated	06.01.22	To receive an update on the progress with wellbeing actions, particularly those that provide guidance for line managers to support their direct reports.	PPF	May 2022	On track	

		Lead Officer: CPO				
Received	20.12.21	Remitted a combined report to note quality impacts, commissioning needs and the wider system which support the Trusts key strategic items to the Trust Board. Executive Lead: Medical Director	Quality	April 2022	Complete	Divisional Transformation Plans will be communicated to the Board. Referenced within item 039c
Delegated	02.12.21	To receive a review of the learning from the Major Incident and its implications for the Trust's EPRR arrangements. Lead Officer: Chief Operating Officer	FPBD	April 2022	Complete	Received within EPRR Annual Report

Liverpool Women's
NHS Foundation Trust

CEO Report

Trust Board
May 2022

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.

Section A - *Internal*

Tributes being paid to renowned gynaecologist and obstetrician, Bob Atlay who has passed away

Many of you may be aware that Bob Atlay, a renowned gynaecologist and obstetrician who was fundamental in shaping women's health in Liverpool, has passed away after a long illness.

Bob's vision and drive helped to modernise gynaecology and obstetrics in the city as well as being instrumental in creating the Liverpool Women's Hospital as we know it today. Bob served as the Trust's first Medical Director from 1996 for a period of 5 years, as part of a 41-year career in the NHS before retiring in 2001.

Many tributes have been paid to Bob which have been featured in the Liverpool Echo along with an obituary in due course.

I think John Kirwan, Consultant Gynaecologist who was a colleague of Bob's during his time at Liverpool Women's, speaks for many who worked alongside him with this tribute:

"We are sorry to hear of the death of Bob Atlay who was a leading light in obstetrics and gynaecology. He was an inspiration to generations of doctors in training who have now become the consultants who are leading, developing and delivering high quality care in women's health. Robert Atlay was a fantastic teacher for undergraduates and junior doctors alike. He treated students with respect and was very inclusive of his junior doctors, and even as a medical student you felt part of the team rather than just someone who was hanging around getting in the way. He will be remembered fondly by many."

We have shared our condolences with Bob's family and our thoughts are with them at this sad time.

Section A - *Internal*

New Director of Midwifery and Head of Midwifery appointments
We are pleased to announce two new permanent senior leadership appointments to support the Family Health Division.

Yana Richens has been appointed to the role of Director of Midwifery. This is a new Trust leadership role reporting to the Chief Nurse and Midwife. Yana is currently Director of Midwifery at Whittington Health NHS Trust in London.

Heledd Jones has been appointed to the vacant role of Head of Midwifery. Heledd is currently Head of Midwifery and Gynaecology Nursing in Betsi Cadwaladr University Health Board, North Wales.

Both Yana and Heledd will be joining LWH in the next few months. We look forward to welcoming them to the Trust and they look forward to meeting many of you when they commence their roles.

BGCS Annual Scientific Meeting in 2024

The Trust has been successful in securing a successful bid for Liverpool to host the British Gynaecological Cancer Society Annual Scientific Meeting in 2024. Congratulations to Mr Mohamed Mehasseb and his team for putting together an excellent application.

WRES Report 2021

The NHS Workforce Race Equality Standard by WRES has been released. We are proud to be the top performing Trust nationally in 2 of the 9 key indicators and in the top 10 nationally for a further 2 indicators. This is a great demonstration of how Liverpool Women's prides itself on being an organisation of equality.

https://drive.google.com/file/d/1mo-uo4nopciSb8d2fz7L1fsytdbH83wI/view?usp=sharing

Section B - *Local*

New Chief Nurse appointed at Liverpool University Hospitals NHS FT
David Melia has been appointed as the new Chief Nurse at Liverpool University Hospitals NHS FT joining from The Mid Yorkshire Hospitals NHS Trust, where he has been Director of Nursing and Quality since 2015.

Originally from Liverpool, David is both a Registered General Nurse and Registered Nurse for People with Learning Disabilities. His main clinical speciality is neurology and neurosurgery and he has previously held Director of Nursing roles at The Walton Centre NHS FT and Warrington and Halton Teaching Hospitals NHS FT.

David is due to start in post on 18 July. Until that point Dame Elaine Inglesby-Burke will continue as Interim Chief Nurse.

Cheshire and Merseyside Specialist and Acute Trusts Briefing
Please see the monthly briefing (March 2022) attached as *Appendix 1*

Stakeholder newsletter: Women's Health and Maternity (WHaM) Programme for Cheshire and Merseyside
Included in *Appendix 2* is the first issue of the new quarterly newsletter. WHaM has produced this to keep their partners and stakeholders informed about all the work they are driving forward in women's health and maternity services across Cheshire and Merseyside.

Section C – *National*

Elective recovery plan to boost capacity and give power to patients

The NHS and government have set out a blueprint to address backlogs built up during the COVID pandemic and tackle long waits for care with a massive expansion in capacity for tests, checks and treatments.

NHS chief executive Amanda Pritchard and Health and Social Care Secretary Sajid Javid announced that the health service will build dozens more community diagnostic centres as part of the new elective care recovery plan.

The 'Delivery plan for tackling the COVID-19 backlog of elective care' will also give patients greater control over their own health and offer greater choice of where to get care if they are waiting too long for treatment.

https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/

Summary of statutory board meetings: CQC and HEE, March 2022
March's summary includes updates on Care Quality Commission's operations, vaccinations as a condition of deployment (VCOD) and the continuing pressures on acute services. Health Education England's meeting included updates on HEE's support for Ukraine, the medical doctor degree apprenticeship and the recovery plan.

https://nhsproviders.org/media/693322/summary-of-statutory-board-meetings-cqc-and-hee-march-2022.pdf

Section C – *National*

NHS Providers overview of the Health and Care Act 2022

The Health and Care Bill received Royal Assent on 28 April 2022, becoming the Health and Care Act 2022. Since the Bill's publication last July, NHS Providers have worked extensively with the Department of Health and Social Care (DHSC), NHS England and NHS Improvement (NHSE/I) and other key stakeholders to help ensure the views of trust leaders shaped the legislation.

This is the biggest change to health legislation in a decade. NHS Providers have summarised below some of the main provisions of the Act and the implications for trusts and systems. You can see a link to their press release here

CMAST
Cheshire and Merseyside Acute and Specialist Trusts

Cheshire and Merseyside
Health and Care Partnership

CMAST Briefing

March 2022

ICS Development

The proposed date for statutory integrated care arrangements to take effect remains 1 July 2022. This is when NHS Cheshire and Merseyside Integrated Care Board (ICB) will be legally and operationally established. The work towards organisational redesign is continuing at pace.

Place appointments

Since the last update, Place directors for NHS Cheshire and Merseyside Integrated Care Board have been confirmed as follows:

Place	Appointed place director
Cheshire East	Mark Wilkinson
Cheshire West	Delyth Curtis
Halton	Anthony Leo
Knowsley	Alison Lee
Liverpool	Jan Ledward
Sefton	Deborah Butcher
St Helens	Mark Palethorpe
Warrington	Carl Marsh
Wirral	Simon Banks

Find out more about the Place Directors, here.

CMAST Development

CMAST chief executives met in March to continue their development work, the session was supported by Mike Farrar and Rob McGough from Hill Dickinson. The March session focused on routes and approaches to decision making. The group took stock on two live issues, one related to clinical pathways (trauma and orthopaedics), the second scenario related to pathology. These examples were considered within the context of CMAST's emerging structures, exploring the issues that need to be considered during any decision making.

Discussions included:

- How priorities might be identified and set
- Scoping and solution identification
- Proposals, including case for change, programme / initiative structure and leadership
- Decision making, including communication and engagement
- Implementation, monitoring and consequence management (in line with any decision making)

CEOs are supportive of continued development of the agreed CMAST priorities into a work plan and the encouragement of networks and system leaders to identify and develop proposals for future consideration. Further work has been identified to continue the development of these principles, progress will be reported to April's CMAST meeting as we build toward a joint Chair and CEO CMAST meeting in May.

CMAST Business Meeting

CMAST received an update and /or agreed action in the following areas:

- Elective Programme Implementation
- 104 week wait activity and actions
- Elective Capital Prioritisation and reporting to the System Oversight Board
- 22/23 Planning Process

Elective Recovery and Transformation Programme

Capital funding

- Cheshire and Merseyside has been allocated £76m of elective capital over 3 years.
- Providers were given the opportunity to submit bids for this capital funding. Across the 13 providers in C&M, 54 bids were received. National guidance requested individual bids of no less than £5m, with a strong focus on the creation of major schemes to establish/expand elective hubs for system use and to increase mutual aid capacity. An MDT panel reviewed the bids against an agreed set of criteria.
- The final list of bids has been submitted and we are now awaiting regional decision.
- We will be developing a 'plan B' list with next level priorities for any additional funding that is made available in the future.

Elective hubs

The two elective hubs are both due to open in June/July 2022; these will be available as flexible system resources

- Elective Hub 1: Broadgreen site, enhanced treatment room, local anaesthetic cases only – with option to use x-ra
- Elective Hub 2: Clatterbridge Site, 2 modular laminar flow theatres, available for a mixture of specialities to reduce the longest waiting patients.

In addition, the programme is working with the three Cheshire acute trusts to develop the elective hub within the Cheshire area to support that population.

Project highlights

- There remains an intense focus from national and regional colleagues on the clearance of 104+ waits by 1st July 2022. The weekly task and finish PTL intensive support group continues to meet, working with specific organisations to track and monitor the long waiters, and to offer support and escalation routes for the key issues experienced by the WL teams. The group have increased the focus on 93+ week waiters and the next step will be to increase the 78 week tracking. TCI dates will be a key focus with expectation that patients will be confirmed dated and not 'pencil dates'.

- The programme is implementing My Planned Care (MPC) across the C&M system. The objective of the MPC platform is to provide patients with information relevant to the hospital and specialty they are under the care of, to ensure that they remain at optimal health while they are waiting for treatment, and to provide information about the likely length of their wait. All North West trusts are working hard to ensure patient guidance for all their specialities and associated procedures is ready and available on the platform, which is already live at https://www.myplannedcare.nhs.uk/nwest

Diagnostics Programme

Community Diagnostics Centres (CDCs)

- 5 CDCs are operational in C&M with plans for additional 4 submitted and regional approval received.
- Work is commencing to implement standardised pathways in key symptom areas; this is expected to result in faster diagnosis, standardisation and equity of access.

Pathology

- Work has commenced to compile the full business case for the 3 hub model. Aiming for full business case detailing the benefits of progressing to Diagnostics Delivery Board by September, for individual boards to sign off by December 2022 with a view to implementation commencing 2023. Trusts are asked to prepare to provide all necessary information (finance, staffing, activity etc) for full due diligence to take place.

Endoscopy

- Capital procurement agreements for trans nasal endoscopy equipment has delivered a saving of £570k.
- C&M Trans Nasal Endoscopy Service commenced In Liverpool. Procedures offered to 4000 patients waiting for gastroscopy.
- Additional 1536 patients will be seen in March as a result of co-ordinated provision of weekend lists.
- All Trusts have committed to deliver 12 points per 4 hour list. Is your Trust delivering on this? Please ask your teams how they are doing and what they need to be able to deliver this agreed level of activity.

Radiology

- 12 international recruits have been offered posts in C&M.
- Network Stakeholder Survey: 69% agreed that there has been an improvement in gaining access to images in C&M and 61% agreed there is a need to change how services are delivered in C&M.

Echocardiography

- C&M activity is 24% down compared to 2 years ago. C&M action plan in place. All trusts asked to review performance.

Urgent and Emergency Care – Gold Command

- The C&M UEC Gold continues to meet weekly bringing together the UEC and Out of Hospital teams. The Acute UEC Silver Cell currently meets 3 times a week.

- High bed occupancy continues to create significant operational pressures for acute providers, with this being the longest sustained period of exceptionally high occupancy levels the system has experienced. As of 30th March, 4 providers were operating at 100% G&A bed occupancy, with the remainder in the high 90's.

- There remains a continued lack of discharge flow for patients no longer meeting criteria to reside to Pathway 1, 2 and 3 settings. As of 24th March,

- This is associated with the continued closure of a substantial proportion of care home capacity across the region. This problem is intensifying with the increase in community infection rates. As of 30th March, the system has 91 care homes fully closed and 12 with partial closure. In addition, there is significant pressure being experienced within domically care resulting in increased numbers of patients waiting for care packages.

- Over the previous two weeks, front door demand on A&E has increased with some trusts experiencing higher numbers than pre-pandemic levels. The lack of exit flow has resulted in further pressure through A&E, in terms of ambulance handover delays and time in department. Modelling suggests this pressure will continue to increase over the next 2 weeks.

- IPC guidance has been cited as a significant contributing factor to the pressures being seen. An informal data request on 23 March 2022 showed circa 145 beds closed as a result of IPC across the acute providers. A number of providers have implemented local policies to manage risk and ensure the safety of patients, and this has been shared across the system. This has been escalated to the regional and nationals team and updated IPC guidance is due to be released in the coming weeks.

- Trusts have seen a clear and sustained uptick in staff sickness, with C&M reporting an average of 8.5% and some Trusts reporting >10%.

- The majority of acutes in C&M have seen in excess of 12% of patients spend longer than 12 hours in department from time of arrival over the last 6 weeks. In terms of ambulance handover times, for C&M over the past 6 weeks, an average of 7.5% of ambulance handovers have been delayed by over 60 minutes, with particular issues concentrated at LUHFT, STHK and WHH in the previous week.

- C&M acute trusts have continued to undertake elective activity wherever possible. However due to staff sickness, non-elective pressures and the lack of bed capacity, elective activity has been impacted. Since January, this has resulted in approximately 300 cancellations per week across C&M.

Finance

Over the past month work has been focussed on delivering a year end balanced financial position across Cheshire & Merseyside and planning for 2022/23. A number of financial plan submissions have been made for both revenue and capital, and whilst each iteration has improved, Cheshire & Merseyside is still forecasting a significant revenue deficit. Further reductions in this deficit are required and work is being undertaken with individual organisations to explore balance sheet opportunities.

Three supporting workstreams have been established to support delivery. These are: financial strategy, governance and risk, and assurance and regulation. The key workstreams will meet the 3 aims of:

- Incentivising recovery and delivery
- Moving of sustainable financial balance
- Making effective decisions

The work stream SRO, Jane Tomkinson, and the newly appointed ICB Chief Finance Officer, Claire Wilson, are producing a proposed timetable supported by collaborative forums to deliver on these workstreams.

Workforce

HR Directors across the system are working together with an aim of improving the workforce supply, training, and development for the following key staffing groups:

- Midwifery / Neonatal
- Paediatric nursing
- Echocardiology staffing
- Critical care nursing
- Acute adult nursing (international recruitment)
- New roles including physicians associates and anaesthetic associates
- Pharmacy – including pharmacy assistants
- Elective recovery
- Clinical placement capacity

Programme plans will be developed over the next few weeks.

In addition they will look to provide professional HR support to some of the established programmes including diagnostics and elective recovery Board.

This work will feed into the wider Cheshire and Merseyside ICB people strategy.

Funding has now been secured from the Cheshire and Merseyside People Board to support some of this work.

Women's Health and Maternity Matters

Cheshire and Merseyside Health and Care Partnership

NEWSLETTER APRIL 2022

Welcome to the first issue of our new quarterly newsletter. It aims to keep our partners and stakeholders informed about the Women's Health and Maternity (WhaM) programme of work that we are driving forward on behalf of the system across Cheshire and Merseyside.

Our vision is for all women, babies, and families to have the best start in life and get the support they need to be healthy and live longer. Transforming women's health and gynaecology services is a key priority across the region and the WHaM programme has launched a Gynaecology Network which will identify opportunities to work collaboratively to improve clinical services, provide equitable access to care and support, improve women's health outcomes, including a return to the services we had prior to COVID-19, wherever possible and when safe to do so.

Women's Health and Maternity Services have had significant press attention over the past few weeks with the release of the final Ockenden Report into maternity safety at Shrewsbury and Telford Hospital NHS Trust. We have also had national news reports detailing increasing waits for gynaecology diagnostics, services and treatment. In December we saw the release of the national vision for women's health from NHSE/I, and the promise of a national women's health strategy in the Spring.

The latter is a milestone that we acknowledged at our events on 8 March to celebrate International Women's Day 2022. There, I stated that it is time to re-set the dial on women's health and transform a system which offers equal access to effective care and support, prioritising care on the basis of need, and raising the profile of risk factors and conditions which have not had the focus and recognition they have deserved for many decades.

Our response has been to initiate an exciting programme of work that promotes and proactively supports enhancing the wellbeing, life chances and outcomes for all women, babies and families across Cheshire and Merseyside.

I also emphasise later in this newsletter our commitment to deliver safer, more equitable maternity services and implement all of the Immediate and Essential actions of the Ockenden Report in all seven of our maternity providers. Ensuring that safety and the voices of women and their families is at the heart of all we do.

We have engaged with our community all the way through this journey and listened to their concerns on everything from fertility to mental health care. We note the increasing links between poverty and impoverished health and recognise that as a system we have a responsibility to reduce health inequalities.

As a programme, we are committed to identifying and exploring non-clinical interventions through social prescribing and through partnerships with others. We also have a successful track record on applying social prescribing innovations to reduce health inequalities.

Some of that work is detailed here. Please, read on, and for a newsletter to remain relevant and important, remember we always need your constructive feedback.

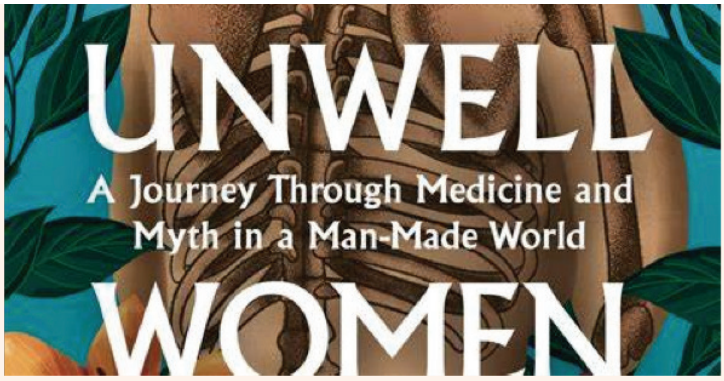
Catherine McClennan
Director for the Cheshire and Merseyside Women's Health and Maternity (WHaM) programme

HEE makes her health, top priority

Health Education England (HEE) brought a novel approach to talking about health on International Women's Day – by featuring medical writer Dr Elinor Cleghorn at an online event.

The author of the celebrated book, "The Unwell Woman" delivered a presentation charting historic misogyny in medicine as she revealed: "As an unwell woman with lupus, I was dismissed, ignored, belittled, I must be hysterical or anxious."

The webinar considered why this 'male by default' is a huge problem for all women and sought solutions. How do we put it right and what needs to happen to build equity?



It also focused on gender, poverty, and health, plus inequalities exacerbated by the COVID-19 pandemic.

WHaM Social Prescribing Lead Jo Ward concluded: "Today is a rallying call to women. Our voices have become stronger and now is the time to shout louder."

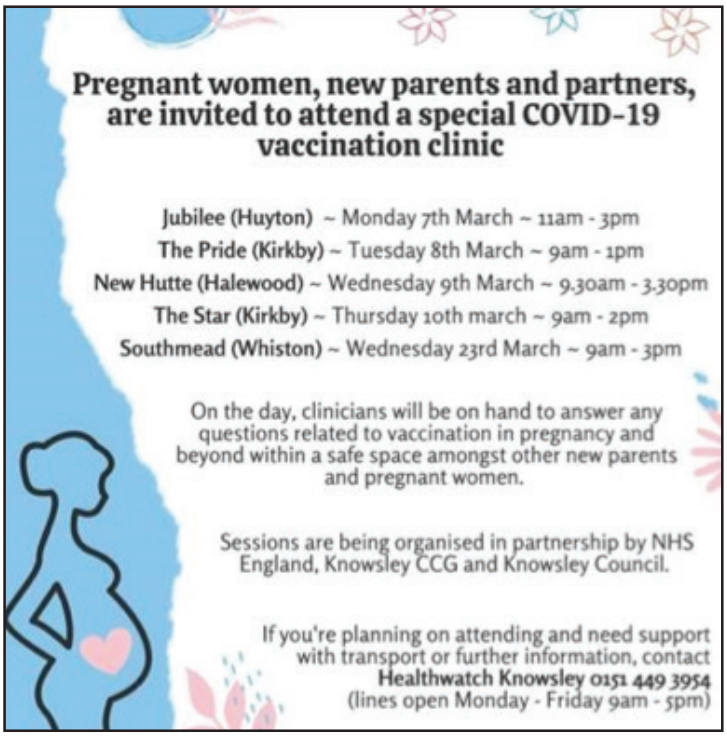
Aiding a sharp rise in vaccinations

A series of clinics backed by our service have helped increase the number of pregnant women receiving a COVID-19 vaccination in Cheshire and Merseyside, to 69%.

Concerns around everything from future fertility to passing the coronavirus onto your unborn child resulted in an initially poor uptake of the vaccine nationally, with a recorded high last October of just 41%.

A pop-up clinic at our International Women's Day event at The PAL Centre in Toxteth, offered women the vaccine and assurances from professionals of its effectiveness and safety.

Dr Devender Roberts Consultant Obstetrician in Fetal Medicine, Liverpool Women's NHS Foundation Trust said: "I am delighted we have made a contribution in reducing fear and scepticism around the vaccine, but the fact that 30% of pregnant women in our region are not protected, means this challenge is far from complete."



Prioritising Ockenden

News headlines have been dominated by the findings, conclusions, and essential actions highlighted in the enquiry into deaths at maternity units in Shrewsbury and Telford.

Those 15 essential actions from the Ockenden Report focus on four themes: safe staffing; training, learning from incidents and listening to families.

As a Local Maternity Neonatal System (LMNS), we have reflected carefully on the report, and urge everyone working within maternity and indeed any health services to do the same (read the full report at https://bit.ly/3xkoiMi) .

We are keen to embed Ockenden into our work and help support improvement in maternity and neonatal services across the Cheshire and Merseyside system.

Our workforce are key players in this process, at what may be a difficult time for them. As one of the main thrusts of the report is enhanced communication, we will continue to listen and learn from those delivering the service on-the-ground. One of the key tools of this engagement process is an online survey, recently distributed to our teams.

The response to Ockenden is very much underway and it is also extremely encouraging to learn that developments are being implemented in the wake of the report, at trusts across our region and beyond.

Silver Birch golden opportunity to tackle trauma

Our specialist midwives are working with Mersey Care NHS Foundation Trust in a unique psychology and midwifery scheme to help women who have suffered trauma/perinatal loss in the maternity and neonatal setting.

A trio of hubs in Wirral, Liverpool and Mid-Mersey (St Helens and Knowsley) have already begun piloting the programme with a dozen women experiencing severe to moderate mental health issues.

Called the Silver Birch Hubs, the clinical priority is to "triage, arrange appointments (consultation) and then to offer a trauma informed birth planning or a grounding and stabilisation group."

One service user said: "I just wanted to thank you setting this up. I really feel better today even after just 1 meeting. It was really interesting, and I enjoyed the session too, thank you."

The Lullaby project - making music together

The Cheshire and Merseyside Women's Health and Maternity (WHaM) programme commissioned the Lullaby project in 2021, after reaching out to Carnegie Hall, New York, and the national charity, Live Music Now, founded by the legendary violinist Sir Yehudi Menuhin and current president Sir Ian Stoutzker.

Working through the WHaM community engagement team with families, the NHS and Live Music Now co-produced a creative intervention to boost wellbeing through an approach that capitalised on 'togetherness' through music.

The Lullaby Project was in part a direct response to the devastating impact of isolation during COVID on both maternal and infant wellbeing but equally in recognition of a pre-existing perinatal mental health crisis amplified by lockdowns. It's based on a simple but effective formula, pairing new mums and 'mums to be' with their own musicians to write and create a very personal lullaby. It has helped women build bonds with their babies and created lasting memories too. It has given women the confidence and inspiration to tune-in and make music and poetry themselves to ensure they stay well.

Delivered by Live Music Now, on behalf of WHaM, the six-session programme sees women create and perform songs for their babies – which are then recorded and performed at a very special concert, the first being held at National Museum Liverpool in December; with others being planned.

One Cheshire mum said: "I think it was really, really special to have something so personal for my son. I just started writing my lullaby and couldn't stop!" Another added: "The whole process and getting to this point was fabulous. I am buzzing."

Lullaby's success was even more remarkable given that it was conducted often online in homes and not face to face – because of lockdown.

Hopes are high that the first face-to-face sessions prove an even bigger hit, with lullabies written and recorded with professional musicians as a keepsake and performed at another grand event this time in collaboration with members of another WHaM creative health project, Holding Time; where women are embracing writing themselves well through poetry and very personal, amazing prose.

This all goes to show women are never just a mum and this is key to wellbeing too. Listen to our Sound Cloud podcast, by visiting https://bit.ly/3KMZrVH

Maternity taskforce long overdue

Cheshire and Merseyside have amongst the poorest health outcomes for mothers and babies in the UK because they are held back by, "environment, life conditions, life chances and access to adequate help and support for our most vulnerable families".

So says Catherine McClennan in a blog for political communications agency, Whitehouse, in which she offers a passionate plea to society to even-up the disparities in health and supports the creation of a new Maternity Disparities Taskforce.

Catherine claimed: "It's taken over 70 years to get women's health on the NHS agenda and yet we have known for a long time that looking after women in pregnancy helps to deliver the best outcomes for babies. But many of the various initiatives and policies to improve maternity services and reduce maternal and infant mortality are not working. This is why our work and focus on health inequalities is so important."

Read the blog at https://bit.ly/3NfiOrW

Singing beginning to Women's Day event

Merseyside and Cheshire women have found out that singing is just what the doctor ordered – literally.

Because they are the first in the country to be given singing lessons on prescription to help assuage mental health issues including depression and isolation.

And guests to our International Women's Day event at the PAL Centre got a taste of the Singing Mama's project before embarking on a day of activity celebrating women healers and highlighting health inequalities.

Meet the team... Saluting SIPs

Welcome to our Smoking in Pregnancy (SIP) team.

Funded by the Cheshire and Merseyside Cancer Alliance (with delivery by the WHaM Programme) as part of their prevention and early diagnosis programme, it aims to increase the quit rates of women smoking in pregnancy and at birth and promote smoke-free pregnancy pathways and supportive interventions.

Some 8.8% of mothers nationally were known to be smokers at the time of delivery (as of Quarter Three, 2021/22), with rates in Cheshire above that, at 10.6%.

This is an exciting opportunity for the LMNS system to work together to tackle the high smoking rates in pregnancy.

The project team consists of Kerry Hogan (Project Manager), Lara Nilssen (Lead Midwife for SIP) and Jo Hunt (Lead Midwife for Health Inequalities). Planning and preparation work is underway, and the team will be inviting several stakeholders including local authority commissioners, CCG commissioners and Stop Smoking Service providers, to come together in the next few weeks to support with the planning and mobilisation of the national delivery model for smoke-free pregnancies.

For further information, please contact Kerry Hogan, Maternal Health Inequalities Project Manager, Women's Health and Maternity (WHaM) Programme kerry.hogan@nhs.net

Want to feature in Meet the Team?
Contact info@improvingme.org.uk

Andrew appointed to ensure equity and excellence in gynaecological services

Eminent Liverpool gynaecologist Professor Andrew Drakeley has been appointed Clinical Lead for Cheshire and Merseyside, Gynaecology Network (CMGN).

Established in November 2021, the CMGN is a key mechanism which focuses on improving access to services and treatment, improving clinical outcomes, and reducing health inequalities in women's health. The network addresses these priorities in collaboration with partners and aligns with work already taking place in the wider system.

Women's Health Project Manager Deb Edwards reported that special interest groups have been established with menopause and endometriosis making headway with collaborative plans to share learning and reduce waiting time for diagnosis and treatment of these debilitating conditions. The remit of these groups will be to look at the equity of services provided throughout our region, skills and competencies of the workforce and ensure that services, pathways and guidelines are standardised across primary, secondary and tertiary care.

Our priorities were established during a call for action to help inform the Government's first Women's Health Strategy. This included a public survey open to all individuals aged 16 plus, evidence from individuals or organisations with expertise in women's health and feedback collated from focus groups.

News in brief

Award scored for sparkling inequalities work

Midwives from the Diamond Team at NHS Mid Cheshire Foundation Trust scooped the Person and Family Care Award 2022 at the Professional Pride awards ceremony.

This rewards excellence in practitioners being advocates for those receiving services and reducing health inequalities. The team's work with diverse communities was commended. Do you have a success story to share with us?
Email info@improvingme.org,uk

Make some news

Our newsletter is just one element of a concerted drive to keep our partners and stakeholders informed about all the work we are driving forward in women's health and maternity services across Cheshire and Merseyside.

We are also committed to showcasing partners, as well as our work.

To join us on that journey and maybe even feature in our next newsletter, please email info@improvingme.org.uk

You can follow us on social media –
https://twitter.com/Improvingme1
https://www.facebook.com/Improvingme1/

Survey underway to allay concerns on inequalities

Research with people whose views are less likely to be heard by professionals is informing a plan to reduce the disparities revealed by COVID-19 in the quality of healthcare. Using online and face-to-face feedback plus a women's health and wellbeing survey, the Equity and Equality plan will be completed by a Task and Finish team in collaboration with leading academics.

Cheshire and Merseyside Women's Health Event

Hold the date – Thursday 7 July 2022, Aintree Racecourse. More details will follow.

Stillbirth study carried out

According to the Office for National Statistics, the UK stillbirth rate reached a record low with the largest decrease recorded since 1927. In 2014, the government announced policies and campaigns to reduce the rate of stillbirths by half in England by 2025 compared with 2010. Our Clinical Lead has been instrumental in national work in this field as well as a recent local review of all stillbirth cases over a two year period in Cheshire and Merseyside. Although this found that we did have lower rates than the national average there were common themes regarding language and additional risk assessments for our most vulnerable women. Further work will be led by Dr Devender Roberts as part of her Quality and Safety remit.

For further information, contact devender.roberts@lwh.nhs.uk

Helping the excluded connect

Language and cultural barriers, plus a lack of access to the internet are creating greater inequalities in women's health, with missed appointments amongst the issues caused. Which is why the Digital Inclusion Project proved such a hit with women in Toxteth, who claimed it enabled them to communicate with confidence.

In fact, so enthused were some delegates that they plan to enrol on further accredited IT courses while another has been offered an apprenticeship!

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/038a***		**Date: 05/05/2022**	
Report Title	**Ockenden Report – Final**			
Prepared by	Marie Forshaw Chief Nurse & Midwife Angela Winstanley Quality & Safety Matron.			
Presented by	Nashaba Ellahi – Deputy Chief Nurse & Midwife			
Key Issues / Messages	**The report provides an update on the Trust's progress relating to the Ockenden Interim Report and outline the immediate steps taken after the publication of the Ockenden Final Report in March 2022, providing a comparison between the key areas of focus between the Interim and Final Reports. An outline of the process and assurance mechanisms for managing the Trust's response to the Final Report is outlined.**			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – N/A ***If no – please outline the reasons for deviation.***			
	The Board is asked to note the report for assurance.			
Supporting Executive:	***Marie Forshaw Chief Nurse & Midwife***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 3.1 Failure to deliver an excellent patient and family experience to all our service users	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Board	March 22	DONM	Assurance provided re progress against Ockenden Interim Report.

EXECUTIVE SUMMARY

The report provides an update on the Trust's progress relating to the Ockenden Interim Report, noting that positive external assurance has been received from a planned visit from the Regional Chief Midwife (RCMW) team and the Cheshire and Mersey Local Maternity System representatives (LMNS).

The report continues to outline the immediate steps taken after the publication of the Ockenden Final Report in March 2022, providing a comparison between the key areas of focus between the Interim and Final Reports. An outline of the process and assurance mechanisms for managing the Trust's response to the Final Report is outlined.

The Board is asked to note the report for assurance.

MAIN REPORT

Introduction

On the 10 December 2020, Donna Ockenden, Chair of the independent review into maternity services at the Shrewsbury and Telford Hospital NHS Trust published an interim report following a clinical review of the first 250 cases where concerns had been raised over the care the patients received from the maternity unit at that Trust[1].

The report described important and emerging findings from the significant concerns raised from these reviews and their associated actions for all Maternity Units in England. The report outlined 7 immediate and essential actions (IEAs), with an associated 12 urgent clinical priorities (UCPs) that all NHS Trusts must implement.

The Board received a detailed report at an Extraordinary Board Meeting on 3 March 2022[2] which outlined the actions and work that had been undertaken at that point to enable the Trust to provide assurance that the full implementation of the Ockenden Essential and Urgent recommendations was underway. The report also provided an opportunity to reflect on the wider issues raised by the Ockenden Report (in addition to the points of compliance) that were identified by the Board in January 2021 and to consider the progress made against these and what future actions may be necessary. This report builds upon this assurance and provides an updated position on progress.

On 30 March 2022, Donna Ockenden published the final report detailing the findings, conclusions, and essential actions. This paper will outline the continuing themes between the final and interim report, highlighting any additional items or matters that will require enhanced focus. The paper will continue to outline the Trust's response to date since the publication of the final report and provide assurance to the Board that appropriate processes are being developed and implemented to ensure a robust response.

Progress against the Interim Report

In response to the publication of the Interim report on 10 December 2020, an Extraordinary Board was formed for the 7 January 2021. This meeting was the starting point of the assurance process for the Board. Progress reports continued to provided to the Quality Committee and the Board with the most recent of these updates being provided in March 2022. A detailed timeline of the Trust's activity and assurance processes is provided in Appendix 1.

Subsequently, on the 12 April 2022 the Trust received a planned visit from the Regional Chief Midwife (RCMW) team and the Cheshire and Mersey Local Maternity System representatives (LMNS). LWH was the first of eighteen trusts in the northwest region to welcome the RCMW Team. This 'Insight Visit' was planned to give the organisation an opportunity to showcase the final pieces of evidence and work completed to demonstrate compliance with the Interim Ockenden Report.

[1] https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust
[2] https://www.liverpoolwomens.nhs.uk/media/4112/20220303-trust-board-public.pdf

The Acting Head of Midwifery (HOM), the Quality & Safety Matron and the Consultant Obstetrician for Risk & Safety provided a presentation demonstrating the final stages of the progress to completion of the outstanding IEAs and UCPs, which was positively received by the Team and LWH Senior Leadership Team. This detailed our self-assessment of full compliance in 11 of the 12 UCPs. The RCMW team spent time discussing and analysis our final evidentiary work and was escorted around the Maternity Unit, where front line clinical staff were able to meet the visiting team. The team interviewed some of the available Family Health Leadership Team as well as other key members of the Maternity Team on the visit including:

- Interim Acting HOM (Deputy HOM Substantiative post)
- Quality & Safety Matron
- Consultant Obstetrician for Risk & Safety
- Governance Manager for Maternity
- Fetal Surveillance Lead MW
- Fetal Surveillance Lead Consultant.
- Educational Lead MW
- Antenatal and Newborn Screening Lead MW
- Maternity Safety Champions

There followed several in-depth discussions that centred around:

- Maternity Staffing – Challenges, the role of the preceptorship and retention programme, sickness and absence pressures relating to COVID-19 and recruitment difficulties.
- Saving Babies Lives Care Bundle Implementation and the challenges faced with some of the associated requirements
- Maternity Training – Core competency framework, LWH agreement to increase head room.
- Senior Leadership Investment with the recent appointment of a HOM and a Director of Midwifery (DOM).
- MVP engagement and the requirement of a rapid but quality appointment to the recently departed MVP Chair

The team gave some initial feedback on the day, which was positive and encouraging in nature. The team commented on the quality and content of the presentation and that the 'bar had been set high' for other organisations within the region to follow. It was noted that the Family Health Division leads had worked to an outstanding level of commitment and with a position of candour and openness where we initially deemed ourselves non-compliant, and subsequently undertaken the work to improve services at LWH. As such, the team commented that the Trust remained potentially overly self-critical in relation to the outstanding UCP of partial-compliance and had self-assessed too harshly. The Team commented on the inquisitive nature of the clinical staff and were pleased to see that staff felt comfortable in approaching them to discuss the findings of the interim report and what had been done locally, as well as the national challenges for front line staff working in Maternity. At the time of writing, a full, detailed response and review of the Insight Visit is awaited, but confirmation of full compliance with all IEAs and UCPs is anticipated.

The Northwest Regional Team requested that the Trust submit evidence of the Ockenden One Year One Report being discussed at public board in March 2022. In response to this, the BAAT which underpinned this was returned to the LMNS and regional Team by the Acting HOM following executive oversight. We await further feedback considering this submission at the time of writing.

Ockenden Final Report

As noted above, the final Ockenden Report was published on 30 March 2022. Everyone connected with maternity care will know that anyone who is receiving or providing maternity care – at Liverpool Women's and elsewhere – will have found reading this report particularly difficult. However difficult to read, the issues raised are vital for improving the safety of maternity care and we thank Donna Ockenden for leading the review but most importantly we thank the families who showed extreme bravery in sharing their experiences and whose contribution will help improve the safety of maternity services in the future.

Recognising that this would be a challenging time for both staff and patients, the Trust took immediate action to produce a staff bulletin and to enhanced senior leadership visibility. Information was also communicated via the Trust's social media channels.

Comparison between the Interim and Final Reports

The Interim Report listed seven essential actions:

1. Enhanced Safety
2. Listening to women and families
3. Staff training and working together
4. Managing complex pregnancy
5. Risk assessment throughout pregnancy
6. Monitoring fetal wellbeing
7. Informed consent

The Final Report includes 15 essential actions:

1. Workforce planning and sustainability
2. Safe staffing
3. Escalation and accountability
4. Clinical governance-leadership
5. Clinical governance – incident investigation and complaints
6. Learning from maternal deaths
7. Multidisciplinary training
8. Complex antenatal care
9. Preterm birth
10. Labour and birth
11. Obstetric anaesthesia
12. Postnatal care
13. Bereavement care
14. Neonatal care
15. Supporting families

The final report builds on the findings of the first Ockenden report reinforcing the importance of establishing and improving critical oversight of patient safety in maternity units. The patterns of poor clinical care identified in the final report mirror issues identified by previous national reports into maternity care. Themes include failures to follow national guidelines, work collaboratively across disciplines, escalate concerns and delays in transfer. Furthermore, the report highlights significant failings in governance procedures and leadership which resulted in repeated missed opportunities and failures to learn.

The review also acknowledges the huge pressure maternity services and staff continue to face, which have been compounded by the pressures arising from Covid-19. The most significant addition from the interim report, is the focus given to the importance of workforce planning and also the recognition of funding issues impacting workforce challenges, particularly in terms of recruitment and retention of midwives and obstetricians.

Trust response to Final Report

The final report has extensive published actions that require a detailed response from all Divisions within the Trust, inclusive of Neonatal, Governance, Maternity, Anaesthesia, Operational and Clinical Support Services. The approach that the organisation proposes to take in its strategic and operational response to the Final Report and the 15 essential actions will be comprised of:

- A comprehensive self-assessment and GAP analysis within all Trust Divisions to enable further learning from the final report.
- A formal governance and reporting structure will be established to provide scrutiny and assurance to Quality Committee and Trust Board on the progress against all Ockenden Report requirements. This will be overseen by the Chief Nurse & Midwife.
- Digital solutions to be sought to enable sighting of Ockenden Final Action Plan into the Trust Board Performance Report. As part of this, the Digital Team have been requested to explore the feasibility of creating an Ockenden Dashboard demonstrating evidence of progress against the essential actions.
- Discussion to be held with the Council of Governors on 12 May 2022 to provide assurance and identify key priorities for the communities we serve.
- Identification of leads at Divisional, Operational and Executive Level.
- Third line assurance planned with MIAA to undertake audit in Quarter 4 2022/23 on progress (scope to be agreed).

This will be an ongoing journey for all of us. We will be working and closely engaging with our staff, women, families, and partner organisations to make sure that we achieve and deliver on the essential actions in full. We will do this together through collaboration, learning and most importantly by listening to the women and families we care for. An update on progress will be provided to each Board meeting throughout the year, and if necessary, beyond.

RECOMMENDATION

The Board is asked to note the report for assurance.

Liverpool Women's
NHS Foundation Trust

Appendix 1

Detailed timeline of Ockenden Interim Report Assurance

10 December 2020

Publication of Ockenden Interim Report

18 December 2020

The Trust was supplied with a GAP analysis spreadsheet tool, from the Local Maternity Neonatal System, (LMNS), that allowed a basic review of current compliance against the 7 IEAS and 12 UCPs. Following a review of the available evidence to demonstrate and support compliance, the organisation submitted our self-assessment, utilising the spreadsheet against the 12 UCPs and 7 IEAs the LMNS on Friday 18th December 2020.

21 December 2020

A LMNS facilitated meeting took place on Monday 21st December 2020 where each Trust presented their self-assessment assurance ratings. The Maternity Safety Champions attended this meeting on behalf of the organisation. As a result, and following some concerns raised by Trusts within the region and in relation to compliance status of other providers within the region, all Trusts were asked to review their ratings and re- submit in light of this challenge. This resubmission was then submitted to NHS England/Improvement by the LMNS/Regional Teams. The organisation received positive feedback from the LMNS that LWH had provided thorough and robust evidence to demonstrate their self-assessment of compliance ratings. Out of the 12 UCPS, LWH rated six as partially compliant and six as fully compliant.

Partially compliant areas were:

- A plan to implement the Perinatal Clinical Quality Surveillance Model
- All Maternity SI's are shared with Trust Boards at least monthly and the LMS, in addition to reporting as required to HSIB (Healthcare Safety Investigation Branch)
- All women with complex pregnancy must have a named Consultant lead, and mechanisms to regularly audit compliance must be in place
- A risk assessment must be completed and recorded at every contact
- A Lead Midwife and Consultant Obstetrician for Fetal wellbeing
- All pathways of care clearly described in written formats on the trust website.

22 December 2020

The Trust also submitted a position statement to the LMS on 22 December 2020 in relation to the Kirkup report, a review into Maternity Care at Morecambe Bay NHS Trust in 2015. (https://www.gov.uk/government/publications/morecambe-bay-investigation-report).

In, 2015 an action plan from the Kirkup Report was created and monitored through the LWH Clinical Governance Committee (CGC) which reported to Governance and Clinical Assurance Committee (now Quality Committee), which is a subcommittee of the Board. It was noted in the minutes of CGC in November 2015 that the organisation did not have any outstanding actions.

Liverpool Women's
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Appendix 1

7 January 2021

The Trust Board received an Ockenden Position statement and the completed Board Assurance Assessment Tool (BAAT) on 7th January 2021. Following a review of the BAAT by the Board of Directors it was returned to the LMNS on the 15 January 2022.

At this time LWH self-assessed and rated ourselves once again against the 12 UCPs and 7 IEAs and declared the following:

- Implementation of the Perinatal Quality Clinical Surveillance Model: Partial compliance
- All maternity SIs are shared with Trust Board at least monthly and the LMS, in addition to reporting to HSIB: Partial compliance
- All women with complex pregnancies must have a named consultant lead: Partial compliance
- Risk assessment must be completed and recorded at every contact: Partial Compliance
- Every unit has a lead MW and Obs for Fetal Monitoring: Partial Compliance
- Pathways of care clearly described in written information format on the Trust Website: Partial Compliance

The Trust Board posed a number of questions in response to the BAAT draft presented on the 7 January 2021 and included the following:

1. How does the board get assurance that when an incident is raised, the loop is properly closed and evidence provided that practice has changed (Trust Wide)?
2. How the Board gets to hear the 'voice' of the patient and their families regarding their experiences. There was some doubt as to whether MVP is enough and/or whether the MVP should have a more visible presence at Board and its Committees.
3. How can the Trust take the lessons learned from Ockenden and apply across the organisation?

4 February 2021

Trust Board received a further Ockenden update regarding progress and a narrative supporting a response to the questions posed in relation to the 7 January 2021 BAAT. This paper also contained the finalised maternity workforce gap analysis, requested by the LMNS, which identified that a full Birth Rate Plus Assessment was clearly necessary. Positively, this update paper, identified that the FHD had completed the necessary actions to demonstrate partial compliance with IEA 6 and the fetal surveillance requirements.

Throughout the Ockenden response journey and in order to enable a robust and complete review of the maternity service against the Ockenden report and previous safety investigation (Kirkup) LWH planned to completed the following in order to provide a sustained, assured response to the recommendations:

- Establish a task and finish group to support progression of all 7 IEAs and the 12 UCPs with senior executive oversight.
- Created a standing agenda item on the monthly maternity risk and clinical meetings to review the progress of associated action plans.
- Regular reports to Family Health Divisional Board for oversight and challenge against compliance status.

Appendix 1

- Monthly reports to Quality Committee for assurance, these included consideration of cultural issues and qualitative factors as well as progress against actions.
- Quarterly reports to Safety and Experience Senate for assurance.
- Provide monthly updates to CCG and the CQC for assurance through CQRM meetings, with external attendance of CCG representative at the Task & Finish Group Meetings.
- Work closely with the LMNS to ensure that all actions are robustly in place, embedded and audited for assurance.

April – May 2021

In the months of April and May 2021, the Quality Committee and the Trust Board of Directors received an Ockenden update that detailed, once again our ongoing compliance against each of the 7 IEAs, 12 UCP's, workforce analysis and NICE Guidance implementation. At this time, the paper narrated a self-reported position of:

- IEA 1 - Partial Compliance
- IEA 2 - Full Compliance
- IEA 3 - Full Compliance
- IEA4 – Partial Compliance
- IEA 5 - Partial Compliance
- IEA6 - Full Compliance
- IEA7 - Partial Compliance
- Workforce Analysis – Full Compliance
- NICE - Partial Compliance

At this time, in the Ockenden Journey, the Family Health Division, led by the Maternity Safety Champions, continued to work through the recommendations and actions pertaining to the IEAs and UCPs. Other Divisions within the Trust were tasked with reviewing IEAs and UCP's, by the Medical Director and were asked to provide a report back in six months as to how lessons learned and information within the Ockenden report could be flexed and used to enhance clinical changes and improvements within their Division. The Task and Finish Group chaired by the Chief Nurse & Midwife continued to provide assurance and strengthened leadership around this workstream.

20 May 2021

The Family Heath Division Leads and Maternity Safety Champions participated in a Q & A forum facilitated and Chaired by the LMNS in relation to any further clarity required for evidence and the assessment process. Clarification included audit size samples, data collation and ongoing work by LMNS to support the actions pertinent to them. It was at this time, the Ockenden evidence portal was opened by the National and Regional team via the NHS Future Collaborations project. The FHD Quality & Safety Matron alongside Consultant Obstetrician Lead for Risk and Safety co-ordinated, completed work/audits and led on the gathering of the evidential supporting documentation to demonstrate work completed.

July 2021

The Quality Committee received a verbal update from the Chief Nurse and Midwife on progress in relation to the Ockenden workstream and confirmed that the organisation had received an allocation of funding to support the work, articulating that the sum of money was much lower than the request bid submitted.
November 2021

Appendix 1

Again, in November 2021, the organisations evidence following to the portal, the organisation was scrutinised and audited by the Clinical Support Unit (CSU) supported by NHSE/I. It was at this time, that feedback via the office Regional Chief Midwife the organisation learned of our results of the assessment of current compliance against the IEAs and UCPs. This assessment identified that of the 122 actions required to demonstrate compliance against the IEAs and UCPs, LWH successfully demonstrated 85 compliant actions and 36 non-compliant actions. Upon receipt of this feedback the head of Midwifery and the Quality & Safety Matron undertook a further review of the evidence. Cross checked against the CSU report and prepared for the appeals process led by the Regional Chief Midwife and her team in a scheduled visit to the organisation.

The Chair of the Maternity Voice Partnership was invited to Trust Board in November 2021 to discuss her role and engagement with service users and their families. Due to personal commitments, the MVP Chair was unable to attend in person and produced a pre-recorded brief of her role, her activities, and planned events and workstreams to support LWH families.

22 November 2021

The Quality Committee received a report from the Medical Director in relation to Trust Wide Services For Liverpool Women's, the underlying principles of the report applied to many services provided by the Trust. Each clinical division, in April and May 2021, was asked to look at the 7 IEAs and 12 UCPs and consider how those recommendations may be applied to their service. A further update was scheduled for Safety & Effectiveness Sub-Committee to in April 2022.

December 2021 – January 2022

The Regional Chief Midwife and team visited the organisation, where a full, open and transparent review of the Ockenden Submission evidence was undertaken by the Head of Midwifery and the Quality & Safety Matron. After the RGM Visit and review of the evidence the organisation learned, via the HOM on 9th December 2021 that a successful appeal was granted and that Liverpool Women's successfully appealed against the some non-complaint actions. Confirmation included that Liverpool Women's remained non-compliant against 7 of the 122 actions required. This information was reported to Quality Committee on the 24 January 2022 and included a action plan and details to turn all remaining non-compliant actions to completed status.

March 2022

The Trust Board of Directors received an update, from the FHD in March 2022 in response to a request from NHSE/I for all Trusts to discuss their current Ockenden compliance status and progress report. This report, titled 'Ockenden One Year On', reflected progress on the implementation of the IEAs and UCPs, actions plan and workstreams detailed to close down the remaining non-compliance actions and reflected on wider implications for the Trust. It further answered the question posed by the Trust Board of Directors, referenced earlier in this paper, made on first receipt of the Ockenden Report in January 2021.

April 2022

Ockenden 'Insight Visit' undertaken by the Regional Chief Midwife and team

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	22/23/038b	Date: 05/05/2022
Report Title	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	
Prepared by	***Angela Winstanley – Maternity Quality & Safety Matron*** ***Marie Forshaw – Chief Nurse and Midwife***	
Presented by	***Nashaba Ellahi – Deputy Chief Nurse and Midwife***	
Key Issues / Messages	This report outlines the scheme requirements for compliance required to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year 4 and the Trust's current status against this. Specific information is required to be noted by the Board. This relates to the following: • Safety Action 9 - Perinatal Surveillance Dashboard Update (Appendix A) • Safety Action 4 – Anaesthetic Workforce paper (Appendix B)	

Action required	Approve ☐	Receive ☒	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			

	The Board is asked to:
	• ***Receive the current position in relation to CNST Year 4***
	• ***Note the specific updates in relation to:***
	  ○ ***Anaesthetic Workforce Paper***
	  ○ ***Perinatal Quality Safety Dashboard.***			

Supporting Executive:	***Marie Forshaw, Chief Nurse and Midwife***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☐

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 3.1 Failure to deliver an excellent patient and family experience to all our service users	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	Monthly	DoN&M	Monthly updates to be provides to the Committee and where required, issues will be escalated to the Board for formal noting and assurance.

EXECUTIVE SUMMARY

This report outlines the scheme requirements for compliance required to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year 4 and the Trust's current status against this. Specific information is required to be noted by the Board. This relates to the following:

- Perinatal Surveillance Dashboard Update (Appendix A)
- Anaesthetic Workforce Paper (Appendix B)

The Maternity Incentive Scheme offers a financial rebate of up to 10% of the maternity premium for Trusts that are able to demonstrate progress against the scheme.

Introduction

NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST.

As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. As in year three, the scheme incentivises ten maternity safety actions.

Trusts that can demonstrate they have achieved all ten safety actions and will recover the element of their contribution relating to the CNST maternity incentive fund, and will receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by **12 noon** on **30 June 2022**. However, it should be noted there has been an imposed submission deferral issued on the 23rd December 2021. It is anticipated, by the FHD that the submission date will be three months post the original deadline of 30 June. The Family Health Senior Leadership team have agreed to continue as is and maintain progress as a means of preparedness and the Executive Team have supported this approach.

Trusts must meet the following compliance conditions:

- Trusts must achieve all ten maternity safety actions.

- The Board declaration form must be signed three times and dated by the Trust's Chief Executive Officer (CEO) to confirm that:
  - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements.
  - The content of the Board declaration form has been discussed with the commissioner(s) of the Trust's maternity services.
  - There are no reports covering either this year (2021/22) or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to our declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before 30 June 2022.

- The Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.

- Trust submissions will be subject to a range of external validation points, these include cross checking with: ---

- MBRRACE-UK data (safety action 1 standard a, b and c),
- NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, standard 2 and 3),
- National Neonatal Research Database (NNRD)
- HSIB for the number of qualifying incidents reportable (safety action 10, standard a)).
- Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

• The regional chief midwives will provide support and oversight to Trusts when receiving Trusts' update at Local Maternity System (LMS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.

• NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.

• NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

Scheme Safety Actions

The table below outlines the ten safety actions for Year four of the scheme.

- **Safety action 1**: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
- **Safety action 2**: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
- **Safety action 3**: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?
- **Safety action 4**: Can you demonstrate an effective system of clinical workforce planning to the required standard?
- **Safety action 5**: Can you demonstrate an effective system of midwifery workforce planning to the required standard?
- **Safety action 6**: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?
- **Safety action 7**: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?
- **Safety action 8**: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?
- **Safety action 9**: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?
- **Safety action 10**: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?

Scheme Management

- In the interests of the ability to share and collate evidence for scheme stakeholders, the Information Team have developed a Microsoft Teams Channel. This will consist of each Safety action spreadsheet being held centrally with action owners given the ability to update and upload actions and evidence as the scheme progresses throughout the coming year. This will have oversight by the FHD Division Management Team and CNST Oversight Committee.

- Every action has been nominated a lead, with associated actions being given to action owners. Action Leads and owners will be responsible for ensuring their progress, challenges and completions are presented and overseen by the FHD CNST Oversight Committee. This meeting, now weekly ,is chaired by the Chief Nurse and Midwife will provide assurance to the FHD Board, with assurance to Quality Committee and Trust Board from the associated assurance paper.

- It must be acknowledged, in the previous paper that the pressure faced by the Family Health Divisional Board in relation to staffing and the operational pressure by the COVID 19 pandemic does pose a challenge to the overall delivery of the Maternity Incentive Scheme. This has been highlighted through divisional board and at an executive oversight meeting. The challenges are managed and escalated through the family health divisional board.

Current Position for Year 4

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

Safety Action Point	Description	Issue / Update for consideration	Status RAG
SA.1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Leads: Ae Wei Tang – Obstetrics Rebecca Kettle – Neonates Angela Winstanley – Midwifery	A. i) 100% all deaths have been reported to MBRRACE within the seven working day timeframe with 100% of deaths having surveillance completed within one month to date. ii) 92% - 46 of 50 cases have had their review started within two months of the death, standard is 95%. The inherent risk with this safety action is that if there is failure to review and report in the recognised timeframe this would become failure to achieve this criterion compliance and would therefore preclude LWH from achieving CNST Year 4. By way of assurance processes, to ensure that compliance is achieved the FHD have implemented actions to ensure timely commencement of case reviews. This will be managed and owned by the safety action leads reporting to clinical leads via FHDB and the governance process for CNST (Appendix 1). Since the pause in the reporting period against the scheme was introduced, we have continued to surveillance report and commence reviews of all applicable deaths in line with the scheme guidance. This data is complicated by the scheme pause, as the MBRRACE-UK reporting system has started to record the deaths of babies, in this pause period as not applicable. If we are to disregard the data of perinatal mortality cases reported in the pause, our current compliance rate would sit at 84%. B. All reports are either in draft format or are planned to be in draft status by the timeline for CNST – 100% C. 100% of families have been informed and offered involvement in the review of their care and that of their baby. D. Q1 21/22 Learning from Deaths Report. - Submitted to QC Sept 21 - Submitted to Trust Board - Nov 21. Q2 21/22 Learning from Deaths Report. - Submitted to QC Nov 21. - Submitted to Board Dec 21. Q3 21/22 Learning from Deaths Report. - Submitted to QC Feb 21	

SA.2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? Leads: Richard Strover & Hayley McCabe	Head of Information has received the following update from NHSD in relation to the scheme guidance and pause period. Safety Action leads do not anticipate any difficulties with the data provision within this safety action unless there was an unanticipated request for data. **CNST Safety Action 2 – submitting data to the maternity services dataset (MSDS)** A letter was circulated to trusts from NHS Resolution in December notifying of a minimum three month pause in the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, due to the impact of the Omicron variant on frontline services. This is being kept under review by NHS Resolution and currently remains on pause. In relation to Safety Action 2, this means that trusts will no longer be assessed on their MSDS data in January. However, trusts should continue to make every reasonable effort to make a submission to MSDS and to apply the principles of the 10 Safety Actions. Revised guidance on the scheme will be published later in the year, once the situation has been reviewed. Following feedback received, the decision has been taken to revise the CNST Maternity Incentive Scheme Safety Action 2 criteria relating to personalised care and support plans (PCSP). Due to this revision the existing metrics relating to PCSP have been removed from the Maternity Services Monthly Statistics publication series. Guidance on the new criteria and timescales for assessment will be released in the next update to the Maternity Incentive Scheme year 4 guidance and reflected in this publication series once available.	
SA.3	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? Leads: Anna Paweletz– Neonates Sarah Kildare – Neonates	All workstreams on track. ATAIN Action Plan has been shared with the LMS. All Transitional Care and ATAIN audits are on track, Q4 Audits have been submitted to the Maternity Safety Champion and will be reviewed at the next Safety Champion Meeting. All requirements for Safety Champion reviews have been complete and will be minuted formally through the Safety Champions meetings.	

	Paula Nelson – Neonates Kate Alldred – Obstetrics		
SA.4	Can demonstrate an effective system of clinical workforce planning to the required standard? Leads: Alice Bird – Obstetrics Christopher Dewhurst – Neonates Neonatal Nursing – Jen Deeney Anaesthetic Workforce – Rakesh Parikh	Obstetric Workforce – Paper submitted to Trust Board in December 2020, outlining the current obstetric position as outlined in the RCOG Workforce document. Requirement for action plan to be formulated by Clinical Lead for Obstetrics and monitored by Clinical Lead for Maternity Neonatal Nursing Workforce – Complete Neonatal Medical Workforce – Complete Anaesthetic Workforce – Rakesh Parikh –– This paper is in Appendix B	
SA.5	Can demonstrate an effective system of midwifery workforce planning to the required standard? Leads: Alison Murray – Interim Head of Midwifery	Full Birth-rate Plus and Maternity Staffing paper received at Trust Board in February 2022. Trust Board paper covered all aspects of the evidential requirements. A further detailed midwifery staffing analysis should be expected to Quality Committee and Trust Board by June 2022.	
SA.6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version 2? Leads: Alice Bird – Obstetrics Angela Winstanley – Midwifery	All Safety Actions within this element are on track for compliance, with action plans and audit standards monitored through the CNST Assurance meeting. An identified risk of the lack of compliance to the CO screening in pregnancy programme at 36 weeks has been rectified. An anomaly with the K2 System since the optimisation update in November has been corrected, with cross divisional input and screening rates are now reported to be <85% for March at the 36wk appointment. This data compliance is being monitored closely the Head of Information, COO, Chief Nurse and Midwife and CNST Assurance meeting. A risk that had been potentially identified with this safety action was the implementation of a formal risk assessment of fetal growth restriction at the 20-week anomaly USS. The MIS requires compliance of 80% of completed risk assessments. The Clinical Lead for Maternity escalated the difficulties within this action and requested clarification from the National Safety Champion, Matthew Jolly. Clarification notes that the risk assessment is the completion of a uterine artery doppler (UAD) US in those women deemed high risk at booking. An audit will be performed to provide evidence that high risk women for FGR are appropriately offered a UAD to demonstrate the compliance of 80% .	

SA.7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services? Leads: Gill Diskin – Midwifery Alison Murray – Midwifery Hannah Sloan – MVP Chair.	Safety Action Leads working with Interim MVP Chair, after resignation of MVP Chair, to collate required evidence to demonstrate compliance with safety standards. The Chief Nurse and Midwife has contacted the LMS Lead to request assurance in relation to the MVP work plan and strategy. Assurance has been provided to the Chief Nurse and Midwife that the continue collaborative work between LWH and the MVP will support this strategy. No issues reported.	
SA.8	Can you evidence that at least 90% of each maternity unit staff group attendance an 'in-house' multi-professional maternity emergencies training session within the last year. Leads: Alison Murray – Midwifery Jonathon Hurst – Neonatal	There is a formal maternity training plan which incorporates all the requirements of the Core Competency Framework in accordance with this safety action. This has been tabled and approved by the FHDB and acknowledgment given to recognise the staffing shortages during COVID have disrupted progress. However, we are endeavouring to meet full compliance prior to submission with the acknowledgment that staffing, and sickness absence are risk to the 90% compliance target. The LWH Maternity TNA has been shared with the Cheshire & Merseyside LMS and it has been confirmed that we are compliant with training requirements and have a validated training programme. Owing to the quality of the maternity TNA provided by LWH the LMS have asked for this to be used as a template for the maternity providers within the Cheshire & Merseyside region.	
SA.9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on Maternity and neonatal safety and quality issues? Leads: Rachel McFarland – Obs Safety Champion Angela Winstanley – Midwifery Safety Champion Fauzia Paize – Neonatal Safety Champion.	There are robust processes in place feeding into the Trust Board monthly via the Perinatal Clinical Quality Dashboard – please see updated version in Appendix A The Trust are now in receipt of the Cheshire and Merseyside LMS Provider Trust Board information pack and will review the governance processes described in the document that support how the Safety Champions will provide the LMS of assurance of perinatal safety.	
SA.10	Have you reported 100% of qualifying cases to HSIB and (for	All cases required have been reported to HSIB. All families have had information on HSIB and Early Notification/NHSR Scheme	

	2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme? Leads: Laura Thorpe Governance.	All DOC duties undertaken. Information pertaining to HSIB reporting is included in the Perinatal Quality Surveillance Paper as well as the Trust Board Performance Report. A full breakdown of all activity pertaining to HSIB, Duty of Candour will be presented to QC and Trust Board when the MIS scheme is re-released after the scheme pause.	

Conclusion

The Board is asked to note the current position in relation to CNST Year 4.

It is asked that the Board takes note of the associated risks to the scheme compliance as detailed within the narrative of this paper.

Appendix A: Safety Action 9 - Perinatal Surveillance Dashboard Update

Appendix B: Safety Action 4 – Anaesthetic Workforce paper

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Maternity Perinatal Quality Surveillance Model: April 2022 (March 22 Data)

CQC MATERNITY RATINGS LAST REPORT – 22/04/2020	Overall	Safe	Effective	Caring	Well Led	Responsive
	Good	Good	Good	Good	Good	Outstanding

Staff Survey Results:	Update Date	Results
Proportion of midwives responding with agree/strongly agree on whether they would recommend LWH as a place to work or receive treatment (reported annually).	Report 2020.	**41%**
Proportion of Specialty Trainees in Obstetrics responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)	Report 2020	**41.3%**

Midwifery Red Flags.	There was a total of 75 red flags closed in March within Maternity. These incidents spanned from December 2021 until March 2022 and follow a period of unclosed red flag incidents within the Ulysses system. All staff are encouraged to recognise and report midwifery red flags using the Ulysses System and the maternity managers strive to close incidents in a timely fashion.
Most reported Red Flag in March 2022	The most reported, closed, red flag incidents in March 2022 relate to ongoing delays of the continuation of the induction of labour process > 4 hours delay. This has been a local designed red flag event, to enable data capture of the delay in ongoing IOL provision. Delay in the continuation of the IOL process, can lead to increasing patient dissatisfaction, a further impact on bed availability and then further delays to incoming inpatient IOLs. These delays are primarily due to either bed space availability on the Delivery Suite, a result of which can be attributed to the temporary suspension of the MLU service at times of low staffing levels and low risk women birthing on the high risk areas. Staffing shortages, due to short- & long-term sickness within Maternity also affect the ability to continue IOL process on the delivery suite.
Actions Taken:	- Insufficient Midwifery Staffing on Divisional Risk Register, extreme risk Number 1705, HOM Lead. - Weekly and Daily Roster Oversight Management by HOM, Matrons and Managers. - Exec Led E-Roster Challenge sessions. - Proactive management of staff sickness and RTW - Use of Escalation Policy where required, including use of non-clinical registrants - NHSP and Agency use – with incentive offered for short notice requirement.

	- Medical Review, DOC/apologies and Escalation of delay to Senior Obstetrician and 104 Bleep Holder. - Ongoing recruitment and retention programme. - Compliance to Birth Rate Plus Report (Jan 2022)
MVP Feedback.	The MVP Chair has announced her resignation from her post as LWH MVP Chair. Recruitment into new position will be facilitated by LWH and the CCG. We have not received any feedback from the MVP this month.
HSIB Referral Details:	**Details of Case - 1** **Case ID: MI – 007512. Ulyesses 87574** Para 5, Bkd at 9wks, BMI 29.38. BP 110/80. A POS. Anxiety and Depression : No Meds. English 1st Lang. Non Smoker. Booking bloods NAD. One moderate risk factor for FGR (Age >35yrs old). One moderate risk factor for Pre Eclampsia: (Age >40yrs old) One moderate risk factor for SGA: Age > 40yrs old, Booked for Growth US at 30/34/38. VTE Risk assessment: Intermediate Risk. Reports in COVID vaccinated at booking. Pregnancy Risk Assessment: High Risk. Antenatal period appropriate management. Seen by Cons Mw for birth plan. Admitted to MAU, PV bleeding, placntal abruption. CTG abnormal. – bradycardia. Cat 1 CS. Cord gases<6.8, tx t NICU for cooling. **LWH Initial Findings and Actions Taken -** Use of intrapartum cardiotocograph assessment in potential non - laboring patient - reasons for this to be clarified through staff statements. Recognition that Subspecialty Registrars, who are named Obstetric Senior Registrars, on High-Risk Intrapartum Areas may require extra support. A lack of job planned daytime delivery suite sessions when a Cons Obstetrician is present is required to enhance ongoing obstetric training. Recognition of acute placental abruption (recognised obstetric emergency) not escalated appropriately. Further information required from staff statements re decision making and escalation to senior team processes. Duty of Candour has been completed. Duty of Candour letter and HSIB Information provided to family. Staff statements to be requested. Staff support and referral to Educational Supervisor. Review of Intrapartum Area Acuity and Staffing. Theatre Activity review of emergency activity and impact on decision making. Review of Senior Registrar job planned Intrapartum time – to ensure Obstetric Training includes daytime high risk intrapartum sessions when Consultant Obstetric is present. Lessons of the Week for P.A.C.E Further lessons of the week for antenatal CTG Documentation to be disseminated immediately. Incident to be used as a IN-SITU SIMS case study. Details to be sent to Education Surveillance Midwife to complete audit of Intrapartum Risk Assessments on K2 to identify areas for improvements and targeted maternity clinician training. **Details of Case - 2** **Case ID : MI 007978** P2. CLC, previous SGA and Asthma. Known drug user. Numerus DNA in pregnancy. Safeguarding plans in place. Difficult antenatal course, evaded midwifery care on some occasions. RLUH for DVT – Neg, incidental finding of anaemia – treated by GP. Attended 2 growth USS, DNA at 36 +2. Tested +ive in pregnancy for substance misuse – plan for newborn in place. Attended LWH in advanced labour, head visible, born within 20 min of admission. Low apgars, tx to NICU. Therapeutic cooling commenced criteria A – cord pH criteria B – Hypotonia Phenobarbitone and midazolam administered, and seizures ceased with no further treatment required, lactate improved within 1 hours of age. CFAM continues to be grossly abnormal and there is poor suck. Significant neuro-deficit anticipated MRI planned. Mother questioned following re drug use prior to birth. **LWH Initial Findings and Actions Taken-**

	Referral to HSIB as a qualifying case – Term admission to NICU requiring therapeutic cooling When substance misuse is identified during pregnancy a referral to substance misuse specialist obstetrician should be offered. Duty of Candour has been performed verbally and in writing Information on HSIB referral and investigation were provided LOTW - When substance misuse is identified during pregnancy a referral to substance misuse specialist obstetrician should be offered Discharge planning meeting to be held to identify a place of safety and support ongoing. **Details of Case – 3** **Case ID: MI 007611** SUDI in Community of 4 day old baby.Low risk pregnancy. 33 year old, G2 P0 (previous TOP) early private USS confirmed IUP. Referral to booking at 5+5/40, BMI 25.1 at booking at 10+5/40, non-smoker, no alcohol since pregnancy confirmed. White British, English first language, no allergies, no social service involvement or complex social factors. No medical conditions, surgical history or medications. Previous varicella in 1996 and mumps in 2005. Blood group A, Rh +ve, folic acid, vitamin D in pregnancy and COVID vaccinations x2 completed. Booking bloods taken, all antenatal screening accepted and urine negative at booking. FGR, pre-eclampsia, GDM and VTE and risk assessments completed- no risk factors identified. Patient seen in Hewitt Centre three times due to fertility issues, subsequently became pregnant before treatment commenced. Ventouse birth in LWH, discharged home after EON – NAD. Breatsfeeding well. LWH alerted via CDOP and Safeguarding of death in Community. P/M results inconclusive. **LWH Initial Findings and Actions Taken-** DOC completed. Check Pulse Ox completion – would not have affected outcome. No referral to PTL clinic – would not have affected outcome. Honesysuckle Support to Family. PMRT review and HSIB Investigation.
Maternity Serious Safety Incidents	**Case 1: Maternity Service Divert: STEISS Number 2022:6420** On Saturday 19.03.2022 Maternity Services at Liverpool Women's Hospital NHS Foundation Trust went into Divert, following escalation for a period of 8 hours and 7 minutes. Time of commencement of Divert: 19.03.2022 at 10.48am Time of Stand down of Divert: 19.03.2022 at 18.55pm. LWH and the Maternity Division have a well-established, 24 hour, four hourly 'helicopter' review that is scheduled from 07.30am. This review is completed by the Maternity Bleep Holder and incorporates an overview of current and planned activity, acuity, occupancy across the intrapartum and inpatient areas, staffing levels and skill mix. The status of both the homebirth and the presence of women in receipt of inpatient continuity of care is also noted. In an 'in hours' (Monday to Friday 07.15 to 19.45) time scale the Maternity Bleep is managed by the senior ward managers and matrons. The 'out of hours' Maternity Bleep Holder provision Monday to Friday (19.45 – 07.15) is held by the Senior Band 7 Intrapartum Shift Leader. The weekend 'out of hours' provision is 8am – 4pm held by the ward managers rostered into do weekend cover. Activity Review and Staffing Level review at 09.00am for Escalation: Agreed that escalation and divert status required. **LWH Initial Findings and Actions Taken:** Agreement required to escalated to STEISS report and SUI Investigation. Affected patients to be contacted, formally in writing. Review of Clinical Incidents reported on Ulysses. Review of Clinical activity in preceding 24-48 hours to identify any key learning.

	Further staff statements to assist with information gathering. Review of Midwifery Red Flags reported. Review of E-Roster and forward planning processes. Review of Yellow Slip activity and effect on acuity within maternity. Contact all patients affected by closure with apology letter Continued advanced monitoring of maternity staffing levels and acuity. Continued use of Bank and Agency Staff to support staffing levels. Continued Consultant Obstetrician oversight with 104 Bleep holders and senior managers to ensure clinical safety Recruitment processes continue for midwifery recruitment. Continued use of retention processes through preceptorship team and PMA. Awaiting further information from staff statements and incident reviews to support SUI process To comply with the Cheshire & Merseyside Escalation & Divert Policy this incident will be reported as a SUI. There at the time of 72hour review have been no patient safety or clinical incidents reported in in direct correlation to the Divert. Appropriate escalation for MDT review and contact of Manager on call to escalate extreme staffing and clinical pressures Appropriate use and escalation of on call Continuity of Care midwifery staff to support staffing pressures Contact all patients affected by closure with apology letter Continued advanced monitoring of maternity staffing levels and acuity. Continued use of Bank and Agency Staff to support staffing levels. Continued Consultant Obstetrician oversight with 104 Bleep holders and senior managers toensure clinical safety Recruitment processes continue for midwifery recruitment. Continued use of retention processes through preceptorship team and PMA. Awaiting further information from staff statements and incident reviews to support SUI process
Perinatal Mortality.	Number of Neonatal Perinatal Deaths in **March 2022: 0** Number of Stillbirth Perinatal Deaths in **March 2022: 1** All perinatal deaths in March 2022 have been reported to MBRRACE and will be subject to a full MDT reviews with an external panel Details and actions plans of every death are detailed in the Quarterly mortality Report presented by the Deputy Medical Director at C Committee and Trust Board
Ockenden 1 Update	On 25 January 2022, the NHS Improvement / England (NHSI/E) Chief Operating Officer and Chief Nursing Officer wrote to trusts requesting that discussions regarding Ockenden progress take place at a public Board before the end of March 2022. The discussion is expected to cover: • Progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance, • Maternity services workforce plans The letter noted that ensuring local system oversight of maternity services was a key element in the Ockenden review and therefore trusts have been requested to ensure progress is shared and discussed with the Local Maternity System (LMS) and ICS. Progress must also be reported to the regional maternity team by 15 April 2022. In April 2022 – the Family Health Division welcomed a visit from the Regional Chief Midwife and her Team where our up-to-date progress can be

	against the remaining outstanding actions. The FHD Team presented our evidence and compliance against the remaining outstanding actions and was very successful. A full report of the visit by the regional chief midwife team is expected and will be shared upon receipt. LWH are now expected to be reported as full compliance with all IEAs. The Board Assurance Assessment Tool has been updated, reviewed by the Executive Team and returned to the LMNS on 14th April 2022.
Risk Register.	Extreme Risks: 20 High Risks:10 Moderate Risks: 4 Low Risk: 1
Maternity Incentive Scheme Progress Year 4.	**Progress against the Year 4 Maternity Incentive Scheme (CNST):** 1. PMRT – Full details of the Trusts progress against the standards in this element are detailed in the quarterly learning from deaths report prepared by the Deputy Medical Director. 2. MSDS – No reported problems. 3. ATAIN – Trust Board have received the ATAIN Action Plan, and this has been shared with the LMNS. Divisional Leads have been updated, named Cons Obstetrician and Midwife planned to take ownership of obstetric and midwifery requirements. 4. Clinical Workforce – Obs workforce paper submitted in January 2022. Neo Nursing and Medical workforce paper to be submitted to Board in April and this is completed. 5. Midwifery Workforce – Detailed staffing paper against Birth Rate Plus Report of 2021 has been sighted at Trust Board. 6. SBLCBv2 –- PTL Risk assessment to be updated. 20 Weeks FGR Risk assessment to be embedded into pregnancy journey. Audits of compliance ongoing. 7. MVP – Continued close working relationship with MVP and MVP/LWH Strategy under development. MVP Chair resignation. 8. Mandatory MPMET and Neonatal Resus Training – MPMET Training session reinstated in face-to-face capacity. Target of 90% of all staff groups to attend by scheme end. See further details below 9. Safety Champions – Safety Issues continue to be escalated. BLSC sighted on Perinatal Clinical dashboard and submitted monthly. 10. HSIB and NHSR Notifications – No issues identified. All HSIB and D.O.C duties completed to date. Details to Trust Board in May 2022. ***A detailed paper is sighted at both Quality Committee and Trust Board where compliance with the MIS scheme is discussed and noted.***

Training Compliance Update	**January 2022**			**February 2022**			**March 2022**		
	MPMET:	Fetal Surveillance:	Newborn Resuscitation:	MPMET:	Fetal Surveillance:	Newborn Resuscitation:	MPMET:	Fetal Surveillance:	Newborn Resuscitation:
Midwifery Staff	70%	3%	66%*	Compliance Data currently under review, full submission of training compliance expected April 2022					

Consultant Obs	73%	11%	73%						
Obstetric Trainees	53%	0%	53%						
Maternity HCA	68%								
Anesthetic Cons	52%								
Anesthetic Trainees									
ODPs	65%								
Cons Neonates			94%						
Neonatal Trainees			95%						
ANNP's			85%						
Neonatal Nurses			84%*						

Maternity Training Compliance Narrative.

Maternity Training Needs Analysis: Liverpool Women's NHS trust (LWHT) is committed to the vision of the National Maternity Review Better Births Report to become safer, more personalized care with women and families receiving high quality care. Robust education and training are key components of providing safe care and contribute to creating a supportive learning environment where all staff are able to learns from incidents and concerns to continuously improve the care we are providing to women, families and babies. The Maternity training needs analysis (TNA) has been developed and identifies the training required to underpin our commitment. It includes the training required to meet the Core Competency Framework for maternity staff. To support this, LWHT maternity has successfully bid for Health Education England funding for safety training. Following publication of the CNST MIS Year 4 in August 2021, the TNA was reviewed and revised further to ensure compliance to CNST Safety Action 8. Updates in relation to the Midwifery Preceptorship programme and have also been included in v1.1 of this document to reflect current practices. The LWH Maternity TNA has been shared with the Local Maternity System Lead Midwife for Quality & Safety, ratified, and agreed and is currently being utilised as a template for other maternity providers within the region as a benchmarking tool. All managers, clinical leads and rota co-ordinators have been contacted and have ensured that staff are booked onto applicable course sessions that are planned and diarised. To note, Anaesthetic trainees are a small cohort of staff (average number 12) who complete a short three-month rotation to Obstetric Anaesthesia at LWH and therefore the compliance figure fluctuates dramatically for this group at the rotation times through the year. The Maternity Education Team have developed an excellent relationship with the rota coordinators who ensures that all obstetric consultant and trainees attend a MPMET session during their placement to achieve compliance. ** Midwifery and neonatal nurse compliance data is based on the one year in house update and does not include and reflect those clinicians who have at reg course and therefore this would supersede annual update. This will require manual verification later. This data has been sighted at the Trust Resuscitation Committee.

Fetal Surveillance Training days commenced in January 2022 to include all elements of the Saving Babies Lives Care Bundle, in addition to the fetal monitoring training requirements. An increased number of courses have been arranged from March 2022, with an increased capacity for attendance. A trajectory is in place to ensure that we meet this requirement. Fetal Surveillance Training prior to January had been completed to a compliance rate of 90%.

	Metric	Standard National standard/Average where available.	Jun-21	Jul-21	Aug-21	Sep-21	Oct 21	Nov-21	Dec 21	Jan 22	Feb 22	Mar 22

Perinatal	1:1 Care in Labour	100% (CNST)	99.6%	99.3%	99.2%	98.6%	99.6%	99.4%	98.1%	98.3%	98.9%	96.5%
	Stillbirth Number >24wk (Adjusted)	Actual Number	2	7	3	1	2	5	2	5	0	5
	Apgar <7 @ 5 Min (>37weeks)	<1.6%	0.8%	0.6%	1.3%	0.8%	05.%	1.15%	1.28%	0.51%	0.59%	1.10%
	Term Admission to NICU	<6%	3.54%	4.01%	4.91%	5.1%	4.52%	7.69%	5.46%	5.90%	TBC	TBC
	Women in receipt of Continuity of Care	100%	15.35%	14.49%	16.67%	19.91%	17.85%	20.52%	20.52%	18.7%	25.2%	TBC
	BAME in receipt of Continuity of Care	100%	29.41%	31.63%	39.81%	47.96%	39.60%	41.58%	37.89%	37.2%	59.46%	37.7%
	Social Depravation Continuity of Care		18.18%	19.89%	24.21%	26.40%	22.26%	24.78%	23.62%	21.7%	28.9%	23.3%
	Provision of Epidural in Labour.	Actual Number	15.1%	20.3%	19.4%	20.3%	22.82%	17.78%	16.78%	18.97%	TBC	TBC
	Obstetric Haemorrhage >1.5L	<2.7%	4.28%	3.96%	3.77%	4.14%	3.37%	4.26%	2.96%	3.2%	4.54%	3.74%
	Coroner Reg 28 Made to Trust		0	0	0	0	0	0	0	0	0	0
	HSIB Report Returned		1	0	0	1	1	1	0	1	0	0
Workforce	Super Numerary DS Shift Leader.	100% (CNST)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Midwifery Sickness	% of workforce	10.13%	12.28%	12.17%	14.11%	13.31%	12.63%	15.26%	16.37%	11.45%	9.64%
	Midwife to Birth Ratio (in Post)	>1:30	30	31	31	32	30	29	30	30	30	30
	Midwifery Vacancy	% of workforce	2.40%	1.40%	4.40%	3.30%	5.32%	8.72%	7.84%	2.46%	2.0%	4.1%
	Rostered Cons on DS (Hrs per Wk)	>60 hrs	91	91	91	91	91	91	91	91	91	91
	Number of Formal Complaints	Actual Number	2	2	1	2	3	2	2	2	0	2
Feedback	Number of Maternity Incidents over 30 Days	Actual Number	188	261	89	161	376	97	119	121	120	234
	FFT Response Rate	>50%	<10%	<10%	<10%	<10%	<10%	<10%	<10%	<10%	<10%	<10%
	Number of PALS/PALS+	Actual Number	74	66	67	46	52	44	32	44	42	31

Conclusion

The Family Health Division ask the Quality Committee to note this paper as assurance that perinatal quality safety is a key priority within the division and its compliance against the implementation of a perinatal quality dashboard and framework. The data that supports this paper is monitored at the Family Health Divisional Board and includes review of all WE SEE KPIs, as developed within the maternity Power BI dashboard. Further to this a review of the Cheshire & Merseyside Variance and Outliers status is undertaken by the Clinical Lead for Maternity at the FHDB. And outlier comments supplied to the LMNS from the Clinical Lead.

1. Introduction

This paper seeks to provide assurance to the Committee that the Anaesthetic work force for obstetric services is meeting the CNST standard.

2. There are no items in the paper to escalate for the attention/action of the committee; the paper is submitted for information.

3. Background

Following are the Maternity CNST Standards for Anaesthetic Medical Workforce:

Anaesthesia Clinical Services Accreditation (ACSA) standard and action: 1.7.2.1

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.

4. Current Rota Arrangements:

This is the current rota arrangement for the anaesthetic medical workforce:

Bleep Holder 156: This bleep is held by anaesthetic consultant specialised in obstetric anaesthesia, generally dealing with all elective caesarean section lists. The bleep is supported by trainee anaesthetist. This shift is active between 8am to 6 pm , all working weekdays. They are part of rapid response team.

Bleep Holder 157: This bleep is held by anaesthetic consultant specialised in obstetric anaesthesia, dealing with multidisciplinary ward rounds with obstetric colleagues, delas with obstetric HDU rounds and any emergency theatre cases. They also oversee pain relief services including epidural for obstetric patients. This shift is active between 8 am to 8 pm. The bleep holder could be two different individuals depending up on on call rota and is active for all working weekdays. This post holder is also supported by trainee anaesthetists. They are part of rapid response team.

Bleep Holder 301: This shift is carried out by suitably trained trainee anaesthetists who has passed obstetric anaesthetic competencies. The sole job of this anaesthetist is to assist any obstetric anaesthesia related services including theatre procedures, pain relief services, ward rounds, trouble shooting, cardia arrest etc. They are part of rapid response team. This bleep is for in person hand over and it is never intended to be unattended at any given time, 24/7 cover. There is no other jobs assigned to this bleep holder other than dedicated obstetric related services. This anaesthetist is supervised by consultant anaesthetists at all time, on site between 8 am to 8 pm by bleep holder 157 during Monday to Thursday. After 8 pm during Monday to Thursday, after 6 pm on Friday and all weekends and bank holiday, they are supported by on call consultant anaesthetist from Home.

Bleep Holder 504: This beep is carried by suitably qualified anaesthetist trainee, who will also in possession of basic obstetric anaesthesia competences but could be slightly more junior in grade. The primary job of this anaesthetists is to cover Gynae HDU, multi-disciplinary ward round alongside with Gynaecology team, deal with any emergency/urgent cases for Gynaecology, acute pain rounds and support to solo consultants on the Gynae floor. This post holder is also for the backup for bleep holder 301 in case of multiple activities on obstetric floors. However, helping out on the obstetric anaesthesia services by this bleep holder can potentially leave gynaecology and other services uncovered. They are part of rapid response team. This bleep is for in person hand over and it is never intended to be

unattended at any given time, 24/7 cover. Supervision for this bleep holder is at similar standard as 301. However Monday to Friday 8 am to 6 pm, they are supervised by consultant anaesthetist bleep holder 226, who is separate than maternity consultants.

On call / emergency cover arrangement for the consultant Anaesthetists : There is 24/7 on call cover provided by suitably qualified consultant anaesthetists specialised in obstetric anaesthesia. Currently on call cover arrangement is as follows:

Monday to Thursday:	8 am to 6 pm: bleep holder 157 for obstetrics 8 am to 6 pm: bleep holder 226 for gynaecology 6 pm to 8 pm: on call consultant, on site 8 pm to 8 am: on call consultant from home
Friday:	8 am to 6 pm: bleep holder 157 for obstetrics 8 am to 6 pm: bleep holder 226 for gynaecology 6pm to 8 am: on call consultant from home
Weekends and bank holidays:	24/7 cover by on call consultant from home

5. **Assurance for ACSA standard**: Above arrangement for anaesthetist medical work force fully satisfy the required ACSA standard 1.7.2.1. The arrangement is evident by anaesthetic rota. . The above arrangement for obstetric anaesthesia services has never been compromised in last five years.

6. **Risks:**

Sickness cover:

Sickness of Anaesthetic trainee holding bleep 301/504 is covered by suitably qualified anaesthetists from the pool of anaesthetic trainees who has worked at LWH before. We currently do not favour having agency anaesthetic trainee due to the nature of the work in LWH. In an unfortunate event of no suitable trainee available to cover sickness, consultant will step down and hold the relevant bleep and carry out duties of that bleep holder. There will also be on call consultant available.

Bleep holder 156 and 157 ‘s sickness or leave is managed by replacement of another suitable consultant. Occasionally to provide this level of cover, we relocate the consultant from Gynea lists to obstetric floor.

Change in curriculum for anaesthetic trainees:

Curriculum changes in the anaesthesia training means, in future we potentially only receive stage 1 trainees who do not have any obstetric anaesthesia experience before coming to LWH. Currently we have successfully argued the need for some stage 2 trainees to be rotate to LWH. Local fellow jobs and extension of consultant cover are potential remedies for this particular challenge in horizon.

7. **Future Ambitions**:

In line with trust medical work force strategy, we are aiming to increase consultant presence on site in stages. Aiming for Consultant anaesthetists lead Twilight shifts from 6 pm to 10 pm as early as August 2022.

8. **Conclusion:**

Current establishment and rota arrangement for anaesthetic work force are complied with the ACSA standard 1.7.2.1.

Quality Committee Chair's Highlight Report to Trust Board
25 April 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee noted continued issues with the telephone triage process, particularly within GED and MAU as escalated by the Patient Involvement & Experience Sub-Committee. The Committee requested that the Executive Team consider the issues as a matter of priority and identify timescales and report back to the next Committee. • The performance report indicated that the 2-week performance remained a challenge with increasing referrals. Capacity has been reviewed to address this challenge and an improvement is expected in April 2022. Further to this a meeting had been planned with the CCG to discuss appropriate referral of patients on to pathways and consider a different route for non-cancer urgent patients.	• Noted continued progress by the Safety & Effectiveness Sub-Committee to monitor and push forward improvement against blood sampling errors in each division. • The Committee noted that a formal response to a recent never event would be presented to the Committee when finalised. It was requested that a thematic review against previous never events be undertaken
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• Comprehensive mapping project completed to understand and ensure alignment between national programmes of work and the Trust's Maternity Transformation Programme and constituent projects currently underway. • The Committee received and approved the CQC Preparedness Framework for 2022/23. It was assured that work is on-going to ensure that the Trust is compliant with the CQC regulations. The framework supports a strengthened approach to engage and raise awareness of staff of the inspection process. The Committee considered evidencing of system working and noted that partnership updates had been added to the Finance, Performance & Business Development Committee workplan which should capture developments. • Commenced Trust patient access to the onsite CT scanner which would improve access and reduce waiting times for Trust patients. • The Committee commended the Clinical Audit Forward plan noting the difficulties to achieve a realistic in-year plan. • The Committee received the Serious Incidents & Learning Report covering the period Quarter 4, 2021/22. During that time ten serious incidents (SIs) had been declared on the StEIS system, eight final SI reports had been submitted to the CCG, and no overdue actions to report. It was noted that the Family Health Division had undertaken a review of the increasing SIs within Maternity to identify any themes which would be presented to the Safety & Effectiveness Sub-Committee. The	• The Committee considered the draft 2022/23 corporate objectives aligned to the Committee. It was recommended that the objectives required further development to become SMARTER prior to submission to the Board for approval. • The Committee approved the Clinical Audit Forward Plan 2022/23.

findings would be included in a future Chairs report and matters escalated if necessary.

- Received assurance of progress and compliance against the ten safety actions and their associated standards for the Maternity Incentive Scheme Year 4. A weekly oversight meeting had been introduced to ensure evidence was in place. The Committee noted the specific updates in relation to:
  - Safety Action 9 - Perinatal Surveillance Dashboard Update
  - Safety Action 4 – Anaesthetic Workforce paper
- The Committee received an overview of the role of the Maternity & Neonatal Safety Champions and was assured that appropriate appointments have been made to the relevant Board level and Specialty Safety Champion roles. The Committee noted the issues identified in Quarter 4 during Board Level Safety Champion Walkarounds and meetings.
- The Committee received a video update against the Ockenden Final report and action taken to date at the Trust. An Ockenden Assurance Visit from the Regional Maternity Team supported by the LMS had been undertaken in April 2022. Initial feedback had been positive and the Trust awaited the final report.
- The Committee noted the seven-day services bi-annual update.

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the Quality related BAF risks noting a formal review had been undertaken to reflect on the content of the BAF and consider the on-going relevance of the content in the context of the Trust's strategic objectives into 2022/23. Narrative changes were identified. No changes to risks scores were recommended. No risks closed on the BAF for Quality Committee.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- A positive meeting
- Satisfactory reports and sighted on the most appropriate issues

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
06.	Board Assurance Framework	Assurance	12.	Serious Incidents & Learning Report Quarter 4	Assurance
07.	Sub-committee Chair Reports	Assurance	13.	CNST Year 4 Assurance	Information
08.	Corporate Objectives: Objective Setting 2022/23	Approval	14.	Safety Champion Update	Information
09.	Quality & Regulatory Update: CQC Preparedness Framework 2022-23	Assurance	15.	Ockenden Report	Information
10.	Quality Performance Report Month 12, 2021/22	Assurance	16.	Seven Day Services Bi-Annual Update	Assurance

11.	Clinical Audit Forward Plan 2022/23	Approval			

3. 2022 / 23 Attendance Matrix

Core members	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie, Chair	✓											
Susan Milner	✓											
Louise Kenny	**A**											
Sarah Walker	**NM**											
Gloria Hyatt	**NM**											
Jackie Bird	**NM**											
Marie Forshaw	✓											
Gary Price	✓											
Lynn Greenhalgh	✓											
Eva Horgan	✓											
Michelle Turner	✓											
Nashaba Ellahi	✓											
Philip Bartley	✓											

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report
May 2022

Trust Board Performance Report

This report has been produced to provide an exception position against the Trust's key performance standards. This page is designed to help readers interpret the report and understand the process for KPI selection and review.

Report Layout:

WE SEE Summary - this provides a breakdown of the number of KPIs that are meeting / failing targets for the most recent month of reported data.

Cover Sheets - these provide an overview of performance with over arching narrative for each of the WE SEE values. In addition a selection of KPIs will be selected for a more in depth review. These are selected based on whether the KPI meets one or more of the following criteria:

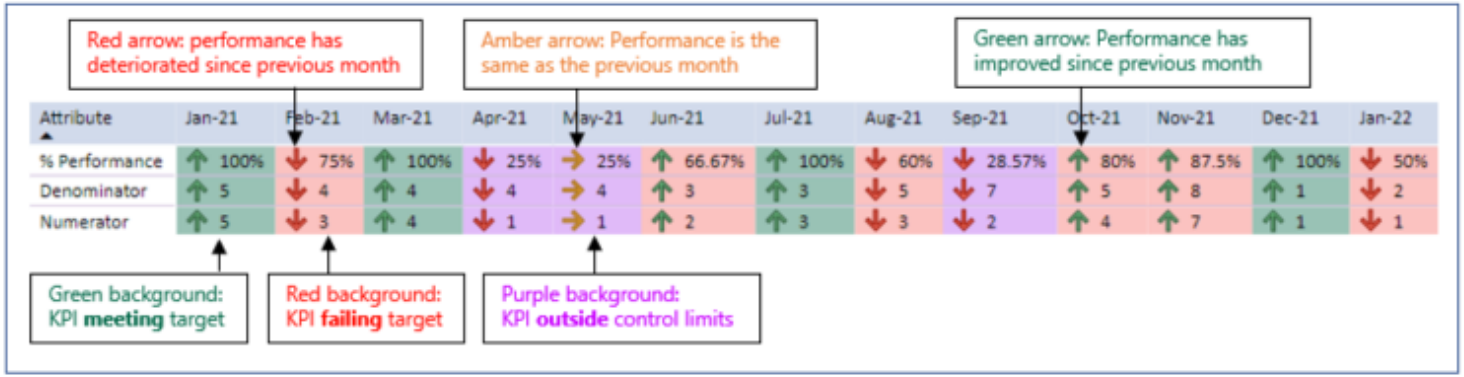
- Outside of a control limit, having previously been within control limits
- A consecutive deterioration of performance over a quarter, which is not insignificant
- A significant drop in performance over the space of a month
- A consecutive improvement in performance over a quarter, which is not insignificant
- A significant increase in performance over the space of a month
- KPIs, that following specific analysis require review, or where a change in measurement or data production require escalation

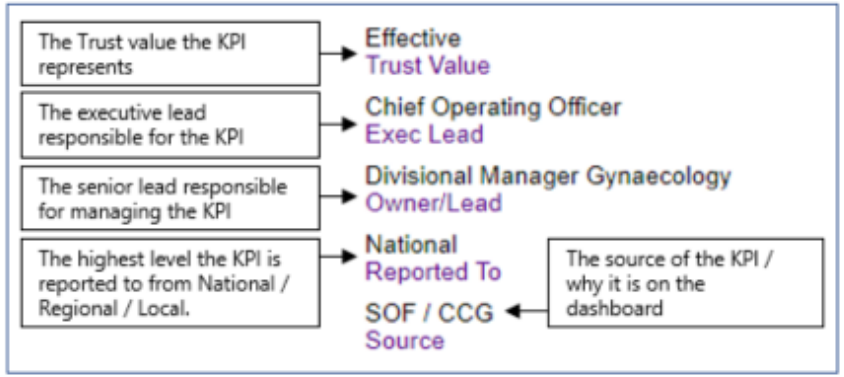
Data Sheets - these provide detailed information for each specific KPI measured. This includes data values for the previous 13 months, a sparkline included performance dating back to April 2018 where available. The sparkline graph includes the performance, target and control limits for the specific KPI. Within the data table the arrows represent whether performance has increased, decreased or remained the same. The colour coding is based on the target type as to whether this movement is positive or negative. All arrows apply to the performance and not other data items. In addition the target, target type, executive lead, operational / clinical owner / lead, source (why are we leasuring the KPI) and data quality kite mark (1 least confidence to 5 highest confidence). Narrative submitted by the KPI owner for the most recent month is included if provided.

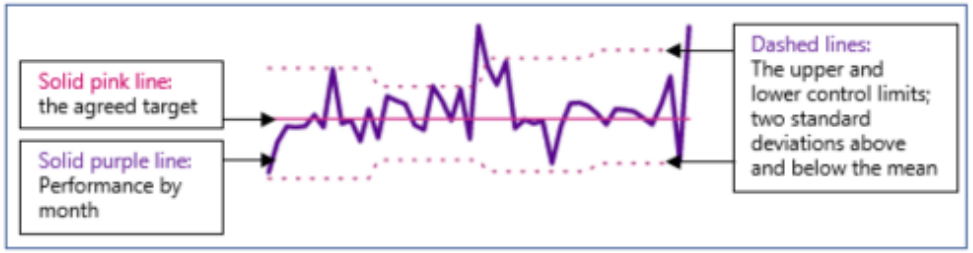
Data Health Check - highlights where KPIs have denominators outside of control limits along with a summary of the data quality kite mark scores for each KPI.

KPI Lineage - shows for each committee / meeting that KPI is included within the performance dashboard

How to interpret the report:



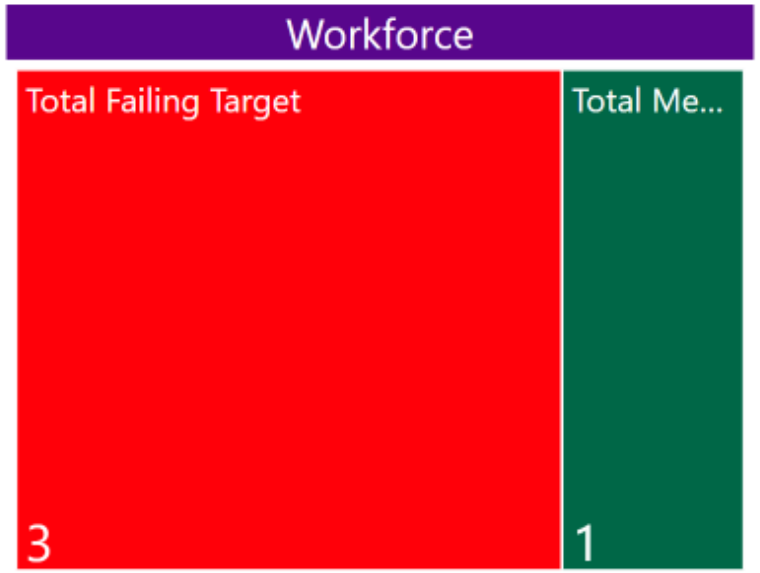


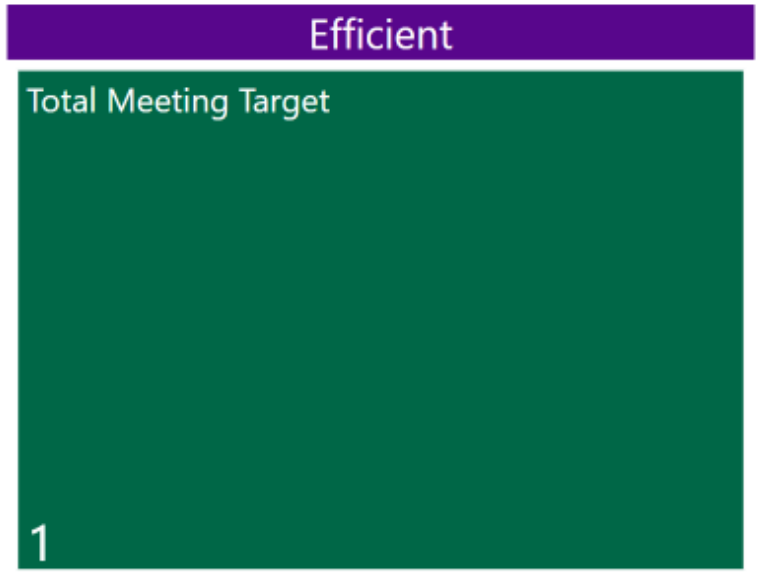


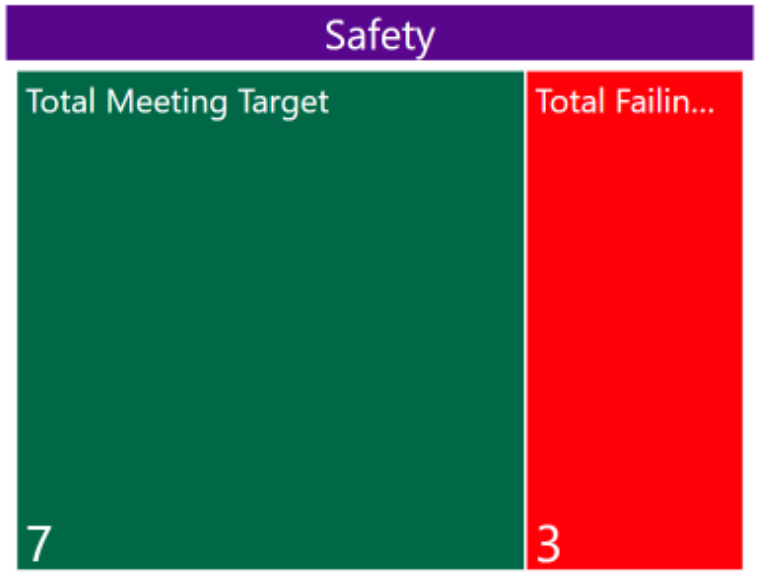
Control limits are set using statistical process control. The standard deviation for each indicator is calculated based on the previous two financial years data unless recalculation is required due to service changes. the upper and lower control limits are two standard deviations above and below the mean performance level. Where appropriate data points will be removed and control limits recalculated if reasons for adverse performance are known and accepted.

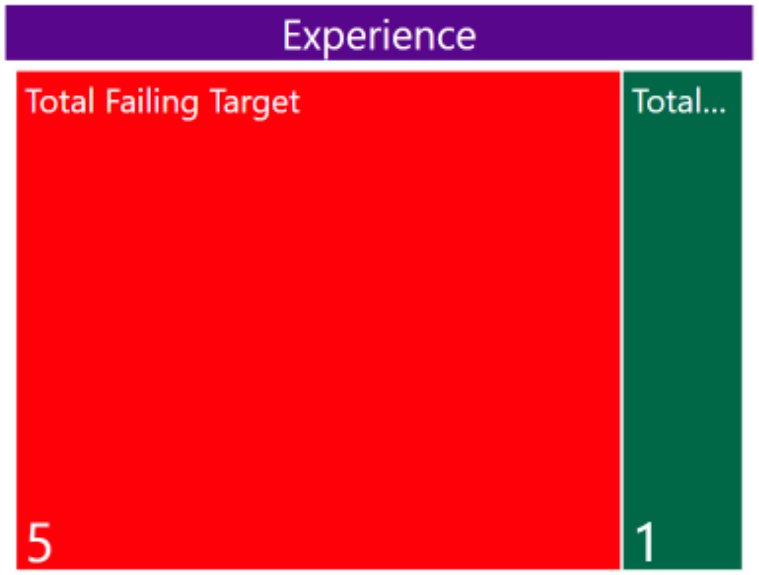
Performance is reported one or two months in arrears depending on submission deadlines. The reporting month is highlighted against each specific KPI.

WE SEE Summary





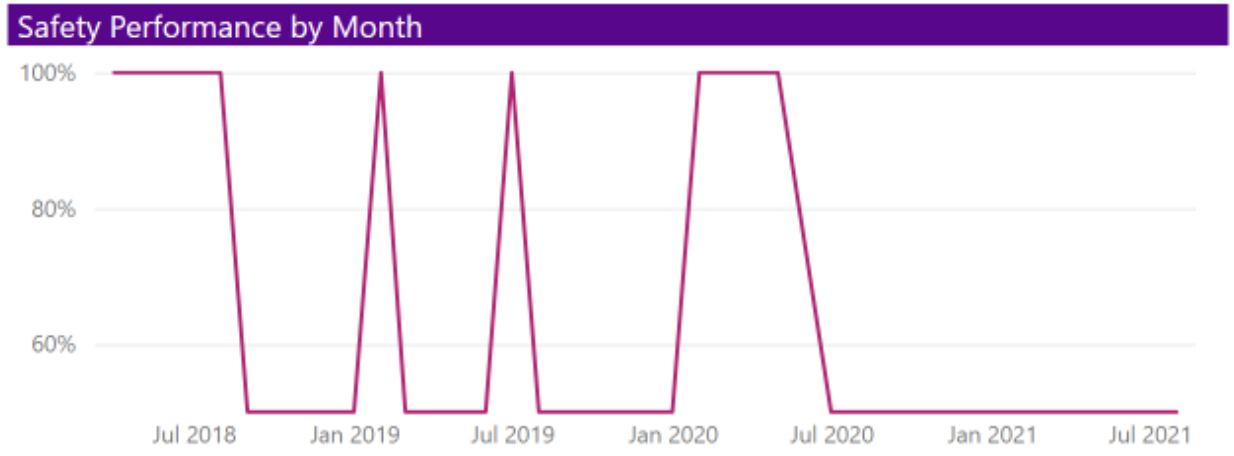




To deliver **Safe** services

Total Failing Target

2



Positive Developments

The Trust has identified a lack of trained SI investigators and will have commissioned training for 20 additional SI investigators. The new process for identifying KPIs to be highlighted for review has been implemented as part of the new performance report layout. This is based on criteria set out in the report cover page. In future months this process will be embedded to provide more focussed narrative for discussion.

Areas of Challenge

The 2ww referral to treatment target and the ED 4 Hr target continue to be a challenge in March and further detail is in the pack

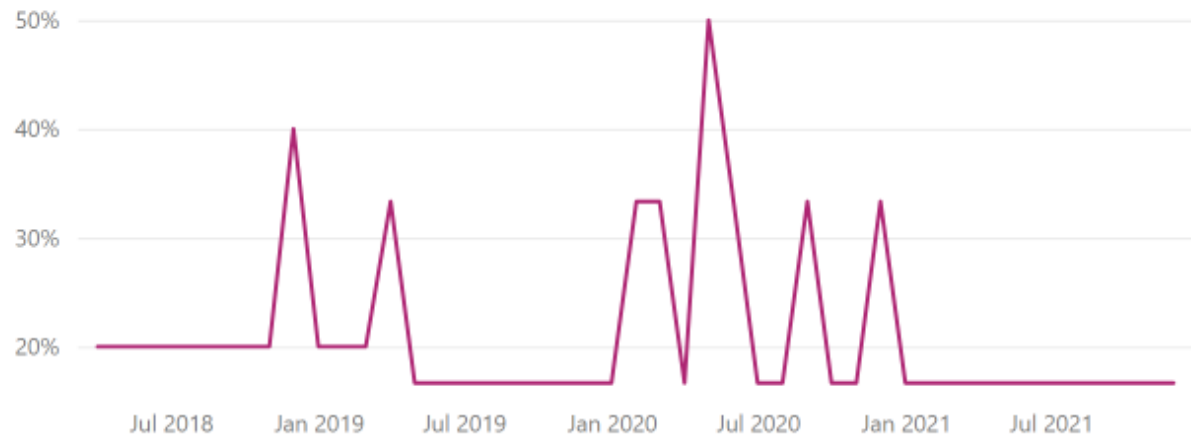
KPI	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
Serious Untoward Incidents: Open	8	7	8	8	8	5	9	9	13	16	19	19	17
Venous Thromboembolism (VTE)	85.48% ↓	84.62% ↓	85.39% ↑	86.51% ↑	84.58% ↓	88.55% ↑	87.96% ↓	90.64% ↑	86.25% ↓	86.39% ↑	84.16% ↓	85.86% ↑	86.38% ↑

These KPIs have been highlighted for the current reporting month based on the criteria highlighted in the report guidance

To deliver the most **E**ffective outcomes

Total Failing Target

6



Positive Developments

The new process for identifying KPIs to be highlighted for review has been implemented as part of the new performance report layout. This is based on criteria set out in the report cover page. In future months this process will be embedded to provide more focussed narrative for discussion.

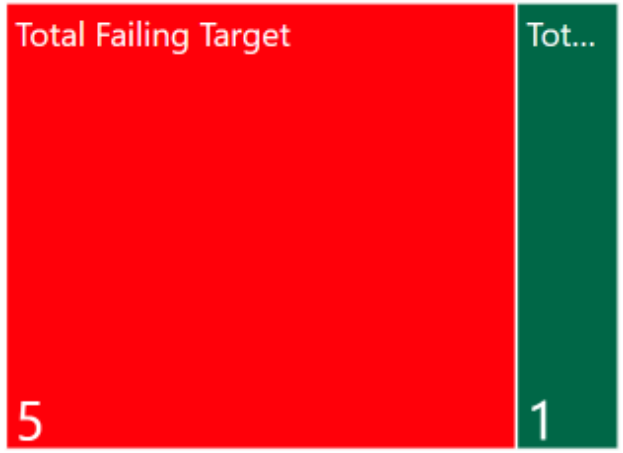
Areas of Challenge

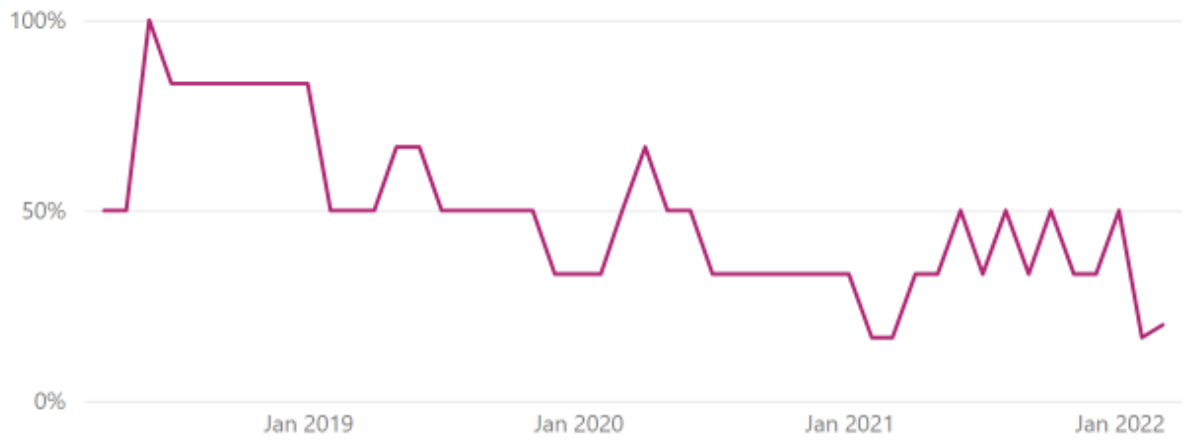
The 2 week performance remained a challenge with increases in referrals, this is a national picture, capacity has been reviewed to address this challenge.

KPI	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
18 Week RTT: Incomplete Pathway > 52 Weeks	290	214	170	194	209	244	256	288	294	354	406	479	544
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	29.41% ↑	34.21% ↑	20% ↓	20% →	16.13% ↓	16.22% ↑	6.06% ↓	18.18% ↑	44.83% ↑	54.55% ↑	34.78% ↓	47.06% ↑	
Cancer: 104 Day Breaches	4	5	3	4	1	3	5	3	3	3	2	2	
Cancer: 2 Week Wait	97.48% ↑	95.71% ↓	97.92 % ↑	96.2% ↓	95.32% ↓	96.42% ↑	96.06% ↓	95.33% ↓	97.04% ↑	95.31% ↓	76.65% ↓	81.91% ↑	
Cancer: 28 Day Faster Diagnosis	69.4% ↑	64.12% ↓	56.72 % ↓	65.18% ↑	61.24% ↓	71.12% ↑	49.12% ↓	64.14% ↑	60.5% ↓	59.93% ↓	54.1% ↓	57.91% ↑	
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	87.5% ↑	84.380 % ↓	78.57 % ↓	68% ↓	64.52% ↓	68.97% ↑	54.05% ↓	56.76% ↑	86.67% ↑	93.1% ↑	84.62% ↓	84.380% ↓	

These KPIs have been highlighted for the current reporting month based on the criteria highlighted in the report guidance

To deliver the best possible **E**xperience for patients and staff





Positive Developments

The new process for identifying KPIs to be highlighted for review has been implemented as part of the new performance report layout. This is based on criteria set out in the report cover page. In future months this process will be embedded to provide more focussed narrative for discussion. The significant increase in the diagnostics performance within month is noted and achieved the the diagnostics recovery plan with more detailed information available within the KPI detail.

Areas of Challenge

GED performance reduced again in March due to sickness and junior doctor challenges however has seen an improvement in early April due to increase in capacity

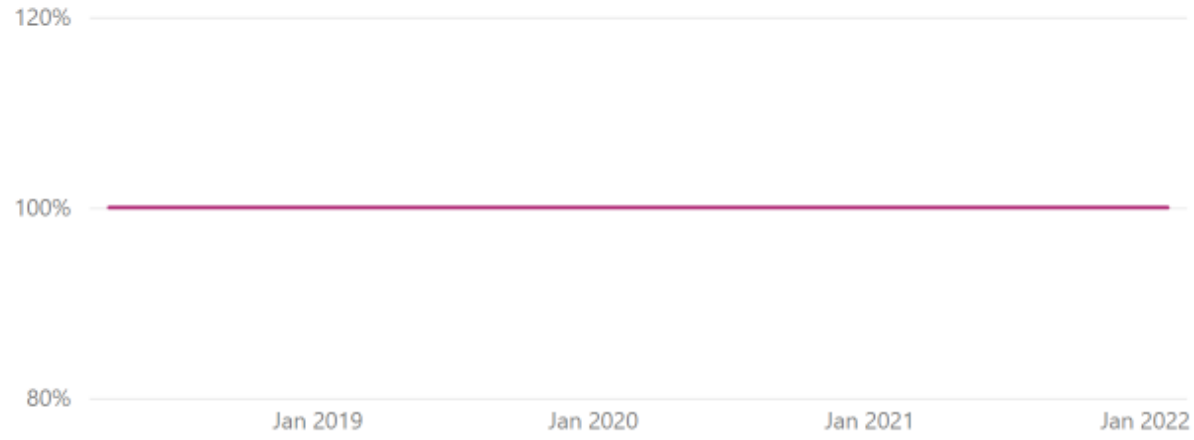
KPI	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	94.83% ↑	97.57% ↑	96.67% ↓	96.37% ↓	95.95% ↓	96.06% ↑	97.43% ↑	96.58% ↓	98.64% ↑	95.36% ↓	97.02% ↑	94.11% ↓	89.73% ↓
Friends & Family Test: Maternity % positive	81.52% ↓	85.6% ↑	89.12% ↑	79.35% ↓	82.03% ↑	77.5% ↓	76.28% ↓	81.52% ↑	81.2% ↓	85.27% ↑	80.14% ↓	84.09% ↑	79.28% ↓

These KPIs have been highlighted for the current reporting month. In depth detail and narrative is included in the reporting pack

To be ambitious and **E**fficient and make best use of available resources

Total Meeting Target

1



Positive Developments

The new process for identifying KPIs to be highlighted for review has been implemented as part of the new performance report layout. This is based on criteria set out in the report cover page. In future months this process will be embedded to provide more focussed narrative for discussion.

Areas of Challenge

Detailed commentary for each of the workforce KPIs is available within the report .

KPI	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022
Financial Sustainability Risk Rating: Overall Score	3	3	3	3	3	3	3	3	3	3	3	3	3

March 2022 – Maternity Facts

NHS
Liverpool Women's
NHS Foundation Trust

Thank you to all our families for choosing Liverpool Women's : Welcome to the world our March 2022 Babies.

595 Total Births

16 Vaginal Birth After CS

16 Home Births

Girls 277

318 Boys

983 Visits to Maternity Assessment Unit

206 Induction of labour

Spontaneous Vaginal Births 304

4 Sets of Twins

Women Booked For Care 873

96 Elective C - Sections

120 Emergency C - Sections

Have you had a March 2022 Baby? Why not send a picture to our Twitter or Facebook account. We'd love to hear from you. @LiverpoolWomens

Births on MLU 49

Instrumental Births 78

Discharges from NICU 75

20 Pool Births

Heaviest Baby 11lb 8oz
Lightest Baby 1lb 7oz

Mothers Day 27th March: 18 Births.

Our busiest day: 14th March: 29 Births.

To deliver Safe Services – Serious Incidents

Overview

There were three SI's reported in March 2022 making a total of 28 SI's reported for the year to date for 2021/22. Comparations to previous years are shown below.

Year Comparison

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
2016-17	1	2	4	2	2	2	5	3	5	3	1	0	30
2017-18	2	4	1	0	0	1	2	4	1	0	5	0	20
2018-19	1	1	1	0	3	2	1	5	0	0	1	2	17
2019-20	2	4	0	0	3	1	1	2	2	0	0	0	13
2020-21	2	2	2	3	2	2	1	3	2	3	2	1	25
2021-22	0	2	3	0	1	4	1	4	3	4	3	3	28

The number of Serious Incidents which occur in any given year can vary considerably as shown above for LWH data only. Due to SI data from Trusts not being published we are not able to benchmark this area. It is important to note that LWH has a clear process for the identification and investigation of SIs and has an open and honest approach to this.

To deliver Safe Services – Serious Incidents

March 2022 Serious Incidents

Service	StEIS Ref.	Reported in Line with Policy	Summary
Maternity	2022 - 5076	Yes	31 year old Type 1 diabetic. At 37 weeks and 5 days attended MAU with abdominal pain reduced fetal movements for several days and reducing insulin requirements. Transferred to delivery suite for continuous CTG and insulin infusion. CTG abnormal not in labour and decision made for category 2 caesarean section at 19.00. Acuity in the delivery suite with three patients awaiting cat 2 caesarean sections. Caesarean section delayed and baby delivered at 22.55 Pale and floppy cord cut immediately. Subsequent admission to the neonatal unit for sepsis screen at 14 hours of age. Baby was observed to have seizures shortly after admission and required medication for three days prior to seizure activity being controlled. MRI has shown evidence of stroke, cerebral artery occlusion large area affected by hypoxia and ischaemia. **Immediate Action Taken:** Support and case review will be offered to staff involved. Case discussion at CTG teaching session **Immediate Lesson Learnt:** Categorization of antenatal (non labour) CTG as abnormal with additional fetal risk factors should prompt an immediate decision for delivery. In the case of high acuity and multiple theatre case pending consideration of opening a second theatre should be made.
Maternity	2022 - 5065	Yes	32-year-old 35+2 weeks attended MAU with abdominal pain CTG commenced immediately and was abnormal from admission no loss vaginally. Medical review not in labour, terbutaline given. Assessed as suitable for artificial rupture of membranes (ARM) IV access obtained and transferred to delivery suite after 2 hours where the CTG became very abnormal. An ARM was performed half an hour later and the liquor was clear there was then a prolonged fetal bradycardia which did not recover and an emergency crash caesarean section under general anaesthetic was performed. The baby was born with no respiratory effort and a HR less than 100bpm and responded to resuscitation and was breathing independently. Following review at 5 hours of age the baby had become hypotonic which fulfilled criteria B and the baby was admitted to NICU for therapeutic cooling. There was evidence of a concealed abruption at delivery and the mothers total blood loss was 2L this was treated appropriately with uterotonics and blood transfusion. **Immediate Action Taken:** Reviewed at PMRT for external opinion and graded D as panel felt decision for delivery could have been taken sooner. **Immediate Lesson Learnt:** Abnormal AN CTG not in labour.
Maternity	2022 - 6420	Yes	On Saturday 19.03.2022 Maternity Services at Liverpool Women's Hospital NHS Foundation Trust went into Divert, following escalation for a period of 8 hours and 7 minutes. Time of commencement of Divert: 19.03.2022 at 10.48am Time of Stand down of Divert: 19.03.2022 at 18.55pm. **Immediate Action Taken:** Contact all patients affected by closure with apology letter Continued advanced monitoring of maternity staffing levels and acuity. Continued use of Bank and Agency Staff to support staffing levels. Continued Consultant Obstetrician oversight with 104 Bleep holders and senior managers to ensure clinical safety Recruitment processes continue for midwifery recruitment. Continued use of retention processes through preceptorship team and PMA. Awaiting further information from staff statements and incident reviews to support SUI process **Immediate Lesson Learnt:** Appropriate escalation for MDT review and contact of Manager on call to escalate extreme staffing and clinical pressures Appropriate use and escalation of on call Continuity of Care midwifery staff to support staffing pressures

To deliver Safe Services – Serious Incidents

HSIB Cases Reported and NHSR Early Notification Scheme

During March 2022 there were 3 cases which met the HSIB criteria and has been reported to HSIB

	Jan	Feb	Mar	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total
2019	0	3	1	0	3	1	2	0	0	0	1	2	13
2020	1	3 (1 rejected)	1 (rejected)	0	0	0	4 (3 rejected)	0	0	2	3 (2 rejected)	0	14
2021	1	1	2	0	2	0	1	0	3	1	3	1	7
2022	2	1	3										6

The main theme of cases being related to cooled babies in the main is due to the Trust having a very low threshold for commencing therapeutic cooling as compared to other neonatal units. A majority of babies are discharged in a short period with no ongoing neurological deficits or harm having occurred.

Duty of Candour

Duty of Candour was completed for the 10 Serious Incidents declared in Quarter 4 as follows: 4 in January, 3 in February and 3 in March 2022

Overdue Actions for reported Sis

At the time of writing this report there are no actions from Serious Incidents which are overdue.

To deliver Safe services - Safer Staffing

Gynaecology: March Fill Rate

Fill-rate –The fill rate for RN in March reflects the change in the establishment template. The overfill of RN on nights was due to a trial of Senior Nurse band 6 cover rostered onto night duty to support the junior staff and the Gynaecology Emergency Department. Safe staffing was maintained throughout March. HDU staff have additionally supported the ward due to low occupancy and demand for HDU beds. The staffing is monitored twice daily in staffing huddles and by divisional senior nursing team.

Attendance/ Absence – sickness absence for the ward is 11.29%, 38% STS, 62% LTS 4.23 WTE on Maternity leave

Vacancies – 0

Red Flags – 0

Bed Occupancy – 42.8%

CHPPD -8.4

Neonates: March Fill Rate

Fill-rate –March has been another quiet month on NICU with occupancy remaining much below average for the first half of the month. Occupancy began to increase from 24th March onwards. Safe staffing has been maintained throughout and fill rates are reflective of occupancy and acuity. The reduced activity has again resulted in low levels of bank usage and has for the second month running allowed flexibly for staff to use leave before year end and complete mandatory training.

Attendance/Absence March sickness is 5.1%, this is down marginally from February sickness levels. Short term sickness sits at 53% with long term sickness making up 47%. Covid sickness and covid special leave made up approximately 3.3%, this is down marginally on the previous month. Maternity leave has reduced to 9.9% FTE and turnover sits at 8% well below the Trust target.

Vacancies – No vacancies are advertised currently. The band 5 nurses recruited in February are finalising employment checks with most having start dates in late April/May, pending NMC registration. Two Band 7 practice educators were appointed after successful interviews held in mid-March.

Red Flags – No red Flags

Bed Occupancy – Unit occupancy has run at 52.8% this continues to run below the expected 80%. IC ran at 45.7%, HD 58.3%, LD 53.7%, and TC at 67.2%. Transitional care has been less busy than previous month. TC staff continue to support postnatal ward with troubleshooting reluctant feeders/small babies and have looked after 31 babies who were receiving IV antibiotics on the postnatal ward.

To deliver Safe services - Safer Staffing

Maternity: March Fill Rate

Fill-rate –Maternity overall continues to report high levels of sickness above the trust target, within its midwifery and support staff groups, however this continues to be on a downward trajectory. Bank and agency usage continues due to sickness rates and to cover vacancy gaps. Due to both long term (LT) and short-term (ST) sickness Maternity has been required to close MLU during this reporting period, to allow a consolidation of midwifery staffing to one clinical area. Clinical activity and staff rostered to MLU have been reallocated across the first floor of Maternity Services, to maintain safe midwifery care. Maternity undertakes a 4-hourly activity /acuity review, which allows senior midwifery staff to maintain safety by rotating staff to the areas of highest clinical need. Midwifery managers have been rostered into clinical rota gaps to support safe staffing during this period while enacting Business Continuity Plans.

Attendance/Absence – Maternity sickness is reported at 11.95% which is a combination of clinical, non-clinical and administration staff. Maternity has seen a decrease in sickness rates with staff resuming back to duty. Maternity sickness has a higher rate of LT sickness than ST sickness (43%STS versus 57%LTS). Ward managers/matrons have individual sickness reviews, and maternity are planning return to work programmes with all LT employees to facilitate appropriate returns to work. A comprehensive sickness review programme overseen by the HRBP and HOM continues on a weekly basis and the oversight has supported the reduction in active LTS cases to a total of 15 live LTS cases.

Vacancies – Current vacancy rate of 27.50wte for midwifery staff. The division continues to note a rise in staff requesting retirement and requests for contractual hours to be reduced. Maternity maintains an active recruitment plan with a rolling NHS jobs advert. At present 6.00wte Band 6 midwives are undergoing recruitment checks expected to commence in post in spring. A commitment to overrecruit for staff Midwives has resulted in the conditional offer of 55.09wte Band 5 Midwives to commence as they receive PIN numbers in autumn - with extensive onboarding activities planned over the summer months. Maternity is currently implementing an International Recruitment programme as part of the Northwest Collaboration with 8 overseas trained midwives, however the lead trust for the collaborative have informed providers that there is an expected delay of the anticipated summer arrival date.

Red flags – Maternity have a positive reporting culture for red flags, with monthly oversight reports at the Maternity Risk and Clinical Meeting. 40 Red Flags were reported in Month (of which 19 can be attributed to a delay of >2hrs from admission to commencement of Induction of Labour and 28 >4hrs attributed to delays in the continuation of ongoing Induction of Labour. Delays were necessary due to capacity and the need to provide 1:1 care in established labour and to maintain safety. Work is underway to improve the patient experience.

Bed Occupancy – Maternity continues to experience high levels of clinical activity. Following the appointment of a Deputy Divisional Manager, Maternity Capacity and Demand work is planned to be undertaken

To deliver Safe services - Safer Staffing

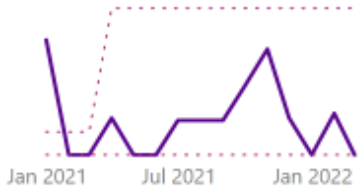
March 2022					
WARD	Fill Rate Day % RN/RM *	Fill Rate Day % Care staff **	Fill Rate Night % RN/RM *	Fill Rate Night % Care staff **	Supporting narrative (RN/RM = *; Care staff = **)
Gynae Ward	89.52%	75.27%	137.10%	100.00%	Fill-rate–The fill rate for RN in March reflects the change in the establishment template. The overfill of RN on nights was due to a trial of Senior Nurse band 6 cover rostered onto night duty to support the junior staff and the Gynaecology Emergency Department. Safe staffing was maintained throughout March, HDU staff have also supported the ward due to the low occupancy and demand for HDU beds. The staffing is monitored twice daily in staffing huddles and by divisional senior nursing team.
Induction & Delivery Suites	90.57%	91.40%	94.54%	90.32%	*Delivery Suite reported high sickness in month (15%), which required the Maternity Bleep holder to redeploy staff to maintain clinical safety and prioritise 1:1 care in labour, which included the intermittent closure of MLU and on occasions redeployment of staff from the Mat Base. Vacant shifts are requested to be filled with bank and agency as required.
Maternity & Jeffcoate	72.35%	80.17%	74.65%	89.29%	*Sickness remains at 13.5% and all vacant shifts are requested to be filled with bank and agency as required. The Maternity Bleep holder to redeploy staff to maintain clinical safety to wards of high acuity throughout the day
MLU	50.81%	35.48%	63.71%	48.39%	*/**As detailed above, due to internal escalation there were eight episodes of closure of MLU- and the staffing fill rate is reflective of the deployment of staff to Delivery Suite to consolidate activity through one area for both RM and Care Staff
Neonates (ExTC)	86.59%	82.26%	87.61%	75.81%	* and ** Fill rates are reflective of occupancy and acuity on the NICU during March. Safer staffing was always maintained.
Transitional Care	51.61%	96.77%	83.87%	64.52%	TC occupancy reduced slightly from February occupancy. Trained staff were redeployed to cover TC when NICU occupancy was low and rooms were closed as indicated in the higher trained than care staff fill rates. Safer staffing was always maintained.

Neonatal Deaths per 1000 live Births

Target: **(Blank)**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Performance Value	0	1.6	0	0	1.5	1.5	1.5	3	4.6	1.6	0	1.8	0

DQKM



Safety
Trust Value

Medical Director
Exec Lead

Clinical Director Family Health
Owner/Lead

Local
Reported To

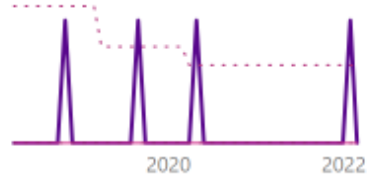
Trust
Source

Never Events

Target: **0**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Performance Value	0	0	0	0	0	0	0	0	0	0	0	1	0

DQKM



Safety
Trust Value

Medical Director
Exec Lead

Head of Governance
Owner/Lead

National
Reported To

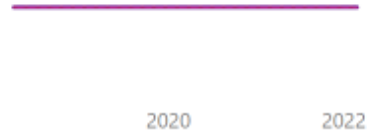
Trust
Source

NHSE / NHSI Safety Alerts Outstanding

Target: **0**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Performance Value	0	0	0	0	0	0	0	0	0	0	0	0	0

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

TBC
Source

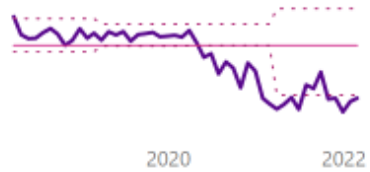
Venous Thromboembolism (VTE)

Target: **>= 95%**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
% Performance	↓ 85.48%	↓ 84.62%	↑ 85.39%	↑ 86.51%	↓ 84.58%	↑ 88.55%	↓ 87.96%	↑ 90.64%	↓ 86.25%	↑ 86.39%	↓ 84.16%	↑ 85.86%	↑ 86.38%
Denominator	↓ 1143	↓ 1053	↑ 1157	↑ 1156	↓ 1167	↑ 1127	↓ 1138	↑ 1111	↓ 1098	↑ 1029	↓ 1111	↑ 1011	↑ 1109
Numerator	↓ 977	↓ 891	↑ 988	↑ 1000	↓ 987	↑ 998	↓ 1001	↑ 1007	↓ 947	↑ 889	↓ 935	↑ 868	↑ 958

DQKM

March 2022 The VTE performance has been reviewed in the performance review meetings. Both have been informed of the need for action to improve performance and this will be monitored at DPR.



Safety
Trust Value

Medical Director
Exec Lead

Deputy Medical Director
Owner/Lead

National
Reported To

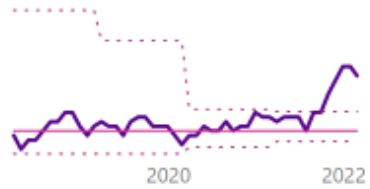
SOF / CCG
Source

Serious Untoward Incindents: Open

Target: **<5**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Performance Value	8	7	8	8	8	5	9	9	13	16	19	19	17

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

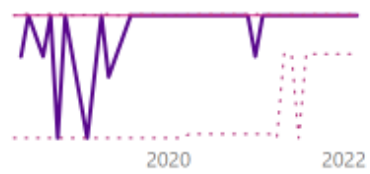
TBC
Source

Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales

Target: **1**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
% Performance	100%		100%	100%		100%	100%	100%	100%	100%	100%	100%	100%
Denominator	1	0	4	1	0	1	4	1	4	3	4	2	3
Numerator	1	0	4	1	0	1	4	1	4	3	4	2	3

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

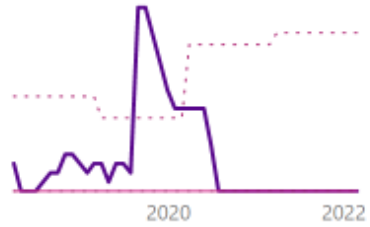
TBC
Source

Serious Untoward Incidents: Number of SUI's with actions outstanding

Target: **0**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Performance Value	0	0	0	0	0	0	0	0	0	0	0	0	0

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

TBC
Source

Serious Untoward Incindents: New (Rolling per year)

Target: **24 /year**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Performance Value	23	20	19	20	19	18	20	20	18	19	20	20	22

DQKM

Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

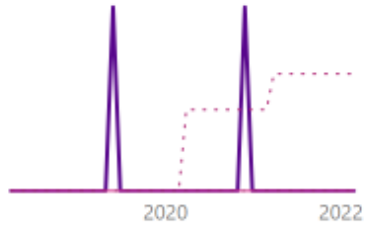
TBC
Source

Infection Control: MRSA

Target: **0**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Performance Value	0	0	0	0	0	0	0	0	0	0	0	0	0

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Infection Control Lead
Owner/Lead

National
Reported To

SOF / CCG
Source

Infection Control: Clostridium Difficile

Target: **1**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Performance Value	0	0	0	0	0	0	0	0	0	0	0	0	0

DQKM

Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Infection Control Lead
Owner/Lead

National
Reported To

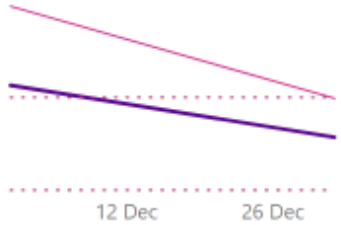
SOF / CCG
Source

Flu Vaccine Uptake Trustwide

Target: **>=100%**

Attribute	Dec-21	Jan-22
% Performance	57.06%	57.06%
Denominator	1933	1971
Numerator	1103	1135

DQKM



Safety
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

National
Reported To

External
Source

18 Week RTT: Incomplete Pathway > 52 Weeks

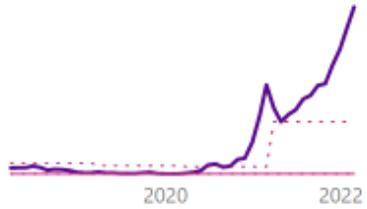
Target: **0**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Performance Value	290	214	170	194	209	244	256	288	294	354	406	479	544

DQKM

January 2022

18 week position is failing nationally due to Covid - main priorities are cancer, urgent and patients waiting over 52 weeks. Additional capacity is continually being sought aligned to Elective recovery.



Effective
Trust Value

Chief Operating Officer
Exec Lead

Deputy Chief Operating Officer
Owner/Lead

National
Reported To

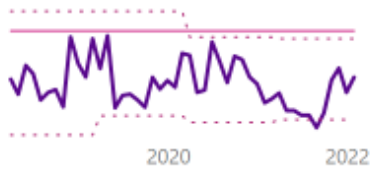
SOF / CCG
Source

All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)

Target: **>=85%**

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% Performance	↓ 26.32%	↑ 29.41%	↑ 34.21%	↓ 20%	→ 20%	↓ 16.13%	↑ 16.22%	↓ 6.06%	↑ 18.18%	↑ 44.83%	↑ 54.55%	↓ 34.78%	↑ 47.06%
Denominator	↓ 9.5	↑ 17	↑ 19	↓ 10	→ 10	↓ 15.5	↑ 18.5	↓ 16.5	↑ 16.5	↑ 14.5	↑ 11	↓ 11.5	↑ 8.5
Numerator	↓ 2.5	↑ 5	↑ 6.5	↓ 2	→ 2	↓ 2.5	↑ 3	↓ 1	↑ 3	↑ 6.5	↑ 6	↓ 4	↑ 4

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

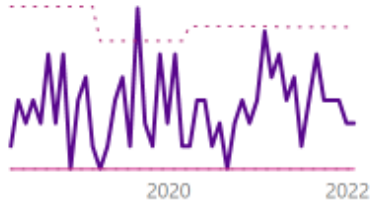
CCG
Source

Cancer: 104 Day Breaches

Target: **0**

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Performance Value	6	4	5	3	4	1	3	5	3	3	3	2	2

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

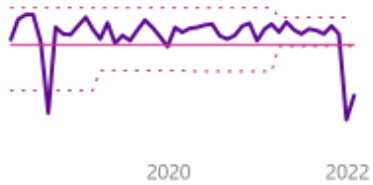
External
Source

Cancer: 2 Week Wait

Target: **>= 75%**

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% Performance	↑ 96.4%	↑ 97.48%	↓ 95.71%	↑ 97.92%	↓ 96.2%	↓ 95.32%	↑ 96.42%	↓ 96.06%	↓ 95.33%	↑ 97.04%	↓ 95.31%	↓ 76.65%	↑ 81.91%
Denominator	↑ 278	↑ 317	↓ 280	↑ 289	↓ 342	↓ 299	↑ 279	↓ 279	↓ 300	↑ 338	↓ 277	↓ 257	↑ 293
Numerator	↑ 268	↑ 309	↓ 268	↑ 283	↓ 329	↓ 285	↑ 269	↓ 268	↓ 286	↑ 328	↓ 264	↓ 197	↑ 240

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

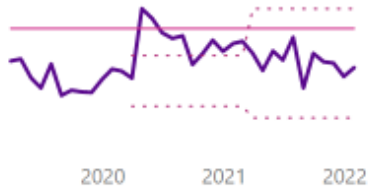
CCG
Source

Cancer: 28 Day Faster Diagnosis

Target: >= 75%

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% Performance	68.46%	69.4%	64.12%	56.72%	65.18%	61.24%	71.12%	49.12%	64.14%	60.5%	59.93%	54.1%	57.91%
Denominator	298	366	262	305	336	307	232	397	290	362	287	305	297
Numerator	204	254	168	173	219	188	165	195	186	219	172	165	172

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

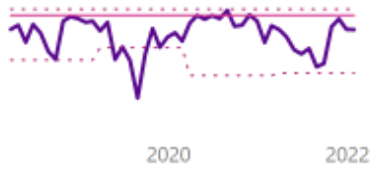
SOF / CCG
Source

Cancer: 31 Days from Diagnosis to 1st Definitive Treatment

Target: >=96%

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% Performance	73.91%	87.5%	84.380%	78.57%	68%	64.52%	68.97%	54.05%	56.76%	86.67%	93.1%	84.62%	84.380%
Denominator	23	24	32	28	25	31	29	37	37	30	29	26	32
Numerator	17	21	27	22	17	20	20	20	21	26	27	22	27

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

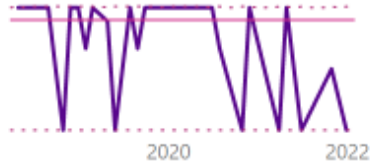
CCG
Source

Cancer: 62 Day Screening Referrals (Percentage)

Target: >=90%

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% Performance			0%	100%		0%				50%		0%	
Denominator	0	0	1	0.5	0	0.5	0	0	0	2	0	1	0
Numerator	0	0	0	0.5	0	0	0	0	0	1	0	0	0

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

CCG
Source

Intensive Care Transfers Out (Rolling 12 Months)

Target: **(Blank)**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Performance Value	11	12	12	14	13	13	11	15	15	15	15	14	15

DQKM

Effective
Trust Value

Medical Director
Exec Lead

Deputy Medical Director
Owner/Lead

Local
Reported To

Trust
Source

Overall size of Elective Waiting List

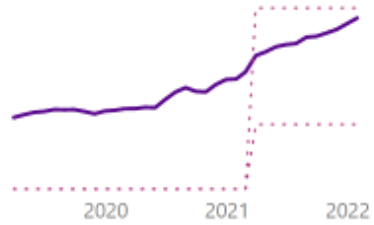
Target: **(Blank)**

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Performance Value	8981	9551	10884	11198	11609	11782	11877	12389	12458	12736	13017	13481	13945

DQKM

February 2022

The overall elective waiting list has increased as a result of the COVID pandemic and increased referrals throughout 21/22. Activity delivery and PTL management is monitored weekly via internal PTL meetings and oversight is provided via a weekly Trust Access Board. A waiting list review was undertaken by MIAA with final report received by the Trust in October 2021. An overarching action plan to address recommendations has been produced and is being taken forward to completion.



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Clinical Sup...
Owner/Lead

National
Reported To

SOF
Source

Proportion of patient activity with an ethnicity code

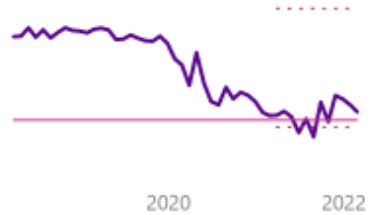
Target: **>=96%**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
% Performance	96.14%	96.15%	96.28%	96.1%	95.59%	96.03%	95.45%	96.58%	95.94%	96.8%	96.68%	96.49%	96.27%
Denominator	16971	15646	15151	16178	15200	14120	15339	14525	15273	13116	14184	13606	15244
Numerator	16316	15044	14588	15547	14529	13560	14641	14028	14653	12696	13713	13128	14675

DQKM

February 2022

Although the Trust continues to meet this target there is an ongoing focus to ensure a patients ethnicity is recorded. The main challenge relates to increases in first attendance virtual appointments and fewer contacts with administrative staff prior to the patient attending.



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

SOF
Source

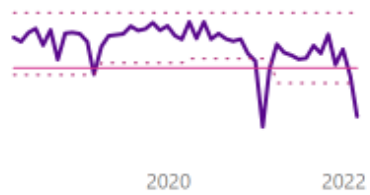
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge

Target: >= 95%

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
% Performance	94.83%	97.57%	96.67%	96.37%	95.95%	96.06%	97.43%	96.58%	98.64%	95.36%	97.02%	94.11%	89.73%
Denominator	1064	947	1021	1073	1036	989	971	1052	883	969	1039	1086	1139
Numerator	1009	924	987	1034	994	950	946	1016	871	924	1008	1022	1022

DQKM

March 2022 Performance has fallen below 95% in March primarily due to increased levels of sickness (Covid related) across nursing and medical staffing groups. Performance expected to increase through April and May 2022



Experience
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

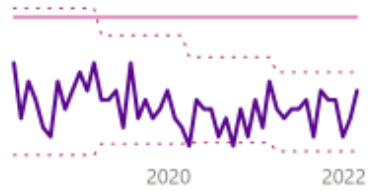
CCG
Source

Complaints: Number Received

Target: <= 15

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Performance Value	8	5	4	5	5	6	2	7	6	6	2	4	7

DQKM



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Audit, Effectiveness an...
Owner/Lead

Local
Reported To

Trust
Source

Diagnostic Tests: 6 Week Wait

Target: >= 99%

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% Performance	89.67%	87.13%	89.29%	93.16%	89.3%	90.95%	82.73%	69.65%	85.81%	87.25%	90.13%	83.08%	94.39%
Denominator	426	404	280	453	654	652	695	794	747	737	628	733	713
Numerator	382	352	250	422	584	593	575	553	641	643	566	609	673

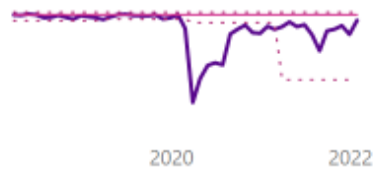
DQKM

Overall performance for each diagnostic area:
Diagnostic Waiting Times
Numerator 673, Denominator 713, Achievement 94.39%, Target 99.00%

Dexa: Numerator 35, Denominator 36, Achievement 97.22%
Non-Obstetric Ultrasound: Numerator 559, Denominator 573, Achievement 97.56%
Cystoscopy: Numerator 3, Denominator 5, Achievement 60.00%
Cystometry: Numerator 76, Denominator 99, Achievement 76.77%

KPI performance is at its highest since February 2020, demonstrating the impact of our Diagnostic recovery plan. Dexa and US scans have worked incredibly hard to maxmimise their performance with limited capacity. Cystometry capacity remains an issue, with a review with the Gynaecology division ongoing. Cystoscopy issues include patients not being fit for intervention, delays with pre-op investigation, and capacity issues.
Mitigating actions?: CSS Divisional Team continues to monitor and validate the PTL for Dexa, Gynae Imaging and Cystoscopy,
whilst the Gynaecology Divisional Team are monitoring and validating the PTL for Cystometry and RMU Imaging. To mitigate capacity issues, the department is looking to recruit 4.2 WTE sonographer vacancies. Similarly, the division is looking to recruit additional administrative capacity to monitor and support compliance.

When will target be achieved?: Q3
Why this timeframe?: National shortage of sonographers and radiographers. This is to allow for a gradual recruitment process.



Experience
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Clinical Sup...
Owner/Lead

National
Reported To

CCG
Source

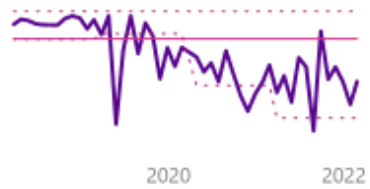
Friends & Family Test: A&E % positive

Target: **95%**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
% Performance	89.29%	83.33%	86.96%	81.25%	90.91%	88.89%	75%	96.67%	86.21%	88.89%	85.71%	80.77%	85.71%
Denominator	28	30	46	32	33	27	36	30	29	36	35	26	28
Numerator	25	25	40	26	30	24	27	29	25	32	30	21	24

DQKM

March 2022 The positive response rate for march has improved from February with 28 patients eligible to respond 24 positive, 1 displeased, feedback will be displayed on the " you said we did" board in the department and shared with staff at huddle



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Nursing Gynaecology
Owner/Lead

National
Reported To

External
Source

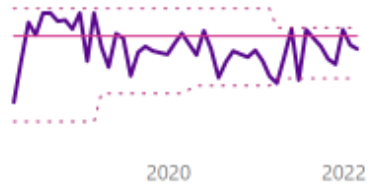
Friends & Family Test: In-patient/Daycase % positive

Target: **0.95**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
% Performance	86.32%	84.76%	90.35%	96.52%	85.45%	96.4%	94.53%	92.79%	90%	88.89%	96.4%	93.07%	92.23%
Denominator	117	105	114	115	110	111	128	111	130	108	111	101	103
Numerator	101	89	103	111	94	107	121	103	117	96	107	94	95

DQKM

March 2022 103 eligible to respond positively, 95 responded. The division is monitoring comments from patients who have provided commentary where their experience was poor for this area. Review for themes include time waiting for surgery and having to fast for long period, treatment plan main cause of poor experience. To discuss at the TOG group re listing



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Nursing Gynaecology
Owner/Lead

National
Reported To

External
Source

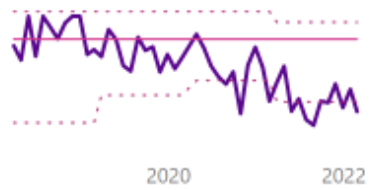
Friends & Family Test: Maternity % positive

Target: **95%**

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
% Performance	81.52%	85.6%	89.12%	79.35%	82.03%	77.5%	76.28%	81.52%	81.2%	85.27%	80.14%	84.09%	79.28%
Denominator	184	125	147	155	128	160	156	184	133	129	146	132	111
Numerator	150	107	131	123	105	124	119	150	108	110	117	111	88

DQKM

March 2022 Women's experience during her pregnancy journey has been affected due to the COVID restriction's. Partner's are allowed to support now during routine outpatient appointments and scans. 2 birth partners can accompany for birth . Staffing is improving in the post natal areas and recruitment has taken place to support the teams.



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Midwifery
Owner/Lead

National
Reported To

External
Source

Digital.Information Data Health Check

All Denominators outside of LCL have been reviewed and accepted as correct

Exec Lead	KPI	Current Month Reported	Target	KPI Meeting Target	Denominator Check
Chief People Officer	Clinical Mandatory Training Compliance	March 2022	>= 95%	No	LCL Breached

KPI Lineage

Metric Description	WE SEE	Board	FPBD	Quality	PPF	Family Health Division	CSS Division	Gynaecology Division	Maternity Clinical	Neonates Clinical (MDT)
18 Week RTT: Incomplete Pathway > 52 Weeks	Effective	Y	Y	Y				Y		
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Experience	Y	Y	Y				Y		
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Effective	Y	Y	Y				Y		
Cancer: 104 Day Breaches	Effective	Y	Y	Y				Y		
Cancer: 2 Week Wait	Effective	Y	Y	Y				Y		
Cancer: 28 Day Faster Diagnosis	Effective	Y	Y	Y			Y	Y		
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Effective	Y	Y	Y				Y		
Cancer: 62 Day Screening Referrals (Percentage)	Effective	Y	Y	Y				Y		
Clinical Mandatory Training Compliance	Workforce	Y		Y	Y					
Complaints: Number Received	Experience	Y		Y						
Diagnostic Tests: 6 Week Wait	Experience	Y	Y					Y		
Financial Sustainability Risk Rating: Overall Score	Efficient	Y	Y							
Flu Vaccine Uptake Trustwide	Safety	Y	Y	Y	Y					
Friends & Family Test: A&E % positive	Experience	Y		Y				Y		
Friends & Family Test: In-patient/Daycase % positive	Experience	Y		Y				Y		

KPI Lineage

Metric Description	WE SEE	Board	FPBD	Quality	PPF	Family Health Division	CSS Division	Gynaecology Division	Maternity Clinical	Neonates Clinical (MDT)
Friends & Family Test: Maternity % positive	Experience	Y		Y					Y	
Infection Control: Clostridium Difficile	Safety	Y		Y						
Infection Control: MRSA	Safety	Y		Y						
Intensive Care Transfers Out (Rolling 12 Month)	Effective	Y		Y						
Mandatory Training Compliance	Workforce	Y		Y	Y					
Neonatal Deaths per 1000 live Births	Safety	Y				Y				Y
Never Events	Safety	Y		Y						
NHSE / NHSI Safety Alerts Outstanding	Safety	Y		Y					Y	
Overall size of Elective Waiting List	Effective	Y					Y	Y		
Proportion of patient activity with an ethnicity code	Effective	Y	Y					Y		
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescale	Safety	Y		Y			Y			
Serious Untoward Incidents: Number of SUI's with actions outstanding	Safety	Y		Y			Y	Y		
Serious Untoward Incindents: New	Safety	Y					Y	Y	Y	
Serious Untoward Incindents: Open	Safety	Y		Y						
Sickness	Workforce	Y		Y	Y					
Turnover	Workforce	Y			Y					
Venous Thromboembolism (VTE)	Safety	Y								

Liverpool Women's
NHS Foundation Trust

Trust Board

Workforce Performance Report
May 2022

Trust Board Performance Report

This report has been produced to provide an exception position against the Trust's key performance standards. This page is designed to help readers interpret the report and understand the process for KPI selection and review.

Report Layout:

WE SEE Summary - this provides a breakdown of the number of KPIs that are meeting / failing targets for the most recent month of reported data.

Cover Sheets - these provide an overview of performance with over arching narrative for each of the WE SEE values. In addition a selection of KPIs will be selected for a more in depth review. These are selected based on whether the KPI meets one or more of the following criteria:

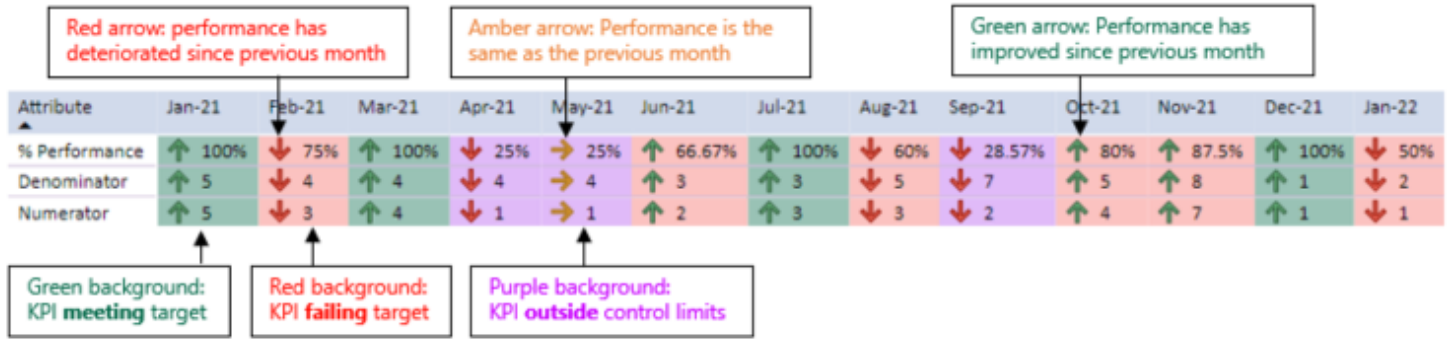
- Outside of a control limit, having previously been within control limits
- A consecutive deterioration of performance over a quarter, which is not insignificant
- A significant drop in performance over the space of a month
- A consecutive improvement in performance over a quarter, which is not insignificant
- A significant increase in performance over the space of a month
- KPIs, that following specific analysis require review, or where a change in measurement or data production require escalation

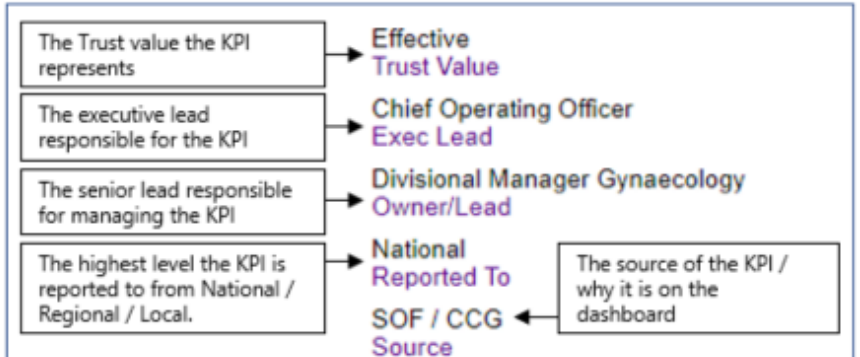
Data Sheets - these provide detailed information for each specific KPI measured. This includes data values for the previous 13 months, a sparkline included performance dating back to April 2018 where available. The sparkline graph includes the performance, target and control limits for the specific KPI. Within the data table the arrows represent whether performance has increased, decreased or remained the same. The colour coding is based on the target type as to whether this movement is positive or negative. All arrows apply to the performance and not other data items. In addition the target, target type, executive lead, operational / clinical owner / lead, source (why are we leasuring the KPI) and data quality kite mark (1 least confidence to 5 highest confidence). Narrative submitted by the KPI owner for the most recent month is included if provided.

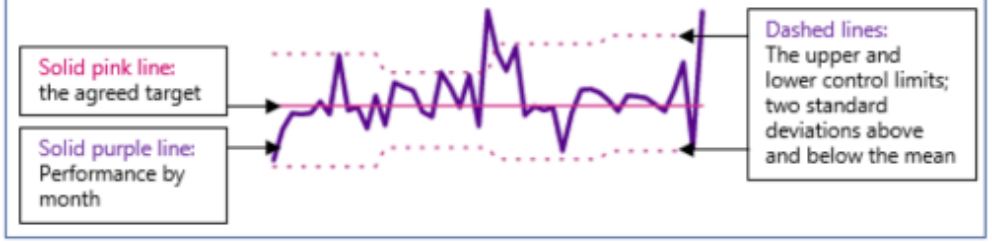
Data Health Check - highlights where KPIs have denominators outside of control limits along with a summary of the data quality kite mark scores for each KPI.

KPI Lineage - shows for each committee / meeting that KPI is included within the performance dashboard

How to interpret the report:



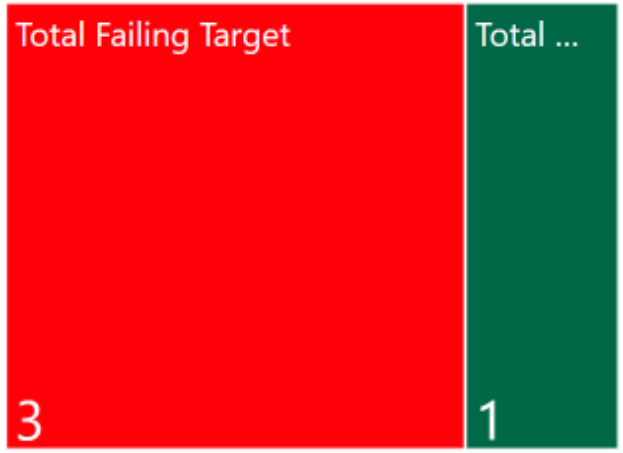


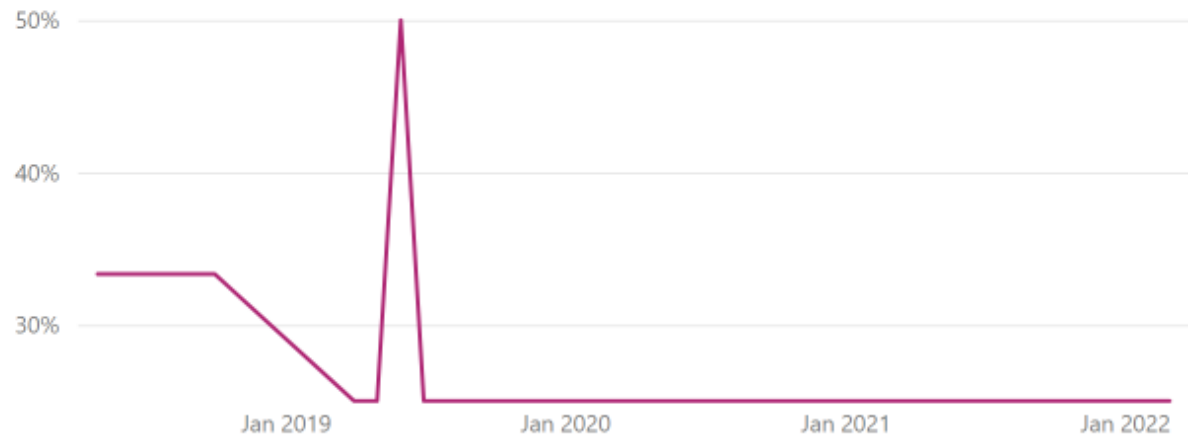


Control limits are set using statistical process control. The standard deviation for each indicator is calculated based on the previous two financial years data unless recalculation is required due to service changes. the upper and lower control limits are two standard deviations above and below the mean performance level. Where appropriate data points will be removed and control limits recalculated if reasons for adverse performance are known and accepted.

Performance is reported one or two months in arrears depending on submission deadlines. The reporting month is highlighted against each specific KPI.

To develop a well led, capable, motivated and entrepreneurial **W**orkforce





Positive Developments

The new process for identifying KPIs to be highlighted for review has been implemented as part of the new performance report layout. This is based on criteria set out in the report cover page. In future months this process will be embedded to provide more focussed narrative for discussion.

Areas of Challenge

Detailed commentary for each of the workforce KPIs is available within the report .

KPI	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
Clinical Mandatory Training Compliance	85.23% ↓	83.42% ↓	79.16% ↓	80% ↑	81.88% ↑	81.17% ↓	81.91% ↑	80.35% ↓	79.21% ↓	78.26% ↓	68.06% ↓	79.22% ↑	78.15% ↓
Mandatory Training Compliance	86% ↓	89% ↑	86% ↓	87% ↑	80% ↓	88% ↑	89% ↑	85% ↓	86% ↑	86.23% ↑	88.17% ↑	87.82% ↓	87.11% ↓
Sickness Absence Rate	5.63% ↓	5.41% ↓	5.72% ↑	6.21% ↑	7.67% ↑	7.99% ↑	8.35% ↑	8.03% ↓	7.93% ↓	10.26% ↑	10.99% ↑	7.64% ↓	9.18% ↑
Turnover Rate	9% →	9% →	9% →	10% ↑	11% ↑	11% →	11% →	13% ↑	12% ↓	12% →	13% ↑	13% →	13% →

Mandatory Training Compliance

>= 95%

KPI095T

Workforce
Trust Value

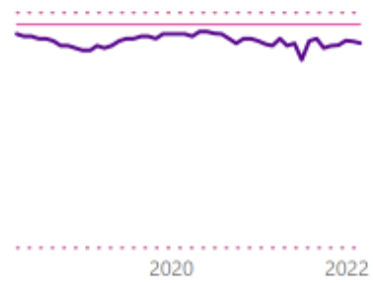
Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

Local
Reported To

Trust
Source

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
% Performance	86%	89%	86%	87%	80%	88%	89%	85%	86%	86.23%	88.17%	87.82%	87.11%
Numerator	0.86	0.89	0.86	0.87	0.8	0.88	0.89	0.85	0.86	0.86	0.88	0.88	0.87



DQKM

The overall Trust mandatory training compliance fell by 0.71%, from 87.82% in month eleven, to 88.11% in month twelve. This is now 7.89% under the Trust's target rate of 95% and rated as amber. In the largest clinical areas, compliance fell by 1.83% in Gynaecology, by 0.19% in Maternity, and by 0.39% in Neonates. At the divisional level, compliance fell by 1.95% in the Gynaecology Division, by 0.23% in Family Health, and by 3.33 in the Corporate Division, but increased by 0.26% in Clinical Support Services.

The HR and L&D teams continue to provide support, information, and training to managers across the Trust. A task and finish group, headed by the Chief Information Officer, has been established to look at E-Learning as a whole, and try and identify ways of making it more accessible and effective, and to ensure that the associated data and reporting are accurate. Auto-enrolment has now been introduced in ESR, making it far easier for staff to enrol on e-learning courses, and making the capture of compliance information more accurate.

While every effort is being made to improve and maintain compliance rates, it is difficult to accurately predict when the target figure of 95% will be achieved, particularly in light of the continuing covid 19 global pandemic and the pressures it has created both operationally and in terms of staffing. Nevertheless, every endeavour continues to be made to bring the figure within Trust target through effective collaboration between line managers, Human Resources and Learning & Development.

Clinical Mandatory Training Compliance

>= 95%

KPI378T

Workforce
Trust Value

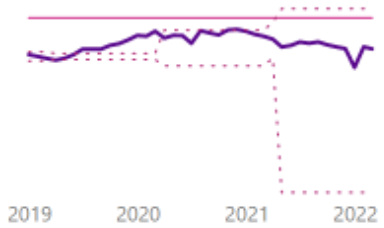
Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

Local
Reported To

Trust
Source

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
% Performance	85.23%	83.42%	79.16%	80%	81.88%	81.17%	81.91%	80.35%	79.21%	78.26%	68.06%	79.22%	78.15%



DQKM

March 2022

The overall Trust clinical mandatory training compliance fell by 1.07% from 79.22% in month eleven, to 78.15% in month twelve. This is now 16.85% under the Trust's target rate of 95% and rated as red. In the largest clinical areas, compliance fell by 2.13% in Gynaecology, by 0.30% in Maternity, and by 0.46% in Neonates. At the divisional level, compliance fell by 3.55% in the Gynaecology Division, by 0.17% in Family Health, and by 1.25% in Clinical Support Services, but increased by 7.26% in the Corporate Division.

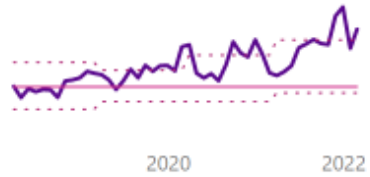
The HR and L&D teams continue to provide support, information, and training to managers across the Trust. A task and finish group, headed by the Chief Information Officer, has been established to look at E-Learning as a whole, and try and identify ways of making it more accessible and effective, and to ensure that the associated data and reporting are accurate. Auto-enrolment has now been introduced in ESR, making it far easier for staff to enrol on e-learning courses, and making the capture of compliance information more accurate.

While every effort is being made to improve and maintain compliance rates, it is difficult to accurately predict when the target figure of 95% will be achieved, particularly in light of the continuing covid 19 global pandemic and the pressures it has created both operationally and in terms of staffing. High sickness levels will also be having an impact. Nevertheless, every endeavour continues to be made to bring the figure within Trust target through effective collaboration between line managers, Human Resources and Learning & Development.

Sickness Absence Rate

Target: <= 4.5%

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
% Performance	↓ 5.63%	↓ 5.41%	↑ 5.72%	↑ 6.21%	↑ 7.67%	↑ 7.99%	↑ 8.35%	↓ 8.03%	↓ 7.93%	↑ 10.26%	↑ 10.99%	↓ 7.64%	↑ 9.18%



Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

National TBC
Reported To

SOF / CCG / Trust
Source

DQKM

March 2022

The single month sickness absence figure increased by 1.54%, from 7.64% in month eleven, to 9.18% in month twelve. This is now 4.68% above the Trust's target figure of 4.50% and is therefore rated as red. In the largest clinical areas, sickness absence fell by 0.34% in Neonates, but increased by 4.07% in Gynaecology and by 0.50% in Maternity. At divisional level, sickness increased in every division: by 4.02% in Gynaecology, by 0.21% in Family Health, by 0.52% in Clinical Support Services, and by 1.91% in the Corporate Division. Overall, the proportion of sickness that was short term increased significantly, from accounting for 38% in month eleven, up to 46% in month twelve. In terms of diagnosis, the top three most common again remained unchanged: cold/cough/flu is the most prevalent diagnoses, followed by anxiety/stress/depression, and then gastrointestinal problems. The figure for sickness specifically resulting from covid 19 increased to 2.69% in month eleven, compared to 2.29% in month twelve.

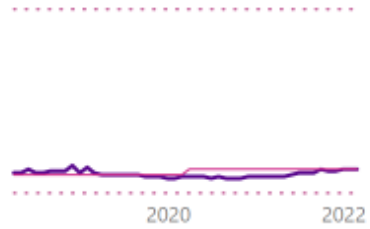
The HR Department are continuing to provide support for managers in managing sickness absence and in supporting staff through this difficult time. A range of measures are in place specifically to address the situation with regards to covid 19. These are available to all staff and include risk assessments, testing and vaccination programmes. A lot of work has also been done in pulling together and communicating to staff a whole range of available support, with a particular focus on health and wellbeing, which can now all be accessed through the Covid 19 Staff Information Hub on the intranet. This compliments the programme of Wellbeing Conversations which is being rolled out for all staff across the Trust. The new Attendance Management & Wellbeing Policy has now been launched, and further training for managers on the application of the policy is being rolled out. Compliance with requirements for all sickness absence to be followed up with the appropriate Return To Work Meeting is now regularly monitored and discussed with local managers.

Efforts to reduce sickness absence are on-going, but it is difficult to accurately predict when the target figure of 4.50% will be achieved, particularly in light of the continuing covid 19 global pandemic and the pressures it has created, both operationally and in terms of staffing. Nevertheless, every endeavour continues to be made to bring the figure within Trust target through effective collaboration between line managers, Human Resources and Occupational Health.

Turnover Rate

Target: <= 13%

Attribute	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
% Performance	→ 9%	→ 9%	→ 9%	↑ 10%	↑ 11%	→ 11%	→ 11%	↑ 13%	↓ 12%	→ 12%	↑ 13%	→ 13%	→ 13%
Numerator	→ 0.09	→ 0.09	→ 0.09	↑ 1	↑ 0.11	→ 0.11	→ 0.11	↑ 0.13	↓ 0.12	→ 0.12	↑ 0.13	→ 0.13	→ 0.13



Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

National TBC
Reported To

SOF
Source

DQKM

January 2020

What is the reason for failure against this target?: There are now ten services rated as green, one rated as amber, and eight are currently rated as red (Clinical Support Management, Gynaecology, Hewitt Centre, Human Resources, Integrated Admin, and Maternity, Neonates and Surgical Services). ;

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/040b***	**Date: 05/05/2022**
Report Title	**National Staff Survey Results 2021**	
Prepared by	Rachel Cowley, Head of Culture and Staff Experience	
Presented by	Rachel London, Deputy Director of Workforce	
Key Issues / Messages	The results of the staff survey highlight that being a member of staff at Liverpool Women's has been particularly challenging over the last 12 months. However there remain areas of good practice and it is encouraging to see positive results in neonatal and some improvements across gynaecology and theatres, pointing to the impact and influence of effective leadership. We recognise maternity is a particularly challenging and complex environment and sustained support will continue to improve engagement and involvement in this area. The key issues raised are being addressed at both a divisional and trust wide level and will inform the development of plans owned by local teams, to drive improvement. Local plans will be integrated into Divisional People Plans monitored by Divisional Boards and a summary of the plans, and the outputs from the Listening Events will be provided as an update at the next PPF.	

Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – N/A ***If no – please outline the reasons for deviation.***			
	The Board is asked to take assurance that although the staff survey results are disappointing, the relevant teams are sighted on the key issues and there are a range of actions in train which should elicit improvements over the next year and beyond. The Board is asked to consider the following initiatives outlined under each of our Big-Ticket items for 2022/23 and support the implementation and embedding of these across the Trust: • Supporting the health and wellbeing of our staff • Engaging and involving our people • Investing in our people and our Leaders • Brilliant Basics Details of initiatives for each Big-ticket item are detailed within the recommendations section of the report.			
Supporting Executive:	**Michelle Turner, Chief People Officer**			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☐

Strategic Objective(s)

To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒	To participate in high quality research and to deliver the most ***effective*** Outcomes	☐

To be ambitious and ***efficient*** and make the best use of available resource	☒	To deliver the best possible ***experience*** for patients and staff	☒
To deliver ***safe*** services	☐		

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1.2 Failure to recruit and retain key clinical staff	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The paper provides an overview of the Staff Survey results for 2021. There has been an overall trend of decline, with 22 statistically significant decreases and 6 increases. Data from our comparison group of Specialist Trusts and national data shows a general downward trend is reflected more widely in NHS organisations, the national picture has reported a decline in many of the scores from questions with some being at their lowers in the past 5 years.

The results of the staff survey highlight that being a member of staff at Liverpool Women's has been particularly challenging over the last 12 months. However there remain areas of good practice and it is encouraging to see positive results in neonatal and some improvements across gynaecology and theatres, pointing to the impact and influence of effective leadership. We recognise maternity is a particularly challenging and complex environment and sustained support will continue to improve engagement and involvement in this area.

The key issues raised are being addressed at both a divisional and trust wide level and will inform the development of plans owned by local teams, to drive improvement. Local plans will be integrated into Divisional People Plans monitored by Divisional Boards and a summary of the plans, and the outputs from the Listening Events will be provided as an update at the next PPF.

The Board is asked to take assurance that although the staff survey results are disappointing, the relevant teams are sighted on the key issues and there are a range of actions in train which should elicit improvements over the next year and beyond.

The Board is asked to consider the following initiatives outlined under each of our Big-Ticket items for 2022/23 and support the implementation and embedding of these across the Trust:

- **Supporting the health and wellbeing of our staff**
- **Engaging and involving our people**
- **Investing in our people and our Leaders**
- **Brilliant Basics**

MAIN REPORT

1. Introduction

The 2021 National Staff Survey was conducted from September to December 2021, with the results being published nationally in March 2022. The survey is carried out by all NHS organisations using a nationally agreed set of questions. As in previous years, the Trust surveyed all its staff rather than just the required minimum sample, and the survey was undertaken by Quality Health. As always, there is a very small window to demonstrate improvement from survey publication in March to the distribution of the next survey in September, therefore results and trends are better compared over a longer period.

As in previous years, our comparator group is 'specialist acute Trusts' (a group of 13) and we are benchmarked against these organisations, despite the majority of our services being akin to an acute Trust.

For the last 2 years we have seen a decline in our response rate, in 2021 it was 53% compared to 55% in 2020. The median response rate for acute specialist Trusts was 54%. In previous years our response rate has been in excess of 60%. The end of the survey period did coincide with the major incident of 14/11 but unfortunately, we were only granted a small extension to the survey window.

The Staff Survey has this year included a number of new questions including questions relating to employee's experiences of the covid pandemic.

Questions have been group to align to the 'NHS People Promise' themes.

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

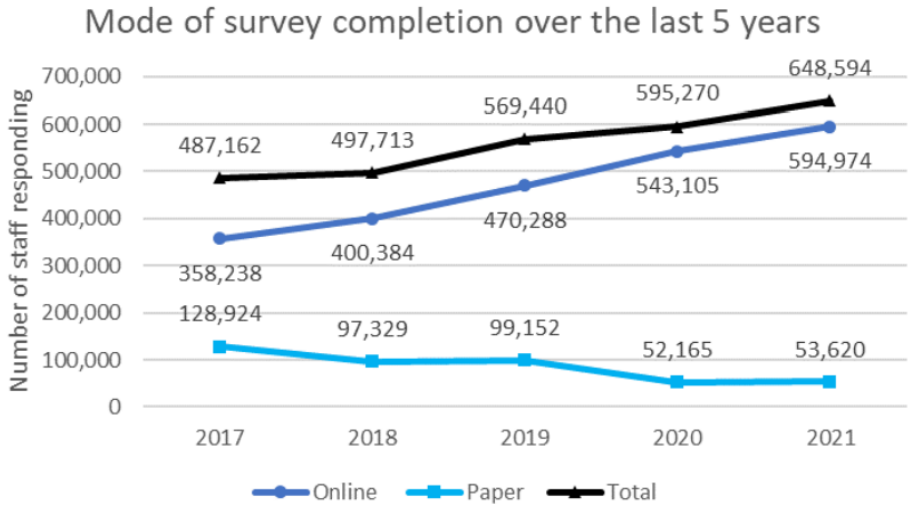
In addition to previous key themes

- Staff engagement
- Morale

The results are shown as a score out of ten for each theme.

2. National Picture

The national picture has reported a decline in many of the scores from questions with some being at their lowers in the past 5 years. The national average response rate was 48% and the graph below demonstrates the national responses over the past 5 years.



Interestingly the graph shows a decline in responses from paper surveys and LWH used a paper survey as they have in previous years.

The results for our comparator groups of specialist trusts shows a general trend of decline. In Cheshire and Merseyside, most Trusts have reported a decrease in positive scores.

3. Action to be taken as a result of the staff survey

As in previous years, the staff survey results will be communicated at a Trust and divisional / departmental level. The results will form a key component of the Divisional People Plans, which are the strategic and operational workplans for each Division.

It should be noted that although the 2021 survey shows some significant decreases, the themes and areas of concern are already recognised and captured within the overall Putting People First 2019-2024 strategy and the annual divisional people plans.

Divisional and Corporate team leaders have met with the Head of Culture and Staff Experience and their HR Business Partners to consider their results against the key themes, allowing time to assess whether actions from previous plans have had a positive/negative/neutral impact and therefore what further action is required. Support has been offered to all Divisional and Corporate team leaders from our Head of L&OD to help understand their data and what their key priorities might be as a response to the 2021 results.

Communication of the staff survey will be undertaken via a number of forums:

- **Executive Team**
- **Divisional Boards –** March and April, to support development of divisional actions
- **Whole Trust –** via email communication and video message from the Chief People Officer. In addition, the Big Conversation on 9th May at 2pm which will enable wider discussion of the staff survey themes and identify 3 or 4 top priority areas of focus for 22/23.
- **Partnership Forum –** to gain buy in to Trust wide actions
- **Individual Teams –** Facilitated sessions have commenced with individual teams via the HR and L&D/OD team to allow teams to have further discussion on key issues for them and support going forward. Specific interventions will be undertaken where there is a specific need.

4. Results

There are **110 core questions in the staff survey** plus 3 additional questions.

In analysing the results, the areas where there has been a statistically significant change (+/- 5%) have been focused on.

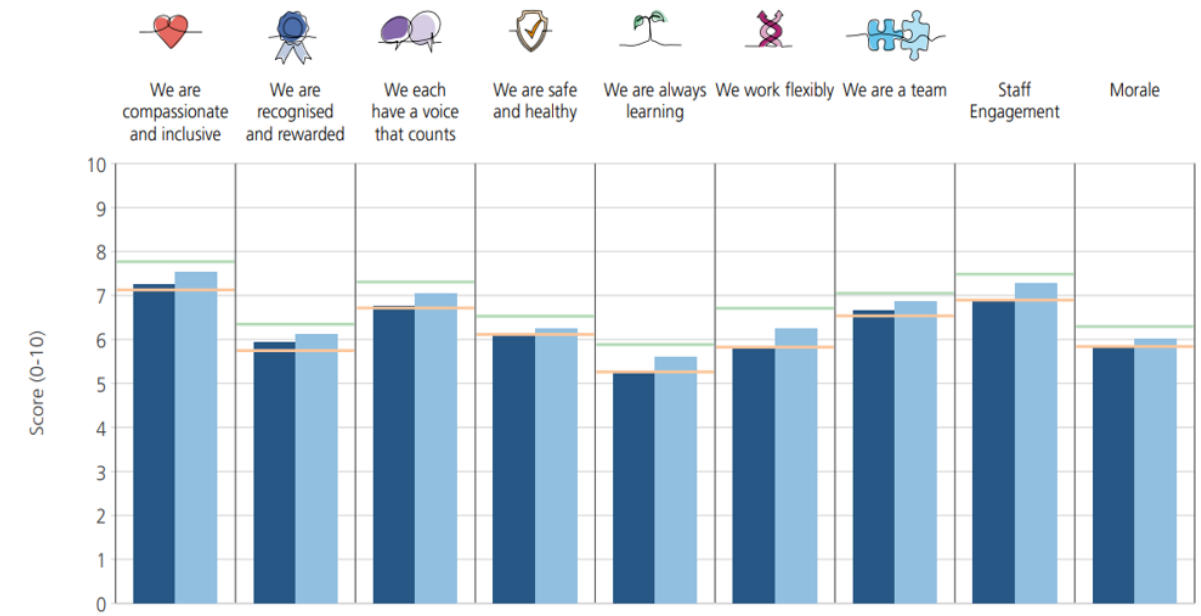
There were 22 questions where there was a statistically significant decline in the score and 6 questions where there had been a statistically significant improvement in the score.

Our overall '**staff engagement'** score has reduced from **7.1** in 2020 to **6.9** in 2021, following a pattern of gradual increase over the previous years.

Responses for other questions remained comparable to with the 2020 results.

As the questions have been grouped under the People Promise themes for the first time in 2021, direct comparison with the theme scores in 2020 is not possible. It is however, evident that LWH scores below the average score (for the 13 comparator Trusts) across all 9 themes.

People Promise and Theme Results



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.3	7.3	6.5	5.9	6.7	7.1	7.5	6.3
Your org	7.3	5.9	6.8	6.1	5.3	5.8	6.7	6.9	5.8
Average	7.5	6.1	7.0	6.2	5.6	6.3	6.9	7.3	6.0
Worst	7.1	5.7	6.7	6.1	5.3	5.8	6.5	6.9	5.8
Responses	784	783	772	766	747	773	780	783	783

Covid has undoubtedly increased pressure on staff and the LWH has experienced staff shortages to unprecedented degrees in the last 12 months, as has every NHS organisation. However, there remain a number of ongoing themes that have been present consistently over a longer time frame.

- ***Getting the basics right*.** We recognise that in some areas, improvements are needed in respect of medium-term workforce and succession planning. At a local level there are variable practices around recruitment, roster management and establishment planning. Over the last 12 months, Investment in posts such as the Deputy Chief Operating Officer, embedding of the divisional team structures through the 'Reach for the Stars Programme' (development programme for the senior divisional teams), nursing and midwifery senior leadership presence including additional scrutiny of rosters and sharing of good practice have all led to some improvements which should be reflected in future surveys

- ***Management and Leadership Vacancies*** in some key operational and N&M posts have created leadership vacuums and pressures on more junior staff in some areas. These issues have largely been resolved. A number of positive programmes have launched this year including the Leadership Programme and Coaching and Mentoring programmes.

- ***Culture*** the continued roll out and embedding of the Fair & Just Culture, captured under the Be Kind banner has continued in 2021 and this year sees the roll out of manager training to over 200 managers.

- ***Employee offer*** there has been focused work in 2021 to simply and relevantly communicate the Trust strategy and ensure that there are clear objectives flowing from the executive team through all levels of the organisation. The LWH employee brand and employment offer will be further developed in 2022.

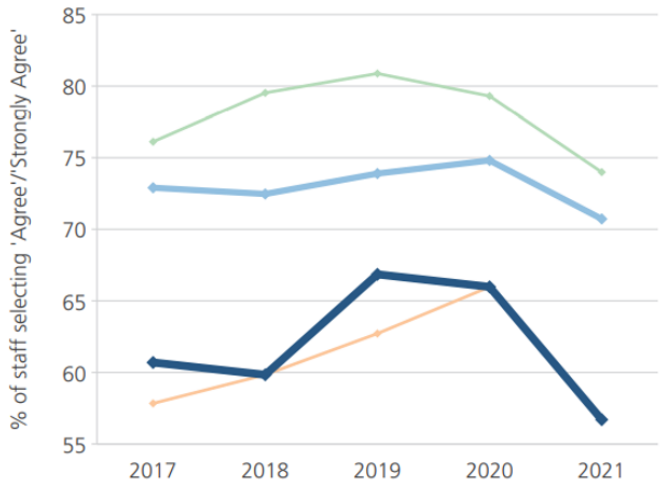
5. Key areas to highlight from the results

As previously noted, out of 113 questions, there were 28 questions which had a statistically significant change.

We have in previous years paid particular attention to the questions ***'would you recommend the organisation as a place to work'*** and ***'if a friend or relative needed treatment, would you be happy with the standard of care in this organisation'*.**

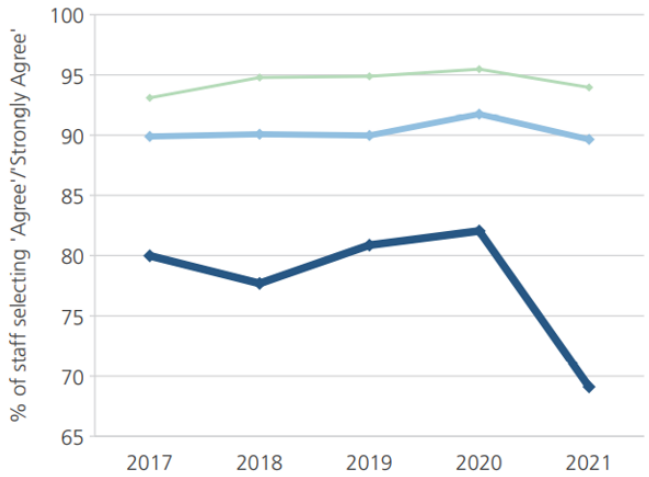
By their nature, these questions are a good barometer of how employees feel about Liverpool Women's as a whole. These questions, along with questions relating to morale, job satisfaction and employee voice, are combined to create the overall 'Staff Engagement Score'. Both these questions have seen a statistically significant decrease in positive scores, and we are the lowest scoring specialist Trust in both categories.

Q21c) I would recommend my organisation as a place to work



	2017	2018	2019	2020	2021
Best	76.1%	79.5%	80.9%	79.3%	74.0%
Your org	60.7%	59.8%	66.9%	66.0%	56.7%
Average	72.9%	72.5%	73.9%	74.8%	70.7%
Worst	57.8%	59.8%	62.7%	66.0%	56.7%
Responses	863	866	820	790	778

Q21d) If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



	2017	2018	2019	2020	2021
Best	93.1%	94.8%	94.9%	95.5%	94.0%
Your org	80.0%	77.7%	80.9%	82.0%	69.1%
Average	89.9%	90.1%	90.0%	91.7%	89.6%
Worst	80.0%	77.7%	80.9%	82.0%	69.1%
Responses	864	861	820	793	777

Another question of note, was the question **' there are enough staff in this organisation for me to do my job properly'. 24.9%** of staff at LWH said there were, compared to 40.7% in 2020 and an average score for the comparator group of 34.7%. There was also a decline in the number of staff who felt they looked forward going to work and were enthusiastic about their job.

It proved unsurprising that the number of staff who had a PDR in the last 12 months declined from 90% to 84%.

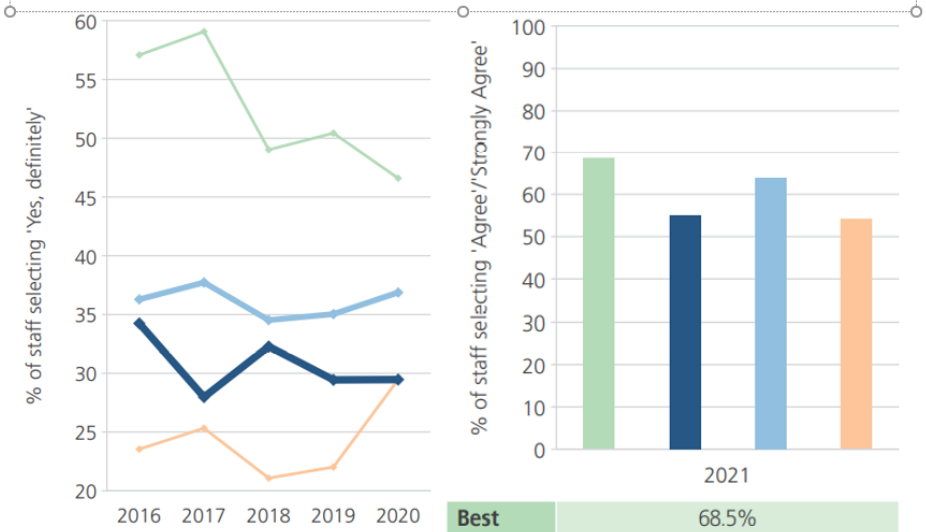
The number of staff feeling ill with **work related stress** has increased from 34.4% to 43.7%, against a comparator group score of 42.3%.

The number of staff reporting experiencing **bullying and harassment from colleagues** has increased from 13.2% to 18.4%, and this represents a bigger increase for LWH than is reflected in the national trend.

There has been an increase in **BAME staff experiencing discrimination from patients / service users** from 8.8% to 16.7%.

In terms of positive indicators, although the wording is different this year, and we are still not meeting the average for the comparator group, there has been a positive increase in the number of staff feeling like the organisation cares for their health and wellbeing

Q11a) My organisation takes positive action on health and well-being
Note in 2020 question was wording slightly differently;
Q11a) Does your organisation take positive action on health and well-being?



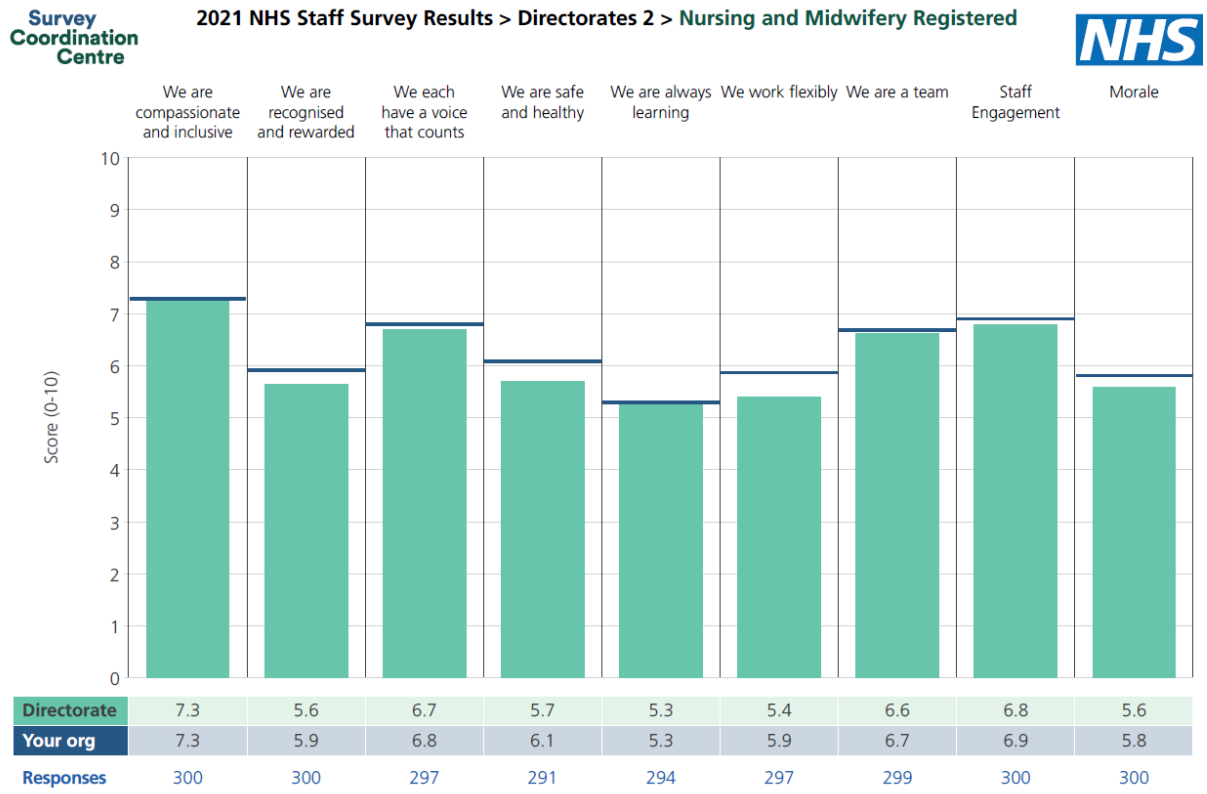
	2016	2017	2018	2019	2020
Best	57.1%	59.1%	49.0%	50.4%	46.6%
Your org	34.2%	28.0%	32.3%	29.4%	29.5%
Average	36.3%	37.7%	34.5%	35.0%	36.9%
Worst	23.5%	25.3%	21.1%	22.0%	29.5%

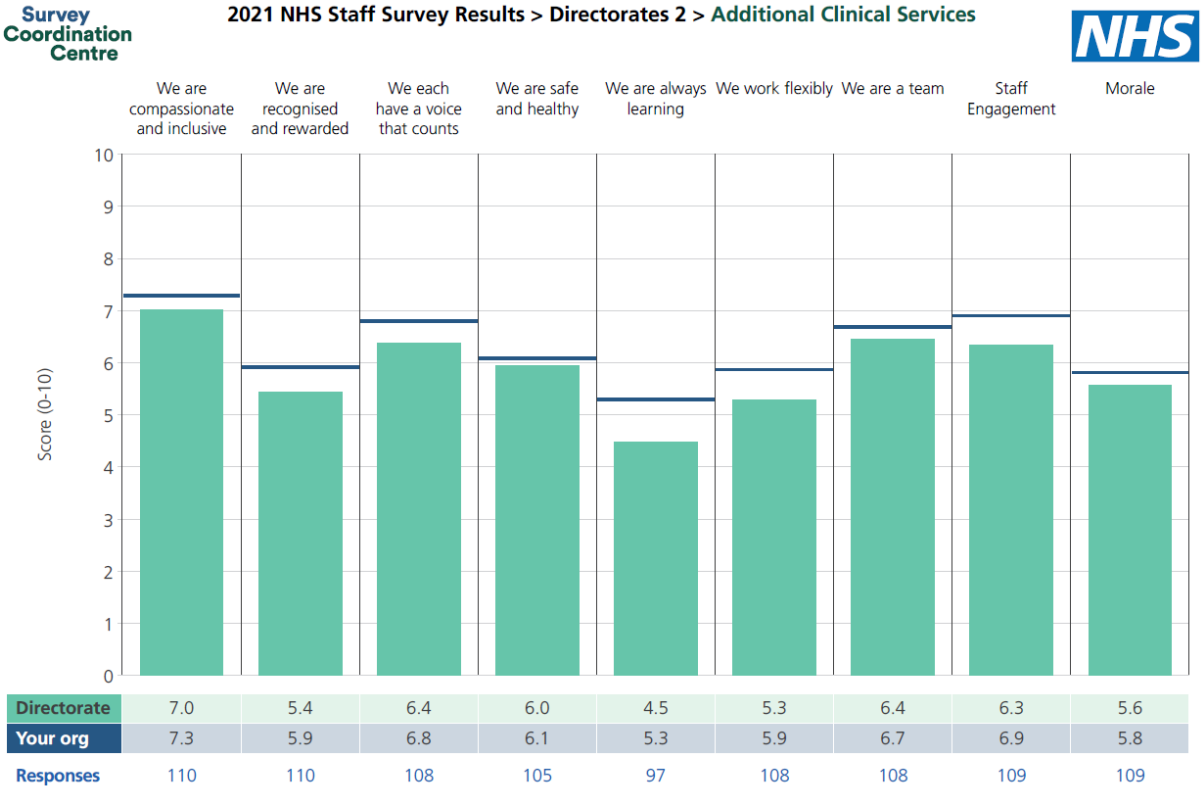
	2021
Best	68.5%
Your org	55.0%
Average	63.9%
Worst	54.2%
Responses	773

There were also positive increases in the areas of **incident reporting** with the number of staff feeling secure raising concerns about unsafe clinical practice rising from 70.3% to 75.5%

6. Results by Division and Staff Group

Results by Staff Group





As in previous years, our largest staff group, **Nursing and Midwifery registered** have scored lower than the average score for the Trust in all areas with the exception of 'We are always learning' and 'we are compassionate and inclusive' where the score was the same as the LWH score. **Healthcare Assistants** (additional clinical services) also scored lower than the Trust average across all areas, particularly in the area 'we are always learning'. This marks a change, as we have seen in previous years, a trend of HCAS reporting more positive scores than registered staff.

Across the other professional groups **Scientific and Technical staff** reported the same as or in excess of Trust average figures with the exception of 'we work flexibly' and 'morale'

Additional Scientific and Technical staff reported scores lower than the Trust average across all themes (with the exception of 'we are always learning').

Administrative and clerical staff scored higher than the Trust average across all scores. This broadly reflects 2020 results. Whilst this staff group encompasses a range of roles, it should be noted that there has been focused improvement work within the admin and access teams which may be reflected in the scores.

Allied health professionals presented a mixed picture, but were interestingly significantly below the Trust average for 'we are always learning' (4.4 against Trust average of 5.3)

Estates and Ancillary broadly reflected Trust average scores, again with the exception of 'we are always learning' (4.4 against Trust average of 5.3)

As in all previous years **Medical and Dental Staff** reported more positive scores than the Trust average. This is the same for corporate areas including **Finance** and **HR, IT and Governance.**

Results by Division

Genetics reported more positively than the LWH average on most questions but significantly lower on the 'we work flexibly' question (3.9 compared to a Trust average of 5.9).

Gynaecology were generally in line with the Trust average score across the 9 themes with the exception of 'we are always learning' and 'we are recognised and rewarded' where they were slightly lower.

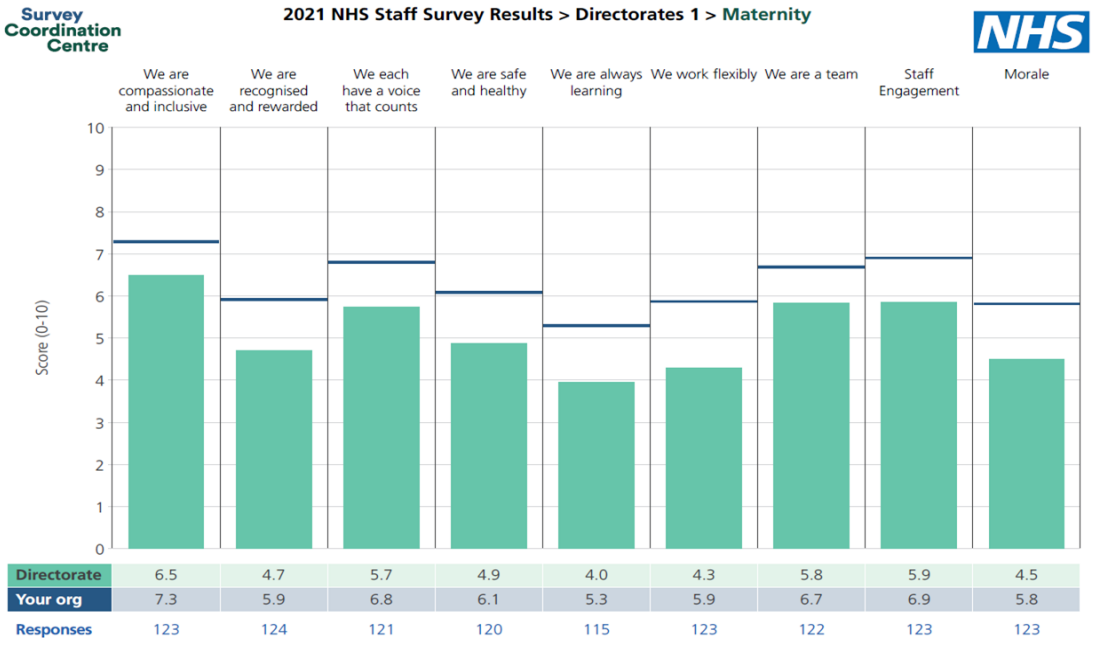
Surgical services were at or above the Trust average across the 9 themes with the exception of 'we work flexibly'.

Hewitt Fertility Centre were slightly below the Trust average across all 9 themes. There is a significant improvement project currently ongoing in Hewitt which is addressing a range of operational and workforce issues.

Pharmacy was consistently below the Trust average across all 9 themes. Over the past 5 years, there have been a number of interventions with the pharmacy workforce to improve morale and engagement, the effectiveness of these interventions clearly needs to be reviewed.

Neonatal were above the Trust average on all themes with the exception of 'we are recognised and rewarded'.

Maternity Reflecting a consistent trend over a number of years, the results for maternity are significantly below the Trust average. During Covid, the maternity service has experienced unprecedented pressures, compounding underlying vacancies and high rates of sickness. The Division has had executive support through the oversight process and has made considerable progress in terms of recruitment and engagement. Appointments into key roles will consolidate the green shoots of improvement.



7. Key areas of staff engagement activity in 2021

Divisional Engagement Activity

As previously noted, Divisions have focused their specific people actions through their Divisional People Plans which are currently being reviewed and will be relaunched in April 2022 following engagement with staff groups.

Trust Wide Engagement Activity

We continue to listen and learn to our staff by monitoring progress through a variety of formats, for 2022 these have been expanded and include:

- quarterly Let's Talk Survey ensuring we report on feedback to Divisional Boards to check progress with their Divisional Annual Plans.
- Listening Events have taken place on a quarterly basis with feedback shared through corporate communications channels.
- our Great Place to Work Group has positive representation from divisions.
- we continue to use our staff feedback machines to gather information on how our staff are feeling.
- Through various staff engagement avenues, we have sought staff views in relation to values and behaviours, which resulted in the launch of our **Be Kind message** aligned to our Trust Values.

- The **wellbeing agenda** has been an area of focus in 2021 We outlined our **'we care' health and wellbeing offer for staff** which includes upgrading of staff break rooms and facilities, improvements in Junior Doctors Mess, improving staff wellbeing outdoor spaces, mental health awareness sessions, as well as the introduction of sleep pods. Promotion of Key Wellbeing dates and events and guest speakers promoting general health, wellbeing, fitness and diversity and inclusion; ex-footballer John Barnes MBE and Professional boxer Callum Smith. In addition, Boo consultancy have provided Care for Yourself session within the Maternity Directorate over recent months.
- **Star of the month notice boards** have been updated and monthly staff awards has been relaunched. New dates for Coaching Conversations were released, dates for coaching and mentoring programme also released.
- The **Great Place to Work Group** launched in May 2021 and will be the key arena for staff to feedback their views on working at LWH as well as for the HR/OD team to test out plans and proposals around staff experience. Whilst it was recognised by this group that not all staff currently feel the Trust is a Great Place to Work, the ambition of the group is to improve communication channels and staff engagement with the Leaders in the Trust, ensure the staff voice is listened to and the Trust learns from staff experience.
- We have launched a new **Leadership Development Programme** for Band 7 leaders with a focus on inclusive, compassionate and a learning leadership style.

8. Conclusion

The results of the staff survey highlight that being a member of staff at Liverpool Women's has been particularly challenging over the last 12 months. However there remain areas of good practice and it is encouraging to see positive results in neonatal and some improvements across gynaecology and theatres, pointing to the impact and influence of effective leadership. We recognise maternity is a particularly challenging and complex environment and sustained support will continue to improve engagement and involvement in this area.

The results of the staff survey will inform both divisional people plans and the workplan for the HR/OD team for the next 12 months. Given the appointment of key posts within both divisional teams and the HR/ OD team, there is confidence that improvements will be made.

Staff have verbally requested for the survey to be moved to an electronic format as this can be completed anywhere at any time. There is clear national evidence that those who have completed paper surveys have seen a decrease in staff responses, therefore it is anticipated that in the National Staff Survey for 2022 LWH will move to all electronic forms to improve access to the survey for our staff.

In addition to the activities from 2021 that are business as usual the Board are asked to consider the following Big-Ticket Items for 2022/23:

- **Supporting the health and wellbeing of our staff**
- **Engaging and involving our people**
- **Investing in our people and our Leaders**
- **Brilliant Basics**

Initiatives for the Big-Ticket items are outlined within the recommendations section of this report.

9. Recommendations

The committee is asked to take assurance that although the staff survey results are disappointing, the relevant teams are sighted on the key issues and there are a range of actions in train which should elicit improvements over the next year and beyond.

The committee is asked to consider the following initiatives outlined under each of our Big-Ticket items for 2022/23 and support the implementation and embedding of these across the Trust:

Supporting the health and wellbeing of our staff

- **Embed Be Kind, launch Be Brilliant** and the Trust values and behaviours in all arenas, including recruitment with a focus on values led recruitment for HCA staff.
- **Human Factors training** and MDT learning will continue to consolidate multidisciplinary relationships in the division.
- Joint working with our **Freedom to Speak Up Guardians** to continue to improve reporting for clinical concerns and expand this to another avenue for staff to raise any workplace concerns they may have.
- We are currently working with our Governance Team to identify the hot spot areas in relation to raising of concerns, to identify areas that may require some additional specialist input and support.
- We are commissioning a **Race and Culture review** for LWH to be conducted by an External ED&I professional (identified by Inclusive Companies) to help identify areas where we can improve.
- **Just Culture** leadership training to be rolled out, along with updated HR policies (sickness absence, disciplinary, resolution) and updated SI process. Full communication of the Just Culture proposals will be shared with all staff and an outline of Behaviours will be shared with supportive examples on how to approach someone if behaviours do not align to the Be Brilliant, Be Kind, Just Culture approach LWH is embracing and embedding.
- Encourage our staff with a **lived experience of a protected characteristic** to disclose this on ESR staff database (will do this through a cleansing exercise in March/April) and encourage them to be part of the staff network groups (BAME and Disability) where they can share their staff experience at LWH. This will allow sharing of best practice, as well as any areas that can be improved, with a focus on **zero discrimination.**

Engaging and involving our people

- **3 Key Messages of the week** has been piloted successfully and will be rolled out Trust wide in May 2022. This is a request for managers to communicate '3 key messages' at every huddle and handover for a 1-week period. This includes the Executive weekly update, Divisional key message and Departmental/Team key message. In 2022/23 this will be visual at the staff entrances and more support from the Great Place to Work Group to ensure key messages are shared with our colleagues.

- **Listening Events** will continue, however the format will change, these will be 6 times a year, Executive Directors will be invited to 2 full sessions, the remainder of the sessions outputs will be reported to Executive Directors through a summary report.
- We are in the process of creating an **anonymous online feedback form** for staff, as well as reintroducing the paper version of a feedback form – both of which can be used at any time throughout the year and look for the staff members input into the solution to be problem / concern.
- quarterly Let's Talk Survey will continue ensuring we report on feedback to staff through a **'You Said… We Did…'** approach for each Division.
- Reintroduction of the **Staff Annual Awards,** offering an opportunity for staff to be nominated for outstanding achievements at LWH.
- **Communicate the agree ratios** and numbers for staffing within all areas on a consistent basis to improve staff knowledge of safe staffing levels.
- **Promote positive stories** shared through PALS and positive learning from patient experience.
- **Ensure Divisional voices across a variety of roles are reconsented** at our Big Conversation events and Great Place to Work Group.

Investing in our people and our Leaders

- There is a **PDR** task and finish group focusing on how we can increase compliance and ensure positive PDR conversations take place with career conversations for all staff.
- **PDR window** for Band 7 and above staff April to June 2022 to enable Board to Ward objective setting.
- Expansion of **EDI training** to focus on EDI in a healthcare environment, aiming to reduce microaggressions and bias.
- **Focused OD Support for the Maternity Leadership team** This has commenced and will continue with the new appointments to create a strong and sustainable leadership team.
- **Roll out of LWH leadership programme to Band 6 staff** building on learning from Band 7 and 8a
- **'We Learn' Prospectus** being devised for sharing with staff so they are aware of the different avenues for learning and development that are available to them.

Brilliant Basics

- Ensure that the basic hygiene factors are met for our staff with ongoing focus on **roster management, recruitment and establishment planning**.
- **Flexible working** A detailed action plan is now in place and divisional engagement is ongoing with the objective of changing the Trust's cultural approach to flexible working and offering a much wider range of options to staff with the objective of increasing control, autonomy and job satisfaction.
- **Health and Wellbeing Committee** will be reviewed with support offered from the great Place to Work Group on how the Health and Wellbeing agenda can best be progressed in 2022/23.
- A new **In-House Psychological Support** team will include a Consultant Clinical Psychologist, Assistant Psychologist and Midwifery Wellbeing Coaches being recruited in 2022/23 to provide support to staff on various levels, including wellbeing, improving morale and

encouraging staff to speak up and help develop the solutions to improve how it feels to work at LWH.

- **Upgrading of Staff Facilities** has been considered and will be supported as outlined in the 'We Care' offer, this includes upgrades to our staff outdoor spaces and the introduction of beehives, wild flower garden and a zen garden, as well as an upgrade to the conservatory space and staff rooms that require refreshing.
- Planned event to promote **Access to Work** and **Reasonable Adjustments** available for all staff, how they can access this and clear steps for managers who are supporting staff following an Access to Work assessment.

Our Head of Culture and Staff Experience continues to analyse the results data by carrying out a more in-depth analysis of the staff survey results to **identify hotspots** where workforce / resource is concern or where there is destabilisation. Liaise with HEE about them supporting a **STAR framework discussion** to look at how we can improve the staff concerns about workforce in hotspots.

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
25 April 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Although cash levels are improved at year end, at £11.2m, these are enhanced by the receipt of PDC and higher capital creditors at year end. As these creditors will be settled in April and May, if the Trust is in a deficit position for 2022/23, cash levels will deteriorate and the Trust will have to rely on distressed finance support from M5. • Areas of challenge identified by the operational performance report with the 2-week wait referral to treatment target and the GED 4-hour target. A capacity review will be undertaken and a meeting with commissioners requested to discuss appropriate referral of patients onto pathways. • The Committee received a presentation detailing the planned budget for 2022/23. Non-Committee Board members joined the meeting at this point to have a detailed discussion on the proposed plan ahead of formal sign off at the extraordinary Board meeting. The Committee was asked to recommend a deficit plan of £5m. It was confirmed that the Trust would not be in breach of statutory obligations as a Foundation Trust by approving a deficit plan. The Committee noted that the impact of Ockenden 2, and any funding associated with this had not been included in the plan and will be amended when available. The CFO agreed to write to the ICS DoF to formalise the position which has been discussed through meetings of the ICS, in particular covering: equity, resourcing for required clinical investments and an open book approach to review of other organisations' position.	• The Committee received an update on the Future Generations Programme noting that engagement activities have been stepped up and, as a result, the programme has received significant local, regional, and national attention. The Counterfactual Case has been updated and approved by the Future Generations Clinical Advisory Group in February 2022 with no disagreement noted. The Counterfactual Case has received external independent scrutiny from the Northern England Clinical Senate. Informal feedback from the Senate Chair noted consensus with the Trust regarding the scenarios outlined within the case. The Trust awaits final written feedback. Activity will continue to push forward the programme, including development of the Strategic Outline Case and development of a more detailed proposal for the future of the Crown Street building, in partnership with local provider organisations. It was noted that a refresh of the financial case was underway. • The Committee received an update on the Crown Street Enhancements (CSE) Programme noting Phase 2 works (CT and MR imaging and colposcopy) had commenced and progressing well against planned timeframe to complete in December 2022. There is a risk that completion of the colposcopy suite (planned for June 2022) will be delayed due to supply chain issues related to current world events, however this is not yet confirmed.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**

• The Committee noted the slight improvement against the 2021/22 Plan and achievement of a small (£34k) surplus for the full financial year (subject to audit). The Committee noted the difficulties in getting to this favourable position given the challenges in year. A number of non-recurrent items were noted.
• Noted during Month 12 that the Cost Improvement Programme (CIP) delivered savings above the £2.0m target, and successful capital spend of £11.7m was incurred by year-end, including digital investments funded by PDC.
• Received assurance regarding the Digital Programme activities underway for EPR, GDE and Digital Maternity. The Committee noted the revenue and capital plan for the
	• Committee agreed to recommend to the Board to approve the I&E position of a £5m deficit with approval of the final plan delegated to the CEO and CFO, with the following caveats:
	  ○ The deficit position does not worsen from this position.
	  ○ A clear and structured cash plan allowing the Trust to adhere to its own treasury policy is in place either within C&M or through an application for PDC from the national team.
	• The Committee recommended Board approval of the draft 2022/23 corporate objectives aligned to the Committee.

Meditech Expanse project as signed off by the Trust Board and the performance against plan.

- The Committee received the Information Governance quarterly update, noting no notable SIRO or Caldicott Guardian related matters.
- Received the Communications, Marketing & Engagement Strategy 2021-24. The Committee noted a focus on communications and engagement within the strategy and a challenge to identify marketing priorities. It was acknowledged that the Communications Team required clarity from divisions and departments of marketing aims to enable effective support. It was recommended that the Executive Team should undertake a reflection on marketing to provide clarity.
- Noted positive progress against the Community Diagnostic Centre workstreams.
- The Committee received the Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2021/22. It was assured that the NHSE/I assurance process had been completed in October 2021 with Trust compliance reported to the Board (November 2021) and summarised within this report. Key activities during 2021/22 included continued Covid-19 incident response, major Incident (November 2021) response and debrief procedure, and continued EPRR workstream actions focused on achieving and maintaining the NHSE EPRR Core Standards for 2022.
- Positive assurance of progress made by the Estates and Facilities Team to ensure that key statutory compliance is being effectively managed. Significant developments and management of the PPM system in Hard FM is now enabling key tasks and checks to be systematically scheduled in accordance with Health Technical memorandum guidelines. The Committee was assured that the Trust was now engaging Authorising Engineers to provide an independent review of services, provide advice and make recommendations for improvement in areas of safety and compliance. The Committee also noted that the governance arrangements had been further strengthened by the reconstituted Estates and Facilities Performance and Assurance Group and was now instrumental in driving improvements in compliance during 2021/22, reporting up to the Committee.

Summary of BAF Review Discussion
(Board Committee level only)

- The Committee reviewed the Finance related BAF risks noting a formal review had been undertaken to reflect on the content of the BAF and consider the on-going relevance of the content in the context of the Trust's strategic objectives into 2022/23. Narrative changes were identified.
- It was recommended that the risk score for BAF Risk 2.4: Major and sustained failure of essential IT systems due to a cyber-attack be increased from possible (3) to likely (4) due to potential increased cyber threat resulting from the current geopolitical situation. The NHS has reflected the increased threat through guidance issued to all NHS providers and arm's length bodies during March 2022. This BAF risk has not met its target for 2021/22. Due to the aforementioned uplift in risk score for Q4 2021/22, it is suggested that a realistic target of '15' be established for 2022/23.
- No risks closed on the BAF for FPBD Committee.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Sufficient time provided to discuss matters thoroughly
- Good contributions and challenge throughout the meeting.

2

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
06.	Board Assurance Framework Review	Assurance	13.	Community Diagnostic Centre Update	Information
07.	Finance Performance Report Month 12 2021/22	Assurance	14.	Emergency Planning Resilience & Response Annual report	Assurance
08.	Operational Performance Report Month 12 2021/22	Assurance	15.	Annual Estates and Facilities Compliance Report	Assurance
09.	Review of 2022/23 Plan	Information	16.	Corporate Objectives 2022/23	Approval
10.	Review of Strategic Progress	Information	17.	Sub-Committee Chairs Reports	Assurance
11.	Digital Services Update	Assurance	18.	Crown Street Enhancements Programme	Information
12.	Communications, Marketing & Engagement Strategy 2021-24 Annual Review	Information			

3. 2022 / 23 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Louise Martin	✓										
Tracy Ellery	✓										
Tony Okotie	✓										
Sarah Walker	✓										
Eva Horgan	✓										
Kathryn Thomson	✓										
Gary Price	✓										
Marie Forshaw	✓										

Present (✓) Apologies (A) Representative (R) Nonattendance (NA) *Non-quorate meetings highlighted in greyscale*

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/41b**		**Date: 05/05/2022**	
Report Title	**Finance Performance Review Month 12 2021/22**			
Prepared by	***Claire Deegan, Deputy Chief Finance Officer***			
Presented by	***Eva Horgan, Chief Finance Officer***			
Key Issues / Messages	***To take assurance from the Month 12 financial position.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – If no – please outline the reasons for deviation.			
	The Board is asked to note the Month 12 Financial Position.			
Supporting Executive:	***Eva Horgan, Chief Finance Officer***			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*							
Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☒				
Strategic Objective(s)							
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒	To participate in high quality research and to deliver the most ***effective*** Outcomes	☒				
To be ambitious and ***efficient*** and make the best use of available resource	☒	To deliver the best possible ***experience*** for patients and staff	☒				
To deliver ***safe*** services	☒						
Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)							
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks*		Comment:					

4.1 Failure to ensure our services are financially sustainable in the long term	
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Finance, Performance and Business Development Committee	25/04/2022	Eva Horgan, Chief Finance Officer	The Committee noted the report.

EXECUTIVE SUMMARY

At Month 12, the Trust is reporting a £34k surplus for the year against a £17k deficit plan. This equates to a breakeven position within the Cheshire and Merseyside Integrated Care System (C&M ICS) after technical adjustments to financial performance are taken into account. The Year to Date (YTD) trust wide position has improved in month due to non-recurrent benefits, such as additional system funding, improved ERF income and additional Health Education England (HEE) allocations. This has been offset by the ongoing pressures in agency staffing, gas and electricity prices. The Trust has also made provision for restructuring costs and potential tax liabilities.

Whilst the Cost Improvement Programme (CIP) delivered savings above the £2.0m target, Elective Recovery Fund (ERF) income is significantly behind plan, and a number of provisions have been made at year end. However, these have been offset by additional funding provided by Cheshire & Merseyside ICS. £1.5m had been agreed in February, and a further £1.5m was agreed in late March.

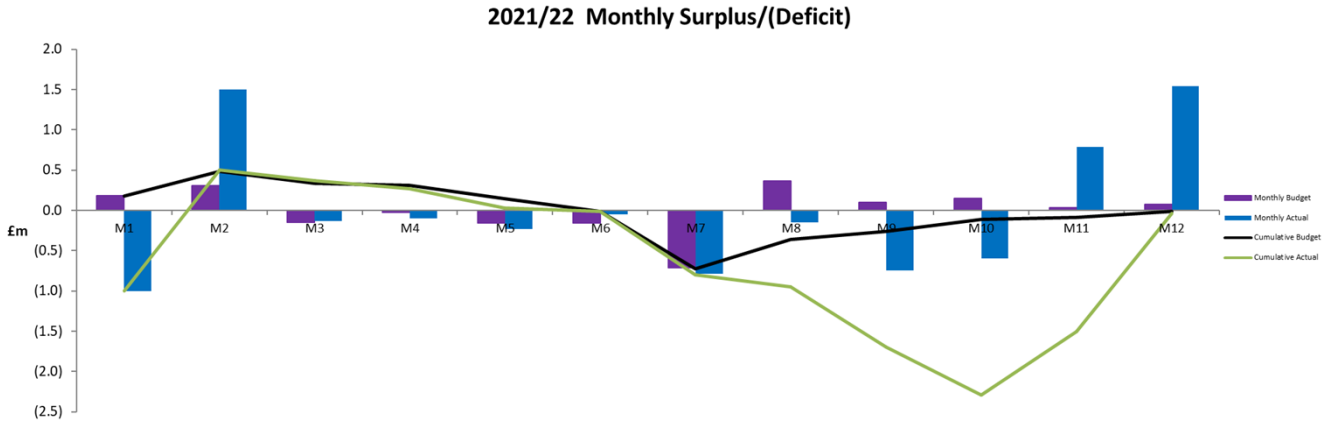
	Plan (Revised)	Actual	Variance	RAG	*R*	*A*	*G*
Surplus/(Deficit) YTD	-£0.1m	£0.0m	£0.1m	↑	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast	£0.0m	£0.0m	£0.0m	↔	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	↔	*4*	*3*	*2+*
Cash	£4.5m	£11.2m	£6.7m	↑	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement	£2.0m	£2.3m	£0.4m	↑	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement	£2.0m	£1.6m	-£0.4m	↓	*>10% off plan*	*Plan*	*Plan or better*
Elective Recovery Fund (net)	£2.4m	£1.8m	-£0.6m	↑	*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£0.0m	£5.7m	£5.7m	↓	*>£0*		*<£0*
Capital Spend YTD	£13.2m	£11.7m	-£1.5m				

MAIN REPORT

1. Summary Financial Position

At Month 12 the Trust is reporting a surplus of £34k for the year against a £17k deficit plan per the revised budget. The graph below shows outturn against the revised plan. Additional income of £3m has been agreed from the system to support the Trust to offset the overall underachievement of ERF income in the second half of the year (H2) and

the additional pressures identified at year end. In relation to the cash payment, £1m of this was received in March 2022 and the remaining £2m is due to be transacted to the Trust in April.



2. Divisional Summary Overview

Financial performance remains a concern for Family Health and Gynaecology divisions in particular with continued pay pressures across services.

Family Health: The division continues to overspend against pay budgets. Work continues to reduce pay pressures driven by agency usage.

Gynaecology: The division was overspent by £3.9m. The overspend is primarily related to activity and income being behind plan.

Clinical Support Services: The division have ended the year with a £120k overspend. This has been driven mainly by increased recharges from other providers.

Agency: Agency spend across the Trust for the year was £3.4m. Work is ongoing to reduce this, particularly in maternity.

Fuel costs: Energy cost pressures for the year were £0.7m.

3. Community Diagnostic Centre

In a change from previous forecasts, income of £1.1m for the Community Diagnostic Centre has been recognised in year against the allocation of £2.4m, with the balance deferred for future use on the CDC.

4. Elective Recovery Fund

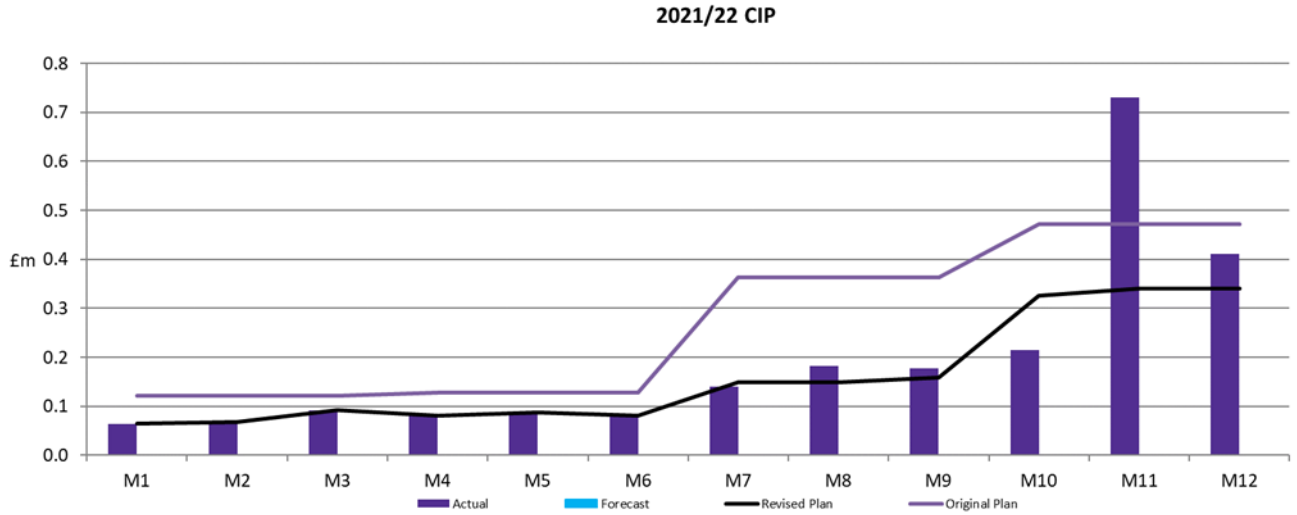
The Elective Recovery Fund was put in place during H1 to incentivise providers to undertake more elective activity and to pay for the additional costs associated with this. The mechanism for ERF has changed in H2 and is based on completed referral to treatment (RTT) pathway activity rather than total cost weighted activity which was used in H1.

The Trust and Cheshire & Mersey needed to achieve a completed referral to treatment (RTT) pathway activity above a 2019/20 89% threshold to achieve ERF payment.

The Trust has had a further £80k of ERF income confirmed for M10 with £301k estimated for M11 and M12. This is a significant improvement from quarter 3.

5. CIP

The CIP plan was revised as part of the H2 planning process and approval. In year monitoring was against the original agreed CIP plans as well as against revised H2 targets. The graph below shows both the original and revised plans and the outturn for the year.



The CIP programme exceeded the plan by £0.38m, but with £0.72m reliance on non-recurrent savings.

6. COVID-19

The Trust has spent £1.4m on direct Covid-19 related costs in 2022/23. Costs identified as Covid-19 related were reallocated to the Covid-19 budget.

7. Cash and Borrowings

The closing cash balance in Month 12 is £11.2m. The position reflects the benefit of not paying out CNST premiums in the final months of each year. It also reflects the receipt of PDC funding for digital investment schemes. Although this is reflected in capital expenditure for 2022/23, the high spend in February and March is held within capital creditors at year end. Cashflow will reduce in M1 and M2 of 2022/23 as these liabilities are paid.

8. Capital Expenditure

The overall capital plan has increased from the original £7m to £13.2m (due to an additional £3.8m for the Community Diagnostic Centre and £2.1m for digital diagnostics). The Trust had forecast an underspend of £1.4m, driven principally by delays on the CDC project. Final outturn for the year was an underspend of £1.47m.

The capital plan for 2022/23 includes all contractually committed spend brought forward from 2021/22 plus all business critical spend identified by the divisional/service leads in the Trust and will be monitored by the capital group on a regular basis.

9. Balance Sheet

Debtors have improved and are at £1.5m at month 12 following debt write offs in the year.

Performance against the Better Payment Practice Code for non-NHS suppliers has reduced slightly from to 85% by value. The Regional Director of Finance has written to trusts to request that attention is given to the Better Payment Practice Code and an action plan put in place to improve from the current position to the target (95%).

Note also that the Trust's retained earnings improved in M12 and are now positive, having dropped to a negative value in M11.

10. Year end statutory accounts

At the end of each year there are some nationally mandated technical adjustments to the accounts which do not impact on the Trust's overall surplus position as the notional cost is directly matched by notional income. As in previous years, these will be transacted in the statutory financial statements but are not included in the ledger values reported above.

11. BAF Risk

There are no proposed changes to the BAF score.

12. Conclusion & Recommendation

The Board is asked to note the position and take assurance from the report.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M12

YEAR ENDING 31 MARCH 2022

Contents

1 NHSI Score

2 Income & Expenditure

3 Elective Recovery Fund

4 Expenditure

5 Covid-19 Expenditure

6 Service Performance

7 CIP

8 Balance Sheet

9 Cashflow statement

10 Capital

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M12
YEAR ENDING 31 MARCH 2022

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	8,098
(b) PDC + Interest Payable + Loans Repaid	1,860
CSC Ratio = (a) / (b)	**4.35**
NHSI CSC SCORE	**1**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25	
LIQUIDITY	
(a) Cash for Liquidity Purposes	(14,086)
(b) Expenditure	131,639
(c) Daily Expenditure	361
Liquidity Ratio = (a) / (c)	**(39.1)**
NHSI LIQUIDITY SCORE	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)	
I&E MARGIN	
(Surplus) / Deficit (Adjusted for donations and asset disposals)	(36)
Total Income	(139,728)
I&E Margin	**0.03%**
NHSI I&E MARGIN SCORE	**2**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)	
I&E MARGIN VARIANCE FROM PLAN	
I&E Margin (Actual)	0.00%
I&E Margin (Plan)	0.00%
I&E Variance Margin	**0.00%**
NHSI I&E MARGIN VARIANCE SCORE	**1**
Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%	
AGENCY SPEND	
YTD Providers Cap	1,788
YTD Agency Expenditure	3,449
	93%
NHSI AGENCY SPEND SCORE	**4**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%	
Overall Use of Resources Risk Rating	**3**

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

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M12
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE	Month 12			YTD			YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income									
Clinical Income	(10,769)	(14,656)	3,886	(126,035)	(132,222)	6,188	(126,035)	(132,222)	6,188
Non-Clinical Income	(577)	(1,243)	665	(6,943)	(7,505)	562	(6,943)	(7,505)	562
Total Income	**(11,347)**	**(15,898)**	**4,552**	**(132,978)**	**(139,728)**	**6,750**	**(132,978)**	**(139,728)**	**6,750**
Expenditure									
Pay Costs	6,691	7,967	(1,276)	77,976	82,227	(4,251)	77,976	82,232	(4,255)
Non-Pay Costs	2,335	4,091	(1,756)	27,917	30,787	(2,869)	27,917	30,782	(2,865)
CNST	1,581	1,519	61	18,968	18,626	342	18,968	18,626	342
Total Expenditure	**10,607**	**13,578**	**(2,970)**	**124,861**	**131,639**	**(6,778)**	**124,861**	**131,639**	**(6,778)**
EBITDA	**(739)**	**(2,321)**	**1,581**	**(8,117)**	**(8,089)**	**(28)**	**(8,117)**	**(8,089)**	**(28)**
Technical Items									
Depreciation	483	522	(39)	5,821	5,629	193	5,821	5,629	193
Interest Payable	3	(2)	5	38	35	3	38	35	3
Interest Receivable	0	(8)	8	0	(10)	10	0	(10)	10
PDC Dividend	183	285	(102)	2,275	2,437	(162)	2,275	2,437	(162)
(Profit) / Loss on Disposal of assets	0	(17)	17	0	(36)	36	0	(36)	36
Total Technical Items	**668**	**781**	**(113)**	**8,134**	**8,054**	**80**	**8,134**	**8,054**	**80**
(Surplus) / Deficit	**(71)**	**(1,540)**	**1,469**	**17**	**(34)**	**51**	**17**	**(34)**	**52**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **2a**
INCOME & EXPENDITURE HOSTED SERVICES: M12
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE £'000	Month 11 Budget	Month 11 Actual	Month 11 Variance	YTD Budget	YTD Actual	YTD Variance
Income						
Clinical Income	(454)	146	(600)	(3,533)	(2,842)	(692)
Non-Clinical Income	0	(20)	20	0	(20)	20
Total Income	**(454)**	**126**	**(580)**	**(3,533)**	**(2,861)**	**(672)**
Expenditure						
Pay Costs	127	66	61	1,224	644	581
Non-Pay Costs	327	(193)	520	2,309	2,217	92
Total Expenditure	**454**	**(127)**	**581**	**3,533**	**2,861**	**673**
(Surplus) / Deficit	**0**	**(0)**	**0**	**0**	**(0)**	**0**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
ELECTIVE RECOVERY FUND ESTIMATE: M12
YEAR ENDING 31 MARCH 2022

	19/20		21/22		21/22 v 19/20				
	Activity	Costed Activity £000	Activity	Costed Activity £000	Activity Variance	Costed Activity Variance	ERF £000	ERF Plan £000	Variance £000
Month 1		**1,715**		**1,597**		**-118**	**520**	**543**	**-23**
DC	530	396	250	199	-280	-197	-71		
EL	100	332	113	417	13	85	230		
OP	6,292	697	5,816	656	-476	-41	210		
OPPROC	1,441	290	1,856	325	415	34	151		
Month 2		**1,625**		**1,631**		**5**	**540**	**646**	**-106**
DC	452	327	303	232	-149	-96	-5		
EL	118	372	127	449	9	77	216		
OP	5,784	616	5,543	623	-241	7	208		
OPPROC	1,440	310	1,869	327	429	17	122		
Month 3		**1,915**		**1,915**		**1,915**	**259**	**205**	**54**
DC	570	406	312	246	-258	-160	-70		
EL	151	413	115	378	-36	-35	69		
OP	6,603	729	6,449	722	-154	-7	190		
OPPROC	1,694	368	1,943	343	249	-25	69		
Month 4		**1,900**		**1,727**		**-173**	**0**	**393**	**-393**
DC	578	434	309	239	-269	-196			
EL	100	294	129	491	29	197			
OP	6,941	756	6,275	692	-666	-64			
OPPROC	1,810	417	1,698	306	-112	-111			
Month 5		**1,793**		**1,527**		**-266**	**0**	**265**	**-265**
DC	598	414	267	223	-331	-191			
EL	102	355	118	383	16	28			
OP	6,037	650	5,512	622	-525	-28			
OPPROC	1,663	374	1,705	298	42	-76			
Month 6		**1,989**		**1,584**		**-405**	**0**	**257**	**-257**
DC	572	394	287	231	-285	-163			
EL	130	450	114	427	-16	-23			
OP	6,834	744	5,584	628	-1,250	-116			
OPPROC	1,951	401	1,509	298	-442	-103			
Month 7		**2,611**		**2,164**		**-447**	**0**	**0**	**0**
Admitted Clock S	469	1,340	268	765	-201	-574			
Non Admitted Cl	1,888	1,271	2,185	1,399	297	127			
Month 8		**2,574**		**2,399**		**-175**	**88**	**778**	**-690**
Admitted Clock S	453	1,294	332	948	-121	-346			
Non Admitted Cl	1,958	1,280	2,270	1,451	312	171			
Month 9		**1,931**		**1,810**		**-121**	**4**	**421**	**-417**
Admitted Clock S	283	808	236	674	-47	-134			
Non Admitted Cl	1,774	1,123	1,771	1,136	-3	13			
Month 10		**2,322**		**2,137**		**-184**	**86**	**194**	**-108**
Admitted Clock S	290	828	309	883	19	54			
Non Admitted Cl	2,230	1,493	1,926	1,255	-304	-239			
Month 11		**2,158**		**2,180**		**22**	**151**	**114**	**37**
Admitted Clock S	278	794	299	854	21	60			
Non Admitted Cl	2,073	1,364	2,024	1,326	-49	-38			
Month 12		**2,322**		**2,200**		**-121**	**151**	**114**	**37**
Admitted Clock S	290	828	297	848	7	20			
Non Admitted Cl	2,230	1,493	2,053	1,352	-177	-141			
Total Income		**24,857**		**22,873**		**-69**	**1,798**	**3,929**	**-2,131**
Removal of Months 7-11 due to C&M underachievement (£135k confirmed M7-10)							-157	0	-157
ERF+ Bid							664	0	664
Welsh ERF							114	0	114
Baseline Variance H1							-42	0	-42
Expenditure							0	-777	777
Total Variance							**2,377**	**3,152**	**-775**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
EXPENDITURE: M12
YEAR ENDING 31 MARCH 2022

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR Actual	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	367	290	77	4,252	4,124	128	4,252	4,124	128
Medical	1,801	2,606	(805)	20,615	21,376	(761)	20,615	21,376	(761)
Nursing & Midwifery	2,952	2,950	2	33,906	35,009	(1,103)	33,906	35,009	(1,103)
Healthcare Assistants	479	693	(214)	5,774	5,581	193	5,774	5,585	189
Other Clinical	412	392	20	4,827	4,779	49	4,827	4,779	49
Admin Support	611	616	(6)	7,356	7,909	(553)	7,356	7,909	(553)
Agency & Locum	70	420	(350)	1,245	3,449	(2,204)	1,245	3,449	(2,204)
Total Pay Costs	**6,691**	**7,967**	**(1,276)**	**77,976**	**82,227**	**(4,251)**	**77,976**	**82,232**	**(4,255)**
Non Pay Costs									
Clinical Suppplies	753	828	(74)	9,098	9,464	(366)	9,099	9,465	(366)
Non-Clinical Supplies	628	1,673	(1,045)	5,527	7,047	(1,520)	5,527	7,042	(1,515)
CNST	1,581	1,519	61	18,968	18,626	342	18,968	18,626	342
Premises & IT Costs	708	1,153	(444)	8,543	9,399	(857)	8,543	9,399	(856)
Service Contracts	245	437	(192)	4,749	4,876	(127)	4,749	4,876	(127)
Total Non-Pay Costs	**3,916**	**5,610**	**(1,694)**	**46,885**	**49,412**	**(2,527)**	**46,885**	**49,408**	**(2,523)**
Total Expenditure	**10,607**	**13,578**	**(2,970)**	**124,861**	**131,639**	**(6,778)**	**124,861**	**131,639**	**(6,778)**

Note that the budget is as per the Original Board approved plan for 2021/22. And that the values above exclude £2,988k in relation to hosted services.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
COVID EXPENDITURE: M12
YEAR ENDING 31 MARCH 2022

EXPENDITURE	MONTH			YEAR TO DATE		
£'000	Budget	Actual	Variance	Budget	Actual	Variance
Pay Costs						
Board, Execs & Senior Managers	0	3	(3)	0	4	(4)
Medical	0	3	(3)	6	30	(24)
Nursing & Midwifery	43	28	15	586	435	151
Healthcare Assistants	11	20	(8)	235	184	51
Other Clinical	0	0	0	(5)	5	(9)
Admin Support	32	17	15	327	285	43
Agency & Locum	0	0	0	90	70	20
Total Pay Costs	**86**	**71**	**16**	**1,240**	**1,012**	**228**
Non Pay Costs						
Clinical Suppplies	8	6	2	124	76	48
Non-Clinical Supplies	0	(0)	0	6	(3)	9
CNST	0	0	0	0	0	0
Premises & IT Costs	14	29	(15)	294	279	15
Service Contracts	0	(0)	0	0	36	(36)
Total Non-Pay Costs	**22**	**34**	**(12)**	**425**	**388**	**36**
Total Expenditure	**109**	**105**	**3**	**1,665**	**1,400**	**264**

Note that the values above include £24k YTD related to Vaccination and LAMP Testing expenditure which should both be reimbursed.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
BUDGET ANALYSIS: M12
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE	MONTH			YEAR TO DATE			YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Maternity									
Income	(4,000)	(3,944)	(56)	(48,003)	(48,156)	153	(48,003)	(48,156)	153
Expenditure	1,998	2,421	(424)	24,049	26,947	(2,897)	24,049	26,947	(2,897)
Total Maternity	**(2,003)**	**(1,523)**	**(480)**	**(23,954)**	**(21,210)**	**(2,745)**	**(23,954)**	**(21,210)**	**(2,745)**
Neonatal									
Income	(1,743)	(1,784)	40	(20,920)	(20,843)	(77)	(20,920)	(20,843)	(77)
Expenditure	1,261	1,265	(5)	15,217	15,273	(56)	15,217	15,277	(60)
Total Neonatal	**(483)**	**(518)**	**36**	**(5,703)**	**(5,570)**	**(133)**	**(5,703)**	**(5,566)**	**(137)**
Division of Family Health - Total	**(2,485)**	**(2,041)**	**(444)**	**(29,657)**	**(26,780)**	**(2,877)**	**(29,657)**	**(26,775)**	**(2,882)**
Gynaecology									
Income	(2,058)	(2,103)	45	(24,547)	(22,310)	(2,236)	(24,547)	(22,310)	(2,236)
Expenditure	1,149	1,328	(180)	13,663	14,720	(1,058)	13,663	14,720	(1,058)
Total Gynaecology	**(909)**	**(775)**	**(135)**	**(10,884)**	**(7,590)**	**(3,294)**	**(10,884)**	**(7,590)**	**(3,294)**
Hewitt Centre									
Income	(936)	(912)	(24)	(9,449)	(9,302)	(147)	(9,449)	(9,302)	(147)
Expenditure	671	739	(68)	8,305	8,809	(504)	8,305	8,809	(504)
Total Hewitt Centre	**(265)**	**(173)**	**(92)**	**(1,145)**	**(494)**	**(651)**	**(1,145)**	**(493)**	**(651)**
Division of Gynaecology - Total	**(1,174)**	**(947)**	**(227)**	**(12,029)**	**(8,084)**	**(3,945)**	**(12,029)**	**(8,083)**	**(3,946)**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	830	1,027	(196)	10,041	10,893	(852)	10,041	10,893	(852)
Total Theatres	**830**	**1,027**	**(196)**	**10,041**	**10,893**	**(852)**	**10,041**	**10,893**	**(852)**
Genetics									
Income	(13)	(25)	13	(150)	(211)	61	(150)	(211)	61
Expenditure	147	149	(2)	1,769	1,543	226	1,769	1,543	226
Total Genetics	**135**	**124**	**11**	**1,619**	**1,331**	**288**	**1,619**	**1,331**	**288**
Other Clinical Support									
Income	(382)	(381)	(1)	(4,451)	(4,734)	282	(4,451)	(4,734)	282
Expenditure	645	789	(144)	7,673	7,512	161	7,673	7,512	161
Total Clinical Support	**263**	**408**	**(146)**	**3,222**	**2,779**	**443**	**3,222**	**2,779**	**443**
Division of Clinical Support - Total	**1,228**	**1,559**	**(331)**	**14,881**	**15,002**	**(121)**	**14,881**	**15,002**	**(121)**
Corporate & Trust Technical Items									
Income	(2,669)	(6,623)	3,955	(28,990)	(37,032)	8,041	(28,990)	(37,032)	8,041
Expenditure	5,029	6,513	(1,484)	55,812	56,858	(1,046)	55,812	56,853	(1,041)
Total Corporate	**2,360**	**(111)**	**2,471**	**26,821**	**19,826**	**6,995**	**26,821**	**19,821**	**7,000**
(Surplus) / Deficit	**(71)**	**(1,540)**	**1,469**	**17**	**(35)**	**52**	**17**	**(35)**	**52**
Of which is hosted;									
Income	(454)	126	(580)	(3,533)	(2,861)	(672)	(3,533)	(2,861)	(672)
Expenditure	454	(127)	581	3,533	2,861	673	3,533	2,861	673
Total Corporate	**0**	**(0)**	**0**	**0**	**(0)**	**0**	**0**	**(0)**	**0**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
CIP: M12
YEAR ENDING 31 MARCH 2022

	Month 12			YTD		
Scheme	**Target**	**Actual**	**Variance**	**Target**	**Actual**	**Variance**
Procurement and Non Pay	109	90	(20)	843	909	67
Estates Utilisation	0	0	0	0	0	0
Staffing and Skill Mix	33	33	0	301	626	325
Outpatients Utilisation	0	0	0	0	0	0
Medicines Management	5	68	63	30	93	63
Service Developments	19	16	(2)	207	227	20
Strategic Review	17	44	27	100	136	36
Theatre Efficiency	0	0	0	0	0	0
Technology Driven Efficiences	0	0	0	0	0	0
Other Savings Plans	157	159	2	471	339	(132)
	340	**411**	**71**	**1,952**	**2,331**	**379**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
BALANCE SHEET: M12
YEAR ENDING 31 MARCH 2022

BALANCE SHEET £'000	YEAR TO DATE Opening	M12 Actual	Movement
Non Current Assets	90,086	101,434	11,348
Current Assets			
Cash	4,235	11,192	6,957
Debtors	4,976	5,717	741
Inventories	410	523	113
Total Current Assets	**9,621**	**17,432**	**7,811**
Liabilities			
Creditors due < 1 year - Capital Payables	(3,447)	(4,929)	(1,482)
Creditors due < 1 year - Trade Payables	(13,728)	(15,647)	(1,919)
Creditors due < 1 year - Deferred Income	(3,136)	(6,983)	(3,847)
Creditors due > 1 year - Deferred Income	(1,592)	(1,558)	34
Loans	(2,136)	(1,525)	611
Provisions	(4,090)	(3,497)	593
Total Liabilities	**(28,129)**	**(34,139)**	**(6,010)**
TOTAL ASSETS EMPLOYED	**71,578**	**84,727**	**13,149**
Taxpayers Equity			
PDC	62,927	70,713	7,786
Revaluation Reserve	7,522	12,851	5,329
Retained Earnings	1,129	1,163	34
TOTAL TAXPAYERS EQUITY	**71,578**	**84,727**	**13,149**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M12
YEAR ENDING 31 MARCH 2022

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	2,460
Depreciation and amortisation	5,629
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	(34)
Movement in working capital	4,214
Net cash generated from / (used in) operations	**12,269**
Interest received	4
Purchase of property, plant and equipment and intangible assets	(10,240)
Proceeds from sales of property, plant and equipment and intangible assets	36
Net cash generated from/(used in) investing activities	**(10,200)**
PDC Capital Programme Funding - received	7,786
PDC COVID-19 Capital Funding - received	0
Loans from Department of Health Capital - repaid	(612)
Loans from Department of Health Revenue - received	0
Loans from Department of Health Revenue - repaid	0
Interest paid	(40)
PDC dividend (paid)/refunded	(2,246)
Net cash generated from/(used in) financing activities	**4,888**
Increase/(decrease) in cash and cash equivalents	**6,957**
Cash and cash equivalents at start of period	4,235
Cash and cash equivalents at end of period	**11,192**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding
Loans from Department of Health - Capital (ITFF) - 2.0% Interest Rate	5,500	(3,975)	1,525
Loans from Department of Health - Capital (Neonatal) - 2.54% Interest Rate	14,572	(14,572)	0
Loans from Department of Health - Revenue - 1.50% Interest Rate	14,612	(14,612)	0
Total	**34,684**	**(33,159)**	**1,525**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **10**
CAPITAL EXPENDITURE: M12
YEAR ENDING 31 MARCH 2022

CAPITAL EXPENDITURE	Year to Date		
£'000	Plan	Actual	Variance
Estates	700	735	(35)
Capital Projects	4,520	3,485	1,035
IM&T	1,388	1,482	(94)
Medical Equipment	302	1,571	(1,269)
Other	101	(277)	378
	7,011	6,996	15
Additional PDC - Digital Maternity	632	585	47
Additional PDC - Frontline Digitisation	1,145	1,022	123
Additional PDC - Digital Diagnostics Capability (DDCP)	80	92	(12)
Additional PDC - Cyber Security	210	180	30
Grand Total	13,197	11,722	1,475

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

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/41c**		**Date: 05/05/2022**	
Report Title	**Digital Annual Review**			
Prepared by	***Matt Connor, Chief Information Officer***			
Presented by	***Matt Connor, Chief Information Officer***			
Key Issues / Messages	**This is the annual report on Digital activities during 2021-2022. The report is intended to provide the Trust Board with assurance that overall digital delivery and performance was effective and aligned to the Trust's corporate objectives.**			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – ***If no – please outline the reasons for deviation.***			
	The Board is asked to review the report and take assurance that the delivery of the digital programme, and the operational performance has resulted in meeting the corporate objective to provide our hospital with the best digital capabilities and embed a digital first culture through delivering the Digital.Generations strategy through to 2025.			
Supporting Executive:	Matt Connor, Chief Information Officer			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 3.1 Failure to deliver an excellent patient and family experience to all our service users	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

N/A

EXECUTIVE SUMMARY

This report is intended to provide assurance on the Digital Services Department activities during 2021-2022 financial year to underpin the Trust's Corporate objectives.

The overarching corporate objective for digital delivery was to **Provide our hospital with the best digital capabilities and embed a digital first culture through delivering the Digital.Generations strategy through to 2025.** This is aligned against the Trust's strategic aim to deliver safe services.

Prior to the start of each year, Digital Services management and wider Trust stakeholders formulate the digital programme which sets out the deliverables to meet the Trust's strategic and operational priorities. During this process, consideration is made to any wider NHS regulatory or other local system requirements. The Digital Programme placed focus on establishing and operating the MEDITECH Expanse Electronic Patient Record (EPR) Programme Board. At the commencement of the 2021-2022 financial year, the Digital Maternity system (K2) had been operational for little over 2 months, therefore the ongoing support and optimisation to embed the system was a significant priority. It is important to reflect that during 2021-2022 the Trust was operating within a Covid-19 environment which continued to place challenges on workforce, programme delivery and supporting new ways of working. Throughout the year, it was important to balance the priorities of the digital programme with the Trust's response to its Covid recovery activities. This report reflects on the activities undertaken by the Digital Services department over the last 12 months, and it brings to the Boards attention the essential operational activities, governance, and controls to deliver a safe and effective digital service.

It has been a productive and busy year with many successes achieved and examples of Digital Services department staff 'being brilliant'. The report demonstrates that overall, the corporate objective to **provide our hospital with the best digital capabilities and embed a digital first culture through delivering the Digital.Generations strategy through to 2025** has been achieved within the digital capabilities in place, accepting that there are issues present relating to multiple systems. However, there are active and effective programmes of work and controls in place to address this through 2022-2023. The operational performance of the department is articulated in the report and provides assurance that the necessary operating controls and governance is in place and being adhered to effectively. The Trust throughout 2021-2022 has continued to embrace and increasing rely on digital technology and the use of data and systems to support performance and quality related informed decision making. It is anticipated that increased digital adoption will continue, and it is important that the support mechanisms in place are effective and have sufficient capacity to provide a responsive service. It is therefore important moving forward that enhanced digital service management reporting is established to provide greater transparency on the performance of the department supporting investment cases where required. Finally, the department has cohesively worked well as a wider team and delivered on its business-as-usual activities to ensure operational services are maintained. Whilst this year has been challenging, it has also been rewarding.

Recommendation

The Board is asked to review the report and take assurance that the delivery of the digital programme, and the operational performance has resulted in meeting the corporate objective to provide our hospital with the best digital capabilities and embed a digital first culture through delivering the Digital.Generations strategy through to 2025.

MAIN REPORT

1. Digital Services Workforce

The Digital Services (IM&T) department is a diverse set of functions and teams comprising of approximately seventy staff. The services delivered include:

Function / Team	Responsibilities include
Information and Performance	Contractual / statutory reporting. Power BI Divisional reporting to aid operational and performance related decision making.
Information Technology	End User IT Support, End User Computing through to Network & Infrastructure. Cyber Security, compliance, and project delivery support.
Patient Records	Provision of timely clinical records in paper & electronic format.
Digital Programme Management Office	Management of the digital programme, governance, and benefits realisation. Programme risks and issues management.
Information Governance	Compliance, standards, and information asset security.
Digital Systems	Support, maintain and develop clinical systems. Provide end user training on clinical systems use.
Clinical Coding	Translation of medical terminology into coded format for Trust performance and activity monitoring and income payments.

The staff that make up these functions are responsible for delivering the digital programme and what we term Business-as-Usual (BAU) activities. The digital programme typically consists of 'new things' such as implementing a new system, major upgrade or change that requires dedicated resources to implement. These 'new things' often impact and affect wider parts of the Trust and as such careful consideration to the change impact, or transition as well as benefits realisation is required. This major component is referred to as Business Change or Business Transformation and will consist of staff within the Digital Programme Management Office, IT, Digital System, IG, Information, and key stakeholders such as Clinical, Midwifery and Nursing Leads to support the implementation and adoption. The term BAU refers to the everyday activities that are required to be fulfilled to ensure that operational services are maintained and are robust. These include (but not limited to): -

- That good data quality is maintained across the Trust.
- That information reporting commitments (both internal and external) are fulfilled.
- That information security principles are applied and monitored through Information Governance oversight.
- That clinical and corporate systems are managed to ensure they function correctly.
- That core network, server and data storage infrastructure is maintained to ensure it is resilient, performant and has the capacity required.
- That cyber security and data backup activities are routinely under-taken to address new cyber threats and keep the Trust's data and systems safe.
- Manage processes to manage end user incidents relating to IT and wider digital issues
- Undertake routine administration activities to provide network accounts for new staff, provide access to data repositories.
- Ensure clinical coding activities are fulfilled to reflect accurate activities and clinical outcomes.

1.1 Digital Leadership

From July 2021, the Chief Information Officer became an executive officer role, and was added to the board of directors as non-voting member. This presents the Digital portfolio with a highly visible opportunity within executive and Trust Board matters and reflects positively on the digital culture and commitment within the Trust leaders to the importance of digital matters within the Trust.

1.2 Clinical Digital Leadership

Significant strengthening of the clinical digital leadership was undertaken. Two associate chief clinical information officers were appointed within Gynaecology Services and Clinical Support Services. An additional Digital Midwife was appointed to support the adoption of the Digital Maternity system (K2). The Clinical Advisory Group for Expanse (CAGE) was firmly established and has met frequently, chaired, and led by clinicians, playing an essential role in the key decision making for the MEDITECH Expanse Electronic Patient Record (EPR) programme. The EPR programme has recruited a Digital Pharmacist and two Digital Lead Nurses. The strengthening of the clinical digital leadership is fundamental to digital success and is ensuring that digital design and implementation is aligned to clinical requirements.

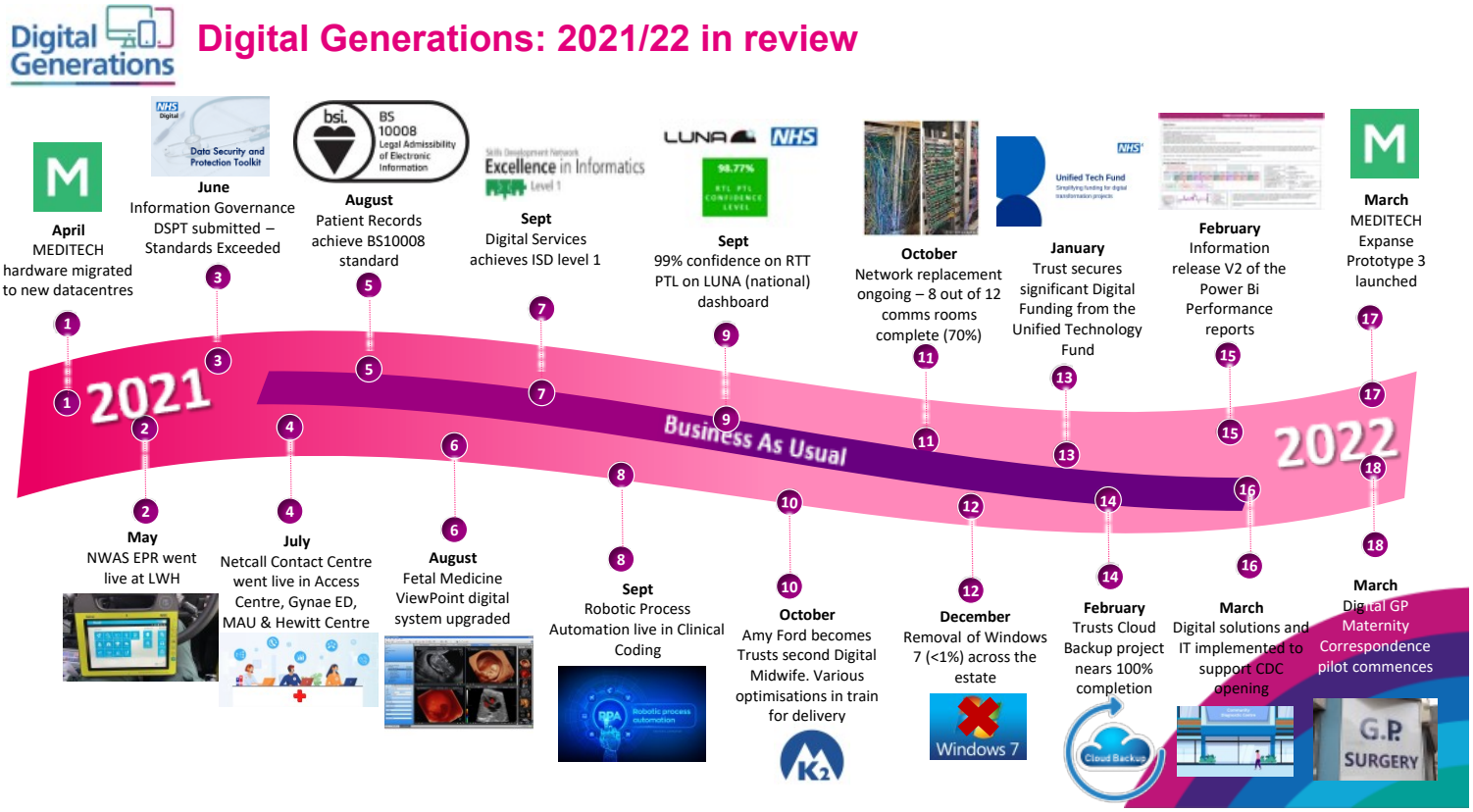
As part of the clinical leadership development, the associate chief clinical information officer for Gynaecology Services undertook the clinical safety officer training which is a requirement under the DCB 0129 and DCB 0160 standards. The associate chief clinical information officer roles for Clinical Support Services and Family Health will undertake the same training.

1.3 Informatics Skills Development Accreditation.

During the year, the Digital Services department worked with the Informatics Skills Development network and supported by Alder Hey to undertake the Informatics Skill Development Network – Excellence in Informatics accreditation assessment. The Trust successfully achieved Level 1 accreditation during July 2021 and was formally awarded at the Connect Conference during September 2021. This process recognises good operational practice particularly regarding leadership, staff development, clear strategy, and communication.

2. Digital Programme

The Digital Programme is a complex and diverse programme underpinning many of the Digital.Generations strategic themes. There have been numerous projects commenced, progressed and concluded during 2021-2022. These are wide reaching and focus on the infrastructure improvements, end user experience, clinical systems, and electronic patient records initiatives. The graphic below presents an illustration of some of the highlights from 2021-2022.



2.1 MEDITECH Expanse EPR Programme

The MEDITECH Expanse EPR programme commenced during November 2020 and became firmly established during 2021-2022. The financial year commenced with the successful implementation of the new EPR technical infrastructure and subsequent migration of the existing MEDITECH Magic system from legacy infrastructure.

The programme swiftly moved into a clinically led, design focus. The programme team received the new 'vanilla' Expanse software in April 2021 and training was subsequently provided to the EPR team to support the design and build phases of the programme. To ensure that clinical considerations and decision making was at the heart of the programme; the clinical advisory group for expanse (CAGE) was established. There has been significant progress within the programme, particularly in the process mapping and the build and configuration of the system. This has resulted in three prototypes of the new system being developed, each seeking clinical, nursing, maternity, operational and other health care professional review and validation. The EPR Programme Board has been actively meeting and has approved the data migration, testing and training strategies. Integration and other key workstreams have been established with regular reporting assurances in place. There have been robust collaboration and peer review arrangements established with Alder Hey.

However, there have been challenges faced during the 2021-2022 year. There have been challenges with securing clinical time in some areas, a reflection that clinical activities are understandably prioritised. These have generally been resolved, however have introduced delays within the programme. There have been several concerns raised to the vendor regarding the functionality of the Electronic Prescribing and Medicines Administration (EPMA) module as well as Outpatients workflow. However, the vendor has acted upon the concerns and put in place a robust delivery plan for changes and new functionality. The programme, as it enters its final phase, is naturally generating increasing levels of complexity. The EPR Programme team have implemented additional assurance mechanisms to provide the EPR Programme Board, Digital Hospital Sub Committee and the Finance, Performance and Business Development Committee required oversight and assurance. Looking forward; the programme will focus on ensuring that communication, data migration, integration, solution validation, reporting and end user training activities and plans are comprehensive. The learning from previous large scale digital implementations such as K2 Digital Maternity will be considered to ensure a successful go-live scheduled for Q4 of 2022-2023.

2.2 Digital Maternity

The Digital Maternity project has focussed on adoption and optimisation during 2021-2022. There has been a significant amount of support to existing and new staff, enabling them to learn the system and embed the use across the Trust which is now establishing evidential organisational memory. The Digital Midwifes, supported by the Digital Services department have successfully implemented three rounds of systems optimisations. These are various departmentally requested, and vendor developed changes to the system to ensure that it is shaped and optimised for optimal Liverpool Women's use. During January 2022, the Trust celebrated "1 year live" with the K2 system. As the system has embedded, the Trust is now benefitting from the real-time access to notes, more comprehensive data set and enhanced reporting.

There have been challenges however which persist and will form part of the work planned for 2022-2023. The generation of GROW charts have been sub-optimal due to a lack of integration between K2 and the Perinatal Institute (GROW). This results in efficient additional manual processes to generate the GROW chart. A project is currently underway that will deliver improved K2 / GROW integration, and this is expected to be delivered during Q2 2022-2023. The Community Maternity staff continue to experience issues with accessing the live record, often resorting to using offline capabilities within the K2 system. This is due to the complex and often external factors affecting the connectivity to the Trust's network and K2 from remote sites. The IT Team have an active programme underway to improve external network connectivity where this is within the gift of the Trust to do so. Significant improvements have been delivered to Belle Vale during 2021-2022 and with other sites to benefit moving forward. Finally, there have been issues experienced by staff when using the system attributed to a lack of knowledge or training. This has been a focus of the Digital Midwives, and significant advancements have been made throughout the year.

2.3 The wider digital programme

Whilst the MEDITECH Expanse EPR Programme and the Digital Maternity programmes are front and centre in terms of priorities and meeting the corporate objectives, there have been significant delivery of other digital projects during 2021-2022. The Digital Departments project management office have:

- Implemented the Fetal Medicine System major upgrade (Viewpoint) replacing the legacy and outdated system.
- Implemented the NETCALL Patient Contact Centre which provides call queuing, recording, and reporting and analysis functionality to aid service delivery improvements to provide the best patient experience. There are activities underway to review and understand call volumes, performance and improve the service we offer.

- Worked collaboratively with Northwest Ambulance Service (NWAS) to deploy their electronic patient record within the Trust.
- Implemented and migrated to a new Colposcopy Digital System.
- Onboarded the Local Maternity System (LMS) service, providing new equipment and migrating their data across.
- Support the implementation of the CDC through delivery of a digital workstream.

2.4 IT Infrastructure and End User Improvement Programme

The IT Infrastructure Programme includes various technology focussed projects to improve the end user experience, IT resilience and performance. The programme of work is aligned to the **Digital.Fundamentals** theme within the **Digital.Generations** strategy. During 2021-2022, there were several projects progressed and some completed. This report will highlight some of the key developments that were underway during 2021-2022.

- **Network Replacement Project** – by the conclusion of the year, 80% of the project has been completed, primarily replacement of the physical network devices and firewall. The final phase which is scheduled for Q2 2022-2023 will replace the Trust's Wi-Fi infrastructure. Due to the invasive nature of network device replacement, the Digital Services project team worked closely with the Trust's operational team to carefully plan downtime.
- **Cloud Backup** – The Trust received NHS Digital Funding in January 2021 to commence with a project to replace the Trust's on-premises backup solution with a cloud backup solution. The new system provides additional data backup protection and can protect cloud services such as Microsoft Teams and Office 365. The project was commenced shortly after funding and has successfully been completed in March 2022, meaning all data backup activities have been transferred to the new system.
- **Fast Logon Project** – This project is aimed to support mitigating the Trust's multiple systems issues through simplifying the logon process to multiple systems. This is an active project that commenced during 2021-2022 and will conclude in 2022-2023.
- **Community Network Connectivity** – The IT team implemented a new network into the Belle Vale Community Maternity site improving the end user experience whilst accessing K2 Digital Maternity from that remote site. Wider connectivity issues persist and will form part of the ongoing work.
- **Office 365** – Office 2010 extended connectivity support formally ends from May 2022. The IT team have worked extensively over Q3 and Q4 of 2021-2022 to remove legacy installations of Office 2010 throughout the Trust and replace with either a full installation of Office 365 or the web version (light) depending staff requirements. Significant user profiling has been undertaken to identify staff roles and requirements to aid appropriate license allocation as there are cost considerations between full and light installations. An Office 365 business case to request additional licenses (based on profiling) was approved by Senior Management Team (SMT) in October 2021. 95% of the project is complete with some residual remote workers to address over the coming weeks.
- **Remote Working** – Significant work continued through 2021-2022 to enhance the Trust's remote working capabilities and to support staff working in a hybrid model (on-site and remote). The Trust's new Virtual Desktop Infrastructure (VDI) service went live in March 2022, with the Safeguarding team being the early adopters. This replaces the Trust's legacy Citrix system. A full transition from Citrix to VDI will continue through 2022-2023 for the wider hospital and community services.
- **Cyber Security** – The department received central funding during 2021-2022 and have been implementing several additional cyber controls and solutions. The Trust's Cyber Security strategy has been developed and is currently commencing its approval process.
- **Removal of legacy desktops** – The IT team have removed legacy Windows 7 computers, completing their upgrade to Windows 10 including various Medical Devices that were operating the Microsoft Windows 7 operating system.

2.5 Enhanced Business Intelligence and Information Reporting

In addition to the increased demand relating to statutory reporting following the Covid-19 pandemic the department has continued to enhance its reporting platforms and utilise the Microsoft Power Platform to make near real-time data easily accessible. Highlights have included:

- Developing discharge letters for both gynaecology and maternity to improve information sharing with GP practices. These are derived directly from the clinical systems and will facilitate more equitable information sharing for women receiving Maternity care at LWH and prevent information being entered multiple times in the community.

- A new Nursing & Midwifery audits platform has been developed and launched to provide a single place for all audits. The platform provides both the audit schedules and results for each individual area as well as divisional and Trust wide views of compliance.

- The performance reports have been redeveloped to include more succinct information in a clearer format. Statistical Process Control (SPC) has been used across appropriate metrics to focus on both performance against a target and variation in performance over time.

- A new maternal medicine referral system has been developed and is awaiting implementation. The app provides external provides the ability to refer into our maternal medicine service, LWH consultants to manage the referrals and MDT discussions and will provide automated responses back to the referring Trust's throughout the process.

- Health Inequalities Dashboard - the dashboard has been developed to review several metrics, based on a national dashboard looking at waiting times and access to services split by ethnicity and multi-index deprivation scores. Several reports have all now incorporated data broken down by ethnicity and deprivation deciles and this will be further rolled out across the Power BI platform.

The Information team have been instrumental in the adoption and increasing use of near real-time data reporting through Power BI Reports and Dashboards. There has been a significant shift towards a data driven culture across the Trust through 2021-2022.

2.6 Cheshire and Merseyside Digital Programme

The Digital Services department have been active participants in the Cheshire and Merseyside (C&M) Digital Programme. The CIO is the C&M Digital Lead and Chair for the Cyber Secure Workstream. Cheshire and Merseyside Digital Matters are reported through the Digital Hospital Sub Committee on a quarterly basis.

2.7 National Digital Programme – What Good Looks Like (WGLL)

The What Good Looks Like NHS X digital framework was launched in September 2021 and has been adopted by Cheshire and Merseyside Health Care Partnership and by all providers. There are 8 success measure covering: Well Led, Smart Foundations, Safe Practice, Support People, Empower Citizens, Improve Care, and Health Populations. The framework has been presented to Digital Department staff during November 2021 and a Trust self-assessment was completed during January 2022 with a various stakeholders including clinical, maternity and nursing to ascertain a considered position. Moving forward into 2022-2023 digital delivery will be assessed and aligned to the best practice framework.

3. Digital Operational Performance

The Digital Operation Performance section describes some of the key operational areas within the Digital Services department and their activities during 2021-2022.

3.1 Information Governance

The Trust made its submission to the Data Security Protection Toolkit (DSPT) in accordance with the national submission deadline of the 30th of June 2021. The position that was submitted was "Standards Met". Because the Trust held Cyber Essential Plus certification and submitted a position of "Standards Met", this was automatically re-assigned by NHS Digital to "Standards Exceeded", which was the Trust's final end of year official position for 2020/2021.

There was 1 ICO reportable incident. This was logged with the ICO in February 2022. The matter is subject to ongoing liaison with the ICO by the Data Protection Officer, but it is not expected that this incident will ultimately be a significant data breach. The IG committee operates on a bi-monthly basis. It met 6 times during 2021-2022.

3.2 Risk Management

There are 2 BAF risks linked to Digital Services:

BAF Risk 2.2: Failure to develop our model of care to keep pace with developments and respond to a changing environment. This is aligned to the deliver safe services strategic priority. During 2021-2022 this risk had an overall score of 16 (4 x 4) which reflects the ongoing issues with multiple systems despite mitigations. The full implementation of the Trust's Electronic Patient Record (EPR) system and optimisations will mitigate this risk.

BAF Risk 2.4: Major and sustained failure of essential IT systems due to a cyber-attack. This is aligned to the deliver safe services strategic priority. During Q1, Q2, and Q3 of 2021-2022 this remained at an overall score of 15 (3 x 5) however during Q4 this increased to a score of 20 (4 x 5) through an increased likelihood due to the geopolitical situation.

The Digital Services department closed the 2021-2022 financial year with 41 live corporate level risks. During the year 4 risks were closed. The live risks are broken down by function and severity in the following table.

Function	Extreme	High	Moderate	Low	Total
IT	1	16	3	0	20
Information	0	6	3	0	9
Information Governance	1	6	4	0	11
Patient Records	0	0	1	0	1

Digital Hospital Sub Committee (DHSC) had oversight of the digital corporate risks as did Trust Corporate Risk Committee. All risks and actions were reviewed and managed within dates.

3.3 Cyber Security

The Cyber Security function operated as business as usual, with bi-weekly operational meetings to review cyber security status and actions. The department successfully maintained its Cyber Security Plus status. The department dealt with 12 High Severity Care Cert alerts (Care Cert alerts are those that the national NHS Digital team communicate to all NHS organisations). High severity alerts must be formally acknowledged within 48 hours and remediated within 2 weeks (or with evidence of a robust action plan). Digital Services department successfully met both conditions for all 12 alerts.

3.4 IT Incident Management Performance

IT Incident Management covers IT support requests logged through the IT Helpdesk. An IT support request can include anything from a network password request to a faulty computer or printer device or to issues with accessing software. The IT Helpdesk function is provided externally through Liverpool University Hospital (LUHFT). The graph shows activity through that service:

The IT Helpdesk function essentially receives the incoming telephone call, web form or email and logs the support request / issue within the IT Helpdesk system software. The incident is categorised and then allocated to the Liverpool Women's IT department. Once received it is assessed and allocated to a Digital Services department function or individual. The majority of incidents are processed by the LWH IT team.

During 2021-2022 the IT Helpdesk logged 15,603 IT incidents in total. On average 1300 calls are logged a month, 935 were successfully resolved and 365 on average residually open at the end of a month. The graph shows increased activity in January 2022, which is normal behaviour following festive period leave (i.e. password expiry issues).

There are various improvements required to the IT Helpdesk function to improve the experience for staff. The current investment in the function is 25k per year which is insufficient to provide a good service level and benchmarks (on Model Hospital) indicate this as an outlier in terms of cost of function. This is in plan to be addressed during 2022-2023. The result of this means that only 1 member of staff is provided by LUHFT to log calls. There is no first-time fix capability or analysis, simply a logging function. This means more calls are passed to the LWH IT team than is necessary (i.e. network logon issues). Trust staff can experience delays when logging their calls via telephone resulting in poor service and experience. Additionally, Trust staff may resort to approaching IT engineers in person to address their issues, and whilst we want to maintain a visible and accessible service, it can mean that incident management activity is not always recorded.

3.5 Information Management and Business Intelligence

The Information & BI team continue to focus on ensuring the department meets the statutory requirements in relating to reporting. The increased reporting schedule has continued through the year following the pandemic with additional daily, weekly, and monthly sitreps and data submissions still in place.

There has been a continued focus on the Trust's Data Quality Maturity Index (DQMI) score and the Trust's CDS, MSDS and ECDS submissions over the last 12 months with a new CDS Data Quality Improvement Group in place feeding in to the Information Reporting & Data Quality Sub-committee. The process has supported an upward trend in the Trust's DQMI score although challenges relating to an ageing PAS and no bespoke A&E module mean this score has plateaued in recent months. The Trust has undertaken significant development on the MSDS to ensure CNST standards are met and continue to extend the clinical activity included within the submission. The most recent version of the ECDS has been implemented and work is underway for the Trust to move to the new CDS 6.3 at the point of MEDITECH Expanse implementation.

The focus of Information Reporting & Data Quality Sub-committee has switched to providing updates through divisional boards rather than asking divisions to attend sperate meetings as outlined in the new data quality strategy. The divisional Power BI workspaces continue to be developed and expanded. A new **Digital.Information** Site has also been launched which aims to provide dedicated webpages combining various reports for a focussed view on information and performance for each area.

3.6 Finance

This section sets out the financial operating performance (revenue) detailing the pay and non-pay aspects for each of the budgets that fall within the responsibility of the Digital Services Department. The finance section also details the capital investment including externally secured funding.

3.6.1 Financial Operating Performance

The Digital Services department budget comprises of 2 main budgets. The largest budget is IM&T which contains 9 individual sub- budgets. The second budget covers Patient Records services.

		Pay Budget			Non-Pay Budget			Total		
		Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
IM&T Budgets	Information	425	408	18	2	25	-23	427	433	-5
	IT	210	289	-80	1,438	1,746	-308	1,648	2,035	-388
	GDE	0	0	0	901	871	30	901	871	30
	EPR	0	0	0	1,282	1,161	121	1,282	1,161	121
	Clinical Coding	207	197	9	0	1	-1	207	198	8
	Information Systems	116	161	-45	0	0	0	116	161	-45
	Switchboard	0	0	0	92	84	8	92	84	8
	Information Governance	192	203	-11	0	1	-1	192	204	-12
	Total Expenditure	1,150	1,258	-109	3,715	3,889	-174	4,865	5,147	-283
	(Contribution) / Loss							4,865	4,922	-57
	Patient Records	498	428	70	206	249	-42	704	676	27
	Overall Position							**5,569**	**5,598**	**-29**

The 2021- 22 full year position for Digital Services department is a £29k deficit against an overall budget of £5,569 (0.5% of overall budget). The Trust received non-recurrent revenue bid income of £225k to offset specific project costs without which the full year position is a £256k deficit reflecting a 4% variation from planned budget.

Full year pay costs are overspent by £39k against a budget of £1,648, reflecting a 2% variance. The main contributing factors included staff overtime and on-call payments.

Overall, non-pay costs are £217k in deficit against a budget of £3,921 reflecting a 2% variance. The main contributing factors include MEDITECH system costs totalling £105k, £53k on other software licences and £59k on Portacabins.

In 2021- 22, Digital Services had a CIP target of £233k relating to Mobile phones and telephony review (£56k) and GDE and Technology Driven efficiencies (£177k). Mobile phone and telephony review was successfully completed releasing £56k in savings. Due to delayed implementation of various technology projects the division was unable to realise any technology driven efficiencies in 2021-22.

Digital Services has a nominated Finance Business partner, monthly meetings are in place to review monthly budget statements between Digital Management team and the Finance Business Partner. Annual budget planning considers current year performance and identified cost pressures.

3.6.2 Capital Investment

The Digital Department were allocated a Trust Capital Budget of £1,459 for 2021-2022. It utilised all the funding within year and an additional £73k as agreed through Finance capital processes. The agreed overspend utilised underspent Trust capital budget. The overall Trust capital spend was £1,532. A couple of items relating to IMT Hardware (end user devices, data centre professional services) were procured at year end of 2020-2021 but were unable to be delivered due Covid-19 supply issues (chip / mobile device shortage) and therefore placed unplanned pressure on the 2021-2022 budget. The other significant capital items related to the Office 2010 replacement project, MEDITECH Expanse EPR programme and digital staffing to support project delivery.

In addition to the Trust Capital allocation, the Digital Services department was successful in securing £3,332 of external funding. Three main funding routes were utilised:

- **Community Diagnostic Centre (CDC) Funding: £1,265 secured for Digital CDC requirements.**
  The secured funding addresses the CDC Digital requirements, an important dependency for the CDC service. The funding includes enabling infrastructure (network, data storage, end user devices), digital systems capabilities to support the new clinical workflow, systems integration, and a Digital Project Manager.

- **NHSX Unified Technology Funding: £1,987 secured.**
  The Unified Technology Fund (UTF) was launched in September 2021 and included various specific funding routes. The Trust submitted successful bids against The Digital Maternity, Frontline Digitisation and Cyber Security funds. The Trust received funding during January and February 2021. A significant amount of resource from Digital Services and Procurement was placed against ensuring the funding was spent within financial year. All agreed funding deliverables were met by the end of the financial year. Whilst product assets have been received and therefore accounted, significant amount activities will continue throughout 2022-2023 to implement and realise benefits.

  The Digital Maternity secured funding will deliver improved and optimised functionality within the Trust's K2 Digital Maternity System, enhance its integration with other systems and provide additional

end user devices including medical devices. The Frontline Digitisation fund will deliver several EPR related benefits including an integrated digital e-Consent solution.

The table below summaries the Digital Capital programme activities:

DIVISION	DIRECTORATE	PROGRAMME	PLAN	ACTUAL	VARIANCE
Digital Services	Trust	Legacy data storage replacement (Isilon)	60	30	30
Digital Services	Trust	Office 2010 replacement / One drive - resource and licenses	70	59	11
Digital Services	Trust	IMT Hardware	0	145	(145)
Digital Services	Trust	Additional Hardware for staff	0	60	(60)
Digital Services	Trust	IMT Cancom professional services	0	72	(72)
Digital Services	Trust	Meditech Expanse Capital Requirement	408	290	118
Digital Services	Trust	Project Staff	850	778	72
Digital Services	Trust	Intranet Redevelopment	22	0	22
Digital Services	Trust	E-Rostering Bid	49	26	23
Digital Services	Trust	Software Licences	0	18	(18)
Digital Services	Trust	K2 interface	0	28	(28)
Digital Services	Trust	Staffing costs	0	26	(26)
TOTAL			**1,459**	**1,532**	**(73)**
The Trust also received PDC funding of £3,332k for the below schemes in 2021/22:					
PDC Bids					
Digital Services	Trust	CDC Digital Services	1,265		
Digital Services	Trust	Digital Maternity	632		
Digital Services	Trust	Frontline Digitisation	1,145		
Digital Services	Trust	Digital Diagnostics Capability Programme (DDCP) funding	80		
Digital Services	Trust	Cyber Security	210		
			3,332		

3.7 External audit

The Digital Services department undertook three Mersey Internal Audit Agency (MIAA) audits during 2021-2022.

- **Global Digital Exemplar (GDE) Assurance Assessment:** This resulted in Substantial Assurance and 12 recommendations to complete with no high-risk recommendations identified.

- **Critical Application Review for K2 Athena Maternity System:** This audit focussed on the IT controls (i.e. user access controls, network security, support arrangements etc) as opposed to the clinical care pathway design and adoption effectiveness. The audit outcome resulted in Moderate Assurance with 12 recommendations to complete; 4 of which were high-risk.

- **Data Security and Protection Toolkit (DSPT) Assessment:** This audit reviewed the evidence and internal assessment levels as provided by the Trust and compared to the national standards to assure an accurate level of DSPT self-assessment and submission. The audit assessed the Trust against 10 standards within the DSPT and concluded substantial assurance rating against each one of them. No recommendations were identified.

In addition to the 2021-2022 commissioned audits, the department continued to work on outstanding recommendations from the 2020-2021 **Cyber Security audit**. The audit identified 38 recommendations which resulted in a significant work plan to address. All remaining actions have been successfully concluded during 2021-2022.

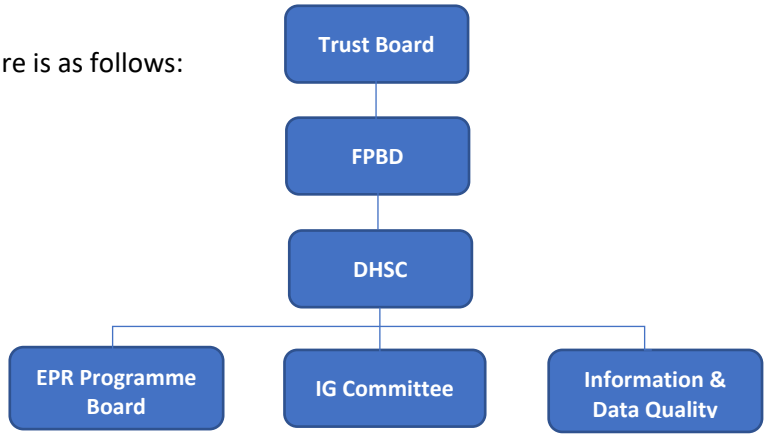
Control Area	High	Medium	Low	1	2	3	4	5	6	7
3.1. User Access Control	7			100%	100%	100%	100%	100%	100%	100%
3.2. Perimeter Protection		5		100%	100%	100%	100%	100%		
3.3. Secure Configuration		6		100%	100%	100%	100%	100%	100%	
3.4. Malware Protection		5		100%	100%	100%	100%	100%		
3.5. Patch Management		7		100%	100%	100%	100%	100%	100%	100%
3.6. Data Recovery		6		100%	100%	100%	100%	100%	100%	
3.7. Awareness and Training		2		100%	100%					

The audit recommendations were monitored through internal digital department meetings, with oversight through Digital Hospital Sub Committee. The formal monitoring was delivered through the Trust's Audit committee.

3.8 Governance

The Digital Services Department is working to an active Digital Strategy called Digital.Generations which was launching in September 2020 and covers the period 2020 to 2024. Digital Department annual plans are developed as part of the Trust's annual planning process and aligns to the Digital Strategy as well as the Divisional Digital requirements. The Digital Strategy implementation and effectiveness is reviewed on a bi-annual basis with a formal report provided to Digital Hospital Sub Committee (DHSC) and to the parent Finance Performance and Business Development (FPBD) committee. FPBD received the Digital Strategy annual review in July 2021 and February 2022.

The governance structure is as follows:



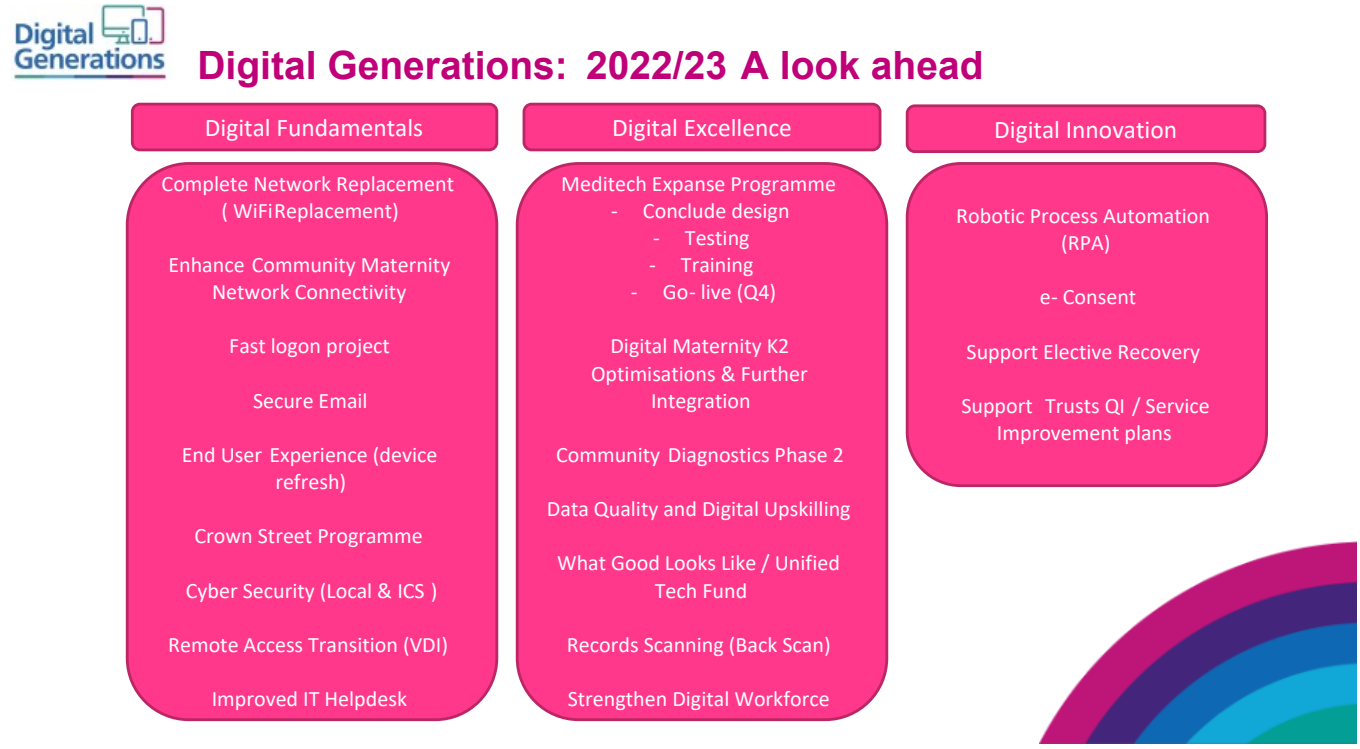
The DHSC terms of reference is reviewed annually. The DHSC cycle of business for 2022-2023 was approved by DHSC in March 2022.

3.9 British Standard 10008: Evidential Weight and Legal Admissibility of Electronic Information

BS 10008 is the British Standard that outlines best practice for the implementation and operation of electronic information management systems, including the storage and transfer of information. The Patient Records department achieved the standard during 2021-2022, which reflects a significant amount of work achieved. The standard will enable the Trust to implement the safe destruction of scanned documentation in line with best practice standards and assurance subject to Trust governance oversight and approval.

4. Digital Delivery: the road ahead

Several of the projects that were commenced during 2021-2022 year will continue as key priorities into 2022-2023. The Data Network Replacement project had been delayed due to Covid-19 during 2021-2022 and therefore the tail end of the project flows into the new year. A primary objective will be delivering the Trust's MEDITECH Expanse EPR Programme, ensuring a safe and well-trained cut over. The focus will then shift onto optimisation and further integration. The department will conclude the associated projects that were enabled through the secured NHS X unified technology funding. There will be a continued focus on optimising the Digital Maternity system, adding requested functionality, configuration changes and improving community connectivity and workflow. The department will continue to deliver on the Digital.Fundamentals strategic theme and supporting the Trust staff with the increasing demand for IT use. The following infographic shows a high-level look ahead to 2022-2023:



Digital Services will support the Trust with exploiting digital innovation through Quality Improvement (QI) initiatives and look to strengthen its Benefits Realisation portfolio, lessons learning and developing a mature Digital Performance framework. Planned programme activities are aligned to the key themes within the Digital Generations strategy. The implementation of the digital programme is monitored regularly through Digital Hospital Sub Committee (DHSC) and the Digital Generations strategy reviewed bi-annually at Finance, Performance and Business Development (FPBD) Committee.

5. Conclusion

It has been a productive and busy year with many successes achieved and examples of Digital Services department staff 'being brilliant'. The report demonstrates that overall, the corporate objective to **provide our hospital with the best digital capabilities and embed a digital first culture through delivering the Digital.Generations strategy through to 2025** has been achieved within the digital capabilities in place, accepting that there are issues present relating to multiple systems, however there are active and effective programmes of work and controls in place to address this through 2022-2023. The operational performance of the department is articulated in the report and provides assurance that the necessary operating controls and governance is in place and being adhered to effectively. The Trust through 2021-2022 has continued to embrace and increasing rely on digital technology and the use of data and systems to support performance and quality related informed

decision making. It is anticipated that increased digital adoption will continue, and it is important that the support mechanisms in place are effective and have sufficient capacity to provide a responsive service. It is therefore important moving forward that enhanced digital service management reporting is established to provide greater transparency on the performance of the department supporting investment cases where required. Finally, the department has cohesively worked well as a wider team and delivered on its business-as-usual activities to ensure operational services are maintained. Whilst this year has been challenging, it has also been rewarding.

5.1 Recommendation

The Board is asked to review the report and take assurance that the delivery of the digital programme, and the operational performance has resulted in meeting the corporate objective to provide our hospital with the best digital capabilities and embed a digital first culture through delivering the Digital.Generations strategy through to 2025.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2022/23/042a*		Date: 05/05/2022	
Report Title	Proposed Corporate Objectives 2022/23			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	Executives			
Key Issues / Messages	***The report proposes the corporate objectives for 2022/23***			
Action required	Approve ☒	Receive ☐	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is asked to approve the 2022/23 Corporate Objectives.			
Supporting Executive:	Executive Team			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Comment: N/A
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment: N/A

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
FPBD, Quality and PPF (via email)	Apr 22	Trust Secretary / Execs	Objectives reviewed, with the majority recommended for approval. Amendments to the Quality Committee objectives requested.

EXECUTIVE SUMMARY

Consideration of the Corporate Objectives 2022/23 have been given by each of the Board Committees, and they are now presented to the Board for approval.

The majority of the objectives were agreed without comment, but the Quality Committee requested that the following two proposed objectives be amended to reduce the element of subjectivity as much as possible to ensure that there was clarity at the end of the year on whether the objectives had been achieved (or not):

- Pro-actively seek the views of diverse communities to inform the design of our services for the future and to receive feedback on our services. Ensuring that voices are listened to and heard, and that meaningful and sustained change is made.
- To put into place a process for the implementation of the Ockenden Final Report recommendations. This will monitor and track progress allowing for timely reporting to the Quality Committee and Board ensuring that the organisation is fully sighted on its position.

The suggested amendments to these objectives are as follows:

- Actively seek and use the diverse views of, patients, their families, and our communities to design and deliver services that best meet their needs. To ensure that services are utilising the findings of this intelligence to identify areas for service improvement and that we can demonstrate communication of the actions we have taken because of the feedback received.
- To implement a formal governance and reporting structure for the implementation of the Ockenden Final Report recommendations. This will monitor and track progress allowing for robust assurance to be provided to the Quality Committee and Board ensuring that the organisation is fully sighted on its position.

The Board received the final outturn position on the 2021/22 Corporate Objectives on 7 April 2021. On reviewing the position, it was suggested that a position statement should be provided on the 2021/22 objectives either not complete or not being taken forward as a 2022/23 corporate objective. This can be found in Appendix 1.

Recommendation

The Board is asked to approve the 2022/23 Corporate Objectives.

MAIN REPORT

NHS
Liverpool Women's
NHS Foundation Trust

Corporate Objectives

2022 – 2023

Our Vision

To be the recognised leader in healthcare for women, babies and their families

Our shared vision at Liverpool Women's is simple and has withstood the test of time. It is underpinned by a shared set of values based around the needs of our people. We encourage these behaviours in all our staff, partners and volunteers to make sure our values are delivered in the same way, every day, to every person we care for.

Our Values	**Care**	**Ambition**	**Respect**	**Engage**	**Learn**

We have a set of five strategic aims which are central to all of our strategies and plans, and through working with patients, staff, governors and our partners we have developed a series of ambitions to push those aims one step further, helping us create the mind-set we need to achieve our vision and be outstanding in everything we do:

Our Aims	To develop a well led, capable, motivated and entrepreneurial workforce.	To be ambitious and efficient and make best use of available resources.	To deliver safe services.	To participate in high quality research to deliver the most effective outcomes.	To deliver the best possible experience for patients and staff.
Our Ambitions	We will be an outstanding employer.	We will deliver maximum efficiency in our services.	Our services will be the safest in the country.	Outcomes will be best in class.	Every patient will have an outstanding experience.

Our partnerships with other providers and organisations across the city are central to delivering our aims; we know we need to work together to make this happen.

To develop a Well Led, capable, motivated, and entrepreneurial Workforce				
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	To progress year on year towards the organisational goal of 25% of our leadership workforce (Band 7 and above) being from an ethnically diverse background. This will require the Trust recruiting to 10 leadership roles each year between 2022-2025 (moving from 23 to 33 in 2022/23).	CPO	Putting People First Strategy	PPF
	To work in partnership with health, education, local authority and community partners to increase the number of employees from an ethnic minority background by 5% year on year to ensure we achieve Riverside representation by 2025, moving from 11% to 16% in 2022/23.	CPO	Putting People First Strategy	PPF
Recruit and retain key clinical staff	Demonstrate improvement from the 2021 NHS Staff survey in relation to staff engagement measures.	CPO	Putting People First Strategy	PPF
	24/7 consultant obstetric workforce and 8am -10pm (twilights) for anaesthetic workforce by 2023	MD	Medical Workforce Strategy	PPF

To deliver Safe services				
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Progress our plans to build a new hospital co-located with an adult acute site	Complete refresh of business case for a new Liverpool Women's Hospital to reflect evolving models of care and system developments.	CFO	Future Generations Strategy	FPBD

Implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	Deliver the Crown Street enhancement work program (including CT and blood bank services) to time and to budget working with system partners to ensure optimal patient benefit across the wider Cheshire and Mersey system.	CFO	Estates Strategy	FPBD
Develop our model of care to keep pace with developments and respond to a changing environment	Deliver the launch of Trust's EPR programme in line with established timescales.	CIO	Digital Generations Strategy	FPBD
	Recover and restore services for our patients and those across Cheshire and Merseyside in line with the National Operational plan requirements for 2022/23.	COO	Our Strategy	FPBD

To deliver the best possible Experience for patients and staff				
Strategic Aim	**Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Deliver an excellent patient and family experience to all our service users	Actively seek and use the diverse views of, patients, their families, and our communities to design and deliver services that best meet their needs. To ensure that services are utilising the findings of this intelligence to identify areas for service improvement and that we can demonstrate communication of the actions we have taken because of the feedback received.	DONM	Clinical & Quality Strategy	QC

	To implement a formal governance and reporting structure for the implementation of the Ockenden Final Report recommendations. This will monitor and track progress allowing for robust assurance to be provided to the Quality Committee and Board ensuring that the organisation is fully sighted on its position.	DONM	Clinical & Quality Strategy	QC

To be ambitious and Efficient and make best use of available resources				
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Ensure our services are financially sustainable in the long term	Ensure efficient and effective use of all available resources, meeting agreed financial targets and working across the Cheshire and Mersey system for optimum outcomes for the region.	CFO	Finance & Sustainability 2021-2025	FPBD
	Ensure the Trust has an updated, long term financial plan in place during 2022/23 to reflect recent and proposed regime changes, with clear views and actions in place in relation to long term sustainability.	CFO	Finance & Sustainability 2021-2025	FPBD
	Develop the Trust's commercial strategy during 2022/23 and pursue appropriate opportunities to maximise Trust income for the benefit of our patients	CFO	Finance & Sustainability 2021-2025	FPBD

To participate in high quality research in order to deliver the most Effective outcomes				
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**

Expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	Maintain and develop key partnerships, ensuring robust governance structures are in place and effective reporting through the Trust's assurance framework.	MD	Our Strategy	FPBD
	Support the developing ICS for C&M and working with the system to improve outcomes for Women's Health including Maternal and Neonatal care.	CEO	Our Strategy	FPBD
Progress our research strategy and foster innovation within the Trust	Provide clear evidence of senior nursing & midwifery research leadership, as per the Trust R&D strategy by March 2023	MD	Research & Innovation Strategy	QC
	Complete refresh of R&D strategy and progress year 1 objectives	MD	Research & Innovation Strategy	QC
Fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Ensure all wards and key areas have ward accreditation completed (twice a year)	DONM	Clinical & Quality Strategy	QC

To develop a Well Led, capable, motivated and entrepreneurial Workforce							
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Year outturn position**	**21/22 Progress Rating**	**Ongoing Oversight**
Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	None that are not proposed to be rolled over.						N/A
Recruit and retain key clinical staff	Train 200 managers in Fair & Just processes	CPO	PPF Strategy	PPF	Training is being rolled out in March with completion by June 2022.		Compliance and progress with training to be overseen by the PPF Committee.

To deliver Safe services							
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Year outturn position**	**21/22 Progress Rating**	**Ongoing Oversight**
Progress our plans to build a new hospital co-located with an adult acute site	Contribute to the development and delivery of the Liverpool-wide estates plan during 2021, building on strategic partnerships for optimal outcomes.	CFO	Estates Strategy	FPBD	Membership of C&M Strategic Estates Group. LWH plans (EOI) presented to C&M and Liverpool place strategic estates boards Sept 21. On track in an area that is developing within C&M. Partnerships with other organisations developing.		This issue is mainstreamed into FG based working groups with assurance provided to FPBD.
	Provide our hospital with the best digital capabilities and embed a digital first culture through delivering the Digital.Generations strategy through to 2025.	CIO	Digital.Generations Strategy	FPBD	The EPR Programme is making steady progress with the EPR build and configuration activities. The programme aims to go-live in Q3 of 22/23, which allows for the system vendor to deliver several localised system requirements. Digital Maternity system is embedding well across the Trust, celebrating a year since go-live. During 22/23 focus continues on optimising the system and delivering improved integration with other Trust systems.		There is a separate EPR objective proposed. The Trust's Digital agenda is monitored closely by the FPBD Committee.
Implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	None that are not proposed to be rolled over.						N/A

To deliver the best possible Experience for patients and staff							
Strategic Aim	**Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 month update**	**21/22 Progress Update**	**Ongoing Oversight**
Deliver an excellent patient and family experience to all our service users	Make progress towards achieving Bliss baby charter accreditation by 2023	DONM	Clinical & Quality Strategy	QC	The NNU are not progressing with formal accreditation due to the financial costs.		This will not be progressed.
	Make progress towards achieving the Unicef Baby Friendly Initiative by 2025	DONM	Clinical & Quality Strategy	QC	Application in process – Accreditation assessment expected in June 2022 Education of staff on-going. Infant feeding team in place		The outcome of the success (or otherwise) of the application will report to the PIEG and through to the Quality Committee.
	Develop and begin to implement the Patient Experience Framework	DONM	Clinical & Quality Strategy	QC	The Women, Babies, and their Families Experience Strategy 2021 – 2026 objectives have been developed after a review of the Patient Experience Framework. Patient Experience Reviews are received from Divisions at the Patient Involvement and Experience Sub Committee which monitor progress against strategy objectives. Key lessons learnt are presented by each area. There has also been a Patient Experience Matron appointed in November 21 who has key objectives linked to the Quality Improvements that are needed to address any shortfalls that was found from undertaking the review of the Patient Experience Framework. The Patient Experience Matron networking externally with groups and listening to what patients want and is also setting up a Co-Design/production group to ensure LWH has robust information before making any changes and has input from patients and partners about what matters to them. Each of the clinical areas has 'You said We did' boards in clinical areas that are visible to patients and visitors to departments and a new Trust template has been developed to give a standardised approach across all areas.		The Framework is overseen by the PIEG which reports to the Quality Committee.
	Deliver the Continuity of Care (COC) priorities in 2021/22	DONM	Clinical & Quality Strategy	QC	Evidence from research and the experiences of women in England in the CQC Maternity Service survey has shown that Continuity of Carer is essential to improving the safety, equity and experience of Maternity care. The vision for Liverpool Women`s Hospital is to be an exemplar in delivering national targets for Continuity of Care and address unwanted variation for all women		There is a pause on the continued roll out of the Continuity of Care (COC) programme whilst the issues raised in the Ockenden Final Report are assessed and understood.

					receiving care at LWH.As a Trust we remain committed to ensuring women are in receipt of Continuity of Care as set out in the NHS - long term plan, and have made progress to ensure women of Black, Asian and Minority Ethnic backgrounds and those living in the most deprived LLSOAs are prioritised in our plans to deliver Continuity of Care. Further priorities for the Trust are to review the action plan which describes how the maternity service will work towards Continuity of Care being the default model of care by 2023, ensuring agreed timescales for implementation, prioritising those women from BAME backgrounds and those living in the most deprived LLSOAs, whilst ensuring transitional arrangements and support are in place to uphold the safety of care of all women across the service. A workforce review by Birth rate plus was commissioned across Cheshire and Merseyside LMS which has now been completed and takes into consideration the increase in complexity of women and the requirements to operationally deliver Continuity of Carer. A review of midwifery establishment has been completed which has demonstrated that we are currently not BR + compliant and therefore a business case will be drafted to address the deficit. Whilst this is ongoing further CoC rollout remains in a pause and reflect period, the operational group continues to forward plan to establish that all national mandated building blocks for the effective delivery of CoC are in place.		

To be ambitious and Efficient and make best use of available resources							
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Year-end outturn**	**21/22 Progress rating**	**Ongoing Oversight**
Ensure our services are financially sustainable in the long term	Appraise options for future organisational form (up to and including merger) by 2022	CEO	Future Generations Strategy	FPBD	This will be reviewed as part of the later Future Generations work and financial modelling. Deferred due to system reconfiguration but discussions and informal options appraisal and supporting work has been undertaken.		This issue is mainstreamed into FG based working groups with assurance provided to FPBD.
	Look for opportunities to maximise use of the Crown Street estate for the benefit of our patients and the whole of Liverpool and C&M	COO	Estates Strategy	FPBD	Bid has been submitted for Community Diagnostic Hub to increase the clinical offer from LWH for Liverpool and Wider Cheshire and Merseyside. FMU, blood bank and CT scanner development in progress and overseen through Crown Street Enhancements Group. Update November: The bid has been successful and implementation group established to deliver on this through Q4 2021/22 to Q2 2022/23		Repeated by other proposed corporate objective
	Ensure post Covid-19 recovery including: • Eliminating 52 week waits • Deliver 100% of 2019/20 activity by November 2021 • Restore all cancer services in Q1 and return to pre pandemic performance levels. • Achieve the 75% faster diagnostic target in Q3	COO	Our Strategy	FPBD	The Trust 52-week position has plateaued in Q2 after an initial reduction in Q1. This is due to reduced theatre and clinical capacity and a need to focus on high priority P2 patients and reduction in planned clinical capacity due to sickness absence and challenges in theatre recruitment. H2 planning will address the increased capacity required to deal with the backlog. (New and Inpatient activity is on plan Follow up and Day case activity is behind plan) Cancer services have been fully restored in Q1. The C&M cancer alliance has commissioned a C&M Gynae Optimal pathway cancer review to address the challenges of late referrals and will report in for Q3. November update: The national H2 ask is to "reduce" 52 week waiters. The Trust is reprofiling to eliminate 52 week waits through summer 2022/23 however at present this is subject to H2 planning confirmation and associated bids. A reduction in overdue follow ups has been seen and no further significant increase in the 52 week position In Line with refreshed national standards the Trust will be reporting no 104 week Breeches from March 2022 onwards. The Trust cancer performance has significantly increased.		Repeated by other proposed corporate objective

To participate in high quality research in order to deliver the most Effective outcomes							
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Year end outturn**	**21/22 Progress Rating**	**Ongoing oversight**
Expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS							
Progress our research strategy and foster innovation within the Trust	Make progress to achieve university hospital status by March 2023	MD	Research & Innovation Strategy	QC	The main barrier in achieving this is the number of University employed staff who deliver clinical sessions at LWH. There has been a retirement of one academic member of staff and another has left the Trust. There have been a number of approaches to the UoL by individuals who want to hold an academic post at UoL/LWH and the MD and other senior members of staff have engaged with showing them LWH and encouraging them to apply for an academic post. There is an upcoming interview for an academic post March/April 2022. It is unlikely that this objective will be achieved by March 2023.		The aim will be to continue to increase the number of clinical academics working at LWH. This will be a challenge and it remains unlikely that this objective will be achieved by March 2023.
Fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Achieve a well-led 'good' rating by 2021	DONM	Clinical & Quality Strategy	QC	The CQC Framework for the trust is now in draft. This will present a plan for our CQC preparedness for 2022/23 and will be introduced in conjunction the ward accreditation programme. This process will include the reviews of the current CQC action plans, with new and updated versions produced and presented by the divisions to the executive team at regular intervals. Updates for the clinical quality strategy will continue to be delivered to Quality Committee, this will be on a bi-annual basis for 2022/23. Further work is ongoing with the divisions to develop this paper for each of the key themes of the strategy, in addition to the clinical priorities for each of the services here at LWH		This remains a priority but the change of rating in year is dependent on when the Trust receives an inspection.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/042b*		Date: 05/05/2022	
Report Title	**Revised Risk Management Strategy for 2022-23**			
Prepared by	*Allan Hawksey, Risk and Patient Safety Manager* *Phil Bartley, Associate Director of Governance and Quality*			
Presented by	*Mark Grimshaw, Trust Secretary*			
Key Issues / Messages	The Board is requested to review and approve the proposed Risk Management Strategy for 2022/23.			
Action required	Approve ☒	Receive ☐	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	For discussion, and if deemed appropriate, approval.			
Supporting Executive:	*Marie Forshaw, Chief Nurse and Midwife*			

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

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Trust Board	07/04/2022	Chair	The strategy required further revision

EXECUTIVE SUMMARY

Risk management should be embedded in all of the Organisation's practices and processes in a way that it is relevant, effective and efficient. The risk management process should be part of, and not separate from, those organisational processes.

In particular, risk management should be embedded into policy development, business and strategic planning and review, and the change management processes. Risk is an inherent part of the delivery of healthcare.

The risk management strategy outlines the Trust's current approach to risk management throughout the organisation.

Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks and responding to them. Risk is defined as the uncertainty in achieving an objective.

To support and enable this process to occur the Trust has a defined Risk Management Strategy in place which is led by the Associate Director of Governance and Quality and supported through the management structure of the organisation.

MAIN REPORT

The following report provides a review of the current Risk Management Strategy (last reviewed in 2021) and provides an updated proposed Risk Management Strategy for 2022/23, which identifies changes which are required to maintain it as a live document.

The Risk Management Strategy has previously been developed with consideration and adoption of available guidance and consultation with the Trust Executives.

Proposed Risk Management Strategy for 2022/23

The Risk Management Strategy (version 15 proposed for 2022 onwards) has undergone a number of amendments and additions (most significantly in 2021) to reflect developments in the Trust's approach to assessment, management and mitigation of risk as follows:

- Reviewed statement of intent from the Chief Executive (subject to finalisation by the Chief Executive)
- Update wording regarding the underpinning of the BAF by Key Strategic Threats
- Risk team profile (and key contacts) including divisional governance management structure
- Delegation of responsibility throughout the Organisation and appropriate oversight of risk (update to section 2.5 and appendix B and C additions)

Risk Management Strategy

Liverpool Women's NHS Foundation Trust

Version 15.0
March 2022

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1 Foreword : Trust Risk Statement (statement to be reviewed and agreed by the Chief Executive) – minor amendments to wording

We are committed to delivering the highest quality services, which are safe and promote the wellbeing of service users, their relatives and carers, staff and stakeholders. We will ensure consistent risk management systems and processes are in place for continuous quality improvement and safer patient care. Managing risk is a key organisational responsibility and as such is seen as an integral part of the Trust's strong governance arrangements. The Trust is committed to implementing the principles of good governance, defined as:

The system by which the organisation is directed and controlled to achieve its objectives and meet the necessary standards of accountability, probity, and openness.

The Trust recognises that the principles of governance must be supported by an effective risk management system that is designed to deliver improvements in patient safety and care as well as the safety of its staff, patients and visitors. This strategy describes a consistent and integrated approach to the management of all risk across the Trust.

The principles of risk management apply to all staff and all areas of the Trust regardless of the type of risk. The Trust Board will ensure that risk management, quality and safety receive priority and the necessary resources within budgets, to achieve the Trust's strategic objectives. The Board recognises that the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of premises and managing finances by their nature incur risks.

The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation. Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the board and management is not surprised by risks that could, and should, have been foreseen.

Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk. Considered risk taking is encouraged, together with experimentation and innovation within authorised limits. The priority is to reduce those risks that impact on patient safety, and reduce the Trust's financial, operational and reputational risks.

Kathryn Thomson
Chief Executive

2 Introduction

Risk management should be embedded in all the organisation's practices and processes in a way that it is relevant, effective and efficient. The risk management process should be part of, and not separate from, those organisational processes. In particular, risk management should be embedded into policy development, business and strategic planning and review, and the change management processes. Risk is an inherent part of the delivery of healthcare. The risk management strategy outlines the Trust's approach to risk management throughout the organisation.

Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks, and responding to them. Risk is defined as the uncertainty in achieving an objective.

This board approved strategy for managing risk identifies accountability arrangements, resources available, and provides guidance on what may be regarded as acceptable risk within the organisation.

This strategy applies to all Trust staff, contractors and other third parties working in all areas of the Trust. Risk management is the responsibility of all staff and managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

The strategy is supported by a comprehensive 'risk assessment and process toolkit' and a programme of mandatory training, underpinning the fundamentals of the patient safety agenda 2019 and NHS England / Improvement and Care Quality Commission ambitions

2.1 The Core Elements of the Strategy

Risk Management Process

The Trust's risk management process ensures that risks are identified, assessed, controlled, and when necessary, escalated. These main stages are carried out through:

- Clarifying objectives
- Identifying risks to the objectives
- Defining and recording risks
- Completion of risk registers and identifying actions
- Escalation and de-escalation of risks

The identification of risk is the essential element of any risk management strategy or process. There needs to be a fully identified and supported approach to this element of risk management which includes formal risk assessment generated for incidents, claims, complaints etc. the identification of any new risks as part of normal business of meetings from papers or concerns raised is beneficial. The use of horizon scanning which is in built into the agendas of a number of committees, sub-committees and groups within the Trust provides a solid foundation in supporting robust discussions within the meeting and the identification of new risk on the horizon. This key element needs to be developed and embedded further within the divisional boards and sub groups to ensure there is a Trust wide approach to identifying risks on the horizon.

Governance Structure to Support Risk Management

There are different operational levels ensuring the governance of risk in the Trust:

- Board of Directors
- Executive Management Team

Divisional Governance Management is supported by divisional governance managers, who work as part of the senior management team within each division.

Risk management by the Board is underpinned by a number of interlocking systems of control. The Board reviews risk principally through the following three related mechanisms:

1. **The Board Assurance Framework (BAF)** sets out the strategic objectives, identifies key strategic threats in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF is cross-referenced with, and contains all risks within the Corporate Risk Register. The BAF can be used to drive the board agenda.

2. **The Corporate Risk Register (CRR)** is the corporate high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust.
3. **Divisional and Local risk registers** are for recording and managing risks to the routine daily activities of each service. Local risks are discussed at team meetings, risks that cannot be managed at the local level may be escalated to the CRR

Additionally, the annual governance statement is signed by the Chief Executive. It sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the annual accounts process and brought to the board with the accounts.

2.2 Aim

The aim of this strategy is to set out the Trust's vision for managing risk. Through the management of risk the Trust seeks to minimise, though not necessarily eliminate, threats and maximise opportunities.

i. The key objectives of risk management at the Trust are to:
   - Reduce the level of exposure to harm for patients, colleagues or visitors by proactively identifying and managing personal risk to a level as low as reasonably practicable.
   - Promote success and protect everything of value to the Trust, such as high standards of patient care, safe working environment, the Trust's safety record, reputation, community relations, equipment or sources of income.
   - Continuously improve performance by proactively adapting to mitigate risk as much as possible and remaining resilient to changing circumstances or events.

ii. The Trust will establish an effective risk management system which ensures that:
   - All risks are identified that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the Trust
   - Priorities are determined, continuously reviewed and managed through objectives that are owned and understood by all staff.
   - Risks to the achievement of objectives are anticipated and proactively identified.
   - Controls are put in place, effective in their design and application to mitigate the risk, and understood by those expected to use them.
   - The operation of controls is monitored by management.
   - Gaps in control are rectified by management in the most appropriate manner determined.
   - Management are held to account for the effective operation of controls.
   - Risks that exceed timescales for completion are proactively reviewed and escalated to the appropriate management for action.
   - Assurances are reviewed and acted on.
   - Staff continuously learn and adapt to improve safety, quality and performance.
   - Risk management systems and processes are embedded locally across operational divisions and in corporate services including business planning, service development, financial planning, project and programme management and education.

2.3 Risk Appetite and Statement

Risk Appetite

The resources available for managing risk are finite and so the aim is to achieve an optimum response to risk, prioritised in accordance with an evaluation of the risks. Risk is unavoidable, and every organisation needs to take action to manage risk in a way that it can justify to a level which is tolerable. The amount of risk that is judged to be tolerable and justifiable is the "risk appetite". (Appendix D provides a guidance template on setting the Trust risk appetite).

Risk appetite is therefore 'the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.' *(Definition from HMT Orange Book, 2005).* It can be influenced by personal experience, political factors and external events.

Risks need to be considered in terms of both opportunities and threats and are not usually confined to money - they will invariably also impact on the capability of our organisation, its performance and its reputation.

We need to know about risk appetite because: If we don't know what our organisation's collective appetite for risk is and the reasons for it, then this may lead to erratic or inopportune risk taking exposing the organisation to a risk it cannot tolerate; or an overly cautious approach which may stifle growth and development. If our leaders do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised and patient outcomes affected.

The Trust will periodically review its appetite for and attitude to risk, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk. The periodic review and arising actions will be informed by an assessment of risk maturity, which in turn enables the board to determine the organisational capacity to control risk. The review will consider:

- Risk leadership.
- People.
- Risk policy and strategy.
- Partnerships.
- Risk management process.
- Risk handling.
- Outcomes.

Risk Appetite Statement

The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, an organisation's risk appetite should address several dimensions:

- The nature of the risks to be assumed.
- The amount of risk to be taken on.
- The desired balance of risk versus reward.

On an annual basis the Trust will publish its reviewed and current risk appetite statement as a separate document. The statement will define the board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question.

Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.

The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk and published publicly.

2.4 Responsibility and Accountability

Liverpool Women's Hospital will ensure that there is accountability, authority and appropriate competence for managing risk, including implementing the risk management process and ensuring the adequacy, effectiveness and efficiency of any controls. This will be facilitated by:

- Identifying risk owners that have the accountability and authority to manage risks.
- Identifying who is accountable for the development, implementation and maintenance of the framework for managing risk.
- Identifying other responsibilities of people at all levels in the organisation for the risk management process.
- Establishing performance measurement and external/internal reporting and escalation processes; and
- Ensuring appropriate levels of recognition.

To enable all staff to fulfil their respective roles and responsibilities the Trust Governance Team will provide support, guidance and training in risk management.

2.5 Individual and Delegated Responsibilities

Risk management is the responsibility of all staff. Ultimately all who work at the Trust have a responsibility for the delivery of high quality, safe care, although this may manifest itself in various day to day to activities conducted by members of staff. The following sections define the organisational expectations of particular roles or groups:

Chief Executive
The Chief Executive is the responsible officer for Liverpool Women's NHS Foundation Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As the 'accountable officer', the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the annual governance statement. Operationally, the Chief Executive has designated responsibility for implementation of this strategy as outlined below.

Chief Finance Officer
The Chief Finance Officer has responsibility for financial governance and associated financial risk.

Chief Nurse and Midwife
The Chief Nurse and Midwife has joint authority for clinical governance and absolute delegated authority for quality improvement, risk management, and complaints, and is executive lead for safeguarding and infection control.

Chief Operating Officer
The Chief Operating Officer is executive lead for health and safety and emergency planning,

Associate Director of Governance and Quality
The Associate Director of Governance and Quality, working closely with the Chief Nurse and Midwife and supported by key staff, will be responsible for systems and processes for risk management and for reporting risk performance to board sub-committees.

Trust Secretary
The Trust Secretary is responsible for maintaining the Board Assurance Framework.

Medical Director
The Medical Director has joint responsibility for clinical governance, and responsibility for audit and clinical effectiveness.

Executive Directors
Executive Directors have responsibility for the management of strategic and operational risks within individual portfolios. These responsibilities include the maintenance of the corporate risk register and the promotion of risk management to staff within their directorates.

Executive Directors have responsibility for monitoring their own systems to ensure they are robust, for accountability, critical challenge, and oversight of risk.

Clinical Directors, Divisional Managers, Heads of Nursing/ AHP and Head of Midwifery
Clinical Directors, Divisional Managers, Heads of Nursing/ AHP and Head of Midwifery take the lead on risk management within the division as the triumvirate and set the example through visible leadership of their staff. They do this by:

- Taking personal responsibility for managing risk.
- Sending a message to staff that they can be confident that escalated risks will be acted upon.
- Ensuring risks are reviewed regularly, updated and acted upon appropriately.
- Identifying and managing risks that cut across delivery areas.
- Discussing risks on a regular basis with staff and up the line to help improve knowledge about the risk faced; increasing the visibility of risk management and moving towards an action focussed approach.
- Communicating downwards what top risks are, and doing so in plain language.
- Escalating risks from the front line.
- Linking risk to discussions on finance, and stopping or slowing down non-priority areas or projects to reduce risk as well as stay within budget, demonstrating a real appetite for setting priorities.
- Ensuring staff are suitably trained in risk management.
- Monitoring mitigating actions and ensuring risk and action owners are clear about their roles and what they need to achieve.
- Ensuring that people feel supported when identifying and escalating risks, and fostering a fair and just culture, which encourages them to take responsibility in helping to manage them.
- Ensuring that risk management is included in appraisals and development plans where appropriate.

Heads of Corporate Services
Heads of Corporate Services will undertake the same roles and responsibilities as those outlined above for the divisional triumvirate.

Patient Safety Specialists
Patient Safety Specialists are new roles identified within the Patient Safety Strategy, of which the Trust has 3 nominated specialists. They are the patient safety experts within the Organisation to provide leadership, visibility and expert support to patient safety work. They are expected to:

- Support the development of a patient safety culture and safety systems.
- Engage directly with the executive team.
- Lead, oversee or support patient safety improvement and ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes.
- Promote patient safety thinking beyond things going wrong to why things routinely go right healthcare and the systems approach to patient safety.
- Implement the rollout out of the new Patient Safety Incident Response Framework expected from Autumn 2022.

Senior Managers

Senior Managers are expected to be aware of and adhere to risk management best practice to:

- Identify risks to the safety, effectiveness and quality of services, finance, delivery of objectives and reputation- drawing on the knowledge of front line colleagues.
- Identify risk owners with the seniority to influence and be accountable should the risk materialise.
- Assess the rating of individual risks looking at the likelihood that they will happen, and the consequence if they do.
- Identify the actions needed to reduce the risk and assign action owners.
- Record risks on the risk register.
- Check frequently on action progress, especially for high severity risks.
- Apply healthy critical challenge, without blaming others for identifying and highlighting risks, or consider that they are being unduly negative in doing so.
- Implement a process to escalate the most severe risks, and use it.

Risk and Patient Safety Manager

The Risk and Patient Safety Manager will be responsible for ensuring that the systems and processes for risk management are monitored and maintained for their effectiveness. They:

- Will lead on effective operational risk management across the Trust as the Governance Lead reporting to the Associate Director of Governance and Quality
- Have oversight of all risk within the Trust
- Triangulates all trust risks through quarterly Integrated Governance Reports to Quality Committee
- Ensure risk is being managed proactively and effectively, ensuring escalation or de-escalation where required.
- Ensure the Ulysses Risk Management system is being fully utilised effectively
- Ensure risk and risk actions are regularly reviewed within required timescales
- Report to the Corporate Risk Sub Committee regarding new risks, closed risk assurance and the effectiveness of risk management across the Trust bi-monthly.
- Plan and undertake provisional underpinning work for the new Patient Safety Incident Response Framework and identify key performance indicators, once operational, for the forthcoming 12-month period.

All Staff

All staff are encouraged to use risk management processes as a mechanism to highlight areas they believe need to be improved. Where staff feel that raising issues may compromise them or may not be effective they should be aware and encouraged to follow guidance on whistle blowing and raising concerns.

Staff side representatives also have a role in risk management including providing support and guidance to staff undertaking risk assessments where appropriate, and providing advice in the event of a dispute to the validity of a risk assessment.

Delegated Responsibilities

Risk Area	Officer Responsible for co-ordination and advice	Responsible for Identification of risks	Responsible for analysis	Responsible for control (where there is a delegated Sub - Committee)
Incident Reporting & Analysis, Risk Registers.	Risk & Patient Safety Manager and divisional	Individual Services Divisional Governance	All departments Divisional Governance	Corporate Risk Sub Committee Safety and

	Governance Managers	Managers Risk & Patient Safety Manager	Managers Risk and Patient Safety Manager	Effectiveness Sub Committee
Board Assurance Framework (BAF)	Trust Secretary	Trust Board Trust Secretary	Trust Executive	Corporate Risk Sub Committee
Clinical and Non-Clinical Claims	Legal Services	Legal Services	Legal Services	Safety and Effectiveness Sub Committee
Complaints	Deputy Head of Patient Experience	Individual Services Divisional Governance Managers Complaints Officers	All departments Divisional Governance Managers Patient Experience Team	Patient Involvement and Experience Sub Committee
Serious Incident Investigations	Risk and Patient Safety Manager Divisional Governance Managers	Individual Services Divisional Governance Managers	All departments Divisional Governance Managers Risk and Patient Safety Manager	Safety and Effectiveness Sub - Committee
Building, land, plant, non-medical equipment – all estates	Deputy Director of Estates and Facilities	Individual services. Patient Facilities Manager Deputy Director of Estates and Facilities	Patient Facilities Manager Deputy Director of Estates and Facilities	Performance and Assurance Group
Catering and Food Hygiene	Deputy Director of Estates and Facilities	Individual services. Patient Facilities Manager Deputy Director of Estates and Facilities	Patient Facilities Manager Deputy Director of Estates and Facilities	Performance and Assurance Group
Emergency Preparedness, Resilience and Response EPRR	EPRR Lead Chief Operating Officer	Individual services EPRR Lead Chief Operating Officer	EPRR Lead Chief Operating Officer	Emergency Preparedness, Resilience and Response Committee
Fire Safety	Fire Safety Officer	Individual Services Fire Safety Officer Chief Operating Officer	Fire Safety Officer Chief Operating Officer	Health and Safety Group
Health and Safety	Health and Safety Manager	Individual Services Health and Safety Manager	Health and Safety Manager Chief Operating Officer	Health and Safety Group

Human Resources	Deputy Director of HR	Deputy Director of HR	Deputy Director of HR	Putting People first Committee
Infection Prevention and Control	Director of Infection Prevention and Control	Infection Prevention and Control Team	Infection Prevention and Control Team	Infection Prevention and Control Committee
Digital Services / Information Governance	Head of Information Governance	Head of Information Governance	Head of Information Governance	Information Governance Committee
Medical Devices	Risk and Patient Safety Manager Medical Director	Risk and Patient Safety Manager	Risk and Patient Safety Manager	Safety and Effectiveness Sub Committee
Medicines Management	Deputy Chief Pharmacist	Deputy Chief Pharmacist	Deputy Chief Pharmacist	Medicines Management Group
Security	Local Security Management Specialist	Local Security Management Specialist	Local Security Management Specialist	Health and Safety Group
Audit and counter Fraud	Deputy Director of Finance	Deputy Director of Finance	Deputy Director of Finance	Audit Committee

2.6 Committee Duties and Responsibilities

The Board sub-committees are responsible for assuring that the risks are being managed appropriately by taking into account the gaps, mitigation and Trust tolerance levels, and for assuring the board where appropriate or raising any concerns to other relevant sub-committee, additionally each board sub- committee should review the board assurance framework and the corporate risk register at each of its respective meetings.

Board of Directors

The board is responsible for ensuring that the Trust has effective systems for identifying and managing all risks whether clinical, financial or organisational. The risk management structure helps deliver the responsibility for implementing risk management systems throughout the Trust.

The responsibility for monitoring the management of risk across the organisation has been delegated by the board to the following inter-relating committees:

- Audit Committee
- Finance, Performance and Business Development Committee
- Quality Committee
- Putting People First Committee

Specific responsibilities for the management of risk and assurance on its effectiveness are delegated as follows:

Audit Committee

The Audit Committee is responsible for providing assurance to the Trust board on the process for the Trust's system of internal control by means of independent and objective review of corporate governance and risk management arrangements, including compliance with laws, guidance, and regulations governing the NHS. In addition, it has the following responsibilities relating to risk:

To maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements.

Finance, Performance and Business Development Committee
This Committee is responsible for providing information and making recommendations to the Trust board on financial and operational performance issues, and for providing assurance that these are being managed safely. The committee will consider any relevant risks within the Board Assurance Framework and Trust corporate risk register as they relate to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the Corporate Risk Committee or the board as appropriate.

Quality Committee
The Committee is responsible for providing the Trust board with assurance on all aspects of quality of clinical care; governance systems including risks for clinical, information and research and development issues; and regulatory standards of quality and safety. The committee will consider any relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the Corporate Risk Committee or the board as appropriate.

Putting People First Committee
The Committee is responsible for providing the Trust board with assurance on all aspects of governance systems and risks related to the workforce, and regulatory standards for human resources. The committee will consider any relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the Corporate Risk Committee or the board as appropriate.

Trust Executive Team
The Trust executive team is responsible for the operational management and monitoring of risk, through the corporate risk register and Board Assurance Framework, and for agreeing resourced treatment plans and ensuring delivery.

2.7 Clinical Services and Corporate Risk Management Arrangements

All service areas will put the necessary arrangements in place within their areas for good governance, safety, quality and risk management.

Clinical services have the responsibility, through the respective governance/risk leads, for the risks to their services and for the putting in place of appropriate arrangements for the identification and management of risks. Services will develop, populate and review their risks, drawing on risk processes to ensure risk registers are kept up to date through regular review.

In doing this, due account will be taken of the Trust's strategic and corporate objectives, particularly in terms of meeting regulatory standards and guidance, national performance standards and targets and relevant legislation, and of the issues and risks relevant to specific areas within the particular services

Operational Board meetings will review risk registers and contribute to the development of the risk registers and ensure that they are in place and operating within the defined tolerances and escalation processes.

Corporate Risk Sub Committee
The Sub Committee consists of a quorate of new members and functions to ensure effective oversight and scrutiny of the entire business of the Trust, the relationship between the Corporate Risk Sub Committee, and the other Board Sub- Committees, is based on inclusiveness, clarity of purpose and constructive challenge. The Corporate Risk Sub Committee will oversee the management of all corporate risks, reviewing closed assurance and new risk reports and will provide the Audit Committee with assurance on the effective

operation of internal controls. The Trust's divisions (Corporate, Family Health, Clinical Support Services and Gynaecology) report to the Committee bi-annually.

3 Process for Managing Risk

Stage 1 – Clarifying Objectives

Whether a new risk has been identified or staff need to know what to do next; clarifying objectives is a critical stage of the risk management process. To understand whether something constitutes a risk it must first be understood what are the objectives/outcomes to be achieved.

Strategic or corporate objectives; to identify and clarify which Trust strategic or corporate objective is relevant to the division, directorate, or service. Look at the Trust business plan and the latest local business plan. If this step is missed or omitted then the risk register will be neither relevant nor effective.

Local objectives should also be considered. By clarifying the objectives it can be identified whether there is a risk to manage.

Stage 2 – Identifying Risks to Objectives

Once the objectives have been identified then risks can start to be identified. Consider the following questions:

- Do you know what all of the risks to the delivery of your objectives or work are, especially those that impact on delivering high quality, safe services?
- What could happen, and what could go wrong?
- How and why could this happen?
- What is depended upon for continued success?
- Is there anyone else who might provide a different perspective on your risks?
- Is it an operational risk or a risk to a strategic objective?

If possible gather those staff together who are able to assist with the identification of risk for the area. Guidance on how to do this is available from the Governance Team (Section 6).

Stage 3 – Defining and Recording Risks

Once the risk has been identified then:

- Undertake a comprehensive risk assessment
    - Describe the risk, so that others understand what the risk is in relation to the description of condition, cause and consequence, being clear for each one.
    - Complete an initial risk assessment score so that the risk is appropriately escalated to management where required
    - Assign an owner to the risk who will oversee the risk management and review the initial score
    - List the key controls (actions) being taken to reduce the likelihood of the risk happening, or reduce the impact.
    - If it is a severe risk (use risk matrix Appendix A) then consider what the contingency action plan is, i.e. what will you do should the risk happen.
    - Rate the likelihood of the risk materialising.
    - Rate the consequence of the risk happening.

All of these things should be recorded which will allow the risk to be recorded on and appropriate risk register(s) following risk assessment, if the risk assessment process has not enabled the risk to be eliminated or managed. The following sections describe in detail how to complete the risk register.

Stage 4 – Risk Register(s)

All service areas are to maintain a local risk register. This register contains operational and strategic risks that are routinely managed within the service, and for which the service has the required resources, controls and mitigation within the parameters of risk set by the risk appetite.

The Corporate Risk Register is a collection of risks that directly impact on to the delivery of the corporate aims. This register is populated by a variety of sources, i.e. risks that cannot be controlled or mitigated in the service area, external audit reports, and principle risks from the board assurance framework.

Traditionally, completing a risk register can be daunting but the aim is to have a simplified process to allow the monitoring of actions and aid decision-making, electronically.

Headings in the register(s) that need to be completed are:

1. The risk identification (ID) is the unique identifier to distinguish the risk from the other risks in your register. The ID will not change throughout the life of the risk.

The risk owner is the individual who is accountable and has overall responsibility for a risk; it may or may not be the same person as the action owner. High severity corporate risks, for example, will be owned by one Executive Director, but there may be many action owners. The risk owner must know, or be informed that they are the owner, and accept this.

2. Source of, how or where the risk was identified. This could include:
   - Business planning.
   - Clinical audit.
   - Complaints/PALS.
   - External audit.
   - External review.
   - Incident.
   - Internal audit.
   - Legislation.
   - Litigation.
   - National risks such as financial fraud
   - NICE guidance.
   - Regulatory standard.
   - Risk Assessment.
3. Risk description as the name suggests, allows the risk to be described. It is important that risks are clearly articulated. If not, then it is difficult to put effective controls, or actions, in place to reduce the risk materialising and contingency plans. Using the following subheadings will help to clearly describe risk:
   - Condition
   - Cause
   - I Consequence

For example:
Condition: Inability to release clinical staff for mandatory training due to staffing levels.
Cause: Results in staff not receiving compulsory training in resuscitation or blood safety.
Consequence: Leading to an increased safety risk to patients.

Getting this right is important as the key controls relate directly to the description of the risk. Key controls are the measures put in place as preventative measures to lessen or reduce the likelihood or consequence of the risk happening and/or the severity if it does. You must ensure that each control (or action where a

gap in control has been identified) has an owner and target completion date.

These must describe the practical steps that need to be taken to manage and control the risk. Without this stage, risk management is no more than a paper based or bureaucratic process.

Not all risks can be dealt with in the same way. The 5T's provide an easy list of options available to anyone considering how to manage risk:

- **Tolerate** – the likelihood and consequence of a particular risk happening is accepted.
- **Treat** – work carried out to reduce the likelihood or consequence of the risk (this is the most common action).
- **Transfer** – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party.
- **Terminate** – an informed decision not to become involved in a risk situation, e.g. terminate the activity.
- **Take the opportunity** – actively taking advantage, regarding the uncertainty as an opportunity to benefit.

In most cases the chosen option will be to treat the risk. When considering the action to take remember to consider the cost associated with managing the risk, as this may have a bearing on the decision. The key questions in this instance are:

- Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.
- When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.

Stage 5 – Escalation and De-escalation of Risks

The consequence of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example from a service risk to Division and up to the corporate risk register reviewed by the Corporate Risk Committee, Board Sub-Committee, and finally the Board.

Risk will be escalated or de-escalated within the defined tolerances and authority to act for each level.

For example: a service risk scoring high or extreme should only be escalated to the corporate risk register if it is **not** manageable within the service. If the risk **is** manageable within the service then it remains on the service risk register. In a case whereby the risk is to be escalated to the corporate risk register, options for controls or mitigation must be offered. The risk owner should discuss and seek approval from their manager before risk escalation to the next level. Once an escalated risk has reached the Corporate Risk Register, the Corporate Risk Committee will consider the risk control options advised and make recommendations for action, the risk will then be de- escalated and returned to the risk owner for implementation. Where a risk is de-escalated this must be communicated to the management level below, and the risk monitored at the appropriate management level and risk forum.

It is important that risks are reviewed regularly to ensure appropriate action, including closing risks or action plans where necessary.

Stage 6 - Closure of Risk

Risk registers need to be current and up to date. It is therefore essential that risks are continually monitored and fully reviewed at least annually. They should be closed under the following circumstances:

- The Risk has materialised.
- The Risk has reached its target score and has remained stable for an acceptable period of time

(following Senior Members authorisation)
All closed risks will be archived and not deleted

3.1 Risk Profile

A summary risk profile is a simple visual mechanism that can be used in reporting to increase the visibility of risks; it is a graphical representation of information normally found on an existing risk register. A risk profile shows all key risks as one picture, so that managers can gain an overall impression of the total exposure to risk.

3.2 Horizon Scanning

Horizon scanning is about identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing formal mechanisms to horizon scanning the Trust will be better able to respond to changes or emerging issues in a planned structured and co-ordinated way. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:

- Legislation.
- Government white papers.
- Government consultations.
- Socio-economic trends.
- Trends in public attitude towards health.
- International developments.
- NHS England publications.
- Local demographics.
- Seeking stakeholders views.
- Risk assessments.

All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.

Board members have the responsibility to horizon scan and formerly communicate matters in the appropriate forum relating to their areas of accountability.

4 Training

Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management.

Training required to fulfil this strategy will be provided in accordance with the Trust's training needs analysis.

All new staff undertake risk management training as part of their Corporate Induction. Training is mandated for all other staff.

Management and monitoring of training will be in accordance with the Trust's statutory and mandatory training policy.

Specific training will be provided for the board, in respect of high level awareness of risk management. Risk awareness sessions are included as part of the board's development programme.

5 Evidence Base

- Home Office Risk Management Policy and Guidance, Home Office (2011).
- A Risk Matrix for Risk Managers, National Patient Safety Agency (2008).
- NHS Audit Committee Handbook, Department of Health (2011).
- UK Corporate Governance Code, Financial Reporting Council (2010).
- 'Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance', Audit Commission (2009).
- The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004).
- Risk Management Assessment Framework, HM Treasury (2009).
- Understanding and Articulating Risk Appetite, KPMG (2008).
- Risk Appetite Frameworks- how to spot the genuine article, Deloitte (2013).
- Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012).
- Good Practice Guide: Managing Risks in Government, National Audit Office (2011).
- Risk Management – principles and guidelines ISO 31000 (2009).
- Patient Safety Strategy (2020)

6 Monitoring Compliance and Audit

The Trust risk team, led by the Associate Director of Governance and Quality oversee all risks recorded on the Ulysses risk management system. The team review all new, closed and outstanding risks and quality assures every risk assessment whether ongoing or completed. The team re-open closed risks if necessary, where it is deemed appropriate action has not been taken and audit risks exceeding timescales, escalating to the appropriate management level where necessary,
This strategy will be reviewed annually.

The Trust Risk Team, which includes the divisional governance managers, are always for available for operational advice / support when required and are contactable as follows:

Name	Role	Extension
Phil Bartley	Associate Director of Governance and Quality	1383
Allan Hawksey	Risk and patient safety manager	4437
VACANT	Governance support officer	4292
Jenny Lamble	Governance support officer	4489
Laura Thorpe	Divisional Governance Manager (maternity)	4433
VACANT	Divisional Governance Manager (gynaecology / Hewitt Centre)	1048
Kelli Platt	Divisional Governance Manager (Neonatal)	1015
Adam Davies	Divisional Governance Manager (Clinical Support Services)	4421

7 Dissemination, Implementation and Access to the Document

This strategy is available on the Trust intranet. All staff will be notified via email of the strategy and other amendments.

8 Key Performance Indicators

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
All verified BAF strategic threats are reported to the Board of Directors at each formal meeting of the Board.	100%	The following mechanisms will be used to monitor compliance with the requirements of this document:	Corporate Risk Sub Committee & Trust Board (when meetings are scheduled)	Bi-Monthly	Trust Secretary
All significant risks are reported to and reviewed as a standing agenda item at each formal meeting of the Corporate Risk Sub-Committee.	100%	• Evidence of reporting verified significant risk exposures to the Board of Directors at each formal meeting. • Evidence of review of significant risk exposure by the Corporate Risk Sub Committee at each formal meeting. • Periodic internal audit of any or all aspects of the Risk Management process as determined by the Audit Committee (risk identification, assessment, control, monitoring and reviews).	Corporate Risk Committee	Bi-Monthly	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)
The risk profiles (for extreme risks not on the corporate risk register) for all divisions are reviewed by the Corporate Risk Sub Committee at a frequency determined by the Corporate Risk Committee as part of a rolling programme of reviews.	100%		Corporate Risk Committee	Bi-Monthly	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)
Local risk registers are in place, maintained and available for inspection.	100%		Corporate Risk Committee	Bi-Monthly	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)
Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and all risks and risk actions are within review date, and none are overdue for review.	100%		Corporate Risk Committee	Bi-Monthly	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)

Annual review and approval of the Trust's Risk Appetite	100%		Quality Committee	Annual Report	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)
Risk management training mandatory for all staff at corporate induction	100%		Quality Committee	Annual Report	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)
Risk management training mandatory for all staff as part of their mandatory training	100%		Quality Committee	Annual Report	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)
Staff compliance with the risk management standard operating procedure (SOP)	100%		Quality Committee	Annual Report	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)

9 Appendices

Appendix A - Risk Descriptors and Grading

Risk Descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Risk scoring = consequence x likelihood (C x L)

	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

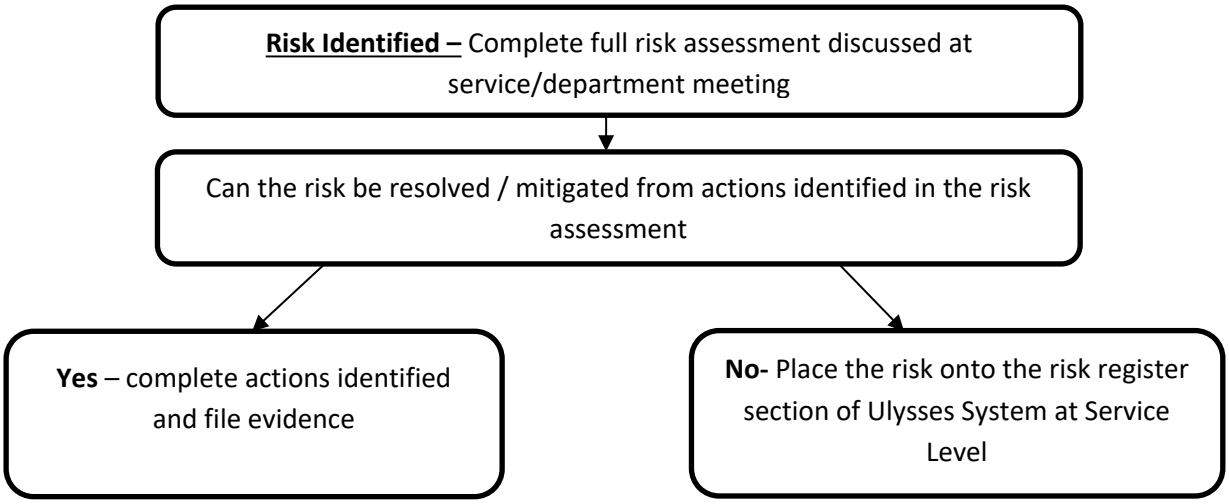
1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

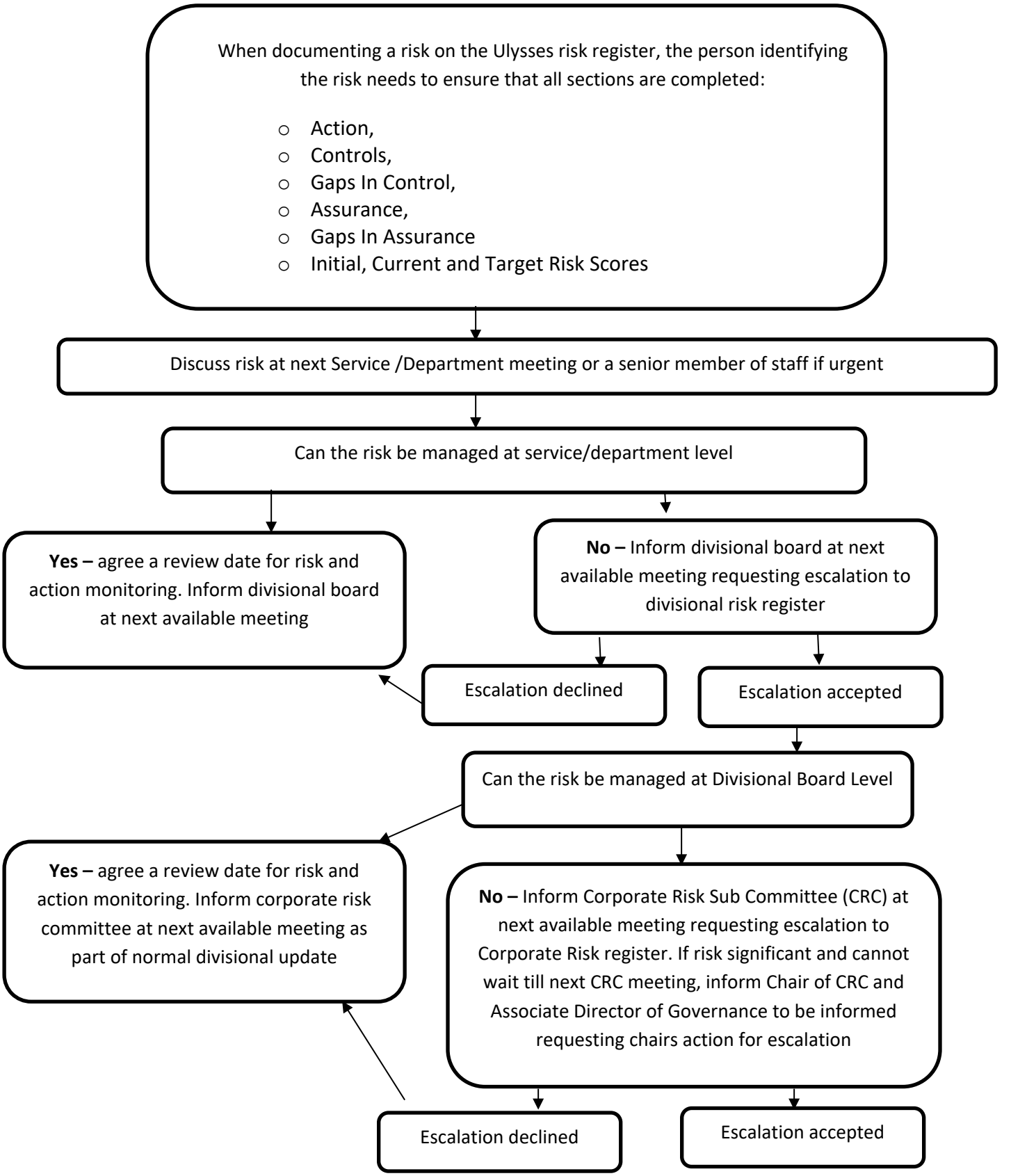
The risk matrix above can be used to provide an initial breakdown of the hazards into 4 Categories as follows:

Low Risk	Acceptable risk requiring no immediate action Review annually Place on the appropriate section of the Risk Register
Moderate Risk	Action planned within one month to reduce risk Commenced within 3 months Place on the appropriate section of the Risk Register
High Risk	Actions planned immediately Review Monthly Place on the appropriate section of the Risk Register
Extreme Risk	Immediate Actions required Reviewed weekly by ET Placed on the Corporate Risk Register

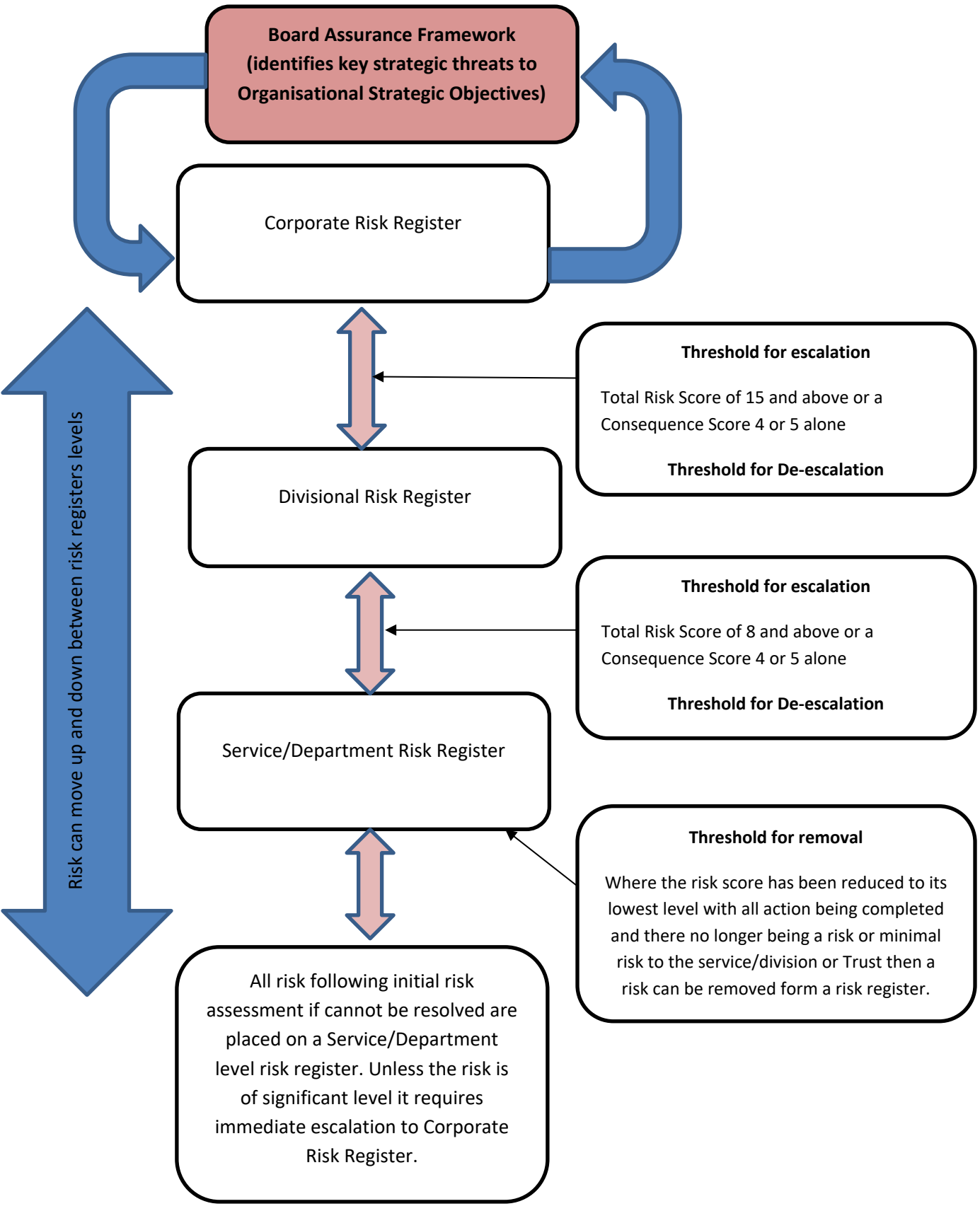
Appendix B – Risk Procedural Steps to Assessment

The following flow chart provides a visual representation of the process of managing risk registers




When documenting a risk on the Ulysses risk register, the person identifying the risk needs to ensure that all sections are completed:
Action,
Controls,
Gaps In Control,
Assurance,
Gaps In Assurance
Initial, Current and Target Risk Scores
Discuss risk at next Service /Department meeting or a senior member of staff if urgent
Can the risk be managed at service/department level
Yes – agree a review date for risk and action monitoring. Inform divisional board at next available meeting
No – Inform divisional board at next available meeting requesting escalation to divisional risk register
Escalation declined
Escalation accepted
Can the risk be managed at Divisional Board Level
Yes – agree a review date for risk and action monitoring. Inform corporate risk committee at next available meeting as part of normal divisional update
No – Inform Corporate Risk Sub Committee (CRC) at next available meeting requesting escalation to Corporate Risk register. If risk significant and cannot wait till next CRC meeting, inform Chair of CRC and Associate Director of Governance to be informed requesting chairs action for escalation
Escalation declined
Escalation accepted
Risks and Risk Registers will be monitored biannual at Safety and Effectiveness Sub Committee and the Corporate Risk Sub Committee.

Appendix C – Risk Procedural Steps to Escalation / De-escalation / Oversight



Appendix D - Initial Equality Impact Assessment

Name of policy/ business or strategic plans/CIP programme:	**Risk Management Strategy v 15**	
Does the proposal, service or document affect one group more or less favourable than another on the basis of:	**No**	**Justification/evidence and data source**
Age	No	No discrimination / inequality identified, the document sets out the Trust's approach and framework for Risk Management, ensuring this is systematic and objective and applied without prejudice or favour.
Disability: including learning disability, physical, sensory or mental impairment.	No	
Gender reassignment	No	
Marriage or civil partnership	No	
Pregnancy or maternity	No	
Race	No	
Religion or belief	No	
Sex	No	
Sexual orientation	No	
Human Rights – are there any issues which might affect a person's human rights?	**No**	**Justification/evidence and data source**
Right to life	No	No impact on human rights, the document sets out the Trust's approach and framework for Risk Management, ensuring this is systematic and objective and applied without prejudice or favour. The aim being to reduce risks to the organisation, its services and the safety and well-being of patients, visitors, staff and the wider public.
Right to freedom from degrading or humiliating treatment	No	
Right to privacy or family life	No	
Any other of the human rights?	No	

Assessment carried out by:

Date:

Signature and Job Title:

Appendix E – Glossary

Action	A response to control or mitigate risk.
Action Plan	A collection of actions that are specific, measurable, achievable, realistic and targeted.
Assessment	A review of evidence leading to the formulation of an opinion.
Assurance	Confidence based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved (Building the Assurance Framework: A Practical Guide for NHS Boards (2003), Department of Health. Taking it on Trust, Audit Commission (2009), Care Quality Commission, Judgement Framework, (2009).
Board Assurance Framework (BAF)	A matrix setting out the organisation's strategic objectives, the risks to achieving them, the controls in place to manage them and the assurance that is available.
Clinical Audit	'A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria the implementation of change' (Principles of Best Practice in Clinical Audit (2002), National Institute of Clinical Excellence).
Compliance	Acting in accordance with requirements.
Contingency plan	The action(s) to be taken if the risk occurs.
Consequence	The result of a threat or an opportunity.
Corporate Governance	The system by which boards of directors direct and control organisations in order to achieve their objectives.
Control	Action taken to reduce likelihood and or consequence of a risk.
Cumulative Risk	The risk involved in several related activities that may have low impact or be unlikely to happen individually, but which taken together may have significant impact and or be more likely to happen; for example the cumulative impact of cost improvement programmes.
Escalation	Referring an issue to the next appropriate management level for resolution, action, or attention.
External Audit	An organisation appointed to fulfil the statutory functions in relation to providing an opinion on the annual accounts of the Trust.
Gap in Assurance	Failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively.
Gap in Control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risk and achieve objectives.
Hazard	A potential source of damage or harm.
Internal Audit	The team responsible for evaluating and forming an opinion of the robustness of the system of internal control.
Internal Control	A scheme of checks used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation.
Inherent/ Initial Risk	The level of risk involved in an activity before controls are applied.

Integrated Risk Management	A process through which organisations identify, assess, analyse and manage all risk and incidents for every level of the organisation and aggregate the results at a corporate level e.g. patient safety, health and safety, complaints, litigation and other risks.
Key Risk / Key Control	Risks and controls relating to strategic objectives.
Likelihood	The probability of something happening.
Mitigation / treatment of risk	Actions taken to reduce the risk or the negative consequences of the risk.
Negative Assurance	Evidence that shows risks are not being managed and/or controlled effectively e.g. poor external reviews or serious untoward incidents.
Reasonable	Based on sound judgement.
Reassurance	The process of telling others that risks are controlled without providing reliable evidence in support of this assertion.
Residual / Current Risk	The risk that is still present after controls, actions or contingency plans have been put in place.
Risk	The uncertainty of outcome of activity, described as the combination of likelihood and consequence, including perceived importance.
Risk Appetite	The level of risk that the organisation is prepared to accept, tolerate and be exposed to at any point in time.
Risk Capacity	The maximum level of risk to which the organisation should be exposed, having regard to the financial and other resources available.
Risk Management	The processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate and anticipate them, and monitoring and reviewing progress.
Risk Matrix	A grid that cross references consequences against likelihood to assist in assessing risk.
Risk Maturity	The quality of the risk management framework.
Risk Owner	The person/group responsible for the management and control of all aspects of individual risks. This is not necessarily the same as the action owner, as actions may be delegated.
Risk Profile	The overall exposure of the organisation or part of the organisational to risk.
Risk Rating	The total risk score worked out by multiplying the consequences and likelihood scores on the risk matrix.
Risk Register	The tool for recording identified risks and monitoring actions and plans against them.
Risk Tolerance	The boundaries of risk-taking that the organisation is not prepared to go beyond.
Strategy	In the NHS a document that sets out the corporate approach and policy to a particular area or work activity. This is sometimes described as a policy, particularly outside the NHS.
Sufficient	Whatever is adequate

Appendix F – Risk appetite

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Good Governance Institute

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

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Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/042c***		**Date: 05/05/2022**	
Report Title	**Board Assurance Framework**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***The report outlines any updates relating to the Board Assurance Framework and any key areas for consideration for the Board.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y ***If no – please outline the reasons for deviation.***			
	The Board requested to review the BAF risks and agree their contents and actions.			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

BAF discussed at FPBD, Putting People First (via email) and Quality Committees since previous version presented to Board on 7 April 2022.

EXECUTIVE SUMMARY

The Board Assurance Framework (BAF) is a monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives, and to ensure it has appropriate oversight of the Trust's risk profile and risk management arrangements.

The BAF items are aligned to the Board's assurance committees, and these were reviewed and discussed during April 2022. Reviews during April were significant with scores for the end of 2021/22 year discussed, target scores for 2022/23 proposed and amendments to the BAF risks themselves considered.

MAIN REPORT

Introduction

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

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

Process for reviewing BAF areas during the meeting

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

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

Changes to BAF

The review process for this month's update has been more extensive than in previous months as it has provided an opportunity to reflect on the content of the BAF (after a year in its current guise) and consider the on-going relevance of the content in the context of the Trust's strategic objectives. A quarter 4 'outturn' score position has also been suggested together with a proposed target score for 2022/23.

To support the clarity of this review, not all track changes are shown, particularly those in relation to the controls, assurances, and actions. These have been extensive and illustrating these as tracked changes would have made it difficult to navigate the document. Significant changes to BAF titles, narrative wording and the strategic threat descriptors are shown with track changes. The table below also outlines the changes made since the previous iteration.

1.1 Failure to be recognised as one of the most inclusive organisations in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)

- No proposed change to BAF score for Quarter 4 – (likelihood 3 x consequence 4). This will mean that the Trust does not meet the target set for 2021/22. Demonstrable progress has been made in this area and therefore it is proposed that the target for this risk in 2022/23 be set at '8'.
- No proposed changes to the BAF title
- Narrative has been updated
- No changes to the strategic threats
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated

1.2 Failure to recruit and retain key clinical staff

- No proposed change to BAF score for Quarter 4 – (likelihood 4 x consequence 5). This will mean that the Trust does not meet the target set for 2021/22. There is likely to be significant risk in this during 2022/23 and therefore it is proposed that the target score be set at '15' rather than '12' (as was the target during 2021/22).
- BAF title has been amended to reflect a wider issue than just clinical staff
- Narrative has been updated
- Descriptor for one strategic threat has been amended.
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated

2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site

- No proposed change to BAF score for Quarter 4 – (likelihood 4 x consequence 4). This will mean that the Trust meets the target set for 2021/22. Demonstrable progress has been made in terms of securing buy-in from key partners and regulators and therefore it is proposed that the target for this risk in 2022/23 be set at '10'. There do, however, remain significant risks to progressing this strategic aim.
- No proposed changes to the BAF title or narrative
- Two additional strategic threats have been added. This enables the BAF to reflect the risk in relation to 1) external partners 2) the local community and 3) the funding issues.
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated

2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment

- No proposed change to BAF score for Quarter 4 – (likelihood 4 x consequence 4). This will mean that the Trust does not meet the target set for 2021/22. It is likely that mitigations will be place for this risk during 2022/23 (new EPR system), effective Divisional Planning but it is unclear at the current time when the benefits for these will be realised. It is for this reason that the proposed target for 2022/23 is a '12'.
- No proposed changes to the BAF title, narrative or strategic threat descriptor
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated

2.3: Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system

- No proposed change to BAF score for Quarter 4 – (likelihood 4 x consequence 5). This will mean that the Trust does not meet the target set for 2021/22. There are several actions in train that should support the Trust in reducing this likelihood score down to 3 once they are completed and moved into the 'controls' column. The target for 2022/23 has therefore been set at 15 (3x5).
- No proposed amendments to the BAF title, strategic threat descriptor or supporting narrative
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.
- There has been a request from NHSI colleagues to meet to discuss this BAF risk – they are seeking assurances that the following aspects are sufficiently covered –
    - Lack of ITU
    - Transfusion service
    - Lack of diagnostics
    - Lack of acute specialities
    - Progress on Clinical pathway established and plans for further implementation
- The outputs from this meeting will be reported to the May 2022 Quality Committee.

2.4: Major and sustained failure of essential IT systems due to a cyber attack

- **Due to recent world events, it is suggested that the environment risk or likelihood for a cyber-attack has increased from possible (3) to likely (4) due to increased cyber threats**. The NHS has reflected the increased threat through guidance issued to all NHS providers and arm's length bodies during March 2022.
- This BAF risk has not met its target for 2021/22. Due to the uplift in score for Q4 2021/22, it is suggested that a realistic target of '15' be established for 2022/23.
- No proposed changes to the BAF title or strategic threat descriptor
- Narrative has been amended.
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

3.1: Failure to deliver an excellent patient and family experience to all our service users

- No proposed change to BAF score for Quarter 4 – (likelihood 4 x consequence 4). This will mean that the Trust does not meet the target set for 2021/22. Whilst there is work underway to strengthen controls, the Ockenden Final Report made several comments about the importance of trusts listening effectively to the patient voice and strengthening the Trust's approach to this will be a significant area of priority during 2022/23. Considering the importance of this and the fact that available controls / assurances remain limited in this area, the target score for 2022/23 has been set at '12' to reflect the current reality. This is an increase on last year's target of '8'.
- No proposed amendments to the BAF title
- Strategic threats updated
- Supporting narrative updated to reference the Ockenden Report.
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

BAF Risk 4.1: Failure to ensure our services are financially sustainable in the long term

- No proposed change to BAF score for Quarter 4 – (likelihood 5 x consequence 4). This will mean that the Trust does not meet the target set for 2021/22. There remains a high degree of uncertainty around the financial landscape and whilst there are strong internal controls in place, the external environment means that it seems unlikely that a target lower than '16' can be set for 2022/23.
- No proposed amendments to the BAF title
- Supporting narrative updated
- Strategic threat descriptor updated
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

BAF Risk 4.2: Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS

- No proposed change to BAF score for Quarter 4 – (likelihood 2 x consequence 4). This will mean that the Trust meets the target set for 2021/22. There remains a high degree of uncertainty around the partnership landscape and the FPBD Committee is responding by requesting strengthened assurance of the effectiveness of the Trust's partnership arrangements (see Committee effectiveness report).
- No proposed amendments to the BAF title or supporting narrative
- Strategic threat descriptor updated to simplify and also recognise that partnerships not solely financially based
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

5.1: Failure to progress our research strategy and foster innovation within the Trust

- No proposed change to BAF score for Quarter 4 – (likelihood 4 x consequence 4). This will mean that the Trust does not meet the target set for 2021/22. Significant progress has been made throughout 2021/22 and appointments joining the Trust should further strengthen this. It is expected that the score for this risk can be scored at '4' for the first quarter of 2022/23 and therefore it suggested to maintain a target score of '4' for 2022/23.
- No proposed amendments to the BAF title
- Strategic threat descriptor updated
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

5.2: Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership

- No proposed change to BAF score for Quarter 4 – (likelihood 3 x consequence 4). This will mean that the Trust does not meet the target set for 2021/22. There is evidence of improvement and strengthened controls heading into 2022/23 (ward accreditation programme, agreed QI Framework etc) that if implemented effectively should provide assurance to reduce the score to '8'. It is therefore suggested to maintain this as the target for 2022/23.
- No proposed amendments to the BAF title, strategic threat descriptor
- Supporting narrative updated
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

New Risks or Strategic Threats

There are two new strategic threats proposed for BAF risk 2.1 – instead of one strategic threat, the proposal is to separate this into the following three areas:

- Inability to effectively communicate the case for change with regulators and key partners and receive buy-in to move project forward.
- Inability to effectively communicate the case for change with the local community and receive buy-in to move project forward.
- Failure to secure capital funding to progress our plans to build a new hospital co-located with an adult acute site

Under BAF Risk 3.1, the strategic threat 'Unable to recover services to pre-Covid-19 levels and beyond', as the issues within this threat have been subsumed into other areas. In its place, two new strategic threats have been identified under this BAF risk:

- Unable to adequately listen to patient voices and our local communities
- Failure to act on the feedback provided by patients, carers, and the local communities.

Closed Risks or Strategic Threats

Since the report was last circulated and discussed at the Board, no risks closed on the BAF.

Conclusions

Board members are asked to comment on the current content and where required make further recommendation for change and agree the current BAF risks.

Recommendation

The Board requested to review the BAF risks and agree their contents and actions.

NHS
Liverpool Women's
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK 2021/2022

Trust Board – May 2022

Board Assurance Framework Key

Risk Rating Matrix (Likelihood x Consequence)					
Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

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

Key to lead Committee Assurance Ratings	
	Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity - no gaps in assurance or control AND current exposure risk rating = target OR - gaps in control and assurance are being addressed
	Amber = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy
	Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each BAF Risk and also to identify any further action required to improve the management of those risks.

Board Assurance Framework: Legend	
Strategic Priority	The 2021/25 strategic priority that the BAF risk has been aligned to.
BAF Risk:	The title of the strategic risk that threatens the achievement of the aligned strategic priority
Rationale for Current Risk Score:	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk.
Strategic Threat:	What might cause the BAF risks to materialise
Provider Licence Compliance:	NHS Improvement provider licence conditions that align to the BAF risk providing assurance on compliance.
Controls:	The measures in place to reduce the risk likelihood or risk consequence and assist secure delivery of the strategic priority.
Assurances:	The measures in place to provide confirmation that the controls are working effectively in supporting the mitigation of the risk.
Gaps in Controls / Assurance:	Areas that require attention to ensure that systems and processes are in place to mitigate the BAF risk Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the BAF risk.
Required Action:	Actions required to close the gap in control/ assurance
Lead:	The person responsible for completing the required action.
Implemented By:	Deadline for completing the required action.
Monitoring:	The forum that will monitor completion of the required action.
Progress:	A RAG rated assessment of how much progress has been made on the completion of the required action.

Risk Descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long- term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on many patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day)	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days)	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff

			Low staff morale Poor staff attendance for mandatory/key training	Loss of key staff Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10– 25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?
The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Board Assurance Framework Dashboard 2021/2022

SA	BAF Risk	Committee	Lead	July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
SA1 Workforce	1.1 Failure to be recognised as one of the most inclusive organisations in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	PPF	CPO	12 (I3 x c4)	12 (I3 x c4)	12 (I3 x c4)	12 (I3 x c4)	⟷	8 (I2 x c4)
	1.2 Failure to recruit and retain key clinical staff	PPF	CPO	20 (I5 x c4)	20 (I5 x c4)	20 (I5 x c4)	20 (I5 x c4)	⟷	12 (I3 x c4)
SA2 Safe	2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site	FPBD	CFO	15 (I3 x c5)	15 (I3 x c5)	15 (I3 x c5)	15 (I3 x c5)	⟷	15 (I3 x c5)
	2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment	FPBD	COO	12 (I3 x c4)	16 (I4 x c4)	16 (I4 x c4)	16 (I4 x c4)	⟷	8 (I2 x c4)
	2.3 Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	Quality	COO	20 (I4 x c5)	20 (I4 x c5)	20 (I4 x c5)	20 (I4 x c5)	⟷	15 (I3 x c5)
	2.4 Major and sustained failure of essential IT systems due to a cyber attack	FPBD	CIO	N/A	15 (I3 x c5)	15 (I3 x c5)	20 (I4 x c5)	↑	12 (I2 x c5)
SA3 Experience	3.1 Failure to deliver an excellent patient and family experience to all our service users	Quality	CNM	12 (I3 x c4)	12 (I3 x c4)	12 (I3 x c4)	12 (I3 x c4)	⟷	8 (I2 x c4)
SA4 Efficient	4.1 Failure to ensure our services are financially sustainable in the long term	FPBD	CFO	20 (I5 x c4)	20 (I5 x c4)	20 (I5 x c4)	20 (I5 x c4	⟷	16 (I4 x c4)
	4.2 Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	FPBD	MD	8 (I2 x c4)	8 (I2 x c4)	8 (I2 x c4)	8 (I2 x c4)	⟷	8 (I2 x c4)
SA5 Effective	5.1 Failure to progress our research strategy and foster innovation within the Trust	Quality	MD	8 (I2 x c4)	8 (I2 x c4)	8 (I2 x c4)	8 (I2 x c4)	⟷	4 (I1 x c4)
	5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Quality	CNM	12 (I3 x c4)	12 (I3 x c4)	12 (I3 x c4)	12 (I3 x c4)	⟷	8 (I2 x c4)

BAF HEAT MAP


Consequence
Likelihood
1 Rare
2 Unlikely
3 Possible
4 Likely
5 Almost certain
5 Catastrophic
4 Major
3 Moderate
2 Minor
1 Negligible
2.1
2.4
2.3
4.2
5.1
1.1
3.1
5.2
2.2
1.2
4.1

Strategic Objective	SA1: To develop a well led, capable, motivated and entrepreneurial WORKFORCE
Committee:	Putting People First Committee
Risk Appetite:	Moderate

Principal risks (BAF)	Risk Score
1.1 Failure to be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	12 (3 x 4)
1.2 Failure to recruit & maintain a highly skilled & engaged workforce	20 (4 x 5)

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

2087 - No change in risk score since last review. Last reviewed 09/03/2022

2323 - No change in risk score since last review. Last reviewed 08/03/2022

1704 – No change in risk score since last review. Last reviewed 11/02/2022.

2491 – No change in risk score since last review. Last reviewed 08/03/2022

Ref	Corporate Risk Register / High Scoring (15+) Risks	Risk Score
2443	Inability to recruit specialised allied health professions in a timely manner	16
1705	Insufficient midwifery staffing levels as recognised by birth rate place plus.	20
2424	Unable to meet safe staffing levels in line with BAPM requirements	15
2087 **(CRR)**	Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	16
2323 **(CRR)**	The Trust is currently non-compliant with standards 2,5,6 of the seven-day service standards (due to insufficient consultant numbers)	15
1704 **(CCR)**	Effective management systems are not in place or sufficient to ensure all employees complete and keep up to date with their mandatory training requirements.	12
2491 (CRR)	Noncompliance with mandated level of fit mask testers qualification, accreditation, and competency	15

BAF Risk 1.1: Failure to be recognised as one of the most inclusive organisation in the NHS with zero discrimination for staff and patients (zero complaints from patients, zero investigations)	**Lead Director:** CPO **Op Lead:** Deputy Director of Workforce	**Review Date: April 2022**	**Ulysses Ref:**

Strategic Priority: SA1: To develop a well led, capable, motivated and entrepreneurial workforce

Lead Committee: Putting People First

Provider Licence Compliance link(s):

N/A

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target	2022/23 Target
12 (3 x 4)	12 (3 x 4)	12 (3 x 4)	12 (3 x 4)	⟷	8 (2 x 4)	8 (2 x 4)

Rationale for current risk score:

The Trust has several strong controls in place against this risk and can demonstrate effective performance in comparison with other NHS trusts. During 2021/22, for the first time, the Trust benchmarked within the top 50 inclusive places to work. However, this is an ambitious aim within the Trust's 2021-25 strategy and will require significant cultural change to achieve together with a continued and unrelenting focus. The Trust can also make progress on the mechanisms that it has in place to hear the views and voices from its diverse staffing and patient communities and ensure that these voices have an impact on service improvement and development. Whilst there is evidence that the Trust has responded well to challenge that the pandemic has posed to the Trust in terms of patient and staff inequalities, this will continue to be a challenge during 2022/23.~~The Trust has several strong controls in place against this risk and can demonstrate effective performance in comparison with other NHS trusts. The Trust also recently benchmarked within the top 50 inclusive places to work. However, this is an ambitious aim within the Trust's 2021-25 strategy and will require significant cultural change to achieve together with a continued and unrelenting focus. The Trust can also make progress on the mechanisms that it has in place to hear the views and voices from its diverse staffing and patient communities and ensure that these voices have an impact on service improvement and development. Whilst there is evidence that the Trust has responded well to challenge that the pandemic has posed to the Trust in terms of patient and staff inequalities, this will continue to be a challenge over the year.~~

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Unable to create a workforce representative of the community we serve	Monitoring of applications for employment within the Trust throughout the recruitment & selection process over a 12-month period via TRAC reporting	Monitored by the EDI Lead and reported through the ED&I Action Plan	To ensure that there are robust processes in place to target advertising, work shadowing opportunities, pre-application training and offering career advice **(Action 1.1 / 1)** To simplify the EIA process **(Action 1.1 / 2)** To further widen opportunities for the local community to join the LWH workforce **(Action 1.1 / 3)** To continue to develop more diverse recruitment and selection processes **(Action 1.1 / 4)**	
	Links with community leaders established to improve under-representation	PPF Strategy and action plan – monitored by PPF Committee		
	Annual review of all employee relation casework to determine if staff are reporting any form of discrimination and to ensure that process is fairly/consistently applied across all staff groups (benchmark against local and national data, where possible)	WRES and WDES submissions		
	All HR policies have up to date equality impact assessments at the point of review, in line with the policy schedule	Policy schedule is currently on track with EIA's being requested as required		
	HR policies reviewed in line with fair and just culture	Policy review process reported to PPF		
	WDES and WRES action plan delivery in line with timescales presented from NHS England	WDES and WRES Action Plan submissions		
	Demographic tracking for training access	In place and monitored by Head of L&D OD		
	Establishment of staff inclusion Networks and work in collaboration with local Trusts to promote staff networks and LGBTQ Network to be launched in 2022.	Progress reported to PPF Committee		
	Reciprocal Mentorship Scheme developed	Feedback through Executive Team		
	Extension of e-learning package to design and deliver specific EDI training and education to all LWH staff	PPF Committee		
	Education and celebration of the key EDI events: Black History Month, Disability History Month, LGBT+ History Month and key faith observance days/festival	Staff Communications		
	Utilising widening participation programmes and alternative ways to advertise and promote our job opportunities to attract local population to work at LWH.	PPF Committee		
	Staff from diverse backgrounds having career conversations with manager	Review of appraisal process – PPF and feedback from staff inclusion networks		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.1 / 1	Robust targeting of job adverts – engagement in health and careers fairs with local community groups for example Pakistani Centre, Al Ghazali Centre	Head of Culture, Inclusion, Wellbeing and Engagement	September 2022 (ongoing)	E&D Sub-Committee	
1.1 / 2	Review of the current Equality Impact Assessment (EIA) process, simplification of document and sufficient guidance and education on how to complete, ensuring this is a meaningful form that is completed at the beginning stages of every project/transformation/CIP/Procedure	Head of Culture, Inclusion, Wellbeing and Engagement	July 2022	E&D Sub-Committee	
1.1 / 3	Establishment of mentoring scheme for 14/15 year olds in the L8 area to encourage them into the midwifery pathway	Head of Culture, Inclusion, Wellbeing and Engagement	September 2022	E&D Sub-Committee	
1.1 / 4	Exploration and implementation of more diverse recruitment and selection processes including diverse interview panels and alternative recruitment methods	Head of Culture, Inclusion, Wellbeing and Engagement	March 2022	E&D Sub-Committee	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating

Unable to effectively engage with our patient and staff groups to understand further the needs of individuals with protected characteristics and respond proactively to identified needs	Patient information leaflets are up to date and accessible for all protected groups. Patient leaflets are on the website that can translate this information into various languages/ fonts and read aloud versions.	Annual audit of patient leaflets to ensure accessibility and usability	Need to create template for patient story capture and response at Divisional level and process to ensure consistent approach is sustainable over time **(Action 1.1 / 4**). To provide assurance regarding Patient Information Leaflet audit to PIEG on an annual basis (**Action 1.1 / 5**) Local ownership of FFT results to enable improvements to be created and implemented at a local level **(Action 1.1 / 6)**	
	Utilisation of the Health Inequalities data within power BI to lead work between the Patient Experience Team and the Cultural Liaison Midwife to target areas of disparity.	Updates from these associated actions are presented and updated through the Patient Involvement and Experience Subcommittee.		
	Engagement with local groups lead by the Patient Experience Matron to listen to the concerns and required adjustments and improvements desired. These include the local Muslim mosque and Merseyside Deaf society	Updates from these interactions, and any associated actions are presented and updated through the Patient Involvement and Experience Subcommittee.		
	FFT Data now included EDI monitoring to allow experience reviews to be compared between groups with and without a protected characteristic	Data is presented at Patient Involvement and Experience Subcommittee.		
	Enhanced communication and patient experience for people with disabilities coming for care at the Trust as part of Reasonable Adjustment activities	Personalised Maternity Care Budgets/ Maternity Early Adopter and Pioneer site – LMS Cheshire and Mersey Patients with learning difficulties, mental health or autism spectrum are allowed relatives to stay with them throughout their stay. Pro-active admissions for these groups with preadmission and discharge planning Admission procedures and assessments e.g. MUST /VTE/ FALLS / risk assessment Maternity Pre-operative assessments Development of a Supporting Patients with Additional Needs Strategy		
	Barriers removed to access/health inequalities to maternity services for all with specific focus to migrant and asylum-seeking women	Barriers identified and measures put in place to remove e.g. Presence of representatives from MRANG in the antenatal clinic to support asylum seekers		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.1 / 4	To create template for patient story capture and response at Divisional level and process to ensure consistent approach is sustainable over time	Head of Audit, Effectiveness and Patient Experience	July 2022	Patient Involvement & Experience Sub-Committee	
1.1 / 5	To provide assurance regarding Patient Information Leaflet audit to PIEG on an annual basis	Head of Audit, Effectiveness and Patient Experience	September 2022	Patient Involvement & Experience Sub-Committee	
1.1 / 6	Local ownership of FFT results to enable improvements to be created and implemented at a local level	Head of Audit, Effectiveness and Patient Experience	September 2022	Patient Involvement & Experience Sub-Committee	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
COVID-19 impact further increasing health inequalities for staff and patients	Move to recovery of pre-covid activity levels whilst adhering to all covid restrictions and requirements Hybrid working where appropriate Eased rules for mask wearing in non-clinical spaces providing 1m distancing can be observed Adherence to national guidance in respect of isolation periods for covid positive staff Clear criteria as to elements of activity and types of patients the Trust can assist with Asymptomatic testing twice weekly for staff Staff 'booster' vaccination and flu plan for 22/23 in place Visiting restrictions Patient testing	Corporate BAU largely maintained despite remote working. Regular Covid-19 response reports to the Public Board EPRR Meetings continued Weekly monitoring of vaccine uptake in staff Weekly monitoring of swabbing of in patients	Levels of Asymptomatic staff testing remain lower than desired	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.1 / 7	Close working with Cheshire and Mersey procurement via Covid Supply Response (CSR)	Head of Procurement	On-going	EPPR	

BAF Risk 1.2: Failure to recruit & maintain a highly skilled & engaged workforce~~Failure to recruit and retain key clinical staff~~

Lead Director: CPO
Op Lead: Deputy Director of Workforce

Review Date: Apr 22

Ulysses Ref:

Strategic Priority: SA1: To develop a well led, capable, motivated and entrepreneurial workforce

Lead Committee: Putting People First

Provider Licence Compliance link:

N/A

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target	2022/23 Target
20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	⇔	12 (3 x 4)	15 (3x5)

Rationale for current risk score:

The Trust has acute and chronic staffing challenges in several areas and a sickness absence rate which has been consistently above target. Staff engagement scores are below the average for peer organisations as measured by the Annual Staff Survey. Maternity staffing issues are acute and have been exacerbated by absence linked to the Covid pandemic and low morale. The Trust has seen an increase in turnover associated with staff opting to leave the service or take retirement. There are significant challenges associated with specialist obstetric anaesthesia recruitment and theatre staffing. Other impacting factors include insufficient numbers of doctors in training, national shortage of nurses & midwives, the clinical risk associated with an isolated site impacting on the recruitment & retention of senior specialist medical staff, the impact of pension tax changes, the ongoing pandemic challenges and the associated recovery of elective activity.~~Whilst the Trust has a significant number of controls and sources of assurance, the Trust does have acute and chronic staffing challenges in several areas and a higher than target sickness rate. The particularly acute issues with maternity staffing are the main driver behind this risk being scored a '5' for likelihood. In the short term, this issue is being exacerbated by significant absences as a result of the Omicron Covid-19 variant and the in the medium term there is a concern about the potential loss of staff if they do not accept the mandatory Covid-19 vaccine. There are also the following issues to consider: Insufficient numbers of doctors in training; ageing 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). Whilst the severity of this issue is not sufficient to rate this risk at '25', the Board should be cognisant that this risk presents one of the most acute challenges to the organisation.~~

~~There are examples of positive assurance in how the Trust has responded to the pandemic in relation to staff wellbeing but there remains some significant challenges during the 'recovery stage' and will require Board oversight and attention.~~

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust.	Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff.	Monthly KPI's for controls.	Quality of appraisals requires further improvement and monitoring **(Action 1.2 / 1)** Further evidence required that robust plans are being reviewed regularly at Divisional Board level **(Action 1.2 / 2)**	
	LWH 'People Promise' to launch in 2022 – bringing together key strands of people strategy including behavioural framework	PPF		
	Behavioural framework developed in partnership with staff in 2021	PFF Committee, In the Loop, Great Place to Work Group		
	Great Place to Work Group Launched as a cross section of staff committed to improving staff experience and a source of two way communication	Great Place to work minutes to PPF		
	Consultant revalidation process.	Outcomes reported to PPF and the Board		
	Reward and recognition processes linked to values.	Monthly KPI's for controls.		
	Pay progression linked to mandatory training compliance	Monthly KPI's for controls.		
	Targeted OD intervention for areas in need to support.	PPF Committee		
	New Leadership Programme and Talent Management framework in place.	Leadership & Talent Strategy		
	Programme of health and wellbeing initiatives including launch of LWH Staff Support Service, recruitment of LWH Psychologist and Wellbeing Coaches	Reported to PPF Committee		
	All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities.	Monthly KPI's for controls.		
	Workforce planning processes in place to deliver safe staffing.	Divisional Board and Divisional Performance Reviews		
	Shared decision making with JLNC and Partnership Forum.	Chair's Report to PPF Committee		
	Putting People First Strategy	Progress reported to PPF Committee		
	Guardian of Safe Working.	Report form Guardian of Safe Working		
	PDR training programme in place and PDR window for band 7 and above in N&M commenced in 2021	Monthly KPI's for controls.		
	Two Freedom to Speak Up Guardians (including representation from a diverse and clinical background)	Bi-annual Speak Up Guardian Reports.		
	Whistle Blowing Policy	Annual Report to PPF and Audit Committee		
	Regular Local Staff Surveys	Quarterly internal staff survey (In the Loop)		
	Regular Listening Events	Listening events increased to bi-monthly		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.2 / 1	To review indicators showing direction of travel for the quality of appraisals	Deputy Director of Workforce	September 2022	PPF Committee	
1.2 / 2	To receive assurance that Divisional Boards are effectively reviewing and updating workforce plans	Deputy Director of Workforce	September 2022	PPF Committee	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Covid-19 pandemic & associated elective recovery has the ongoing potential to impact staff morale, wellbeing and retention ~~The Covid-19 pandemic has the potential to impact staff wellbeing, particularly in relation to morale and a result of changed ways of working.~~	Staff working from home where appropriate, use of virtual meetings and enhanced IT provision Refreshed staff absence process and monitoring with increased flexibility Regular staff communications Listening Event for staff completed to consider what further action the Trust could take to ensure staff are protected as much as possible. Specific sessions held for staff with protected characteristics. Risk Assessments undertaken for shielding & vulnerable staff	PPF Committee Feedback from staff side	None noted.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
N/A					

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes.	Annually agreed funding contract with HEE	PPF Committee, HEN Visit	Further utilisation of the rota management system. E-Rostering System not fully utilised **(Action 1.2 / 3)** Requirement for assurance that workforce plans are reviewing regularly at Divisional Board level **(Action 1.2 / 4)** Requirement to respond effectively to Ockenden recommendations regarding staffing **(Action 1.2 / 5)** Clinical risks associated with isolated site impact upon recruitment & retention of specialist medical staff **(Action 1.2 / 6)**	
	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 for AFC staff implemented with doctors implemented by early 2022	PPF Committee		
	Director of medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN	Quarterly reporting by Guardian of Safe Working, GMC Survey		
	Guardian of Safe Working Hours appointed in 2016 under new Junior Doctor Contract.	Quarterly reporting by Guardian of Safe Working.		
	Acting down policy and process in place to cover junior doctor gaps	Quarterly reporting by Guardian of Safe Working.		
	National Revalidation process ensuring competent staff.	Revalidation report to PPF Committee		
	Shared decision making and review of risk with JLNC.	Chair's Report to PPF Committee		
	Succession Planning and Talent Programmes	PPF Committee		
	NHSE/I leadership programme to reduce sickness	PPF Committee		
	Shared appointments with other providers	PPF Committee		
	Secured operating time at the LUH	PPF Committee		
	Increased consultant recruitment with incentives Neonatal Partnership	PPF Committee		
	Maternity introduction of ACP Midwives	PPF Committee		
	Work underway to ensure that the number of staff without a Covid-19 vaccine is minimised	PPF Committee		
	Flexible working programme	PPF Committee		
	Bi-annual safe staffing reports	PPF Committee and Board		
	Birth rate Plus Report	Board		
	NHSP utilisation for bank staff			
	Preceptorship for nursing and midwifery staff			

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.2 / 3	E-rostering system for doctors - Allocate is implemented for O&G and work commenced for other specialties	Deputy Director of Workforce	June 2022	PPF Committee	
1.2 / 4	To provide evidence that robust workforce plans are being reviewed regularly at Divisional Board	Deputy Director of Workforce	September 2022	PPF Committee	
1.2 / 5	Respond to Ockenden recommendations relating staffing	Deputy Director of Workforce	September 2022	PPF Committee	
1.2 / 6	To ensure that staffing issues are included and noted as a key risk in discussions regarding the single site risk.	CPO	On-going	Board	

Strategic Objective	SA2: To deliver SAFE services
Committee:	Quality Committee & Finance, Performance & Business Development Committee
Risk Appetite:	Low

Principal risks (BAF)	Risk Score
2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site	15 (3 x 5)
2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment	12 (3 x 4)
2.3 Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	20 (4 x 5)
2.4 Major and sustained failure of essential IT systems due to a cyber attack	20 (4 x 5)

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

2084 - No change in risk score since last review. Last reviewed 08/11/21

2085 - No change in risk score since last review. Last reviewed 15/09/2021

2086 - No change in risk score since last review. Last reviewed 07/12/21

2296 – Risk moved from 16 to 9 - Discussed as part of the 24/7 transfusion project - machine is still under contract extension

2321 - No change in risk score since last review. Last reviewed 09/03/2022

2469 – No change in risk score since last review. Last reviewed 13/01/2022

2470 – No change in risk score since last review. Last reviewed 09/03/2022

Ref	Corporate Risk Register / High Level (15+) Risks	Risk Score
1961	Risk to patient safety, including risk of misdiagnosis, inaccurate reporting of imaging findings, and lack of evidence that imaging has been performed on PACS.	16
2397	Following a recent serious incident, there is a risk that patients will not be informed of abnormal imaging results from LWH or external organisations when the results are received at the Trust	16
2341	There is a risk that during the Covid-19 pandemic, adult patients who suffer a cardiac arrest will receive suboptimal resuscitation	16
2386	Risk of personal and sensitive information being compromised or being misused	15
2316	Risk of women needing to access emergency care with pregnancy complications and not being able to access advice or care at the point needed. Impact on the safety of patients, (physical/psychological harm)	16
2446	A number of patients who had been waiting for Gynaecology surgery (P4) and had pre-operative scans that were missed / not reviewed in time, subsequently had escalation of diagnosis and further management plan.	16
2084 **(CRR)**	Uncertainty of adequacy of 24/7 access to specialist input to support changing patient profiles and needs, new guidance and the Chief Medical Officer's recommendation of the specialist multidisciplinary team approach to treatment planning and co-ordination, including pre-operative, surgical and up to level 3 post-operative care for improved patient safety and improved outcomes.	6
2085 **(CRR)**	Uncertainty around access to dedicated diagnostic capacity and physiological measurement needed to support needs of a changing patient demographics and an increase in complex multiple comorbidities and meeting the pre-operative assessment standards of the AAGBI and the RCoA, to assess patients' clinical risk and plan for additional requirements for their safety and provide an optimal experience.	12
2086 **(CRR)**	Uncertainty about provision of adequate on-site Blood bank stocking all major blood products necessary to support the needs of the Maternity service.	9
2296 **(CRR)**	The LWH laboratory autoview analyser (the machine used to process Blood Group and Save samples on site) will no longer be supported as of 1st March 2020. This machine cannot continue to be used after this date.	9
2321 **(CRR)**	Due to the Trust not being located next to or with acute services, it is unable to meet the National Recommendations for Maternal Medicine	15
2469 **(CRR)**	Allocation of resources to carry out water safety checks and maintenance has failed to achieve required targets despite prioritising this work and reducing resources for other tasks	9
2470 **(CRR)**	Water cold water temperatures in the new NICU build are being recorded as 2% higher than hospital cold water temperatures.	9

BAF Risk 2.1: Failure to progress our plans to build a new hospital co-located with an adult acute site

Lead Director: CFO
Op Lead: Head of Transformation & Strategy

Review Date: Apr 22

Ulysses Ref: TBC

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

Integrated Care Condition

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target	2022/23 Target
15 (3 x 5)	15 (3 x 5)	15 (3 x 5)	15 (3 x 5)	⟷	15 (3 x 5)	10 (2 x 5)

Rationale for current risk score:

The Trust's services being located on an isolated site away from an acute centre, remains the most significant risk to the organisation. The Trust can demonstrate strong controls in relation to developing the clinical evidence base for the move and has achieved buy in from significant stakeholders. There remains however, a lack of system support outside of the C&M region to secure the capital case.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Inability to effectively communicate the case for change with regulators and key partners and receive buy-in to move project forward.~~Inability to effectively communicate the case for change with regulators, key partners and the local community and receive buy-in to move project forward.~~	Continuing dialogue with regulators	CEO and Chair maintaining on-going dialogue Support for Expression of Interest submitted 9th September 2021 from C&M. Trust has shared EOI with C&M partners, positive support received Regional and national NHSE leaders have visited the Trust and been briefed about the case for change, including Amanda Doyle, Jackie Dunkley-Bent, Ruth May	Lack of system support outside of Cheshire and Mersey to secure the capital case H&CP submissions for capital bids not successful despite system agreement of clinical case Business case refresh is led by Trust rather than commissioners as with previous case Public consultation required Transfer of commissioning arrangements from CCGs to ICS Potential change in ICS Board in April 2022 Requirement for commissioners to agree process to manage non-compliance with service specifications and standards where no further provider action can be taken. Case for change and counterfactual case to be presented to HOSCs Lobby systems and MPs for active support External review/testing of counterfactual case - ongoing External review/testing of refreshed case for change, following completion of FGCAG work/business case refresh - ongoing	
	Future Generations Strategy Update	Available on the Trust website Future Generations Strategy has been included within refreshed overall corporate strategy and is a key supporting strategy within Trust strategic framework Future Generations Clinical Advisory Group has been reconstituted		
	Business case refresh	Refresh of business case is underway, informed by work of FGCAG. Work includes review of compliance against new clinical standards, counterfactual case refresh, future model of care, updated of clinical case for change (taking account of changes at LWH, in system and health and care landscape over last 5 years)		
	Active management with all commissioners	Good meetings with CCG via Clinical Quality and Performance Group (CQPG) Relationships with key ICS stakeholders established Escalation of risks of isolated site to system level The Trust is working closely with Liverpool CCG to plan pre-consultation engagement, engagement with HOSCs and draft consultation timeline.		
	Future Generations project group established with the Trust	Reports to the FPBD		
	External validation of case for change	Output from Clinical Summit report (2019)		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.1/1	Management of Future Generations Strategy through Project Management Office	Head of Strategy and Transformation	August 2021 - ongoing	Board	
2.1/2	Business case refresh – completion of options appraisal and refreshed model of care for future of women's and neonatal services	Head of Strategy and Transformation	May 2022	Board	
2.1/3	Business case refresh – refreshed estates modelling and schedule of accommodation for new build	Head of Strategy and Transformation	May 2022	Board	
2.1/4	External validation of case for change and counterfactual case	Medical Director	April 2022	Board	
2.1/5	Commence public consultation (external control of this action by commissioners and NHSE/I)	Head of Communications and Marketing	December 2022	Board	
2.1/6	Development and completion of business case (OBC, FBC stages) through New Hospitals Building Programme approach (external control of this by NHSE/I)	Head of Strategy and Transformation	March 2024	Board	
2.2 / 7	Lobby systems and MPs for active support	Head of Communications and Marketing	September 2022	Board	
2.2 / 8	Build relationships with key ICS personnel	Medical Director	September 2022	Board	
2.2 / 9	Meetings with key partners to share case for change and counterfactual case and request explicit support	Medical Director, Head of Strategy and Transformation	April 2022	Board	
2.2 / 10	Request re-prioritisation of C&M capital schemes	Chief Finance Officer	April 2022	Board	
2.2 / 11	Meeting with specialised commissioners to discuss management of non-compliance with standards, where no further action can be taken by the Trust to mitigate non-compliance.	Medical Director, Chief Finance Officer	April 2022	Board	

	2.2 / 12	Presentation of case for change and counterfactual case at HOSC	Medical Director, Head of Strategy and Transformation	June/July 2022	Board		

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Inability to effectively communicate the case for change with the local community and receive buy-in to move project forward.	Future Generations Strategy Update	Available on the Trust website Future Generations Strategy has been included within refreshed overall corporate strategy and is a key supporting strategy within Trust strategic framework Future Generations Clinical Advisory Group has been reconstituted	Further communication required of strategy and Future Generations position within strategy with local community, patients and public	
	Pre-consultation Business Case and public consultation	Trust refresh of Strategic Outline Case is underway, informed by work of the FG CAG. Much of this information can be used by commissioners to complete a PCBC ready to inform public consultation. Stage 1 Assurance meeting has been arranged with NHS England and commissioners to carry out strategic sense check and agree governance and process	Stage 1 Assurance meeting needs to take place Public consultation required – this must be led by commissioners No clear agreement at present regarding commissioners vs provider responsibility for completion of PCBC	
	Discussion of case for change with patients, public and local community	Refreshed case for change and counterfactual case will need to be shared with public, patients and the local community. Case for change and counterfactual case have already been validated by partners and independent clinical senate.	Lobby systems and MPs for active support Case for change and counterfactual case not yet shared with public Engagement with local community required regarding case for change and counterfactual case	
	Comms and Engagement Activities	The Trust is working closely with Liverpool CCG to plan pre-consultation engagement, and draft consultation timeline. Currently reviewing outcomes of previous engagement exercises and updating publicly available information.	Further work required to engage women and their families in option appraisal process and model of care development	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.1 / 13	Promotion of Trust Strategy and FG Strategy as part of overall Strategy Comms and Engagement plans	Head of Communications and Marketing	April 2022 – Sept 2022	Board	
2.1 / 14	Stage 1 Assurance meeting to take place with NHSE	Chief Finance Officer	April 2022	Board	
2.1 / 15	Agreement of responsibility for production of pre-consultation business case with commissioners	Chief Finance Officer	June 2022	Board	
2.1 / 16	Public consultation regarding options to address case for change (external control of this action by commissioners)	Chief Finance Officer	December 2022	Board	
2.1 / 17	Present case for change and counterfactual case at public Board meeting	Medical Director	June/July 2022	Board	
2.1 / 18	Comms and engagement campaign and public engagement activities to support consultation, options appraisal, model of care development	Head of Communications and Marketing	July 2022	Board	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Failure to secure capital funding to progress our plans to build a new hospital co-located with an adult acute site	Submission of Expression of Interest to New Hospital Building Programme	Expression of interest submitted September 2021 Support for Expression of Interest submitted 9th September 2021 from C&M. Trust has shared EOI with C&M partners, positive support received	Lack of system support outside of Cheshire and Mersey to secure the capital case WHH scheme prioritised in C&M – request re-prioritisation Funding option not yet agreed	
	Engagement with Liverpool City Council re alternate source of funding	Previous application for funding submitted and agreed 2019 New ongoing engagement to refresh request and model funding options		
	Engagement with regional and national teams regarding capital funding options	Regular meetings between CFO and regional teams to discuss capital funding options Engagement with LUHFT CEO to discuss capital funding options		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.1/ 19	Approval of EOI (external control of this by NHSE/I)	Chief Finance Officer	June 2022	Board	
2.2 / 20	Engagement with LCC to develop and potentially agree alternate capital funding source	Chief Finance Officer	April – July 2022	Board	

BAF Risk 2.2: Failure to develop our model of care to keep pace with developments and respond to a changing environment

Lead Director: COO
Op Lead: Deputy COO

Review Date: Jan 22

Ulysses Ref:

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target	2022/23 Target
12 (3 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	⟷	8 (2 x 4)	12 (3x4)

Rationale for current risk score:

The lack of an EPR (and as a corollary, having in place a disparate number of systems), remains a significant risk to the organisation because information is spread across disparate systems leading to information being incomplete, hard to find in a timely manner and a potential for inaccuracies due to manual transfer of information. However, there is evidence of pro-active mitigating controls and progress being made in the procurement and subsequent implementation of an integrated Meditech EPR system. The Trust can demonstrate evidence of being open and responsive to change in service development and delivery, but further work can be done to strengthen the approach to horizon scanning and longer term, strategic planning at a Divisional level.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Trust's current clinical records system (paper and Electronic) are sub-optimal.	Approved Digital Generations Strategy	Quarterly risk assessments completed	Multiple Clinical Systems issues remain **(Action 2.2 / 2)**	
	Approved Meditech Expanse Business Case	FPBD Committee overview and scrutiny	Ability of clinical staff to engage with the system development due to time and financial impact **(Actions 2.2 / 1, 2.2 / 3, 2.2 / 4)**	
	Maintenance of present system	Digital Hospital Committee oversight	Optimisations to K2 system and refinements which are required **(Action 2.2 / 5)**	
	Development of individual / service solutions e.g. PENs (Gynaecology) and Staff training	Approved EPR Business case which define clear direction and preferred solution.	Not all Trust using LHCRE for patient information exchange **(Action 2.2 / 6)**	
	Incident reporting	EPR programme board chaired by MD		
	Tactical solutions including the implementation of K2 Athena system	Independent lessons learnt Positive review		
	Exchange/LHCRE enables for patent information sharing	MIAA Critical Application Audit (rolling programme across trust systems) Reporting into Audit Committee and Digital Hospital Group		
	Virtual Desktop technology to aid staff working flexibly.	Safety and Effectiveness Sub-Committee		
	Additional network resilience for LUHFT supplied systems (K2/PENS/CRIS) to reduce risk of unplanned systems downtime	Safety and Effectiveness Sub-Committee		
	PACS upgrade removes a separate login for that system, reducing multiple systems issues.	Digital Hospital Sub-Committee		
	Task and Finish group established to ensure that clinical investigation undertaken at external trusts have been actioned accordingly.			
	Appropriate task and finish groups established as required by Safety and Effectiveness sub-committee			
	Digital clinical leadership business case developed			

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.2 / 1	Develop staff communication plan for new system	CIO	December 2022	Digital Hospital Committee oversight	
2.2 / 2	Ongoing review of systems and mitigations quarterly (report to FPBD & QC)	CIO	February 2022	FPBD and Quality Committees	
2.2 / 3	Issue appropriate communication to all staff in relation to digital development by multiple means and forms	CIO	April 2022	Digital Hospital Committee oversight	
2.2 / 4	Develop a business case for appropriate digital training capabilities for the Trust	CIO	April 2022	Digital Hospital Committee oversight	
2.2 / 5	Implement required system optimisations as identified by Maternity and other Trust stakeholders	CIO	April 2022	Digital Hospital Committee oversight	
2.2 / 6	Task and Finish group to explore mitigations and identify new solutions to ensure the results of clinical investigations are reviewed and actioned. Ensuring documentation of this process can be provided	CIO	April 2022	Digital Hospital Committee oversight	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Clinical service strategies that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities	Operational 'Plans on a page' for Divisions	Divisional Board meetings	To improve horizon scanning processes to constantly review and update plans on a page **(Action 2.2 / 7)**	
	Operational planning process	Operational plans and budgets	To understand commissioning priorities emerging from developing ICS **(Action 2.2 / 7)**	
	Availability of data on service trends and demographics	Divisional Boards	To ensure that Divisions are fully utilising data to understand changing service demands **(Action 2.2 / 8)**	
	Workforce plans	Divisional Boards		

					To ensure that workforce plans are informed by trends and data led intelligence. **(Action 2.2 / 9)**		
	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status	
	2.2 / 7	Use of effective horizon scanning at Divisional Boards to review and update 'plans on a page' – to include emerging intelligence around commissioning priorities from developing ICS	Deputy COO	July 2022	Executive Team		
	2.2 / 8	To ensure that Divisions are fully utilising data to understand changing service demands	Deputy COO	September 2022	Executive Team		
	2.2 / 9	To ensure that workforce plans are informed by trends and data led intelligence.	Deputy COO	September 2022	Executive Team		

BAF Risk 2.3: Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	**Lead Director: Chief Operating Officer** **Op Lead:** Head of Strategy & Transformation	**Review Date: Apr 2022**	**Ulysses Ref: TBC**

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Quality Committee

Provider Licence Compliance link:

N/A

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target	2022/23 Target
20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	⟷	15 (3 x 5)	15 (3 x 5)

Rationale for current risk score:

The Trust's services being located on an isolated site away from an acute centre, remains the most significant risk to the organisation and to patient safety. Good progress is being made on mitigating measures to make the Crown Street site safer with a number of significant capital projects either completed, underway or planned. It should be acknowledged that the impact of this risk cannot be fully mitigated whilst the Trust operates on an isolated site.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Location, size, layout and accessibility of current services do not provide for sustainable integrated care or safe and high-quality service provision.	Programme for a partnership in relation to Neonates with AHCH has been established. £15m capital investment in neonatal estate to address infection risk Transfer arrangements well established for neonates Transfer arrangements for adults	Neonatal partnership updates provided to the Board IPC Reports Transfers out monitored by Partnership Transfers out monitored at HDU Group	Transfers are often subject to delay due to the Trust being considered a 'place of safety'. Transfer of adults requires accompanying clinical staff, which can lead to staffing pressures on the ward. **(Action 2.3/2)** Onsite and partnership mitigations cannot fully address the clinical risk - this can only be achieved through co-location. Arrangements not formally agreed and underpinned by detailed SLA. **(Action 2.3/3)** Lack of 24/7 transfusion laboratory on site leads to delay in patients receiving transfusion. **(Action 2.3/4, 2.3/5)** Emerging clinical standard leading to potential loss of services and increase in difficulty in relation to recruitment of consultants. Twilight cover to be in place from April 2022 (Maternity) and January 2022 (Neonates). There remains an on-going challenge in relation to Anaesthetics recruitment. **(Action 2.3/6)** Full provision for paediatric resus cover not in place **(Action 2.3/7)** Financial and workforce constraints for delivery of additional facilities on site. **(Action 2.3 / 1)** Construction works not yet complete to accommodate new FMU, colposcopy suite, CT & MR Imaging suites – due to complete December 2022 **(Action 2.3/8)** 24/7 transfusion laboratory not yet established – aim for completion September 2022 **(Action 2.3/4)** Colposcopy decant not yet complete – aim for completion June 2022 **(Action 2.3/9)** Full CDC Services not yet implemented **(Action 2.3 / 10)** Expansion of telemedicine across more providers for neonatal services and implement within maternity **(Action 2.3 / 11)** Signed SLA with LUHFT required **(Action 2.3 /3)**	
	Formal partnership and board established with Liverpool Universities Hospitals with respect to: -Diagnostics -Medical and surgical expertise -Intensive care facilities -Theatre access at Liverpool Universities Hospitals for women with Gynae cancers -Provision of maternity expertise at LUHFT sites -Provision of Gynaecology expertise at LUHFT sites -Placenta accreta service, including specialist imaging and supervision of review from Sheffield Teaching Hospitals NHS FT	Partnership activity to report through to FPBD and Board on a quarterly basis		
	Blood product provision by motorised vehicle from nearby facility, with protocols in place to prioritise transport of blood products.	Serious incidents, should they occur are tracked and reported through the governance framework,		
	Investments in additional staffing inc. towards 24/7 cover - Maternity	Staff Staffing levels reports to board		
	Investments in additional staffing inc. towards 24/7 cover - Anaesthetics	Staff Staffing levels reports to board		
	Investments in additional staffing inc. towards 24/7 cover – Gynaecology, including additional investment in ANP roles within GED	Staff Staffing levels reports to board		
	Investments in additional staffing inc. towards 24/7 cover - Neonates	Staff Staffing levels reports to board		
	Enhanced resuscitation training provision - Paediatric	Training compliance rates reported to PPF Committee		
	Enhanced resuscitation training provision - Adult	Training compliance rates reported to PPF Committee		
	Crown Street Enhancements Programme Board established to oversee: -Construction work required to accommodate new FMU, colposcopy suite, CT & MR Imaging suites (ongoing) -Implementation of Robotic Assisted Surgery (complete) -Implementation of 24/7 transfusion laboratory on site (ongoing) -Decant into and new ways of working within FMU (complete) -Decant into and new ways of working within colposcopy (ongoing)	Crown Street Enhancements Programme progress reviewed monthly at FPBD		
	Community Diagnostic Centre established at Crown Street, to include the following diagnostics with access for LWH patients: -Imaging – CT, MR, X-ray, ultrasound -Physiological – ECHO, ECG, BP monitoring, Spiro, FeNO, Sleep studies -Pathology	Community Diagnostic Centre Oversight Group reviews progress on a fortnightly basis. Progress also reported to and monitored by regional CDC Programme Board.		
	Divisional Operational Plans completed	Divisional Boards		
	Use of telemedicine to facilitate consultations both at Crown Street and other sites	Divisional Boards		
	Historic controls still in place include: -Use of cell salvage -Expanded role of anaesthetists to cover HDU patients -Existing informal links with partner organisations -ANP roles -Transfer of patients for urgent imaging and critical care -Theatre slots at LUHFT -ACHD Partnership	Quality Committee		

	Progress being made in relation to building relationships with LUFT - Task and finish groups established, reporting into the Partnership Board with LUHFT setting out arrangements for partnership working across all four LWH and LUHFT sites	Partnership Board meetings and involvement in wider Estates Strategy Mapping of requirements from and interdependencies with LUHFT across all Trust specialties				
	Gap Reference	**Required Action**	**Lead**	**Implement By**	**Monitoring**	**Status**
	2.3 / 1	Agree funding for all mitigations on site are included in operational planning	Deputy Chief Finance Officer	April 2022	FPBD Committee	
	2.3 / 2	Provision of staffed and dedicated ambulance to facilitate transfer of adult patients to be explored.	Deputy Chief Operating Officer	TBC	Quality Committee	
	2.3 / 3	Detailed agreements to form part of SLA with LUHFT, clearly explaining routes of access and expectations of both organisations.	Deputy Chief Finance Officer	September 2022	Partnership Board, TBDG	
	2.3 / 4	Project to establish 24/7 transfusion laboratory on site at Crown Street	Head of AHPs	September 2022	Crown Street Enhancements Programme Board, FPBD	
	2.3 / 5	Implement remote issue of blood products to minimise delay in transfusion	Head of AHPs	April 2022	Crown Street Enhancements Programme Board, FPBD	
	2.3 / 6	Continue to recruit to secure 24/7 Anaesthetics cover	Clinical Directors	January 2023	TBDG	
	2.3 / 7	Clear SOP to be implemented for paediatric resus provision	Deputy Medical Director	January 2022	Quality Committee	
	2.3 / 8	Complete construction of colposcopy, CT & MR imaging suites	Head of Strategy and Transformation	December 2022	Crown Street Enhancements Programme Board, FPBD	
	2.3 / 9	Project to manage decant and new ways of working within colposcopy	Deputy Divisional Manager for Gynaecology	June 2022	Crown Street Enhancements Programme Board, FPBD	
	2.3 / 10	Deliver CDC project plan to establish CDC services: -Imaging – CT, MR, X-ray, ultrasound -Physiological – ECHO, ECG, BP monitoring, Spiro, FeNO, Sleep studies -Pathology	Head of Strategy and Transformation/ Deputy Chief Operating Officer	December 2022	CDC Oversight Group, FPBD	
	2.3 / 11	Project to expand use of telemedicine technology across more providers for neonatal services and implement within maternity	Divisional Manager for Family Health	March 2022	Trust Executive	

BAF Risk 2.4: Major and sustained failure of essential IT systems due to a cyber attack

Lead Director: CIO
Op Lead: CIO

Review Date: April 2021

Ulysses Ref: TBC

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: FPBD Committee

Provider Licence Compliance link:

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target	2022/23 Target
N/A	15 (3 x 5)	15 (3 x 5)	20 (4x5)	↑	12 (2 x 5)	15 (3x5)

Rationale for current risk score:

The Trust's Digital Services department places cyber security management at the core of operational activities, ensuring it maintains its Cyber Essentials standard. Various controls are implemented that are considered effective and this reduces the likelihood of a cyber-attack impact. However, if a cyber-attack was successful the impact would likely be catastrophic to Trust services, likely rendering digital systems that clinical services are increasingly dependent on, unavailable for a period of time. The Digital Services department continue to strengthen controls through process refinement and the introduction of security technologies. On the basis of this, the impact is considered catastrophic (5). Due to recent world events, the environment risk or likelihood for a cyber-attack has increased from possible (3) to likely (4) due to increased cyber threats from Russia. The NHS has reflected the increased threat through guidance issued to all NHS providers and arm's length bodies during March 2022.~~The Trust's Digital Services department places cyber security management at the core of operational activities, ensuring it maintains it's Cyber Essentials plus standard. Various controls are implemented that are considered effective and this reduces the likelihood of a cyber-attack impact. However, if a cyber-attack was successful the impact would likely be catastrophic to Trust services, likely rendering digital systems that clinical services are increasingly dependent on, unavailable for a period of time. The Digital Services department continue to strengthen controls through process refinement and the introduction of security technologies. On the basis of this, the impact is considered catastrophic and likelihood is considered as possible resulting in an overall score of 15.~~

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective cyber controls and technology, inadequate investment in systems and infrastructure, failure in skills or capacity of staff or service providers, poor end user culture regarding cyber security and IT systems use, inadequate contract management. **Consequence: Reduced quality or safety of services, financial penalties, reduced patient experience, loss of reputation, loss of market share / commissioner contracts.**	Microsoft Windows security and critical patches applied to all Trust servers on all servers\laptops and desktop devices on a monthly basis. Network switches and firewalls have firmware updates as and when required installed. Wifi network firmware patches applied for Controllers and Access points. Mobile end devices patched as and when released by the vendor. Externally managed network service provider to ensure network is a securely managed with underpinning contract. Robust CareCert process to enact advice from NHS Digital regarding imminent threats. Network perimeter controls (Firewall) to protect against unauthorised external intrusion. Robust Information Governance training on information security and cyber security good practice. Regular staff educational communications on types of cyber threats and advice on secure working of Trust IT systems. Additional cybersecurity communications in relation to Covid phishing/ scams, advising diligence. Enhanced VPN solution including increased capacity to secure home working connections into the Trust. Review and updating of information security policies and home working IG guidance to support staff who are remote working. Malware protection identifies and removes known cyber threats and viruses within the Trust's network and at the network boundaries. Cyber Security Monitoring System identifies suspicious network and potential cyber threat behaviour. National CareCert alerts inform of known and imminent cyberthreats and vulnerabilities Mobile device management – providing enhanced security for mobile devices	Cyber Essentials Plus Standards/KPIs IMT Risk Management Meeting Digital Hospital Sub Committee MIAA Cyber Controls Review Cyber Essentials Plus Accreditation Cyber Penetration Test NHS Care Cert Compliance	Lack of Cyber Security strategy **(Action 2.4 / 1)** Lack of Network Access Controls within the physical network **(Action 2.4 / 2)** Effective USB port control **(Action 2.4/ 3)** Lack of visibility of medical devices **(Action 2.4 / 4)**	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.4 / 1	Implement a Cyber Security strategy	CIO	June 2022	FPBD	
2.4 / 2	Procure and implement Network Access Control (NAC) solution	CIO	Dec 2022	DHSC	
2.4 / 3	Purchase and implement software for USB port control	CIO	September 2022	DHSC	
2.4 / 4	Improve grip, control and governance on medical devices	CIO	October 2022	Medical Devices / DHSC	

Strategic Objective	SA3: To deliver the best possible EXPERIENCE for patients and staff
Committee:	Quality Committee
Risk Appetite:	Low

Principal risks (BAF)	Risk Score
3.1 Failure to deliver an excellent patient and family experience to all our service users	12 (3 x 4)

Ref	Corporate Risk Register / High Level (15+) Risks	Risk Score
2418	Lack of support and appropriate care for patients presenting with mental health conditions	16
2430	Network outlier for pre-term mortality - rate is higher than the national average	16
2427	Covid lockdown between March 2020 and July 2020 and then September 2020 and subsequently December 2020 to March 2021, resulting in prolonged wait for elective surgery for benign gynaecologic procedures	16
2350	Due to the need to reduce patient attendance / stop elective activity and adhere to social distancing as a result of Covid-19 a number of services within Gynaecology have had to cease or changes the way in which they are delivered	15
2304	Failure to achieve 31 day and 62 day national cancer targets, and having monthly 104 day breaches	16
1966 **(CRR)**	Risk of safety incidents occurring when undertaking invasive procedures	12
2088 **(CRR)**	Lack of on-site specialist paediatric care and support services Neonatal surgery provision and Level 3 neonatal intensive care unit and lack of on-site provision for CT & MRI scanning and Blood bank and Transfusion Lab.	12

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

1966 - No change in risk score since last review. Last reviewed 12/01/2022.

2088 - No change in risk score since last review. Last reviewed 09/03/2022

BAF Risk 3.1: Failure to deliver an excellent patient and family experience to all our service users

Lead Director: CN&M
Op Lead: Deputy Director of Nursing & Midwifery

Review Date: Apr 2022

Ulysses Ref: TBC

Strategic Priority: SA3: To deliver the best possible EXPERIENCE for patients and staff

Lead Committee: Quality Committee

Provider Licence Compliance link:

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target	2022/23 Target
12 (3 x 4)	12 (3 x 4)	12 (3 x 4)	12 (3 x 4)	⟷	8 (2 x 4)	12 (3 x 4)

Rationale for current risk score:

The Trust has strong evidence in relation to its response to the Covid-19 pandemic and continues to receive positive feedback from significant patient surveys. To improve further, it is imperative that the organisation ensures that it can listen to patient voices and the local community and ensure that services are responsive and can cater to differing needs. The evidence for how effective the organisation is undertaking this can be strengthened from the current position.

The Ockenden Final Report made several comments about the importance of trusts listening effectively to the patient voice and strengthening the Trust's approach to this will be a significant area of priority during 2022/23. Considering the importance of this and the fact that available controls / assurances remain limited in this area, the target score for 2022/23 has been set at '12' to reflect the current reality.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Unable to adequately listen to patient voices and our local communities~~Unable to recover services to pre-Covid-19 levels and beyond~~	Women, babies and their families experience strategy 2021 - 2026	Patient Involvement & Experience Sub-Committee	External MVP involvement in reviewing complaints processes Lack of assurance patient stories are shared at local divisional level Evidence how the divisions are using this data to influence their service design and improvements	
	PALs and Complaints data	Patient Involvement & Experience Sub-Committee		
	Patient Stories to Board	Board Meeting		
	Friends and Family Test	Patient Involvement & Experience Sub-Committee		
	National Patient Survey	Patient Involvement & Experience Sub-Committee		
	Healthwatch feedback	Patient Involvement & Experience Sub-Committee		
	Social media feedback	Patient Involvement & Experience Sub-Committee		
	Membership feedback	Council of Governors		
	Patient Experience Matron in place to build relationships with local community leaders and mechanisms for hearing feedback on the Trust's services	Reports Patient Involvement and Experience Sub-Committee and attends CoG Comms and Engagement Group		
	Bespoke Patient Surveys	Patient Involvement & Experience Sub-Committee		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
3.1 / 1	MVP to conduct a review of complaints process	Head of Audit, effectiveness, and Patient Experience	October 2022	Patient Involvement & Experience Sub-Committee	
3.1 / 2	Formal process implemented to track and monitor bespoke surveys requested.	Head of Audit, effectiveness, and Patient Experience	November 2022	Patient Involvement & Experience Sub-Committee	
3.1 / 3	Development and improvements to the Patient experience Review reports produced by the Divisions and reported to PIESC	Divisional Management Teams	September 2022	Patient Involvement & Experience Sub-Committee	
3.1 / 4	Development of a process to share the board presented patient stories to a wider audience such as divisional board and team meetings.	Patient Experience Matron. Head of Comms. Divisional Management Teams	December 2022	Patient Involvement & Experience Sub-Committee	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Failure to act on the feedback provided by patients, carers, and the local communities.~~Unable to adequately listen to patient voices and our local communities to ensure that services are responsive and cater to differing needs and are sensitive to the inclusion~~	Failure to act on the feedback provided by patients, carers, and the local communities.	Women, babies and their families experience strategy 2021 - 2026	MVP review needed of complaints actions and themes for improvement presented at PIESC No formal external process in place to monitor completion of complaint/ PALS+ action plans. Poor performance against Trust KPI for displeased FFT responses Gaps in QI understanding/training that is being addressed by the recently approved QI framework in the 4-year workplan.	
	Family Liaison Service	Action plans for complaints and PALS+ cases		
	PALs and Complaints data	Action plans for National surveys		
	Friends and Family Test	Action Plans for Bespoke Surveys		
	National Patient Survey	KPI for Displeased comments responses in FFT		
	Healthwatch feedback	QI Framework		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
3.1 / 5	MVP to become involved in the review of information presented at PIESC	Head of Audit, Effectiveness and Patient Experience	Aug 2022	Patient Involvement & Experience Sub-Committee	

~~and diversity of the populations that we serve.~~	3.1 / 6	Creation of formal external process to monitor completion of complaint/ PALS+ action plans	Head of Audit, Effectiveness and Patient Experience	November 2022	Patient Involvement & Experience Sub-Committee		
	3.1 / 7	Improvement of compliance against Trust KPI relating to displeased comments in FFT	Divisional Management Teams	August 2022	Patient Involvement & Experience Sub-Committee		

Strategic Objective	SA4: To be ambitious and EFFICIENT and make the best use of available resources
Committee:	Finance, Performance and Business Development Committee
Risk Appetite:	Moderate

Principal risks (BAF)	Risk Score
4.1 Failure to ensure our services are financially sustainable in the long term	20 (5 x 4)
4.2 Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	8 (2 x 4)

Ref	Corporate Risk Register / High Level (15+) Risks	Risk Score
None identified to date		

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

BAF Risk 4.1: Failure to ensure our services are financially sustainable in the long term

Lead Director: CFO
Op Lead: Deputy CFO

Review Date: Apr 22

Ulysses Ref: TBC

Strategic Priority: SA4: To be ambitious and EFFICIENT and make the best use of available resources

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target	2022/23 Target
20 (5 x 4)	20 (5 x 4)	20 (5 x 4)	20 (5 x 4)	⟷	16 (4 x 4)	16 (4 x 4)

Rationale for current risk score:

The Trust has a well-defined and evidence backed case that whilst it remains on an isolated site, it is not financially sustainable. This position is worsening each year as the impact of prior capital investment, ongoing and increasing revenue investment in staying safe on site, and other pressures such as CNST premium costs and the costs of implementing Ockenden actions are added into the cost base. The financial regime is becoming more constrained into 2022/23 and beyond, as Cheshire and Merseyside is deemed above target funding and so has had a convergence factor in addition to the efficiency requirement applied.

The Trust has undertaken what it can to manage costs and has robust financial controls in place as externally evidenced to and validated by audit. A Financial Recovery Board is in place to manage the position and the emerging Integrated Care System and region have a clear understanding of the Trust's underlying deficit however due to the overall constraints on the financial position are not able to guarantee that a shortfall in funding will not be in place.

Additional funding may be available e.g. through Ockenden but is unlikely to be sufficient to meet the Trust's requirements. If deficits are in place year on year further cost will be added associated with revenue cash support. ~~The Trust has a well-defined and evidence backed case that whilst it remains on a single site, long-term financial sustainability will be compromised. Progress has been made to identify strategic solutions to this issue, but these remain unresolved. Whilst plans are in place, there also remains significant on-going uncertainty regarding the financial regime, introduction of Integrated Care Systems and consequent change in commissioning landscape and the impact of changing clinical requirements with resource implications. That said, these changes could also present opportunities for the Trust that the Board should remain aware of. The Trust can demonstrate robust short-term and 'business as usual' financial controls – evidenced by feedback from internal and external audit. However, a number of cost increases have been approved in relation to quality and safety (including maintaining safety on site and the Clinical Case for Change, investment in maternity services, and service developments such as Robotic Surgery). The Trust has also delivered lower levels of recurrent CIP in 2020/21 and 2021/22 than in previous years. The underlying financial position has therefore deteriorated. This increases the challenge for the Trust; however, this is also coupled with additional funding routes being made available, particularly in relation to Maternity.~~

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Trust is not financially sustainable in the long term	5 Year financial model produced giving early indication of issues	5 Year plan approved (BoD Nov 2014) Long Term Plan Submission Nov 19	Whilst plans are in place, there remains significant on-going uncertainty regarding the financial regime, introduction of Integrated Care Systems and consequent change in commissioning landscape and the impact of changing clinical requirements with resource implications. Model to be refreshed by July 2022. **(Action 4.1 / 1)**	
	Future Generations business case demonstrates the Trust is financially viable long term if the preferred option of co-location with an adult acute site is funded.	Future Generations Clinical Strategy and Business Plan (BoD Nov 15 – refreshed in 2020) Sustainability and Transformation Plan (FPBD, Jul 16) PCBC Approval (FPBD, Oct 16)	Implementation of business case is dependent on decision making external to the Trust (CCG, NHSE/I) National CDEL Issue Lack of capital nationally Time has now elapsed, and business case is in process of being refreshed. This will be a Strategic Outline Case. There remains uncertainty as to where and by who this will be assessed Additional work being undertaken to quantify financial benefits of co-location. **(Action 4.1 / 5)**	
	Early and continuing dialogue with NHSE/I and Cheshire and Merseyside ICS	System top up agreed to achieve breakeven for Half One 2021/22 and also Half Two 2021/22, meaning a breakeven plan is in place for 2021/22	Deficit plan likely in 2022/23. Significant financial challenge across C&M as a whole. Increasing costs (e.g. Ockenden) without income matching this. **(Action 4.1 / 4)**	
	Engagement in place with Cheshire and Mersey Partnership to review system solutions	Submission of Cheshire and Mersey STP capital bid Summer 2018 ranked no1 of schemes Active participation in C&M planning processes Trust Expression of Interest as part of New Hospital Programme has not been prioritised by Cheshire and Merseyside in 2021 but was mentioned as (joint) second priority in feedback.	Position potentially superseded by development of ICS Feedback to both ICS and North West region provided. Expression of Interest not ranked first in C&M. **(Action 4.1 / 5)**	
	Clinical Engagement and support for proposals	Northern Clinical Senate Report supporting preferred option both in 2017 and 2022.		
	Reduction in CNST Premium and achievement of Maternity Incentive Scheme.	Process in place regarding CNST MIS. Prior achievement of MIS. Engagement with NHS Resolution and learning from claims and incidents. Direct engagement with NHS Resolution.	Potential resourcing issues to manage this. Actual premium costs still increasing significantly despite achievement of years two and three of CNST Maternity Incentive Scheme.	

		Increased resource in Maternity to manage this.				
	Reduction in back office overheads costs.	Oversight on costs at FPBD and Board Focus on benchmarking and efficiencies, including joint working where possible.			Requirement for resource in relation to recovery and covid.	
	Development of Community Diagnostic Centre.	Upfront capital and revenue funding provided. Letter of comfort from ICS. Funding agreed for 2022/23 and general commitment to ongoing			Significant revenue implications on an ongoing basis, not directly related to LWH patients. No definitive ongoing revenue funding source in place (although 2022/23 funding agreed). **(Action 4.1 / 8)**	
	Gap Reference	**Required Action**	**Lead**	**Implement By**	**Monitoring**	**Status**
	4.1/1	Refresh LTFM	CFO	July 2022	FPBD Committee / Board	
	4.1/2	Agree financial plan for 2022/23 with NHSI/E and C&M	CFO	April 2022	Board	
	4.1/3	Agree required cash support for 2022/23 with NHSI/E and obtain revenue support	CFO	May 2022	FPBD Committee	
	4.1 /4	Work with regional team, commissioners and Local Maternity System to ensure staffing costs and pressures, particularly in relation to maternity, Ockenden and revised clinical standards are funded or as much funding as possible is made available	CFO	May 2022	FPBD Committee	
	4.1 /5	Work towards business case production and approval	CFO	July 2022	Board	
	4.1 /6	Work with commissioners and ICS on revised financial models including population-based approach and Aligned Incentive and Payment contracts	CFO	March 2023	FPBD Committee	
	4.1 / 7	Ensure financial position well understood by regional team and clearly articulated.	CFO	March 2023	FPBD Committee	
	4.1 / 8	Agree ongoing funding model for Community Diagnostic Centre	CFO	March 2023	FPBD Committee	
Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*		**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*		**Gaps in Controls/Assurance** (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
Risk that the Trust will not deliver agreed plan or have sufficient cash resources in the 2022/23 financial year~~Risk that the Trust will not deliver a breakeven position or have sufficient cash resources in the 2021/22 financial year~~	Monthly reporting and monitoring of position including taking corrective action where required. Sign off of budgets by budget holders and managers, and holding to account against those budgets Divisional performance reviews Working within ICS/system to ensure issues understood and Trust secures required amount of available funding.		FPBD Committee Internal Audit- high assurance for all finance related internal audit reports in 2020/21 and 2021/22. External Audit Mitigations being worked up in case of identified risks materialising		Lack of contractual income position due financial framework in place following the Covid-19 pandemic, gap in baseline position and block payment compared to actual activity and cost, risk to CIP and income streams, timing of recovery and uncertainty over future regime. Reliance on Cheshire & Merseyside position and NHS Improvement/England national team to support proposed baseline adjustment for Elective Recovery Funding.	
	Gap Reference	**Required Action**	**Lead**	**Implement By**	**Monitoring**	**Status**
	4.1/9	Ensure regular reporting in place and corrective action taken where needed	Deputy Director of Finance	April 2023	FPBD Committee	
	4.1/10	Ensure full CIP programme in place with relevant QIAs etc	Deputy Director of Finance	April 2022	FPBD Committee	
	4.1/11	Agree sufficient cash resource	CFO	April 2022	FPBD Committee	
	4.1/12	Mitigations to be worked up	CFO	May 2022	FPBD Committee	

BAF Risk 4.2: Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	**Lead Director: Medical Director** **Op Lead:** Deputy COO	**Review Date: Apr 22**	**Ulysses Ref: TBC**

Strategic Priority: SA4: To be ambitious and EFFICIENT and make the best use of available resources

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

Integrated Care

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target	2022/23 Target
8 (2 x 4)	8 (2 x 4)	8 (2 x 4)	8 (2 x 4)	⟷	8 (2 x 4)	8 (2 x 4)

Rationale for current risk score:

The Trust has well defined partnerships and relationships with a number of key stakeholders. These have been strengthened and added to during the Covid-19 pandemic response. The regulatory and system landscape remains uncertain, and the Board will be looking for additional clarity on future arrangements (and the Trust's assured role in this) in order to mitigate this risk and work towards the target score and improve the overall assurance rating on the controls.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Conflicting priorities of clinical services for different providers and/or ineffective governance may lead to ineffective use of resources (clinical, financial, people) amongst ICS partners~~Conflicting priorities, financial pressures (system financial plan misalignment) and/or ineffective governance resulting in a breakdown of relationships amongst ICS and ICP partners and an inability to influence further integration of services across acute, mental, primary and social care~~	Quarterly Partnership Reporting to FPBD and Board in 2022/23	FPBD and Board meetings	Governance arrangements are developing **(Action 4.2 / 1)** Governance arrangements are developing for LMS **(Action 4.2 / 2)**	
	Robust engagement with ICS discussions and developments through CEO and Chair	CEO Report updates to the Board		
	Evidence of cash support for the Trust's 2021/22 breakeven position	Trust budget agreed by the Board		
	Chair of the Maternity Gold Command for Cheshire and Merseyside	Executive Team reporting		
	C&M Maternal Medicine Centre	Chairs reports feed into the Maternity Transformation meetings		
	Neonatal partnership in place with Alder Hey	Regular updates to the Board		
	Partnership Board in place with LUHFT and involvement in wider Estates Plan	Updates provided to the Quality Committee and Board		
	Positive and developing relationship with Merseycare NHS FT	Updates provided to the FPBD Committee		
	LMS Hosting Arrangement	Updates provided to the Board		
	Finance Directors Group	Updates provides to the Executive Team and through the governance structure when appropriate		
	Health care partnership are using existing memorandum of understanding in relation to staff movement between local hospital at time of staffing need.	Agreed at Board		
	LWH have provided assistance to LUFT by taking over LWH N~~n~~on o~~O~~bstetric Ultrasound scanning activity	Mutual aid reported through to the Quality Committee and Board		
	LWH identified as Gynaecology Oncology Hub for Cheshire and Mersey.			
	Theatre sessions provided at LWH for other Trusts such as Colorectal for LUFT			
	Provision of mutual aid to NWAST by supporting staff testing on LWH site for them			
	Provision of Mutual aid to NWAST for staff Covid-19 vaccinations			

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
4.2 / 1	Continue to provide updates to the Board regarding the development of the ICS, highlighting when decision points are likely	CEO	On-going	Board	
4.2 / 2	Development and embedding of governance arrangements for the LMS (one year review meeting scheduled for April 2022)	COO	June 2022	Board	

Strategic Objective	SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes
Committee:	Quality Committee
Risk Appetite:	High

Principal risks (BAF)	Risk Score
5.1 Failure to progress our research strategy and foster innovation within the Trust	8 (2 x 4)
5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	12 (3 x 4)

Ref	Corporate Risk Register / High Scoring (15+) Risks	Risk Score
2336	There is risk to the Trust, as it is not currently meeting the CQC Regulations and national guidance in relation to the care of children aged 18 and below within the Gynaecology services	15
2232 **(CRR)**	There is a risk that due to a number of causes the Trust is unable to meet the safety requirements related to Blood Transfusion	15
2295 **(CRR)**	Inability to achieve and maintain regulatory compliance, performance and assurance.	8
2329 **(CRR)**	There is a risk to the Trust is not meeting it requirements for the safe and proper management of medicines	12

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

2232 - No change in risk score since last review. Last reviewed 16/02/2022.

2295 - No change in risk score since last review. Last reviewed 13/01/2022

2329 - No change in risk score since last review. Last reviewed 04/03/2022

BAF Risk 5.1: Failure to progress our research strategy and foster innovation within the Trust

Lead Director: MD
Op Lead: Director of Research

Review Date: April 2022

Ulysses Ref: TBC

Strategic Priority: SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes

Lead Committee: Quality Committee

Provider Licence Compliance link:

N/A

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target	2022/23 Target
8 (2 x 4)	8 (2 x 4)	8 (2 x 4)	8 (2 x 4)	⟷	4 (1 x 4)	4 (1 x 4)

Rationale for current risk score:

The Trust has a well-established and successful research process and has been particularly active in the support provided to the wider system during Covid-19. To strengthen this area and further mitigate this risk, the Trust should look to widen participation in research across the organisation making links explicit with quality improvement activity. There is also an opportunity to further enhance the Trust's research profile in the local system but also nationally and internationally.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
If high quality research staff cannot be engaged and retained, then research activities will not be fulfilled leading to challenges in recruitment and retention of staff, damage to reputation or withdrawal of funding~~If high quality research staff cannot be engaged and retained, then research activities will not be fulfilled leading to withdrawal of funding or damage to reputation~~	Excellent support continues to be provided to medical staff in identifying and nurturing talent, ensuring projects suggested by new researchers are feasible and of high quality and establishing mentorship for individuals who wish to have a research component as part of their future career. Nursing, Midwifery and Allied Health Professional Talent pipeline developed to provide further support and development for non-medical workforce in relation to the research agenda. The Trust has now appointed a Director of Midwifery who has a strong research background. She will support and facilitate midwifery research.	The Trust in-house research management infrastructure continues to operate in a robust and efficient manner. Its performance can be demonstrated via various internal and external reporting mechanisms. Monitored via RD&I Subcommittee Implementation of the talent pipeline will be monitored via the RD&I sub committee RD&I sub-committee (also attended by three Professors of Midwifery from the respective local universities)	Ongoing funding will be required to support the talent pipeline **(Action 5.1 / 1)**	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.1 / 1	To secure funding to support the talent pipeline	Medical Director	September 2022	Research and Development Sub-Committee	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Continued engagement with the City-wide integrated approach to innovation is necessary in order to further promote, develop and innovation ideas from the Trust's workforce.	Engagement with Liverpool Health Partners	Regular innovative ideas are identified and supported, for example Life Start Trolley, Butterfly Pillow, Butterfly Shelf, parenteral nutrition product, speculum for the diagnosis of urogenital atrophy. Such ideas are supported in-house and via outsourced expert help and advice. Regular attendance at RD&I sub-committee by LHP theme leads	Further development of this strategic principle is required to enable the Trust to empower its staff in engaging with a City-wide integrated approach to innovation.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.1 / 2	Continue progress towards university hospital status application	Medical Director	March 2023	Research and Development Sub-Committee	
5.1 / 3	Continue Trust engagement with population health and longitudinal studies / workstreams Update – C-Gull programme scheduled to start in Q1 22/23 – Trust is engaged.	Medical Director	July 2022	Research and Development Sub-Committee	

BAF Risk 5.2: Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	**Lead Director: CN&M** **Op Lead:** Assoc. Director of Governance and Quality	**Review Date: Apr 22**	**Ulysses Ref: TBC**

Strategic Priority: SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes

Lead Committee: Quality Committee

Provider Licence Compliance link:

General Licence Condition 7

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target	2022/23 Target
12 (3 x 4)	12 (3 x 4)	12 (3 x 4)	12 (3 x 4)	⟷	8 (2 x 4)	8 (2 x 4)

Rationale for current risk score:

The Trust has a current rating of 'requires improvement' for well-led from the most recent CQC inspection and received a warning notice regarding medicine management. Good assurance is in place regarding the Trust's response to this (supported by MIAA audit) and the warning notice being withdrawn. Further work required to refine process and to ensure that the Trust always remains 'inspection ready'.

The Trust was subject to an external well-led review and themes relating to effective lesson learning and establishing a quality improvement methodology were identified, mirroring findings from the CQC inspection and feedback from commissioners. Progress has been made in relation to both areas, but this needs to go further to achieve the target score.

~~The Trust has a current rating of 'requires improvement' for well-led from the most recent CQC inspection and also received a warning notice regarding medicine management. Good assurance is in place regarding the Trust's response to this with only two actions remaining outstanding and the warning notice being withdrawn. Further work required to refine process and to ensure that the Trust remains 'inspection ready' at all times.~~

~~The Trust was subject to an external wee-led review and themes relating to effective lesson learning and establishing a quality improvement methodology were identified, mirroring findings from the CQC inspection and feedback from commissioners. Progress has been made in relation to both of these areas but this needs to go further to achieve the target score.~~

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
If the Trust fails to comply with the CQC fundamental standards and if actions arising from the CQC visit are not implemented at sufficient pace then clinical standards may not be met leading to significant patient harm, deterioration in patient outcomes, a failure to maintain a CQC rating of 'good' and a serious reputational risk to the Trust.	CQC Framework to be implemented – to include well-led framework, and the on-going development of the CQC self-assessment process including a review of previous CQC action pans.	Quality Committee Executive Team oversight Divisional Board and performance review meetings Trust Board	Ward Accreditation and CQC Self-Assessment process yet to be implemented **(Action 5.2 / 1)** Number of policies and SOPs out of review date **(Action 5.2 / 2)**	
	Horizon scanning for changes in the CQC's regulatory approach	Quality Committee		
	Planned monthly engagement meetings with CQC	Quality Committee		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 1	To implement updated Ward Accreditation programme	Deputy Director of Nursing & Midwifery	July 2022	Quality Committee	
5.2 / 2	Ensure all policies and procedures are within their review date	Assoc. Director of Quality & Governance	July 2022	Quality Committee	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective understanding and learning following significant events and evidencing improved practice and clinical outcomes.	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 Serious Incident Feedback form Serious Incident panels Safety is included as part of executive walk rounds. Risk Management Strategy Link on desktop of computer with a link to lesson learnt section of web page	CQPG Meetings Reporting of incidents and management of action plans through Safety & Effectiveness Sub-Committee Reflection of risks and Corporate Risk Register and Board Assurance Framework CQC Assessment Annual Quality Account Report Monthly meetings with the divisions and Assoc. Director of Quality & Governance and Dep. Chief Nurse & Midwife to review the risk profile, ensuring we move at pace being able to evidence the work we are doing, including any learning from incidents/events etc Discussions with staff on walk arounds conducted by the Director of Nursing & Midwifery and senior clinical staff. Shared learning page now live on the intranet	Lack of testing of action plans following audits to ensure they lead embedded change – will be supported by ward accreditation once in place **(Action 5.2 / 3)** Inconsistent completion and dissemination of actions and improvement plans – signs of improvement but with further work required. **(Action 5.2 / 4)** Lack of consistent between divisional governance meetings (noted in recent well-led report) **(Action 5.2 / 3)** Human Factors training compliance and availability **(Action 5.2 / 5)**	

	Use of the action planning module is to be embedded across all divisions		The Governance team to use weekly meetings for review actions and ensure shared. Governance team to ensure oversight and reporting of progress		Root Cause Analysis training compliance and availability **(Action 5.2 / 6)**		
	Dip sampling of SI's and review of action previous plans that were submitted to CCG's to ensure changes in practice were embedded and successful.		Quality Committee		Monitoring compliance with risk management training **(Action 5.2 / 7)**		
	Route Cause Analysis training booked for 35 staff in May and June 2022.						
	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status	
	5.2 / 3	To ensure that Divisional Governance meetings are consistent and seek evidence of actions / lessons being embedded	Deputy COO	July 2022	Safety & Effectiveness Sub-Committee		
	5.2 / 4	Develop better reporting from the Ulysses System There is a continuing commitment to improving reporting using Ulysses. A recent development has been the agreement to cross-tabulate incidents and complaints using Ulysses using a formal process.	Head of Governance & Quality	July 2022	Safety & Effectiveness Sub-Committee		
	5.2 / 5	Business case for the provision of Human Factors Training to be developed and submitted to education governance committee	Medical Ed Lead	July 2022	Safety & Effectiveness Sub-Committee		
	5.2 / 6	Root Cause Analysis training for staff to be reviewed and updated and to recommence via teams	Head of Risk	July 2022	Safety & Effectiveness Sub-Committee		
	5.2 / 7	Governance team to monitor compliance levels with risk management training and highlight staff who are noncompliance to the Divisions and provide compliance update to Safety and Effectiveness Sub-committee.	Head of Risk	On-going	Safety & Effectiveness Sub-Committee		
Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*		Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*		Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*		Overall Assurance Rating
Ineffective and / or ill-defined quality improvement methodology will result in the Trust missing opportunities to improve the safety, effectiveness and experience of care.	Quality Improvement training materials available on Trust Intranet		Training levels reported to the Quality & Clinical Audit Group		Opportunities to engage individuals in QI training limited, particularly during pandemic Evidence of QI projects being undertaken but not 'formalised'		
	Quality Improvement projects tracked		Safety & Effectiveness Sub-Committee				
	Quality Account tracking key projects		Annual Quality Account				
	Quality Improvement Framework developed and agreed		Quality Committee				
	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status	
	5.2 / 8	Continuous review of the trusts approach to QI to enable the planning of priorities identifying improvements required	Assoc. Director of Governance & Quality	On-going	Quality Committee		
	5.2 / 9	Increase levels of QI training	Assoc. Director of Governance & Quality	July 2022	Quality Committee		
	5.2 / 10	Simplify process to encourage staff to record QI projects within formal framework	Assoc. Director of Governance & Quality	June 2022	Quality Committee		
	5.2 / 11	Establish what changes can be made to Ulysses to align the system better with the flow of QI projects.	Assoc. Director of Governance & Quality	September 2022	Quality Committee		
	5.2 / 12	To create a platform for completed QI projects to be showcased and shared trust wide.	Assoc. Director of Governance & Quality	September 2022	Quality Committee		

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/043*		**Date: 05/05/2022**	
Report Title	**Emergency Planning Resilience and Response Annual Board Report**			
Prepared by	*Lorraine Thomas, Emergency Planning & Business Continuity Manager*			
Presented by	*Gary Price, Chief Operating Officer*			
Key Issues / Messages	*This Emergency Preparedness, Resilience and Response (EPRR) Annual Report provides a summary of EPRR approach and activities for 2021/22.*			
Action required	**Approve** ☐	**Receive** ☐	**Note** ☒	**Take Assurance** ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is asked to note the report.			
Supporting Executive:	*Gary Price, Chief Operating Officer*			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
FPBD	**Apr 22**	**COO**	**The Committee noted the report**

EXECUTIVE SUMMARY

This Emergency Preparedness, Resilience and Response (EPRR) Annual Report provides a summary of EPRR approach and activities for 2021/22. The EPRR strategy implemented by the EPRR Committee aims to support the Trust to meet its duties under the Civil Contingencies Act 2004. These duties are supported by the requirement for compliance to the NHSE/I EPRR Core Standards. The NHSE/I assurance process was completed in October 2021 with Trust compliance reported to the Board (November 2021) and summarised within this report.

Key activities for 2021/22 include continued Covid 19 incident response led by the Chief Operating Officer - Emergency Accountable Officer, including implementation of national guidance and submission of situation reports and assurances across all aspects of Covid 19 incident response. The Major Incident (November 2021) debrief procedure and EPRR work-stream actions remain a priority for 2022 with progress against actions detailed within this report.

EPRR work-streams going forward will remain focused on achieving and maintaining the NHSE EPRR Core Standards for 2022, including completing actions identified within the major incident debrief procedures.

MAIN REPORT

INTRODUCTION

Introduction

As a category 1 responder under the civil contingencies Act 2004 the Trust is required to prepare for emergency and business continuity incidents and ensure that it has the capacity and capability to respond effectively to emergency situations including major incidents. Whilst managing emergency situations the Trust must as far as is reasonably practicable maintain business continuity, prioritising critical service delivery when necessary.

The Trust aims to meet its duties within a framework that is safe, effective, caring, responsive and well-led. The Trust EPRR agenda is led by the EPRR Accountable Emergency Officer (Chief Operating Officer) supported by the Emergency Planning & Business Continuity Manager. In order to meet its legal duties the Trust holds a portfolio of emergency and business continuity plans which have been developed in consultation with divisional teams and relevant corporate leads.

The Trust is required to work in cooperation with other Category 1 Responders including other NHS Trusts and the emergency services, in relation to emergency planning processes and incident response. The Trust is represented at the Merseyside Local Health Resilience Partnership at both strategic and operational level. The partnership led by NHSE/I aims to coordinate and direct cooperative working including in relation to risk management and shared learning from exercises and incident response.

EPRR work streams continue to focus on compliance to the NHSE/I EPRR Core Standards in order to support preparedness for emergency incidents and ensure compliance in external assurance and audit processes. EPRR objectives for 2021 were detailed as below and this report discusses the meeting of these objectives.

- Discussion of EPRR priorities via the EPRR Committee;
- Review of EPRR Risks;
- Review of Trust emergency plans and arrangements;
- Business continuity planning for scheduled service disruption;
- Provision of EPRR training;
- Working in cooperation with other healthcare responders;
- Effective incident response.

Risk Review

EPRR risks are regularly reviewed and updated including consultation at the EPRR Committee and reporting to Corporate Risk Committee. Specific risks in relation to the major incident response (November 2021) continue to be reviewed and monitored within the Environment Safety sub-committee led by the Associate Director.

Trust Emergency & Business Continuity Plans

The Trust holds a portfolio of emergency plans which are subject to a process of review as directed by Trust governance procedures and as required by changing national, regional and local structures, priorities or lessons learned. All emergency plans are subject to consultation

and approval via the EPRR Committee. The following plans were reviewed and approved in 2021/22.

- Adverse Weather Plan;
- Business Continuity SOP;
- Communications & Media Action Card;
- Fuel Shortages Plan (road fuel);
- High Profile Patient SOP;
- Hospital Evacuation Strategy;
- Pandemic Influenza Plan;
- UK International Terrorism Threat Level Action Card;
- Winter Plan.

In addition to the above the Hospital Lockdown Plan has been reviewed and is currently under consultation. Due to continuing actions in relation to the major incident (November 21) security work-stream, the Hospital Lockdown Plan will be approved for a shorter term with a view to further review following completion of security workstream actions.

The Trust Chemical, Biological, Radiological and Nuclear / Hazardous Materials Plan (CBRN/HazMat Plan) is currently under review in line with Trust governance procedures including review of the supporting training arrangements.

Departmental Business Continuity Plans Review

As an action from the EPRR Core Standards Review 2021 a review was undertaken of departmental business continuity plans which is due to complete April 2022. Outstanding actions identified by departments will be incorporated into an action plan and monitored via the EPRR Committee (current status in Appendix 1).

Incident Control Centre Activations

Major Incident Covid 19 Incident Response

- The Trust Incident Control Centre led by the Chief Operating Officer continued to operate throughout 2021/22, including via virtual mode, in response to the Covid 19 Pandemic. Trust incident response arrangements were aligned to national operating principles, directives and guidance. The virtual ICC continued to monitor work streams including; review of clinical services, infection, prevention and control measures including social distancing, PPE procurement, utilisation and mask fit testing, controlled site access, safe staffing and risk assessment procedures, staff and patient testing and vaccination programme, clinical guidance and visiting arrangements. The Trust Covid 19 Inquiry Working Group is currently led by Board Secretary.

Major Incident Maternity Capacity Escalation

- The Trust Incident Control Centre was activated 19th July 2021 in response to maternity capacity issues experienced across Cheshire & Merseyside and impacting on Trust services. Following dynamic risk assessment, the Trust declared a major incident due to increased maternity capacity demand at a time of reduced staffing levels linked in part to Covid 19. The incident was managed via a series of meetings led by Trust Strategic Command which remained focused on delivering safe and effective services and supporting staff. The Trust was in direct communication with NHSE/I North who were monitoring and managing the wider response. Following incident stand-down and

based on shared learning the Trust contributed to the review of the Cheshire & Merseyside Capacity Escalation Policy the Trust was designated Chair of Cheshire & Merseyside Strategic Command Maternity Services Escalation meetings.

Major Incident Vehicle Explosion

- The Trust incident control centre was activated 14th November 2021 in relation to a major incident involving a vehicle explosion outside the hospital main reception. The incident was confirmed to be terrorism related and required a multi-agency response. The Trust incident response was led by strategic command with support of tactical command roles and under the direction of Merseyside Police where appropriate. The Trust response aimed to maintain safety and security of staff, patients and visitors to the hospital including implementing hospital lockdown and operating controlled access in consultation with Merseyside police. The incident was complex and required a coordinated response. Multi-disciplinary debrief procedures were led by the designated Associate Director with identified learning and actions organised into service led work-streams. The EPRR action plan detailing progress to date is embedded below. Further actions to support identified learning are being managed via the Trust Environmental Safety Working Group led by the Associate Director. The Trust plans to share and rehearse actions within emergency planning exercises to be scheduled for May & June 2022 and delivered in collaboration with NHSE/I NW (Cheshire & Merseyside) EPRR Team. Identified good practice and lessons learned from both the incident and the exercises will also be shared with local NHS Trusts via the Local Health Resilience Partnership.

  Action Plan is shared as a supporting document for the Board.

Business Continuity Planning

The Trust developed business continuity plans to support the following planned infra-structure works. This provided the opportunity to implement contingencies and test business continuity plans and rehearse strategic, tactical and operational incident response roles including internal alerting procedures, external notification arrangements and staff communications.

Business Continuity Plans were implemented to support the following scheduled infrastructure upgrades 2021/22:

- Electrical infrastructure works 11th March 2021
- Electrical circuit breaker replacement 6th May 2021
- Meditech Magic Migration scheduled 20th April 2021
- Meditech disc verification 29th June 2021
- Meditech Patch application 26th January 2022
- Netcall Downtime 19 July 2021
- Telephony application of patches 27th July 2021
- IT Communications Rooms F & PPU, 28th & 29th May 21
- IT Communications Rooms T & C, 26th & 27th June 21
- IT Communications Rooms T&K, 24th & 25th July 2021
- IT Communications Room H, 4th September 2021
- IT Communications Rooms NICU 1st October 2021
- IT Communications Rooms E & A 12th & 13th November 2021
- IT Communications Room B, 4th February 2022

EPRR leads worked in collaboration with estates, information and technology and operational leads to develop business continuity plans to support the above. Staff communications were released and external notification of the plans and arrangements were provided on all occasions to NHSE/I Cheshire & Merseyside, Liverpool Clinical Commissioning Group, North West Ambulance Service, and where applicable Merseyside Fire & Rescue Service. Lessons learned were identified within debrief procedures, shared at the EPRR Committee and incorporated within subsequent planning procedures.

External Audit and Assurance

EPRR submitted an Assurance Board Report (November 2021) based on the outcomes of the NHSE/I EPRR Core Standards review for 2021. In summary 38 EPRR Core Standards were applicable to NHS Specialist Trusts and the Trust met 34 of the relevant standards with a rating of 'Green'. Four 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 2021/22. In addition seven deep dive criteria relating to medical oxygen provision were assessed with a rating of amber. The deep dive criteria were not included within the Trust compliance rating.

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 was submitted to NHSE/I NW. EPRR actions are monitored via the EPRR Committee with medical oxygen criteria monitored by the Estates Committee with oversight via the EPRR Committee.

On conclusion of the national assurance process which includes oversight by NHSE/I, the Trust will receive confirmation of the assessment outcome via NHSE/I NW.

Training

- Exercise Paperback (IT systems outage) was delivered in May 2021 and attended by information technology, operational and clinical roles. The exercise included rehearsal of Trust strategic, tactical and operational command roles and information systems incident response. An action plan was developed including information technology and operational actions with monitoring via the EPRR Committee.

- Programme of induction training for directors and managers joining the on-call rota continued throughout 2021-22 providing training / refresher training on aspects of EPRR including legal duties, accountability, command and control structures and responsibilities, escalation and communication, emergency plans and resources.

- Fire Warden training delivered by Fire Safety Advisors continues to be monitored by the EPRR Committee.

- CBRN training procedures will be reviewed for 2022/23 as identified within NHSE/I EPRR Core Standards.

Conclusion / Recommendation

The EPRR activities and achievements discussed within this report demonstrate that the Trust remains focused on continuing to meet its duties under the CCA 2004 and aims to maintain a substantial level of compliance to the NHSE EPRR Core Standards for 2022.

Specific objectives for 2022/23 include:

- Discussion of EPRR priorities via the EPRR Committee;
- Review and prioritisation of EPRR Risks;
- Review of Trust emergency plans and arrangements based on lessons learned / shared learning;
- Business continuity planning including for scheduled service disruption as required;
- Provision of EPRR training including delivery of a tabletop and live exercise based on major incident response;
- Delivery of an exercise based on business continuity response to an information technology scenario;
- Delivery of a hospital evacuation exercise;
- Continued working in cooperation with other healthcare responders;
- Implementation of actions to support effective incident response.

Appendix 2

Departmental Business Continuity Plan Review 2021/22 (March 2022)

Department	BCP Lead Responsibility	Role	BCP Revised
Estates & Facilities	Linda Martin	Patient Facilities Manager	March 2020
Finance Procurement	David Dodgson	Financial Controller	March 2022
Genetics	Ellen Gerrard Tom White	Divisional Manager Clinical Support Services Deputy Divisional Manager	March 2022
Gynaecology	Matt Butcher Toni Gleave	Divisional Manager Gynaecology & Hewitt Fertility Centre	December 2019
Hewitt Centre	Matt Butcher Toni Gleave	Divisional Manager Gynaecology & Hewitt Fertility Centre	January 2022
Human Resources	Janet Hinde	Workforce Information Manager	March 2022
IM&T	Phil Moss	Head of Technology	December 2021
Imaging	Ellen Gerrard Lowry Lloyd -Preston	Divisional Manager Clinical Support Services Clinical Lead - Imaging	March 2022
Integrated Governance	Phil Bartley	Associate Director Quality & Governance	February 2022
Neonates	Jennifer Deeney	Head of Neonatal Unit	December 2021
Maternity	Eleanor Stanley	Divisional Manager Family Health	December 2021
PAS	Debbie Pink	Patient Access Manager	March 2022
Pharmacy	Daniel Collins	Deputy Chief Pharmacist	January 2022
Safeguarding	Amanda McDonagh	Associate Director of N&M Safeguarding Lead	January 2022
Theatres	Ellen Gerrard Lowry Lloyd -Preston	Divisional Manager Clinical Support Services Head of Clinical Support Services	March 2022

Liverpool Women's
NHS Foundation Trust

Jargon Buster

We know that the language used in healthcare can sometimes be quite confusing, especially when acronyms are concerned. To make life a little easier, we will try to ensure that we spell out acronyms in full at first mention and then put the abbreviation in brackets, for example, Strategic Clinical Network (SCN) in our reports and minutes.

We've also put together a list of acronyms that you might see throughout our documentation. If you spot a gap, please email our Trust Secretary on mark.grimshaw@lwh.nhs.uk.

The following webpage might also be useful - https://www.england.nhs.uk/participation/nhs/

A		
A&E	Accident & Emergency	hospital department specialising in the acute care of patients who arrive without a prior appointment with urgent or emergency trauma
AC	Audit Committee	a committee of the board – helps the board assure itself on issues of finance, governance and probity
AGM	Annual General Meeting	a meeting to present and agree the trust annual report and accounts
AGS	Annual Governance Statement	a document which identifies the internal controls in place and their effectiveness in delivering effective governance
AHP	Allied Health Professionals	health care professions distinct from dentistry, optometry, nursing, medicine and pharmacy e.g. physiotherapists, radiographers, speech therapists and podiatrists
AHSC	Academic Health Science Centre	a partnership between a healthcare provider and one or more universities
AHSN	Academic Health Science Network	locally owned and run partnership organisations to lead and support innovation and improvement in healthcare
ALOS	Average Length of Stay	the average amount of time patients stay in hospital
AMM	Annual Members Meeting	a meeting that is held every year to give members the opportunity to hear about what the trust has done in the past year; could be part of the AGM
AO	Accountable Officer	senior person responsible and accountable for funds entrusted to their trust; for NHS provider organisations this person will be the chief executive
ALB(s)	Arms Length Bodies	an organisation that delivers a public service but is not a ministerial government department; these include HEE, HSCIC, HRA, HTA, NHSE, NICE, Monitor, NHSBSA, NHSBT, NHSI, NHSLA, MHPRA, CQC, PHE (See individual entries)
	Agenda for Change	the NHS-wide grading and pay system for NHS staff, with the exception of medical and dental staff and some senior managers; each relevant job role in the NHS is matched to a band on the Agenda for Change pay scale

B		
BAF	Board Assurance Framework	the key document used to record and report an organisation's key strategic objectives, risks, controls and assurances to the board
BCF	Better Care Fund	this fund creates a local single pooled budget to incentivise the NHS and local government to work more closely together in local areas
BMA	British Medical Association	trade union and professional body for doctors
BAME	Black Asian Minority Ethnic	terminology normally used in the UK to describe people of non-white descent
BoD	Board of Directors	executive directors and non-executive directors who have collective responsibility for leading and directing the trust
	Benchmarking	method of gauging performance by comparison with other organisations

C		
CAMHS	Child and Adolescent Mental Health Services	specialise in providing help and treatment for children and young people with emotional, behavioural and mental health difficulties
CapEx	Capital Expenditure	an amount spent to acquire or improve a long-term asset such as equipment or buildings. Typically, capital is raised via a loan, but it can come from reserves and is paid back/written off over a number of years from revenue income. This is a contrast with revenue spend which is always from in-year income
CBA	Cost Benefit Analysis	a process for calculating and comparing the costs and benefits of a project
CBT	Cognitive Behavioural Therapy	a form of psychological therapy used mostly in depression but increasingly shown to be a useful part of the treatment for schizophrenia
CCG	Clinical Commissioning Group	groups of GPs, clinicians and managers who are responsible for commissioning local health services in England (all GP practices must belong to a CCG)
CDiff	Clostridium difficile	a bacterial infection that most commonly affects people staying in hospital
CE / CEO	Chief Executive Officer	leads the day-to-day management of a foundation trust, is a board member and the accountable officer for the trust.
CF	Cash Flow	the money moving in and out of an organisation
CFR	Community First Responders	a volunteer who is trained by the ambulance service to attend emergency calls in the area where they live or work
CHC	Continuing Healthcare	Whereby those with long-term or complex healthcare needs qualify for social care arranged for and funded by the NHS
CIP	Cost Improvement Plan	an internal business planning tool outlining the Trust's efficiency strategy
CMHT	Community Mental Health Team	A team of mental health professionals such as psychiatrists,

		psychologists, social workers, community psychiatric nurses and occupational therapists, who work together to help people manage and recover from mental illness.
CoG	Council of Governors	the governing body that holds the non-executive directors on the board to account for the performance of the board in managing the trust, and represents the interests of members and of the public
COO	Chief Operating Officer	a senior manager who is responsible for managing a trust's day-to-day operations and reports to the CEO
CPD	Continuing Professional Development	continued learning to help professionals maintain their skills, knowledge and professional registration
CPN	Community Psychiatric Nurse	a registered nurse with specialist training in mental health working outside a hospital in the community
CQC	Care Quality Commission	The independent regulator of all health and social care services in England
CQUIN	Commissioning for Quality and Innovation	a sum of money that is given to providers by commissioners on the achievement of locally and nationally agreed quality and improvement goals
CSR	Corporate Social Responsibility	A business practice which incorporates sustainable goals, usually positive impacts on environmental, economic and social factors, into a business model
CT	Computed Tomography	A medical imaging technique
CFO	Chief Finance Officer	the executive director leading on finance issues in the trust
	Caldicott Guardian	A board level executive director responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian

D		
DBS	Disclosure and barring service	conducts criminal record and background checks for employers
DBT	Dialectical behavioural therapy	A type of psycho-therapy, or talk therapy, which has been developed from CBT to help those experiencing borderline personality disorder
DGH	District General Hospital	major secondary care facility which provides an array of treatment, diagnostic and therapeutic services, including A&E
DHSC	Department of Health and Social Care	the ministerial department which leads, shapes and funds health and care in England
DN	Director of Nursing	The executive director who has professional responsibility for services provided by nursing personnel in a trust
DNA	Did Not Attend	a patient who missed an appointment
DNAR	Do Not Attempt Resuscitation	A form issued and signed by a doctor, which tells a medical team not to attempt CPR
DPA	Data Protection Act	the law controlling how personal data is collected and used
DPH	Director of Public Health	a senior leadership role responsible for the oversight and care of matters relating to public health
DTOCs	Delayed Transfers of Care	this refers to patients who are medically fit but waiting for care

		arrangements to be put in place so therefore cannot be discharged
	Duty of Candour	a legal duty on hospital, community, ambulance and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm

E		
E&D	Equality and Diversity	The current term used for 'equal opportunities' whereby members of the workforce should not be discriminated against because of their characteristics. This is promoted by valuing diverse characteristics in a workplace.
ED(s)	Executive Directors *or* Emergency Department	senior management employees who sit on the trust board *or* alternative name for Accident & Emergency department
EHR	Electronic Health Record	health information about a patient collected in digital format which can theoretically be shared across different healthcare settings
EOLC	End of Life Care	support for patients reaching the end of their life
EPR	Electronic Patient Record	a collation of patient data stored using computer software
ESR	Electronic staff record	A collation of personal data about staff stored using computer software

F		
FFT	Friends and Family Test	a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care
FOI	Freedom of Information	the right to ask any public sector organisation for the recorded information they have on any subject
FT	Foundation Trust	a public benefit corporation, which is a legal body established to deliver healthcare to patients / service users and has earned a degree of operational and financial independence
FTE	Full Time Equivalent	a measurement of an employees workload against that of someone employed full time e.g. 0.5 FTE would be someone who worked half the full time hours
FTSU	Freedom to speak up	An initiative developed by NHS Improvement to encourage NHS workers to speak up about any issues to patient care, quality or safety
	Francis Report	the final report, published in 2013, of the public inquiry into care provided by Mid Staffordshire NHS FT chaired by Sir Robert Francis QC

G		
GMC	General Medical Council	the independent regulator for doctors in the UK
GDP	Gross Domestic Product	thevalueofacountry'soveralloutputofgoodsand services
GDPR	General Data Protection Regulations	The legal framework which sets the guidelines for collecting and processing personal information from individuals living in the European Union

H		
HCAI	Healthcare Associated Infection	these are infections that are acquired in hospitals or as a result of healthcare interventions; MRSA and Clostridium difficile can be classed as HCAIs if caught whilst in a healthcare setting
HCA	Health Care Assistant	staff working within a hospital or community setting under the guidance of a qualified healthcare professional
HDU	High Dependency Unit	an area in a hospital, usually located close to the ICU, where patients can be cared for more extensively than on a normal ward, but not to the point of intensive care, e.g. patients who have had major surgery
HEE	Health Education England	the body responsible for the education, training and personal development of NHS staff
HR	Human Resources	the department which focusses on the workforce of an organisation including pay, recruitment and conduct
HRA	Health Research Authority	protects and promotes the interests of patients and the public in health research
HSCA 2012	Health & Social Care Act 2012	an Act of Parliament providing the most extensive reorganisation of the NHS since it was established, including extending the roles and responsibilities of governors
HSCIC	Health and Social Care Information Centre	the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care
HTA	Human Tissue Authority	regulates the removal, storage, use and disposal of human bodies, organs and tissue for a number of scheduled purposes such as research, transplantation, and education and training
HWB / HWBB	Health& Wellbeing Board	a local forum to bring together partners from across the NHS, local government, the third sector and the independent sector, led by local authorities
	Health Watch	A body created under the Health and Social Care Act 2012 which aims to understand the needs and experiencesofNHSserviceusersandspeakontheir behalf.

I		
IAPT	Improved Access to Psychological	an NHS programme rolling out services across England

	Therapies	offering interventions approved by the National Institute of Health and Care Excellence for treating people with depression and anxiety disorders
IG	Information Governance	ensures necessary safeguards for, and appropriate use of, patient and personal information. Key areas are information policy for health and social care, IG standards for systems and development of guidance for NHS and partner organisations
ICP	Integrated Care Pathway	a multidisciplinary outline of care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through diagnosis and treatment to positive outcomes
ICS	Integrated Care system	Groups of NHS providers, commissioners and local authorities working together to improve health and care in the local area
ICT	Information Communications Technology	an umbrella term that includes any communication device or application, encompassing: radio, television, cellular phones, computer and network hardware and software, satellite systems, as well as the various services and applications associated with them
ICU *or* ITU	Intensive Care Unit Intensive therapy unit	specialist unit for patients with severe and life threatening illnesses
IP	Inpatient	a patient who is hospitalised for more than 24 hours
IT	Information Technology	systems (especially computers and telecommunications) for storing, retrieving, and sending information
IV	Intravenous	treatment which is administered by injection into a vein

K		
KLOE(s)	Key Line of Enquiries	detailed questions asked by CQC inspectors which help to answer the five key questions to assess services: are they safe, effective, caring, responsive and well-led?
KPIs	Key Performance Indicators	indicators that help an organisation define and measure progress towards a goal
	King's Fund	independent charity working to improve health and health care in England

L		
LD	Learning Disability	a disability which affects the way a person understands information and how they communicate

LGA	Local Government Association	the national voice of local government in England and Wales. It seeks to promote better local government and maintains communication between officers in different local authorities to develop best practice
LOS	Length of Stay	a term commonly used to measure the duration of a single episode of hospitalisation

M

M&A	Mergers & Acquisitions	mergers bring together two or more bodies to form a new legal entity and disband the merging bodies. acquisitions are take-overs of one body by another
MD	Medical Director	a member of the board who has a clinical background and has professional responsibilities for doctors and dentists in the trust
MHPRA	Medicines and Healthcare Products Regulatory Agency	an executive agency of DHSC which is responsible for ensuring that medicines and medical devices work and are acceptably safe
MIU	Minor Injuries Unit	A unit which treats injuries or health conditions which are less serious and do not require the A&E service
MoU	Memorandum of Understanding	describes an agreement between two or more parties
MRI	Magnetic Resonance Imaging	a medical imaging technique
MRSA	Methicillin-Resistant Staphylococcus Aureus	a bacterium responsible for several difficult-to-treat infections in humans
MSA	Mixed Sex Accommodation	wards with beds for both male and female patients

N

NAO	National Audit Office	an independent Parliamentary body in the United Kingdom which is responsible for auditing central government departments, government agencies and non-departmental public bodies. The NAO also carries out Value for Money audits into the administration of public policy
NED	Non Executive Director	directors who are appointed, but not employed by the trust; they have no executive responsibilities and are responsible for vetting strategy, providing challenge in the boardroom and

		holding the executive directors to account
NHSBSA	NHS Business Services Authority	a Special Health Authority of DHSC which provides a range of services to NHS organisations including: NHS Prescription Services, NHS Pensions, Help With Health Costs, Student Services, NHS Dental Services, European Health Insurance Card, Supplier Management (including NHS Supply Chain) and NHS Protect
NHSBT	NHS Blood and Transplant	a Special Health Authority of DHSC responsible for providing a reliable, efficient supply of blood, organs and associated services to the NHS
NHSE	NHS England	an executive non-departmental public body with a mandate from the Secretary of State to improve health outcomes for people within England
NHSI	NHS Improvement	The Independent regulator of NHS Foundation Trusts
NHSLA	NHS Leadership Academy	national body supporting leadership development in health and NHS funded services
NHSP	NHS Professionals	provides bank (locum) healthcare staff to NHS organisations
NHSX		A unit designed to drive the transformation of digital technology in the NHS
NICE	National Institute for Health and Care Excellence	provides national evidence-based guidance and advice to improve health and social care
NIHR	National Institution for Health Research	The largest funder of health and social care research in the UK, primarily funded by the Department of Health and Social Care
NMC	Nursing and Midwifery Council	nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
	Never Event	serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. NHS England defines the list of never events every year
	NHS Digital	The information and technology partner to the NHS which aims to introduce new technology into services
	NHS Providers	NHS Providers is the membership organisation for NHS public provider trusts. We represent every variety of trust, from large acute and specialist hospitals through to community, ambulance and mental health trusts.

	Nolan Principles	key principles of how individuals and organisations in the public sector should conduct themselves comprising of: selflessness, integrity, objectivity, accountability, openness, honesty, leadership. Set by the Committee for Standards in Public Life, an independent advisory non-departmental public body set up to advise the prime minister on ethical standards
	NHS Resolution	not-for-profit part of the NHS which manages negligence and other claims against the NHS in England on behalf of their member organisations. Also, an insurer for NHS bodies
	Nuffield Trust	independent source of evidence-based research and policy analysis for improving health care in the UK, also a charity

O

OD	Organisational Development *or* Outpatients Department	a systematic approach to improving organisational effectiveness *or* a hospital department where healthcare professionals see outpatients (patients which do not occupy a bed)
OOH	Out of Hours	services which operate outside of normal working hours
OP	Outpatients	a patient who is not hospitalized for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment
OPMH	Older People's Mental Health	mental health services for people over 65 years of age
OSCs	Overview and Scrutiny Committees	established in local authorities by the Local Government Act 2000 to review and scrutinise the performance of public services including health services
OT	Occupational Therapy	assessment and treatment of physical and psychiatric conditions using specific activity to prevent disability and promote independent function in all aspects of daily life

P

PALS	Patient Advice & Liaison Service	offers confidential advice, support and information on health-related matters to patients, their families, and their carers within trusts

PAS	Patient Administration System	the automation of administrative paperwork in healthcare organisations, particularly hospitals. It records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient
PbR	Payment by Results or 'tariff'	a way of paying for health services that gives a unit price to a procedure
PCN	Primary care network	A key part of the NHS long term plan, whereby general practices are brought together to work at scale
PDSA	Plan, do, study, act	A model of improvement which develops, tests and implements changes based on the scientific method
PFI	Private Finance Initiative	a scheme where private finance is sought to supply public sector services over a period of up to 60 years
PHE	Public Health England	a body with the mission to protect and improve the nation's health and wellbeing and reduce health inequalities
PHSO	Parliamentary and Health Service Ombudsman	an organisation which investigates complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England
PICU	Psychiatric Intensive Care Unit *or* Paediatric Intensive Care Unit	a type of psychiatric in-patient ward with higher staff to patient ratios than on a normal acute admission ward *or* an inpatient unit specialising in the care of critically ill infants, children, and teenagers
PLACE	Patient-Led	Surveys inviting local people going into hospitals as
	Assessments of the Care Environment	part of a team to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance
PPI	Patient and Public Involvement	mechanisms that ensure that members of the community --- whether they are service users, patients or those who live nearby – are at the centre of the delivery of health and social care services
PTS	Patient Transport Services	free transport to and from hospital for non-emergency patients who have a medical need
	Primary Care	the first point of contact with the NHS for most people and is delivered by a wide range of independent contractors, including GPs, dentists, pharmacists and optometrists, it also includes NHS walk-in centres and the NHS 111 telephone service

Q		
QA	Quality assurance	monitoring and checking outputs to make sure they meet certain standards
QI	Quality improvement	A continuous improvement process focusing on processes and systems
QIA	Quality Impact Assessment	A process within NHS trusts which ensures the quality of service is systematically considered in decision- making on service changes
QUI	Qualities and Outcomes Framework	The system for performance management and payment of GP's in the NHS

R		
R&D	Research & Development	work directed towards the innovation, introduction, and improvement of products and processes
RAG	Red, Amber, Green classifications	a system of performance measurement indicating whether something is on or better than target (green), below target but within an acceptable tolerance level (amber), or below target and below an acceptable tolerance level (red)
RGN	Registered General Nurse	a nurse who is fully qualified and is registered with the Nursing and Midwifery Council as fit to practise
RoI	Return on Investment	the benefit to the investor resulting from an investment of some resource. A high RoI means the investment gains compare favourably to investment cost. As a performance measure, RoI is used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments.
RTT	Referral to Treatment Time	the waiting time between a patient being referred by a GP and receiving treatment

S		
SALT	Speech and Language Therapist	assesses and treats speech, language and communication problems in people of all ages to help them better communicate
SFI	Standing Financial Instructions	Policy used for the regulation of the conduct of an NHS trust in relation to all financial matters
SHMI	Summary Hospital Level Mortality Indicator	reports mortality at trust level across the NHS in England using standard and transparent methodology
SID	Senior independent Director	a non-executive director who sits on the board and plays a key role in supporting the chair; the SID carries out the annual appraisal of the chair, and is available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair
SIRO	Senior Information Risk Officer	a senior manager who will take overall ownership of the organisation's information risk policy
SITREP	Situation Report	a report compiled to describe the details surrounding a situation, event, or incident
SLA	Service Level Agreement	an agreement of services between service providers and users or commissioners
SoS	Secretary of State	the minister who is accountable to Parliament for delivery of health policy within England, and for the performance of the NHS
SRO	Senior Responsible officer	A leadership role which is accountable for the delivery and outcome of a specific project
STP	Sustainability and Transformation Partnership	Partnerships formed between local councils and NHS services to help plan and run services, and agree system-wide priorities
SUI	Series Untoward Incident / Serious Incident	A serious incident which resulted in one or more of the following: unexpected or avoidable death, a never event, a prevention of organisation's ability to continue to deliver healthcare services, abuse, or loss of confidence in a service
SWOT	Strengths, Weaknesses, Opportunities, Threats	a structured planning method used to evaluate the strengths, weaknesses, opportunities and threats involved in a project or in a business venture
	Secondary Care	NHS health service provided through hospitals and in the community

T		
TTO	To Take Out	medicines to be taken away by patients on discharge

	Tertiary Care	healthcare provided in specialist centres, usually on referral from primary or secondary care professionals

V

VTE	Venous Thromboembolism	a condition where a blood clot forms in a vein. This is most common in a leg vein, where it's known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE)
VfM	Value for Money	used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it both acquires and provides, within the resources available to it

W

WLF	Well Led Framework	a set of indicators that seek to identify how well led an organisation is, also used as a framework for board governance reviews
WRES	Workforce Race Equality Standard	a metric to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of black and minority ethnic (BME) board representation
WTE	Whole-time equivalent	See FTE

Y

YTD	Year to Date	a period, starting from the beginning of the current year, and continuing up to the present day. The year usually starts on 1st April for financial performance indicators