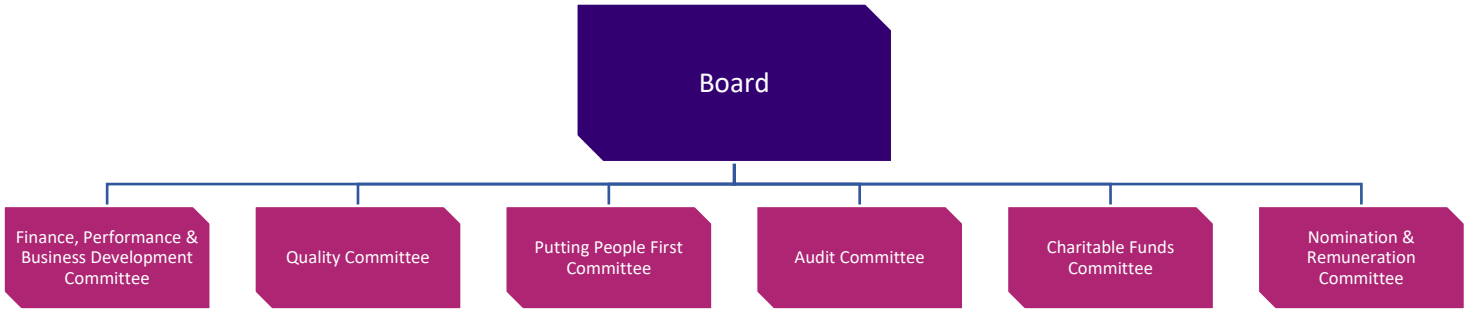
Liverpool Women's NHS Foundation Trust

Trust Board

8 February 2024, 09.30am
Boardroom, LWH & Virtual, via Teams



NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

Location	Boardroom, LWH and Virtual (via Teams)
Date	8 February 2024
Time	9.30am

AGENDA					
Item no. 23/24/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
242	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	09.30 (5 mins)
243	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
244	Minutes of the previous meeting held on 11 January 2024	Confirm as an accurate record the minutes of the previous meeting(s)	Written	Chair	
245	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
246	Board thank you	To receive	Verbal	Chair	09.35 (5 mins)
247	Staff Story – Accessibility Improvements	To receive service outline	Presentation	Chief Operating Officer	09.40 (20 mins)
248	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	10.00 (5 mins)
249	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	10.05 (15 mins)
MATERNITY					
250	Maternity Staffing report 1st July- 31st December 2023	To receive	Written	Chief Nurse	10.20 (10 mins)
QUALITY & OPERATIONAL PERFORMANCE					
251a	Chair's Report from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	10.30 (60 mins)
251b	Quality & Operational Performance Report	To note the latest performance measures	Written	Chief Operating Officer	
251c	Mortality and Learning from Deaths Report Quarter 2, 2023/24	For assurance	Written	Medical Director	

251d	Guardian of Safe Working Hours Quarter 3 2023/24	To receive	Written	Medical Director	
251e	Maternal Death HSIB Report and response	To receive	Written	Chief Nurse	
BREAK 11.30 – 11.35					
PEOPLE					
252a	Chair's Report from the Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	11.35 (20 mins)
252b	Workforce Performance Report	To note the latest performance measures	Written	Chief People Officer	
252c	Freedom to speak up – Bi-annual Update	To note	Written	Chief People Officer	
FINANCE & FINANCIAL PERFORMANCE					
253a	Chair's Report from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	11.55 (40 mins)
253b	Chair's Report from the Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
253c	Chair's Report from the Charitable Funds Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
253d	Finance Performance Review Month 9 2023/24	For assurance - To note the status of the Trust's financial position	Written	Chief Finance Officer	
253e	Immediate Quality and Safety Actions Investment	For approval	Written	Chief Finance Officer	
BOARD GOVERNANCE					
254a	Charitable Funds Strategy	To approve	Written	Chief Finance Officer	12.35 (5 mins)
254b	Board Assurance Framework	For assurance / approval	Written	Trust Secretary	12.40 (10 mins)
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
None noted.					Consent
CONCLUDING BUSINESS					
255	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	12.50 (5 mins)
256	Chair's Log	Identify any Chair's Logs	Verbal	Chair	

257	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
258	Jargon Buster	For reference	Written	Chair	
Finish Time: 12.55					

Date of Next Meeting: 11 April 2024

12.55 – 13.05	*Questions raised by members of the public*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

The Board of Directors is invited to adopt the following resolution:

'That the Board hereby resolves that the remainder of the meeting to be held in private, because publicity would be prejudicial to the public interest, by reason of the confidential nature of the business to be transacted'. [Section (2) of the Public Bodies (Admission to Meetings) Act 1960]

Liverpool Women's
NHS Foundation Trust

Meeting Guidance Notes

Meetings are an essential part of any NHS Foundation Trust's decision-making process. To ensure that these meetings are productive and efficient, it is crucial to follow proper etiquette and behaviours before, during, and after the meeting. Here are some guidance notes to keep in mind:

Before the Meeting:

- Review the agenda: Before attending the meeting, make sure to review the agenda to understand the purpose of the meeting, the topics that will be discussed, and what is expected of you.
- Come prepared: Bring any necessary documents or materials to the meeting, such as reports, data, or notes.
- Ensure your apologies are sent if you are unable to attend and *arrange for a suitable deputy to attend in your absence - members are expected to attend at least 75% of all meetings held each year.

  **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.*

- Be punctual: Arrive on time, or better yet, a few minutes early, to ensure that you are ready to start the meeting promptly.
- Check the technology: If the meeting is a hybrid one, meaning some participants are attending in person and others are attending remotely, make sure to check the technology beforehand. Ensure that the meeting room has adequate audio-visual equipment, such as microphones and cameras, to allow remote participants to participate fully.
- Communicate with remote participants: If you are attending the meeting remotely, make sure to communicate any special requirements or needs to the meeting organizer in advance. This will help them to accommodate you better during the meeting.
- Test the connection: Make sure to test your internet connection and any required software or applications beforehand to avoid technical issues during the meeting.

During the Meeting:

- Listen actively: Listen attentively to what others are saying and avoid interrupting or talking over others. This will help you to fully understand the issues being discussed and contribute to meaningful discussions.
- Be respectful: Respect others' opinions and perspectives, even if you disagree with them. Avoid using derogatory language and be courteous and professional at all times.
- Stay focused: Stay focused on the agenda and avoid going off-topic. This will help the meeting to stay on track and achieve its objectives.
- Pay attention to the camera: If you are attending the meeting remotely, make sure to look at the camera instead of the screen when speaking. This will help to create a more engaging experience for in-person participants.
- Mute when not speaking: If you are attending the meeting remotely, make sure to mute your microphone when not speaking to avoid background noise.
- Encourage participation: Encourage participation from both in-person and remote participants. Ask remote participants for their opinions and actively engage them in the discussion.

Standards and Obligations

These points outline key behaviours and processes to be followed during our meetings.

- Minutes should note when there is no consensus, including who agreed and disagreed.
- Members must be open and declare any conflicts of interest to the committee chair, who should be notified if any conflicts of interest are perceived. If concerns are not adequately addressed, members may consider whistleblowing or contacting the Senior Independent Director for high-level concerns.
- At the end of the meeting, a standing item should identify new risks to the organization and document them in the relevant risk register with appropriate scores. These steps ensure transparency, accountability, and effective risk management within the NHS Foundation Trust.

After the Meeting:

- Follow up: Follow up on any action items assigned to you during the meeting promptly.
- Share the recording: If the meeting was recorded, share the recording with all participants, both in-person and remote. This will allow everyone to review the discussion and follow-up on any action items.
- Provide feedback: If you have any feedback or suggestions on how the meeting could be improved, share them with the appropriate person.
- Evaluate the technology: Evaluate the technology used during the meeting and identify any areas for improvement. This will help to ensure that future hybrid meetings are even more effective.
- Thank participants: Thank the chairperson and other participants for their time and contributions.

In conclusion, following proper etiquette and behaviours before, during, and after the meeting, as well as specific considerations for hybrid meetings, will help to ensure that our meetings are productive, efficient, and respectful. Remember to come prepared, listen actively, stay focused, follow up promptly, and provide feedback.

Liverpool Women's
NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held in the Boardroom and Virtually via Teams at 9.30am on 11 January 2024

PRESENT

Robert Clarke	Chair
James Sumner	Chief Executive
Jenny Hannon	Chief Finance Officer / Executive Director of Strategy & Partnerships / Deputy Chief Executive
Zia Chaudhry MBE	Non-Executive Director
Dr Lynn Greenhalgh	Medical Director
Michelle Turner	Chief People Officer
Sarah Walker	Non-Executive Director
Gary Price	Chief Operating Officer
Gloria Hyatt MBE	Non-Executive Director
Tracy Ellery	Non-Executive Director / Vice-Chair
Louise Martin	Non-Executive Director
Jackie Bird MBE	Non-Executive Director

IN ATTENDANCE

Matt Connor	Chief Information Officer
Nashaba Ellahi	Deputy Director of Nursing & Midwifery
Yana Richens	Director of Midwifery (until item 234)
Heledd Jones	Head of Midwifery (until item 234)
Angela Winstanley	Quality & Safety Matron (until item 234)
Debby Gould	Quality Improvement and Safety Lead, Cheshire and Merseyside Local Maternity and Neonatal System (LMNS) (until item 234)
Catherine McClennan	Senior Responsible Officer, Cheshire and Merseyside Local Maternity and Neonatal System (LMNS) (until item 235)
Tim Gold	Designate Chief Transformation Officer
Lesley Mahmoud	Member of the Public
Felicity Dowling	Member of the Public
Teresa Williams	Member of the Public
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Prof. Louise Kenny CBE	Non-Executive Director / SID
Dianne Brown	Chief Nurse

Core members	**Jan 23**	**Feb**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan 24**
Robert Clarke - Chair	⚐	⚐	⚐	⚐	⚐	⚐	⚐	⚐	⚐	⚐	⚐	⚐
James Sumner – Chief Executive	Non-member										⚐	⚐
Kathryn Thomson - Chief Executive	⚐	⚐	⚐	⚐	⚐	⚐	⚐	⚐	⚐	⚐	NM	
Tracy Ellery - Non-Executive Director / Vice-Chair	⚐	⚐	⚐	A	⚐	A	⚐	⚐	⚐	⚐	⚐	⚐

Louise Martin - Non-Executive Director	🏳	🏳	🏳	🏳	🏳	A	🏳	A	🏳	🏳	🏳	🏳
Prof Louise Kenny - Non-Executive Director	🏳	🏳	🏳	🏳	A	A	🏳	🏳	🏳	🏳	🏳	A
Dianne Brown – Chief Nurse	🏳	🏳	A	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	A
Gary Price - Chief Operating Officer	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳
Michelle Turner - Chief People Officer	🏳	🏳	A	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳
Dr Lynn Greenhalgh - Medical Director	🏳	🏳	🏳	🏳	A	🏳	🏳	🏳	🏳	🏳	🏳	🏳
Zia Chaudhry – Non-Executive Director	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳
Gloria Hyatt – Non-Executive Director	A	🏳	🏳	A	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳
Sarah Walker – Non-Executive Director	🏳	🏳	🏳	🏳	🏳	🏳	A	🏳	🏳	A	🏳	🏳
Jackie Bird – Non-Executive Director	🏳	🏳	🏳	🏳	🏳	🏳	A	A	🏳	🏳	🏳	🏳
Jenny Hannon - Chief Finance Officer / Executive Director of Strategy & Partnerships	🏳	🏳	🏳	🏳	A	🏳	🏳	🏳	🏳	🏳	🏳	🏳
Matt Connor – Chief Information Officer (non-voting)	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳

23/24/	
228	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. Apologies were noted as above and no new declarations of interest were made.
229	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
230	**Minutes of the previous meeting held on 14 December 2023** Subject to the following amendment, the minutes of the Board of Directors meeting held on 14 December 2023 were agreed as a true and accurate record: • Resolution for item 221c to state "Noted and received the Month ~~6~~7 2023/24 Finance Performance Review" Non-Executive Director, Jackie Bird, noted that the assurances received post-meeting regarding the Maternity & Newborn Safety Investigation Programme (MNSI) Letter of Concern, referenced in item 226, had been satisfactory.
231	**Action Log and matters arising** Updates against action log were noted.
232	**Chair's & CEO announcements** The Chair reported that a Liverpool Provider Joint Committee had been held on 21 December 2023. Progress on pathway changes had been acknowledged, along with the recognition of further opportunities for collaboration, particularly in relation to cardiac and stroke services. Enablers necessary to support collaborative efforts, with a specific emphasis on digital systems, were highlighted.

	The Chief Executive reported his recent chairing of the Women's Services Program Board noting that this body would report into the Integrated Care Board (ICB) Women's Subcommittee on progress. Risks associated with women presenting at hospital sites other than Crown Street during pregnancy were acknowledged, prompting the need for assurances of safety improvements in the immediate term, alongside plans for medium and long-term enhancements. Effective communication internally and externally with stakeholders regarding these plans was deemed essential. Further details regarding the costs of immediate safety measures at Crown Street were outlined by the Chief Executive and these had been estimated to be c. £2.5m. Pending Board approval, the ICB had indicated their agreement that the Trust could extend the deficit position and it was explained that the costs would be factored into the three-year long-term recovery plan. The Board noted the update.
233	Maternity Incentive Scheme (CNST) Year 5 2023 – Final Position Paper & Board Declaration The Chair opened the discussion, noting that CNST compliance underwent regular reviews by both the Quality Committee and the Board throughout the year. Stressing the importance of understanding the practical implications of compliance on patient safety, he sought assurance in this regard. The Head of Midwifery presented a detailed overview of the compliance status against each of the ten safety standards. Safety Action One was discussed, with particular attention given to section D. This related to deaths of babies born and deceased within the Trust requiring a multidisciplinary team (MDT) review using the Perinatal Mortality Review Tool (PMRT). The criteria required 95% of reviews to commence within two months of the death. The Trust was reporting 94.11% compliance, with 32 out of 34 cases reported to MBRACCE. It was explained that an NHS resolution letter dated October 24, 2023, allowed the rescheduling of MDT PMRT review panel meetings impacted by industrial action, accepting it if an approved action plan by Trust Boards ensured rescheduling within a 12-week period from the MIS compliance period's end. It was noted that the required action plan had been completed. The Quality Committee had expressed satisfaction with the provided assurances. Discussion for Safety Action Six focused on preventing smoking in pregnancy. The Tobacco Dependence Unit was now delivered by the Trust. Non-Executive Director, Sarah Walker, reported that the Quality Committee had explored this matter in detail in December 2023, expressing satisfaction with the plans to bring the service in-house, noting that it would provide opportunities for the enhanced auditing of data. Updates on diabetes service improvement were shared, highlighting the presence of a diabetes specialist midwife and a dietitian. However, challenges in the population cohort meant that this issue would need close monitoring. Safety Action Eight showed smoother progress with training compliance compared to previous years and this was attributed to better planning and aligned rosters. The Maternity Incentive Scheme Year 5 compliance journey was outlined, with increased external rigour and scrutiny acknowledged. Non-Executive Director, Sarah Walker, referenced a commendatory letter from NHS resolution regarding the Trust's governance approach which had been received in relation to the Year 4 submission. The Senior Responsible Person (LMNS) thanked the Trust for the presentation. She highlighted the depth and intensity of the work apparent and outlined the role of the LMNS in reviewing evidence for Year 5. It was suggested that the LMNS would retain a watching brief on the progress being made by the Trust regarding smoking cessation during the Year 6 scheme. The Chief Executive expressed encouragement for the team's attitude toward continuous improvement. The Trust Chair desired to see outlined ambitions when the Year 6 criteria become available, suggesting that this be reviewed by the Quality Committee.

	Chair's Log: For the Quality Committee to receive an overview of the Trust's approach for compliance with the Maternity Incentive Scheme Year 6 once the criteria is made available ensuring that this demonstrates adequate ambition. The Board resolved to: • Receive the final position in relation to CNST Year 5 • Give instruction to CEO and ICB Lead to sign Board Declaration form for onwards forwarding to NHS Resolution by 1 February 2024
234	Quality, Operational & Workforce Performance Report The Board considered the Quality, Operational & Workforce Performance Report. The Chief Operating Officer commenced by expressing gratitude to the teams for their support during the recent industrial action and then proceeded to highlight the following key points. Elective care performance remained above trajectory, and the Trust was now planning for 2024-25, incorporating the associated requirements e.g., expectation to eliminate 52-week waiters. Regarding cancer performance, the Chief Operating Officer acknowledged the provision of more up-to-date data in the Board pack as requested in the previous meeting. It was observed that referrals had increased, and this trend was anticipated to continue into 2024-25 – this would be factored into operational planning. Cancer 62-day performance trajectories continued to be monitored through the regional Tier 2 Cancer improvement meetings. Despite the impact of industrial action, the Trust remained on track against its trajectory as of mid-December 2023. Over the year, the number of women on a cancer pathway had decreased from 600 to 400, with improved histology turnaround times a factor supported by Liverpool Clinical Laboratories. Addressing the 28 Day Faster Diagnosis Standard, it was acknowledged that compliance remained a challenge, but confidence existed that, with additional capacity from Cancer Alliance funding and updated systems, the trajectory could be met in the current year. Non-Executive Director, Sarah Walker, raised concerns about the increase in referrals and sought clarification on the system's effectiveness in addressing inappropriate referrals. The Chief Operating Officer highlighted collaborative efforts with primary care, including a recent letter sent to GPs. The Medical Director shared the introduction of a new referral form and educational sessions for GPs. The Chief Executive noted pathways admission via the Gynaecology Emergency Department, prompting a discussion on differentials between referrals and those admitted via this route. Chair's Log: For the Quality Committee to receive data on cancer referral pathways including a breakdown of those admitted following attendance at the Gynaecology Emergency Department. The Chief People Officer referenced a small deterioration in mandatory training compliance with this attributed to increased staff absence in December 2023 due to sickness and industrial action. Improvement was expected in January and February 2024. Non-Executive Director, Jackie Bird, questioned the Trust's confidence in filling gaps outlined in the Safe Staffing Report. The Deputy Director of Nursing & Midwifery noted that a rolling recruitment program was in place but acknowledged the challenges in Advanced Neonatal Nurse Practitioner (ANNP) recruitment. To support meeting this gap, a hybrid clinical fellow post had been introduced. The Chief People Officer noted improved insight into talent pipelines and needs within Trust divisions, emphasising ongoing efforts to plan effectively. Non-Executive Director, Louise Martin, sought an explanation for reduced performance in estates and facilities metrics. She emphasised the need for a clear distinction between compliant and noncompliant ratings for statutory areas. The Chief Operating Officer acknowledged the performance deterioration, mainly attributed to staff sickness absence, with expectations of improvement as staff returned to work. Clinical areas had been prioritised to support patient safety.

	The Board of Directors received and noted the Quality, Operational & Workforce Performance Report.
235	Finance Performance Review Month 8 2023/24 The Chief Finance Officer presented the Month 8 2023/24 finance performance report which detailed the Trust's financial position as of 30 November 2023. At Month 8, the Trust was reporting a year-to-date deficit of £12.8m, indicating a £2.0m adverse variance to the planned budget. This deficit included £3.1m from non-recurrent (one-off) items. The full year forecast at Month 8 projected a £15.5m deficit, aligning with the submitted plan, but risks were highlighted. The Cost Improvement Programme (CIP) delivery was £1.1m behind the Year-to-Date target at Month 8, with a full-year target of £8.3m. The Trust was focused on rapid recovery to achieve robust, recurrent savings in both the short and long term. The cash balance at the end of Month 8 was £6.5m. In November 2023, the Trust submitted a revised forecast ('H2') to the Cheshire and Merseyside Integrated Care Board (C&M ICB) and subsequently to NHS England National team. The approved forecast indicated an adverse variance of £7.2m, resulting in a full-year deficit of £22.6m. Additional industrial action in December 2023 and January 2024 was estimated to further impact finances by £0.7m - £1m. The Board was requested to approve the formal submission of the revised H2 forecast at Month 9, projecting a £23.4m deficit, following national guidance. The Trust had strong controls in place governing the use of temporary staffing. At Month 8, the Trust had a favourable variance of £1.1m against plan. Non-Executive Director Tracy Ellery inquired about the c. £2.5 million (referenced in item 232) additional expenditure and its in-year impact, to which the Chief Executive confirmed no impact in quarter four of the financial year. Tracy Ellery also questioned the financial sustainability rating of three instead of four, with the Chief Financial Officer attributing it to effective agency control. Non-Executive Director Louise Martin highlighted Table Eight in the appendix (capital expenditure) and queried the significant variance for items marked as 'other'. It was agreed that detail would be provided to the Finance, Performance & Business Development Committee. Chair's Log: For the FPBD Committee to receive additional detail regarding the capital expenditure variance attributed to 'other'. In response to a query from the Chair, it was agreed to provide additional narrative to the next Board meeting regarding the confidence for the Aligned Payment Incentive trajectory. Action: To provide additional narrative to the next Board meeting regarding the confidence for the Aligned Payment Incentive trajectory. The Board of Directors: • Noted and received the Month 8 2023/24 Finance Performance Review • Approved the revised 'H2' forecast outturn of £23.4m deficit for 2023/24, with a tolerance of £0.2m.
236	Charitable Funds Annual Report & Accounts 2022/23 The Chief Finance Officer informed the Board that the documents were being submitted for approval, considering the Board's role as the charitable trustee. The accounts underwent review by an independent examiner, and a letter of representation was included in the meeting pack. It was emphasised that submission to the Charity Commission was required before 31 January 2024.

	Non-Executive Director, Zia Choudhry, Chair of the Charitable Funds Committee, confirmed the Committee's satisfaction with the annual accounts and report and the Committee had recommended approval to the Board. Notably, progress had been achieved in resolving the interindebtedness position between the charity and the Trust, reaching an acceptable level. The meeting acknowledged that the Charity's strategy was under development and would be submitted for consideration and approval at the February 2024 Board meeting. The Board of Directors approved the 2022/23 Annual Report and Accounts in its role as the Corporate Trustee of the Charity. *The following item was withdrawn from the consent agenda and discussed accordingly.*
237	Emergency Preparedness, Resilience and Response (EPRR) Assurance 2023/24 The Chair highlighted that due to the Trust reporting a non-compliance position, the item was removed from the consent agenda for Board discussion. The Chief Operating Officer provided context, noting that the NHS England assurance process for checking the EPRR Core Standards submissions had changed significantly for 2023/24. Compliance levels across trusts in the Cheshire & Merseyside system had been uniformly lowered, and it was explained that the assessment of the Trust having partially compliant areas was not indicative of a lack of organisational preparedness but rather due to a call for increased evidence. An action plan detailing how the Trust would progress with areas of non-compliance was being developed, with updates of progress required every three months via Local Health Resilience Partnership meetings. Since the check and challenge several standards had already been improved upon to fully compliant. The Chief Executive, drawing from experience at Liverpool University Hospitals NHS Foundation Trust, suggested presenting a timeline and trajectory for the completion of necessary actions. Non-Executive Director Jackie Bird inquired about the possibility of peer review for the Trust's submitted evidence. The Chief Operating Officer noted that this would be explored but provided assurance that the Trust's internal team had recently been strengthened, enhancing the capacity for evidence review. The Board of Directors • Noted the Trust's EPRR assurance score as non-compliant and • Agreed that the FPBD Committee would continue to oversee increased compliance through 2024.
238	Review of risk impacts of items discussed The Chair identified the following risk items: • Delivery of the Maternity Incentive Scheme to ensure enhanced patient safety and deliver the financial rebate – the assurance received at the meeting was noted as positive. • On-going challenges resulting from Industrial Action whilst acknowledging the support from staff. • Cancer performance • The Trust's financial position, particularly with the potential for extending the deficit in 2024/25.
239	Chair's Log The following Chair's Logs were noted: • For the Quality Committee to receive an overview of the Trust's approach for compliance with the Maternity Incentive Scheme Year 6 once the criteria is made available ensuring that this demonstrates adequate ambition.

	• For the Quality Committee to receive data on cancer referral pathways including a breakdown of those admitted following attendance at the Gynaecology Emergency Department. • For the FPBD Committee to receive additional detail regarding the capital expenditure variance attributed to 'other'.
240	Any other business & Review of meeting None noted. Review of meeting No comments noted.
241	Jargon Buster Noted.

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
8 February 2024

Key	Complete	On track	Risks identified but on track	Off Track

Meeting Date	Ref	Agenda Item	Action Point	Owner	Action Deadline	RAG Open/Closed	Comments / Update
11 January 2024	23/24/235	Finance Performance Review Month 8 2023/24	To provide additional narrative to the next Board meeting regarding the confidence for the Aligned Payment Incentive trajectory	Chief Finance Officer	~~February 2024~~	Complete	Included within item 253d
9 November 2023	23/24/185b	Workforce Performance Report	For future workforce reports to include a more granular understanding of staff morale, break compliance and frequency of shift changes in areas beyond maternity.	Chief People Officer	~~February 2024~~ April 2024	Risks identified	To be considered as part of an overall review of the Integrated Performance Report.
12 October 2023	23/24/164	Mortality and Learning from Deaths Report Quarter 1, 2023/24	For additional clarity to be provided on the oversight framework in place at Trust, System and Regional levels for neonatal mortality.	Medical Director	February 2024	Complete	Included within item 251c
12 October 2023	23/24/164	Mortality and Learning from Deaths Report Quarter 1, 2023/24	To ensure that commentary regarding ethnicity being a potential contributory factor to mortality be included within future learning from deaths reports.	Medical Director	February 2024	Complete	Included within item 251c – full year analysis planned for next quarterly report.
12 October 2023	23/24/161	Maternity Staffing report 1 January-30 June 2023	For future bi-annual maternity staffing reports to include additional context including C-Section and IoL rates and how these impact staffing models.	Chief Nurse	February 2024	Complete	Included in item 250

14 September 2023	23/24/134a	Perinatal Quality Surveillance & Safety Dashboard	To provide a briefing to the Board explaining the long-term increase in the C-Section and Induction of Labour rate.	MD	~~November 2023~~ April 2024	Risks identified	Requested that this action be deferred due to current capacity challenges in the obstetric consultant workforce.
14 September 2023	23/24/131	Patient Story	To explore the formalisation of collaboration and joint working with mental health care providers relating to the Trust's menopause service.	MD	April 2024	On track	
13 July 2023	23/24/084	Staff Story	For the Board to receive an update in six months on the progress made to improve the accessibility of the Trust's estate	COO	February 2024	Complete	To be updated in item 247

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	11.01.2024	To receive additional detail regarding the capital expenditure variance attributed to 'other'.	FPBD	February 2024	Open	
Delegated	11.01.2024	To receive data on cancer referral pathways including a breakdown of those admitted following attendance at the Gynaecology Emergency Department.	Quality	February 2024	Open	
Delegated	11.01.2024	To receive an overview of the Trust's approach for compliance with the Maternity Incentive Scheme Year 6 once the criteria is made available ensuring that this demonstrates adequate ambition.	Quality	March 2024	Open	
Delegated	09.11.2023	To assess the deliverability of the Trust's established Equality, Diversity & Inclusion corporate objectives. Executive Lead: Chief People Officer	PPF	January 2024	Closed	Reported in PPF Committee item 23/24/100

Delegated	09.11.2023	To receive an update on the work underway to review the model of care currently provided at the HDU and for this to also consider the evolving health needs of the population.	Quality Committee	February 2024	Open	Scheduled for the February 2024 Committee
Delegated	09.11.2023	To explore the potential opportunities to support the Trust's Volunteer Service.	CFC	January 2024	Open	Discussion underway between Volunteer team and Fundraising to explore potential funding support.
Delegated	14.09.2023	To undertake a full review of the current speak up arrangements and the underpinning cultural programmes of work to support that; with a specific focus on the approaches and mechanisms in place to support those members of staff who may have cultural barriers to speaking up. Executive Lead: Chief People Officer	PPF	January 2024	Closed	Reported in PPF Committee item 23/24/79

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/249***		**Date: 08/02/2024**	
Report Title	**Chief Executive's Report**			
Prepared by	***James Sumner, Chief Executive Officer***			
Presented by	***James Sumner, Chief Executive Officer***			
Key Issues / Messages	***To provide the Board of Directors with details of key activities and issues from the Chief Executive since the last update in December 2023.***			
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 of Directors is asked to note the content of the report.			
Supporting Executive:	***James Sumner, Chief Executive 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* N/A	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 report sets out details of key issues the Board need to be appraised of, and activity which the Chief Executive has been involved in, since December 2023.

MAIN REPORT

ITEMS FOR INFORMATION

Care Quality Commission – Unannounced Inspection

The Trust received an unannounced Care Quality Commission (CQC) inspection of our Maternity services on 15 January 2024. The inspection was part of the process for the Regulator to review the actions taken by the Trust in relation to the Section 29A Warning Notice, received in January 2023.

I'd like to thank everyone who was on hand during the inspection to welcome the inspection team and to give them everything they needed. It was encouraging to see that we were able to demonstrate confidence and assurance in everything that we are doing.

There were no major issues of concern to report during the inspection and the initial feedback from inspectors was positive. The CQC requested additional information following their inspection and the Trust has responded in a timely way. We will now await an inspection report from the CQC in due course.

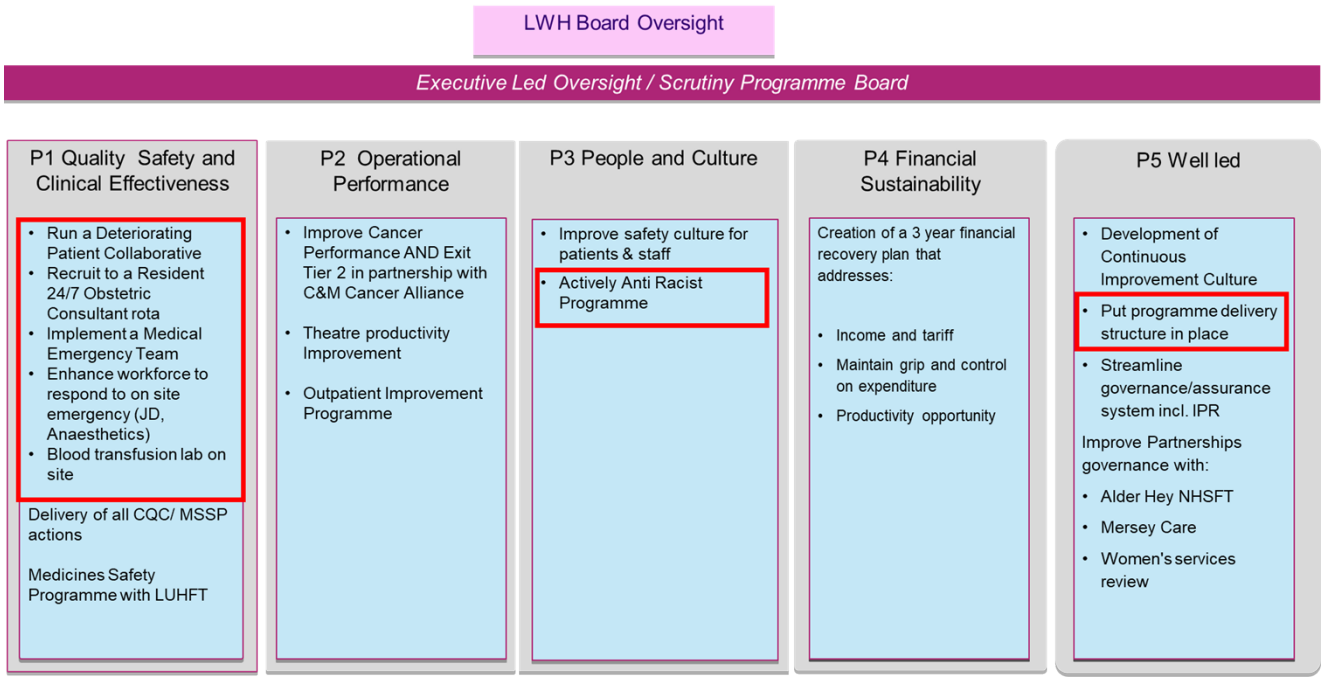
System Oversight Group

The National Oversight Framework (NOF) was established by NHS England to monitor Integrated Care Boards (ICBs) and NHS trusts. It aims to ensure quality care, access, financial stability, and effective leadership and uses five national themes for assessment: quality, access, prevention, resources, and leadership. Trusts are placed in a segment following assessment with a sliding scale of autonomy and intervention from segment one (least) to segment four (most). The Trust has been placed in segment 3 and as a result the Trust attends System Oversight Group meetings with the Cheshire & Merseyside Integrated Care Board (ICB). The first two meetings have been focused on developing the exit criteria for the Trust to move from segment three to segment two and this is now close to finalisation. A key mechanism for the Trust to deliver the necessary actions is through the development of an improvement programme – please see the section below for further details.

Improvement Programme

Over the next few weeks, the Trust will be launching a Trust Improvement Programme across the organisation. This will help to align our Trust priorities across several key workstreams and will also filter down across divisions to ensure that there is clarity on what the key measures of performance should be.

The diagram below outlines a high-level summary of the programme and illustrates examples of what the areas of focus will be under each priority. Those areas that have been highlighted in a red box will require additional funding to deliver and further detail on this can be found in item 253e on the agenda.



Maternity and Newborn Safety MNSI Investigations programme – Site Visit

The Maternity and Newborn Safety MNSI Investigations programme is part of a national strategy to improve maternity safety across the NHS in England (formerly known as HSIB) The Maternity and Newborn Safety Investigations (MNSI) programme investigates certain cases of:

- early neonatal deaths, intrapartum stillbirths and severe brain injury in babies born at term following labour in England.
- maternal deaths in England.

On 25th January MNSI Team attended Liverpool Women's NHS Foundation for a quarterly review meeting, the team presented a summary of current cases they have reviewed and gave recommendations to the team at LWH.

In 2023 LWH referred 14 cases to MNSI, 13 for Maternity one for Gynaecology. Five cases did not meet criteria and were rejected, Nine cases were accepted 2 maternal deaths and 7 babies for cooling. Five investigations have concluded and four remain open.

The MNSI team commended LWH on the responsiveness and openness during interviews which have been conducted with staff, the team commended the Non-English Speaking Team (NEST) and the innovative work and investment on the anti-racist approach adopted throughout the Trust.

There is a specific report on the agenda regarding a recent MNSI case and the Trust's response to this.

Joint Chair Appointment

David Flory CBE has been appointed as joint Chair of Liverpool University Hospitals NHS Foundation Trust (LUHFT) and Liverpool Women's NHS Foundation Trust. He will start this joint role in March 2024.

The two Trusts have a history of working in partnership and collaboration, and the joint Chair role is designed to build on this foundation.

David was previously appointed to Chair LUHFT for a 12-month term starting in February 2023. David has a track record of delivering healthcare services and brings experience and understanding of the population health needs across Liverpool City Region.

Robert Clarke will be leaving us at the end of February after 8 years as Chair of Liverpool Women's and it is important to note the significant contribution that Robert has made to the Trust in his time here.

Executive Director Appointments

Matt Connor is our current Chief Information Officer at Liverpool Women's. He has recently been appointed as **Joint Chief Digital Officer** for Liverpool Women's and LUHFT from February. I know everyone at LUHFT will appreciate the expertise and experience he will bring from Liverpool Women's and it will be an exciting time for the Trust's two digital teams to work together more closely going forward.

Tim Gold has recently been appointed as **Chief Transformation Officer** for both Liverpool Women's and LUHFT**.** Tim has worked with LUHFT recently through his previous role at NHS England and he has a long history of transformation and improvement roles across several sectors. Tim will be joining us from the middle of February and his initial focus will be on the Trust's new Improvement Programme, as noted above.

Liverpool Women's Awarded Health Tech Team of the Year 2023/24

Liverpool Women's NHS Foundation Trust has been awarded Health Tech Team of the Year 2023/24 at the recent HTN Now Awards.

In July 2023 Liverpool Women's became the first in the UK to implement a brand new Electronic Patient Record (EPR) system, MEDITECH Expanse. Internally this was branded as 'digiCare' bringing all systems together that staff use to access patient records.

The legacy EPR system, MEDITECH Magic was implemented back in 1996 and no longer met the changing digital demands of the Trust. This was a huge change which resulted in a journey that involved all staff, at the centre was a dedicated Clinical Digital and Programme Team who led the successful delivery of the implantation with the primary focus on patient safety and the clinical processes involved.

Liverpool Women's among top 50 most inclusive UK employers for 3rd year running

Liverpool Women's NHS Foundation Trust has been ranked number 41 in the 2023 Inclusive Top 50 UK Employers List (IT50) which was officially revealed at the Inclusive Awards in December 2023.

Compiled by Inclusive Companies, the IT50 acknowledges and ranks businesses which are most consistent throughout the whole of their organisation and encompass all types of diversity.

Now in its eighth year, the Inclusive Top 50 UK Employers List is the definitive cross-industry index harnessing both best practice and innovation with the goal of driving inclusion for all. It comprises the 50 most inclusive companies in the UK as chosen by a dedicated panel of judges, based on each organisation's performance across all strands of diversity - gender, disability, age, LGBTQ+, race, faith and religion.

The depth and manner of assessment which results in the IT50 List requires organisations to show consistent and sustainable activity. "Our judging panel is looking for cultural change rather than the 'peaks and troughs' often seen by well-meaning organisations whose EDI activities are actions are in

response to national or world events making the news," says Paul Sesay, Founder and CEO of Inclusive Companies. "We work closely with organisations to create cultural transformation that ensures diversity and inclusion are embedded into everything they practice and the IT50 recognises those employers who are getting this right."

You can see the full list here: www.inclusivecompanies.co.uk/inclusivetop50/2023rankings

Liverpool Women's fertility centre becomes first in UK to offer state-of-the-art technology for managing frozen eggs and embryos

The Hewitt Fertility Centre, based at Liverpool Women's Hospital is the first UK clinic to adopt TMRW's state-of-the-art technology for the safe management of frozen eggs and embryos, providing a new standard of care for fertility patients.

TMRW Life Sciences, a fertility technology company, is expanding globally with its automated IVF lab technology now adopted in the United Kingdom. The Hewitt Fertility Centre will be the first clinic outside the U.S. to implement TMRW's CryoRobot Select (CRS), an automated platform for safe management and storage of frozen eggs and embryos. This move aligns with the UK's Health Strategy, addressing the increasing demand for assisted reproductive technology. In 2022, the government extended storage time limits for frozen eggs and embryos from 10 to 55 years. The CRS, with a 94% reduction in potential points of failure compared to manual systems, allows for digital identification, tracking, and remote monitoring, enhancing safety and precision in fertility treatments. TMRW's partnership with The Hewitt Fertility Centre signifies its global expansion and commitment to elevating care standards. The CRS received CE Mark approval in September, marking a significant milestone for TMRW's global impact.

Employee and Team of the Month

Employee of the Month goes to Thomas Austin, Learning and Development Facilitator. Tom received several nominations saying he is a shining star, a helpful and kind person who demonstrates the Trust values and behaviours. He is always very welcoming to staff and visitors alike.

Team of the Month went to the GED Team. Nominations said that they are a great team who work together during difficult and overwhelming times. They go above and beyond and are the first point of care in an emergency. They are always professional, friendly and caring.

SYSTEM / NATIONAL UPDATE

NHS Cheshire and Merseyside Integrated Care Board

Please see the link below to access to the meeting papers and webcast recording for the NHS Cheshire & Merseyside ICB meeting held on 25 January 2024:

https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/nhs-cheshire-and-merseyside-integrated-care-board/25-january-2024/

Maternity care, inequalities, and research: Victoria Atkins announces fresh women's health priorities for 2024

Victoria Atkins has laid out the government's priorities for women's health in 2024, including research, maternity and inequalities.

Speaking at the women's health summit in London, Atkins outlined a five-point plan which included:

- Bolstering maternity care
- Improving care for menstrual conditions
- Expanding women's health hubs
- Tackling inequalities and disparities
- Enabling more research

The first priority will be supported by the continued delivery NHS England's three-year plan for maternity and neonatal services, as well as ensuring women understand how they will be cared for during and after their pregnancy.

PARTNERSHIP UPDATE

Effective partnerships are a critical factor in ensuring the Trust provides safe and effective care for women, babies, and families. The Trust delivers tertiary, complex, and regional services from a site isolated from adult and paediatric acute services, therefore the Trust has established and developed a range of partnerships within Liverpool (and beyond) to ensure clinical risks are reduced, pathways are aligned where possible, and timely and appropriate transfers of care are made between organisations as required. As a small provider, the Trust also regularly reviews developing partnership arrangements to identify opportunities for economies of scale. The Trust's two largest partnerships are with Liverpool University Hospitals NHS FT (LUHFT) and Alder Hey NHS FT (Liverpool Neonatal Partnership).

Key highlights within partnership development during the last period:

- The Trust has continued to work with Alder Hey to establish broader partnership working arrangements.
- The LUHFT/LWH Partnership Board has developed a shared risk register, to ensure consistent understanding and management of shared risks across the two organisations.
- The LUHFT/LWH Partnership Board has developed a performance dashboard to better understand the volume of transfers between organisations and the volume of pregnant patients treated at LUHFT.
- The LUHFT/LWH Partnership Board is exploring joint operating models to strengthen and create more resilience within anaesthetics and community diagnostic services.
- The Trust has continued to engage with the Liverpool Adult Congenital Heart Disease (ACHD) Partnership, and St Mary's Hospital in Manchester, to provide safe and effective care for pregnant women with ACHD.
- Working with the Cheshire and Merseyside Acute and Specialist Trust provider collaborative, the Trust has been successful in securing £5m from the Targeted Investment Fund to develop its ambulatory estate.

A Women's Hospital Services in Liverpool Programme Board has established by the Women's Services Committee (WSC), a subcommittee of NHS Cheshire and Merseyside Integrated Care Board (ICB) in accordance with its constitution.

The Programme Board will be chaired by myself, and its primary purpose is to: *Develop a clinically sustainable model of care for hospital-based maternity and gynaecology services that are delivered in Liverpool.*

A detailed stakeholder engagement and involvement plan will be developed to ensure that all key stakeholders, including staff, patients, and the public, are involved, engaged, and communicated with on a regular basis.

Regular programme reports will be produced and formally presented to the WSC. These reports will also be provided to the LWH Board.

PERFORMANCE UPDATE

The Trust's Quality & Operational Performance Report is included separately within the meeting pack. This highlights the current performance against a range of metrics. It is the intention that this section in future reports will summarise the key indicators showing significant or statistical change.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/250***		**Date: 08/02/2024**	
Report Title	**Maternity Staffing report 1st July-31st December 2023**			
Prepared by	Heledd Jones, Head of Midwifery			
Presented by	Dianne Brown, Chief Nurse			
Key Issues / Messages	The Maternity Staffing Oversight Report outlines the requirements of Maternity Incentive Scheme Safety Action 5 and details LWH current position. This forms the required evidential standard for submission to Trust 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):			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	It is recommended that the Board accepts and receives the information in this paper.			
Supporting Executive:	***Dianne Brown, Chief Nurse***			

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: This relates to Midwifery staffing vacancies
Link to the Corporate Risk Register (CRR) – CR Number:	**Risk Number: 1705 closed on 23.11.2023**

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Trust Board		**Dianne Brown**	

EXECUTIVE SUMMARY

The Maternity Staffing paper is provided to the Board of Directors and outlines the requirements of the Maternity Incentive Scheme (MIS) Safety Action 5 (SA5). The report sets out the Liverpool Women's NHS Foundation Trust (LWH) position in the context of midwifery staffing. This report covers the six-month period from 1st July 2023 to 31st December 2023 as is required for MIS. There was a request by Trust board to include additional information on Induction of Labour and Caesarean Section and how this affects staffing within this paper.

The report highlights the following areas for discussion and noting (July-December 2023).

- LWH midwifery and Maternity Support Workers (MSW) budgeted posts for financial year 2023/24 equates to 357.26wte, which includes 3.73wte additional MSW.
- Budgeted posts are inclusive of 23% headroom for midwives and 21.4% uplift for MSW.
- Vacancy rate is 9.82wte in month 9 (December 2023). Total recruitment in progress is 9.82wte. New recruits will commence in post between February-March 2023, on receipt of their NMC Pin number.
- Sickness absence rate is 8.61% in December 2023 which is a reduced position from the same period in 2022 at 12.41%.
- Midwife: Birth ratio in December 2023 is 1:20 against a national recommendation of 1:28.
- There were 201 red flags reported between July- December 2023 which is an increase of 108 from the previous reporting period (January 2023-July 2023) where 93 red flags were reported. Majority of the red flags relate to delays in ongoing Induction of Labour, owing to capacity and demand. An induction of labour Quality Improvement project is established, with estates work scheduled to be completed 29.2.24 to create a separate IOL area consisting of 5 rooms. This will help to improve patient flow on Delivery Suite to be able to expedite IOL patients to continue the process whilst also improving the patient experience.
- Of significance is the reduction in the number of midwifery red flags reported during the last two years, 294 MRF reported in 2023 in comparison to 427 in 2022.
- Supernumerary shift co-ordinator on Delivery Suite is maintained at 100% for the past six months.
- 1:1 care in labour achieved a compliance rate of 99.59% - 100% in the reporting period, against a standard of 100%.
- The CS rate in 2023 at LWH was 43.83% an increase of 3.05% compared to CS rate in 2022. Overall, 1 in 4 women have an operative birth in LWH.
- The average rate of planned IOL in 2023 at LWH was 38.08% 1.72% below the average rate in 2022.
- With the increase in operative birth, it is recommended that a BR+ Audit be included in the annual workforce planning of Maternity Services at LWH.

It is recommended that the Board accepts the information in this paper as assurance that there are robust systems and processes in place that fulfil the requirements of CNST MIS, SA5.

1.0 Introduction

To provide the Trust Board with a six-monthly update of the 2023/2024 staffing establishment reviews in relation to midwifery workforce requirements. To report against the workforce requirements identified in 2023/2024 to achieve safe staffing across Maternity Services in the Trust.

2.0 Workforce planning- Birth Rate Plus

The Maternity Incentive Scheme (MIS) Year 5 Safety Action 5 requires that Trusts demonstrate an effective system of midwifery workforce planning. Birth Rate Plus (BR+) is a recognised tool for workforce planning and strategic decision-making. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour.

A Birth Rate plus refresh audit was completed in April 2023 and the report received in May 2023. Included in the assessment is the staffing required for antenatal, intrapartum, and postnatal inpatient and outpatient services, including community births. Birth Rate+ calculates the clinical establishment based on agreed standards of care and includes the midwifery management and specialist roles required to manage maternity services. A skill mix of 90/10 is applied to clinical staffing between midwives and maternity support workers (Band 3). The recommendation is to provide total care to women and their babies over 24 hours, 7 days a week basis, inclusive of the local percentage for annual, sick & study leave allowance and for travel in community. 23% uplift for midwives and 21.4% uplift for MSW's has been calculated to enable this.

3.0 Maternity Staffing Establishments

Birth Rate Plus refresh audit was completed in maternity at LWH in April 2023 based on FY22/23 annual activity and total births of 7386 (1st April 2022-31st March 2023). The report published in May 2023 recommended a workforce establishment of 353.53wte inclusive of 90:10 skill mix (90% midwives and 10% maternity support worker).

LWH midwifery and MSW budgeted posts for financial year 2023/24 equates to 357.26wte, which includes 3.73wte additional Maternity Support Workers,

CNST Maternity Incentive Scheme Year 5, Safety Action 5 requires a clear breakdown of Birth Rate+ or equivalent calculations to demonstrate how the required establishment has been calculated. In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of Birth Rate+ or equivalent calculations. Where Trusts are not compliant with a funded establishment based on Birth Rate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. The plan to address the findings from the full audit or tabletop exercise of Birth Rate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

Midwifery and MSW funded establishment 2023/24 compared to the Birth Rate Plus audit requirements (May 2023) illustrated below in Table 1:

Maternity Tables - 2023/24

Table 1 - Funded Establishment	2023/24 BRP Reccomendation Wte	2023/24 LWH Funded Establishment Wte	2023/24 Variance Budget to BRP Wte
Clinical	287.87	287.37	- 0.50
Clinical - Support Staff	30.11	34.14	4.03
Total Direct Care Giving Midwives	317.98	321.51	3.54
Non-Direct Care	35.55	35.75	0.20
Total Budget to BRP Model	353.53	357.26	3.73
Clinical		8.17	
Clinical - Support Staff		50.90	
A&C		31.20	
Total Funded Roles outside of the BRP Model	-	90.27	-
Total Establishment	353.53	447.53	3.73

Table 1- Funded establishment 2023/24

3.1 Care Hours Per Patient Per Day (CHPPD)

	DAY Average fill rate Midwives (%)	DAY Average fill rate Support staff (%)	NIGHT Average fill rate Midwives (%)	NIGHT Average fill rate Support staff (%)
Induction of Labour and Delivery Suite	82.25%	86.9%	85.95%	94.2%
Maternity Base and Jeffcoate	88.95%	101.65%	84.2%	99.9%
Midwifery Led Unit (MLU)	85.05%	65.75%	83.2%	70.75%
Care hours per patient per day	**Midwives**	**Support staff**	**Overall**	
Induction of Labour and Delivery Suite	14.6	2.5	17.1	
Maternity Base and Jeffcoate	2.4	1.1	3.5	
Midwifery Led Unit (MLU)	35.4	7.7	43.1	

Table 2: Safe Staffing, Rota Fill Rates December 2023

Data in Table 2 is the rota fill rates for December 2023. CHPPD relates only to hospital wards where patients stay overnight and is calculated by taking all the shift hours worked over the 24-hour period by Registered Midwives and Maternity Support Workers and dividing this by

the number of patients occupying a bed at midnight. The data is aggregated each day over the month. In maternity mothers and babies are included in the census.

CHPPD data is rarely referenced in Maternity Services, and not included in national reports. However, maternity services do review CHPPD and comment on this within the monthly fill rates report submitted within the integrated board report that Trust Board receives each month.

It is important to note that the use of CHPPD will only capture the care hours provided to each bed and does not capture all the activity on the ward such as the turnover of patients through that bed within the 24-hour period or recognise the acuity of the patient receiving the care.

By itself, CHPPD does not reflect the total amount of care provided on a ward nor does it directly show whether care is safe, effective, or responsive. It should therefore be reviewed alongside patient acuity and dependency data as CHPPD is not a metric to either determine registered nurse/ midwife requirements nor provide assurance for safe staffing.

CHPPD data does not routinely capture; part shifts worked by staff, supervisory ward managers and the flexible use of staff across a service pathway, such as a staff member moving to another ward for a shift/part of shift. These staffing strategies, along with factors such as, the acuity/dependency of the patients on the ward, and if there are any empty beds, allow the Matrons to risk assess staffing provision on a shift-by-shift basis to maintain safe staffing levels.

3.2 Maternity Staffing (Planned versus Actual)

Maternity has a process for daily review of planned versus actual staffing, this information is fed into the Trust bed meetings that occur three times per day. In addition, staffing is reported Trust wide in the daily virtual huddle (Bronze command) which consists of senior managers and the manager on call. LWH procure the services of NHS Professionals to fill bank shifts and if required agency shifts, to support temporary staffing shortfalls. Twice weekly meetings are held to monitor staffing fill rates and to allocate bank shifts to ensure consistent and safe staffing levels. Bank shifts have consistently been allocated to provide safe midwifery staffing cover owing to maternity leave and sickness.

One of the main service priorities is to maintain safe midwifery staffing levels. Maternity staffing and acuity are assessed on a 4hrly basis by the Maternity Bleep Holder and should staffing fall by the numbers of midwives to provide safe care, the Maternity Escalation Guideline (V3.4) is followed which includes the redeployment of staff. Midwives and MSW undertake a rotational training programme, allowing midwives to rotate between all clinical areas, ensuring a workforce that are skilled to work across all clinical areas of the maternity service. The Maternity Bleep holder consistently reviews staffing with the aim of redeploying non- direct care givers to address periods of high acuity in clinical activity to maintain a safe clinical staffing ratio.

4.0 Maternity Workforce Measures

4.1 Midwifery vacancies:

Maternity Tables - 2023/24

Table 1 - Funded Establishment	2023/24 BRP Reccomendation Wte	2023/24 LWH Funded Establishment Wte	M9 Contracted Establishment Wte	M9 Variance to Budget Wte
Clinical	287.87	287.37	284.55	2.82
Clinical - Support Staff	30.11	34.14	27.11	7.03
Total Direct Care Giving Midwives	317.98	321.51	311.66	9.85
Non-Direct Care	35.55	35.75	35.78	- 0.03
Total Budget to BRP Model	353.53	357.26	347.44	9.82
Clinical		8.17	6.32	1.85
Clinical - Support Staff		50.90	57.25	- 6.35
A&C		31.20	29.98	1.22
Total Funded Roles outside of the BRP Model	-	90.27	93.55	- 3.28
Total Establishment	353.53	447.53	440.99	6.54

Table 4a: Midwifery vacancies

4.2 Recruitment Table 4b lists the Midwifery recruitment pipeline together with tentative dates for commencing employment in maternity services at LWH.

Recruitment	
Recruited staff Band 5 and 6 (commencing in post month 11 & 12).	9.82wte
Total recruitment in progress	9.82wte

Table 4b**:** Recruitment in progress

Maternity has 19.24% (22 heads) ongoing maternity leave, with projected 13wte rolling rate. The workforce profile is reviewed monthly by the senior midwifery team with support from the HR Business Partner. Approval to over recruit has been requested taking into consideration the 3.0wte monthly midwifery attrition rate and projected 13wte rolling basis of maternity leave.

Quarter 3 of the current financial year resulted in a successful midwifery recruitment campaign, with the employment of 34 newly qualified midwives, resulting in nil vacancies in month 7. Months 8 & 9 have seen a monthly attrition of 3wte mainly due to retirement and a steady stream of midwives requesting to reduce contracted hours, with the objective of improving work/home life balance.

4.3: Sickness absence

Whilst sickness absence is a continuing challenge in the service, there are improvements being seen in the overall sickness rate which stood at 8.61% in December 2023, in comparison to 12.41% in December 2022 (table 5). Sickness across Maternity was at 6.44% in July 2023, which is a four-month downward trend, and it is the lowest rate seen since August 2020. The sickness in maternity was at its lowest rate in 12 months. The four-month positive trend in Maternity ceased in August 2023 following an increase in sickness absence to 7.94% (1.5% increase). The increase is attributed to short term absence in month with the

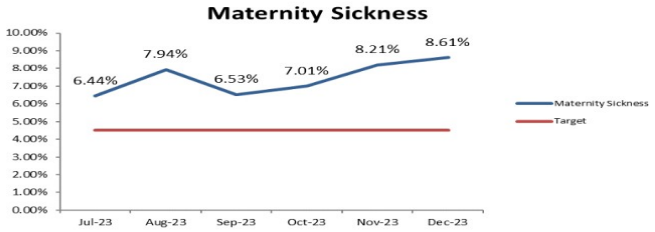
services most prevalent occurrences (bar 28 days +) taking place between 0-1 and 1-2 days which equates to 18 and 14 occurrences respectively. The increase seen in Maternity sickness in August 2023 improved in September 2023 to stand at 6.53% (1.41% improvement) and this takes the service back to a comparable % as seen in July 2023. As previously, bar LTS absence (28 days +), the most absences in month occurred at 0-1 day (21 occurrences) and 2 days (18 occurrences).

Sickness across Maternity increased slightly to 7.01% for October 2023. Weighting in Maternity is towards LTS cases at 53%. In November 2023, a further increase is seen at 8.21%, and this follows a pattern in recent years whereby sickness increases in the winter months. At the same point in November 2022, sickness in Maternity stood at 12.41%. Weighting in service is towards LTS cases at 62% in Maternity, following a more equal balance last month, this reflects several absences moving into the formal long-term process in month. Sickness in Maternity has slightly increased in December 2023, to stand at 8.61% overall. Again, the increase seen follows a pattern in recent years whereby sickness increases in the winter months. Weighting in the service for December 2023 is towards LTS cases at 62% in Maternity.

Divisional sickness reviews continue as does the emphasis on completing return to work interviews. Regional data continues to identify the North-West as the highest region for absence at 5.8% in August 2023, however the Trust was no longer an outlier in this period with a rate of 5.4% against other Trusts reporting 6% and above. As a comparator, Birmingham Women's & Children's NHS Foundation Trust were reporting an absence level of 5.0% in the same period.

Robust management practice continues, and assurance can be provided that where there is LTS sickness, cases are managed in line with policy with the majority of current LTS cases in the 0–3-month timescale.

Table 5: Sickness absence



4.4: Turnover

Staff turnover for 2023 is 7.85% which is 5.15% below the Trust threshold of 13%. Overall, there are no concerns to raise with respect to turnover in the service and the matter of retention is linked to both the wider Maternity Transformation agenda and the recently published NHS Long Term Workforce Plan.

The service continues to receive retire and return requests, along with general flexible working requests, these are considered on a weekly basis by the senior midwifery leadership team to ensure consistency and fairness in decision making.

4.5 Age Profile

Registrants

Majority registrants (midwives) employed in LWH Trust are in the 31-35 age group (12.28%), followed by 10.53% in the 26-30 age group. This reflects the work that is required to retain midwives at the Trust and the investment in the Preceptorship team, not only to provide clinical support but also pastoral care. Of notable significance is the reduction in the number of staff in the 60+ age group, however 9.43% of the midwifery workforce are in the 56-60 age group. Late career midwives require specific support in terms of sharing their years of experience whilst they wind down in preparation for retirement. (Table 6 Age Profile of Staff at LWH).

Support workers

An opposite is seen in the support worker age profile with the majority support workers employed in maternity services being in the 51-55 age group (3.73%) followed by the 36-40 age group (3.07%). The service is exploring opportunities for support workers to develop their careers along the midwifery apprenticeship routes.

Maternity	HCA	NMC
<20Years	0.00%	0.00%
21-25	1.54%	8.55%
26-30	1.10%	10.53%
31-35	1.10%	12.28%
36-40	3.07%	9.43%
41-45	1.75%	9.21%
46-50	2.19%	7.46%
51-55	3.73%	7.24%
56-60	2.41%	9.43%
61-65	3.07%	4.82%
65-70	0.22%	0.44%
71years	0.22%	0.22%
	20.39%	**79.61%**

Table 6: Age Profile December 2023

5.0: Training and Personal Development Reviews (PDR)

Maternity services have undertaken a key piece of work to improve the ongoing challenges faced with being unable to achieve training and PDR thresholds as noted in Table 7. The Division have placed themselves in oversight, with weekly check and challenge by the Head of Midwifery at the Senior Midwifery Leadership Operational Group meetings. All training and

PDR compliance data is reported monthly at Family Health Divisional Board. Notable improvement is evident in the last 6 months.

	31.6.2023	31.12.2024
Mandatory	86.84%	89.93%↑
Clinical	76.18%	88.90%↑
Local	76.75%	91.73%↑
PDR	81.03%	85.45%↑

Table 7: Training and PDR

6.0 Quality of Care measurements:

6.1 Midwife to Birth Ratio

National recommendations suggest a 1:28 midwife to birth ratio, this ratio is monitored monthly through the maternity dashboard and published externally as part of our Strategic Clinical Network (SCN) dashboard. At present the maternity service is reporting a ratio of 1:20 (December 23 position, Table 8) which is reflective of midwifery turnover and current vacancy.

Midwife to Birth					
July 23	August 23	September 23	October 23	November 23	December 23
1:23	1:21	1:21	1:20	1:19	1: 20

Table 8: Midwife to birth ratio

6.2 Supernumerary Shift Coordinator on Delivery Suite

Within LWH Labour Ward, supernumerary shift leader compliance is consistently maintained at 100% as listed (Table 9). This role is pivotal in providing oversight into all birth activity within the Labour Ward, Maternity Assessment Unit and Maternity Base Ward, and provides a helicopter view of all staffing/workforce requirements as well as birth activity. During night-time hours the Labour Ward shift co-ordinator carries the maternity bleep (104) for maternity services. The Labour Ward shift co-ordinator is rostered independently from the core midwifery staffing, and this is evidenced in e-roster with a distinct marker against the shift coordinator indicating supernumerary status.

Supernumerary Shift Coordinator					
July 23	August	September	October 23	November	December
100%	100%	100%	100%	100%	100%

Table 9: Supernumerary status

6.3: 1:1 Care in Labour

NICE (2021) guidance supports one to one care in established labour, as one of the indicators of effective midwifery workforce planning. LWH has consistently across intrapartum areas of Midwifery Led Unit (MLU) and Labour Ward (Consultant high risk care), achieved a compliance rate between 98.62% and 100% in this reporting period.

1:1 Care in Established Labour					
July 23	August	September	October 23	November	December
100%	99.79%	100%	99.59%	99.57%	100%

Table 10: 1:1 midwifery care in labour

MIS (Year 5), Safety Action 5 requires organisations to produce an action plan when compliance is less than 100%. As part of the review of the non-compliance to this required standard, each case where 1:1 care is not achieved has been reviewed to ensure no adverse clinical outcomes have occurred. The common themes identified for non-compliance include midwifery sickness and an increase in service acuity, which is reflective of the nature of maternity services including precipitate labour or presentation of a woman about to birth imminently.

This action plan held within maternity services is monitored at Maternity Risk and Clinical Meetings and reviewed as part of the assurance process to Family Health Divisional Board upwardly reporting to safety and effectiveness committee, as well as external reporting to the LMS.

To ensure patient safety, all women waiting for a bed on delivery suite or for an available midwife to provide 1:1 care in labour receive care as per Induction of Labour Guidelines (v9.1). This means that women are cared for in an induction of labour bay with care overseen by a midwife. Women waiting for transfer to delivery suite for ongoing induction of labour are subject to a twice daily multi-disciplinary review to prioritise case-based need. The Maternity bleep holder and the Multi-Disciplinary Team review inductions of labour who are scheduled to come in the following day to identify and pre-empt any areas of challenge. All red flags are reviewed in Maternity Clinical Risk meeting.

6.4 Increasing rates of Induction of Labour (IOL) and operative birth effect on the midwifery workforce:

Induction of Labour (IOL)

Rates of IOL are approximately 1 in 10 pregnancies globally, and 1 in 4 in high income countries (Jones et al. 2022). Rates of IOL have risen steadily over the last 15 years, with UK induction rates rising from 20.4% in 2007-8 to 33% in 2022 (NHS Digital, 2022). Whilst this may be attributed to an increase in complex pregnancies over this period (National Maternity Review, 2015) there are also increasing rates of women opting to undergo elective IOL for non-medically indicated reasons, often termed “social inductions”.

The average rate of planned IOL in 2023 at LWH was 38.08% in 2023 1.72% below the average rate in 2022. This reflects the increased clinical demand for IOL driven by nationally implemented programmes: Each Baby Counts (2020) report and the subsequent Saving Babies Lives Care Bundles (SBLCB V1,2 and 3). The rate of IOL has risen steadily over the last 10 years (NHS Digital, 2023) with subsequent delays in the induction process as services attempt to meet demand. At LWH we are responding to the increase through workforce planning and re-configuration of estates in the maternity unit. The Senior Leadership team recognise the issues with ongoing delays in IOL and a Task and Finish group has been convened along with an Estate reconfiguration developed and approved by Executive Team, to create 5 additional IOL beds. Estate work is in progress and is on

trajectory to be completed by the 29th February 2024. Incidents of delays to commencement and ongoing IOL are reported as midwifery red flags indicators within midwifery staffing reports and on review of the data there have been less delays in IOL during 2023, in comparison to 2022.

Induction of Labour rates	2022	2023
July	38.2%	38.2%
August	40.9%	38.7%
September	39.7%	38.9%
October	40.7%	39.4%
November	37.8%	37.6%
December	41.5%	35.7%
CS average rate (6 months)	**39.8**	**38.08**

Table 11: Induction of Labour (IOL) rates

Caesarean Section (CS):

NICE guidance on CS (2021) recommends that when a woman with no medical indication for a caesarean birth requests a CS, health professionals must ensure that women receive balanced and accurate information and offer to discuss alternative birth options which may help address concerns they have about the birth. However, if women persist in their request for a CS a planned CS should be made available. Currently 31% of births in the UK is by CS with approximately 16% by elective CS. In the past 20 years, the c section rate in the UK has risen by roughly 50% from 1 in 5 to 1 in 3 births.

The average rate of CS in 2023 at LWH was 43.83, an increase of 3.05% in comparison to the average CS rate in 2022. (Table 12) Overall, 1 in 4 women have an operative birth in LWH.

Caesarean Section rates	2022	2023
July	41.47%	42.31%
August	41.47%	45.77%
September	39.38%	44.06%
October	41.92%	42.21%
November	40.27%	42.88%
December	40.20%	45.75%
CS average rate (6 months)	**40.78%**	**43.83%**

Table 12: Caesarean Section rates

The increase in operative birth and IOL adds to the workload of midwives and maternity support workers, owing to increased length of stay, antenatally for women undergoing IOL and post-natally for women undergoing CS. A Birth Rate Plus audit was completed in LWH in April 2023 and the results reported in May 2023. Birthrate Plus is responsive to local factors such as demographics of the population, socio-economic needs, complexity of care and associated services. An individual service will produce a case mix based on clinical indicators of the wellbeing of the mother and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and

delivery and the degree to deviations from obstetric normality. Five different categories are created, the lower the score the more normal are the processes of labour and delivery. The case mix in LWH indicates that just over 60% of women are in the 2 higher categories IV and V which is slightly above the average for England of 58% based on 55 maternity units from a wide range of size and location. This is reflective of the increasing rates of IOL and caesarean sections which are being performed.

With the increase in operative birth, it is recommended that a BR+ Audit be included in the annual workforce planning of Maternity Services at LWH.

6.5: Midwifery Continuity of Carer (MCoC)

A paper detailing a review of the interim (6 month) suspension of the Midwifery Continuity of Carer (MCoC) model at Liverpool Women's NHS Foundation Trust was presented to Quality Committee in November 2023.

Detailed in the paper was the current hybrid / shift-based model that has been in place since May 2023, which was rolled out to release midwifery hours to support safe staffing levels within the inpatient areas following the CQC inspection, whilst also maintaining an element of enhanced support for the most vulnerable women who were allocated to the MCoC pathway.

The paper also included what the effect of the new model of MCoC (Table 13) had on both midwife and patient satisfaction levels over the past 6 months, and the recommendation to continue with this model for the next 12 months.

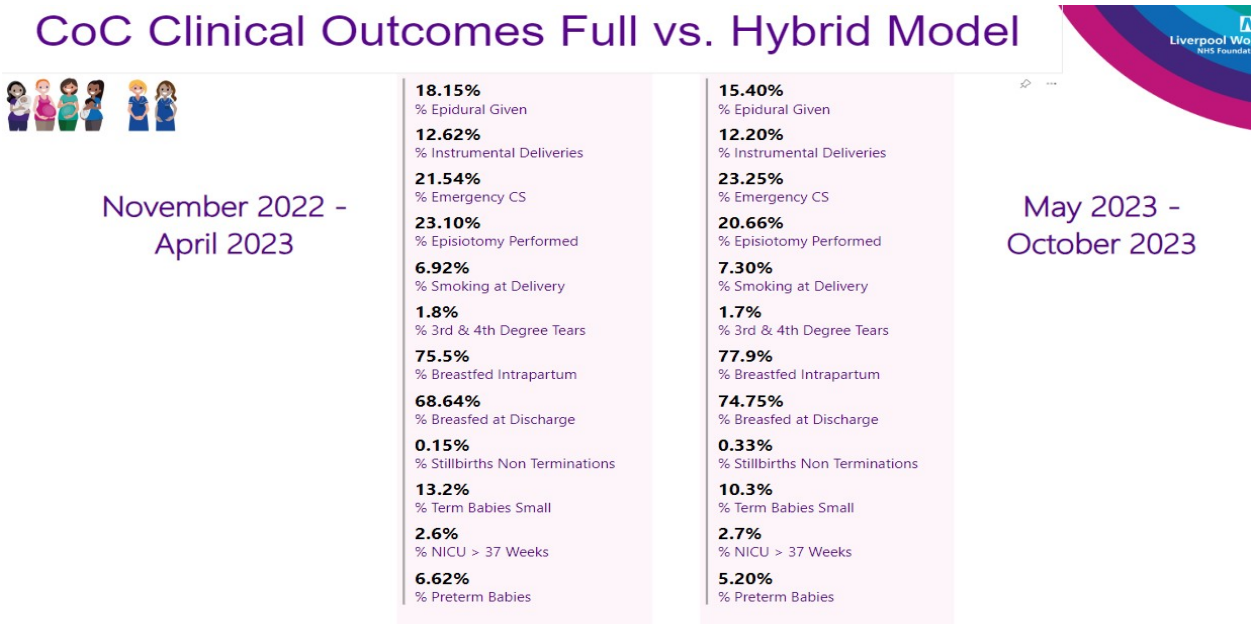
Prior to the suspension in May 2023, the MCoC teams were very successful in achieving the evidence-based objectives set out in the Better Births Report (2015) and the Cochrane Systematic review Sandall (2016). Outcomes demonstrated that women on this MCoC pathway had lower numbers of epidurals, instrumental deliveries, emergency caesareans, NICU admissions <37 weeks. Lower numbers of women reported smoking at delivery, and more women were breast feeding at delivery and discharge from midwifery care. Whilst the new model is limited to 6 months of data, indications are that these positive outcomes continue.

The staff within these teams have worked hard to ensure that disruption to the continuity in the antenatal and postnatal period was minimal with the introduction of the new model and are commended for their dedication to the women that they have cared for during the period of transition. The change in model was, in part, also due to the continued escalation of the MCoC midwife teams and recognising the effects it had on staff retention and midwives' health and wellbeing. The paper outlined the positive changes felt by the midwives in a hybrid / shift based MCoC model.

The proposal to retain the current model for a period of 12 months, ensures that women continue to receive continuity in the antenatal and post-natal period with the opportunity for their named midwife, or one of their team to care for them in labour. Retaining this model also offers midwives, the ability to retain their skills in both the intrapartum area and community, thus addressing retention risks which are associated to an on-call model of MCoC. The current model has also proved attractive for newly qualified midwives who have trained to work in MCoC as students. Attracting more midwives to work in this model will enable any potential plans to roll out more MCoC teams in the future.

Approval to continue with the Midwifery Continuity of Carer, shift-based model for a 12-month period, followed by further review, was agreed by the Quality Committee

Table 13: Midwifery Continuity of Carer clinical outcomes



6.6: Birth Rate Plus Acuity App Implementation and Progress

The Birth Rate Plus Acuity App was implemented in Maternity Services in LWH in July 2022. The BR+ acuity App assesses real time staffing based on the clinical needs of women and babies for intrapartum areas. Using the BR+ classification system the App provides an assessment of women's needs during their episode of care in Labour Ward and Midwifery Led Unit, recorded in real time on a 4hourly basis. This enables service leaders to determine whether the Labour Ward and Midwifery Led Unit is adequately and safely staffed throughout the day and night.

Birth Rate plus consultancy have in December 2023 developed an App to assess women and babies needs during their episode of care on Maternity Base (Maternity Ward). Approval has been secured to implement the BR+ App on Maternity Base in February 2024.Birth Rate Plus consultancy have not declared an intent to develop an App to assess real time staffing based on the clinical needs of pregnant women who present to Maternity Assessment Units (MAU).

7.0: Clinical Incidents and Midwifery Red Flags

A total of 2595 clinical incidents were reported on Ulysses during July-December 2023, this is an increase of 591 in comparison to the previous 6 months, indicating a positive reporting culture, which encourages improvement and learning. Top 5 causes are listed below:

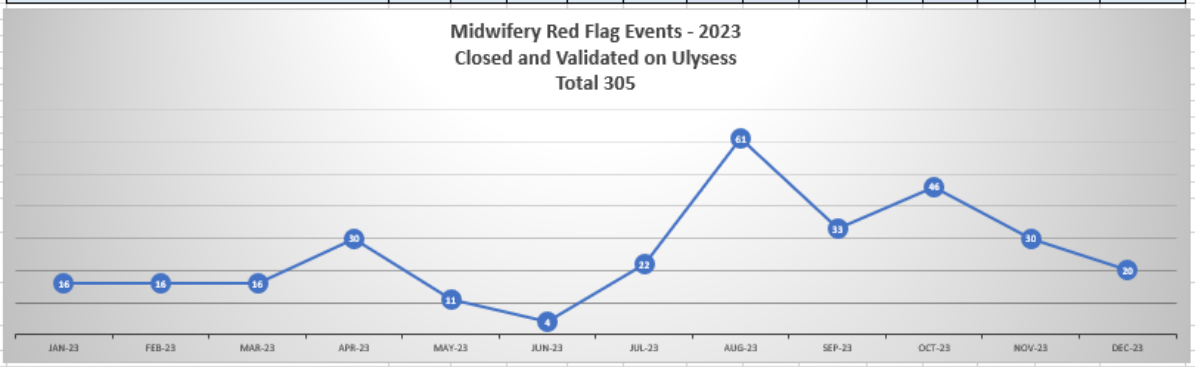
1. Investigations
2. Clinical management
3. Admission/transfer/discharge
4. Midwifery Red Flags
5. Staffing

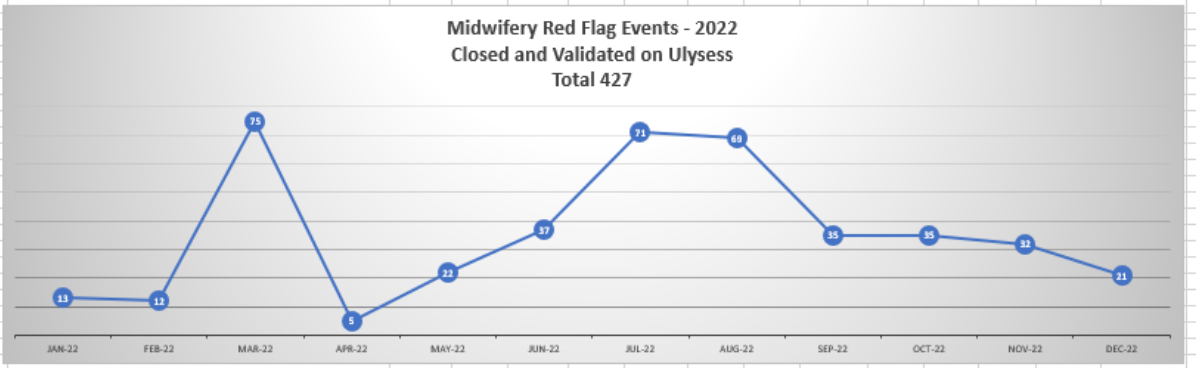
Of significance is the reduction in the number of staffing clinical incidents reported in the first 6 months of 2023 in comparison to the same period in 2022.

Midwifery Red flag reporting is a key component indicator reported against in the Maternity Incentive Scheme (MIS), Year 5 papers presented to Trust Board in the Bi- Annual Maternity Safe Staffing Report. There were 212 red flags reported between July- December 2023 which is an increase of 119 from the previous reporting period (January 2023-July 2023) where 93 red flags were reported. A spike in the number of midwifery red flags were reported in August 2023 in accordance with the marked increased in acuity. Of significance is the reduction in the number of midwifery red flags reported during the last two years, 305 MRF reported in 2023 in comparison to 427 in 2022. Of note, in November 2023 the MRF flag for reporting delays in the ongoing process of Induction of Labour was amended from >4hs to >12hs in line with other Maternity providers in Cheshire and Mersey.

Table 14: Red flag themes

Midwifery Red Flag Event - Validated	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Year End
1:1: Care in Labour Not Supported	5	2	2	2	1	0	0	5	0	3	2	0	22
>30 min Delay in Presentation to Triage	6	2	5	12	1	2	1	5	0	6	0	0	40
>2 hour delay in admission to IOL	5	2	0	0	0	0	2	12	5	6	3	2	37
>4 hour delay in ongoing IOL (LWH MRF) >12hrs from Nov 23	0	10	6	14	9	1	18	36	28	31	25	17	195
Delay in time critical activity	0	0	1	0	0	0	0	3	0	0	0	0	4
Delay in pain relief >30 mins	0	0	1	0	0	1	1	0	0	0	0	0	3
Missed medication during hospital admission	0	0	0	0	0	0	0	0	0	0	0	0	0
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	0	0	0	0	0	0	0
Full clinical examination - presenting in labour	0	0	0	0	0	0	0	0	0	0	0	0	0
Missed or Delay Care (Suturing)	0	0	1	2	0	0	0	0	0	0	0	1	4
Total	16	16	16	30	11	4	22	61	33	46	30	20	305





7.1: Serious Incidents (SI) and Patient Safety Incident Investigations:

Serious Incidents / PSII

6 Serious incidents (1 of which was de-escalated by the ICB), 5 PSII and 1 never event were reported in between July-December 2023. Also, two maternal deaths reported to HSIB/MNSI and to MBRRACE. All SI's reported to ICB as per trajectory.

The Maternity Division communicates learning from serious incidents/ PSII's via the following methods:

- Immediate feedback to staff
- Sharing Lessons of the Week via Microsoft Teams
- Appreciation letters being sent to staff involved in incidents when good practice has been identified.
- Investigating Officer presenting the case at the Trust Safety Check in meeting.
- Cases shared at ward safety and governance meetings.

Maternity Services are reviewing how they can strengthen the embedding of learning from incidents. This forms part of Ockenden essential actions 5.4 and 5.5 (Ockenden Report 2022).

The Family Health Division Senior Leadership Team have oversight of all SI actions to ensure that actions are completed in a timely manner. Monitoring takes place monthly at Maternity Risk and Clinical meetings, reporting to Family Health Divisional Board. Simultaneously outstanding SI actions will be reported at the Trust Safety and Effectiveness meeting and to Trust Quality Committee via the Chairs report.

8.0: Patient Experience

8.1 Complaints and Compliments

During this period Maternity received a total of seven complaints and all complaint investigations were completed in a timely manner. apart from One concern received in December which the investigation is underway with response due in March 2024. Complaints received related to alleged failure to treat infection in a timely manner, postoperative concerns following caesarean section, misdiagnosis of a cleft palate and one complaint relating to a community midwife reporting a family to police services. There is currently one outstanding SMART action from a complaint investigation that is being addressed.

In addition to the formal complaints received, the Maternity Directorate received several requests from women for debrief meetings, all of which were arranged with a designated staff member/ lead with the aim of supporting the service user to resolve their concern. All learning is shared with maternity staff at the Maternity Risk and Clinical monthly meeting.

8.2 Maternity Neonatal Voice Partnership (MNVP)

Maternity staff met with the MNVP Chair on a weekly basis to discuss and address any issues raised by service users and quarterly meetings are arranged and led by the MNVP Chair. The MNVP led on a 'Fifteen Steps for Maternity inspection' in the Maternity Assessment Unit (MAU) in October 2023 where there was positive feedback in relation to staff who were described as warm, friendly, attentive, and polite. The Chair of the MVP compiled a report

including some minor recommendations from the 15 steps that took place on the Maternity Assessment Unit.

The pilot project of 24hs visiting for birthing partners on Maternity Base concluded and overwhelmingly women told us that they wanted this to continue. Feedback to the MVNP has been positive and a full evaluation is in the process of being completed.

8.3 Friends and Family Feedback

A total of 654 FFT responses were received during the six-month period July-December 2023. 95% responses said they were pleased with the care and treatment they received and 5% were displeased. Many responses acknowledge that staff were caring and kind, but there was a view from the families that reduced staffing had contributed to the lack of support and delays in care particularly on the postnatal ward.

Top themes for Maternity Services based on displeased comments:

- Delays in administration of medication/pain relief. Action To address this concern a midwife is allocated on each shift on Maternity Base to administer medication.
- Delays in discharge- Action this area of concern is included in the Maternity Base improvement group where Pharmacy are now present on Maternity Base from 10am to 12 noon to support discharges and TTOs.
- Action A midwife is now allocated on a 24/7 shift pattern to perform the Newborn and Infant physical examination screening (NIPE) to further enable timely discharge.
- Action Staff attitude and behaviour- Intentional Rounding has been introduced on Maternity Base, which involves the Matron, Ward Manager or shift leader speaking to every inpatient daily to ask them about their experience on the ward, and to address at the point of care any concerns that they may have.
- Action Patients requesting that their birthing partner be permitted to stay with them on the ward to provide support. 24hs visiting for birth partners is now in place, following a pilot project, women's voices overwhelmingly confirmed that they wanted their partner to stay with them whilst on the postnatal ward.

9.0: Maternity Triage performance

Sustained improvement has been achieved in the performance of Triage assessment, during the past 11 months following implementation of a revised midwifery staffing model in the Maternity Assessment Unit. As illustrated in Table 13, 99.79% of women attending MAU are triaged within a period of 30 minutes from presenting to the department in December 2023 (Table 15).

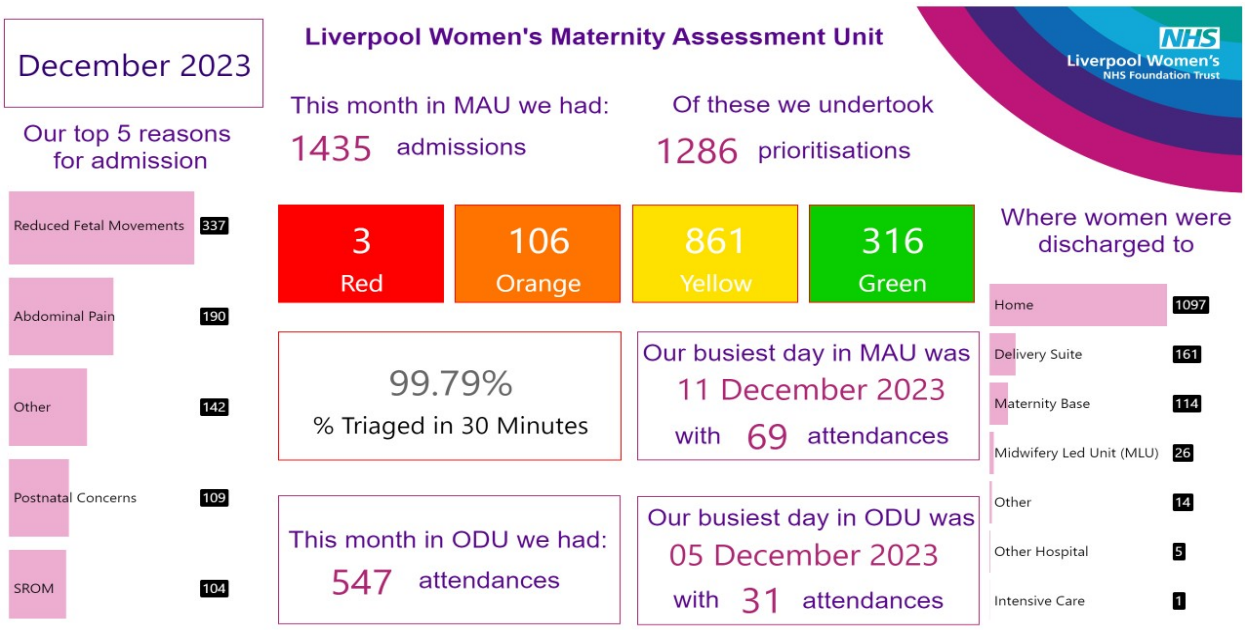
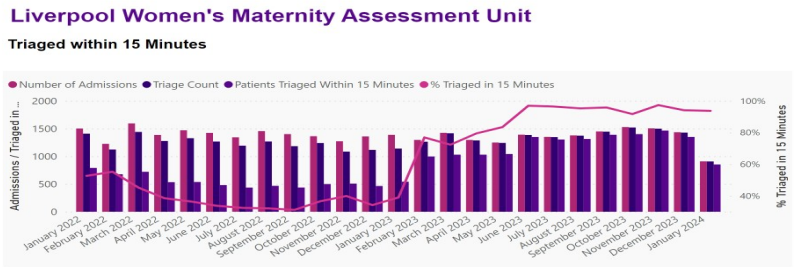


Table 15: MAU admissions and Triage assessment times

From the 31 May 2023 Triage assessment time was changed to 15minutes in line with the BSOTS model (Birmingham Symptom Specific Obstetric Triage System), which is consistent with all Maternity providers in Cheshire and Mersey region. A trajectory was set to achieve 75% Triage performance by the 31 July 2023, performance has superseded the trajectory with 83.39% compliance in 15minutes triage achieved by the 17 July. In addition to the above a midwife is allocated to telephone triage shifts, covering 24hs over 7 days per week, with 100% compliance since implementation of the revised model on the 28 January 2023.

Table 16: MAU 15-minute triage assessment performance



10.0: Staff Experience

During the six-month period July-December 2023, 11 members of staff have been subject to non-physical assaults/verbal assaults from patients and visitors, this is an increase of 8 from the previous 6-month reporting period. There were no reports of physical harm caused to staff. Of the 11 incidents reported:

- Verbal abuse- patient on staff = 5
- Verbal abuse – visitor on staff = 4
- Physical assault – no injury patient on staff = 1
- Verbal abuse -staff on staff = 1

The Preceptorship Lead Midwives continue to positively contribute to supporting the retention of midwives via a robust programme of clinical induction and pastoral care for all new midwife recruits to Liverpool Women's Hospital. They are currently supporting the 35wte newly qualified midwives who commenced in post in October 2023. The Maternity Preceptorship Team were successful in winning the NHS Pastoral Care Quality Award for their work supporting international midwives who have joined the Trust. Launched in March 2022, the NHS Pastoral Care Quality Award scheme is helping to standardise the quality and delivery of pastoral care for internationally educated nurses and midwives across England to ensure they receive high-quality pastoral support. It's also an opportunity for trusts to recognise their work in international recruitment and demonstrate their commitment to staff wellbeing both to potential and existing employees. The team also won the Nursing Times award for the best Preceptorship programme of 2023 in England.

Staff also have access to the Trust Psychologist, Health and Wellbeing coaches and to Freedom to Speak up Guardians.

11.0: Actions & Recommendations

Update against previously reported actions taken during July 2023-December 2023:

- Appointment of a diabetes specialist midwife role to achieve compliance with NICE guidance. Post holder commenced in September 2023.
- Recruitment of a Maternal Medicine Specialist midwife who commenced in post in October 2023.
- Induction of labour midwifery co-ordinator commenced in post in October 2023 and has commenced an IOL Quality Improvement project.
- Appointment of midwifery band 6 shift leaders on the Maternity Ward. All Mat Base shift leaders attended a local leadership day in December 2023 as a baseline for their journey into leadership.
- Focus applied in the last 6 months on recruiting to midwifery leadership positions from all ethnic groups.

- Tailoring interventions to midwifery career stages and local requirements, through professional development and shadowing opportunities, one example being secondment of a midwife to the Governance team on a 12-month basis.
- Maternity Transformation Programme focusing on delivery of the objectives in the Three- Year Delivery Plan for Maternity and Neonatal Services.
- Alignment with University education providers to ensure that the future midwifery workforce is aligned with local population need. Senior Midwifery leadership team meet on a bi-monthly basis with Lead Midwives for Education from 3 local universities.

Actions to be taken July 2023-December 2023:

- Growing, retaining, and supporting our workforce by further investing in ACP roles, Business Case to be developed requesting six ACP trainee posts.
- Implementation of Tobacco Dependency Advisor posts (Band 4) which will support women who smoke at the time of booking to quit smoking during pregnancy. Tobacco Dependency Advisory Service to commence from 29.1.2024.
- Explore opportunities for support workers to do their midwifery training through apprenticeship programmes.
- Continue in our efforts to recruit to midwifery leadership positions from all ethnic groups.

12.0: Conclusion

It is recommended that the Trust Board receive and note the information provided in this paper and take assurance for how safe staffing is managed, recruited, and retained to keep women and babies safe within Maternity services.

13.0 References

National Maternity Review, 2015. *Better Births: Improving outcomes of maternity services in England, A Five Year Forward View for maternity care.* England: The National Maternal Review

NHS Digital (2022) NHS Maternity Statistics, England 2021-22. [Online] NHS Maternity Statistics, England - 2021-22 - NHS Digital

Caesarean birth guidance: NICE 2021

Independent Maternity Review: Ockenden Report 2022.

Cochrane review of models of midwifery care: Sandall et al 2016

Quality Committee Chair's Highlight Report to Trust Board
30 January 2024

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway

• The Committee discussed the never event noting the immediate action taken and advised that learning must be taken for any future procurement of staff from other providers to seek assurance regarding their professional standards and adherence to Trust clinical practice.
• The Committee had a detailed and robust discussion in relation to a maternal death in March 2023. The Maternity and Newborn Safety Investigations (MNSI) completed an independent investigation into the Maternal death which included interviews with staff involved, a full review of documentation, site visits and with involvement from the family. The report received provided a summary of the case, immediate actions taken at the time and further actions taken considering feedback and recommendations from the external case review. Key themes identified included Ethnicity and health inequalities and recognition of deteriorating condition. Relevant external escalations and reporting had been completed in line with good practice and the Trust had been recognised and praised by MNSI for its openness and transparency in both the reporting and escalation of the incident and during the investigation process. The Committee noted actions identified and in progress to address the areas of improvement relating to policy, and two Trust wide improvement collaboratives relating to deterioration of the patient and cultural bias that would embed and sustain the required change to prevent reoccurrences. The two Trust wide improvement ambitions would form part of the Trust 2024/25 priorities for Quality and will report appropriately through the Improvement governance process.
• The Committee noted the following matters from the Quality Performance Report:
  ○ Cancer referrals continue to be high with rates significantly above pre-pandemic levels. Alongside pressures with capacity due to Industrial Action this would have an impact on the pace of recovery during M9 and M10.
  ○ The 28 Day Faster Diagnosis Standard continued to be below the national standard however there was an improvement in M8 in line with the recovery trajectory, with further improvement being seen in M9. The rate of activity delivery for Faster Diagnosis patients remained high with more patients being seen per working day in M9 than in M7 and M8. Recent period of industrial action was likely to have an impact.
  ○ Number of overdue appointments increased in M9 due to a reduction in clinical activity and the prioritisation of Cancer referrals. Text message validation actions took place in M9 to look at removing patients from the follow-up waiting list who no longer wanted an appointment. For the services chosen in M9, a removal rate of 6-7% was identified resulting in circa 200 patients to be removed. Further sub-specialties would be identified and this process would continue into 2024/25.
• The Trust has also agreed to support Mutual Aid for Warrington & Halton Hospitals by supporting the delivery of some inpatient procedures. The Trust is working with system partners to deliver this and ensure this is recognised for the year end position.
	• Received the analysis of adult clinical incidents attributable to the Isolation of LWH services from other specialist services and an analysis of clinical incidents reported by the Neonatal service attributable to the Isolation of LWH neonatal services from other specialist services for Quarter 2 2023/2024. The Committee agreed the purposefulness of the report to demonstrate the importance of the Future Generations workstream and working in collaboration with other specialist services to improve the outcomes for patients. It was recommended that the reports be shared with divisions to ensure divisional oversight and escalation of any risks identified onto the corporate risk register.
	• The Committee received the learning from Deaths Report for Quarter 2. One maternal death was reported during Quarter 2 of a patient who died in the postnatal period with presumed sepsis. The case was being investigated by the coroner and MNSI. The cause of death had not yet been provided to the Trust. The Committee queried any themes of the maternal deaths discussed and was referred to the Appendix 'Thematic Review of Maternal Deaths in the last 10 years' to consider past cases and themes. A report would be provided to the Committee when the MNSI complete their investigation.

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 received the Quality and Regulatory update noting reportable key issues in month. Six patient safety incident investigations (PSII) had been reported since the last update, three of which had been externally reportable for investigation. (ALL)
• The Committee noted an unannounced CQC inspection had taken place on 15 January 2024, to follow up on the Warning Notice that was served in February 2023. Feedback was largely positive with data requests made by the CQC following the inspection. (ALL)
• The Committee noted the following positive matters from the Quality Performance report:
  ○ Diagnostics position continues to be positive for M9 and remains ahead of NHSE trajectory to be 95% compliant for 6 weeks DM01 by March 2025. M10 is likely to show a small deterioration but will remain above 90% and no patients waiting above 13 weeks for a diagnostic scan/procedure.
  ○ Urgent care targets continue to improve in M9, with AED performance above 90% and back on trajectory. The time spent in department has reduced in month which was a positive step forward with a contributory factor of EPAU clinics moving out of the department in early November. Further work remained and would be incorporated in the GED Improvement workstream being launched in Quarter 4.
  ○ MAU Triage performance continued to be high and above 95%, with improvement sustained for over 9 months.
  ○ Gynaecology Elective recovery continued to deliver ahead of the NHSE trajectory for patients over 65 weeks. A deterioration in performance for M10 is forecast due to the impact of recent Industrial Action. Recovery measures had been put in place during January to improve the position for M11 and ensure the Trust is back on target. New national gynaecology elective strategy is due to be released.
  ○ Turnaround time for urgent biopsies from LCL had significantly improved
• Took assurance from the medicines management assurance report, noting that a recent stocktake review paper had been presented to the Safety and Effectiveness Subcommittee with identified risks and recommendations including a full risk assessment of service deficiencies to ensure individual risks could be placed on the appropriate risk registers. (ALL)
• Received the Family Health Divisional Safety Champions Report for quarter 3. It was noted that this information would be provided within the Perinatal Dashboard going forward. (WELL LED)
	• Approved the Research, Development and Innovation Sub-Committee terms of reference subject to a minor amendment to the membership.
	• Noted the Learning for Deaths report Quarter 2, and submission of the report to the Trust Board.

Summary of BAF Review Discussion (Board Committee level only)
• The Committee reviewed the related BAF risks and noted no recommended changes to BAF scores. • Noted a significant update to the controls and assurance framework in an attempt to rationalise and provide focus of BAF Risk 2 - Inability to ensure the on-going sustainability of clinical services and prevent patient harm by maintaining a high standard of care at the current Crown Street site. This would be further supported by the development of the Trust's Improvement Plan – to be reflected in Q4 and onwards. • No risks closed on the BAF for Quality Committee.
Comments on Effectiveness of the Meeting / Application of QI Methodology
• Transparent discussion of maternal deaths • Fewer reports on the agenda allowed focussed discussion on appropriate issues by the Committee

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
163.	Review of BAF risks: Quality related risks	Information	**168.**	Quality Performance Report Month 9 2023/24	Information
164.	Clinical incidents attributable to the isolation of LWH services from other specialist services Quarter 2	Information	**169.**	Medicines Management Assurance Report Quarter 3, 2023/24	Assurance
165.	Sub-Committee Chair Reports	Assurance	**170.**	Mortality and Perinatal Report (Learning from Deaths) Quarter 2	Assurance
166.	Quality and Regulatory Update	Information	**171.**	Family Health Divisional Safety Champions – Q3 23-24 Report	Information
167.	Maternal Death MNSI formerly HSIB Action/ Improvement plan	Information			

3. 2023/24 Attendance Matrix

Core members	April	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Sarah Walker, (Chair) Non-Executive Director	A	✓	✓	✓	✓	A	✓	✓	✓		
Louise Kenny, Non-Executive Director	✓	✓	A	A	A	✓	A	A	A		
Gloria Hyatt, Non-Executive Director	✓	✓	✓	✓	✓	A	✓	✓	✓		
Jackie Bird, Non-Executive Director	✓	✓	A	✓	A	✓	✓	✓	✓		
Dianne Brown, Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Lynn Greenhalgh, Medical Director	✓	✓	✓	✓	A	✓	✓	✓	✓		
Gary Price, Chief Operating Officer	✓	A	✓	✓	✓	A	A	✓	✓		
Jenny Hannon, Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	A	✓		
Michelle Turner, Chief People Officer	✓	✓	✓	✓	A	✓	A	A	✓		
Nashaba Ellahi, Deputy Director of Nursing & Midwifery	A	✓	✓	✓	✓	✓	✓	A	✓		
Philip Bartley, Associate Director of Quality & Governance	A	✓	✓	✓	A	A	A	A	✓		
Yana Richens, Director of Midwifery	A	✓	A	✓	A	✓	✓	✓	✓		
Heledd Jones, Head of Midwifery	A	✓	✓	A	✓	✓	✓	✓	A		

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/251b*		Date: 08/02/2024	
Report Title	Quality & Operational Performance Report			
Prepared by	*Joe Downie, Deputy Chief Operating Officer*			
Presented by	*Gary Price, Chief Operating Officer, Dr Lynn Greenhalgh, Medical Director and Dianne Brown, Chief Nurse*			
Key Issues / Messages	*Key headlines from the Integrated Performance Report, noted within the report.*			
Action required	Approve ☐	Receive X	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 *If no – please outline the reasons for deviation.*			
	To receive 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* All	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Key metrics reviewed and discussed at the Board Committees in January 2024. Information provided in the Executive Summary.			

EXECUTIVE SUMMARY

Performance Report Contents

Metrics Summary

Despite the challenges of industrial action Urgent Care Metrics have continued to perform well in line with national standards for the 4 hr ED target and Maternity Assessment Unit Triage (MAU) for the period of this report. The sustained MAU triage was noted at the CQC Maternity unannounced inspection feedback in January 2024.

Elective Recovery continues in line with the Trusts trajectories. We are in line to achieve the over 65-week national trajectory by the end of March 2024. This good performance is supported by sustained high routine diagnostic wait performance which has consistently been above 90%. As a result, the Trust is engaged with the Cheshire and Mersey System to offer mutual aid to support other Trusts who may be in a more challenged position around very long waiting patients. Finance Performance and Business Development Committee (FPBD) and Quality Committee both sought assurance that the Trust was balancing our elective recovery with supporting the system and were assured that mutual aid was not compromising LWH trajectories.

Outpatient and Theatre Productivity will need to play an enhanced role in 2024/25 and FPBD was appraised of the national Further Faster Gynaecology NHSE programme that the Trust will adopt as part of its Improvement Plan

Discussion also took place at Quality Committee and FPBD Committee about the need to consider a much longer term and strategic approach to elective recovery. Particularly the increasing long waits for first outpatient attendance and the number of overdue follow ups. The committee was informed that the Chief Operating Officer is working up a longer 2–3-year proposal to support the Trusts elective recovery and propose improved models of delivery for C&M for General Gynaecology first outpatient appointments which is where the most significant problems are. These proposals are anticipated to coincide with the planning round.

The ability to diagnose cancer within 28 days remains a significant challenge (FDS) although no increased incidence of cancer has been noted. Both Quality Committee and FPBD were appraised of the increased FDS in December to 36% despite industrial action. The Tier 2 Cancer Improvement Plans were shared with committees who were informed that whilst the Cheshire and Mersey Cancer Alliance and Specialist Commissioners are supportive of the Trusts Cancer Improvement Plan that delivery remains a challenge with the significant and consistent increase in referrals. The positive engagement with Primary Care on attempting to improve referral pathways was noted. Regular updates are provided to the Executive Team and Quality Committee and FPBD for assurance.

Appendix 1: Assurance & Variation Icons Descriptions

	Variation/Performance Icons		
Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

	Assurance Icons		
Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix 2: Assurance Category Descriptions

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** — **Celebrate and Understand** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** — **Celebrate** • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** — **Celebrate and Understand** • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** — **Celebrate** • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
~	**Good** — **Celebrate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** — **Investigate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Investigate and Take Action** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average** — **Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H	**Concerning** — **Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** — **Investigate** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.
L	**Concerning** — **Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** — **Investigate** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
↗				**Unsure** — **Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event above the upper process limits; a continued upward trend or shift above the mean. • There is no target set for this metric.
↘				**Unsure** — **Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event below the lower process limits; a continued downward trend or shift below the mean. • There is no target set for this metric.
○				**Unknown** — **Watch and Learn** • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

Appendix 3 – Perinatal Dashboard

INTRODUCTION

The Perinatal Quality Surveillance & Safety dashboard provides an overview of quality and safety performance in maternity and neonatal services at LWH to give assurance to the Trust Board and to highlight areas of concern which require further scrutiny.

MAIN BODY

The requirement for Trust Boards to implement a locally agreed dashboard, is a required standard of the Maternity Incentive Scheme (MIS). The dashboard should be presented to the Trust Board by the Board Level Safety Champions, monthly. Evidential requirements as laid out within the MIS guidance require that discussions surrounding safety intelligence are taking place at Board level. The Perinatal Quality Surveillance & Safety dashboard is presented monthly at the Maternity Risk meeting, the Neonatal Operational Management meeting, and at Family Health Divisional Board, following which it is cascaded by the maternity safety champions to staff via e-mail, closed social media groups and clinical departmental meetings.

	Metric	Standard/ National Standard	Dec-23
Perinatal	1:1 Care in Labour	100% CNST	100.00%
	Stillbirth Number >24 weeks (Adjusted)	Actual Number	3
	Stillbirth Adjusted % per 1,000 Birth		1.65%
	Apgar <7 @ 5 Minutes (>37wks)	<1.6%	1.30%
	Term Admission to NICU	<6%	5.11%
	Women in receipt of CoC	100%	18.80%
	BAME in receipt of CoC	100%	39.60%
	Social Depravation of CoC	No standard	20.62%
	Provision of Epidural in Labour	No standard	17.69%
	Coroner Reg 28 Made to Trust	Actual Number	0
	HSIB Referals Accepted	Actual Number	1
Workforce	HSIB Completed Reports Returned	Actual Number	0
	Supernumerary Shift Leader	100% CNST	100%
	Midwifery Sickness	% of Workforce <=5%	8.61%
	Midwife to Birth Ratio (in Post)	<=28	20
	Midwifery Vacancy	% of Workforce	2.20%
Feedback	Rostered Cons Hrs on DS	>60	106.5
	Number of Formal Complaints	Actual Number	1
	Number of Maternity Incidents over 30 days	Actual Number	26
	Number of PALS/PALS +	Actual Number	43

Perinatal Quality Surveillance & Safety narrative

Midwifery Red Flags:	20 red flags were reported during December 2023 a reduction of 10 from the previous month. The most reported red flag incident related to delay in the provision of ongoing induction of labour process (>12 hours) with 17 incidents reported, in comparison to 25 in November 2023. An IOL QI project is ongoing. Of note, in November 2023 the MRF flag for reporting delays in the ongoing process of Induction of Labour was amended from >4hs to >12hs in line with other Maternity providers in Cheshire and Mersey. Total of 305 Midwifery Red Flags reported in 2023 compared to 427 in 2022.
MNSI Referral Details:	One case reported to MNSI in December 2023 and information has been requested by the investigators. There are five cases currently being investigated by MNSI. These are all on track and progressing within the timeframes set out by MNSI.
Maternity Serious Safety Incidents	There were no PSIIs declared during December 2023 across maternity. There are 26 incidents that remain open 30 days after they were input onto the system, all are in the process of being investigated. All incidents are reviewed each morning (Monday to Friday) at the Daily Huddle and issues for escalation are highlighted. There are two staff members currently providing focused support for reviewing and investigating the incidents within the Web Holding File and the Governance Team continue to provide support and guidance for any member of staff that needs assistance in updating or closing incidents.
Perinatal Mortality.	Number of Neonatal Perinatal Deaths in December 2023: **1** Number of Stillbirth Perinatal Deaths in December 2023**: 3** All cases have been reported to MBRRACE and parental support continues to be provided by the Honeysuckle Team. The process for reporting PMRT cases has been reviewed and strengthened, particularly in Neonatal, to ensure all timeframes are met and reviews are held in a timely manner.
FHD Risk Register.	Risks are reported and monitored at Family Health Divisional Board and at the LMP Operational Programme Board, to demonstrate mitigation and risks remain on track. There are currently five risks scoring at 15 or above, as detailed below:

ID	Description	Current Score	Target Score	Progress
2088 Neo	Lack of onsite specialist staff and services, no co-location of neonatal and paediatric services	20	10	On track
2743 Mat	In ability to comply with National guidance for the management of women with pre-existing and pregnancy related diabetes leading to poor outcomes and failure of implementation of SBL3	16	9	On track
2746 Mat	Lack of DSN due to short and long term sickness leading to no DSN support for the women with diabetes in pregnancy - failure to comply with local and national guidelines	16	4	On track
2430 Neo	Network outlier for pre-term mortality - rate is higher than the national average	16	6	On track
2667 Neo	Delay in access to timely radiography out of hours and impact on delays in diagnosis and treatment of baby	15	10	On track

Family Health Division have a total of 43 open risks on the Risk Register - Maternity services have 35 Risks and Neonatal have 8.
All Risk Status are in date.
All Risk descriptions have been updated to reflect condition, cause, and consequence descriptors.
Governance team provide ongoing support and risk register management training for all staff across the Division.

Family Health Safety Champions.

Safety Champions Walkaround January 2024 - Area Visited: Maternity Base.

Issue Highlighted:
Digital Equipment (Computers, Printers, Blood Sample Labelling Machines) not always available, equipment and computers not always ready for use, some waiting for repair. Not all computers are connected to a printer, some systems not available on all computers.
Action:
Digital diagnostic completed on Mat Base on the 15.1.2024. New equipment including new laptops to be ordered for ward areas. Computer at every bedside requested. Mobile phlebotomy cart/mobile phone in every room. Increase of printer provision, with improved connectivity.
Issue Highlighted:
Midwifery staff keen to use knowledge and education gained in university to commence EON examinations at start of employment, rather than waiting for a protracted amount of time and further VIVA examination.
Action:
Highlighted to Deputy Head of Midwifery, Consultant Neonatologist and Neonatal Safety Champion. Neonatal Safety Champion, Dr S Babarao is further investigating with Preceptorship Team, Screening Team, and Neonatal Education Consultant Lead. Further feedback to follow.
after the review.
Issue Highlighted:
K2 System doesn't currently have a gestational specific chart for plotting results of SBRs/Bilirubin Results. Charts currently paper based and not always available for ward (Linked to issues with printer availability as they are printed from Badger Net).

	Action: Escalated to K2 Digital MW and possibility for integration into Version 6 of K2. Work ongoing got scope out feasibility as LWH use bespoke charts rather than the nationally recognised charts. K2 System developers are aware and ongoing discussion and development plans underway.
MNVP Feedback.	A formal evaluation of the overnight visiting trial on Mat Base has concluded recommending that 24hr visiting continue as per feedback from service users. Positive feedback was obtained from a listening event with families at the NEST (Non-English-speaking antenatal clinic). 15 steps undertaken on the Neonatal Unit which was positively evaluated by service users.
Midwifery Sickness	Sickness absence is a continuing challenge in midwifery; however, improvements are being seen in the overall sickness rate which stood at 8.61% in December 2023, in comparison to 12.41% in December 2022. The increase seen follows a pattern in recent years whereby sickness increases in the winter months. Weighting in the service for December 2023 is towards LTS cases at 62% in Maternity. Divisional sickness reviews continue as does the emphasis on completing return to work interviews.

Conclusion

The Family Health Division requests that the Trust Board receive this paper and seek assurance that perinatal quality surveillance and safety is a key Divisional priority, and this report provides sufficient evidence of our ongoing compliance and progress with the implementation of a perinatal quality dashboard and framework.

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report

January 2024

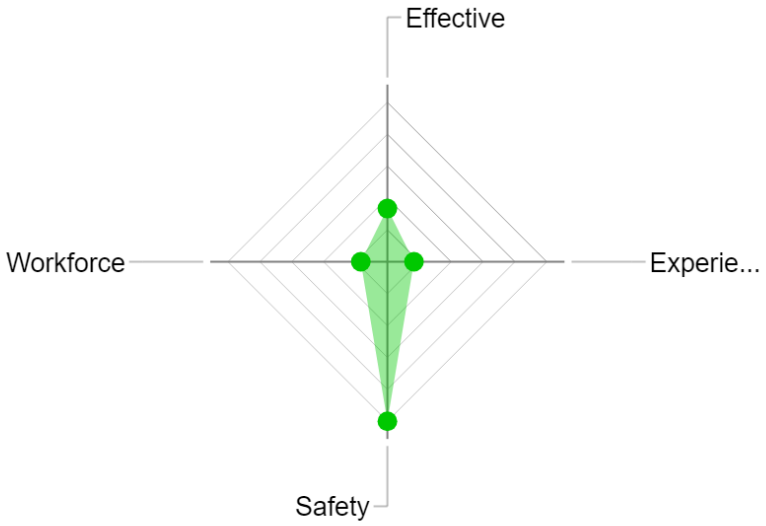
Section 1: Assurance Radar Charts by Trust Values

The indicators included in this report, have been stratified based on the level of assurance to be derived and using the NHSEI categorisation within 'Making Data Count'.

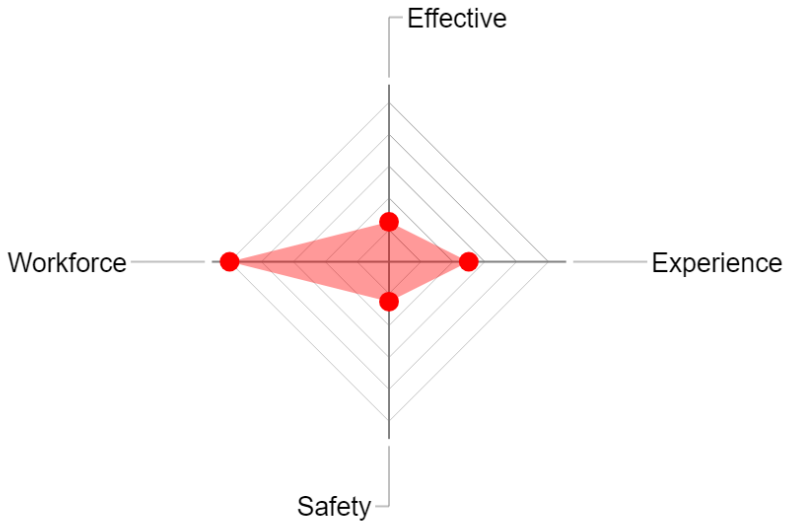
KPIs Passing Target for Six Months	10
KPIs Failing Target	8
KPIs Hit and Miss	15
KPIs No Target	5

KPIs Improving Variation	12
KPIs Concerning Variation	2
KPIs Common Cause Variation	24

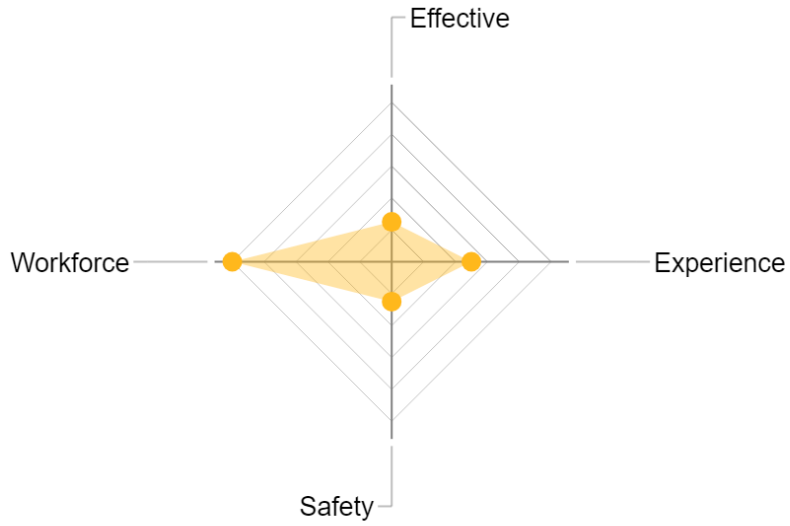
Consistently Passing



Consistently Failing



Hit and Miss



Section 2: Integrated Performance Metrics

Indicators are grouped here into assurance levels and variance. See Appendix 1 & 2 to understand how categories have been derived

Excellent - Celebrate & Learn

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 104 Weeks	<=	0	0	P	L
MAU - Face to face Maternity Triage within 30 Mins	>=	>= 95%	99.79%	P	H
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	>=	100%	100.00 %	P	H
Serious Untoward Incidents: Number of SUI's with actions outstanding	<=	0	0	P	L
Turnover Rate	<=	<= 13%	10.45%	P	L

Good - Celebrate & Understand

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 65 Weeks	<=	0	151	P	
18 Week RTT: Incomplete Pathway > 78 Weeks	<=	0	0	?	L
Complaints: Number Received	<=	<= 15	6	P	
Diagnostic Tests: 6 Week Wait	>=	>= 99%	94.61%	?	H
Infection Control: Clostridium Difficile	<=	0	0	P	
Infection Control: MRSA	<=	0	0	P	
NHSE / NHSI Safety Alerts Outstanding	<=	0	0	P	
Serious Untoward Incidents: Open	<=	<5	2	?	L
Venous Thromboembolism (VTE)	>=	>= 95%	95.85%	?	H

Average - Investigate & Understand

KPI	Target < or >	Target	P	A	V
Neonatal deaths per 1,000 total live births	<=		0		
Neonatal Unit Deaths > 22wks Gest Inborn	<=		1		
Neonatal Unit Deaths > 22wks Gest Inborn and Out Born	<=		2		
Neonatal Unit Deaths > 22wks Gest Out Born	<=		1		
18 Week RTT: Incomplete Pathway > 52 Weeks	<=	0	1465	?	
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	>=	>= 95%	90.38%	?	
Cancer: 31 Day decision to treat to treatment	>=	>=96%	66.67%	?	
Cancer: 62 Day referral to Treatment	>=	>=85%	23.08%	?	
C-Gull Recruitment	<=		206	?	
Friends & Family Test: In-patient/Daycase % positive	>=	95%	85.34%	?	
Neonatal deaths 24-31+6 Weeks Inborn babies	<=	0.063	0.00%	?	
Never Events	<=	0	0	?	
Number of Open Patient Safety Incident Investigations	<=	8	16	?	
Proportion of patient activity with an ethnicity code	>=	>=96%	97.56%	?	
Total Number of Patient Safety Incident Investigations (Rolling)	<=	30	16	?	

Integrated Performance Metrics

Indicators are grouped here into assurance levels and variance. See Appendix 1 & 2 to understand how categories have been derived

Concerning - Investigate

KPI	Target < or >	Target	P	A	V
Friends & Family Test: A&E % positive	>=	95%	66.28%	F	
Friends & Family Test: Maternity % positive	>=	95%	86.72%	F	
Mandatory Training	>=	>= 95%	93.11%	F	H
Mandatory Training (Clinical)	>=	>= 95%	88.22%	F	H
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	>=	>= 80%	38.65%	F	
Serious Untoward Incidents: New (Rolling per year)	<=	24 /year	31	F	
Sickness Absence Rate	<=	<= 4.5%	7.02%	F	L
Overall size of Elective Waiting List	<=		19444		H

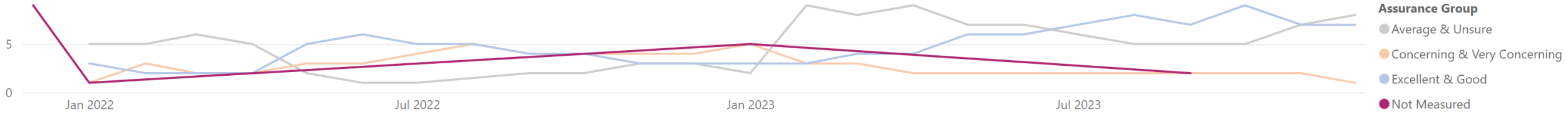
Very Concerning - Investigate & Take Action

KPI	Target < or >	Target	P	A	V
Cancer: 28 Day Faster Diagnosis	>=	>= 75%	27.97%	F	L

Investigate & Understand

KPI	Target < or >	Target	P	A	V

Section 3: To deliver **Safe** Services

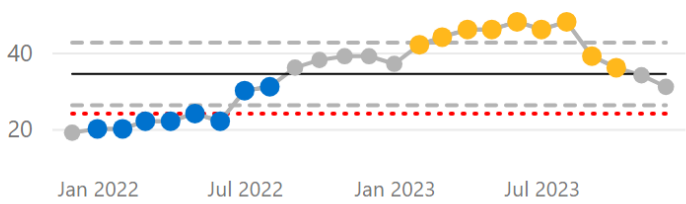


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
MAU - Face to face Maternity Triage within 30 Mins	Excellent	December 2023	>= 95%	>=	99.79%	P	H	
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	Excellent	August 2023	100%	>=	100.00%	P	H	
Serious Untoward Incidents: Number of SUI's with actions outstanding	Excellent	December 2023	0	<=	0	P	L	
Infection Control: Clostridium Difficile	Good	December 2023	0	<=	0	P		
Infection Control: MRSA	Good	December 2023	0	<=	0	P		
NHSE / NHSI Safety Alerts Outstanding	Good	December 2023	0	<=	0	P		
Serious Untoward Incidents: Open	Good	December 2023	<5	<=	2	?	L	
Venous Thromboembolism (VTE)	Good	December 2023	>= 95%	>=	95.85%	?	H	
Neonatal deaths 24-31+6 Weeks Inborn babies	Average	December 2023	0.063	<=	0.00%	?		
Neonatal deaths per 1,000 total live births	Average	December 2023		<=	0			
Neonatal Unit Deaths > 22wks Gest Inborn	Average	December 2023		<=	1			
Neonatal Unit Deaths > 22wks Gest Inborn and Out Born	Average	December 2023		<=	2			
Neonatal Unit Deaths > 22wks Gest Out Born	Average	December 2023		<=	1			
Never Events	Average	December 2023	0	<=	0	?		
Number of Open Patient Safety Incident Investigations	Average	December 2023	8	<=	16	?		
Total Number of Patient Safety Incident Investigations (Rolling)	Average	December 2023	30	<=	16	?		
Serious Untoward Incidents: New (Rolling per year)	Concerning	December 2023	24 /year	<=	31	F		

To deliver **Safe** Services - Exceptions

Serious Untoward Incidents: New - Chief Nurse

Assurance Category	Concerning
Date	December 2023
Target	24 /year
Target < or >	<=
Performance	31
Assurance	F
Variation	



The Trust Launched PSIRF in September 23 which has made the New SUI's a now redundant KPI, However the SUI KPI is being kept open until all ongoing SUI's (2 remaining) have been submitted to the ICB, estimated early 2024

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

To deliver Safe services - Safer Staffing

December 2023					
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	83.06%	61.29%	145.16%	100.00%	December staffing fill rate on days is reflective of the increase this month of long-term sickness, alongside maternity leave. Safe staffing has been maintained due to the low bed occupancy of 35.28% in the inpatient area and the ability to flexibly rotate staff from the HDU area who also had low bed occupancy at 50% The fill rate 145.16% RN on nights remains above the 100% as this is reflective of senior RN cover rotating between GED and inpatient area.
Induction & Delivery Suites	86.24%	81.72%	81.94%	96.77%	*The template from RM in DS changed from 13 to 15 MW per shift due to the temporary pause of MCOC model of care in May 2023, and no longer having the availability of 4 on call midwives. Midwives who continued working in the hybrid model are rostered for one Intrapartum shift per week and contribute to the overall establishment for Delivery Suite. Approval for this way of working has been gained from Quality Committee to support our workforce developing and maintaining skills until review in Q3 24/25. Vacant shifts are requested to be filled with bank and agency up to planned staffing numbers.
Maternity & Jeffcoate	87.24%	84.68%	88.31%	93.55%	*/**The Maternity bleep holder redeployed staff to maintain clinical safety to areas of high acuity and to ensure appropriate discharge flow to release capacity and ensure safe care maintained across maternity services. All vacant shifts requested to be filled with bank at earliest opportunity. Sickness in Month for Maternity Ward was 12.89% of which 48% was STS with the leading cause being cough/cold/flu, which due to short notice provided challenges in fill with temporary solutions. The Maternity bleep holder redeployed staff to maintain clinical safety across the maternity floor.
MLU	81.45%	80.65%	84.68%	64.52%	*/**There were no episodes of closure during the month, occupancy was reduced which allowed the safe delivery of Intrapartum and early postnatal care. Due to high acuity and high numbers of IOLs in Delivery Suite, on occasions staff were redeployed meeting the needs of complexities of women using our service.
Neonates (ExTC)	95.08%	101.61%	92.02%	95.16%	Fill rates reflect the neonatal unit occupancy in December. With total occupancy over the month at 82.4% which is an increase in total occupancy of 8.4%. Occupancy in ITU areas reduced to 88.2% from 103% in November. The number of and acuity of the babies on the unit is reflected in the RN fill rates. Care staff fill rates in December are reflective of the high ITU and HDU acuity on the unit where low dependency RNs were moved to support staffing in ITU. Safe staffing was maintained and CHPPD (Care Hours Per Patient Day) are as would be expected.
Transitional Care	64.52%	87.10%	83.87%	64.52%	Fill rates reflect the transitional care occupancy in December, where most of the care is provided by care staff who are clinical support workers in this area, thus higher numbers of care staff than registered staff. TC occupancy was low at 51%, therefore some shifts only required 1 member of staff. Safe staffing was maintained and CHPPD (Care Hours Per Patient Day) are as would be expected.

To deliver Safe services - Safer Staffing

Gynaecology: December Fill Rate

Fill rate – The underfilled staffing rate for December on the day shift reflects the Long-term sickness and Maternity Leave. Safe staffing has been maintained due to the low bed occupancy in the inpatient ward and the High Dependency Unit (HDU). The low bed occupancy allowed the manager to rotate staff from the HDU to support the inpatient area. The high fill rate of RN on nights remains above 100% as this is reflective of senior RN cover rotating between GED and inpatient area to provide senior clinical leadership and to maintain safety out of hours.
Attendance/ Absence – sickness and absence for the month of December was recorded 12% an increase of 0.63% compared to November which was recorded as 11.37%. Long term sickness increased from previous month and contributed to the high levels of long-term sickness at 83.20% whilst short-term sickness contributed to 16.80%. Maternity leave in October accounted for 1.61%WTE staff.
Vacancies – 1wte post out on TRAC
Red Flags – No red flags reported in December.
Bed Occupancy – In December bed occupancy for the Gynaecology inpatient unit is recorded as 35.28%, The High Dependency Unit bed occupancy is recorded as 50%.
CHPPD – For the month of December the CHPPD overall was reported to be 7.5 a decrease compared to the previous month which was 8.0. The split between Registered and Unregistered care staff was 4.6 for Registered Nurse staff and 2.9 for Health Care Assistant.

Neonates: December Fill Rate

Fill rate – Occupancy increased significantly from October to November across the acute area of the neonatal unit and remained above 80% in December.
Safe staffing has been maintained and fill rates are reflective of acuity and occupancy. There was 1 maternity patient transferred out of LWH to a local neonatal unit due to no ITU beds available on NICU at LWH, due to high acuity / no ITU beds on NICU, and the appropriate escalation process was followed.
There was 1 incident reported of a delay in repatriation of a baby to their local neonatal unit, which was escalated appropriately to the Northwest Neonatal Operational Delivery Network.
Attendance/ Absence – Sickness was reported at 6.85% in December which is an increase from the previous month, the top reason for sickness in December was anxiety/stress/depression. Long term sickness has increased to 75.64 %. All sickness is being managed in line with the attendance management policy. In cases where staff are experiencing stress, anxiety, and depression, they have been signposted to LWH staff support and are being contacted regularly by team leaders.
Vacancies – Turnover increased to 17% in November and reduced to 12.69% in December. Most of the leavers reflect being successfully promoted to newly created Liverpool Neonatal Partnership posts. There are 22 band 5 vacancies on the neonatal unit in December 2023, These vacancies have been approved and will be advertised on Trac in February, there were 5 staff appointed from the band 5 interviews in November 2023. There are 4 band 5 vacancies on Transitional care and band 2 support workers which have been approved at vacancy panel and are going out to advert in January. There have been ongoing challenges recruiting to vacant ANNP posts therefore the advert was withdrawn and a plan to move to hybrid clinical fellow/ANNP posts made. Interviews for these posts took place in December 2023. 3 applicants were successful and will commence in July 2024.
Red Flags – There are no Neonatal Nursing red Flags reportable.
Bed Occupancy –The total unit occupancy increased above the expected 80% at 82.4% in December. Occupancy rates for December per area were: ITU 88.2%; HDU 86.3%; LDU 76.6% and TC 51.2%. LDU, HDU and TC occupancy were below expected in December.
CHPPD – Within the critical care areas the care hours provided in December are as would be expected for babies being nursed in ITU with 12.5 Care hours per patient day (CHPPD) overall. The breakdown shows higher hours of registered nurse care and lower non- registered care. This split of 11.3 hrs of registered nurses and 1.2 healthcare support workers, is what is expected considering that most of these babies need care by a nurse qualified in speciality. The Transitional care CHPPD is reflective of the way in which non- registered care leads TC supported by registered staff and parents, there was a split of 4.3 hours by non-registered nurse and less by registered nurses of 4.2 hrs, but appropriate for care delivery with overall care hours at 8.5 care hours per patient day. Care in TC is more about supporting the family to provide care for their baby therefore less care hours provided by registered and non-registered nursing staff.

To deliver Safe services - Safer Staffing

Maternity: December Fill Rate

Fill-rate – Where planned staffing requirements could not be met due to unavailability, all vacant shifts were escalated to NHSP to attempt to cover with temporary staffing solutions. There has additionally been the requirement for deployment of specialist Midwives, ward managers and matrons for periods of time to ensure safety, particularly in peaks of high activity in MAU to maintain triage time within 30mins noting performance was achieved at 99.7%, and 94.08% of those within 15min BSOTS target, with average time from presentation to triage occurring in 8mins. Maternity continued to undertake a minimum 4-hourly activity /acuity review, which allows senior midwifery staff to maintain safety by rotating staff to the areas of highest clinical need using risk based responsive decision making, with daily reporting into the LMNS and consideration of mutual aid to other providers if able to support.

Attendance/ Absence – Maternity continues to report levels of sickness above the Trust threshold of 4.5% which is included in the headroom, within its midwifery and support staff group. Sickness in Month increased to 8.61%, this follows a pattern in recent years whereby sickness increases in the winter months. At the same point last year however, sickness in Maternity was 12.41% and overall, throughout the year 2023 the service has noted improved attendance levels. In December, 38% was STS with the leading cause being cough/cold/flu, which due to short notice reporting and the holiday period, provided challenges in fill with temporary staffing solutions for both registered and care staff. Maternity LTS is 62%. Divisional LTS management meeting led by HR and DHoM also take place with the Managers/ Matrons, with escalation meetings for short term absence patterns also ongoing as required. Robust management practice continues, and assurance can be provided that where there is LTS, cases are managed in line with policy with the majority of current LTS cases are in the 0–3-month timescale. Maternity leave equates to 19.24 wte (22 headcount) all of whom are within the Registered Midwives staffing group and is reflective of a changing age profile of the workforce with approximately 40% of Registered Midwives employed at the Trust under the age of 40.

Vacancies – The Maternity Service had 9.82wte Midwifery vacancies at the end of M9, due to reduction in hours and retirements, however a pipeline of Internationally Educated Midwives currently working as MSWs whilst awaiting their NMC PIN will reduce this overall position, alongside NQM completing their course as part of a winter cohort and expected to commence in Trust by M11 and are currently engaged in pre-employment and onboarding processes. A proactive approach to recruitment continues with an Open Day being planned in Q4 to showcase services and employment opportunities at LWH.

Red Flags – During December 20 Midwifery Red Flags were identified. 1:1 Care in Labour was maintained at 100%. Reported red flags 2 delays of >2hrs from admission to commencement of IOL and 17 delays of >12hrs for ongoing IOL (regional red flag), which affected patient experience. Mutual aid was requested from other LMNS providers to support delay in IOLs at LWH due to capacity, however this increase in demand was also reflected across the system and therefore couldn't be supported by other providers. IOL Rate in December reduced to 36%, however peaks in activity due to unpredictability of the requirement for urgent IOL have created challenges.

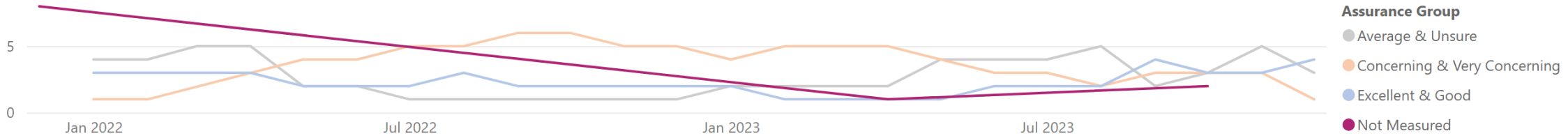
CHPPD – Since April 2021, CHPPD in Maternity has included the number of babies in the total number of patients per inpatient ward at the 23.59hrs data capture. For Intrapartum Areas, Delivery and MLU care during established labour is required to be 1:1 with a registered midwife, with support staff utilised to assist with the functioning of the ward or help in the postnatal period once the birth care episode is completed prior to transfer to Maternity Ward. CHPPD as reported at 17.1 in December for Delivery Suite which is a decrease from November which was 18.0. As CHPPD calculation combines hours provided by registered and care staff it is not the most sensitive indicator for Intrapartum Care. 1:1 Care provided by a Midwife to all women is a more accurate measure. Despite the decrease in CHPPD, 100% of women received 1:1 care by a Midwife which is increased performance from November. The Maternity Ward is mixed antenatal and postnatal ward and therefore the fluctuation of case mix will be significant to CHPPD calculations, due to babies being inclusive in the total and classed also as patients. It is reported at 3.6 for December which is consistent with the previous months. Nationally the refresh of the BirthRate Plus Ward Based Accuity Tool which will provide a real time evidence-based data to support staffing deployment decisions on Maternity Ward is now completed, with a go live date planned for 29th January. This will provide rapid safe staffing assurance on the changing complexity of ward-based care in Maternity services here at Liverpool Womens.

Planned Preventative maintenance

Compliant | partial compliant | Non Compliant

PPM Description	Responsibility/ Contractor	HTM/HBN Reference	Frequency				Comments
			Annual	6-Monthly	Quarterly	Monthly	
FIRE							
Fire Alarm Testing (W, 3M)	Tailored Fire						Weekly testing to ensure that all panels sound alarms and all panels talk to each other and send a fire signal to the Fire Alarm Receiving Centre to alert the Fire & Rescue Service. 3Monthly testing of 25% of all devices on site.
Fire Doors (M)	Estates						Monthly inspection of all fire doors.
Fire Damper Inspection Test	VSS & Swegon						Annual fire damper inspecion of all dampers in ventilation ductwork.
Fire Fighting Equipment (12m)	Tailored Fire						Annual inspection of all fire extiguishers.
Dry Risers (12M)	Tailored Fire						Annual inspection of all dry risers.
Fire Hydrants (12M)	Tailored Fire						Annual inspection of all fire hydrants.
Emergency Light test (M,12M)	Estates						Monthly test of all emergency lights in the hospital. Annual 3 hour battery discahrge test of all emergency lights in the hospital. There are approx 2000 lights to test monthly and annually.
WATER							
Water Treatment (M) (heating and cooling)	Cheshire Scientific						Monthly test of the quality and condition of our heating and cooling water to ensure that it is treated with the correct chemcials to prevent corrosion of the pipe work.
Water Tank Cleaning (12M)	Cheshire Scientific						Annual clean and disinfection of all our potable water tanks used for drinking water.
Water Sampling (M)	Cheshire Scientific						Monthly water sampling in kitchns, staff rooms, water fountains, birthing pools, NICU and HDU for water quality testing for e-coli, coliforms, Legionella pneumophila and Pseudomonas Aeruginosa
Water Safety PPMs	Estates						Weekly, monthly, 3 monthly and 6 monthly servicing and testing of water heaters, water temperatures, water safety devices, such as thermostaic mixing valves, showers and taps.
SECURITY							
Access Control System (3M)	Clarion						3 monthly servicing and testing of access control system.
CCTV (3M)	HESIS						3 monthly servicing and testing of CCTV system, 110 cameras.
Intruder Alarm (6M)	Clarion						6 monthly service and testing of our Intruder alarm and panic buttons.
Baby Tagging System (3M)	Xtag						3 monthly service and testing of our baby tagging system.
LIFTS							
Passengers & Goods Lift (M, 12M)	Rubax						Monthly and annual service and testing of our lifts.
Ladder & Access Platforms (6M)	Ladder Safety Services						6 monthly inspection of ladders and step ladders.
ELECTRICAL							
Commercial Dishwashers (6M)	JLA						6 monthly service and inspection of our diswashers.
Commercial Washing Machine Dryers (6M)	JLA						6 monthly service and inspection of our washig machines and dryers.
Electric Boilers (12M)	JLA						Annual service of our water boilers in staff room and kitchens.
Kitchen Equipment (6M)	JLA						6 monthly service of all equipment in Main kitchen and ward/department kitchens.
Portable Appliances Testing (12M)	OCS						Annual portable applinace testing (PAT).
Food Trolleys (6M)	Socomel						6 monthly service of meal trolleys.
Weighing Equipment (3M)	Accurate weight						3 monthly service and calibration of patient weighing scales.
Fixed Appliance Testing (12M)	Parr group						Annual test and inspection of electrical installations.
Bed Pan Washers service (6M)	Dekomed						6 monthly service of bed pan washer/disinfectors.
Bed Pan Washers Testing (3M)	Dekomed						3 monthly testing of bed pan wash/disinfectors.
Nurse Calling System (3M)	Austco						3 monthly service and testing of all nurse call systems.
External Light Cleaning (12M)	Estates						Annual clean of all car park and road way lighting.
Internal Light Cleaning (12M)	Estates						Annual clean of all internal light fittings.
Lightning Protection (12 M)	PTSG						Annual service and testing of the lighting protection system.
Generator Testing (W,M,6M,12M)	Ingrams/Estates						Weekly, monthly, 6 monthly and annual service and testing of our emergency generators.
Trend Building Management System (M)	BTS						Monthly service on our Building Management System (BMS) for conrolling all heating /ventilation and hot water.
LV Distribution System (12M)	Estates						Annual inspection of our Low Voltage distribution systems (230 volts)
HV Distribution System (12M)	Ipsum						Annual service and inspectiom of our High Voltage distribution system (1000 to 11000 volts)
Refridgeration (6M) Catering/Domestic	Effective Air						6 monthly service and inspectionof our refrigeration systems.
MEDICAL GASES							
Medical Gases (3M)	Medigas Services						3 monthly service and testing of our Medical Gases systems, Medical Air compressors, Oxygen, Nitrous Oxide, Entonox (50% Oxygen and 50% Nitrous Oxide, Medcial vacuum pumps, Nitrogen & Carbon Dioxide pipeline systems and manifolds.
HVAC (Heating, ventilation and air conditioning)							
Boiler Burners (6M)	Engie						6 monthly service on our heating boilers gas and oil burners.
Pressure Units (6M)	Engie						6 monthly servic and inspection of our pressure units associated with heating and hot water systems.
Main chiller unit (6M)	Engie						6 monthly service and inspection of our chillers for air conditioning and ventilation systems.
Air conditioning (6M)	Effective Air						6 monthly service and inspection of all our conditujoning units in clinical, non clinical departments and IT data centres and comms rooms.
Ventilation System(6M) (AHU)	Estates / Effective Air						6 monthly and annual service and inspection of 42 ventilation systems to critical and non critical clinical and non cliniclal wards and departments.
NICU Chiller Units (3M)	Carrier						3 montly service and inspection of the chillers for NICU's ventilation systems.
Ceiling Grills Extract Fans (6M)	Estates						6 monthly clean of all ceiling ventilation grills in all departments.
OTHER							
Car Park Pay & Display (6M)	Newpark						6 monthly service and inspection on our car park barriers and equipment.
Grass Cutting and Grounds Maintenance	Rice lane landscapes						Grass cutting and grounds and gardens seasonal maintenance.
Windows maintenance (12M)	Fenestral						Annual inspection of all window restrictors in clinical areas on the first and second floor.

Section 4: To deliver the most **Effective** Outcomes



KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Cancer: 62 Day referral to Treatment	Average	November 2023	>=85%	>=	23.08%			
Cancer: 31 Day decision to treat to treatment	Average	November 2023	>=96%	>=	66.67%			
18 Week RTT: Incomplete Pathway > 104 Weeks	Excellent	December 2023	0	<=	0	P	L	
Cancer: 28 Day Faster Diagnosis	Very Concerning	November 2023	>= 75%	>=	27.97%	F	L	
Diagnostic Tests: 6 Week Wait	Good	December 2023	>= 99%	>=	94.61%		H	
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Average	December 2023	>= 95%	>=	90.38%			
Proportion of patient activity with an ethnicity code	Average	December 2023	>=96%	>=	97.56%			
18 Week RTT: Incomplete Pathway > 78 Weeks	Good	December 2023	0	<=	0		L	
18 Week RTT: Incomplete Pathway > 65 Weeks	Good	December 2023	0	<=	151	P		
18 Week RTT: Incomplete Pathway > 52 Weeks	Average	December 2023	0	<=	1465			
Overall size of Elective Waiting List	Concerning	December 2023		<=	19444		H	

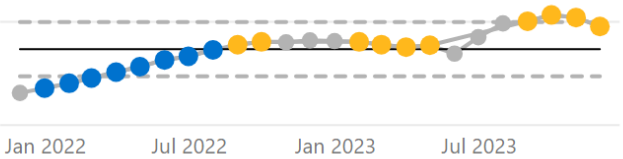
*Following KPI's have nationally set targets as part of Operational Planning Guidance for 23/24:

18 Week RTT: Incomplete Pathway > 52 Weeks (KPI002T)
18 Week RTT: Incomplete Pathway > 65 Weeks (KPI498)
Diagnostic Tests: 6 Week Wait (KPI204)
Cancer: 28 Day Faster Diagnosis (KPI359)
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge (KPI008)

To deliver the most **Effective** Outcomes - Exceptions

Overall size of Elective Waiting List - Chief Operating Officer

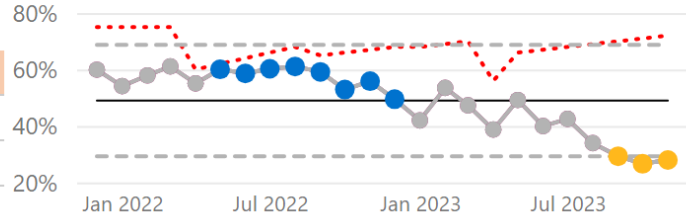
Assurance Category	Concerning
Date	December 2023
Target	
Target < or >	<=
Performance	19444
Assurance	
Variation	



Waiting list is reducing. Focus on validation and actions through the Data Quality group are demonstrating improvements in removing patients incorrectly kept on waiting list when should be removed. Actions underway through Access sub-committee to support clinical staff through dIgi care changes to identify correct outcomes following clinical appointments - this is showing an improved position. Work ongoing through both groups to reduce the PTL size to pre digi care go live figures

Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

Assurance Category	Very Concerning
Date	November 2023
Target	>= 75%
Target < or >	>=
Performance	27.97%
Assurance	
Variation	

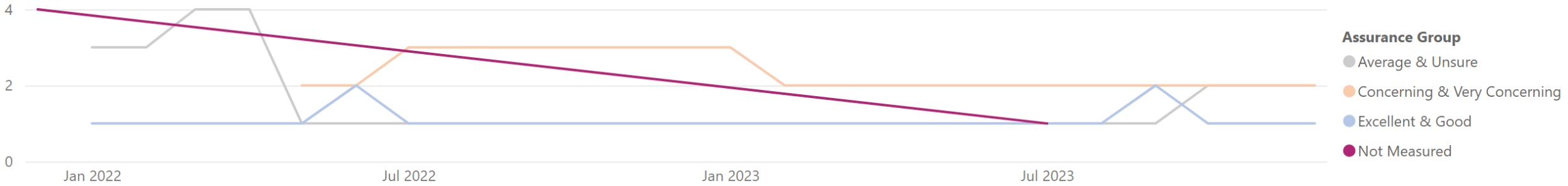


Number of hysteroscopy procedures performed has doubled since July. Weekly tracker of activity being monitored. All routine activity has been converted to Rapid Access to support the position. Impact of actions is demonstrated in KPI467.

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Section 5: To deliver the best possible **Experience** for patients and staff

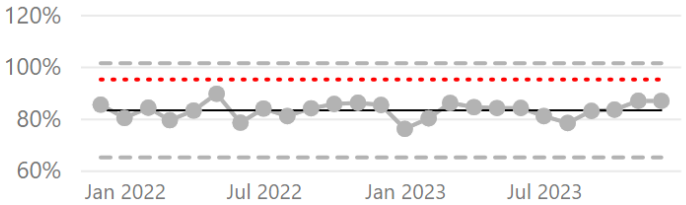


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Complaints: Number Received	Good	December 2023	<= 15	<=	6			
C-Gull Recruitment	Average	December 2023		<=	206			
Friends & Family Test: In-patient/Daycase % positive	Average	December 2023	95%	>=	85.34%			
Friends & Family Test: A&E % positive	Concerning	December 2023	95%	>=	66.28%			
Friends & Family Test: Maternity % positive	Concerning	December 2023	95%	>=	86.72%			

To deliver the best possible **Experience** for patients and staff - Exceptions

Friends & Family Test: Maternity % positive - Chief Nurse

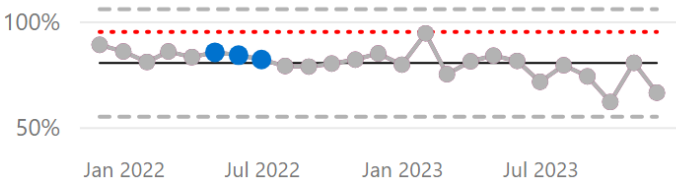
Assurance Category	Concerning
Date	December 2023
Target	95%
Target < or >	>=
Performance	86.72%
Assurance	
Variation	



Number of FFT responses remain static. Working with MNVP Chair and Deputy Chair to try and encourage more women to complete feedback.

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

Assurance Category	Concerning
Date	December 2023
Target	95%
Target < or >	>=
Performance	66.28%
Assurance	
Variation	



Despite attempts to increase updates on waiting times FFT themes for December highlight patients feedback regarding this still being present. We have reviewed and distributed the GED escalation policy so that any challenges regarding 4 hour review can be appropriately supported

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

KPI Lineage & Data Quality Overview

Metric Description	WE SEE	DQ Kite Mark	Board	FPBD	Quality	PPF	Family Health Division	CSS Division	Gynaecology Division	Maternity Clinical
18 Week RTT: Incomplete Pathway > 104 Weeks	Effective	5	Y	Y	Y				Y	
18 Week RTT: Incomplete Pathway > 52 Weeks	Effective	5	Y	Y	Y					
18 Week RTT: Incomplete Pathway > 65 Weeks	Effective	5	Y	Y	Y				Y	
18 Week RTT: Incomplete Pathway > 78 Weeks	Effective	5	Y	Y	Y				Y	
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Effective	5	Y	Y	Y				Y	
Cancer: 28 Day Faster Diagnosis	Effective	5	Y	Y	Y			Y	Y	
Complaints: Number Received	Experience	5	Y		Y					
Diagnostic Tests: 6 Week Wait	Effective	5	Y	Y	Y			Y	Y	
Friends & Family Test: A&E % positive	Experience	5	Y		Y				Y	
Friends & Family Test: In-patient/Daycase % positive	Experience	5	Y		Y				Y	
Friends & Family Test: Maternity % positive	Experience	5	Y		Y		Y			Y
Infection Control: Clostridium Difficile	Safety	5	Y		Y					
Infection Control: MRSA	Safety	5	Y		Y					
Mandatory Training	Workforce	5	Y		Y	Y				
Mandatory Training (Clinical)	Workforce	5	Y		Y	Y				
MAU - Arrival to Triage within 30 Mins	Safety	5	Y	Y	Y		Y			Y
Neonatal deaths 24-31+6 Weeks Inborn babies	Safety	5	Y				Y			
Neonatal deaths per 1,000 total live births	Safety	5	Y				Y			
Neonatal Unit Deaths > 22wks Gest Inborn	Safety	5	Y				Y			
Neonatal Unit Deaths > 22wks Gest Inborn and Out Born	Safety	5	Y				Y			
Neonatal Unit Deaths > 22wks Gest Out Born	Safety	5	Y				Y			
Never Events	Safety	5	Y		Y					
NHSE / NHSI Safety Alerts Outstanding	Safety	5	Y		Y		Y			Y
Overall size of Elective Waiting List	Effective	5	Y					Y	Y	
Proportion of patient activity with an ethnicity code	Effective	5	Y	Y					Y	
Serious Untoward Incidents: New	Safety	5	Y		Y					
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescale	Safety	5	Y		Y					
Serious Untoward Incidents: Number of SUI's with actions outstanding	Safety	5	Y		Y				Y	
Serious Untoward Incidents: Open	Safety	5	Y		Y					
Sickness	Workforce	5	Y		Y	Y				
Turnover	Workforce	5	Y			Y				
Venous Thromboembolism (VTE)	Safety	5	Y		Y					
Cancer: 31 Day decision to treat to treatment	Effective		Y	Y	Y				Y	
Cancer: 62 Day referral to Treatment	Effective		Y	Y	Y				Y	
C-Gull Recruitment	Experience		Y		Y		Y			
Number of Open Patient Safety Incident Investigations	Safety		Y		Y					
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Workforce		Y	Y	Y	Y				
Total Number of Patient Safety Incident Investigations (Rolling)	Safety		Y		Y					

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/251c*	Date: 08/02/2024		
Report Title	Mortality and Learning from Deaths Report Quarter 2, 2023/24			
Prepared by	**Chris Dewhurst, Deputy Medical Director.** Lidia Kwasnicka, Gynaecologist; Ai-Wei Tang, Consultant Obstetrician; Rebecca Kettle, Consultant Neonatologist and			
Presented by	**Lynn Greenhalgh, Medical Director**			
Key Issues / Messages	The Board is asked to review the contents of the paper and take assurance that there is adequate processes and progress against the requirements laid out by the National Quality 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.*			
	It is it is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths. *As per The Learning from Deaths framework requirements the Board is requested to note:* • *number of deaths in our care* • *number of deaths subject to case record review* • *number of deaths investigated under the Serious Incident framework* • *number of deaths that were reviewed/investigated and as a result considered due to problems in care* • *themes and issues identified from review and investigation* • *actions taken in response, actions planned and an assessment of the impact of actions taken.*			
Supporting Executive:	Lynn Greenhalgh Medical Director			

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: N/A
Link to the Corporate Risk Register (CRR) – CR Number:	Comment: No

EXECUTIVE SUMMARY

This “Mortality and Learning from Deaths” paper presents the mortality data for Q2 2023/24. The learning from review of deaths will be from deaths that occurred in Q1 2023/24 or earlier if deaths have been subjected to external reviews such as Maternity and Neonatal Safety Investigations (MNSI) or Coronial investigations.

In quarter 2 there were the following deaths:

Adult deaths	**0 (1 who was operated on at LWH but died in RLUH)**
Direct Maternal Deaths	**1**
Stillbirths	**4 (excluding ToP, rate 2.2/1000births)**
Neonatal deaths (inborn)	**8 (4.8/1000 live births)**

There was 1 **maternal death** of a woman who gave birth in August 2023 who died in the postnatal period with presumed sepsis. The case is being investigated by the coroner and through MNSI. The cause of death has not yet been provided to the trust. The care was impacted upon by lack of co-located services.

The MNSI report for case HO who died in Q4 22/23 from post-natal sepsis has been provided to the trust. The MNSI report provides several findings for the trust and a wide ranging action plan has been developed. The learning form this death is also part of the trust wide anti-racism strategy.

There is an additional paper embedded in this report providing an overview of maternal mortality over the past 10 years

There were no **gynaecology deaths** in Q2 2023/24.

There were 4 **stillbirths**, excluding terminations of pregnancy (TOP) in Q2 2023/2024. This has resulted in an adjusted stillbirth rate of 2.2/1000 live births for Q2 23/24 and continues the trend of being lower than in previous years.

There were 8 deaths on the NICU. 4/8 (50%) of the deaths were from pregnancies originally booked outside of Liverpool. There were 7 babies who were inborn and died at LWH resulting in a **neonatal mortality** rate of 3.8/1000 livebirths. There were 4 deaths in preterm in-born infants (24 to 31+6 weeks), resulting in an annual mortality of 10.9% in this population. This is above the NWODN benchmark of 6.3%, however there are ongoing discussions with the appropriateness of this benchmark with both the ODN and the National Neonatal Audit Project (NNAP).

The review of neonatal deaths from Q1 23/24 (n=10) did not identify any care issues which may have made a difference to the outcome. There were 3 cases with issues identified which would not have affected the outcome in the antenatal and neonatal care. Two of the issues identifed related to not being co-located with neonatal services.

Of the 13 stillbirths/neonatal deaths, 4 (31%) were **in non-white mothers**. This is higher than the birthing population for 2021-22 (c 15.5%). 8/13 (62%) stillbirths/neonatal deaths resided in the most deprived decile for Index of multiple deprivation. Given the small numbers, these data will need to be reviewed in larger data sets for meaningful assessment.

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

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

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

MAIN REPORT

This is the quarter 2 2023/24 mortality report for adults, stillbirths and neonates. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust. This is in accordance with recommendations by the National Quality Board "National Guidance on Learning from Deaths" and the Care Quality Commission. It outlines the work taking place operationally and being overseen by the Safety and Effectiveness Sub - Committee and Quality Committee.

The data presented in this report relates to Q2 2023-24. The learning relates to deaths in Q1 22/23 or earlier. This is due to the multidisciplinary review of deaths not occurring in the quarter when the death occurred.

Additional data/information relating to mortality is presented in the embedded word documents.

1 Adult Mortality

The data relating to adult mortality is pure data and is not standardised mortality data (such as SHMI) due to the low number of deaths in our care and the complexity of the patients cared for by the Trust. The use of pure data and not standardised mortality rates has been previously agreed with the CCG/ICB as the Trusts approach to monitoring mortality rates.

The requirement is to report adult deaths that occur at LWH. However given the isolated nature of our services, women who deteriorate whilst an in-patient at LWH will be transferred to other hospitals for ongoing care any may die at external trusts. The learning from deaths report now also includes information related to these deaths. These deaths may not be reported the quarter after the death occurs due to data collection and sharing and this is highlighted.

1.1 Obstetric Mortality Data Q2 2023/24

There was **1 maternal death in Q2 2023/24**.

G was a 29-year-old Black African woman in her third pregnancy who delivered by elective caesarean section at 40 weeks. She was non-English speaking and interpreter services were used throughout her pregnancy and postnatal period. The delivery and initial postnatal period were uncomplicated. G was admitted with suspected urosepsis on day 9 of her postnatal period. She was treated as per the red sepsis guidance and discharged after 48 hours with oral antibiotic cover.

The patient attended LWH again in the late afternoon of the postnatal day 23 with the signs of severe sepsis. She was commenced on red sepsis pathway as per Trust protocol but did not respond to the initial treatment and due to rapid deterioration in her clinical condition she was transferred to the Royal Liverpool and Broadgreen University Hospital (RLBUH) for intensive care treatment. G died in intensive care at RLBUH in the early morning of day 24 postnatally. The cause of death has yet to be confirmed, but it is presumed to be related to sepsis of currently unknown origin.

Initial review identified lack of co-location of Adult services as a contributory factor. The case has been referred to the Coroner and to HSIB for investigation. Learning from these investigations will be included in future reports.

1.2 Learning from Obstetric Mortality Data

Due to the significant time delay for investigations to conclude following a maternal death, the deaths will continue to be reported through this paper until the learning is concluded.

Case AS Q3 2021/22

In Q3 2021/22, there was one death of a white British woman who died approximately 8 weeks after delivery. This case was subject to a Coronial investigation and, as per the requirements of the Ockenden review, a multiagency review has been completed with learning presented in previous reports. The Coroner's inquest was undertaken in November 2023 and concluded:

> A died from natural causes, most probably due to sudden arrhythmic cardiac event with morphologically normal heart, possibly caused by A having suffered from anorexia nervosa for an extended period, and unwell during pregnancy, when she ultimately delivered her daughter Poppy on [date]."
>
> The formal cause of death is as follows:
>
> 1a) Sudden Arrhythmic Death Syndrome (SADS) with a morphologically normal heart
>
> The Coroner explicitly confirmed to the family that there was no neglect from the hospital in relation to As care.

Hill Dickinson has fed back that *Dr Clement-Jones was an incredibly positive witness for the Trust as he showed a willingness to reflect on A's care and accept where changes in the care may have been warranted, but was robust and comprehensive in his explanations of A as having been a complex case, with the management of low potassium being a difficult task.*

As the learning from this case has concluded it will not be included in future Learning From Deaths Reports.

Case HO Died Q4 2022/23

This related to the death of a black African woman at 18 weeks gestational age who deteriorated whilst an in-patient at LWH. She was transferred to LUFHT where she sadly died. This death has been investigated via a Serious Untoward Incident investigation (led by the Gynaecology division due to her presenting the GED) a HSIB investigation and is also being investigated by the Coroner. The cause of death has been recorded as

1A- acute intestinal ischaemia
1B- Thrombophilia and pregnancy.

The SI report (2023/5813) identified the following as a root cause of the incident:

- The lack of onsite surgical team and managing the patient in isolation and not ‘shared care’ with other acute specialties.
- Lack of co-location of LWH with acute trust.

The finalized HSIB report was provided to the Trust in December 23. This report included multiple findings including the following:

1. It is likely that culture, ethnicity, or health inequalities impacted upon the diagnosis, escalation and the care that the Mother received.
2. The pain scoring system used to document the Mother's pain was inaccurate, incomplete and not in line with local guidance. A standardised approach to pain scoring supports holistic review and care planning.
3. The gynecology ward routinely uses the national early warning score version 2, rather than the Maternity Early Warning score and this impacted upon recognition and escalation of deteriorating condition.
4. Due to sickness, there were less staff on the ward than expected.
5. The national junior doctors’ industrial action impacted upon on escalation and decision making as staff did not escalate up the hierarchical chain as all the
6. The gynecology clinicians were consultant level (acting down) and this impacted upon the timing of imaging, diagnosis, and surgery.

There is an extensive action plan associated with this report which will be monitored through the Family Health Divisional Board and Safety and Effectiveness committee. The findings from this report have also fed into the trust wide anti-racism strategy and deteriorating patient collaborative.

Socio Demographic characteristics of Maternal Mortality over the past 10 years
The three most recent maternal deaths have all occurred in non-white women. Circa 1 in 6 (14% in MSDS submission 2022) of LWH mothers are non-white.

In the 2022 MBRRACE report the risk of maternal death was nearly four times higher among women from Black ethnic minority backgrounds compared with White women and this continues to be the case in the most recent report. The risk was almost twice as high for women from Asian backgrounds and it has not changed since 2018 report

As the number of deaths are small caution must be taken with interpreting the ethnicity data. A recent paper by the Maternal safety Champion has reviewed maternal mortality in the last 10 years at LWH (see Appendix for the paper). Reviewing the last 10 years of maternal deaths identifies that all of the other 13 deaths were in white women. Thus in the last 10 years the maternal mortality in non-white women (3/16 or 18%) is similar to our current booking population. However, the recent deaths may be indicating a shift in the mortality demographics.

From the review of the last decade of maternal mortality 13/16 (81%) maternal deaths lived in 20% of the most deprived areas. In the total booking population 69% of mothers were in the bottom quintile. 11/16 (68%) lived in the most deprived 10% of areas. Compared to a booking population of 55%. There is therefore an excess mortality seen at LWH related to deprivation, however this is not statistically significant (p =0.30 at the quintile level).

This report has been made available to Board members via AdminControl.

1.3 Gynaecology Mortality data Q1 2022/23

There were 0 expected deaths within Gynaecology Oncology in Q2 2023/24.
There was 0 unexpected death within Gynaecology services in Q2 2023/24.

2023/24	Expected	Unexpected	Deaths of LWH patients transferred as in-patients
Q1	1	0	0
Q2	0	0	0
Q3			
Q4			
ANNUAL	**1**	**0**	**1**

Table 1 Gynaecology Mortality LWH

1.4 Learning from Gynaecology Mortality Q1 22/23 2022/23

There were no deaths in Q1 2022/23. The learning from the case HO is included in the section on maternal mortality above.

2 Stillbirths

2.1 Stillbirth data

There were 4 stillbirths, excluding terminations of pregnancy (TOP) in Q2 2023/2024. This has resulted in an adjusted stillbirth rate of 2.2/1000 live births for Q2 23/24.

STILLBIRTHS	Sept-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May - 23	June - 23	July - 23	Aug - 23	Sept - 23	TOTAL 2023/24
Total Stillbirths	3	2	2	6	2	4	1	5	4	10	5	3	3	30
Stillbirths (excluding TOP)	**1**	**1**	**2**	**5**	**1**	**3**	**0**	**0**	**2**	**1**	**3**	**1**	**0**	**7**
Births	656	649	596	619	630	519	613	613	599	554	629	612	587	3594
Overall Rate /1000	3.0	4.7	6.7	9.7	3.2	7.7	1.6	8.2	6.7	18.1	7.9	4.9	5.1	8.3
Rate (excluding TOP)/1000	**1.5**	**1.6**	**3.4**	**8.1**	**1.6**	**5.8**	**0**	**0**	**3.3**	**1.8**	**4.8**	**1.6**	**0**	**1.9**
Pregnancy loss 22-24 weeks (excluding TOP)	1	1	1	1	1	0	0	1	0	2 (twins)	0	1	0	4

Table 1 Stillbirth rates for past 12 months . The stillbirth rate for this 23/24 so far is 1.9/1000 births.

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

Table 2: Quarter and Annual Stillbirth rate/1000 births since 2019/20 (excluding terminations)

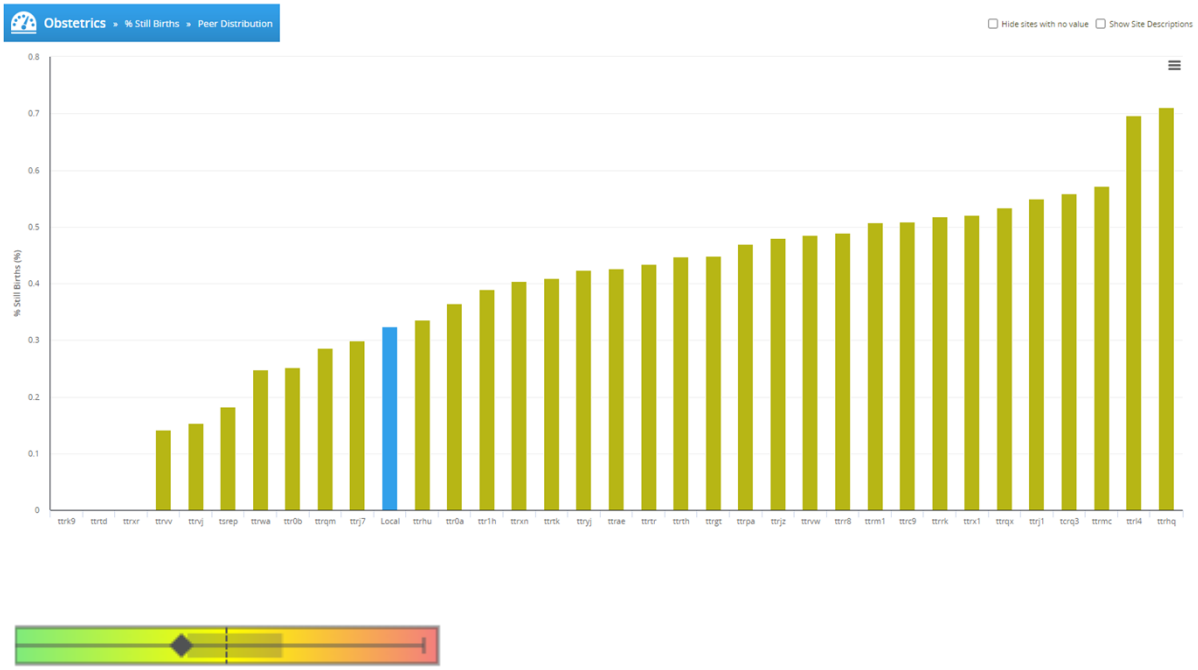


Figure 1 and 2. Stillbirth data with LWH benchmarked against other large maternity services (>7000 deliveries) Q2 2023-24. The blue bar LWH data demonstrating the observed rate is within the lowest quartile for stillbirths.

When benchmarked against similar large organisations, we are below the interquartile range and at the lower end for stillbirth mortality. Whilst this is encouraging, the numbers are small, and this is encouraging particularly given the low stillbirth rate seen in Q1.

2/5 women were BAME. This is higher than the booking population but caution needs to be taken given the small numbers. In the past we have not seen an excess of BAME representation in the stillbirth population and annual data is required to make any meaningful assessment.

4/5 (80%) of stillbirths occurred in women residing in the most deprived IMD deciles.

2.1 Learning from Stillbirth and PMRT reviews Q4 22/23 2022-23 N=11

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

The reviews of Q1 23/24 stillbirths (n=6) identified that 1 (17%) case had antenatal care issues which would not have changed the outcome of the pregnancy. This related to midwifery reviews when patients are under the care of the FMU service.

There was one issue in the postnatal care related to external noise in the bereavement room.

Grade	Care in antenatal period	Percentage (%)	Care provided after Stillbirth	Percentage (%)
A	5	83.3	5	83.3
B	1	16.7	1	16.7
C	0	0	0	0
D	0	0	0	0

Table 3 PMRT review panel grading of care provided in cases of Stillbirth (N=6)

The attached appendices provide information on progress with on-going actions from related to prior stillbirths.

3. Neonatal Mortality

3.1 Neonatal mortality Data Q2 2022/23

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

The table below presents the total number of deaths at LWH, the mortality for babies born at LWH, the number of deaths eligible to report to MBRRACE and the number of deaths of inborn babies born at between 24 to 31+6 weeks gestational age. This last group is reported national by the national neonatal audit project and monitored locally by the ODN. The benchmark of 6.3% is locally derived by the ODN. The threshold was the overall mortality in the UK between 2015 – 2018 for the population of 24 – 31+6 week babies. As LWH receives IUTs of (higher risk) preterm mortality it is unlikely that our mortality would be below the average for the whole population. This issue is being discussed with the ODN to identify a more suitable benchmark.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	March-24	Total
Births	613	599	554	629	612	587							3594
INBORN Neonatal Mortality (all live births)	2	1	9*	3*	4	1							20
Total mortality on NICU	3	1	6	3	4	1							18
INBORN + DIED LWH Neonatal mortality	2	1	6	2	4	1							16
IUT Mortality	0	0	5*	0	4	0							9
PNT Mortality	1	0	0	1	0	0							2
INBORN (+died LWH) Neonatal Mortality Rate/1000LB	3.2	1.7	10.8	4.8	6.5	1.7							4.5
MBRRACE eligible deaths *Excl. congenital anomaly*	*0* *0*	*1* *1*	*3* *2*	*1* *0*	*4* *2*	*1* *1*							*10* *6*
Benchmark: MBRRACE data 2021 *3.36/1000LBs* *(excl. congenital anomaly) 1.44/1000LBs*	*0* *0*	*1.7* *1.7*	*5.4* *3.6*	*1.6* *0*	*6.5* *3.3*	*1.7* *1.7*							*2.8* *1.7*
NWNODN benchmark INBORN 24-31 w	*0*	*1*	*2*	*0*	*3*	*1*							*7*
Benchmark (NNAP >6.3% of admissions)	*0*	*5.3*	*14.2*	*0*	*25*	*10*							*10.9%*
NWNODN benchmark INBORN 24-27 w	*0*	*1*	*1*	*0*	*1*	*1*							*4*
Benchmark (NNAP >15% of admissions)	*0*	*20*	*50*	*0*	*25*	*25*							*17.4%*

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

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

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

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

In this quarter there were 8 deaths on the NICU. 4/8 (50%) of the deaths were from pregnancies originally booked outside of Liverpool.

There were 4 deaths in the in-born preterm population (24 to 31+6 weeks). This resulted in a 10.9% mortality figure. The benchmark figure of 6.3% is derived from the overall mortality in this population nationally, however as LWH receives the majority of extreme preterm babies from Cheshire and Merseyside, the mortality in our inborn population would be expected to be higher than the national average. The use of this benchmark continues to be discussed with the ODN.

6/8 babies (75%) were white British. 1 was of Asian background and 1 black African.

Half (4/8) deaths occurred in families who live in the most deprived decile (similar to the booking population).

3.3. Learning from neonatal mortality reviews for Q1 23/24

There were 10 deaths subject to a PMRT review. There were no cases identified with care issues which were likely to have made a difference to the outcome.

There were 3/10 (50%) cases whereby issues were identified in the antenatal care provided by LWH that would not have affected the outcome.

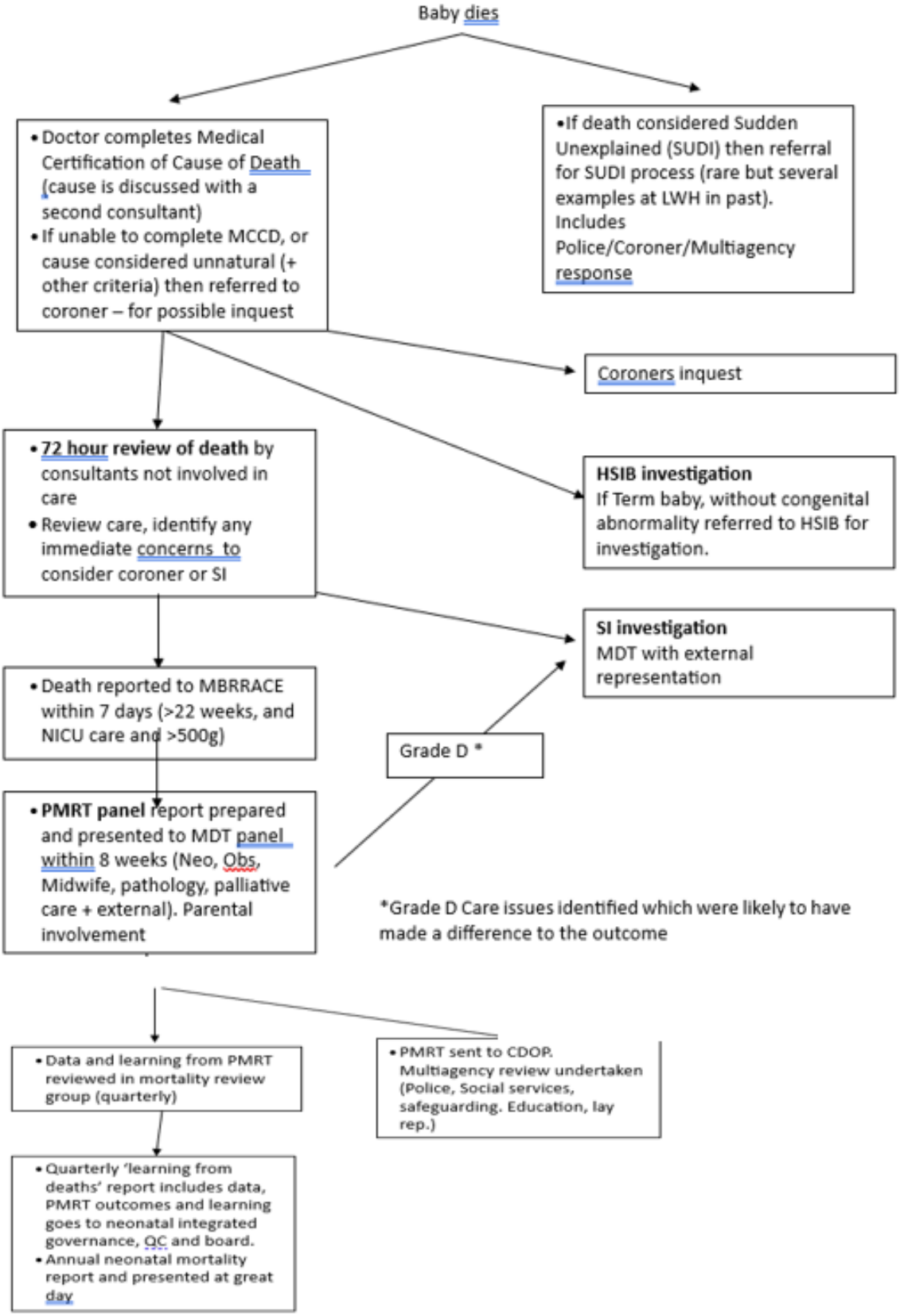
There were 4/10 (40%) cases whereby issues were identified in the neonatal care provided by LWH that would not have affected the outcome. Two of these cases related to not being co-located with neonatal surgical services.

One baby (not included in the LWH PMRT data) died at AHCH and underwent review there. Non-colocation of NICU and surgical services were identified as impacting upon the care provided. This case has been presented at the LNP board.

3.4 Assurance Process around Neonatal Mortlaity.

In October 2023, the board requested an update around the oversight framework in place at the trust , system and regional levels for neonatal mortality. The oversight and assurance is multifaceted and will depend upon the circumstances of the death.

The process is mapped out below.



Notes relating to the oversight of Neonatal Deaths.

Role of the Medical Examiner

Medical examiners are senior medical doctors provide independent scrutiny of the causes of death, outside their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. The medical examiner system is currently set up for adult deaths and as of April 24 will be also providing additional scrutiny for neonatal deaths. The medical examiner for neonatal deaths will be undertaken by two paediatric intensive care consultants operating under the ME examiner system at LUFHT.

Sudden Unexpected Death in Infancy (SUDI)

SUDI is defined as a death (or collapse leading to death) of a child, which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent. SUDI is a descriptive term used at the point of presentation, and will include those deaths for which a cause is ultimately found (‘explained SUDI) and those that remain unexplained following investigation Whilst this definition is more readily associated with unexpected deaths in the community setting, it also applies to deaths of infants in the hospital setting. However, there are situations that would not trigger a SUDI protocol, such as the infant who is well but deteriorates with overwhelming sepsis. National guidance also includes the following: *When a newborn infant suddenly collapses and dies on a neonatal unit, consideration should be given as to whether a joint agency response is required. In most situations this would not be appropriate.* (Sudden unexpected death in infancy and childhood Multi-agency guidelines for care and investigation, November 2016)

For any cases considered to be a SUDI, a discussion with the coroner is held who will decide if the SUDI protocol is initiated.

Perinatal Mortality Review Tool (PMRT) panel

Since January 2018, all perinatal deaths of babies born from 22+0 weeks gestational age are reviewed using a standardised perinatal mortality review tool. This tool assigns grading to the care in the antenatal, neonatal and post-bereavement care. All PMRT review panels at LWH have external representation of clinicians including neonatologists, obstetricians and midwives.

The PMRT data is presented in the LWH Learning from Deaths quarterly report and also to the NW ODN.

Child Death Overview Panel (CDOP)

Child Death Overview Panels became a statutory function in 2008. The over-riding purpose of reviewing all child deaths is to reduce the risk of future deaths or harm to children. CDOP is the final stage of the Child Death Review (CDR) process. CDOPs undertake reviews of all deaths of children normally resident within any of the local authority areas where a death certificate has been issued. CDOPs are multiagency and hold strategic partners to account in relation to any identified matters relating to the death, or deaths, that are relevant to the welfare, public health and safety of children. Merseyside CDOP hold neonatal specific panels which are attended by am LWH neonatal consultant.

Benchmarking

MBRRACE collect and report "extended perinatal mortality" data (stillbirths and deaths within 28 days for babies born at >22+0 weeks. The MBRRACE report however focusses on births from 24 weeks gestational age). The MBRRACE report allows benchmarking of mortality for stillbirths, neonatal mortality and both combined between similar organisations. It adjusts for several confounding variables.

LWH also participate in benchmarking through the **Vermont Oxford Network**. This is a voluntary network providing data for babies less than 1500g or 29+6 weeks gestational age. It includes 1086 centres around the world including a number in the UK. This data base allows us to benchmark mortality with similar centres in the UK and around the world.

4. Recommendations

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

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

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.
- the care issues identified in the antenatal management from referring trusts. It is recommended that a review of antenatal care findings from the previous PMRT reviews is undertaken and if any common themes identified that this is presented to the local maternity system

5. Appendices

- Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report – Q2 (July – Sept 2023)
- Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report Template

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Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report – *Q2 (July – Sept 2023)*

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

Contents

PROVIDER:	**LIVERPOOL WOMEN'S HOSPITAL**
COMPLETED BY:	**AI-WEI TANG**
DATE COMPLETED:	**NOVEMBER 2023**

1. EXECUTIVE SUMMARY:

a. There were 4 stillbirths, excluding terminations of pregnancy (TOP), in the 2nd Quartile (July – September 2023) of 2023/2024. This results to an adjusted stillbirth rate of 2.2/1000 for this Quartile.

b. In this quartile, there was 1 pregnancy loss (excluding TOP) born between 22-24 weeks gestation.

c. All stillbirths and pregnancy loss between 22-24 weeks in Q1 of 2023/24 (N=6, but 5 patients as 1 set of twins) have been subject to a full multidisciplinary review panel meeting utilising the PMRT tool with external clinician presence.

d. All bereaved parents were invited to be involved in the review process by submitting comments and questions via the Honeysuckle Team for discussion at the MDT Review. 2 of 5 families in Q1 submitted questions and comments which were discussed by the MDT panel.

e. The MDT reviews of 3 Stillbirths and 3 pregnancy loss in Q1 have found no antenatal and postnatal care issues identified in 5 cases, and care graded B (*care issues identified which would have made no difference to the outcome of the pregnancy*) in 1 case, in accordance with the MBBRACE Grading system.

f. There were no Grade C or D (*care issues identified which may have, or were likely to have made a difference to the outcome of the pregnancy*) in the review of Q1 cases.

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2. DASHBOARD AND BENCHMARKING

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

STILLBIRTHS	Sept-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May - 23	June - 23	July - 23	Aug - 23	Sept - 23	TOTAL 2023/24
Total Stillbirths	3	2	2	6	2	4	1	5	4	10	5	3	3	30
Stillbirths (excluding TOP)	**1**	**1**	**2**	**5**	**1**	**3**	**0**	**0**	**2**	**1**	**3**	**1**	**0**	**7**
Births	656	649	596	619	630	519	613	613	599	554	629	612	587	3594
Overall Rate /1000	3.0	4.7	6.7	9.7	3.2	7.7	1.6	8.2	6.7	18.1	7.9	4.9	5.1	8.3
Rate (excluding TOP)/1000	**1.5**	**1.6**	**3.4**	**8.1**	**1.6**	**5.8**	**0**	**0**	**3.3**	**1.8**	**4.8**	**1.6**	**0**	**1.9**
Pregnancy loss 22-24 weeks (excluding TOP)	1	1	1	1	1	0	0	1	0	2 (twins)	0	1	0	4

Table 2: Stillbirths (excluding terminations)

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

Table 3: Stillbirth (>24 weeks) by Cause (Q1, 2023/24)

Reported cause of death (based on CESDI 2018)	No.	Transferred care for delivery in LWH
Termination of pregnancy for fetal abnormality	17	
Fetal/chromosomal abnormality	0	
Pre-eclampsia	0	
Antepartum haemorrhage (abruption)	0	
Medical disorder	0	
Multiple pregnancy	0	
SGA (<10th centile)	1	
Mechanical	1	
Infection	1	
Specific placental condition	0	
Unclassified	0	

In Q4, there were 3 pregnancy losses between 22-24 weeks, reviewed through the PMRT process, and the cause of death was:

- Fetal growth restriction with placental insufficiency
- Complications relating to monochorionic twin pregnancy

3. MORTALITY REVIEWS AND KEY THEMES (Q1 cases, including 3x pregnancy loss 22-24 weeks)

Table 4. PMRT review panel grading of care provided in cases of Stillbirth (N=6)

Grade	Care in antenatal period	Percentage (%)	Care provided after Stillbirth	Percentage (%)
A	5	83.3	5	83.3
B	1	16.7	1	16.7
C	0	0	0	0
D	0	0	0	0

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

Antenatal Care

Review panel grading	Reason for grading	Level of investigation (StEIS/Level 2/PMRT with external)	HSIB (yes/no)	Learning	Actions / QI plan aligned to theme
B	Communication by CMW that MW reviews not required as under FMU	PMRT	No	Importance of continuing CMW reviews as type of care provided different from FMU	Information sent by CMW matron to all regarding importance of regular CMW despite receiving regular hospital care

Postnatal/Bereavement Care

Review panel grading	Reason for grading	Level of investigation (StEIS/Level 2/Level 1/PMRT with external)	HSIB (yes/no)	Learning	Action / QI plan aligned to theme
B	Excessive noise level in bereavement room – not soundproof	PMRT	No	Increased awareness of noise levels in intrapartum areas	Poster on DS door to remind to be quiet on entering intrapartum area

a. PMRT PANEL ATTENDANCE and PARENTAL ENGAGEMENT

There was the presence of at least an external Obstetrician or Midwife in the PMRT reviews of all 6 cases of Q1 reviewed

4. INTRAPARTUM & TERM STILLBIRTHS (Q2 cases)

There was 1 case of intrapartum preterm labour at 23 weeks gestation and 1 term stillbirth (37+4 weeks). Initial 72hr review and MDT PMRT review of these cases showed no care issues that may have changed outcome.

5. SAFEGUARDING/UNBOOKED AND LATE BOOKERS (Q2 cases)

In Q2, there was 1 case of ongoing safeguarding concerns, who was under care of enhanced MW team and getting support for substance misuse.

There was one woman of Black African ethnicity who booked pregnancy late and was not provided with appropriate antenatal care. This case has been escalated to be reviewed through the PSII framework.

6. SOCIO-DEMOGRAPHICAL (Q2 cases)

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

Gestation at Stillbirth	Number (N=5)
<24 weeks	1
<28 weeks	0
28-31 weeks	2
32-36 weeks	1
> 37 weeks	1

Of these women, only 1 smoked in pregnancy.
4 of 5 women live in the lowest decile IMD score for residential address

7. LANGUAGE BARRIERS (Q2 cases)

Although there were 2 women who were of ethnic minority, there were no language barriers in any of these cases.

8. SMALL FOR GESTATIONAL AGE <10th centile (Q2 >24 weeks, N=4)

There were 2 cases of SGA. 1 case of FGR (0.2nd) was associated with placental insufficiency, where there were missed opportunities to have diagnosed FGR, hence investigated as a PSII. There was another case of SGA where serial growth scans

were performed, and SGA was undetected as birthweight was on the 9th centile. The cause of death for this was related to umbilical cord pathology as it was a hypocoiled and tethered cord, likely resulting in specific changes to the placenta.

9. FETAL ABNORMALITIES DEATHS (known and unknown)

In Q2 of 2023/24, there was a case of T18 confirmed antenatally.

10. LEARNING FROM DEATHS from Q1 of 2022/23

Areas for learning in the antenatal period are as summarised in Table 5 in the report, and all the actions have been completed.

11. LEARNING / GOOD PRACTICE / COMPLETED ACTIONS

Completed actions and recommendations from the last quarterly report include:

- Learning shared with all CMW on the need to continue have regular CMW reviews despite regular hospital or FMU reviews
- Recommencement of simulation training

Ongoing actions that are in progress, and discussed in various working groups include:

- Lack of pathway for CMW review in women who are booked to deliver in LWH but live out of area, and the need for this pathway to be reviewed, and has been transferred for tracking and action on the MRC log
- Capacity and demand review of services in FMU, including appointment waiting times for general clinic and specialised joint neonatal, FMU and Alder Hey services clinic; and addressing of MW staffing issues to ensure one-to-one care in DS
- Training of bereavement support champions to provide additional support to Honeysuckle team, and also ensure stillbirth investigations, including genetic tests have been appropriately requested for.

12. Benchmarking and CNST Compliance

As part of intelligence gathering the following sources were used for horizon scanning:

CQC, NCEPOD,NHS Digital, NHSE/I (includes LMS), NHSR, PHE, RCOG, RCM, MBRRACE-UK, HSIB, Ockenden, CNST Maternity Incentive Scheme

CNST compliance for Year 5 (from 30th May 2023 to current, 23/11/23)

Parameters	No. Cases	Completed (Percentage)
Reported to MBBRACE (7 days) – 100%	16	16 (100%)
PMRT MDT review started (2 months) – 95%	16	16 (100%)
PMRT report in Draft (4 months) – 50%	8 (others post qualifying period)	8(100%)
PMRT report Published (6 months) – 50%	6 (others post qualifying period)	6 (100%)
Parents informed of review – 95%	15	15 (100%)

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Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report Template

(includes Perinatal Mortality Review Tool summary – see Appendix)

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

Contents

PROVIDER:	**LWH**
COMPLETED BY:	**DR REBECCA KETTLE**
DATE COMPLETED:	**30TH OCTOBER 2023**

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

- Quarter 2 neonatal mortality rate is 4.8 /1000 LB for inborn births
- There were 0 cases in which care issues identified were considered may have or likely to have made a difference to the outcome (grade C/D)
- LWH preterm mortality is above the NWNODN benchmarking flags for the year to date – there is ongoing work to further understand this
- 2 highest causes of death are prematurity and congenital anomalies

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2. DASHBOARD AND BENCHMARKING

Table. 1 Neonatal mortality dashboard with benchmarking data

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	March-24	Total
Births	613	599	554	629	612	587							3594
INBORN Neonatal Mortality (all live births)	2	1	9*	3*	4	1							20
Total mortality on NICU	3	1	6	3	4	1							18
INBORN + DIED LWH Neonatal mortality	2	1	6	2	4	1							16
IUT Mortality	0	0	5*	0	4	0							9
PNT Mortality	1	0	0	1	0	0							2
INBORN (+died LWH) Neonatal Mortality Rate/1000LB	3.2	1.7	10.8	4.8	6.5	1.7							4.5
MBRRACE eligible deaths	*0*	*1*	*3*	*1*	*4*	*1*							*10*
Excl. congenital anomaly	*0*	*1*	*2*	*0*	*2*	*1*							*6*
Benchmark: MBRRACE data 2021													
3.36/1000LBs	*0*	*1.7*	*5.4*	*1.6*	*6.5*	*1.7*							*2.8*
(excl. congenital anomaly) 1.44/1000LBs	*0*	*1.7*	*3.6*	*0*	*3.3*	*1.7*							*1.7*
NWNODN benchmark INBORN 24-31 w	*0*	*1*	*2*	*0*	*3*	*1*							*7*
Benchmark (NNAP >6.3% of admissions)	*0*	*5.3*	*14.2*	*0*	*25*	*10*							*10.9%*
NWNODN benchmark INBORN 24-27 w	*0*	*1*	*1*	*0*	*1*	*1*							*4*
Benchmark (NNAP >15% of admissions)	*0*	*20*	*50*	*0*	*25*	*25*							*17.4%*

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

Table 2: Neonatal Death Rate per quarter

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

Table 3: Neonatal Mortality by MCCD A. cause Q2 23_24

Reported cause of death (based on CESDI 2018)	No.	IUT / PNT	Other information
Prematurity	3	1 PNT	All 22 and 23 weeks gestation
Respiratory	1		
Congenital anomaly	3	3 PNT	Hydrops fetalis TOF with congenital cardiac anomaly Multicystic dysplastic kidneys with pulmonary hypoplasia
Neurological	1	1 IUT	Severe bilateral intraventricular haemorrhage
Infection	1	1 IUT	
Renal			
Other	1		Coroners case – cause awaited

Coroners Cases 23_24:

Month	Case	Updates
June	AR	Referred to coroner, raised as SUDI PM found bacterial meningitis closed by coroner as natural causes
August	EM	Hydrops fetalis, cervical dislocation – PM due to be reported end of November
October	KH	SUDI declared by coroner; Police and social aspects stepped down PM report pending coroners investigation open

3. MORTALITY REVIEWS AND KEY THEMES

Table 4.1. PMRT review panel grading of care provided in cases of Neonatal Death Q1 (23_24)

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the baby up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A	4	5	10
PMRT grade B	5	5	-
PMRT grade C	-	-	-
PMRT grade D	-	-	-
Total cases	9*	10	10

**Birth hospital not able to join the review so AN remained ungraded – this is a HSIB / MNSI case and is being reviewed through that process also*

Alder Hey Mortality after transfer of care from NICU

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

- In quarter 1 23_24 1 baby who died at AHCH on review of the care by both the neonatal and surgical teams was felt to have been impacted by the non co-location of NICU and specialist neonatal surgical services, this was agreed at AH HMRG and the case has already been highlighted as an example to the LNP board

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

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

Review panel grading	Antenatal / Intrapartum Neonatal Bereavement	Reason for grading	Level of investigation(StEIS/Level 2/Level 1/PMRT with external)	HSIB (yes/ no)	Learning	Actions / QI plan aligned to theme
B	Antenatal / Intrapartum	Missed opportunity for joint obstetric and neonatal counselling whilst an inpatient at 22 weeks.	PMRT with external	No	Obs Cons on WR to highlight AN patients for counselling to NICU team.	Twice daily safety huddles to highlight AN patients as well as LW.
B	Antenatal / Intrapartum	Images from portable US machine on MatBase were not able to be stored for review.	PMRT with external	No		
B	Antenatal / Intrapartum	Earlier opportunity to give AN steroids – although regularly reviewed, reviews did not always include neonatal team.	PMRT with external	No	Daily joint review / discussion for extremely preterm gestation ladies	Joint obstetric and neonatal meeting to agree approach to steroids especially at extremely preterm gestations.
B	Neonatal	Hypothermia after admission to NICU	PMRT with external	No	Closer attention and	Thermoregulation team to extend QI

					awareness to thermal regulation after admission	work to include first 6 hours of admission. Findings presented at neonatal CG day.
B	Neonatal	11 incidents, incl. insulin medication error, unplanned extubation, skin injury from extravasation	PMRT with external	No	Medication incident managed through usual pathways. UE continue to be monitored post QI, incidence remains steady at the improved level,	Regular reminders for UE QI learning points via LOTW and ongoing monitoring. Medicines group to monitor errors and feedback themes or wider learning.
B	Neonatal	Non co-location with neonatal surgical services	PMRT with external	No	LNP development of NICU at AHCH	LNP development of NICU at AHCH
B	Neonatal	Non co-location with neonatal surgical services	PMRT with external	No	LNP development of NICU at AHCH	LNP development of NICU at AHCH

a. PMRT PANEL ATTENDANCE

4 MDT Neonatal PMRT panels held for Q3 babies, all had at least 1 external representative. All meetings had an external neonatologist,1 of the 4 meetings had an obstetric, midwife and neonatal external panel member, 2 meetings had an external neonatologist and midwife and 1 meeting had an external obstetrician and neonatologist.

Panel meeting	External Neonatologist	External Obstetrician	External Midwife
June	✓	✓	✓
July	✓	✓	✓
September	✓	✓	✓
September	✓	✓	✓
October	✓		
October	✓	✓	✓

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

There was 1 LWH born baby who died at term due to congenital anomaly of multicystic dysplastic kidneys with pulmonary hypoplasia.

5. SAFEGUARDING/UNBOOKED AND LATE BOOKERS

2 babies who died in the neonatal period during Q2 were born to women who had previous safeguarding issues identified, but cases had been closed to safeguarding. No late bookers or unbooked pregnancies, 1 baby born at home following self-discharge.

6. SOCIO-DEMOGRAPHICAL

5/8 babies were extremely premature (<28 weeks), 2 of those babies were born at 22 weeks gestation.

Ethnicity data available shows 6 / 8 babies born to mothers of white -british background, 1 of Asian background and 1 of black African background.

All 8 babies died within the neonatal period <28 days of life. 3 were early neonatal deaths <72 hours of age.

Of the 8 deaths in Q2 6 live in the lowest 3 deciles of index of multiple deprivation according to booking postcode, 4 in the lowest decile.

7. LANGUAGE BARRIERS

All families spoke English and did not require interpretation.

8. FETAL ABNORMALITIES DEATHS (known and unknown)

4 deaths were associated congenital anomalies including 2 cases of hydrops fetalis, trachea-oesophageal fistula with congenital cardiac anomaly and multicystic dysplastic kidneys with pulmonary hypoplasia.

9. LEARNING / GOOD PRACTICE.

Below are comments received from families through the PMRT parent feedback process.

FAMILY 1:

We felt so cared for by many members of all the teams we interacted with at LWH. We wanted to specifically thank Sri for his thoughtfulness, care and attention to Aarin and for listening to all of our concerns; Caroline Batin-Robinson for all her support when Aarin was being palliated and after his death; Emma (NICU nurse) who made hand and footprints of Aarin before he became critically ill, and we felt looked after us like friends; Karen (NICU nurse) who cared for Aarin whilst he was very ill and then on the day he was extubated and Becki (obs ANP) who had complete control of the room when I gave birth in MAU. This experience has taught us that the care a family receives after a patient has died is every bit as important as the care they had during their life. For this we are forever grateful to the honeysuckle and snowdrop teams.

FAMILY 2:

As heartbreaking as the situation was, the support and care we received from the nurses, doctors and consultants at LWH were very much appreciated, and dignity was given at all times. The time we got to spend in the Honeysuckle suite was precious and we are grateful that such a room exists, we would like to thank the bereavement nurse [redacted], especially for her support during this time and for creating our last memories with little Miley. In addition a big thanks to the nurses who worked with Miley on her last day of life, [redacted]. We would like to show our appreciation to nurse [redacted] who looked after Miley during her time at Alder Hey, it made us at ease knowing a nurse from LWH neonatal unit with experience was there who kept us informed and excellent care to our daughter. In addition, we would also like to show our appreciation to all the nurses that looked after Miley during her time in room 4 prior to her surgery, especially nurses [redacted] to whom we were able to create the best of memories with our little girl over her 30days of life.

FAMILY 3:

Requested we did not do a PMRT review for their baby as they could not fault the care they had received across all the hospital specialities.

Liverpool Women's NHS Foundation Trust

Trust Board

Agenda Item	**23/24/251d**			**Date: 08/02/2024**
Report Title	**Guardian of Safe Working Hours Quarter 3 2023/24**			
Prepared by	***Kat Pavlidi, Guardian of Safe Working Hours***			
Presented by	***Kat Pavlidi, Guardian of Safe Working Hours***			
Key Issues / Messages	**The Board is advised:** • **rota establishment continues to fluctuate throughout the year with processes in place to mitigate the use of high-cost agency locums wherever possible by using internal bank, doctors in training and ANNPs, with 179 shifts being put out for cover in all three specialities out of hours.** • **Six exception reports were submitted relating to difference in hours of work and loss of natural breaks. One work schedule review took place relating to starting hours. No educational exception reports were submitted.** • **This report does not include data on gaps caused by the ongoing Industrial Action both by the Junior Doctor or Consultant cohorts, as with previous reports since IA started taking place**			
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 read and note this report from the Guardian of Safe Working Hours.			
Supporting Executive:	***Lynn Greenhalgh, Medical Director***			

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* BAF risk 1	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
PPF	**Jan 24**	**MD**	**See PPF Chair's Report.**

EXECUTIVE SUMMARY

The Board is advised:

- rota establishment continues to fluctuate throughout the year with processes in place to mitigate the use of high-cost agency locums wherever possible by using internal bank, doctors in training and ANNPs, with 179 shifts being put out for cover in all three specialities out of hours.
- Six exception reports were submitted relating to difference in hours of work and loss of natural breaks. One work schedule review took place relating to starting hours. No educational exception reports were submitted.
- This report does not include data on gaps caused by the ongoing Industrial Action both by the Junior Doctor or Consultant cohorts, as with previous reports since IA started taking place.

The Guardian of Safe Working advises the Board that in her view the hours and templates are safe and compliant in each service and in line with the Junior Doctor contract, however there are still concerns intensified by the continued rota gaps which need covering to ensure patient care is provided.

REPORT

1. Introduction

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

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

This report covers all of the above for the reporting period 1st October – 31st December 2023, and relates to the third quarter of the year.

2. Guardian Report

2.1. Aggregated exception reports including outcomes

During this quarter, six exception reports were made, all from O&G doctors.

Period	Specialty	Grade	Reason	#exceptions	No: hours	Outcome
Q2	O&G	Tier 1	Hours	4	3 ½	TOIL Payment
Q2	O&G	Tier 1	Natural breaks	2	-	TOIL

The exception report submitted for extra time worked led to a Level 1 work schedule review due to the frequent early start time expected for doctors attending theatre (0800), which is outside of their start time set out in their original work schedule (0830). There is an expectation that doctors should see patients preoperatively alongside the consultant, both for patient safety and doctor's training. Due to the amount of theatre lists being run (up to 5 per morning) this happens frequently enough that work schedules need to be changed to address this. The GoSWH will be monitoring these work schedule changes overtime to ensure that doctors are renumerated appropriately and working within the national JD contract.

There were two ERs relating to lack of breaks during a shift. The GoSWH continues to acknowledge the barriers that doctors face leading to them frequently not submitting exception reports. All Post Graduate Doctors (PGDs) are encouraged regularly to Exception Report when they work outside of their contracted work schedule. The newer groups of PGDs are more in tune with the Junior Doctors Contract and are more likely to complete ERs when working outside of their contracted hours.

Work is ongoing by the GoSWH and DME to improve acceptance of using ERs by all doctors and education for Supervisors to encourage their PGDs to submit ERs regularly. The GoSWH meets with each new batch of rotating doctors in each specialty as well as discussing ERs during the bimonthly Junior Doctor Forums. Anecdotally there are many issues but as they are not always reported, it can be difficult to lead any change.

2.2. Details of fines levied

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

2.3. Data on rota gaps

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

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

This quarter there was an increased number of doctors within the anaesthetic service being asked to provide support for the Tier 1 doctor on call. This is mainly due to the trainees rotating through the anaesthetic speciality being mostly of Tier 1 grade, especially important due to the high-risk environment of obstetric anaesthesia. The total number of shifts were 14 throughout the quarter.

2.4. Data on locum usage

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

Anaesthetics

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training/bank/ trust Dr cover	Consultant cover	Unfilled
October 23	120	10	10	0	0
November 23	120	21	21	0	0
December 23	120	8	8	0	0

Of the 39 locum shifts in Q3, all shifts were covered by the current PGD cohort undertaking additional shifts, bank doctors, and Trust doctors. During this reporting period, no shifts remained uncovered due to short term sickness. The number of gaps in this reporting period has increased compared to the previous quarter (19). However

it is of note that this is due to the extra 14 shifts used to support the Tier 1 doctors and would otherwise have been a smaller increase had these shifts not been required.

Neonates

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training Dr's/ANNPs cover	Consultant cover	Unfilled
October 23	168	4	4	0	0
November 23	168	8	8	0	0
December 23	168	1	1	0	0

Of the 13 locum shifts in Q3, all shifts were covered by the current PGD cohort undertaking additional shifts, ANNPs, bank doctors, and Trust doctors. During this reporting period, no shifts remained uncovered due to short term sickness. The number of gaps in this reporting period has decreased again by half compared to the previous quarter (35).

Genetics

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

Obstetrics and Gynaecology

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training/bank/trust Dr cover	Consultant cover	Unfilled
October 23	252	28	26	0	2
November 23	252	55	46	0	9
December 23	252	44	38	0	6

Of the 127 locum shifts in Q3, shifts were covered by the current PGD cohort undertaking additional shifts, bank doctors, and Trust doctors. This reporting period, 17 shifts remained uncovered due to short term sickness but were mainly relating to weekend 08.30-13.00 Tier 1 gaps which have traditionally not been covered if the gap remains. The number of gaps in this reporting period has remained relatively stable compared to the previous quarter (122).

As predicted all services saw a continued absence rate due to issues such as sickness and doctor burnout. This is a trend that is being noted throughout the last few years, with this issue becoming unsustainable for the Trust, and within the PGD group. This leads to continued low morale and has increased the support for ongoing Industrial Action, in turn affecting the care patients receive and the Trust's financial position even further.

3. Other relevant data

There is an ongoing Workforce Planning project which is looking into required clinical cover throughout all services within LWH and looking into using Medical Associate Practitioners (MAPs) to help plug the gaps, closely balancing the need for service provision and training to be maintained.

This project has also borne a 'Time to Train' report, which looks at how many hours per week are needed for each doctor to have adequate training in their specialty, as well as allowing for self-development and mandatory training, as well as providing safe clinical service to the Trust for the amount of work needed.

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

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

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

5. Conclusion

The Board are advised:

- the number of gaps in this quarter has increased within the Anaesthetic service, mainly due to the need for Tier 1 doctor support shifts.
- The Trust continues to appoint locally employed doctors to help reduce the long-term gaps and therefore help with service provision.
- There are several expected gaps in Q4 of 2023-2024 and this has already been escalated to the Clinical Divisions and Executive teams, with requests made to consultants to help support the gaps when possible.

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

However, the GoSWH notes that the service continues to be at breaking point and this is not expected to improve any time soon. Although rotas are created to be safe, the number of gaps and shifts needing to be covered at short notice is not safe. The Workforce Planning project is needed to be implemented as fast (and safe) as possible, to help give adequate breathing space to all working within LWH.

6. Recommendations

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/251e***		**Date: 08/02/2024**	
Report Title	**Maternal Death HSIB Report and response**			
Prepared by	**Dianne Brown Chief Nurse**			
Presented by	**Dianne Brown Chief Nurse**			
Key Issues / Messages	***The Trust reported a case of a maternal death to regulatory bodies in March 2023. This report provides a summary of the case, immediate actions taken at the time and further actions taken considering feedback and recommendations from the external case review.***			
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): Funding requirements have been identified through the development of response which has been included within a formal summary paper which will be presented to the Board of Directors in February 2024 (item 253e).			
	For Decisions - in line with Risk Appetite Statement – Y ***If no – please outline the reasons for deviation.***			
	To receive the report and note Trust wide improvements that have been identified to ensure learning is embedded and sustained.			
Supporting Executive:	Dianne Brown Chief Nurse			

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)

2 - Inability to ensure the on-going sustainability of clinical services and prevent patient harm by maintaining a high standard of care at the current Crown Street site **3 – Failure to deliver an excellent patient and family experience to all our service users**	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	**30/01/2024**	**Chief Nurse**	**Noted contents.** **Accepted recommendations**

EXECUTIVE SUMMARY

In March 2023, the Trust reported an incident of a maternal death which had occurred within Liverpool University NHS FT, (LUHFT) following a transfer of care from the Gynaecology ward at Liverpool Women's NHS FT (LWH).

The Maternal death relates to 31-year-old black African woman who was 18 weeks pregnant and was seen within the Gynaecology Department (LWH). The woman later deteriorated at LWH requiring a critical care transfer to LUHFT where she further deteriorated and sadly died.

The Maternal Death was incident reported on Ulysses (Incident reporting System) by LWH and declared as a Serious Incident on the 17 March 2023, and was also subsequently reported via StEIS to external regulators and the Integrated Care Board. As this was a maternal death, the case was also referred to Maternity and New-born Safety Investigations (MNSI), which prior to October 2023 was formally known as The Health Service Investigation Body (HSIB). MNSI completed an independent investigation into the Maternal death which included interviews with staff involved, a full review of documentation, site visits and with involvement from the family.

On the 1 December 2023 the Trust received correspondence from MNSI that documented "Escalations of Concerns" in relation to this case and a further neonatal case which was under preliminary review (report awaited). Both cases were initially reviewed by the MNSI concerns panel on 7 November 2023.
The concerns noted by the panel were as follows.

- The impact of systemic cultural bias and stereotyping on the provision of safe and effective care across both investigations.
- The approach presented by some staff, and information gathered from staff interviews, gives the impression that cultural bias and stereotyping may sometimes go unchallenged and be perceived as culturally acceptable within the Trust.

A response was completed and shared by the Trust. Furthermore, details of the MNSI concerns were discussed and highlighted in the Trust's Rapid Quality Review meeting on 7 December 2023, at which MNSI was in attendance as a stakeholder. The Trust presented an overview of the concerns raised by MNSI and shared details of the commitment and actions established to tackle systemic cultural bias and stereotyping with the care they provide. This overview was also included within the Trust response letter to MNSI. The Trust received a further formal notification on the 19 December 2023 from MNSI stating that they were satisfied with the Trust response and therefore closed the escalation.

A final investigation report was subsequently received by the Trust in December 2023.
In response to the findings of the MNSI report the Trust has reviewed and considered thematic learning from other historic reported incidents which have included elements of inequalities or related to issues of recognising and acting upon patient deterioration. It was acknowledged that there was a theme across multiple incidents relating to the management of deterioration and a theme relating to incidents that included an element of inequalities. Therefore, in

addition to the formal actions identified in relation to policy and process, senior clinical leaders have agreed that there are two fundamental improvement themes which require a more systematic approach to improvement, which will embed and sustain positive behavioural and cultural change. These two areas identified are as follows.

- Development of a deteriorating patient collaborative
- Focussed Anti Racism strategy and implementation plan.

It is relevant to note that this incident occurred during Industrial Action taken by Post Graduate Doctors when Consultants Gynaecologist were covering all elements of care delivery. It is considered that this may have impacted on decisions made, timeliness of escalation and a clinical bias in terms of fresh eyes and situational awareness.

The Board of Directors are requested to receive this report acknowledge the learning identified and actions agreed and to note the previous presentation and discussions held at the Quality Committee in January 2024. The delivery of actions will be overseen through the Safety and Effectiveness Committee, with the two Trust improvements identified above (deterioration and anti-racism), and the implementation of a medical emergency team will be delivered through the Trust 2024/2025 Improvement plan and reported accordingly.

MAIN REPORT

1.0 Introduction

On 13 March 2023 a 31-year-old Black African woman who was 18 weeks pregnant was admitted via NWAS to the Gynaecology Emergency Department (GED) with acute abdominal pain. She was subsequently admitted to the Gynaecology Ward with a management plan to observe for potential premature labour and treat for constipation. On 14 March 2023 she deteriorated, and an ultrasound scan was performed revealing the death of the unborn fetus. Further deterioration resulted in a Critical Care transfer to LUHFT where she sadly died 2 days later on16 March 2023. Appropriate reporting was duly completed to regulatory bodies and duty of candour completed. The maternal death was reported to His Majesty's Coroner and the cause of death was recorded to have been of a natural cause.

The maternal death was also reported to MNSI who undertook a maternal death review. MNSI Maternity and Newborn Safety Investigations is the independent national investigator for patient safety in England. MNSI undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions, 2018), taken from Each Baby Counts and MBRRACE-UK.

The role of MNSI is to investigate serious patient safety risks and to produce rigorous, non-punitive, and systematic investigations and to develop system-wide recommendations for learning and improvement**.** MNSI utilises a standard process, reviewing medical records, conducting interviews with staff, families, and subject matter experts. When MNSI investigate an incident, it is expected that there would not be an internal Trust process and that they will take sole investigatory duties.

An Immediate Hot Debrief was held with staff involved and all staff were offered follow up psychological support as required.

A further briefing of senior leaders and Executive colleagues was held on 4 December 2023, to share the report and preliminary findings. There was an ask for all leaders to read and reflect on the report and to consider the additional clinical actions required of the Trust to enhance safety for women from a global majority. Learning from the report has been shared at local huddles and handovers within the clinical areas using an SBAR format to support changes in practice and recommendations for improvement. The report and findings will also be shared in Quarter 1 within the weekly safety check in and Great Day for wider learning.

The ongoing actions will be addressed in the development of the Quality Priorities for 2024/2025 which is currently in development.

The correspondence received was also shared with Maternity and Neonatal Safety Board Champions to discuss at the meeting on 13 December 2023.The Chief Nurse had offered to meet personally with family members as part of the process, however this has been declined at this stage.

2.0 Context

MMBRACE data demonstrates that women from the global majority are significantly more likely to die in pregnancy or shortly afterwards than white women, as are their babies. The October 2023 MBRRACE-UK report evidenced that between 2019 and 2021, there remains an almost four-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to white women. This disparity remains statistically unchanged from 2018-2020.

The Trust has also identified themes from reported incidents and near misses relating to harm occurred by global majority women, which have included inappropriate management of clinical deterioration. This builds on the current and well documented risk associated with the isolation from adult acute services of this site.

3.0 MNSI Investigation Findings and Analysis

The HSIB findings of the investigation has identified themes believed to have contributed to the patient's clinical deterioration, which reflect failure to recognise, respond and escalate the patient's condition. Specific areas highlighted that require improvement were noted within the report as. The HSIB investigation report concluded with five recommendations which have been accepted by the Trust and have formed part of a detailed improvement plan.

3.1 Pain scoring and Pain Management

HSIB report that the pain scoring systems used did not support staff to escalate concerns when assessing the woman's pain relief needs. There was no effective response to the pain relief given, which should have raised suspicion of a more serious illness and prompt further escalation to the wider team for exploration of the patients' symptoms to inform care planning.

The Gynaecology team are working on the following actions to ensure that a standardised approached is used to measure and assess a woman's level of pain. Actions include.

- Review of Guidelines "Analgesia in Pregnancy" and "Analgesia in Gynaecology Surgery" is being undertaken by the Consultant Anaesthetic Team and will be completed by the end of January 2024.
- Electronic pain assessment and escalation are now available and in use Digicare, (electronic patient record) with training to support appropriate completion. This will be audited monthly and reported through the Gynaecology Divisional Board.
- The oversight of compliance of pain assessments, care plans and comfort checks to be reported to Divisional Governance as part of the matron's audits, compliance is routinely monitored, and outcomes appear consistently good.
- Monitor occurrence of daily pain round by anaesthetist and escalate and rectify if non-occurrence. Consider provision for weekend cover as part of business planning.

3.2 Recognition of deteriorating condition and escalation of observations

Ambulance and Gynaecology departments routinely use the National Early Warning Score (NEWS2). NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. However, In the last two 'Saving Mothers Lives' reports substandard care was identified where signs and symptoms were not recognised and acted upon. Both reports recommended that a national Obstetric Early Warning Scoring system should be introduced and used for all obstetric women, including those being cared for outside the obstetric setting (CEMACH 2007, CMACE 2011).

The Confidential Enquiry into Maternal and Child Health (CEMACH) (2007) suggests that within Obstetrics a modified early obstetric warning tool specifically designed for pregnant women is used (MEOWS)

In this case the NEWS 2 assessment tool was used, furthermore recording was not in line with local guidance suggesting its use may have impacted on the level of care that the patient received once she was admitted to the gynaecology ward and that there was delayed recognition that intervention was required. Whereas use of MEOWS, would have demonstrated the need for an increase in frequency of her observations and earlier escalation to the multidisciplinary team.

It was noted that observations were not performed as the patient was being "*difficult refusing to have her observations undertaken due to the amount of pain she was experiencing*." This led to missed opportunities to detect deterioration and escalate concerns.

The Gynaecology division have implemented the following actions to ensure that when pregnant women are admitted within the gynaecology service, staff are supported to undertake and document clinical observations using the nationally recommended MEOWS chart in line with local guidance.

- MEOWS charts to be implemented for pregnant women within Gynaecology services. (MBRRACE-UK, 2022). This will be fully operational by Mid-February 2024.

- A training plan for medical staff and Nurses has commenced to enable staff to undertake, interpret and respond to MEOWS in line with trust policy.
- Compliance with local NEWS/ MEOWS policy will be monitored through real time reporting through Digicare and is the responsibility of the shift leader to ensure reliability in compliance with the policy.
- Daily and weekly sit reps in development for reporting week commencing 12/02/2024
- A new audit of MEOWS/NEWS compliance is being developed and will be reported through to the Divisional Board in January 2023

3.3 Escalation and management of condition

There were missed opportunities for escalation to gynaecology colleagues or other Multidisciplinary teams when there was a suspicion of a bowel obstruction, and escalation to the anaesthetic team was not considered.

Decision making impacted upon the care that she received and with the level of pain that she experienced; earlier intervention to support addressing pain was required.

There was an opportunity for an X-ray to be performed earlier and for CT imaging to be undertaken. Additionally, there were opportunities for an MRI scan to be discussed and a referral made to LUHFT at an earlier time. HSIB considers that earlier imaging would have resulted in an earlier diagnosis and different pathway of care. This would likely have had an impact upon the level of pain that she experienced over the previous 24 hours. It is acknowledged that Industrial Action and care being solely Consultant delivered has impacted on the escalation and decisions made when responding to this escalation of need. Early feedback from MNSI has indicated this is an emerging theme from other Trust and one that needs to be considered in terms of planning for any future and further IA.

Immediate actions have included a development and training session with Gynaecology Consultants relating to the management of acute presentations with surgeons from Liverpool University NSHFT.

Actions agreed are detailed below.

- Agreed the development and implementation of a trust wide simulation training programme to cover the identification and management of the deteriorating patient.
- Consideration to issues identified relating to medical cover and for this to be discussed at Medical Staffing Committee and for the learning to be considered in any future planning of Industrial action.
- The development of trust wide Medical Emergency Team to respond to the clinically deteriorating patient. Which will provide a “fresh eyes approach. In acute hospitals, MET teams are established to respond to all adult medical emergency calls and cardiac arrests. They are usually comprised of junior doctors and nursing staff from specialities such as general medicine and critical care. Historically Liverpool Women’s Hospital has not had a MET team, as it does not employ staff from appropriate specialties. Implementation of a MET team is essential to ensure that those patients who do experience a medical emergency have access to the same level of care available in other acute hospital settings across England. A paper outlining the funding

requirements is due to be presented at the Board of Directors in February 2024 and it is understood will be positively received. Without doubt this would have made a difference fir the care this woman received.

- Attendance at CCrISP (Care of the Critically ill Surgical Patient) course by all consultants with priority for GED consultants and T1 (on call) consultants by June 24. Funding has been identified and individuals prioritised.
- Gynaecology Registered Nurses on the inpatient ward to attend inhouse HDU course, to upskill. This is on track for completion by the end of March 2024
- Review staff with ILS/AIMS training and increase the number of staff with qualification if required and add to TNA for 2024-25
- Review of current SOP relating to surgical review of LWH patients requiring early review from acute services will be completed by June 2023

3.4 Ethnicity and Health Inequalities

The maternal death was reported to His Majesty's Coroner and the cause of death was recorded to have been of a natural cause.

However, the report from MNSI did conclude that ethnicity and health inequalities impacted on the care provided to the patient, suggesting that an unconscious cultural bias delayed the timing of diagnosis and response to her clinical deterioration. This was evident in discussions with staff involved in the direct care of the patient. As discussed earlier this is an emerging issue documented and reported across all NHS services which needs significant, thoughtful, and targeted focus to illicit the required cultural and behavioural changes

The Trust is committed to addressing any cultural bias with the care and services it provides through an improvement programme approach of education, awareness raising, reflective learning, patient and community engagement, employment initiatives and change in clinical practice under the banner of being an Actively Anti Racist organisation.

As part of the organisation's Improvement Programme, and in addition to the Anti racist statement and framework signed off by the Board of Directors in September 2023, we will develop an Anti-Racism Hub to deliver a 3 year Actively Anti Racist Programme. Year 1 (24/25) will see the following actions:

- Establishment & recruitment to Anti Racism hub (including clinical roles)
- Commission independent Cultural Survey of staff, service users, leavers, partners, volunteers & students to inform next stage of programme & develop action plan in context of findings.
- Delivery of anti-racism training to leadership cohort, wider workforce, and all new starters (including ongoing action learning sets and reflective practice; Team coaching)
- Review clinical practice and escalation protocols through learning identified through incidents and adverse outcome reporting for women from the global majority accessing the organisation's care.
- Every member of staff will be mandated to undertake a four-hour face-to-face interactive group session specifically designed to address anti-racism and cultural bias. Sessions have been scheduled from January – July 2024, will reach all 1,700

staff and will be co-delivered by staff member with lived experience. This training will be supplemented by ongoing action learning sets to consolidate learning.
- A series of reflective sessions for staff on Gynaecology designed in partnership with the Head of Nursing for Gynaecology, Professional Nurse Advocates and the OD / ED&I team, to create a safe space to explore the specific matters raised in the investigation and address the issue of bystander culture.
- Anti-Racism communications campaign launched with high visibility messaging Trust-wide.
- Programme of interactive Board development and book club implemented.

Strategy and benchmarking

- Independent ED&I consultant identified to undertake an independent cultural diagnostic of the organisation and provide recommendations on creating a more inclusive and compassionate culture.
- ED&I dashboard developed for inclusion in Board-level performance data to ensure monitoring of qualitative and quantitative data.
- Comply with and complete all standards in the ED&I Improvement Framework and Northwest BAME Assembly framework.
- Broaden the reach of the inclusion network to involve staff from across the organisation in collective activities to tackle racism.

Communications, Listening and Support

- Ongoing support to ensure the REACH (Race, Ethnicity and Cultural Heritage) group can provide a safe space for peer support as well as to feed back issues and concerns to executive level – an Executive Director to be allocated to this group.
- Through our Consultant Clinical Psychologist, offer bespoke racial trauma therapy.
- Continue to work with women and families with the Maternity Voices partnership and patient experience and engagement team.

In addition to the action summarised above the following actions are already underway across the Trust.

- Power BI DNA rates by ethnicity, deprivation score, patient characteristics are captured and analyzed to inform service offer and risk.
- Ethnicity, culturally appropriate care, and communication are actively considered & probed in SIs, Complaints, Incidents, Access targets, DNA.
- Significant programme of engagement events undertaken to listen to community voices, women, and their families.
- Innovative utilisation of bi-lingual volunteers to support patient experience and to ensure that effective communications are optimised.
- All QI projects required to consider health inequalities impact prior to registration.

Conclusion

The Trust has provided sub optimal care to a woman who had sadly died following care received here at the Trust. Whilst we do not know if the eventual outcome could have been prevented, we do know that there are serious and significant lessons to be learnt and changes in practice, behaviour, and culture must follow. Sadly, failures relating to the management of

a deteriorating patient are well documented and that risk is increased by the geography of this site and the lack of co-location with adult acute services.

Relevant external escalations and reporting have been completed in line with good practice and the Trust has been recognised and praised by MNSI for its openness and transparency in both the reporting and escalation of the incident and during the investigation process.

The actions identified and in progress will address the areas of improvement relating to policy and its reliable application. However, it is the two Trust wide improvement collaboratives relating to deterioration and Anti racism that will go further to embedded and sustain the required change to prevent reoccurrences The implementation of the medical emergency team will provide a significant enhancement in terms of safety and resilience to support operational care delivery across all services.

Recommendations

The Board of Directors are asked to accept and note the report presented, the actions completed and further planned interventions to address the issues raised.

It is recognised that some actions are deliverable locally and they will be managed and monitored through a local action plan which will be overseen by Safety and Effectiveness chaired by the Chief Nurse. The two Trust wide improvement ambitions relating to the deterioration of patient and active anti racist culture work will form part of the Trust 2024/25 priorities for Quality and will report appropriately through the Improvement governance process and Quality Committee The early work from these workstreams will inform the model of care for the new medical emergency team which will be implemented early in 2024.

Putting People First (PPF) Committee Chair's Highlight Report to Trust Board
22 January 2024

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The workforce performance report identified that sickness rates had marginally increased, PDR performance had decreased slightly, mandatory training had remained static, and turnover had increased. Initial listening events had been held in the neonatal department in relation to recruitment and retention and any potential impact from the Lucy Letby trial on the profession. • The Committee received the Guardian of Safe Working Hours (Junior Doctors) quarterly report – Quarter 3 2023/24 noting that the hours and templates were safe and compliant in each service and in line with the Junior Doctor contract, however concerns remain in relation to the continued rota gaps which need covering to ensure patient care is provided.	• The Committee received the Audit and Sickness Report update and actions to effectively manage and improve sickness absence rates in the Trust including the completion of return-to-work interviews and wellbeing conversations. The Gynaecology Division was identified as a department with significant challenges and had been asked to review their position and check appropriate resources were in place. The importance of local leaders knowledge and understanding of their team members to improve sickness absence rates within their departments was noted. A further 6-month update would be presented to the Committee. • The Committee received initial data from the 2023 Staff Survey. At this stage, the data can only be shared within the organisation and is subject to minor changes once the data is aggregated with all NHS Trusts at a National Level. There had been a reduction in response rate from 60% in 2022 to 52% in 2023, but the Trust remained above the average response rate for the survey provider. • The Committee received an update on current actions in relation to Equality, Diversity & Inclusion and work towards the achievability of the corporate objectives relating to ED&I. The Committee noted the Workforce Race Equality Action Plan, as a national requirement, and noted that actions would be captured within the anti-racism improvement plan. • The Committee took assurance that Trust had signed up to the NHS England Sexual Safety Charter, and had initiated a workstream for sexual safety to be overseen by the Trust Safeguarding Sub-Committee. The Trust was in the process of completing a gap analysis against the ten principles of the sexual safety charter. • The Committee noted development towards the People Strategy through the PPF workshops held during 2023, which identified four key themes: Inclusion / Anti Racism, Workforce Planning and Supply, Leadership, Culture & Experience. It was noted that these themes would be used to inform the development of a People Plan for 2024/25, and that People and Culture would form a pillar of the new Corporate Strategy.
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**
• Received a positive staff story from a Pharmacy Technician, who joined the Trust with no prior pharmacy experience. With the support and guidance from the Pharmacy Team, she commenced training courses and had developed her professional career. The Committee noted the involvement of line managers to ensure flexibility of the service to support development of staff and that line managers should be reminded of their role to support and develop staff. (WELL LED) • The Committee took positive assurance from the overview of the current workforce position of the Clinical Support Services. The report outlined performance against key workforce metrics,	• Recommend to the Board a de-escalation of risk score of BAF Risk 1 from '16' to '12' • The Committee approved the Retirement Policy and Procedure policy update.

such as vacancy rates, retention rates, sickness absence, and mandatory training compliance along with outlining ongoing/planned activity that will influence and drive improvement. No new risks identified. (ALL)

- The Committee received the Chief People Officer report which provided an overview of the key national, regional and LWH people issues. (WELL LED)
- Received a presentational overview of the staff support service introduced in 2022 and receiving an increase in referrals since the service was introduced. It had been a valuable support for a significant number of staff. The Team would consider how to help support others by e.g. feeding back to management, raising awareness of issues whilst maintaining confidentiality. (ALL)

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the PPF aligned BAF risks, and discussed the proposal to reduce the risk score from 16 to 12 of BAF Risk 1 - Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities. It was highlighted that this risk related to the workforce in its entirety and positive indicators collectively suggest a favourable trajectory for workforce engagement and satisfaction. It was acknowledged that risks persist, particularly in relation to postgraduate doctors and rota gaps, continued vigilance and proactive measures would be crucial for sustaining and building upon these improvements throughout the year.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- The Committee received detailed reports allowing for robust discussion

2. Summary Agenda

No.	Agenda Item	Purpose	Rating	No.	Agenda Item	Purpose	Rating
93.	Board Assurance Framework (BAF): Workforce related risks	Assurance		100.	Equality, Diversity and Inclusion including WRES/WDES/Gender Pay Gap	Approval	
94.	Staff Story – Pharmacy	Information		101.	Staff Support Service Annual Report	Information	
95.	Service Workforce Assurance Report: Clinical Support Service	Assurance		102.	Guardian of Safe Working Hours (Junior Doctors) Quarterly Report – Quarter 3 2023/24	Assurance	
96.	Chief People Officer Report	Information		103.	Safeguarding Update – Domestic Abuse and Sexual Violence Charter	Assurance	
97.	PPF Workforce Performance Report	Information		104.	Summary of the strategy workshops and next steps for the PPF strategy	Information	
98.	Audit and Sickness Report Update	Information		105.	Policies for approval	Approval	
99.	Staff Survey 2023: Initial update based on raw data			106.	Sub Committee Chair Reports	Assurance	

3. 2023 / 24 Attendance Matrix

Core members	May	Jun	September	Nov	Jan	Mar
Gloria Hyatt, Chair, Non-Executive Director	✓	✓	✓	✓	✓	
Louise Martin, Non-Executive Director	✓	A	A	✓	✓	
Zia Chaudhry, Non-Executive Director	A	✓	✓	A	✓	
Michelle Turner, Chief People Officer	✓	✓	✓	✓	✓	
Dianne Brown, Chief Nurse	A	A	A	A	✓	
Gary Price, Chief Operations Officer	✓	A	✓	✓	✓	
Jen Huyton, Deputy Chief Finance Officer	A	A	✓	✓	✓	
Liz Collins, Staff Side Chair	✓	✓	✓	✓	✓	
Dyan Dickins, MSC Chair	A	A	A	✓	✓	

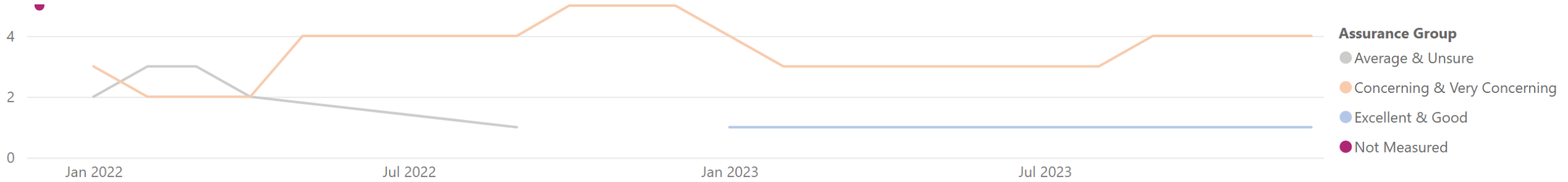
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) Non-Member (NM) *Non-quorate meetings highlighted in greyscale*

Liverpool Women's
NHS Foundation Trust

Trust Board

Workforce Performance Report
January 2024

Section 6: To develop a well led, capable, motivated and entrepreneurial **Workforce**

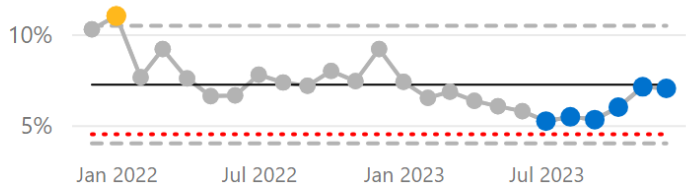


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Turnover Rate	Excellent	December 2023	<= 13%	<=	10.45%	P	L	
Mandatory Training	Concerning	December 2023	>= 95%	>=	93.11%	F	H	
Mandatory Training (Clinical)	Concerning	December 2023	>= 95%	>=	88.22%	F	H	
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Concerning	December 2023	>= 80%	>=	38.65%	F		
Sickness Absence Rate	Concerning	December 2023	<= 4.5%	<=	7.02%	F	L	

To develop a well led, capable, motivated and entrepreneurial **Workforce** - Exceptions

Sickness - Chief People Officer

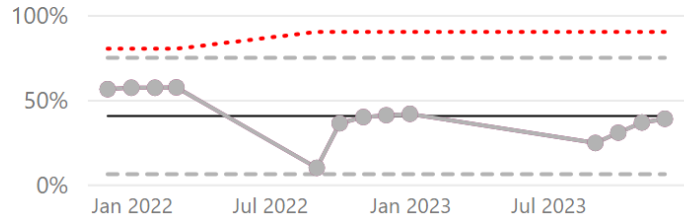
Assurance Category	Concerning
Date	December 2023
Target	<= 4.5%
Target < or >	<=
Performance	7.02%
Assurance	
Variation	



Sickness absence in Gynaecology as a service has increased to 12.22% (0.69% increase) with daily oversight of unavailability being undertaken and robust management via formal processes also occurring, reporting expectations have also been reiterated. This matter is discussed also at the monthly Divisional Performance Review with Executives, allowing further oversight.

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

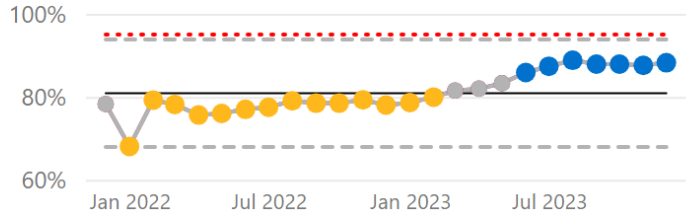
Assurance Category	Concerning
Date	December 2023
Target	>= 80%
Target < or >	>=
Performance	38.65%
Assurance	
Variation	



Uptake of vaccines across the Trust has increased in December to COVID-19 23.7% and FLU 37.3%. Whilst uptake has not increased significantly. Weekly vaccine drop-in clinics have ended, there were regular walkaround clinics across the Trust offering both Covid-19 and Flu vaccines, staff can also email covid.vaccines@nhs.uk to request a vaccine.

Mandatory Training (Clinical) - Chief People Officer

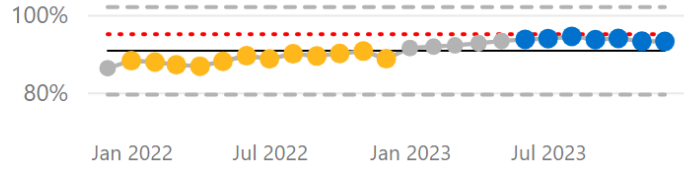
Assurance Category	Concerning
Date	December 2023
Target	>= 95%
Target < or >	>=
Performance	88.22%
Assurance	
Variation	



Compliance increased by 0.64% and is now at 88.22%. All directorates and divisions saw increases in their compliance figures. CSS is the only directorate which is showing above Trust Target with 95.01%. Compliance continues to be reviewed on a weekly basis by divisional management teams. Validation sessions have just taken place and will impact on CMT figures until staff can update their training.

Mandatory Training - Chief People Officer

Assurance Category	Concerning
Date	December 2023
Target	>= 95%
Target < or >	>=
Performance	93.11%
Assurance	
Variation	



Compliance decreased by 0.07% down to 93.11%. 3 divisions have increased in December, CSS by (0.02%), Corporate by (0.11%) and Gynae by (0.33%) while Family Health decreased by (0.29%) but are still with 90%. The following areas saw a reduction in Mandatory Training, Maternity by (0.04%) and Neonates by (0.71%) while Gynae saw an increase by (0.65%) and is above Trust Target. Compliance continues to be reviewed on a weekly basis by divisional management teams.

Liverpool Women's NHS Foundation Trust

Board of Directors

COVER SHEET

Agenda Item (Ref)	*23/24/252c*		Date: 08/02/2024	
Report Title	Freedom to speak up – Bi-annual Update			
Prepared by	Dr Srinivasarao Babarao - Freedom to Speak Up Guardian Nicola Pittaway - Freedom to Speak Up Guardian			
Presented by	Dr Srinivasarao Babarao - Freedom to Speak Up Guardian Nicola Pittaway - Freedom to Speak Up Guardian			
Key Issues / Messages	***This report is to inform the Board of the number and themes of any concerns raised in the reporting period. The report will also cover key updates relating to the work of the Freedom to Speak Up Guardians and any progress made against the strategy 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):			
	For Decisions - in line with Risk Appetite Statement – Y			
	The Board of Directors is asked to note the contents of this report and the ongoing approach to promoting Freedom to Speak at Liverpool Women's Hospital and take assurance from • ***the Guardians' assessment of the Trust's compliance with NHSE's expectations of Trusts with respect to Freedom to Speak Up*** • ***MIAA's Significant Assurance finding following its audit of the Trust's processes for Speaking Up***			
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* 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
PPF Committee	Nov 23	K Robinson	Assurance

EXECUTIVE SUMMARY

This report is to update the Board of Directors on any developments over the last 6 months, including the results of the MIAA audit undertaken relating to the processes in place to support Speaking Up and the trust review of the letter from NHSE to all Trust boards following the verdict in the trial of Lucy Letby.

This report also covers the number of concerns raised to the Freedom to Speak Up and highlights any themes or trends that have been identified including any associated actions.

Also included is an update on compliance with the essential training modules linked to freedom to speak up and details of the biannual temperature check survey scores relating to speaking up.

The Board of Directors is asked to note the contents of this report and the ongoing approach to promoting Freedom to Speak at Liverpool Women's Hospital and take assurance from

- the Guardians' assessment of the Trust's compliance with NHSE's expectations of Trusts with respect to Freedom to Speak Up
- MIAA's Significant Assurance finding following its audit of the Trust's processes for Speaking Up

NHS England letter to all integrated care boards and NHS Trusts

On 18th August 2023, NHSE wrote to all integrated care boards and NHS Trusts in response to the verdict in the trial of Lucy Letby. In this letter, there were specific comments relating to freedom to speak up and governance relating to implementation and oversight. The Trust's position was assessed against the expectations set out in the letter and presented to the People Committee on 20 November 2023; the Committee were assured that there were appropriate processes in place to support the speak up agenda in the Trust.

NHSE requirement	Trust position/assessment
All staff must have easy access to information on how to speak up	Staff can currently obtain information on how to speak up and raise concerns via information contained on the staff intranet, staff app, Trust policy, multiple posters/card leaflets/ across the trust. There is a one clicks button on desktops taking people to the FTSUG information. This information is presented at every Trust corporate induction and other staff inductions such as Junior Doctors and included as part of the Midwifery preceptorship program. We monitor how accessible and visible speak up information is via the Biannual temperature check survey. This records if people have seen FTSU information and if they feel it is enough.
Relevant departments, such as Human Resources, and Freedom to Speak up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme	Freedom to speak up guardians and the HR Team are aware of the scheme including the strict acceptance criteria and the limited number of places on the scheme each year. (Capacity for 2023 was increased to 30 places) The Trust has indicated to the National Guardian's Office and NHSE its preparedness to support any individual who may require support having raised concerns in another organisation.
Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or those who are in lower paid roles may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes to support speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.	We can evidence that staff from lower banded jobs do approach the guardian based on reviewing the details of the cases received. One Guardian works unsociable hours and visits different areas of the Trust during this time to converse with staff and promote the Guardian role. One of the Trust Guardians is from the Global Majority. Work is planned, in conjunction with HR/EDI lead and staff networks, to use the ESR data to identify staff that may have cultural barriers to speaking up and individually contact staff in these groups to provide assurance there is speaking up support available to them when they need it.

Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.	A Guardian attends each People Committee of the Board. Guardians have regular meetings and direct access to NED WB lead, Chairman and CEO plus immediate direct access to all Exec Directors as required. Assurance is provided via the Annual report, Biannual PPF updates which includes temperature check survey results. Staff survey results also covered this area. The Trust has seen a continued increase in this score for 2022, being in the top 10 most improved organisations in England. A Guardian attends PPF committee, Board of Directors, and Audit Committee to present the Annual report. Also attend divisional meetings to provide updates, as required.
Boards are regularly reporting, reviewing, and acting upon available data.	Evidence in PPF minutes and subsequent board minutes. Regular meetings between the Guardians and the Trust CEO and Chair to discuss themes and trends of concerns being raised. Following the MIAA Audit (see below) trends, themes and volume of concerns will be shared with Divisional Boards

MIAA Audit – Results

In May 2023 the Trust commissioned Mersey Internal Audit Authority (MIAA) to review the control processes over Freedom to Speak Up (FTSU) within the Trust as part of the Annual Audit plan.

The scope of the Audit was to review the control processes over Freedom to Speak Up (FTSU) within the Trust. The review focused on the following sub-objectives:

Sub Objective	Risk
Policies and procedures are in place which have been approved by the Trust Board and reflect national guidance	Lack of certainty/consistency if policies and procedures are not documented.
Policies and procedures are communicated to all staff	Insufficient awareness and therefore might not be followed.
Mechanisms are in place to cater for the raising of concerns openly and/or on a confidential basis	All staff may not raise their concerns.
All concerns raised are followed up including provision of feedback to the requestor	Diminished confidence in the process if follow up not complete.
Lessons learned and relevant actions taken from concerns raised	Appetite to use process may dwindle if staff cannot see action being taken.
A regular report is submitted to the Trust Board setting out any issues with regard to implementation of the Policy and procedures	Trust Board may not be able to take timely action if not aware of issues arising.

The final report was submitted to the Trust in October 2023. The overall result was:

- "**Substantial Assurance**" - There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

The review highlighted a gap in controls in relation to ensuring that any lessons learnt arising from FTSU investigations are shared across the Trust. This has required a more formal process to be put in place to share the themes and trends updates that currently come to Putting People First Committee (PPFC), to the wider divisional boards. There has also been a small addition to the recording spreadsheet that the Guardians use to add a lesson learnt section.

The review also identified that the Putting People First Committee (PPFC), Terms of Reference (ToR) did not include any references to Freedom to Speak Up. Although there is evidence that these FTSU update papers were submitted to the Committee, an action was required to update the ToR. All recommendations are now completed.

The full report can be found for Board members in the AdminControl portal.

Freedom to Speak Up Month – October 2023

Every year in October the National Guardian's Office, together with Freedom to Speak Up Guardians and leaders, managers, and workers across the healthcare sector, celebrate Speak Up Month – a month to raise awareness of Freedom to Speak Up and make speaking up 'business as usual' for everyone.

The theme for Speak Up Month 2023 was "**Breaking Barriers".** The National Guardian office wanted to be focusing on removing the obstacles which people feel stop them from speaking up as only by understanding and raising awareness of what these barriers are, can we then start to address them. Fostering a culture of openness and psychological safety where everyone can feel confident and safe to speak up is business critical. The National Guardian office hear examples where people stay quiet for fear that speaking up may lead to mistreatment, or where workers feel speaking up is futile - that nothing will be done as a result. Overcoming these barriers is essential, not just for our culture at work, but for people who use our services.

We wanted to spread the message that by speaking up, everyone can help us learn and improve. By listening up, we can make sure we understand what needs to change. By following up we can ensure that our learning leads to action and make speaking up business as usual. During this month the National Guardians office released a series of blogs, videos and special podcasts features to both Guardians and on their social media platforms.

During the month we shared articles and video blogs from the National Guardian Office including:

- New episodes for the Speak Up, Listen Up, Follow Up Podcast featuring Peter Duffy MBE and Dr Patricia Mills discussing the barriers they faced during their speaking up experience
- Professor Partha Kar shares how he overcomes the barriers to speaking up and why Freedom to Speak Up is so important to him, both personally and professionally
- Claire Murdoch, NHS England's National Mental Health Director and Chief Executive of Central and North West London NHS Foundation Trust, reflects on the barriers to speaking up as a chief executive and in mental health.
- Donna Ockenden explores the barriers in maternity services.
- Tommy Hyun, Freedom to Speak Up Guardian at John's Ambulance explores removing the barriers for volunteers.

To support these activities locally, as well as working with the Communications team, we have been dropping into other areas of the Trust more frequently. This was to offer the opportunity for staff to discuss concerns or just find out more about how the Guardians support the speaking up culture across the Trust.

These awareness activities did produce an increase in the average number of concerns raised in a month and these will be reported in the Q3 and Q4 end of year figures.

As part of this, in conjunction with our communications team, we produced this graphic showing the yearly performance from the annual report. This seemed to be very well received and we are now looking at what others can be produced.

Cases Received Q1 and Q2 23/24

During Q1 and Q2 2023/24 the Guardian service received a total of 26 concerns, which is an increase of 2 from the equivalent periods in 2022/23 when 23 concerns were received.

During Q1 and Q2 there have been some themes to highlight in relation to the concerns raised. There continues to be a consistent element of concerns that are still related to HR Issues about interaction with them and their managers/ supervisors and other staff. The training module for managers is to help with these interactions. It is hoped that as we increase the compliance with this module this will improve. Written guidance for managers to assist in dealing with concerns has also been produced which again should assist in this area.

Concerns were raised by some staff members relating to Trust policies and procedures that staff felt were not being consistently followed and adhered to for all staff. We have been working with the staff members concerned and involving managers or leaders to address concerns when requested.

Freedom to Speak Up Temperature Check surveys

As committed to in the Freedom to Speak up strategy, we are undertaking temperature check surveys to understand how the role of Guardian is resonating the workforce and what we need to focus on. The six-month frequency run in October and April each year. The most recent survey was open throughout October 2023. The 47 responses as received are shown below:

1. Are you aware we have Freedom to Speak Up Guardians in the Trust?

More Details

Yes	43
No	4

2. Do you know the role of the Freedom to Speak Up Guardians and why they are there for you?

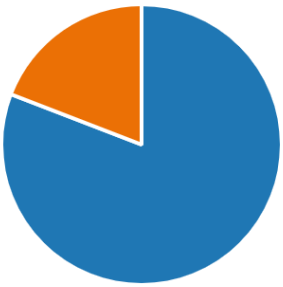
More Details Insights

Yes	42
No	5

3. Do you know how to contact the Freedom to Speak Up Guardians?

More Details Insights

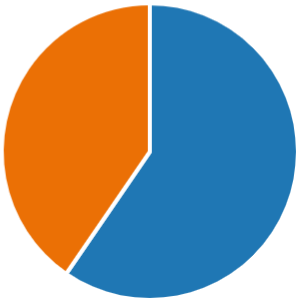
Yes	38
No	9



4. Do you feel comfortable contacting them if you have a concern?

More Details Insights

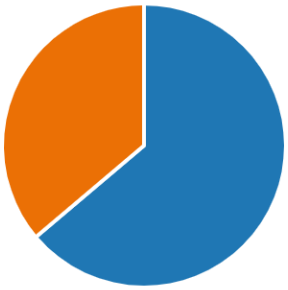
Yes	28
No	19



5. Do you think Freedom to Speak Up information is visible enough across the Trust?

More Details Insights

Yes	30
No	17



6. Have you seen any Freedom to Speak Up information displayed across the Trust within the last week?

More Details

Yes	30
No	17

Responses compared to the April 2023 survey:

- **91%** of respondents are aware we have Freedom to Speak up Guardians within the Trust – Down from 93%
- **89%** are aware of the role of the guardians and why they are there for them – up from 85%
- **81%** are aware of how to contact the Freedom to Speak up Guardians – up from 80%
- **60%** were comfortable contacting the Guardians with a concern – down from 70%

- **64%** said F2SU information is visible enough - up from 62%

- **64%** saying they have seen any information displayed across the Trust in the last week. – up from 53%

As part of the survey, respondents are asked to provide additional comments or thoughts on the freedom to speak up at Liverpool Women's. some positive examples are:

- *Excellent service*
- *Very approachable Freedom to speak up Guardians in the Trust*
- *Thanks for being there. Very much appreciated.* 👏
- *I have worked at LWH for a long time, and I can see the Trust has improved the visibility of F2SUG within the Trust over the years.*
- *Having a FSUG is good.*
- *Kevin Robinson is an absolute asset to the Organisation.*

What is evident from the comments in this recent survey is there continues to be a suspicion and a lack of trust that needs to be focussed on. Comments such as

- *not confidential*
- *We have been advised in our department to keep our issues in-house, so I feel that this service is pointless are our management don't want to deal with the issues directly.*
- *I would not feel safe or comfortable to go to the F2SUG/HR/managers within the Trust - I have not seen anything different throughout the years within the department I worked in. I have lost my confidence and faith in the Trust's SMT, with all the UNFAIR and bullying treatment I've been through over all these years.*
- *Having a FSUG is good however even when issues are raised to the Exec they don't act - so also seems pointless having a FSUG.*

These comments will be used to influence communication key messages moving forward. We will continue to promote the service and benefits of the guardian service and continue to make ourselves available to attend team and divisional meetings to reiterate the benefits of the Guardian service.

FTSU Training compliance

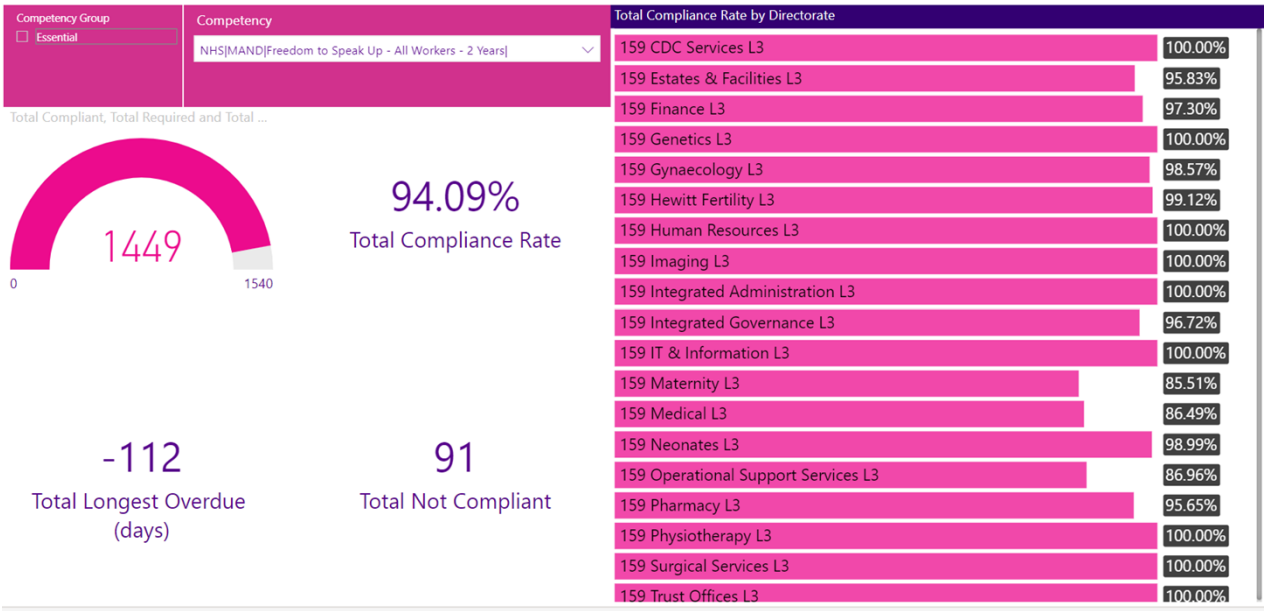
During 2022/23, 3 freedom to speak up modules, created by the National Guardian office, were launched. LWH has adopted all three modules, and the first 2 of these modules and they were categorised as "essential" training.

The "**Speak Up**" module is for all workers and as you can see from the information below has an over 90% compliance rate, with 1389 staff completing the module. The "**Listen up**" training is key to help managers and leaders to consistently display the behaviours that encourage and support speaking up. The "listen up" training is designed to help managers and leaders be aware of how their behaviour influences the confidence of people to speak up and what to do when concerns are raised to them.

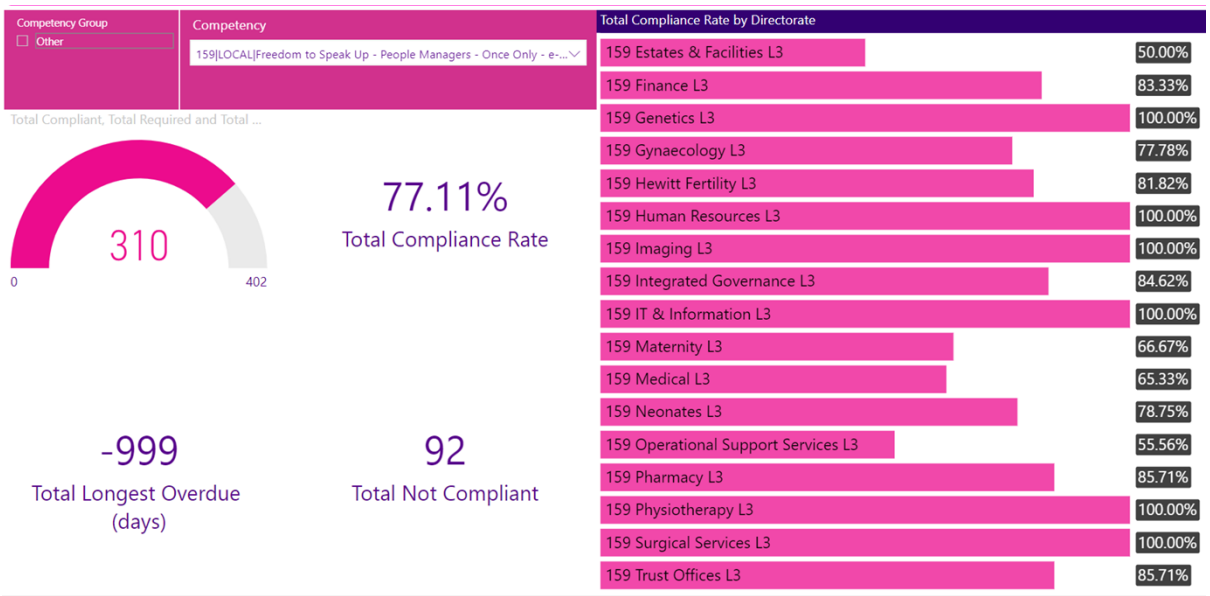
In September 2023/34 the final module for LWH was launched. **"Follow up**" completes the package. Developed for senior leaders – including executive and non-executive directors, lay members and governors – and aims to promote a consistent and effective Freedom to Speak Up culture across the system which enables workers to speak up and be confident they will be listened to, and action taken.

Compliance with each module is shown below:

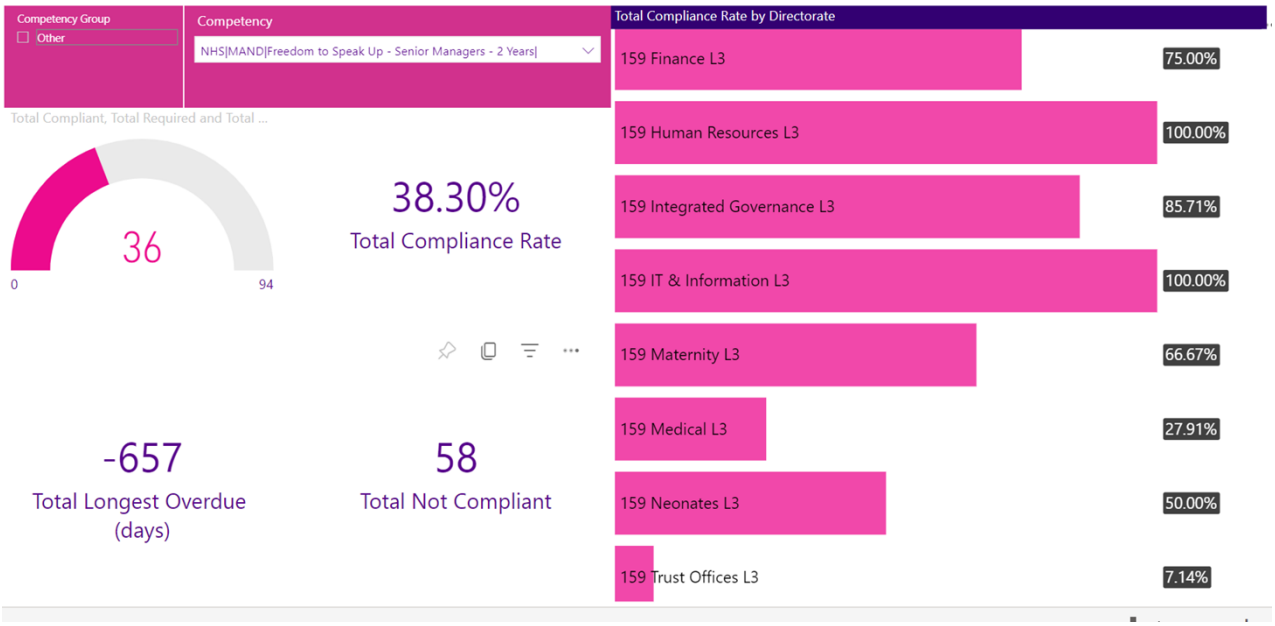
Speak Up Module – All workers



Listen Up Module – People Managers



***NEW* Follow Up Module – Senior Leaders – including executive and non-executive directors**



Freedom to Speak up Guardian resource

In December 2023, Kevin Robinson left the Trust to take up a new Guardian role in Manchester. Following a competitive interview process, Nicola Pittaway, Patient Experience Officer, was appointed to the role and will work alongside Dr Shri Babarao, Consultant Neonatologist as a Trust Guardian.

A dedicated safe and confidential space for the Guardians has now been identified and is undergoing some minor adaptations but will be available to the Guardians and staff within the next few weeks.

RECOMMENDATION

The Board of Directors is asked to note the contents of this report and the ongoing approach to promoting Freedom to Speak at Liverpool Women's Hospital and take assurance from

- the Guardians' assessment of the Trust's compliance with NHSE's expectations of Trusts with respect to Freedom to Speak Up
- MIAA's Significant Assurance finding following its audit of the Trust's processes for Speaking Up

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
31 January 2024

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 the following matters from the operational performance report:
  ○ Cancer performance continues to be challenged, as high referral rates impact upon faster diagnosis standard and the 62-day metric performance based on current backlog clearance. The Committee was informed of actions being taken as part of a Suspected Cancer Referral Optimisation Plan in partnership with primary care.
  ○ Overall, it was noted that Industrial Action had negatively impacted the Trust's progress against its performance targets and there would be significant challenges to meet targets and trajectories by year-end. However, there was confidence that capacity was in place to make and sustain improvement.
• The Committee noted that at Month 9 2023/24 the Trust was reporting an overall net position £14.7m deficit, which represents a £2.7m adverse variance to plan year to date, supported by £2.9m of non-recurrent items. The reported forecast outturn at Month 9 is £23.4m deficit, which represents an £8.0m adverse variance to plan.
• Whilst the 2024/25 planning guidance had yet to be published, the Committee received a presentation on the approach and current assumptions. A significant risk was noted in relation to the 2024/25 Cost Improvement Target expectations of 5%.
	• The Committee asked for further assurance on the work to reduce overdue appointments.
	• The Committee requested further detail on the progress against the 2023/24 Cost Improvement Programme at the next meeting.
	• The Committee requested an update on YTD activity and financial performance of the CDC at the next meeting (this will be incorporated into the M10 service line reporting).

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 following positive assurances from the operational performance report: (ALL)
  ○ Urgent care targets have improved following a deterioration in performance in M7, with improved figures for M8. MAU Triage performance continues to be high and above 95%, with improvement now sustained for over 6 months.
  ○ The Diagnostics position continues to improve with performance over 96% for M8, ahead of NHSE trajectory to be 95% compliant for 6 weeks DM01 by March 2025. The Trust anticipates improving further through M9 with an ambition to be at 99% compliant by March 2024.
  ○ The Gynaecology Elective recovery reported as on track, aligning with the NHS England trajectory for patients over 65 weeks. The Trust is expected to exceed the trajectory by the end of Q3, showing improvement after a decline in Q2. Industrial Action by Junior Doctors in December and January will impact elective activity, but efforts are underway to recover lost activity in January 2024. The goal is to eliminate patients waiting over 78 weeks by the end of M9. Noted that the Trust had received requests for mutual aid and an offer of support for urogynaecology patients was being developed.
	• Approved the Trust's Modern Slavery Statement for 2023 on behalf of the Trust Board.
	• Agreed to recommend an increase in likelihood from 4 to 5 of the BAF risk 5 score to the Trust Board.

• The positive impact that recruitment into the clinical coding team has had on ensuring that clinical coding was now up to date.
• The Committee took positive assurance from the Digital Services Update noting that the DigiCare Programme was now in an optimisation phase. The Committee also noted that:
  ○ the Trust had been awarded Health Tech Team of the Year 2023/24
  ○ funding had been secured for a patient engagement portal.
  ○ The Trust's K2 Maternity electronic notes system had been in place for three years.	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the related BAF risks. The Committee agreed with the proposal to increase the score for the BAF Risk 5 – '**Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term' –** noting that the likelihood of this risk has been assessed at Quarter 3 as '5 - almost certain' rather than '4 - likely. At Month 9, the Trust is reporting an adverse variance to plan of £2.7m year to date and a full year adverse variance forecast of £8m. A discussion was held regarding BAF Risk 4 – '**Impact to the safety of patient care services due to the lack of effective Digital Systems adoption, Strategy implementation and Cyber Security breaches influenced through cyber threats, staffing and financial resources'** – and whilst a reframing of the name of the risk was agreed, no change to the scoring has been recommended to the Board for Q3.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- All members fully engaged in constructive debate during the meeting. This ensured thorough consideration and challenge of all agenda items brought before the FPBD committee. The standard of supporting committee papers was noted to be very good.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
158.	Review of BAF risks: FPBD related risks	Assurance	**162.**	Digital Services Update	Assurance
159.	Operational Performance Report Month 9, 2023/24	Information	**163.**	Crown Street Enhancement Progress Review	Information
160.	Finance Performance Report Month 9, 2023/24	Assurance	**164.**	Modern Slavery Act 2015 Annual review	Approval
161.	2024/25 Planning Update	Information	**165**	Sub-Committee Chair Reports & TOR	Assurance

3. 2023 / 24 Attendance Matrix

Core members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Louise Martin, Non-Executive Director (Chair)	✓	✓	✓	✓	✓	✓	✓	✓		✓		
Tracy Ellery, Non-Executive Director	✓	✓	✓	✓	A	✓	✓	✓		✓		
Sarah Walker, Non-Executive Director	A	✓	A	✓	A	✓	A	✓		✓		
Jenny Hannon, Chief Finance Officer	✓	✓	✓	✓	A	✓	✓	✓		✓		
Kathryn Thomson, Chief Executive	✓	✓	A	A	✓	✓	✓	NM				
Gary Price, Chief Operations Officer	✓	A	✓	✓	✓	✓	✓	✓		✓		
Dianne Brown, Chief Nurse	✓	✓	✓	A	✓	✓	✓	✓		✓		
Matt Connor, Chief Information Officer	✓	✓	✓	✓	A	✓	A	✓		✓		

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

Audit Committee Chair's Highlight Report to Trust Board

25 January 2024

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• In reviewing the Follow up of Internal Audit and External Audit Recommendations, the Committee noted that there had been several re-opened recommendations following review from both MIAA and internal staff due to a need to strengthen the evidence for closure. This has been communicated to Executive leads to ensure clear ownership and a potential need for training for review leads had been identified.	• It was agreed that the draft internal audit plan for 2024/25 would be circulated to Audit Committee members ahead of the next meeting in March 2024. It was noted that assessing the rigour of the Trust's Improvement Plan and developing governance structures would be factored into the plan. • The Committee requested that in reviewing a learning report from a recent fraud prosecution of a theatre manager from West Hertfordshire Hospitals NHS Trust, a 'true for us' approach was taken rather than the completion of a checklist. • In reviewing the External Inspections and Accreditations Register, the Committee asked that teams undertake local assessments ahead of planned visits wherever possible.
Positive Assurances to Provide	**Decisions Made**

• Three internal audit reports were received:
  ○ 2023/24 Risk Management [Core Controls] [High Assurance]
  ▪ Overall, control design for risk management within the Trust was robust.
  ○ 2023/24 Financial Reporting and Integrity [High Assurance]
  ▪ Overall, the Trust has a strong system of internal control in relation to Financial Reporting and Integrity.
  ○ 2023/24 Assurance Framework Review [Meets Requirements]
  ▪ The organisation's AF is structured to meet the NHS requirements; is visibly used by the organisation; and clearly reflects the risks discussed by the Trust Board. The organisation considers risk appetite regularly and the risk appetite is used to inform the management of the AF.
• The internal audit programme for 2023/24 was noted as being slightly behind schedule but there were no concerns for delivery by year-end or concerns that may impact the Head of Internal Audit Opinion.
• The Committee noted the anti-fraud update.
• The External Auditor noted that whilst there would be some changes in the audit team for 2023/24, there would be consistency maintained. It was requested that overlap from the team undertaking the Liverpool University Hospitals NHS FT audit be minimised. A useful debrief had been held with the finance team following the 2022/23 audit and it was expected that the accounts audit and value for money work would take place and report concurrently this year.
• The Committee noted that there was a general trend of reducing waiver volume compared to the previous year.
• The Committee was assured by a report outlining the preparation being undertaken towards the 2023/24 financial statements. The report included an update on the work undertaken to date to close out the 2021/22 ISA260 recommendations. Noted that there have been no bad debt write-offs to date.
	• The Committee reviewed and approved a five-year extension to the Memorandum of Understanding (MoU) that has existed between MIAA and all providers in Cheshire and Merseyside since 2019 for both internal audit and anti-fraud services.

The outstanding debtors will be subject to further review in the last two months of the year and any agreed write-offs will be communicated to the Committee.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- No issues raised.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
061	Follow up of Internal Audit and External Audit Recommendations	To receive and review an update of actions taken.	066	Preparation of the 2023/24 Financial Statements • Including Debt Write Off	For assurance
062	MIAA Internal Audit Reports a) Internal Audit Progress Report b) Internal Audit Follow Up Report c) Anti-Fraud Progress Report 2023/24 d) Insight Update	To note the contents and any recommendations from the report.	067	Board Assurance Framework (BAF)	To receive assurance
063	External Audit Progress Report and Sector update	To receive update	068	Chairs reports of the Board Committees	Review of Chair's Reports for overarching assurance.
064	Waiver Report – Q3 Financial Year 2023/24	To note	069	Internal Audit and LCFS Provision – MIAA MoU agreement (3 + 2 years from April 2024)	To discuss
065	Management of External Visits, Inspections & Accreditations	For assurance			

3. 2023 / 24 Attendance Matrix

Core members	June	July	October	January	March
Tracy Ellery	✓	A	✓	✓	
Zia Chaudhry	✓	✓	✓	✓	
Jackie Bird	A	✓	✓	✓	

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

Charitable Funds Committee Chair's Highlight Report to Trust Board
22 January 2024

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Expenditure was lower than the equivalent period the previous year. The team were continuing to work with estates and family health colleagues to make progress on bereavement suite and flat refurbishment works. • The Committee considered wider implications of not spending funds on designated fundraising campaigns in a timely manner e.g., mona lisa laser appeal, Big tiny steps appeal. The Committee was informed that a new process had been implemented to ensure fundraising campaigns are approved by appropriate governance mechanisms ahead of initiating fundraising publicly. The Committee noted an Executive action to re-consider the escalation process for the fundraising team to raise matters with the Trust.	• Noted planned fundraising campaigns in 2024, including launch of Ibbie's Appeal to raise funds for the Neonatal team to provide food, travel and help for Neonatal families. The Charity was focussed on increasing participation in corporate events within the region and engaging with corporate organisations for donations. It was recommended that an engagement event with staff would be beneficial to identify fundraising initiatives and improve divisional ownership of fundraising schemes. • The Committee was informed that the Charity had received a £39k grant to develop an e-consent system. A business case had been prepared and a charitable fund application completed. A risk in relation to the grant was highlighted, the grant is for one year at a time and the e-consent system would be a three-year commitment. Once this risk is mitigated the application would be presented to the Committee for approval. • Received the Charity's operational plan and budgets for the 2024/25 financial year.
Positive Assurances to Provide	**Decisions Made**
• Noted overall positive performance against the Investment Portfolio • The year-to-date income position was at £415k, which included income from the Strictly event held in December and receipt of a grant funding for the E-consent initiative for fertility services. • The Committee noted robust discussion had taken place ahead of approving use of the staff welfare fund to support staff attendance to a national awards ceremony. It had been deemed appropriate use. Whilst aware that the Trust was not permitted to make discretionary spend due to financial constraints the Committee requested that fund-holders remained mindful to ensure appropriate use of the staff welfare fund. • It was confirmed that a higher percentage basis of distribution of charity monies was transacted on patient welfare initiatives compared to staff welfare initiatives. • The Committee was assured by the review of costs of the fundraising team, both pay and non-pay during 2023/24, which demonstrated the changes and potential increase in costs to raise the profile of the Charity and maximise potential revenue in future years.	• Recommended approval of the Charity Strategy 2023 – 2027 to the Board of Trustees, subject to minor additions.
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Noted positive discussion.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
37.	Investment Position Update	Information	40.	Review of expenditure - fundraising costs versus other	Assurance
38.	Quarterly charity and finance integrated report	Information	41.	Liverpool Women's Charity Strategy 2023 – 2027	Approval

39.	Annual Operational Plan 2024/25	Information			

3. 2023/24 Attendance Matrix

Core members	June 2023	November 2023	January 2024
Zia Chaudhry (Chair), Non-Executive Director	✓	✓	✓
Louise Martin, Non-Executive Director	✓	✓	✓
Jackie Bird, Non-Executive Director	A	✓	✓
Jenny Hannon, Chief Finance Officer	A	✓	✓
Jennifer Huyton, Deputy Chief Finance Officer	✓	✓	✓
Dianne Brown, Chief Nurse	✓	A	✓
Matt Connor, Chief Information Officer	A	✓	A
Claire Deegan, Head of Financial Services	✓	✓	✓
Kate Davis, Head of Fundraising	✓	✓	✓

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**23/24/253d**		**Date: 08/02/2024**	
Report Title	**Finance Performance Month 9 2023/24**			
Prepared by	***Jen Huyton, Deputy Chief Finance Officer / Deputy Director of Strategy***			
Presented by	***Jenny Hannon, Chief Finance Officer / Executive Director of Strategy and Partnerships***			
Key Issues / Messages	***To note the Month 9 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 9 Financial Position.			
Supporting Executive:	***Jenny Hannon, Chief Finance Officer / Executive Director of Strategy and Partnerships***			

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 – Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
FPBD Committee	31/01/24	Chief Finance Officer	The report was received by the Committee.

EXECUTIVE SUMMARY

The Trust has a challenging financial plan for 2023/24 of £15.5m deficit. At Month 9 the Trust reported a £14.7m deficit which represents a £2.7m adverse variance to plan. This position is supported by £2.9m of non-recurrent items. The forecast outturn reported at Month 9 was a £23.4m deficit, which represents an £8.0m adverse variance to plan. Cost Improvement Programme (CIP) delivery is behind the YTD target by £1.5m, with plans to accelerate delivery in quarter 4.

The cash balance was £6.1m at the end of Month 9.

MAIN REPORT

1. Summary Financial Position

	Plan	Actual	Variance	RAG	R	A	G
Surplus/(Deficit) YTD	-£12.0m	-£14.7m	-£2.7m	5	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast M9	-£15.5m	-£23.4m	-£8.0m	5	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	1	*4*	*3*	*2+*
Cash	£3.2m	£6.1m	£2.9m	6	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£5.7m	£4.2m	-£1.5m	1	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£5.7m	£2.8m	-£2.9m	6	*>10% off plan*	*Plan*	*Plan or better*
Aligned Payment Incentive	102%	99%	-3%	5	*>10% off plan*	*<10% off plan - plan*	*Plan or better*
Non-Recurrent Items YTD	£0.8m	£2.9m	£2.1m	5	*>£0*		*<£0*
Capital Spend YTD	£4.7m	£3.2m	-£1.5m	5	*>10% off plan*	*Plan*	*Plan or better*

At Month 9 the Trust is reporting a £14.7m deficit, which represents a £2.7m adverse variance to plan year to date (YTD). This is supported by £2.9m of non-recurrent items. The reported forecast outturn at Month 9 was £23.4m deficit, which represents a £8.0m adverse variance to the full year submitted plan. This position has been reported to Cheshire and Merseyside Integrated Care Board (C&M ICB).

The Trust is currently in NHS Oversight Framework segment 3 (NOF3) and has jointly developed exit criteria with the ICB.

2. Approval of Revised Forecast Outturn

On 21 November 2023 a revised forecast outturn was submitted to the ICB for inclusion in their revised system forecast outturn. The Trust's forecast outturn was a deficit of £22.6m, which represents an adverse variance to plan of £7.2m. This forecast did not include any further impact of industrial action, in line with instruction from NHS England (NHSE). Following agreement of system positions during December, providers and systems were instructed

to formally vary their forecast at Month 9, in line with the submitted forecast, plus the impact of industrial action which took place in December and January. This was assessed at £0.8m, bringing the revised forecast deficit to £23.4m (an adverse variance of £8.0m to the submitted plan). This revised forecast was formally approved by the Trust Board on 11 January 2024.

3. Financial Recovery

Underlying Position

As noted above, the YTD position is supported by £2.9m of non-recurrent items, of which £2.1m was unplanned. The adjusted position in Month 9 (following removal of key non-recurrent items) is a deficit of £17.6m.

The key drivers of the underlying year to date position are reported to the ICB and reviewed by NHSE. They are:

- Undelivered CIP (£1.5m); non-pay and income CIP targets.
- Industrial action costs (£0.6m) and net income impact (£0.7m), offset by non-recurrent income £1.0m.
- API underperformance excluding industrial action impact (£0.5m), offset by impact of reduction in activity targets by 4% £0.5m.
- Impact of pay award (£0.2m)
- Unwinding of 2022/23 pay investment (£1.6m)
- Investment in maternity post CQC inspection (£0.6m)
- Excess inflation and other non-pay pressures (£0.3m)
- Operational pressures (£0.9m) including nursing & midwifery, medical staffing, unfunded cost pressures in corporate areas and estates non-pay related pressures, off-set by £0.7m anaesthetic consultant vacancies and £0.3m interest receivable above plan.

The above drivers are offset by £1.7m non-recurrent items, resulting in the actual adverse YTD variance from plan of £2.7m.

Whole Time Equivalents (WTE)

Whole Time Equivalents are shown in Appendix 1. At Month 9 WTEs total 1,666, compared to 1,688 at M12 2022/23, with a shift away from temporary (bank and agency) towards substantive staff. Between Month 8 and Month 9, WTEs have decreased by 34.1, driven by leavers amongst nursing and midwifery staff, and reduced temporary staffing usage, in relation to previous substantive recruitment, sick leave, and reduced working hours and industrial action during December). Recruitment to substantive clinical posts remains ongoing, with required posts approved on a weekly basis by the Vacancy Control Panel.

Cost Improvement Programme

The Trust has a cost improvement programme target of £8.3m. This equates to 5.3% of expenditure. At Month 9, the Trust is forecasting delivery of £7.3m, which represents an adverse variance to target of £1.0m. The variance is driven by forecast non-delivery of a single high-risk income scheme (relating to out of area low volume activity).

At Month 9, there is an adverse variance of £1.5m against the £5.7m target. £0.5m of CIP was delivered in month. The Trust remains focussed on identifying and implementing robust schemes through a programme of targeted financial recovery. The risk associated with delivery of the CIP programme is currently estimated to be £1.3m.

Industrial Action

The impact of industrial action in December and January has been included in the YTD and forecast positions respectively. Providers and systems have been instructed to exclude the impact form any further industrial action in February or March from their positions, however, should this materialise, it will present an additional risk to the financial position.

Finance Recovery Actions

The Trust produced a long-term financial recovery plan, approved by the Trust Board in September 23. This plan indicates that to return to a breakeven financial position, the Trust requires system support and structural change, particularly in relation to income.

The Trust has implemented a financial recovery programme with enhanced infrastructure, documentation, and governance, has established a Project Management Office (PMO) (from within existing resources) to support delivery. The Financial Grip and Control Working Group have implemented accompanied by a defined set of criteria and exemptions (to ensure clinical safety) for approval of spend.

The recovery plan will be refreshed as part of annual planning, clearly defining those elements of the Trust's underlying financial deficit which are influenceable, and those which require structural support to resolve. The recovery plan will be fully aligned with the Trust's Improvement Plan for 2024/25 and will form part of NOF-3 exit criteria.

4. Divisional Summary Overview

During Month 9, virements were processed to ensure CIP targets were appropriately allocated to divisional budgets, in line with the agreed financial recovery plan. Additionally, elective recovery funding (previously held centrally) was allocated to divisional budgets. Virements are shown in Appendix 1.

Family Health
The Family Health Division has an adverse variance of £1.3m YTD. This is a movement of £0.9m compared to the prior period, however the primary driver for this movement is the budget virement noted above and does not indicate a deterioration in divisional run rate. This position includes recognition of £0.8m non-recurrent favourable impact related to receipt of non-recurrent CNST MIS funds relating to Year 4.

£1.9m of the adverse variance relates to Maternity, offset by £0.6m favourable variance in Neonatal. In addition to the budget virement noted above, the Maternity variance continues to be driven by pay pressures in medical staffing (caused by junior doctor rota gaps and step-down costs in relation to industrial action, noting that non-recurrent funding for industrial action has been recognised centrally rather than within divisions) and midwifery staffing (caused by cover for sickness, vacancies earlier in the year, and maternity leave). The Neonatal favourable variance is driven predominantly by vacancies in ICU nurse staffing. Active recruitment is underway and is reflected in the forecast.

The Family Health Division have well-managed agency usage and have made substantial progress in recruiting to substantive posts to reduce risk of reliance on temporary staffing solutions. There was no agency usage in maternity in Month 8 or 9.

Gynaecology
The Gynaecology Division has an adverse variance to plan of £1.5m YTD, comprised of £1.7m adverse in Gynaecology and £0.2m favourable in the Hewitt Fertility Centre. This is an improvement of £0.4m compared to the prior period. As above, the primary driver for this movement is the favourable budget virement and it does not indicate an

improvement in run rate. The Gynaecology position continues to be driven by medical staffing (in relation to junior doctor pressures, industrial action, and costs of recovery), nursing and support staff pay pressures, and income underperformance (related to Aligned Payment and Incentive (API) and industrial action (see below for further details)).

The Hewitt Fertility Centre's favourable variance is driven by income overperformance through increased activity.

Clinical Support Services (CSS)
CSS are £1.1m adverse to plan YTD. This is an improvement of £0.2m compared to the prior period (driven by the favourable budget virement and does not indicate a material change in run rate). The variance is driven by:

- Imaging pay (£0.5m) in relation to staffing pressures not funded through budget setting.
- Pathology services (Liverpool Clinical Laboratories) above budgeted levels of activity (£0.3m).
- Theatres (£0.7m), driven by nursing, Operating Department Practitioner (ODP) and support staff costs partially mitigated by vacancies in anaesthetic medical staffing.

Adverse variances are partially offset by favourable variances in Genetics (£0.3m), related to vacancies and income overperformance.

5. Income Performance

Aligned Payment Incentive (API)

At Month 9, the Trust has delivered 99% (in terms of £s) and 99% (in terms of activity) of its adjusted 2019/20 baseline year to date. The Trust's submitted average activity target for 2023/24 is now 102%, reduced from 106% as part of the national package of measure to mitigate the impacts of industrial action during 2023/24.

Overall, the API position is behind plan by £0.7m at Month 9. The YTD underperformance is due to a combination of the following:

- Industrial action (for which non-recurrent income has been recognised to mitigate impact prior to Month 9).
- Implementation of the Trust's new Electronic Patient Record system, Digicare (for which a planned reduction in activity was required) – impact specifically in Month 4.

Within the adverse YTD position, there is some variation in API performance. Quarter 1 was significantly above target, driven by use of insourcing. There was also some over delivery in Month 8, when no industrial action took place.

The API forecast at Month 9 assumes that for ICB commissioned activity, the revised target of 102% will be achieved in Months 10, 11, and 12 (with a subsequent adjustment to the forecast for Month 10 based on known industrial action). This equates to £0.2m in excess of average performance YTD, based on the recent appointment of two consultants in gynaecology and an assumption that no further industrial action will take place in Months 11 or 12 (in line with national reporting guidance). For NHSE commissioned activity, the API forecast is in line with YTD performance. Achievement of this position is contingent on no further industrial action taking place, and no unexpected issues impacting the consultant workforce.

The Trust has reported to the ICB the risk presented by any further industrial action, and likely impact to the overall forecast outturn should it take place.

6. Cash and Borrowings

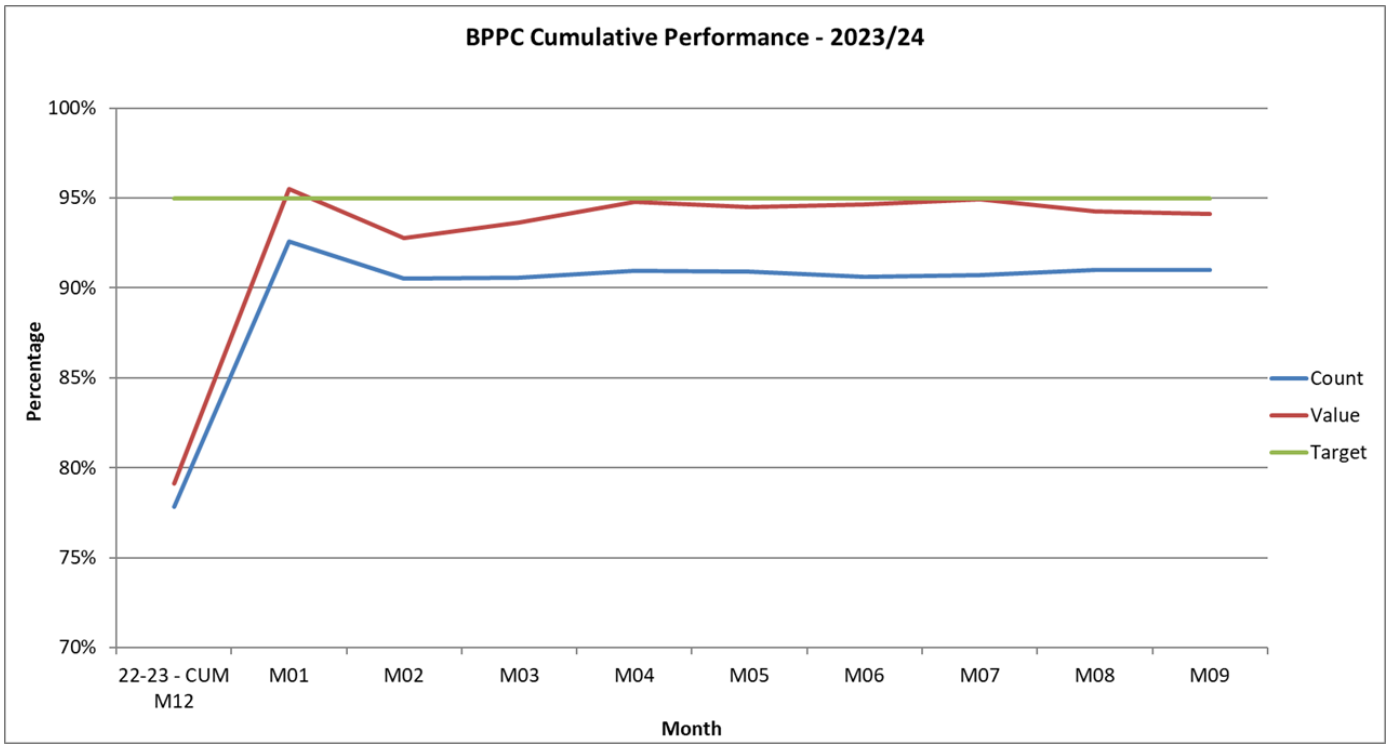
The Trust's cash and bank balance at the end of Month 9 was £6.1m. This was £2.4m ahead of plan, driven by cash from NHS Resolution and timing of payment runs. The average cash balance in Month 9 was £11.5m (£12.3m from Month 1 to Month 9).

The Trust received £21.4m in cash advances from the ICB to December 2023. This will be repaid in full over January, February, and March. The Trust has now received agreement from the national provider finance team for up to £21.2m of national distressed finance, to be paid across quarter 4 (the first tranche was received on 22 January). This will enable the Trust to remain within the national cash threshold of the higher of £1m/2days expenditure, but below the Trust's own threshold of 15 days of £6m. Cash is reviewed daily to minimise risk.

The additional impact of the distressed finance and reduced cash in quarter 4 has been reflected in the forecast Public Dividend Capital (PDC) and interest to year end.

7. Better Payment Practice Code (BPPC)

The NHS has a target to pay at least 95% of all NHS and non-NHS trade payables within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The chart below shows the performance percentages by both count and value for the current and previous financial year.



8. Balance Sheet

In Month 9 most other areas of the balance sheet are consistent with the previous month other than the reduction in cash and a £1.7m increase in debtors. This arises from the increase in accrued income, of which £1m relates to national funding for the impact of industrial action year to date. This has been allocated to the Trust by the ICB and was paid over in Month 10.

The increase in deferred income reflects the final £2m cash advance received from the ICB in December as part of the total £21.4m cash advances (to be repaid in quarter 4).

9. Capital Expenditure

The Trust's capital programme for 2023/24 totals £5.2m. YTD expenditure is £1.5m behind plan, an improvement from the Month 8 position. The Trust is still forecasting to meet the plan by year end. In Month 9 the Trust has been informed that £0.3m of the approved Targeted Investment Fund (TIF) investment in ambulatory service infrastructure has been allocated to 2023/24, to enable the Trust to move forward with the project without delay. The total capital programme is therefore now forecast as £5.4m.

Digital expenditure is ahead of plan YTD and forecast following the significant investment in the Digicare project, and overall infrastructure investment. Work on the Midwife Led Unit (MLU) refurbishment has now commenced, and the estates programme has been commissioned and is ongoing, with purchase orders in place.

Medical equipment, including replacement hysteroscopes and ultrasound machines, has now been delivered.

10. Agency

The Trust has strong controls in place governing the use of temporary staffing. At Month 9, the Trust has a favourable variance of £1.3m against plan. Actual costs of £0.5m YTD are predominantly driven by theatres (vacancy), and maternity (sickness and vacancy). There was no usage of maternity agency spend in Month 8 and 9, due to successful recruitment of substantive midwives.

11. Board Assurance Framework (BAF) Risk

The Finance, Performance, and Business Development Committee have reviewed the BAF score and recommend that it is increased to 20. The likelihood of this risk has been assessed at quarter 3 as '5 - almost certain' rather than '4 – likely' due to the YTD forecast at Month 9. Please see the BAF agenda item for further details.

12. Conclusion & Recommendation

The Board is asked to note the Month 9 position.

Appendices

Appendix 1 – Board Finance Pack, Month 9

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M9

YEAR ENDING 31 MARCH 2024

Liverpool Women's
NHS Foundation Trust

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST NHS ENGLAND RATIOS: M9 YEAR ENDING 31 MARCH 2024	1

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	(8,000)
(b) PDC + Interest Payable + Loans Repaid	2,396
CSC Ratio = (a) / (b)	**(3.34)**
NHSE CSC SCORE	**4**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25	
LIQUIDITY	
(a) Cash for Liquidity Purposes	(28,025)
(b) Expenditure	116,781
(c) Daily Expenditure	425
Liquidity Ratio = (a) / (c)	**(66.0)**
NHSE LIQUIDITY SCORE	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)	
I&E MARGIN	
Deficit (Adjusted for donations and asset disposals)	14,804
Total Income	(108,342)
I&E Margin	**-13.7%**
NHSE I&E MARGIN SCORE	**4**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)	
I&E MARGIN VARIANCE FROM PLAN	
I&E Margin (Actual)	-13.70%
I&E Margin (Plan)	-11.00%
I&E Variance Margin	**-2.70%**
NHSE I&E MARGIN VARIANCE SCORE	**4**
Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%	
Note: NHSE 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 NHSE 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.	
AGENCY SPEND	
YTD Providers Cap (Equal to Plan)	1,754
YTD Agency Expenditure	484
	-72%
NHSE AGENCY SPEND SCORE	**1**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%	
Overall Use of Resources Risk Rating	**3**

Note: scoring a 4 on any of the metrics will lead to a financial override score of 3.
The overall ratio is determined using weighted average of each score and then rounding down

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M9
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	Month 9 Budget	 Actual	 Variance	YTD Budget	 Actual	 Variance	YEAR Budget	 Forecast	 Variance
Income									
Clinical Income	(11,502)	(11,851)	349	(103,017)	(102,589)	(428)	(137,517)	(137,638)	121
Non-Clinical Income	(636)	(550)	(87)	(5,507)	(5,753)	246	(7,416)	(7,314)	(102)
Total Income	**(12,139)**	**(12,401)**	**262**	**(108,524)**	**(108,342)**	**(182)**	**(144,933)**	**(144,952)**	**19**
Expenditure									
Pay Costs	7,541	8,109	(568)	68,541	73,696	(5,155)	91,104	100,465	(9,361)
Non-Pay Costs	3,216	3,627	(410)	28,977	27,737	1,240	38,631	38,834	(202)
CNST	1,800	1,793	7	16,203	15,348	854	21,603	20,305	1,298
Total Expenditure	**12,558**	**13,528**	**(970)**	**113,720**	**116,781**	**(3,061)**	**151,339**	**159,604**	**(8,265)**
EBITDA	**419**	**1,127**	**(708)**	**5,196**	**8,440**	**(3,243)**	**6,406**	**14,652**	**(8,246)**
Technical Items									
Depreciation	548	579	(31)	4,935	4,727	208	6,579	6,467	113
Interest Payable	2	1	1	17	12	5	21	18	3
Interest Receivable	(17)	(50)	33	(150)	(439)	289	(200)	(531)	331
PDC Dividend	221	265	(44)	1,985	2,078	(93)	2,645	2,871	(226)
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	(122)	122	0	(42)	42
Total Technical Items	**754**	**794**	**(40)**	**6,787**	**6,256**	**531**	**9,045**	**8,783**	**262**
(Surplus) / Deficit	**1,174**	**1,922**	**(748)**	**11,983**	**14,696**	**(2,713)**	**15,451**	**23,435**	**(7,983)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2a
UNDERLYING INCOME & EXPENDITURE: M9
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	Month 9 Budget	Month 9 Actual	Month 9 Variance	YTD Budget	YTD Actual	YTD Variance	UNDERLYING FOT Budget	UNDERLYING FOT Forecast	UNDERLYING FOT Variance
Income									
Clinical Income	(11,502)	(12,061)	559	(103,017)	(102,109)	(908)	(137,517)	(136,943)	(574)
Non-Clinical Income	(636)	(550)	(87)	(5,507)	(5,662)	155	(7,416)	(7,223)	(193)
Total Income	**(12,139)**	**(12,611)**	**472**	**(108,524)**	**(107,771)**	**(753)**	**(144,933)**	**(144,166)**	**(767)**
Expenditure									
Pay Costs	7,541	8,027	(486)	68,541	73,830	(5,289)	91,104	99,986	(8,882)
Non-Pay Costs	3,216	3,678	(461)	28,977	28,962	15	38,631	39,957	(1,325)
CNST	1,800	1,793	7	16,203	16,195	7	21,603	21,603	(0)
Total Expenditure	**12,558**	**13,497**	**(939)**	**113,720**	**118,987**	**(5,267)**	**151,339**	**161,546**	**(10,207)**
EBITDA	**419**	**886**	**(467)**	**5,196**	**11,217**	**(6,020)**	**6,406**	**17,380**	**(10,974)**
Technical Items									
Depreciation	548	579	(31)	4,935	4,727	208	6,579	6,467	113
Interest Payable	2	1	1	17	12	5	21	18	3
Interest Receivable	(17)	(50)	33	(150)	(439)	289	(200)	(531)	331
PDC Dividend	221	265	(44)	1,985	2,078	(93)	2,645	2,871	(226)
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	0	(0)	0	0	(0)
Total Technical Items	**754**	**794**	**(40)**	**6,787**	**6,378**	**409**	**9,045**	**8,825**	**220**
(Surplus) / Deficit	**1,174**	**1,681**	**(507)**	**11,983**	**17,595**	**(5,612)**	**15,451**	**26,205**	**(10,753)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2b
WTE: M9
YEAR ENDING 31 MARCH 2024

TYPE	DESCRIPTION	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	Movement M8 - M9	Movement M12 - M9
SUBSTANTIVE	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	631.94	648.33	649.61	645.49	636.13	640.11	636.48	658.66	668.25	655.72	(12.53)	23.78
	ALLIED HEALTH PROFESSIONALS	82.04	81.95	81.35	83.27	83.57	85.45	86.39	86.27	85.87	84.95	(0.92)	2.91
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	11.78	11.31	11.31	12.31	11.31	12.31	14.31	12.31	14.31	14.31	0.00	2.53
	REGISTERED HEALTH CARE SCIENTISTS	49.22	53.62	54.54	54.34	55.34	57.34	60.98	65.47	67.23	67.63	0.40	18.41
	HCA & SUPPORT TO CLINICAL STAFF	234.51	237.51	244.48	237.49	242.70	241.16	247.75	242.56	235.98	232.33	(3.65)	(2.18)
	MANAGERS & SENIOR MANAGERS	59.92	63.32	64.32	61.32	59.02	62.57	62.09	60.39	57.99	60.69	2.70	0.77
	ADMIN AND ESTATES STAFF	13.00	13.00	13.00	14.00	14.00	15.00	15.00	15.00	15.00	15.00	0.00	2.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	288.12	288.08	284.17	285.09	279.25	276.78	278.59	275.93	276.62	276.69	0.07	(11.43)
	MEDICAL AND DENTAL	185.09	190.90	191.67	193.80	190.34	197.14	200.02	195.05	195.72	194.66	(1.06)	9.57
	ANY OTHER STAFF	14.00	14.00	14.00	14.00	14.00	14.00	14.00	13.60	13.99	13.99	0.00	(0.01)
SUBSTANTIVE TOTAL		**1,569.62**	**1,602.02**	**1,608.45**	**1,601.11**	**1,585.66**	**1,601.86**	**1,615.61**	**1,625.24**	**1,630.96**	**1,615.97**	**(14.99)**	**46.35**
BANK	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	47.33	37.81	43.37	45.40	34.57	30.12	36.07	36.62	39.71	32.91	(6.80)	(14.42)
	ALLIED HEALTH PROFESSIONALS	17.42	13.00	16.78	15.67	11.15	10.48	13.45	13.31	14.60	10.70	(3.90)	(6.72)
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	-	-	-	-	-	-	-	-	-	-	0.00	0.00
	REGISTERED HEALTH CARE SCIENTISTS	0.28	0.91	0.64	0.46	0.37	0.27	1.60	1.16	0.60	0.45	(0.15)	0.17
	HCA & SUPPORT TO CLINICAL STAFF	31.22	25.76	25.13	24.57	21.87	19.20	18.79	19.07	21.07	18.64	(2.43)	(12.58)
	MANAGERS & SENIOR MANAGERS	-	-	-	-	-	-	-	-	-	-	0.00	0.00
	ADMIN AND ESTATES STAFF	-	0.23	0.12	0.09	-	0.05	-	-	0.07	0.07	0.00	0.07
	OTHER INFRASTRUCTURE & SUPPORT STAFF	6.25	7.27	6.44	4.36	4.89	6.82	4.20	2.34	5.35	3.17	(2.18)	(3.08)
	MEDICAL AND DENTAL	2.00	2.80	2.80	2.00	2.00	1.94	1.97	0.93	0.03	0.03	0.00	(1.97)
	ANY OTHER STAFF	-	-	-	-	-	-	-	-	-	-	0.00	0.00
TOTAL BANK		**104.50**	**87.78**	**95.28**	**92.55**	**74.85**	**68.88**	**76.08**	**73.43**	**81.43**	**65.97**	**(15.46)**	**(38.53)**
AGENCY	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	8.23	10.49	2.03	0.08	2.11	2.76	2.68	3.14	-	-	0.00	(8.23)
	ALLIED HEALTH PROFESSIONALS	4.04	1.23	3.26	3.26	2.92	2.60	3.28	2.90	2.95	0.21	(2.74)	(3.83)
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	-	-	-	-	-	-	-	-	-	-	0.00	0.00
	REGISTERED HEALTH CARE SCIENTISTS	-	-	-	-	-	-	-	-	-	-	0.00	0.00
	HCA & SUPPORT TO CLINICAL STAFF	-	-	-	-	-	-	-	-	-	-	0.00	0.00
	MANAGERS & SENIOR MANAGERS	-	-	-	-	-	-	-	-	-	-	0.00	0.00
	ADMIN AND ESTATES STAFF	1.00	-	-	-	-	-	-	-	-	-	0.00	(1.00)
	OTHER INFRASTRUCTURE & SUPPORT STAFF	-	1.73	-	-	-	-	-	-	-	-	0.00	0.00
	MEDICAL AND DENTAL	0.10	-	-	-	-	-	-	-	0.95	-	(0.95)	(0.10)
	ANY OTHER STAFF	-	-	-	-	-	-	-	-	-	-	0.00	0.00
AGENCY TOTAL		**13.37**	**13.45**	**5.29**	**3.34**	**5.03**	**5.36**	**5.96**	**6.04**	**3.90**	**0.21**	**(3.69)**	**(13.16)**
TRUST TOTAL		**1,687.49**	**1,703.25**	**1,709.02**	**1,697.00**	**1,665.54**	**1,676.10**	**1,697.65**	**1,704.71**	**1,716.29**	**1,682.15**	**(34.14)**	**(5.34)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M9
YEAR ENDING 31 MARCH 2024

EXPENDITURE £'000	MONTH 9 Budget	MONTH 9 Actual	MONTH 9 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	482	490	(9)	4,334	4,452	(118)	5,573	5,933	(359)
Medical	2,182	2,238	(56)	19,641	20,273	(631)	26,188	27,782	(1,594)
Nursing & Midwifery	3,202	3,377	(175)	28,654	30,701	(2,048)	38,400	41,844	(3,444)
Healthcare Assistants	555	567	(13)	4,991	5,581	(589)	6,655	7,443	(788)
Other Clinical	188	604	(417)	2,469	4,896	(2,426)	3,038	6,902	(3,864)
Admin Support	784	802	(18)	7,050	7,310	(259)	9,403	9,949	(546)
Agency & Locum	149	30	119	1,401	484	917	1,848	613	1,234
Total Pay Costs	**7,541**	**8,109**	**(568)**	**68,541**	**73,696**	**(5,155)**	**91,104**	**100,465**	**(9,361)**
Non Pay Costs									
Clinical Suppplies	841	1,099	(258)	7,557	8,383	(825)	10,085	11,567	(1,482)
Non-Clinical Supplies	776	859	(83)	6,735	5,593	1,142	8,876	7,638	1,237
CNST	1,800	1,793	7	16,203	15,348	854	21,603	20,305	1,298
Premises & IT Costs	867	964	(97)	7,813	7,493	320	10,413	10,599	(185)
Service Contracts	733	760	(26)	6,871	6,269	603	9,257	9,029	228
Total Non-Pay Costs	**5,017**	**5,419**	**(403)**	**45,180**	**43,085**	**2,094**	**60,235**	**59,139**	**1,096**
Total Expenditure	**12,558**	**13,528**	**(970)**	**113,720**	**116,781**	**(3,061)**	**151,339**	**159,604**	**(8,265)**

Note that the values above exclude hosted services and Technical Items.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M9
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	MONTH 9 Budget	MONTH 9 Actual	MONTH 9 Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR - Underlying Budget	YEAR - Underlying Actual	YEAR - Underlying Variance
Maternity									
Income	(3,726)	(4,052)	326	(37,660)	(37,447)	(214)	(51,058)	(50,132)	(926)
Expenditure	1,418	2,627	(1,208)	21,610	23,318	(1,708)	29,100	31,582	(2,481)
Total Maternity	**(2,308)**	**(1,426)**	**(882)**	**(16,050)**	**(14,128)**	**(1,921)**	**(21,957)**	**(18,550)**	**(3,407)**
Neonatal									
Income	(1,655)	(1,602)	(54)	(15,009)	(15,348)	339	(20,016)	(20,385)	369
Expenditure	1,335	1,247	88	12,016	11,722	294	15,991	15,584	408
Total Neonatal	**(320)**	**(355)**	**35**	**(2,993)**	**(3,626)**	**633**	**(4,025)**	**(4,802)**	**777**
Division of Family Health - Total	**(2,628)**	**(1,780)**	**(848)**	**(19,042)**	**(17,754)**	**(1,288)**	**(25,982)**	**(23,352)**	**(2,631)**
Gynaecology									
Income	(2,069)	(2,158)	89	(20,443)	(19,743)	(700)	(27,374)	(26,296)	(1,078)
Expenditure	1,849	1,656	193	13,562	14,555	(992)	17,953	19,628	(1,675)
Total Gynaecology	**(220)**	**(502)**	**282**	**(6,880)**	**(5,188)**	**(1,692)**	**(9,421)**	**(6,667)**	**(2,754)**
Hewitt Centre									
Income	(846)	(921)	75	(7,861)	(8,170)	309	(10,689)	(11,098)	409
Expenditure	897	865	33	7,386	7,479	(93)	9,848	10,101	(253)
Total Hewitt Centre	**51**	**(56)**	**107**	**(475)**	**(691)**	**216**	**(841)**	**(997)**	**156**
Division of Gynaecology - Total	**(169)**	**(558)**	**389**	**(7,355)**	**(5,879)**	**(1,476)**	**(10,262)**	**(7,664)**	**(2,598)**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	1,222	1,173	49	9,528	10,217	(689)	12,590	13,767	(1,178)
Total Theatres	**1,222**	**1,173**	**49**	**9,528**	**10,217**	**(689)**	**12,590**	**13,767**	**(1,178)**
Genetics									
Income	(4)	(6)	3	(32)	(112)	80	(42)	(130)	88
Expenditure	166	128	38	1,495	1,244	251	1,993	1,703	290
Total Genetics	**163**	**122**	**41**	**1,463**	**1,132**	**332**	**1,951**	**1,573**	**378**
Other Clinical Support									
Income	(542)	(606)	64	(5,376)	(5,222)	(154)	(7,102)	(7,027)	(75)
Expenditure	919	970	(51)	8,212	8,850	(638)	10,784	12,387	(1,603)
Total Clinical Support	**377**	**365**	**13**	**2,836**	**3,628**	**(792)**	**3,683**	**5,360**	**(1,678)**
Division of Clinical Support - Total	**1,762**	**1,659**	**103**	**13,828**	**14,977**	**(1,149)**	**18,223**	**20,701**	**(2,477)**
Corporate & Trust Technical Items									
Income	(3,297)	(3,057)	(240)	(22,143)	(23,159)	1,016	(28,651)	(30,744)	2,092
Expenditure	5,506	5,658	(153)	46,696	46,511	185	62,124	64,494	(2,370)
Total Corporate	**2,209**	**2,601**	**(393)**	**24,553**	**23,352**	**1,201**	**33,472**	**33,750**	**(278)**
(Surplus) / Deficit	**1,174**	**1,922**	**(748)**	**11,983**	**14,696**	**(2,713)**	**15,451**	**23,435**	**(7,983)**
Of which is hosted;									
Income	0	(1)	1	0	(859)	859	0	(859)	859
Expenditure	0	1	(1)	0	859	(859)	0	859	(859)
Total Corporate	**0**	**0**	**(0)**	**0**	**0**	**0**	**0**	**(0)**	**0**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
CIP: M9
YEAR ENDING 31 MARCH 2024

TYPE	Scheme	MONTH 9			YTD			FULL YEAR		
		Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Income	Income Non-Patient Care	126	83	-43	727	479	-248	663	637	-26
	Income Private Patient	63	14	-49	281	212	-69	458	471	13
	Income Patient Care	-	34	34	-	101	101	201	201	0
	Income Other (balance - please provide description)	61	13	-47	530	131	-399	2,038	1,038	-1,000
	Unidentified - Income	-	-	0	-	-	0	-	-	0
	TOTAL INCOME	**250**	**144**	**-106**	**1,538**	**922**	**- 616**	**3,360**	**2,348**	**-1,013**
Pay	Service re-design - pay	18	10	-8	163	80	-83	171	171	0
	Establishment reviews	4	108	105	10	543	533	713	754	41
	E-Rostering	2	0	-2	19	1	-18	2	2	0
	Other - pay (balance - please provide description)	-	-	0	-	-	0	-	-	0
	Unidentified - pay (please provide commentary)	288	-	-288	1,735	-	-1,735	-	-	0
	TOTAL PAY	**312**	**118**	**-194**	**1,927**	**624**	**- 1,303**	**885**	**927**	**41**
Non-Pay	Medicines optimisation	14	6	-7	123	43	-80	105	105	0
	Procurement (excl drugs) -non-clinical	1	1	0	5	2	-3	4	4	0
	Procurement (excl drugs) - medical devices and clinical consumables	15	- 0	-15	131	8	-122	23	20	-3
	Service re-design - Non-pay	190	156	-34	1,691	2,302	612	2,905	2,904	-1
	Pathology & imaging networks	0	-	0	4	-	-4	-	-	0
	Fleet optimisation	2	3	1	13	20	7	29	29	0
	Other - Non-pay (balance - please provide description)	23	37	14	157	266	108	665	742	78
	Digital transformation	10	-	-10	91	-	-91	13	13	0
	Unidentified - non-pay	-	-	0	-	-	0	348	245	-103
	TOTAL NON-PAY	**255**	**203**	**-52**	**2,214**	**2,642**	**427**	**4,091**	**4,062**	**-29**
	TOTAL CIP DELIVERY	**817**	**466**	**- 351**	**5,679**	**4,187**	**- 1,492**	**8,336**	**7,336**	**(1,000)**

Note: The value above reflects the actual CIP delivered and to both the ICB and NHSE.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
BALANCE SHEET: M9
YEAR ENDING 31 MARCH 2024

BALANCE SHEET £'000	YEAR TO DATE Opening	M9 Actual	Movement
Non Current Assets	102,405	100,770	(1,635)
Current Assets			
Cash	9,790	6,120	(3,670)
Debtors	9,647	12,085	2,438
Inventories	839	1,075	236
Total Current Assets	**20,276**	**19,280**	**(996)**
Liabilities			
Creditors due < 1 year - Capital Payables	(2,002)	(697)	1,305
Creditors due < 1 year - Trade Payables	(26,820)	(18,803)	8,017
Creditors due < 1 year - Deferred Income	(4,492)	(26,283)	(21,791)
Creditors due > 1 year - Deferred Income	(1,530)	(1,506)	24
Loans	(918)	(612)	306
Loans - IFRS16 leases	(50)	(37)	13
Provisions	(628)	(567)	61
Total Liabilities	**(36,440)**	**(48,505)**	**(12,065)**
TOTAL ASSETS EMPLOYED	**86,241**	**71,545**	**(14,696)**
Taxpayers Equity			
PDC	79,115	79,115	0
Revaluation Reserve	8,679	8,679	0
Retained Earnings	(1,553)	(16,249)	(14,696)
TOTAL TAXPAYERS EQUITY	**86,241**	**71,545**	**(14,696)**

**the opening non-current asset value and revaluation reserve has been revised following changes to the accounts agreed with external audit in June*

***Note that the cash balance includes ICB cash advances and national cash support.*

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M9
YEAR ENDING 31 MARCH 2024

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	(13,167)
Depreciation and amortisation	4,721
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	10,345
Net cash generated from / (used in) operations	**1,899**
Interest received	439
Purchase of property, plant and equipment, ROU and intangible assets	(4,560)
Proceeds from sales of property, plant and equipment and intangible assets	238
Net cash generated from/(used in) investing activities	**(3,883)**
PDC Capital Programme Funding - received	0
Loans from Department of Health - repaid	(306)
Interest paid	(7)
PDC dividend (paid)/refunded	(1,373)
Net cash generated from/(used in) financing activities	**(1,686)**
Increase/(decrease) in cash and cash equivalents	**(3,670)**
Cash and cash equivalents at start of period	9,790
Cash and cash equivalents at end of period	**6,120**

Finance Support	2023/22 Qu4 £000	2023/24 Qu1 ACTUAL £000	2023/24 Qu2 ACTUAL £000	2023/24 Qu3 CONFIRMED £000	2023/24 Qu4 FORECAST £000	2023/24 Total £000
ICB cash support	6,000	6,800	9,600	5,000	0	21,400
ICB cash repayment	(6,000)	0	0	0	(21,400)	(21,400)
Alder Hey advance for 2024/25 neonatal partnership	0				2,000	2,000
Nattional cash support	4,500	0	0	0	22,100	22,100
Total support required						**24,100**
DH Loan repayment	612	0	306	0	306	612
DH Loan outstanding at year end	918					306

Liverpool Women's NHS Foundation Trust

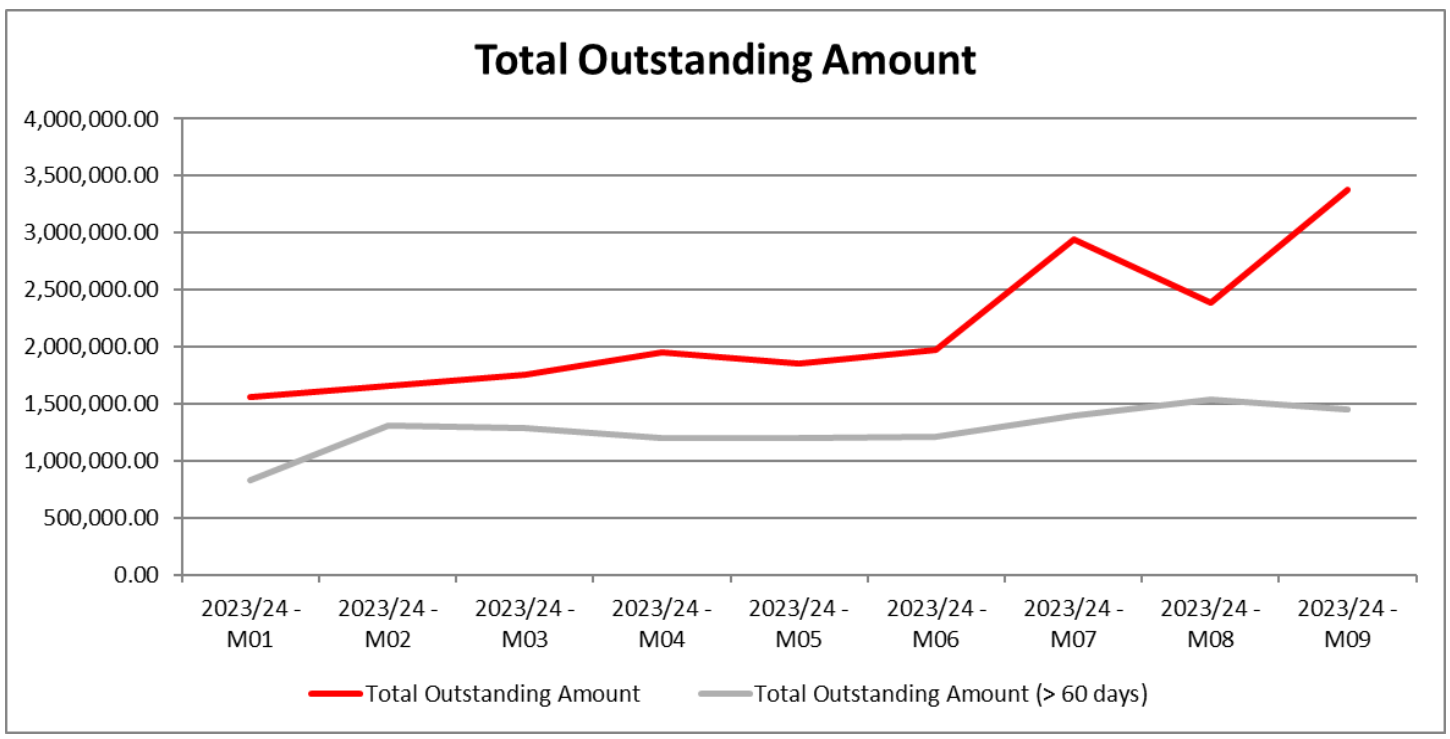
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CAPITAL EXPENDITURE: M09
YEAR ENDING 31 MARCH 2024

		Year to Date			Full Year - Original Plan			Full Year - Revised Plan		
Area	Capital Scheme	Plan	Actual	Variance	Plan	Forecast	Variance	Plan	Forecast	Variance
IT	EPR frontline digitisation	540	682	(142)	560	910	(350)	910	910	(0)
IT	IT/digital investment - Infrastructure Investment	975	1,150	(175)	1,290	1,238	52	1,238	1,238	(0)
IT	IT/digital investment - Hardware	354	126	228	354	143	211	140	143	(3)
IT	Community diagnostic equipment	153	0	153	153	153	0	153	153	0
IT	Community diagnostic IT	65	0	65	65	65	0	65	65	0
Estates	Building works/refurbishment - Maternity	950	41	909	950	350	600	950	350	600
Estates	Building works/refurbishment - Neonatal	180	0	180	180	40	140	180	40	140
Estates	Building works/refurbishment - Gynaecology	136	0	136	300	0	300	300	0	300
Estates	Estates programme	500	472	28	560	709	(149)	686	709	(23)
Medical Equipment	Medical equipment - Clinical Support - Fluoroscopy	241	0	241	241	0	241	0	0	0
Medical Equipment	Medical equipment - Clinical Support - Theatres	107	110	(3)	107	148	(41)	126	148	(22)
Medical Equipment	Medical equipment - All other clinical areas	1,041	687	354	1,041	1,140	(99)	1,172	1,140	32
Medical Equipment	Medical equipment - leased blood gas analysers	139	37	102	139	139	0	139	139	0
Other	Contingency/VAT savings/slippage to 2024-25/accommodate in 2022/23	(690)	(80)	(610)	(905)	0	(905)	(1,023)	0	(1,023)
Total capital charged to CDEL		**4,691**	**3,225**	**1,466**	**5,035**	**5,035**	**(0)**	**5,035**	**5,035**	**0**
CSS	PACS - image sharing - CAMRIN programme	49	0	49	49	49	0	49	49	0
Gynaecology	Bereavement Suite - gynaecology - CHARITY	70	0	70	70	70	0	70	70	0
Estates	Ambulatory - TARGETED INVESTMENT FUND	0	24	(24)	0	250	(250)	250	250	0
TOTAL CAPITAL		**4,810**	**3,249**	**1,561**	**5,154**	**5,404**	**(250)**	**5,404**	**5,404**	**0**

Notes:
1. The Trust's capital plan was orignally oversubscribed, resulting in the requirement to place several less urgent schemes, or those where external funding was applied for, to be paused in order to manage the programme within resource limits.
2. Proposed variations to the plan are considered by the Capital Group and approved by the Executive Committee. This is shown in the 'revised plan' section above.
3. 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 figures shown in the cashflow statement which are on a "Cash" basis.

Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 9
AGED DEBTORS BALANCE: M09
YEAR ENDING 31 MARCH 2024

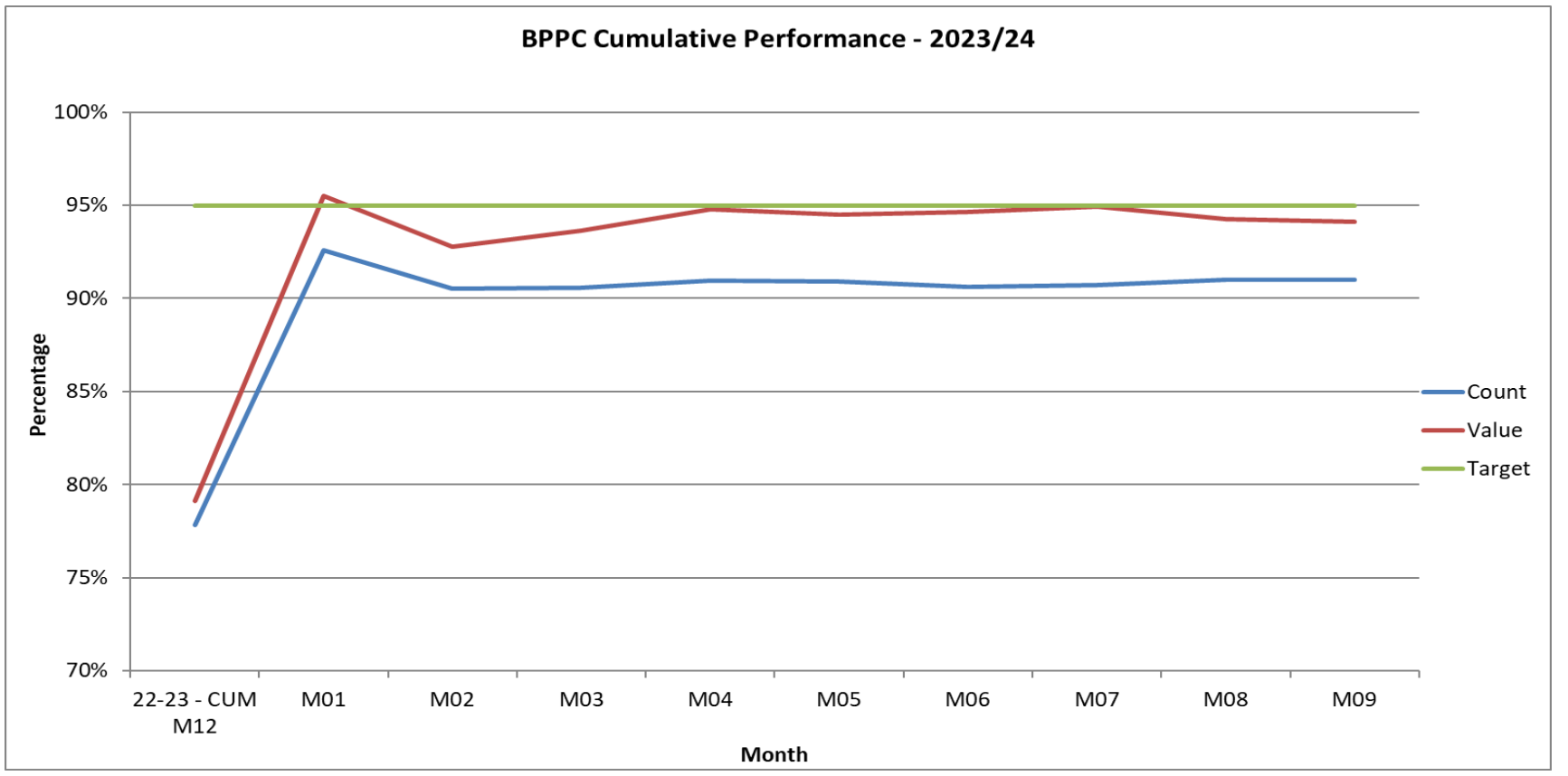


Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 10
BETTER PAYMENT PRACTICE CODE (BPPC) - CUMULATIVE PERFORMANCE FOR M09
YEAR ENDING 31 MARCH 2024

The NHS has a target to pay at least 95% of all NHS and non-NHS trade payables within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The below shows the cumulative performance percentages by both count and value for the current and previous financial year.

2023/24



	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
Cumulative Performance - Count	93%	91%	91%	91%	91%	91%	91%	91%	91%			
Cumulative Performance - Value (£)	96%	93%	94%	95%	94%	95%	95%	94%	94%			

2023/24 performance TOTAL YTD

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **11**
AGENCY USAGE: M9
YEAR ENDING 31 MARCH 2024

		MONTH 9			YTD			FULL YEAR		
Division	Directorate	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Family Health	Maternity	0	0	0	-	157	(157)	-	157	(157)
Gynaecology	Gynaecology	0	27	(27)	-	96	(96)	-	163	(163)
Gynaecology	HFC	0	1	(1)	-	18	(18)	-	18	(18)
CSS	Theatres	0	(1)	1	-	124	(124)	-	153	(153)
CSS	CDC	0	0	0	12	15	(3)	12	15	(3)
CSS	Imaging	0	3	(3)	-	70	(70)	-	105	(105)
Corporate	All Corporate Directorates	149	1	148	1,240	4	1,236	1,835	4	1,831
Total Agency		**149**	**30**	**119**	**1,252**	**484**	**768**	**1,848**	**613**	**1,235**
Performance against cap/plan		**194**	**30**	**164**	**1,754**	**484**	**1,270**	**2,333**	**613**	**1,720**

Note that the agency premium budget is held centrally (with the exception of CDC ring-fenced funding).
The Trust is reporting performance against the NHSE plan in the absence of the 2023/24 provider cap.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 12
VIREMENTS: M9
YEAR ENDING 31 MARCH 2024

Directorate	Account Code/Type	Total	Description
CIP VIREMENT M9			
CENTRAL INCOME	INCOME	(345,784)	2023 - 24 CIP Virement to revised plan
CLINICAL SUPPORT SERVICES	INCOME	45,005	2023 - 24 CIP Virement to revised plan
CONTRACTS	NON PAY EXPENDITURE	5,000	2023 - 24 CIP Virement to revised plan
ESTATES	INCOME	(102,000)	2023 - 24 CIP Virement to revised plan
ESTATES	NON PAY EXPENDITURE	(9,390)	2023 - 24 CIP Virement to revised plan
FINANCE	NON PAY EXPENDITURE	51,169	2023 - 24 CIP Virement to revised plan
FINANCE	PAY EXPENDITURE	200,000	2023 - 24 CIP Virement to revised plan
GENETICS SERVICES	PAY EXPENDITURE	(4)	2023 - 24 CIP Virement to revised plan
GOVERNANCE	PAY EXPENDITURE	(2,333)	2023 - 24 CIP Virement to revised plan
HONEYSUCKLE	NON PAY EXPENDITURE	(16,000)	2023 - 24 CIP Virement to revised plan
HR & MARKETING	INCOME	5,000	2023 - 24 CIP Virement to revised plan
HR & MARKETING	PAY EXPENDITURE	(1,800)	2023 - 24 CIP Virement to revised plan
OPERATIONAL MANAGEMENT	NON PAY EXPENDITURE	(225,500)	2023 - 24 CIP Virement to revised plan
SERVICING OF FINANCE	INCOME	(3,333)	2023 - 24 CIP Virement to revised plan
SERVICING OF FINANCE	NON PAY EXPENDITURE	(272,006)	2023 - 24 CIP Virement to revised plan
TRUST OFFICES	INCOME	100,000	2023 - 24 CIP Virement to revised plan
TRUST OFFICES	NON PAY EXPENDITURE	(6)	2023 - 24 CIP Virement to revised plan
RESEARCH AND DEVELOPMENT	NON PAY EXPENDITURE	(59,750)	2023 - 24 CIP Virement to revised plan
LEARNING AND DEVELOPMENT	INCOME	15,996	2023 - 24 CIP Virement to revised plan
IM&T	NON PAY EXPENDITURE	38,990	2023 - 24 CIP Virement to revised plan
RISK MANAGEMENT	INCOME	810,627	2023 - 24 CIP Virement to revised plan
RISK MANAGEMENT	NON PAY EXPENDITURE	838,850	2023 - 24 CIP Virement to revised plan
RISK MANAGEMENT	PAY EXPENDITURE	428,613	2023 - 24 CIP Virement to revised plan
CORPORATE	**TOTAL**	**1,501,344**	
GYNAECOLOGY	INCOME	(12,677)	2023 - 24 CIP Virement to revised plan
GYNAECOLOGY	NON PAY EXPENDITURE	100,000	2023 - 24 CIP Virement to revised plan
GYNAECOLOGY	PAY EXPENDITURE	(1,562)	2023 - 24 CIP Virement to revised plan
HEWITT FERILITY CENTRE	INCOME	(79,834)	2023 - 24 CIP Virement to revised plan
HEWITT FERILITY CENTRE	NON PAY EXPENDITURE	115,350	2023 - 24 CIP Virement to revised plan
GYNAECOLOGY	**TOTAL**	**121,277**	
THEATRES	NON PAY EXPENDITURE	83,912	2023 - 24 CIP Virement to revised plan
THEATRES	PAY EXPENDITURE	(42,839)	2023 - 24 CIP Virement to revised plan
IMAGING	NON PAY EXPENDITURE	(4)	2023 - 24 CIP Virement to revised plan
PHARMACY	NON PAY EXPENDITURE	(18,000)	2023 - 24 CIP Virement to revised plan
CLINICAL SUPPORT SERVICES	**TOTAL**	**23,069**	
MATERNITY	INCOME	(433,000)	2023 - 24 CIP Virement to revised plan
MATERNITY	NON PAY EXPENDITURE	(602,615)	2023 - 24 CIP Virement to revised plan
MATERNITY	PAY EXPENDITURE	(580,075)	2023 - 24 CIP Virement to revised plan
NEONATAL	NON PAY EXPENDITURE	(30,000)	2023 - 24 CIP Virement to revised plan
FAMILY HEALTH		**(1,645,690)**	
ELECTIVE RECOVERY VIREMENT M9			
RISK MANAGEMENT	NON PAY EXPENDITURE	(105,360)	2023- 24 Elective Recovery Fund Allocation
RISK MANAGEMENT	PAY EXPENDITURE	(391,374)	2023- 24 Elective Recovery Fund Allocation
CORPORATE	**TOTAL**	**(496,734)**	
GYNAECOLOGY	NON PAY EXPENDITURE	52,680	2023- 24 Elective Recovery Fund Allocation
GYNAECOLOGY	PAY EXPENDITURE	241,965	2023- 24 Elective Recovery Fund Allocation
GYNAECOLOGY	**TOTAL**	**294,645**	
IMAGING	PAY EXPENDITURE	43,046	2023- 24 Elective Recovery Fund Allocation
THEATRES	NON PAY EXPENDITURE	52,680	2023- 24 Elective Recovery Fund Allocation
THEATRES	PAY EXPENDITURE	106,363	2023- 24 Elective Recovery Fund Allocation
CLINICAL SUPPORT SERVICES	**TOTAL**	**202,089**	
Total		**0**	

Trust Board

COVER SHEET

Agenda Item (Ref)	**23/24/253e**		**Date: 08/02/2024**	
Report Title	**Immediate Quality and Safety Actions Investment**			
Prepared by	***Jennifer Huyton, Deputy Chief Finance Officer / Deputy Director of Strategy***			
Presented by	***Jenny Hannon, Chief Finance Officer / Deputy Chief Executive Officer***			
Key Issues / Messages	***The paper sets out a range of safety and quality interventions and their associated costs as part of the Trust's Improvement Plan requiring Board approval***			
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): None currently identified, ICS aware			
	For Decisions - in line with Risk Appetite Statement – ***If no – please outline the reasons for deviation.***			
	The Board are asked to approve recommendation of investment of £2.9m revenue costs and £0.1m capital (as part of the Trust's overall capital programme) in 2024/25 to support the delivery of the immediate actions in the Trust improvement plan.			
Supporting Exec:	**Jenny Hannon, 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)	
1.2 Failure to recruit and retain key clinical staff	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Executive Committee	24/01/24	CFO	Approved
Trust Board – verbal notification of requirement	11/01/24	CFO	Noted

EXECUTIVE SUMMARY

Several immediate actions are required to improve quality and safety at Liverpool Women's Hospital, in the context of delivering high risk and tertiary services from an isolated site. The cost impact resulting from delivery of these actions will fall into the 2024/25 financial year and beyond, and consequently will form part of the annual planning process. However, as these actions require immediate progression, they are presented to the Trust Board for approval ahead of financial and operational plan approval.

Actions and associated costs are summarised below:

Requirement	WTE	Draft Proposal £000s	2024/25 £000s	2025/26+ £000s
Resident 24/7 Obstetric Consultant*	3.0	400	242	604
Medical Emergency Team	17.6	1,000	921	1,586
Transfusion on site	5.5	300	345	423
Actively Anti Racist Programme (Year 1)	3.6	190	206	58
Programme Structure Delivery	4.0	210	258	271
Deteriorating patient Collaborative	3.4	285	252	-
LWH Direct Overheads	-	-	104	61
ACPs/Post Graduate Doctors	10.0	-	700	TBC
Total	**47.2**	**2,385**	**3,027**	**3,003**

This paper describes each action and rationale for implementation.

The Board are asked to approve recommendation of investment of £2.9m revenue costs and £0.1m capital (as part of the Trust's overall capital programme), as set out below, in 2024/25.

MAIN REPORT

1. Introduction and Background

Liverpool Women's Hospital faces several clinical safety and quality risks as a result of delivering tertiary and high-risk services from a site isolated from adult acute services. These risks are well evidenced and have been independently confirmed through clinical senate review. The Trust continues to work with system partners to determine a long-term sustainable solution, considering actions in the short, medium, and long-term. The Trust has developed an improvement plan which sets out clear priorities in the short term. This paper seeks to set out the short-term actions requiring resource, with medium and long-term overseen by the Women's Services Committee.

This paper summarises the proposed immediate safety and quality actions, the projected cost implications, and rationale for the intervention. All investments are subject to post implementation review to ensure that the deployment of resources delivers the required outcomes.

2. Summary of Immediate Interventions Required

Investment required to address immediate quality and safety issues is summarised below. This list was derived through engagement with senior clinical leaders both at the Trust and in partner organisations.

Requirement	WTE	Draft Proposal £000s	2024/25 £000s	2025/26+ £000s
Resident 24/7 Obstetric Consultant*	3.0	400	242	604
Medical Emergency Team	17.6	1,000	921	1,586
Transfusion on site	5.5	300	345	423
Actively Anti Racist Programme (Year 1)	3.6	190	206	58
Programme Structure Delivery	4.0	210	258	271
Deteriorating patient Collaborative	3.4	285	252	-
LWH Direct Overheads	-	-	104	61
ACPs/Post Graduate Doctors	10.0	-	700	TBC
Total	**47.2**	**2,385**	**3,027**	**3,003**

**Please note this is comprised 2.0WTE obstetric consultants, plus 1.0WTE administrative support.*

The table provides the initial draft costs for reference/comparison, against the current estimate (following additional work up) for 2024/25 and recurrent costs in 2025/26 and beyond. The direct overheads cost is comprised of IT equipment, licenses and training required to on-board new staff.

Costs are split between capital and revenue investment in the table below:

Requirement	2024/25		2025/26+	
	Capital	Revenue	Capital	Revenue
Resident 24/7 Obstetric Consultant	-	242	-	604
Medical Emergency Team	-	921	-	1,586
Transfusion on site	50	295	-	423
Actively Anti Racist Programme (Year 1)	-	206	-	58
Programme Structure Delivery	-	258	-	271
Deteriorating patient Collaborative	-	252	-	-
LWH Direct Overheads	47	57	-	61
ACPs/Post Graduate Doctors	-	700	-	TBC
Total	**97**	**2,930**	**-**	**3,003**

At present there is no known funding route for the above costs, therefore implementation of these actions will represent a cost pressure to the Trust in 2024/25 (and beyond), in addition to existing, known cost pressures already reflected in the financial position.

The next section provides further detail on each pf the proposed actions.

3. Actions

Resident 24/7 Obstetric Consultant
The 2021 RCOG report '*Roles and Responsibilities of the consultant providing acute care in obstetrics and gynaecology*' noted the transition towards resident night working for consultants in some Trusts. Safety recommendations and the rising complexity of cases has resulted in an increasing need and expectation for consultants to attend overnight whilst non-resident on-call. The Ockenden Review and organisations such as MBRRACE have also advocated for greater consultant involvement in patient care.

A thematic review of serious untoward incidents over the period of 2017 to 2022 was presented to Quality Committee in December 2022 and demonstrated that 21% of Serious Incidents had a contributary factor of staffing issues, which related to lack of consultant presence in the majority of cases. Cancelled clinics, lack of consultant presence out of hours and absence of a senior decision maker in clinical areas were specified within the Serious Incident reports. Implementing 24/7 resident consultants in obstetrics will help to address senior cover across the service. Expected or potential benefits of increased consultant presence include:

- Reduction in adverse outcomes.
- Improved patient experience.
- Adequate team support and supervision, including locum doctors.
- Setting standard for expected professional behaviours and safety culture.

This action proposes that two further obstetric consultants are recruited in 2024/25. This will provide the Trust with sufficient WTE to cover a 24/7 on-site consultant rota.

It has been assumed that consultants will be recruited during the 2024/25 financial year, and costs will therefore be phased. Once implemented, the 24/7 rota will have a cost implication (premium cost of paying for overnight shifts).

Band	Requirement	Recurrent/Non-Recurrent	WTE	2024/25	2025/26+
Consultant	2 additional WTE	Recurrent	2.00	159	286
Consultant	midnight - 7am cover	Recurrent	0.00	68	287
3	Consultant admin	Recurrent	1.00	15	31
			3.00	**242**	**604**

Medical Emergency Team (MET)
In acute hospitals, MET teams are established to respond to all adult medical emergency calls and cardiac arrests. They are usually comprised of junior doctors and nursing staff from specialities such as general medicine and critical care. Historically Liverpool Women's Hospital has not had a MET team, as it does not employ staff from appropriate specialties. Implementation of a MET team is essential to ensure that those patients who do experience a medical emergency have access to the same level of care available in other acute hospital settings across England. It is proposed that a MET team is introduced, with the following structure (subject to refinement as development of the model progresses):

Role	Band	Requirement	Recurrent/Non-Recurrent	WTE	2024/25	2025/26
Consultant	Consultant	5 PA cover	Recurrent	0.50	56	79
Registrar	Registrar	24/7 cover	Recurrent	5.08	286	400
ODP	8a	24/7 cover ACP	Recurrent	5.42	276	535
Nurse	8a	24/7 cover ACP	Recurrent	5.42	276	535
Admin	3	37.5 hour daytime contract plus headroom	Recurrent	1.21	27	38
				17.63	**921**	**1,586**

The governance and supervision models for the proposed team are yet to be determined, however it is expected that close partnership working with Liverpool University Hospitals NHS FT will be required. Phased recruitment is assumed from quarter 2 2024/25.

Transfusion On-site

Lack of access to on-site 24/7 blood transfusion services to support effective management of major haemorrhage is a key risk in delivering complex and high-risk services from the Crown Street site. Liverpool Women's is a significant outlier in terms of time to receive transfusion and receipt of O-negative blood in place of cross-matched blood, as well as in terms of wastage. The requirement is specified in NICE standards as well as relevant service specifications, and the requirement for this service is increasing as caesarean section rates and associated rates of conditions such as placenta accreta increase.

The Trust has been working on establishing this service, in partnership with Liverpool Clinical Laboratories, for several years, however there is a national workforce shortage and therefore a significant challenge in securing appropriate staff to deliver the service. Two options are under consideration; traditional staff support transfusion mechanism, and utilisation of robotic equipment with minimal staff support. The table below shows costs of the first option. The second option would require an initial capital investment of approximately £250k, followed by ongoing revenue costs of £56k per year.

Role	Band	Requirement	Recurrent/Non-recurrent	WTE	2024/25	2025/26
Staff support	6	5 x Band 6 staff with on-costs	Recurrent	5.5	295	413
Equipment				0	50	10
				5.50	**345**	**423**

Actively Anti-Racist Programme

MMBRACE data demonstrates that women from the global majority are significantly more likely to die in pregnancy or shortly afterwards than white women, as are their babies. The October 2023 MBRRACE-UK report evidenced that between 2019 and 2021, there remains an almost four-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to white women. This disparity remains statistically unchanged from 2018-2020.

The national Maternity and Newborn Safety Investigation team recently issued the Trust with a letter of concern, having identified two cases of concern stating the potential impact of cultural bias in the care of those women, leading to poor outcomes. The Trust is committed to addressing any cultural bias with the care and services it provides through an improvement programme approach of education, awareness raising, reflective learning with our patients and community, employment initiatives and change in clinical practice under the banner of being Actively Anti Racist. This programme of work has commenced but requires further resourcing to move on at pace with delivery through the establishment of a multi- disciplinary Anti Racism hub.

It is proposed that the Trust establishes an Anti-Racism Hub and 3-year Actively Anti Racist Programme. Year 1 requirements are as follows:

- Band 8b Head of Diversity & Culture (12-month fixed term contract or secondment).
- Band 6 or 7 Clinician (nurse/midwife or AHP – 12 months secondment).

- Band 6 OD Practitioner to facilitate to Actively Anti Racist Action Learning Sets & support the trust-wide training programme which has already launched and must be completed in year (fixed term or 12-month secondment).
- Band 3 Admin support for team (22.5 hrs fixed term or secondment).
- Commission independent Cultural Survey of staff, service users, leavers, partners, volunteers & students to inform next stage of programme. This may extend into 24/25 dependent upon start date of successful provider.

Role	Band	Requirement	WTE	2024/25	2025/26
Head of Diversity & Culture	8B	12 month ftc or secondment	1.00	65	23
Clinician	7	12 month ftc or secondment	1.00	47	17
OD Practitioner	6	12 month ftc or secondment	1.00	40	14
Admin Support	3	12 month ftc or secondment	0.60	13	5
Independent Cultural Survey		External provider	0.00	40	-
			3.60	**206**	**58**

Programme Structure Delivery

A joint Chief Transformation Officer has been appointed between Liverpool Women's Hospital and LUHFT. This role will establish a programme delivery office to ensure that quality and safety improvement programmes are implemented swiftly and effectively without adverse impact to existing staff and capacity, as well as maximise opportunities for further joint working and efficiency. Requirements are set out below:

Role	Band	Requirement	Recurrent/Non-recurrent	WTE	2024/25	2025/26
Head of IPDU	8C	Programme support	Recurrent	1.00	89	93
IP Delivery Support	7	Programme support	Recurrent	2.00	126	132
IP Admin	5	Programme support	Recurrent	1.00	43	45
				4.00	**258**	**271**

Deteriorating Patient Collaborative

Patients in hospital can deteriorate and at times this is not recognised or acted upon quickly. This is exacerbated at Liverpool Women's, as these instances are less frequent than in other settings, and because the Trust is isolated from other adult acute specialties. Prompt and effective treatment is critical in ensuring optimal outcomes. It is not uncommon for hospitalised patients to exhibit early warning signs before deteriorating. The key to optimal outcomes is recognition of these warning signs followed by an appropriate and timely response.

The Advancing Quality Alliance (AQuA) developed a collaborative approach to support organisations to improve their early recognition of the deteriorating patient. The programme combined theory, practical application and group discussions to support learning. The Trust intends to implement this approach through a 9-month programme aimed at identifying opportunities for improvement, devising and implementing an action plan. Costs for the programme are set out below. These are expected to be non-recurrent, however it is possible that some ongoing investment may be required – this will be determined during the course of the 9-month programme.

Role	Band	Requirement	Recurrent/Non-recurrent	WTE	2024/25	2025/26
Programme Support	-	AQUA to initiate programme support	Non-recurrent	-	60	-
Programme Manager	8a	9 month programme support	Non-recurrent	0.50	27	-
Data Analyst	6	9 month programme support	Non-recurrent	0.50	20	-
Programme Clinical Leadership	Consultant	9 month programme 2 PA support from LUHFT	Non-recurrent	0.20	21	-
Clinical/medical input	Consultant	9 month programme (1PA per week Obs/Gynae/Neo/Anaes)	Non-recurrent	0.40	39	-
ACCIO	Consultant	9 month programme (1PA per week between 3)	Non-recurrent	0.10	10	-
Clinical Fellow Support	Clinical Fellow	9 month programme (recruit 1wte to support on-call)	Non-recurrent	0.50	28	-
Nursing & Midwifery Support	5	9 month programme (1 day per week Neo, Mat, Gynae, Anaes)	Non-recurrent	0.80	26	-
Digital Nurse/Midwife	7	9 month programme (1 day per week)	Non-recurrent	0.20	9	-
Chief Nurse Information Officer	8a	9 month programme (1 day per week)	Non-recurrent	0.20	11	-
				3.40	**252**	**-**

Junior Doctors/Advanced Care Practitioners
The Trust consistently experiences significant challenge in securing sufficient junior doctors (in obstetrics, gynaecology, and anaesthetics) to ensure rotas are adequately covered and safe out of hours care is provided. The Trust is managing several risks in relation to this, including delay to treatment due to junior doctor availability and the impact this has on the ability to provide safe and effective care.

The Trusts current establishment for junior doctors in obstetrics and gynaecology is 50.0WTE, comprising 39 doctors in training provided through the Deanery (for whom partial funding is received), and a further 11.0WTE Trust-funded roles (implemented as a necessary cost pressure to the Trust).

An analysis has been undertaken by the Deputy Medical Director and Clinical Directors to assess current rota requirements (at a granular level) for all clinical services, benchmarked against current establishment. Current rota numbers do not reflect current activity levels. There are several drivers for the increasing gap between the service requirements and post-graduate doctor resource:

1. A reduction in the number of doctors rotating to Liverpool Women's Hospital (LWH). There is no prospect of any more obstetrics and gynaecology (O&G) trainees rotating to LWH.
2. A reduction in the clinical time provided by each doctor due to training and study leave requirements. Analysis has evidenced that study leave, annual leave, and other training account for 40% of time for a doctor on the O&G rota.
3. An increasing trend for less than full time working (at 60% or 80%) where the host Trust is unlikely to be able to recruit to the deficit.
4. An increase in service requirements both due to increased number of consultants, increased activity, changes to service standards/recommendations (for example Ockenden and CQC), and increasing patient acuity (for example increasing numbers of women requiring access to diabetes clinics).
5. Changes to national training programmes, meaning doctors come to LWH with limited experience of obstetrics and gynaecology.

The revised rota indicates that 75.8WTE is required to adequately meet rota requirements, accommodate training, and annual/sick leave. This is a significant increase, some of which is already included within the Trust's current run rate (materialising as temporary staffing pressures); however, the majority of this gap is currently being met by flexing existing staffing, meaning doctors are required to spend a greater proportion of their time covering out of hours rotas, reducing their time spent learning during the day. This has impacted on training experience and is reflected in the Trust's deteriorating GMC Survey scores.

Further scrutiny of the proposed rota is underway, to ensure proposed increased requirements are robust, prioritised, and phased appropriately and realistically, with this work forming part of the annual planning process, however it is clear from existing analysis that a significant increase to junior doctor establishments is required.

There is a national shortage of available O&G trainees. The Trust has been successful in investing in advanced care practitioners (ACPs) establishing a more sustainable, Trust-employed workforce with greater resilience and less dependence on variable supply of doctors. Therefore, it is proposed that the gap is partially addressed through investment into the maternity and gynaecology ACP workforce, with the additional benefit of creating a highly skilled clinical workforce with fulfilling job roles which can be retained by the Trust in the long term. It is proposed that the remainder of the gap is addressed through increasing the junior doctor establishment. This is projected to result in a pressure of no more than £0.7m in year 1, noting that this represents an initial part-year effect and phasing of implementation, offset against existing temporary staffing pressures, and receipt of one-off training income (£0.3m) for ACPs. This pressure will increase in future years and is currently estimated to be approximately £2.0m recurrently (split between doctors and ACPs).

4. Governance and Next Steps

The proposed investment outlined in this paper is presented to the Trust Board for approval, in line with Standing Financial Instructions (SFIs).

Indicative costs have been communicated to the Integrated Care Board (ICB), who have acknowledged the requirement, but have not indicated funding at this stage. Therefore, there is no identified funding source, and this will represent an additional cost pressure to the Trust in the 2024/25 financial year and beyond. The Trust will continue to pursue opportunities for efficiency, where possible, to offset these costs.

Delivery of the immediate actions outlined in this paper will be overseen by the proposed programme delivery team.

5. Conclusion and Recommendation

The Board are asked to approve recommendation of investment of £2.9m revenue costs and £0.1m capital (as part of the Trust's overall capital programme) in 2024/25 to support the delivery of the immediate actions in the Trust improvement plan.

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/254a***		**Date: 08/02/2024**	
Report Title	**Charitable Funds Strategy**			
Prepared by	***Helen Chainey, Strategic Projects Manager*** ***Jennifer Huyton, Deputy Chief Finance Officer / Deputy Director of Strategy***			
Presented by	***Jenny Hannon, Chief Financial Officer / Executive Director of Strategy and Partnerships***			
Key Issues / Messages	***To present the Charitable Funds Strategy for Trust Board approval.***			
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 N/A			
	For Decisions - in line with Risk Appetite Statement – Y			
	The Board is asked to approve the Charitable Funds Strategy.			
Supporting Executive:	***Jenny Hannon, Chief Financial Officer / Executive Director of Strategy and Partnerships***			

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* Choose an item.	Comment: N/A
Link to the Corporate Risk Register (CRR) – CR Number:	Comment: N/A

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Charitable Funds Committee	22/06/23	Head of Fundraising	Revision requested.
Executive Committee	01/11/23	Head of Fundraising	Feedback provided.
Charitable Funds Committee	23/11/23	Head of Fundraising	Final amends requested.
Charitable Funds Committee	22/01/24	Head of Fundraising	Final version received and accepted, recommendation of approval to Trust Board.

EXECUTIVE SUMMARY

Over the last 12 months, the Fundraising Team has developed a new strategy for the Liverpool Women's Hospital (LWH) Charity (Appendix 1). Development of the strategy has been supported by the strategy team and overseen by the Charitable Funds Committee. The Charitable Funds Committee reviewed the strategy on 22 January 2024, and it is now presented for Trust Board approval.

This paper briefly describes the development process and outlines how delivery of the strategy will be monitored.

The Trust Board is asked to approve the Charitable Funds Strategy for publication.

MAIN REPORT

1. Development of the Strategy

A draft Liverpool Women's Charity Strategy 2023 - 2027 was developed by the Fundraising Team and initially presented to the Charitable Funds Committee at the meeting held 22 June 2023. In this meeting, the Committee requested an increased focus and greater detail on how the Charity would enhance patient and staff experience, and that additional clarity be added to the draft strategy, using stakeholder engagement to identify additional major projects/themes.

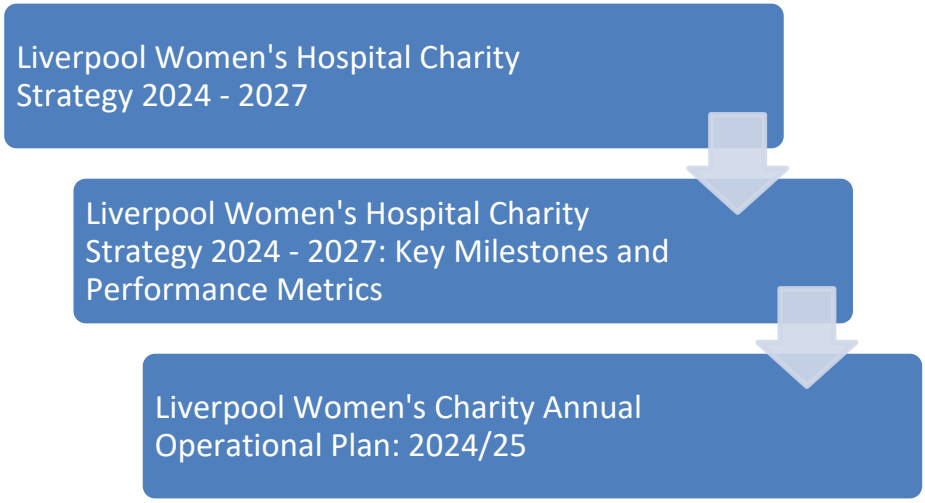
The Fundraising Team, supported by the Strategic Projects Manager, carried out further engagement, and incorporated the Committee's feedback into the next iteration of the strategy, which was discussed at the meeting held 23 November 2023. At this meeting, the Committee suggested further refinements, including making reference to the role and purpose of the Charity's new Patron, Dame Lorna Elizabeth Muirhead, and including further focus and attention on research within strategic aims.

The Committee received the final version of the strategy at the meeting held 22 January 2024, noted final, minor amendments, and approved recommendation of the strategy to the Trust Board for approval.

2. Performance and Delivery Monitoring

The Charitable Funds Committee noted the need to measure progress against the aims and objectives within the strategy, using milestones and key performance indicators. Key milestones have been identified within the strategy, and the Fundraising Team are in the process of developing key performance indicators (KPIs), which will be in place by the end of the financial year. These will be collated into a single, brief document 'Charity Strategy 2024 – 2027: Key Milestones and Performance Metrics', which will be used as a basis to monitor delivery and ensure progress remains on track. The schedule of reporting delivery against the milestones and KPIs will be agreed with the Committee.

The team will also produce an annual operational plan each year. This will enable alignment with the Trust's operational planning cycle and provide greater opportunity to respond to need identified by clinical divisions during their own planning processes. The plan for 2024/25 was reviewed by the Charitable Funds Committee on 22 January 2024.



3. Conclusion and Recommendation

The Liverpool Women's Hospital Charity Strategy 2024 – 2027 has been developed over the last 12 months. The Charitable Funds Committee reviewed the strategy on 22 January 2024 and recommended its approval to the Trust Board.

The Trust Board is asked to approve the Charitable Funds Strategy for publication.

Appendices

Appendix 1

Liverpool Women's Hospital Charity Strategy 2024 – 2027

Liverpool Women's Hospital Charity Strategy 2024 – 2027

January 2024

Foreword

Over the years Liverpool Women's Hospital Charity has demonstrated the Trust's shared values based around the needs of our women, babies and their families, our staff, our volunteers, and our community. The Charity has strived to support all our staff and the people we care for, by pursuing opportunities to develop and invest in our services across the hospital.

Our unique position as the only Trust providing care exclusively to women, babies, and their families in the UK, leads to a wealth of charitable opportunities. After listening to our stakeholders, we have formulated a new strategic plan for 2024 – 2027, in the context of a difficult economic climate and a need for increased charitable funds.

Our women, babies and their families are at the heart of everything we do. The Charity raises funds on behalf of the Trust to enhance overall patient experience, by providing services and equipment above and beyond that which can be funded by the NHS. These enhancements make a big difference to the comfort and wellbeing of our patients.

We support our staff by providing improvements to staff areas, facilities and wellbeing initiatives, which helps our staff to provide the best possible care for our women, babies and families. We also support staff with training and research opportunities which support the Trust's strategic priorities.

Over the course of this strategy, we will continue to build on our strengths while seeking opportunities to improve our ways of working, so that the Charity can provide an even better service to our beneficiaries.

We ask for the continued support of the entire hospital and wider community to make this plan a success.

Zia Chaudhry

Chair of the Charitable Funds Committee

January 2024

Our Background

The Liverpool Women's NHS Foundation Charitable Trust is an independent registered charity, which exists to raise, receive, manage and distribute donations for the benefit of the charitable purposes of the Liverpool Women's NHS Foundation Trust.

As a result of achieving Foundation Trust status in April 2005 the main umbrella charity changed its name from "Liverpool Women's Hospital Charitable Trust" to "The Liverpool Women's NHS Foundation Charitable Trust". This name change was approved by the Corporate Trustee on 2nd September 2005 and subsequently approved by the Charity Commission. The Charity adopted a working name, "Liverpool Women's Charity", which was approved by the Charity Commission on 16th September 2009. Our registered Charity number is 1048294.

The Liverpool Women's NHS Foundation Trust (the NHS Foundation Trust) is the Corporate Trustee of the Charitable Funds governed by the Trustee Act 2000 and the Charities Act 2011.

We are registered with the Fundraising Regulator and adhere to the Code of Fundraising Practice as outlined by the Standards Committee.

Our Mission and Purpose

Three clear areas of focus emerged when we developed our overarching *Trust* strategy with staff, patients, and community: having the best people, giving the safest care, and providing outstanding experiences.

The mission of the Liverpool Women's Charity is to make a genuine difference for the women, babies and families cared for by the Trust, and the people providing that care, above and beyond that which is provided by the NHS.

The Charity supports the Trust's vision of being *the recognised leader in healthcare for women, babies and their families* by providing:

- Additional facilities and an improved environment for patients and staff.
- Additional equipment that can make a real difference to patient care.
- Opportunities for staff welfare initiatives and access to training and development.
- Opportunities to further medical knowledge through research.

Our values are aligned to those of the Trust and reflect them in our policies, procedures and how we interact with the communities we serve – Care, Ambition, Respect, Engagement and Learning.

This strategy document supports a consistent, effective and professional approach to communications and fundraising ability of the Charity. It provides a framework to ensure the Charity is fit for purpose and is flexible enough to develop its activities in line with Charitable Fund purposes as set out in the governing documents.

Our Patron

In July 2023 the LWH Charity was delighted to announce Dame Lorna Elizabeth Muirhead as its first Patron.

Dame Lorna Elizabeth Muirhead DCVO DBE CStJ DL FRCOG (née Fox) is a past President of the Royal College of Midwives and from 2006 until her retirement in 2017 she served as the Lord Lieutenant of Merseyside. In 1992 Dame Lorna became a member of the Council of the Royal College of Midwives (RCM) and, in 1997 was elected as President. Dame Lorna served two terms of office, until 2004. Throughout this time she continued to work as a clinical midwife at Liverpool Women's Hospital.

Dame Lorna has a wealth of knowledge and experience in all aspects of maternity care and has extensive links with key partners in midwifery and the NHS. We will work closely with Dame Lorna to utilise her contacts and networks in enabling the Charity to provide even better support to our staff, women, babies, and families. We will engage her support in making applications to Trust and Foundations and sourcing statutory funding opportunities.

We also plan to identify two ambassadors who will support Dame Lorna in championing the LWH Charity and are currently seeking suitable supporters to fill these roles.

Dame Lorna said "It is an exciting time for LWH Charity and I am proud to be involved in shaping the future direction and delivery of outcomes to improve the patient and staff experience at LWH".

Our Context

National context

The charitable funds sector, and NHS charitable funds in particular, have seen significant change since 2020. During the first stages of the COVID-19 pandemic, traditional fundraising activities were heavily restricted, but at the same time the value of the NHS had never been clearer, and the British public's desire to support NHS staff, patients and services was arguably at its highest. NHS Charities Together launched their first ever national appeal for the NHS and raised over £150m to support staff as they faced the biggest crisis in the NHS's history. While those initial phases of the pandemic have now passed, there has been a lasting impact on the sector. Additionally, the current cost-of-living crisis has had a significant impact, both increasing the need for charitable funds and reducing the ability of many people to provide charitable donations.

Local Context

The Charity operates in a challenging local environment. Liverpool is an area with significant social deprivation (increasing the need and demand for charitable services) and there are seven specialist and acute NHS Trusts in the city, each with their own charity, which limits the local charitable giving available to each Trust.

Trust Strategic Context

Liverpool Women's NHS Foundation Trust is the main beneficiary of the Charity and is a related party by virtue of being a corporate Trustee of the Charity. By working in partnership with the Trust, the charitable funds are used to the best effect for the benefit of the people served by the Trust.

When deciding upon the most beneficial way to use the charitable funds, the corporate Trustee has to take into regard the main objectives, strategic plans of the Trust, whilst ensuring that the grants reflect the wishes of patients and staff.

The Charity aids the Trust's vision of becoming the recognised leader in healthcare for women, babies and families, through supporting delivery of its overarching strategy, Our Strategy. Our Strategy aims to ensure that the Trust has the best people, giving the safest care and providing outstanding experiences. The Charity's strategic priorities are aligned to Our Strategy, with a primary focus on people and experience.

https://www.liverpoolwomens.nhs.uk/media/3815/our-strategy-v5.pdf

Our Achievements

In 2019, the Charity appointed its first Head of Fundraising. This led to an increase in visibility, a strong and inspiring independent Charity brand, and an ability to prioritise strategic fundraising projects. The Charity is now seeing a culture of investment and involvement in fundraising at Executive and Board level, further raising the profile and allowing for growth and effective decision making. Fundraising has been embedded as part of the corporate induction, and benefits from increased staff engagement.

The Charity has a strong community fundraising income stream, with the majority of income coming from grateful patients. In addition, the Charity has received a tranche of significant support from NHS Charities Together following the pandemic. We are now a member charity and as such, are informed of any funding initiatives and opportunities that occur. However, the Charity's success is more than just financial. It centres around public relations and gifts in kind, as well as community partnership and engagement.

We have introduced a successful programme of challenge activities for all staff and supporters to engage with to raise funds for the Charity. The programme includes abseiling and skydiving opportunities, race entries and overseas trekking challenges.

The Charity has established a number of annual successful in-house events including:

- Strictly Come Dancing gala.
- Pink & Purple Pram Push.
- Fashion Show.

- Go Neon for Neo Day.
- Christmas Fair and regular calendar of stall holder events.

The Charity engages with charitable trusts and foundations and corporate organisations to secure grants to support our project fundraising. We have launched a Liverpool Women's Charity specific lottery and legacy campaign. The Charity also benefits from the Little Woollens Shop which is staffed full time by volunteers and sells knitwear handcrafted by our volunteer knitters.

In recent years, our fundraising campaigns have included:

- Our Big Tiny Steps Appeal which has improved the experience and environment for families accessing our neonatal unit.
- Fundraising to purchase a Mona Lisa Touch Laser which provides a new gynaecological service for women and offers an opportunity to carry out vital research for women following cancer treatment.
- Our Bereavement Suite Appeal which aims to transform clinical rooms on both our gynaecology and maternity wards into comfortable, home-like spaces to be used by families who have sadly experienced a pregnancy loss or still birth.

Support for the Charity's social media platforms is growing and provides positive stakeholder engagement for the Trust.

Our Strategic Priorities for 2024 - 2027

The Charity aims to make a genuine difference to the women, babies and families cared for by Liverpool Women's NHS Foundation Trust by actively supporting delivery of the Trust's strategic plan, focusing on ***people*** and ***experience***.

To achieve our goal we have set four strategic aims:

1. Our Women, Babies and their Families - Enhancing the wellbeing and experience of our service users through the provision of a high quality, well equipped and supportive environment.

   We will:

   - Provide wraparound packages of care and support for our families accessing our neonatal unit, by providing wholesome nutritious meals twice a day for families staying with us.
   - Provide four mOm Incubators for our maternity ward to reduce the risk of hypothermia by 2025/2026.
   - Provide birthing pools, lighting and furnishings as part of the Maternity Led Unit and Induction of Labour refit by 2025.
   - Support bereaved parents through providing facilities and peer support events.
   - Refurbish our physiotherapy gym to provide a dedicated space for our patients to receive bespoke physiotherapy during 2024.

- Refurbish our Imaging department during 2024.
- Identify and develop a new flagship campaign by 2025.

2. Our Staff and Volunteers – Enabling our staff and volunteers to provide the best care by supporting their development, health, and wellbeing.

   We will
   - Ensure all staff breakroom facilities are comfortable and fit for purpose, providing a dedicated space for staff to relax and take part in wellbeing initiatives.
   - Work with the Staff Wellbeing Committee to identify new ways to support staff.
   - Increase city engagement for gifts in kind to facilitate staff gifts and care packages.
   - Develop a charitable funding education package for staff and volunteers as they are often first point of contact for people with charity-related queries.
   - Provide opportunities for staff to take part in and own fundraising initiatives.
   - Progress applications with NHS Charities Together around staff welfare funds
   - Support the training needs of our volunteers.

3. Our Community – Tackling health inequalities and improving healthcare outcomes for our local community through supporting education, innovative research opportunities and clinical developments.

   We will:
   - Explore opportunities to develop and establish a “scan in a van” service to bring Liverpool Women’s services to the heart of the community.
   - Increase awareness of our services and interaction with our local community by working with community groups and leaders.
   - Collaborate with colleagues to develop community ambassadors.
   - Identify new clinical developments and research opportunities suitable for charitable funding, through working in partnership with the Liverpool Women’s Hospital Research, Development and Innovation Team.

4. Our Charitable Performance - Maximising our contribution by ensuring our Charity is fit for purpose, sustainable and working collaboratively with partners.

   We will:
   - Commit to fundraising £1 million over the next three years.
   - Establish clear lines of accountability for staff and the consideration of relationships within and outside the Trust in respect of charitable funds.
   - Establish and review income streams/income generation activities that have a positive impact on the Charity’s work.
   - Develop and embed a new charitable funds grant application process during 2024.

- Ensure sound governance and compliance with legislation and good practice guidance issued by the Charities Commission, the Fundraising Regulator, the Trust, and any other regulatory bodies.
- Provide a Trust Wide framework to ensure the Charity is fit for purpose and is flexible enough to develop its activities in line with charitable fund purposes set out in the governing documents.
- Establish a performance management process to include involvement of stakeholders, promote efficiency and define and monitor reporting mechanisms.
- Ensure the Charity optimises use of resources through effective management.

Our Fundraising and Communications

With a variety of funding resources, it is essential that the Charity provides a consistent, transparent, effective and professional approach to donations and fundraising activities. This will assure agencies of the Charity's internal monitoring processes and that access to funds is legitimately improving patient care in accordance with the Trust's vison and values.

As a charity regulated by the Fundraising Regulator, we strive to achieve the highest standards in all our fundraising communications and will continue to do this, with reference to relevant professional and statutory bodies guidance and regulation. Developing positive long term relationships with all our donors and supporters underpins all our actions around our fundraising.

We welcome feedback from supporters and others who are approached for funds as this develops and improves our activities.

Everyone we contact has the opportunity to remove themselves from future communications and we are committed to adhering to these choices, recognising the need to protect vulnerable people and carefully monitoring the content and frequency of our approaches to individuals.

The Charity has diversified its income streams to ensure future sustainability. We concentrate on grateful patient fundraising, gifts in memory, lottery, legacy giving, sponsorship from charitable Trusts and Foundations and corporate organisations, and a range of challenge and workplace events.

The team continually engages with staff, patients and supporters, the work of the Charity and its successes and appeals are regularly shared.

Our Approach to Investment

The Charity will continue to outsource management of the investment portfolio to investment management experts and consider their advice. The portfolio will remain mixed, to maximise gains and reduce risks.

The Charity remains committed to reflecting the ethics of the NHS and the impact of investments on the wider community. On this basis the investment strategy currently excludes investments in:

- Tobacco
- Armaments
- Gas and oil stocks.

The Charity will continue to review the investment strategy at least annually, taking appropriate advice, and considering the ethical implications.

Our Governance and Monitoring

All stakeholders (internal and external) have various roles and responsibilities within our Charity Strategy.

The Trust Board, as Corporate Trustee, is ultimately responsible for ensuring that the Charity complies with legislation and good practice guidance, has a clear vision and manages the Charity in accordance with the Charities purpose, as set out in the governing document.

The Charitable Funds Committee is responsible for setting the mission, purpose and objectives of the charity and will be clear on how it will achieve them. They will further set achievable targets and indicators of success and will review performance against these to identify whether the aims of the Charity are being met. The Head of Fundraising is responsible for the local awareness, implementation, and compliance with the requirements of this strategy.

Trust employees and volunteers are often the first point of contact for people with charity-related queries and as such, should familiarise themselves with the function of the charity. They are responsible for keeping themselves updated on any changes to the Charity Strategy and are expected to adhere to the Code of Fundraising Practice, seeking support from the Head of Fundraising as and when required.

The Charity's approach to fundraising has clearly defined processes in place for the protection of the Trust, the Charity, patients, their families, and other stakeholders.

A Trust-wide framework is in place which ensures that the Charity is fit for purpose and is flexible enough to develop its activities.

The implementation of the revised Liverpool Women's Charity Strategy will ensure a continual consistent, effective, and professional approach to fundraising. Key milestones have been identified to ensure the delivery of objectives, which are detailed within the supporting implementation plan; 'Charity Strategy 2024 – 2027: Key Milestones and Performance Metrics'. To ensure the strategy is delivered, we will carry out regular review and monitoring against these objectives, and report performance to the Charitable Funds Committee every six months.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/254b***		**Date: 08/02/2024**	
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 on their contents and actions.*** • ***Agree the suggested Q3 scores***			
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* All	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 the PPF, FPBD and Quality Committees since the previous version was presented to Board in December 2023.

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.

This report provides an outline of each BAF risk, the proposed scoring for Quarter 3 2023/24 and any comments made by the Board's Committees during recent meetings.

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 because of the review of assurances and/or identification of risks, whether there is a need to commission additional assurance to be reported to future Board and / or Committee meetings. In particular, the Board needs to ask itself whether it is attaining adequate assurance against its highest scoring risks i.e., are these areas of risk driving the Board and Committee agendas. 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 following provides an outline of each BAF risk, the proposed scoring for Quarter 3 2023/24 and any comments made by the Board's Committees during recent meetings:

1 – Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities

Proposed Reduction Justification: The reduction from '16' to '12' is justified by several positive developments. First, the 'big conversation' held in September 2023 revealed a positive sentiment among the staff, reflecting an improvement in the overall staff culture. Second, the Trust's consistent recognition among the top 50 inclusive employers for the third consecutive year signifies sustained efforts in fostering diversity and inclusivity. Additionally, the indictive data (subject to change) from the 2023 Staff Survey shows promising signs of improvement. While acknowledging that risks persist, particularly in relation to postgraduate doctors and rota gaps, the Trust has received assurance regarding robust mitigating plans, instilling confidence in effective risk management. A business case for securing the required additional roles is also in development.

These positive indicators collectively suggest a favourable trajectory for workforce engagement and satisfaction. Therefore, the proposed reduction in the risk score from '16' to '12' is supported by tangible evidence of progress. Continued vigilance and proactive measures, especially in addressing issues related to the junior medical workforce, will be crucial for sustaining and building upon these improvements throughout the year.

Updates to the Controls, Assurances and Actions have been made.

The PPF Committee debated the proposed risk score reduction at its meeting in January 2024. It was highlighted that this risk related to the workforce in its entirety and positive indicators collectively suggest a favourable trajectory for workforce engagement and satisfaction. It was acknowledged that risks persist, particularly in relation to postgraduate doctors and rota gaps, continued vigilance and proactive measures would be crucial for sustaining and building upon these improvements throughout the year. It was noted that the scoring would also be related to the approval of elements included within the improvement plan.

2 - Inability to ensure the on-going sustainability of clinical services and prevent patient harm by maintaining a high standard of care at the current Crown Street site

- Score proposed to remain at '20'.
- Significant update to the controls and assurance framework in an attempt to rationalise and provide focus.
- This will be further supported by the development of the Trust's Improvement Plan – to be reflected in Q4 and onwards.

3 – Failure to deliver an excellent patient and family experience to all our service users

- Proposed to maintain the risk score at '6'
- Assurance and control framework updated

~~4 – Inadequate digital strategy and sub-optimal clinical records systems increase the risk of major IT system failures due to cyber-attacks, compromising patient safety and Trust operations~~ Impact to the safety of patient care services due to the lack of effective Digital Systems adoption, Strategy implementation and Cyber Security breaches influenced through cyber threats, staffing and financial resources

- Proposed to maintain the risk score at 16.
- Rationale updated as follows:
  The successful introduction of the MEDITECH Expanse EPR, which by design has improved systems integration with other Trust systems, supported the reduction of the risk score from '20' to '16' through a reduction to the consequence risk score. It is acknowledged that the reduction of the consequence risk score is unusual but this was undertaken for the following reason – "The assessment of consequence from a cyber threat perspective has resulted in a rating reduction from catastrophic to major based on the multi-layered technical controls which have proven effective in terms of alerting and protection resulting capability to contain the impact of a successful in some scenarios". However, it is also acknowledged that this also changed the nature of the risk and therefore there is a proposed change to the risk name.

  It was hoped that the 'likelihood' score would reduce in this quarter but it has been asserted by the Executive Lead that the 'optimisation' phase of DigiCare needs to mature and embed ahead of recommending such a reduction.
- Assurance and control framework updated
- Additional actions to strengthen the assurance and control framework have been added.

5 – Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term
• Proposed to increase the risk score from '16' to '20' (likelihood score has increased) • Rationale updated as follows: • The likelihood of this risk has been assessed at Quarter 3 as '5 - almost certain' rather than '4 - likely. At Month 9, the Trust is reporting an adverse variance to plan of £2.7m year to date and a full year adverse variance forecast of £8m • Assurance and control framework updated • Actions updated
6 – The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative
• Proposed to maintain the risk score as '6'. • Rationale updated as follows: 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 Trust has strengthened partnerships further during Q2 by securing agreement to appoint a shared Accountable office with partners Liverpool University Hospital NHS FT. ToRs have been drafted for a new Partnership Board with AHCH. In addition, the ICB's Women's Services Committee has begun making progress towards delivery. • Assurance and control framework updated
7 - Failure to meet patient waiting time targets
• Proposed to maintain the risk score at '6' • Assurance and control framework updated

Other issues

Updates have been made to the Corporate Risk Register and High Scoring risks linkages. Appendix 1 has also been updated. Once more BAF scores from neighbouring trusts are available, this will support an analysis of the Trust's risk scores against comparable areas to support calibration.

The Trust's governance and assurance framework is currently being reviewed with changes likely to be implemented from April 2024 onwards. The alignment with these changes and the BAF will be important and the Board Development session scheduled for March 2024 will provide an opportunity to consider this further.

Closed Risks or Strategic Threats

No closed risks.

Recommendation

The Board requested to

- review the BAF risks and agree on their contents and actions.
- Agree the suggested Q3 scores

Liverpool Women's
NHS Foundation Trust

Board Assurance Framework 2023/24

Trust Board

February 2024

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

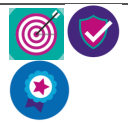
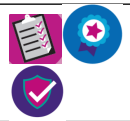
Director Lead	
CEO	Chief Executive
CPO	Chief People Officer
COO	Chief Operating Officer
CFO	Chief Finance Officer
CIO	Chief Information Officer
CN	Chief Nurse
MD	Medical Director

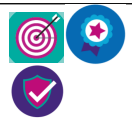
Key to lead Committee Assurance Ratings	
	Green = Positive assurance: the Committee / Board is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity - no gaps in assurance or control AND current exposure risk rating = 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 Aim	The 2021/25 strategic aim 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.
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. Level 1 – Operational oversight Level 2 - Board / Committee oversight Level 3 – external (independent) oversight
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.
Progress:	A RAG rated assessment of how much progress has been made on the completion of the required action.

Board Assurance Framework Dashboard 2023/2024

BAF Risk	Strategic Aim(s)	Committee	Lead	May 2023	Q2	Q3	Q4	Q2Q Movement	2023/24 Target
1 – *Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities*		PPF Committee	Chief People Officer	16 (I4 x c4)	16 (I4 x c4)	12 (I3 x c4)			12 (I3 x c4)
2 - Inability to ensure the on-going sustainability of clinical services and prevent patient harm by maintaining a high standard of care at the current Crown Street site.		Quality Committee	Chief Operating Officer / Medical Director	20 (I4 x c5)	20 (I4 x c5)	20 (I4 x c5)			15 (I3 x c5)
3 – *Failure to deliver an excellent patient and family experience to all our service users*		Quality Committee	Chief Nurse	12 (I3 x c4)	8 (I2 x c4)	8 (I2 x c4)			8 (I2 x c4)
4 – *Impact to the safety of patient care services due to the lack of effective Digital Systems adoption, Strategy implementation and Cyber Security breaches influenced through cyber threats, staffing and financial resources.*		FPBD Committee	Chief Information Officer	20 (I4 x c5)	16 (I4 x c4)	16 (I4 x c4)			15 (I3 x c5)
5 – *Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term*		FPBD Committee	Chief Finance Officer	16 (I4 x c4)	16 (I4 x c4)	20 (I5 x c4)			12 (I3 x c4)
6 – *The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative*		FPBD Committee	Medical Director / Chief Finance Officer	9 (I3 x c3)	6 (I2 x c3)	6 (I2 x c3)			6 (I2 x c3)

7 - Failure to meet patient waiting time targets		Quality Committee	Chief Operating Officer	16 (l4 x c4)	16 (l4 x c4)	16 (l4 x c4)			12 (l3 x c4)

BAF HEAT MAP

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic				BAF 2 BAF 5	
4 Major		BAF 3	BAF 1	BAF 4 BAF 7	
3 Moderate		BAF 6			
2 Minor					
1 Negligible					

BAF Risk 1 – *Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Challenges with Workforce Supply, particularly in relation to medical and other clinical staff, combined with a lack of staff engagement, may result in an inability to deliver safe, high quality care and organisational objectives.	The Trust may struggle to provide safe and effective care, achieve organisational objectives, and engage effectively with patients and staff due to the staffing challenges.	If the Trust is unable to address these staffing challenges, it may result in negative outcomes for patients and staff, including reduced trust in the quality of care provided, a negative impact on staff morale, and potential legal and regulatory consequences for failing to create a diverse workforce that is representative of the community it serves. Additionally, it may negatively impact the Trust's reputation and lead to reduced patient confidence.

	We will be an outstanding employer	✓		**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience	✓		**To be ambitious and efficient and make the best use of available resources**	
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Putting People First Committee**	**Lead Director:**	**Chief People Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	4	4	3		3	**March 2024**	Our risk appetite for workforce **is moderate.** Liverpool Women's NHS Foundation Trust has a moderate appetite for risk to this objective. The Trust operates in a complex environment in which it faces challenging financial conditions and changing demographics alongside intense political and regulatory scrutiny. However, the continued delivery of high-quality healthcare services and service sustainability requires some moderate risk to be accepted where this is likely to result in better healthcare services for patients. Support for moderate risk in service redesign that requires innovation, creativity, and clinical research to improve patient outcomes are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.
Consequence	4	4	4		4		
Risk Level	16	16	12		12		

Rationale for risk score and quarterly update – *January 2024*

Existing Rationale: The Liverpool Women's NHS Foundation Trust has grappled with acute and chronic staffing challenges, exacerbated by low morale, high sickness absence rates, and maternity staffing issues. Turnover, recruitment challenges in specialist areas, and an inadequate number of doctors in training further compound the situation. National shortages of nurses and midwives, coupled with the clinical risk associated with an isolated site, have intensified the complexities. The recent pandemic, recovery of elective activity, and industrial action have added additional strain. The Trust's previous BAF iterations have consistently scored staffing-related risks high, with Risk 1.2 (Failure to recruit & maintain a highly skilled & engaged workforce) marked as a '20'. The 2022 Staff Survey outcomes and improvements in sickness and mandatory training rates led to an initial score of '16' for the opening of 2023/24. Progress in diversity and inclusivity, exemplified by the Trust's inclusion among the top 50 inclusive places to work for the second consecutive year, supported a further reduction to '12'.

Proposed Reduction Justification: The reduction from '16' to '12' is justified by several positive developments. First, the 'big conversation' held in September 2023 revealed a positive sentiment among the staff, reflecting an improvement in the overall staff culture. Second, the Trust's consistent recognition among the top 50 inclusive employers for the third consecutive year signifies sustained efforts in fostering diversity and inclusivity. Additionally, the indictive data (subject to change) from the 2023 Staff Survey shows promising signs of improvement. While acknowledging that risks persist, particularly in relation to postgraduate doctors and rota gaps, the Trust has received assurance regarding robust mitigating plans, instilling confidence in effective risk management. A business case for securing the required additional roles is also in development.

These positive indicators collectively suggest a favourable trajectory for workforce engagement and satisfaction. Therefore, the proposed reduction in the risk score from '16' to '12' is supported by tangible evidence of progress. Continued vigilance and proactive measures, especially in addressing issues related to the junior medical workforce, will be crucial for sustaining and building upon these improvements throughout the year.

Key Controls and Assurance Framework

Key Controls:

- Putting People First Strategy articulates the actions the Trust will take to support the development of a skilled and motivated workforce. A new iteration of this strategy for 2024 onwards is in development.
- Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff which includes a structured career conversation enabling identification of future talent. Consultants and other clinical staff also undertake a re-validation process. All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities.
- PDR window for Band 7 and above to support the clear dissemination of shared divisional objectives
- A tiered leadership programme is in place which is compulsory for new leaders at all levels of seniority and has had high levels of attendance
- A long-standing set of values linked to a behavioural framework. Great Place to Work Group Launched as a cross section of staff committed to improving staff experience and a source of two-way communication
- Comprehensive review of mandatory training undertaken with competencies linked to roles and detailed reporting at 3 levels, core, clinical and speciality specific. Training data validated on a quarterly basis by workforce and senior nursing / midwifery team.
- Pay progression linked to mandatory training compliance
- Targeted OD intervention for areas in need to support.
- LWH Staff Support Service in place, a trauma informed staff wellbeing service including psychologists and health and wellbeing coaches
- Workforce planning processes aligned to annual planning processes and Divisional Workforce Plans in place in place to deliver safe staffing.
- Utilisation of workforce tools and methodologies to plan safe staffing including Birthrate Plus and BAPM
- Medical Workforce Review Group to review development of alternative roles and undertake roster reviews to enable effective workforce planning
- Two Freedom to Speak Up Guardians (including representation from a diverse and clinical background) which supports a culture of openness and transparency, supported by the Whistleblowing Policy
- Annual NHS Staff Survey, supported by 3 Pulse surveys in the other quarters.
- Bi-Annual Trust wide listening events - Big Conversation- led by Executive and Non-Executive Directors
- Local governance structures to support compliance with HR KPIS including review of mandatory training in senior nursing/ midwifery meetings
- Shared appointments with other provider across a range of clinical and corporate services
- Extension of opportunities for new ways of working including hybrid working and an increase in flexible working in clinical areas
- NHSP utilisation for bank staff has reduced agency expenditure and improved governance
- Award winning preceptorship programme for midwifery staff
- Industrial action working group
- Commitment to Anti-Racism and an ED&I annual improvement plan focused on increasing diversity at all levels, specifically leadership roles. Associated actions include a positive discrimination scheme, career conversations , reciprocal mentoring, diverse interview panels and widening participation programmes Links with community leaders established to improve under-representation and a range of pre-employment programmes and work experience opportunities
- WDES and WRES action plan delivery in line with timescales presented from NHS England
- Establishment of staff inclusion Networks and work in collaboration with local Trusts to promote staff networks and LGBTQ Network to be launched in 2022.
- Education and celebration of the key EDI events: Black History Month, Disability History Month, LGBT+ History Month and key faith observance days/festival
- Utilising widening participation programmes and alternative ways to advertise and promote our job opportunities to attract local population to work at LWH.
- Management of industrial action planning via the strike planning committee
- Introduction of Advanced Practitioners, Surgical Assistants and Physicians Associates
- Nursing, Midwifery & AHP Review Group focused on recruitment and retention
- Establishment control process underway to ensure accurate reporting of vacancy levels
- Positive culture of partnership working including shared decision making with JLNC and Partnership Forum.
- Systems of 2-way communication with postgraduate doctors including junior doctors forum and monitoring of junior doctors working hours and experience through the GMC Survey and Guardian of Safe Working.
- Director of medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN
- Local ownership of staff survey and pulse check results to enable improvements to be created and implemented at a local level

		Assurance Level	Assurance Rating	Overall Assurance Rating
Key Assurances:	The ED&I sub-committee oversee progress against ED&I actions	**2**		
	Annual quality of appraisal audit (November 2022)	**2**		
	Annual mandatory training audit (November 2022)	**2**		
	WRES and WDES submissions	**2**		
	PPF Strategy and action plan – monitored by PPF Committee	**2**		
	Policy schedule for all HR policies	**2**		
	Policy review process reported to PPF	**2**		
	Range of internal and 2-way staff communications	**1**		
	EDI Lead and monitoring through the ED&I Action Plan networks	**1**		
	Monthly KPI's for controls.	**2**		
	Great Place to work minutes to PPF	**2**		
	Divisional Board and Divisional Performance Reviews	**2**		
	Chair's Reports to PPF Committee	**2**		
	Report form Guardian of Safe Working	**2**		
	Bi-annual Speak Up Guardian Reports.	**2**		
	Annual Report whistle blowing report to PPF and Audit Committee	**2**		
	Quarterly internal staff survey (Let's Talk)	**1**		
	KPI reports from all outsourced services, Recruitment, Payroll and Occupational Health	**2**		
	Reports and feedback from Big Conversation into the Board and Divisional Boards	**2**		

Gaps in Control / Assurance:

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 / 11)

To further widen opportunities for the local community to join the LWH workforce (Action 1.1 / 4)

To continue to develop more diverse recruitment and selection processes (Action 1.1 / 4)

Enhance availability and quality of training across all protected characteristics including disability and inter-sectionality (Action 1.1 / 9)

Embedding of LWH as an Anti-Racist Organisation – *actions to be defined as part of the Improvement Programme*

Development of ED&I Strategy (Action 1.1 / 11)

Need to ensure that career conversations are being undertaken for all staff, particularly racially minoritized staff with a focus on their development and talent management (action 1.1 / 9)

Maximise the benefits of using rostering and job planning systems (Action 1.2 / 3)

Requirement to respond effectively to Ockenden recommendations regarding staffing (Action 1.2 / 5)

	A suite of KPIs which measure the performance of the People Services including customer feedback based on the nationally developed questions	**2**				Clinical risks associated with isolated site impact upon recruitment & retention of specialist medical staff (Action 1.2 / 6) Implement establishment control and revised integrated workforce report to improve workforce planning processes (Action 1.2 / 9) Recognise that some people services are better delivered at scale and look at the potential to further collaborate or outsource(Action 1.2 / 8) Business Case for additional clinical roles to support 24/7 cover to be developed (Action 1.2 / 10)
	Assurance that MT competencies are assigned correctly via sign off from practice educators and Heads of Nursing	**2**				
	Ownership of workforce plans at Divisional Level (reported via Divisional performance reviews).	**1**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
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	Deputy Chief People Officer	Ongoing	Wellbeing Coach and Assistant Psychologist vacancies will be targeted via universities with specific focus on racially minoritised communities. Review piece with Patient Experience to identify and prioritise communities within which to target entry level roles. HCA and admin roles- specific careers event in Toxteth (small numbers of roles). Advertisement of key roles via Inclusive Companies jobs page in place. Supported internships for BAME individuals from the local area to commence in January 2023.	
1.1 / 4	Exploration and implementation of more diverse recruitment and selection processes including diverse interview panels and alternative recruitment methods Diverse interview panels have commenced but are yet to be consistently applied to all senior roles.	Deputy Chief People Officer	~~January 2023~~ March 2024	Process in place to ask staff with protected characteristics to join interview panels for Band 8A and above. Employees with protected characteristics have been invited to take part in national training to participate in recruitment processes in other NHS Trusts. Access to pool of interviewers via the ICB in addition to REACH network. Will audit consistency of application (new deadline suggested)	
1.1 / 9	Enhance availability and quality of training across all protected characteristics including disability and inter-sectionality	Deputy Chief People Officer	~~December 2022~~ April 2024	Enhanced training for senior leaders developed, additional baseline training in development, additional training around neurodiversity etc required. Roll out to subject to budget setting (new date suggested)	
1.1 / 11	Development of ED&I Strategy	Deputy Chief People Officer	~~January 2023~~ April 2024	This will be included as a major strand of a revised PPF Strategy – to be rolled out by April 2024	
1.2 / 3	E-rostering system for doctors - Allocate is implemented for medical staffing	Deputy Chief People Officer	~~November 2022~~ April 2024	O&G implemented, Neonates and Anaesthetics to roll out by April 2024	
1.2 / 5	Respond to Ockenden recommendations relating staffing	Deputy Chief People Officer	~~September 2022~~ April 2024	Midwifery staffing levels are compliant – no current vacancies and we are adherent to BR+ recommendations. Additional roles being funded via CNST monies to support Ockenden recommendations. 24/7 Obs cover remains in development.	
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		
1.2 / 7	To ensure that workforce data tracks the key indicators and areas of risk through development of integrated workforce report	Deputy Chief people Officer	November 2023	Report in development	
12 / 8	To work collaboratively within the C&M and NW system to implement shared services or ways or working to improve quality and / or efficiency	CPO	Ongoing	LWH actively participating in regional workstreams	
1.2 / 9	To introduce scrutiny of the performance of the people function through KPIS (in addition to the existing workforce KPIS)	Deputy Chief People Officer	November 2023	Review national KPIS when published	
1.2/10	Business Case for additional clinical roles to support 24/7 cover to be developed	CPO / MD	April 2024		

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2491	2641	
4 Major		2660	2087, ~~1704~~, 2549	2760, 2732, 2578	2768, 2770
3 Moderate					2645
2 Minor					
1 Negligible					

[Return to Dashboard](#)

Ref	Description	Risk Rate Score
	Corporate Risks	
2641	Condition: There is a significant risk to the dietetic service and delivery of patient care at LWH	20
2660	In November Occupational Health alerted the Trust via Infection Prevention Committee that there were clinical staff in the organisation who were not compliant with screening / evidence of immunity/ up to date vaccination for a) EPP procedures and b) HEP B	8
2087	Condition: 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.	12
2491	Noncompliance with mandated level of fit mask testers qualification, accreditation and competency.	15
~~1704~~	~~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~~
2549	Condition: Staff shortages in the Ultrasound Team within the Imaging Department due to Vacancies and 5 staff members leaving in May & June 22	12
2645	NWAS INDUSTRIAL ACTION FOR 21 AND 28 DECEMBER 2022 Condition: National ambulance and NHS trade unions recently announced two days of strike action. GMB, Unite, and Unison members will take part in industrial action on the 21 December, with GMB also taking a further 24 hours of action on the 28 December. Specifically, as follows: _GMB - 21 and 28 December 00.01 to 23.59 _Unite - 21 December 00.01 to 23.59 _Unison - PES staff only 21 December 12:00 - 00.00	15
2732	Condition: Following the CQC review (January 2023) it was again identified and highlighted within the CQC initial report regarding the lack of medical cover out of hours within GED	16
2549	Condition: Staff shortages in the Ultrasound Team within the Imaging Department due to Vacancies and 5 staff members leaving in May & June 22	12
	High Scoring (15+) Divisional Risks	
2768	Condition: Shortage of middle grade and Consultant level Anaesthetics medical workforce	20
2760	Condition: Lack of on-site leadership and governance structure for MRI and CT	16
2770	Condition: Risk to Anaesthetics capacity for out of hours emergency Obstetrics and Gynaecology procedures	20
2758	Condition: Lack of on-site Imaging Medical Cover, currently dependant on 3 external providers for Radiologist support	16

BAF Risk 2 – *Inability to ensure the on-going sustainability of clinical services and prevent patient harm by maintaining a high standard of care at the current Crown Street site.*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Inadequate comprehension of the evolving healthcare requirements of the local population, along with a failure to adequately consider the needs of marginalized groups or communities during the formulation of clinical service strategies, increases the risk of patient harm. The omission of all viable precautions to guarantee the safety of services delivered from the Crown Street site, while enhancing our facilities for the well-being of our patients and the broader system, exacerbates this risk.	Clinical service strategies that do not adequately foresee the changing healthcare needs of the local population and do not address health disparities may lead to patient harm. Moreover, the current services' location, size, layout, and accessibility may not support sustainable integrated care or the safe delivery of high-quality services. The failure to implement all feasible measures to ensure the safety of services provided from the Crown Street site, while enhancing our facilities for the benefit of patients throughout the system, amplifies the risk of patient harm.	The consequences of these issues include suboptimal patient outcomes, heightened health disparities, and the unsustainability of clinical services. This could lead to inefficient care delivery, jeopardized patient safety, and a diminished patient experience. Failing to optimize the Trust's available facilities and ensure their safety could result in adverse events, an increased threat to patient safety, and potential damage to the Trust's reputation.

	We will be an outstanding employer			**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience	✓		**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Quality Committee**	**Lead Director:**	**Chief Operating Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	4	4	4		3	**March 2024**	Our risk appetite for safety is **low.** Our fundamental strategic aim describes our commitment to patient and staff safety. When and wherever possible we will apply strict safety protocols for all clinical and non-clinical activity. We will not compromise the safety of our patients, we will report, record, and investigate our incidents and we will ensure that we continue to learn lessons to improve the safety and quality of our services.
Consequence	5	5	5		5		
Risk Level	20	20	20		15		

Rationale for risk score and quarterly update – ***September 2023***

One of the most critical risks facing the Trust stems from its location on an isolated site, detached from an acute centre, posing an immediate-term threat to patient safety. Beyond geographical remoteness, patient harm risks encompass:

- Delays in accessing specialist care: Patients needing unavailable specialised treatment may experience critical delays, especially endangering critically ill individuals.
- Reduced resource access: Isolated hospitals contend with limited resources, leading to diagnostic and treatment delays, heightening short-term patient harm risk.

Mitigation measures include significant investments in enhancing the Crown Street site's safety, with emergency department improvements and a new neonatal intensive care unit. Additionally, proactive horizon scanning, and strategic planning enhance preparedness.

Despite robust efforts, some immediate-term risk persists due to geographic isolation, as confirmed by an independent review in February 2022. The Trust faces substantial immediate-term risks to the organisation and patient safety, despite proactive measures, necessitating ongoing vigilance.

Key Controls and Assurance Framework

Key Controls:

- Programme for a partnership in relation to Neonates with AHCH has been established which supports collaboration between the LWH and AHCH sites reducing risk for transfers
- Formal partnership and board established with Liverpool Universities Hospitals to support shared recognition of risks and ways that collaboration can be utilised to help mitigate this
- Blood product provision by motorised vehicle from nearby facility, with revised protocols in place to prioritise transport of blood products.
- Investments in additional staffing inc. towards 24/7 cover - Anaesthetics joint anaesthetic appointments with LUHFT
- Investments in additional staffing inc. towards 24/7 cover – Gynaecology, including additional investment in ANP roles within GED
- Investments in additional staffing inc. towards 24/7 cover - Neonates
- Enhanced resuscitation training provision – Adult – to reduce risk of critically ill patient on site
- Crown Street Enhancements Programme Board established to oversee progress against existing improvement programmes and horizon scan for additional opportunities:
- Community Diagnostic Centre established at Crown Street, for additional diagnostic capacity, reducing transfers and speeding up access.
- Theatre slots at LUHFT with access to colorectal surgeons
- Purchase of sentinel node biopsy and 3D laparoscopic kit
- Operational 'Plans on a page' for Divisions – incorporates horizon scanning section
- Operational planning process
- Availability of data on service trends and demographics
- SOP implemented for paediatric resus provision
- Liverpool Clinical Services Review (LCSR) review outcome prioritising the sustainability of women's services as one of the top clinical risks in the system
- Use of telemedicine to facilitate consultations both at Crown Street and other sites (for Neonates)
- Use of cell salvage & ROTEM
- Innovative use of bedside clotting analysis and fibrinogen concentrates
- Early order of blood products (high wastage)
- Out of hours transfusion lab provided off-site by LCL
- Outreach midwife post
- Gynaecology Tier 2 rota providing cover for LWH and Liverpool Place
- Expanded role of anaesthetists to cover HDU patients and provide pain service
- Upskilling of HDU staff
- SLAs in place for clinical support services from LUHFT
- Ambulance transfer of patients for urgent imaging or other diagnostics not currently provided on site
- Planned pre-op diagnostics provided off-site by LUHFT
- Appointment of resus officers, upgrading of resus trolleys and provision of automated defibrillator trolleys
- Transfer of patients for critical care
- Workforce plans are informed by trends and data led intelligence
- Deep-dive reports on isolated site risks and incidents maintaining a 'live' view of the level of risk and contributing factors

		Assurance Level	Assurance Rating	Overall Assurance Rating
Key Assurances:	Divisional Board meetings with divisional risk meeting themes reporting	1		
	Operational plans and budgets	2		
	Transfers out monitored by Partnership Transfers out monitored at HDU Group Critical Care transfers subject to PSII	3		
	Serious incidents, should they occur are tracked and reported through the governance framework,	1		
	Partnership activity to report through to Board on a quarterly basis	2		
	Staff Staffing levels reports to board	2		
	Training compliance rates reported to PPF Committee	2		
	LWH working as part of NW Maternal Medicine Network	3		
	Crown Street Enhancements Programme progress	2		
	Community Diagnostic Centre Oversight Group reviews progress on a fortnightly basis. Progress also reported to and monitored by regional CDC Programme Board.	2		
	Partnership Board meetings and involvement in wider Estates Strategy	2		
	Mapping of requirements from and interdependencies with LUHFT across all Trust specialties	2		
	Single Site risk reports – provided to QC and Board since July 2022 on a regular basis	2		
	Corporate Risk Committee – wider opportunity to review significant risk	1		
	Engagement from appropriate Executives in designated working groups	2		

Gaps in Control / Assurance:

Delivery of the short-term actions identified and agreed by the Women's Services Programme Board regarding isolated site clinical risks (Action 2/10)

To ensure that Divisions are fully utilising data to understand changing service demands (Action 2.1)

Need to improve the sustainability and deliverability of the dietetic service provided at LWH (Action 2/9)

Assurance regarding process to develop and oversee the medium – long term actions regarding the isolated site clinical risks (Action 2/11)

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
2/1	To ensure that Divisions are fully utilising data to understand changing service demands	Deputy COO	April 2024	5 year transformational plans include section on horizon scanning to support future planning – further evidence required that data is being utilised as effectively as possible to support this.	

				Updated performance reports will support this. Suggest that deadline is amended to reflect the need to assess the maturity of this process.	
2/9	Improvements to the sustainability and delivery of Dietetic Service required	Chief Nurse	April 2024		
2/10	Assurance regarding delivery of short term actions identified and agreed by the Women's Services Programme Board regarding isolated site clinical risks	Medical Director	September 2024		
2/11	Assurance regarding process to develop and oversee the medium – long term actions regarding the isolated site clinical risks (Action 2/11)	Medical Director	September 2024		

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2316, 2232, 2323	2641	
4 Major			2087, 2329, 1635, 2759, 2732, 2088, 2709/10, 1966, 2085, 2321, 2296, 2430, 2768		
3 Moderate	2488	2469			2395
2 Minor		2726	2086, 2084		2606
1 Negligible					

Ref	Description	Risk Rate Score
	Corporate Risks	
2641	Condition: There is a significant risk to the dietetic service and delivery of patient care at LWH	20
2087	Condition: 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.	12
~~2469~~	~~Condition: 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 - see risk 2274.~~	~~6~~
2329	Condition: There is a risk to the Trust is not meeting it requirements for the safe and proper management of medicines	12
1966	Condition: Risk of safety incidents occurring when undertaking invasive procedures.	12
2085	Condition: 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 co-morbidities, and meeting the pre-operative assessment standards of the Association of Anaesthetists of GB & Ireland (AAGBI) and the Royal College of Anaesthetists (RCoA), to asses patients' clinical risk and plan for additional requirements for their safety and provide an optimal experience.	12
2232	Condition: 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
~~2488~~	~~Condition: Failure to meet clinical demand for red blood cells~~	~~3~~
2296	Condition: 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.	12
2086	Condition: Uncertainty about provision of adequate on-site Blood bank stocking all major blood products necessary to support the needs of the Maternity service.	9
2321	Condition: Due to the Trust not being located next to or with acute services, it is unable to meet the National Recommendations for Maternal Medicine.	12
1635	Risk of delays to treatment due to significant problems with the junior doctor rotas-vacancies and maternity leave.	16
~~2084~~	~~Condition: 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~~

Return to Dashboard

2088	Condition: Lack of on-site specialist staff and services	20
2323	Condition: The Trust is currently non-compliant with standards 2,5,6 of the seven-day service standards	15
2395	Condition: Ambulatory gynaecology demand is exceeding current capacity	15
2606	Failure to comply with national infection trajectory specifically in relation to E. coli bacteraemia	10
~~2709~~	~~Families and children are at risk of not receiving a co-ordinated approach to early help. The trust is not in a position to evidence early help work undertaken by Front Line Staff leading to the LA and Safeguarding Children Partnership Board raising concerns against the Trust that multi agency policy is not being appropriately implemented.~~	~~12~~
~~2710~~	~~Safeguarding information contained on Bulletin Board within Meditech and the associated safeguarding flags cannot be migrated onto Digicare. This will lead to front line staff being required to check the old system when patients attend and transcribe information onto new record. This is open to human error risk.~~	~~12~~
~~2726~~	~~Lack of administration, analyst and surveillance support for IP&C Team due to an open vacancy since 19/05/2023. Risk of compliance in regards to the Hygiene Code for the provision of suitable accurate information on infections (reporting locally, to ICB and into the HCAI DCS system)~~	4
2732	Following the CQC review (January 2023) it was again identified and highlighted within the CQC initial report regarding the lack of medical cover out of hours within GED.	16
High Scoring (15+) Divisional Risks		
2768	Condition: Shortage of middle grade and Consultant level Anaesthetics medical workforce	20
2759	Condition: Risk of sustainability of HSSU service	16

BAF Risk 3 – *Failure to deliver an excellent patient and family experience to all our service users*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Inadequate systems and processes in place to listen to patient voices and our local communities, including lack of patient and community engagement mechanisms. Failure to act on the feedback provided by patients, carers, and the local communities. Inadequate systems and processes for timely patient care and inability to effectively engage with patient groups with protected characteristics.	Inability to adequately listen to patient voices and our local communities, and failure to act on the feedback provided by patients, carers, and the local communities. Inability to effectively engage with our patient groups to understand further the needs of individuals with protected characteristics and respond proactively to identified needs.	Decreased patient satisfaction, lack of trust in the Trust's ability to provide effective care, and negative impact on the Trust's reputation. Failure to effectively engage with patient groups with protected characteristics may result in poor patient experience and reduced access to appropriate care, as well as potential legal or regulatory issues. Overall, the risk is the inability of the Trust to provide patient-centred care that meets the needs of the local population, including those with protected characteristics, leading to decreased patient outcomes, decreased patient satisfaction, and potential legal or regulatory issues.

	We will be an outstanding employer			**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience	✓		**To be ambitious and efficient and make the best use of available resources**	
	To participate in high quality research in order to deliver the most effective outcomes	✓			

Responsibility for Risk			
Committee:	**Quality Committee**	**Lead Director:**	**Chief Nurse**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**3**	**2**	**2**		**2**	**March 2024**	Our risk appetite for experience is **low.** Liverpool Women's NHS Foundation Trust has a low-risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality and sustainability of the Trust and its patients, may affect the experience of our patients, the reputation of the Trust or the reputation of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Senior Management Team. Despite retaining this a 'low' risk appetite the Quality Committee agreed that the Trust would need to be more ambitious in its attempts to better understand the views of patients and local communities.
Consequence	**4**	**4**	**4**		**4**		
Risk Level	**12**	**8**	**8**		**8**		

Rationale for risk score and quarterly update – January 2024

The reduction in the risk rating from 12/25 to 6/25 reflects significant progress in strengthening controls and assurances within the organization. Several actions addressing gaps in control and assurance have been successfully closed out, contributing to this improvement. Additionally, recent positive external assurances, such as the 2022 inpatient survey results (published in August 2023) indicating improved patient satisfaction, a decrease in complaints, and an increase in compliments, have contributed to the overall reduction in risk.

However, to further enhance risk mitigation, it remains imperative that the organization continues to prioritize listening to patient voices and the local community while ensuring services remain responsive to diverse needs. The evidence of how effectively the organization accomplishes this must be further bolstered from its current position.

The Ockenden Final Report emphasized the critical importance of trusts effectively listening to the patient voice. Accordingly, strengthening the Trust's approach in this area will be a significant focus in 2023/24 and an updated Quality Strategy is in development.

Key Controls and Assurance Framework

Key Controls:

- Women, Babies, and their Families Strategy 2021 - 2026
- PALs and Complaints data
- Patient Stories to Board
- Friends and Family Test
- National Patient Surveys
- Healthwatch feedback
- Social media feedback
- Membership feedback
- Patient Experience Matron and Patient Involvement and Experience Facilitator in place to build relationships with local community leaders and mechanisms for hearing feedback on the Trust's services
- Bespoke Patient Surveys
- Patient experience review reports produced by the Divisions and reported to Patient Involvement and Experience Sub Committee
- BBAS – Ward Accreditation Scheme
- PLACE assessment
- MNVP
- Care Opinion
- Patient Experience Walkabouts
- Matron Walkabouts
- Non-Executive Director Quality Walkabouts
- Managing Concerns and Complaints Policy
- Annual Quality Schedule returns to the ICB (WELL-LED-01CARING-01)
- Bi-monthly update on status of patient leaflet at the Patient Involvement and Experience Sub Committee
- Women, Babies and their Families experience Strategy 2021 - 2026
- KPI for displeased Friends and Family and Bi-Monthly reports from the Divisions at the Patient Involvement and Experience Sub Committee.
- KPI for Complaint responses
- KPI for Complaint action plans
- K041 national return
- Patient information leaflets are accessible for all protected groups. Patient leaflets are on the website that can translate this information into various languages/ fonts and read aloud versions.
- Utilisation of the Health Inequalities data within power BI to lead work between the Patient Experience Team and the EDI Manager to target areas of disparity.
- Engagement with community groups led by the Patient Experience Matron and Patient Involvement and Experience Facilitator to listen to the concerns and required adjustments and improvements desired. These include the Whitechapel Homeless (Liverpool), Rotunda (deprived areas and different ethnic minorities), Irish Community and Travellers, Deaf Society, Chinese Community, North Liverpool, Storrington Avenue, Norris Green (deprived areas), Women's Health and Social Care Groups (WHISK), Women's Muslim Association, Brain charity, Chinese community and other groups that show Health Inequalities are forming part of the Trust Schedule of Involvement Events.
- An Involvement calendar produced that reflects all listening and engagement events that the Trust participates in.
- FFT Data now included EDI monitoring to allow experience reviews to be compared between groups with and without a protected characteristic.
- Enhanced communication and patient experience for people with disabilities coming for care at the Trust as part of Reasonable Adjustment activities
- Barriers removed to access/health inequalities to maternity services for all with specific focus to migrant and asylum-seeking women as part of the NEST work.
- Role created in patient experience team to improve engagement with the local community groups
- Regular Divisional reporting on protected characteristics for staff and their experience

		Assurance Level	Assurance Rating	Overall Assurance Rating		
Key Assurances:	Annual audit of patient leaflets to ensure accessibility and usability	1			**Gaps in Control / Assurance:**	Work being undertaken to review the pathway for trans patients going through fertility prior to the commencement of hormone therapy - The trans female pathway for sperm storage has been reviewed and is now a scientific led pathway, avoiding unnecessary delays due to waiting times to see a Consultant medic. The patients are often referred with NHS funding in place or funding is requested by the Hewitt funding team and are then booked into the sperm cryopreservation clinic. From referral to completion of sperm storage will take approx. 12 weeks as this includes extended screening for potential donation to ensure the patient has all reproductive choices for future relationships. Now the pathway is working well, the trans male pathway (egg storage) now needs further attention as we work with CMagic and GPs with special interest in gender identity, to ensure secondary investigations are managed appropriately. This includes further training for our nursing team to again, ensure we avoid unnecessary delays in waiting for a Consultant appointment as this can be nurse-led. We expect this piece of work to be completed by April 2024, monitoring progress through our Clinical Transformation team. The education starts on Weds 20th December with Adrian Harrop a GP-SI presenting at the Hewitt annual training day on 'Healthcare for trans patients'. All referrals for fertility preservation for gender reassignment are over the age of 18 MNVP oversight of complaints actions and themes for improvement presented at PIESC – MNVP on the distribution list for the Patient Involvement and Experience Sub Committee. Gaps in effective delivery of Access Policy including training of staff associated with RTT pathway management – Access policy currently under review for sign off in April 2024. Reviewed following implementation of digi care and revision of SOPs to reflect new system and processes. RTT validation audit took place in September 2022 by external company which demonstrated that application of
	Personalised Maternity Care Budgets/ Maternity Early Adopter and Pioneer site – LMS Cheshire and Mersey	1				
	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	1				
	Admission procedures and assessments e.g. MUST /VTE/ FALLS / risk assessment Maternity	1				
	Pre-operative assessments	1				
	Development of a Supporting Patients with Additional Needs Strategy Barriers identified and measures put in place to remove e.g. Presence of representatives from MRANG in the antenatal clinic to support asylum seekers	1				
	Patient Involvement & Experience Sub-Committee review the progress against the Women's, Babies and Families Experience Strategy. This is undertaken in June of each year and any concerns are escalated to the Quality Committee via the Chairs report.	2				
	Patient Involvement & Experience Sub-Committee review PALs and Complaint data quarterly via the Themes and Trend report, and any concerns raised are escalated to the Quality Committee via the Chairs report.	2				
	The Trust Board Meeting has a patient/women's story to Board most months throughout the year	2				

	Patient Involvement & Experience Sub-Committee review the Friends and Family data as part of the Themes and Trends report that is reviewed quarterly. Friends and Family themes and trends from each Division are reviewed at every Patient Involvement & Experience Sub-Committee meeting. Friends and Family also form part of the Trust Performance report that each Division must review. A KPI regarding displeased comments has also been added. This has given each area the opportunity to review displeased comments and act on them. This also enables the areas to display the 'you said we did' data out in the areas. The Patient Involvement and Experience Sub Committee has a standing agenda item for the relevant Divisions to discuss the key findings from the Friends and Family and show what improvements have been made as a result and to also discuss any Quality Improvement Projects that they are undertaking	**2**				RTT rules against patient pathways was excellent with less than 2% error rate, noted as best Gynaecology PTL management from 56 Trusts audited. This report was submitted to Executive team to demonstrate effectiveness of PTL management. Timescales for delivery of key elective recovery programme actions – Trajectories for Elective Recovery have been set and monitored weekly & monthly with regional NHSE colleagues and through Access sub-committee. These are reported monthly to Trust sub-committees through the Integrated Performance Report. Actions noted at Access sub-committee for delivery of recovery actions and progress against targets is provided by Operational teams. Work to reconfigure the MLU estate to maximise efficiencies for IOL - Work is ongoing and phase 1 of the development has been completed. Phase 2 is likely to be delivered by April 2024
	Patient Involvement & Experience Sub-Committee review the results of the National Maternity Survey, National Inpatient Survey and the National Cancer Survey Annually. All surveys are also reviewed by the Trust Quality Committee.	**2**				
	Patient Involvement & Experience Sub-Committee have both Healthwatch Sefton and Healthwatch Liverpool on the group as active participants.	**2**				
	Communications team and Patient Experience Team work together reviewing the social media comments and these form part of the quarterly themes and trends reports that are reviewed at Patient Involvement and Experience Sub Committee.	**2**				
	Patient Experience Matron reports on community engagement and relationships via the Patient Involvement and Experience Sub-Committee report and attends CoG Comms and Engagement Group to share experiences.	**2**				
	Patient Involvement & Experience Sub-Committee listen to the Patient Experience Strategy updates from each Division via the Patient Experience review paper and any patient experience intelligence that they have.	**2**				
	Safety and Effectiveness Sub Committee review the BBAS quarterly and any issues are escalated to the Quality Committee via the chairs report. Patient Experience Matron forms part of the accreditation team	**2**				
	Patient Involvement & Experience Sub-Committee review the outcomes form the PLACE assessment, this is also on the Quality Committee	**3**				
	Patient Experience Matron attends the MNVP meetings and MNVP chair is part of the circulation list for Patient Involvement and Experience Sub Committee.	**2**				
	Patient Involvement & Experience Sub-Committee review the Friends and Family themes and trends quarterly	**2**				
	Matrons' operation group reviews the feedback gained and issues escalated on the chairs report to the Nursing and Professional forum	**1**				
	Complaints annual report is approved by Quality Committee and the Quarterly themes and trends report is discussed at Patient Involvement and Experience Sub Committee. The Integrated Governance report includes Patient Experience data and is reviewed at Quality Committee.	**2**				
	The Quality schedule is reviewed by the ICB and this covers an annual submission for Well Led 01 and Caring 01. The reports are also discussed at the CQPG.	**2**				
	External reporting to NHSE digital to monitor the complaints activity	**3**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)					
Ref:	**Action required**	**Lead**	**Due Date**	**Quarterly Progress Update**	**RAG**
3/5	Divisional Boards to review Patient Experience Data prior to being reviewed by the Patient Involvement and Experience Sub Committee	Divisional Management Teams	Dec 23	Head of Patient Involvement and Experience and Patient Experience Matron are on Divisional Boards.	
3/7	QI projects need to be developed from patient voices and experience-based co-design.	Quality Manager	April 2024	Patient Experience Team have registered QI projects as part of patient voices and a Lived Experience Panel is in development.	

3/8	Improvement of compliance against Trust KPI relating to displeased comments in FFT and to ensure that Power BI is updated so the 'You said we did data' can be extracted	Divisional Management Teams	Feb 2023	All Divisions report on the Displeased Comments at the Patient Involvement and Experience Sub Committee. The compliance against this KPI has improved over time and current performance 76% (November 23)	
3/10	Continue to provide updates to the Board regarding the Elective Recovery Plan through Divisional Performance Reviews and to FPBD on a monthly basis through the Integrated Performance Report	Deputy COO	On-going	Updates on Elective Recovery are provided to the Board and FPBD through the Integrated Performance Report – a paper summary is submitted every month which highlights actions delivered and progress against trajectory. Also, a Chairs report is produced monthly from Access sub-committee which is submitted to FPBD which gives updates on positive assurances and key risks associated with elective recovery delivery.	
3/11	Work to reconfigure the MLU estate to maximise efficiencies for IOL.	FH Div Manager	April 2024	Work is ongoing and phase 1 of the development has been completed. Phase 2 is likely to be delivered by April 2024	

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2316, 2667		
4 Major			2087	2485, 2418	
3 Moderate					
2 Minor			2084		
1 Negligible					

Return to Dashboard

Ref	Description	Risk Rate Score
	Corporate Risks	
2087	Condition: 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.	12
2084	Condition: 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
	High Scoring (15+) Divisional Risks	
2418	Condition: Lack of support and appropriate care for patients presenting with mental health conditions	16
2485	Condition: Limited access to MRI scan (currently 5-6 weeks wait) needed for cancer patient pre-treatment (both surgical and radiotherapy treatment). MRI requested and undertaken at CCC as per pathway, as expertise in reporting is there and feeds into specialist MDT. Of note MRI added into clinical pathway as part of BGCS stratification for surgery during the first wave of COVID pandemic - this is considered best practice.	16
2316	Condition: Risk of women needing to access emergency care with pregnancy complications and not being able to be triaged in the MAU within 30 minutes of presenting at the department as per BSOTS. Impact on the safety of patients (physical and psychological);	15
2667	Risk: Delay in access to timely radiography out of hours	15

BAF Risk 4 – *Impact to the safety of patient care services due to the lack of effective Digital Systems adoption, Strategy implementation and Cyber Security breaches influenced through cyber threats, staffing and financial resources.*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Sub-optimal clinical records system, including both paper and electronic systems. Inability to embed aims and objectives in the Trust's digital strategy. Insufficient financial and staffing resources to adequately support and protect the digital service provision.	Major and sustained failure of essential IT systems due to a cyber-attack, leading to the inability to access patient records, deliver care, and support administrative functions. Sub-optimal clinical records systems, including difficulty in accessing or locating information, duplication of effort, and potential errors or omissions in patient care. Failure to embed aims and objectives in the Trust's digital strategy may lead to ineffective use of technology and missed opportunities to improve patient outcomes and experiences.	Patient safety compromised due to inability to access critical clinical information in a timely and accurate manner. Disruption to Trust operations and reduced capacity to deliver care. Reputational harm to the Trust, as well as potential regulatory or legal issues. Failure to embed aims and objectives in the Trust's digital strategy may result in missed opportunities to improve efficiency, quality, and safety of patient care. Overall, the risk is the inability of the Trust to effectively manage and utilize digital systems, including clinical records, leading to potential patient safety issues, operational disruption, and reputational harm.

	We will be an outstanding employer			**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience			**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Finance, Performance & Business Development Committee**	**Lead Director:**	**Chief Information Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**	**4**	**4**		**3**	**March 2024**	Our risk appetite for safety is **low.** Our fundamental strategic aim describes our commitment to patient and staff safety. When and wherever possible we will apply strict safety protocols for all clinical and non-clinical activity. We will not compromise the safety of our patients, we will report, record, and investigate our incidents and we will ensure that we continue to learn lessons to improve the safety and quality of our services.
Consequence	**5**	**4**	**4**		**5**		
Risk Level	**20**	**16**	**16**		**15**		

Rationale for risk score and quarterly update – January 2024

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 from Q1 and Q2 assessments. The assessment of consequence from a cyber threat perspective has resulted in a rating reduction from catastrophic to major based on the multi-layered technical controls which have proven effective in terms of alerting and protection resulting capability to contain the impact of a successful in some scenarios. However, if a cyber-attack was successful the impact would likely have a major negative impact on Trust services, likely rendering digital systems that clinical services are increasingly dependent on, unavailable for a period. The Digital Services department continue to strengthen controls through process refinement and the introduction of security technologies.

Contributing to the consequence reduction is the successful introduction of the MEDITECH Expanse EPR which by design has improved systems integration with other Trust systems. Whilst there is ongoing programme to further improve integration and system adoption (through the stabilisation and optimisation phases of the DigiCare programme), there is a demonstrable progress to mitigate the multiple systems elements of this risk. There remains to risk to adoption due to staff engagement, availability, and digital staffing resources, however, to control these activities are prioritised based on safety assessment.

Based on this, the impact is considered major (4). Due to recent world events, the environment risk or likelihood for a cyber-attack increased in the last quarter 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 current situation with regards to adopting of a new EPR system influences the likelihood remaining 4 for this reporting period as the Trust develops the optimisation phase of the programme.

Key Controls and Assurance Framework

Key Controls:

- Successful implementation of digiCare MEDITECH EPR
- Enhanced integration between MEDITECH EPR and other Trust systems over the legacy environment.
- Stabilisation and optimisation phases planned and underway to ensure system is 'used as intended', with oversight at digiCare EPR Programme board.
- Clinical Safety Officer processes established and operating, ensuring clinical risk through digital design and use is identified and mitigated.
- Approved EPR Staffing business case.
- Approved Digital Generations Strategy.
- Approved Meditech Expanse Business Case.
- Approved Trust Cyber Strategy.
- Fully resilient external (Internet/Clinical) network links.
- Improved Community Network connectivity.
- Incident reporting based on clinical safety focus.
- Tactical solutions including the implementation of K2 Athena system.
- Exchange/LHCRE enables for patent information sharing.
- Virtual Desktop technology to aid staff working flexibly.
- PACS upgrade removes a separate login for that system, reducing multiple systems issues.
- Task and Finish group established to improve Order and Results reporting for Pathology, Radiology.
- Appropriate task and finish groups established as required by Safety and Effectiveness sub-committee
- Digital clinical leadership business case approved.
- Optimisations to K2 system and refinements implemented
- Fast User Logon Project (Imprivata) successfully rolled out to majority (75%) of Trust, simplifying multi-application logon experiences for staff.
- 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.
- Effective USB Port Control implemented.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.
- Mobile device management – providing enhanced security for mobile devices
- Implementation of Multi-Factor Authentication (MFA) to support reduction of risk of unauthorised or privileged system access due to user account credentials being compromised.
- digiCare MEDITECH Expanse optimisations programme established.
- Ongoing review of systems and mitigations quarterly
- Robust implementation plan for Secure Boundary (Web Filtering)

		Assurance Level	Assurance Rating	Overall Assurance Rating
Key Assurances:	Quarterly risk assessments completed	1		
	FPBD Committee overview and scrutiny	2		
	Digital Hospital Committee oversight	2		
	Approved EPR Business case which define clear direction and preferred solution.	2		
	digiCare EPR programme board chaired by CIO	2		
	Clinical Safety Officer governance to mitigate clinical risk through digital use.	2		
	Independent lessons learnt Positive review	3		
	MIAA Critical Application Audit (rolling programme across trust systems)	3		
	Effective Staff communications on Digicare	1		
	Cyber Essentials Plus Standards/KPIs	3		
	IMT Risk Management Meeting	2		
	Medical Devices Committee	2		
	MIAA Cyber Controls Review	3		
	Cyber Essentials Plus Accreditation	3		
	Cyber Penetration Test	3		
	NHS Care Cert Compliance	3		

Gaps in Control / Assurance:

Multiple Clinical Systems issues remain (Action 4/5)

Variation in training experience and capability (4/6)ICS wide Shared Care Record programme not fully implemented/ active programme of work)

Lack of visibility of Internet of Things (IoT) and medical devices (Action 2.4 / 4)

Resilience / single points of failure within the IT staffing. (4/7)

Ineffective service desk provision (4/8)

Lack of effective local asset ownership (4/9)

Additional resilience improvements to back up solution required. (4/10)

Conclude implementation, adoption of Secure Boundary (4/11)

Improve network segmentation (4/12)

Improve User Account Directory Services hygiene (4/13)

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG

4/4	Improve grip, control and governance on medical devices	CIO	December 2024	Digital attendance at Medical Devices Committee. Asset inventory of medical devices under review. Funding for Digital solution to protect medical devices submitted to ICS in October. External MIAA audit concluded in Dec, with review of recommendations underway,	
4/5	Optimise digiCare MEDITECH Expanse to reduce multiple systems effect through efficient processes and integration.	Associate Dir - Information	March 2025	EPR staffing business case approved, optimisation programme underway. Task and finish groups established.	
4/6	Establish effective digital training capability and end user experience	EPR Systems Manager	March 2024	EPR staffing business case approved, training booking on processes currently being optimised.	
4/7	Review IT staffing structure and identify potential options to improve resilience and capacity	Associate Dir - Technology	March 2024	To be considered during financial planning for 24/25	
4/8	Address the Ineffective service desk provision	CIO	July 2024	Commence collaborative work with LUHFT to resolve.	
4/9	Implement an Information Asset Ownership workshop and awareness campaign	Head of Records & IG	March 2025	Cultural shift in organisational asset ownership mindset to be challenged through 24/25 as digital objective.	
4/10	Enhance backup solution resilience	Associate Dir - Technology	December 2025	Business case underway for 24/25 capital planning consideration	
4/11	Conclude implementation of Web Filtering (Secure Boundary)	Associate Dir - Technology	September 2024	Implementation is underway. Careful consideration of impact – mitigation is place in monitoring mood initially.	
4/12	Improve Network segmentation	Associate Dir - Technology	March 2025	Business case underway for 24/25 capital planning consideration	
4/13	Improve User Account Directory Services hygiene	Associate Dir - Technology	March 2025	Review of options including collaboration with LUHFT to be undertaken initially.	

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic					
4 Major				2772	
3 Moderate			~~2603~~		2531
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
~~2603~~	~~Condition - Current Intranet in poor condition and no longer fit for purpose.~~	~~9~~
High Scoring (15+) Divisional Risks		
2531	Condition - Inadequate and unsustainable IT Helpdesk Provision	15
2772	Lack of IT equipment available on Mat Base to enable staff to complete contemporaneous documentation.	16

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BAF Risk 5 – *Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Insufficient funding, or failure to secure funding, from external sources. Inadequate cost control and/or cost reduction measures. Inadequate financial management and controls, including lack of effective financial planning and forecasting.	Risk that the Trust will not have sufficient cash resources in the 2023/24 financial year, resulting in inability to pay suppliers, staff, or meet other financial obligations. Risk that the Trust will not deliver agreed plan in the 2023/24 financial year, including inability to meet operational targets or clinical quality standards. The Trust is not financially sustainable in the long term, potentially leading to intervention from external regulators and the Trust no longer being a going concern.	The Trust fails to meet its financial plan and is unable to secure sufficient resource to safely deliver its clinical services, resulting in negative outcomes for patients and staff, reduced trust in the quality of care provided.

	We will be an outstanding employer			**Our services will be the safest in the country**	
	Every patient will have an outstanding experience			**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Finance, Performance & Business Development Committee**	**Lead Director:**	**Chief Finance Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	4	4	5		3	**March 2024**	Our risk appetite for efficient is **moderate** This is in respect to meeting our statutory financial duties of maintaining expenditure within the allocated resource limits and adherence to departmental and internal expenditure and financial controls. This includes the demonstration of value for money in our spending decisions, while ensuring quality and safety is maintained.
Consequence	4	4	4		4		
Risk Level	16	16	20		12		

Rationale for risk score and quarterly update

The Trust has a well-defined and evidence-backed case that it is not financially sustainable due to the size of the organisation and resulting lack of economies of scale, the particular mix of services including the costs of delivering maternity services as well as remaining on an isolated site. This situation is exacerbated each year due to capital investment, ongoing revenue investment in delivery of services, and other pressures including a reduction in top up income. The Trust is facing a significant financial challenge in 2023/24 and is at risk of not being able to deliver its financial plan.

The likelihood of this risk has been assessed at Quarter 3 as '5 - almost certain' rather than '4 - likely. At Month 9, the Trust is reporting an adverse variance to plan of £2.7m year to date and a full year adverse variance forecast of £8m. The Trust has applied for Cash Support from the Department of Health to ensure liabilities are met on an ongoing basis. The primary drivers leading to the adverse variance to plan include ongoing requirements in previous workforce investments, addressing CQC actions and the costs associated with Industrial Action. The Trust has produced a long-term financial recovery plan which demonstrates that recovery is not possible without implementation of strategic, system-wide solutions including additional income into the Trust to support the costs of delivering maternity care and associated CNST costs. The Trust introduced a targeted program of Financial Recovery in July 2023 to support the in-year and long-term position and continues to work with system partners to resolve the underlying deficit issues. The Trust continues to maintain strong financial grip and control processes on expenditure and identify further opportunities for increased productivity and efficiency.

Key Controls and Assurance Framework		
Key Controls:	• Financial Recovery Plan produced and shared with ICS with ongoing dialogue in relation to solutions • Consistent achievement of the safety standards associated with the CNST Maternity Incentive Scheme. • Reference costs at 103 (latest data) indicating cost efficiency in the context of an isolated site and compared to other Trusts	• Trust is part of the system-wide expenditure controls group with the ICB reviewing grip and control and expenditure on a monthly basis. • Agency and Premium Pay is well controlled as demonstrated in the low overall usage (0.7% of pay budget at M8).

	• Finance Recovery Board in place with multiple workstreams to address the identified drivers of the deficit, each supported by Executive Sponsors.
	• Rapid transformation workstreams identified.
	• Collaboration and efficiency at scale is developing across Liverpool and C&M, underpinned by findings of Liverpool Clinical Services Review.
	• Internal audit reports giving strong assurance in relation to financial controls and reporting and Cost Improvement Plans
	• Cost Improvement identification process in place, including QIA and EIA process, supported by the establishment of and internal PMO.
	• Monthly reporting and monitoring of position including taking corrective action where required.
	• Monthly review of financial position with divisional leadership and CFO ahead of financial close down
	• Sign off of budgets by budget holders and managers, and holding to account against those budgets
	• Divisional performance reviews
					• Vacancy control panel in place, meeting weekly to consider all posts, with Executive Committee review and approval.
					• Revised non-pay expenditure controls in place
					• Detailed log of investments since 2019/20 and prior has been produced with post-implementation review underway.
					• Review of services and related costs and income
					• The 'No PO No Pay' policy has been re-enforced.
					• Partnership working with other providers to enhance efficiency and minimise duplication
					• Cash management controls in place:
					  • 13-week cashflow updated weekly showing impact of cash advances received to date and any requested cash support
					  • Explanation of need for cash provided with triangulation to financial position
					  • Internal Audit plan for the year shared with ICB, showing cash/treasury management as a key area for review.
					  • Cash balances reviewed by the CFO and DCFO on a daily basis
					  • Successful application for central Cash Revenue Support

		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**		
	Long term financial recovery plan produced and submitted (Sept 23)	**2**				
	Recovery plan with agreed actions in place; monitored through Financial Recovery Board, Executive Team and Finance, Performance and Business Development Committee and reported to Board.	**2**				
	Establishment of Women's Services Committee to address medium to long term issues ~~s~~	**2**				
	Place based focus on resources initiated (Jan 24)	**2**				
	Active participation in C&M planning processes and ongoing regular review of financial position at system level	**2**				
	Process in place regarding CNST MIS. Prior achievement of MIS. Engagement with NHS Resolution and learning from claims and incidents.	**2**				
	Focus on benchmarking and efficiencies, including joint working where possible.	**2**				
	FPBD and Board (monthly reports)	**2**				
	FPBD Committee receives monthly reports, chair's reports from the Financial Recovery Board and specific recovery centred reports.	**2**				
	Internal Audit- high assurance for all finance related internal audit reports in 2020/21, 2021/22 and 2022/23. Substantial Assurance 2022/23 in relation to Recovery Plan	**3**				
	External Audit – no amends to accounts and largely low rated recommendations in ISA260.	**3**				
	Mitigations being worked up in case of identified risks materialising	**2**				
	Agency use monitored regularly	**2**				
	Enhanced grip and control to manage influenceable spend	**2**				
	Approval of cash support	**2**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)					
Ref:	**Action required**	**Lead**	**Due Date**	**Quarterly Progress Update**	**RAG**
5/4	Deliver outcomes from Financial Recovery Board workstreams	CFO	March 2024	Ongoing	
5/5	Identify full CIP programme	CFO/COO	April 2023	Ongoing – workshops held	
5/6	Monitoring and management of existing CIP programmes	CFO/COO	Ongoing	Ongoing – through financial recovery programme	
5/7	Delivery of activity and income targets	COO	Ongoing	Ongoing, delivery at risk due to industrial action	

5/8	Careful monitoring of cashflow forecast and close working with ICB to manage cash in year	CFO	Monthly	Ongoing, with additional discussions with system partners regarding options for cash support	
5/9	Negotiation of CDC contract for 2024/25 and beyond	COO	February 2024		
5/10	Active participation in the Women's Services ICB Sub-Committee	MD	Ongoing	Ongoing – meetings held in September 2023, workstreams established.	
5/11	Progression of estates workstream with LUHFT	CFO	December 2023	Ongoing - outputs reported to LWH/LUH Partnership board in September 2023, with further work agreed.	
5/12	Focussed review of productivity to support 24/25 planning	COO	March 2024		

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic					
4 Major				1635, 2722, 2730	
3 Moderate			2301		
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
2301	Condition: There is both an operational and a financial risk related to the position in relation to contracts and SLAs for services provided to and by the Trust.	12
1635	Risk of delays to treatment due to significant problems with the junior doctor rotas-vacancies and maternity leave. This is placing severe strain on the ability to fulfil the on-call rota as well as covering in hours duties. There is an increased reliance on locums, causing financial pressures. The risk include potential gaps in the rota which may put patients at risk, regular locum use which may result in potential compromise to the quality of the service provided and risk to the training provision of junior doctors if they are being moved around to fulfil the basic rota.	16
High Scoring (15+) Divisional Risks		
2722	Condition: There is a risk to the division being overspent against budget due to unfunded cost pressures identified as part of the annual planning process.	16
2730	Condition: Trust has insufficient internally generated capital to expand ambulatory estate	16

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BAF Risk 6 – *The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Conflicting priorities and objectives among clinical services providers in the Integrated Care System (ICS), including differing views on clinical strategy, resource allocation, and accountability. Ineffective governance structures or processes that do not facilitate effective decision-making or resource allocation.	The Trust may struggle to engage effectively with provider, commissioner, and other partners across the system. The Trust may also struggle to maintain those partnership relationships required to safely deliver its services from an isolated site.	If the Trust is unable to engage effectively with system partners, this could result in limitations in the Trust's ability to influence system plans and decision-making, including during contract negotiation with commissioners and agreement regarding capital funding to deliver the Future Generations Programme. Additionally, if the Trust is unable to maintain partnership relationships with providers, it may have a negative impact on the Trust's ability to deliver safe care, resulting in negative outcomes for patients and staff, reduced trust in the quality of care provided.

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	Every patient will have an outstanding experience			**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes	✓			

Responsibility for Risk			
Committee:	**Finance, Performance & Business Development Committee**	**Lead Director(s):**	**Chief Finance Officer & Medical Director**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**3**	**2**	**2**		**2**	**March 2024**	Our risk appetite for effective is **high.** A level of service redesign to improve patient outcomes that requires innovation, creativity, and clinical research are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.
Consequence	**3**	**3**	**3**		**3**		
Risk Level	**9**	**6**	**6**		**6**		

Rationale for risk score and quarterly update

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 Trust has strengthened partnerships further during Q2 by securing agreement to appoint a shared Accountable office with partners Liverpool University Hospital NHS FT. A shared Chair and joint Chief Digital Officer and Chief Transformation Officer roles confirmed during Q3. ToRs have been drafted for a new Partnership Board with AHCH. In addition, the ICB's Women's Services Committee has begun making progress towards delivery.

Key Controls and Assurance Framework

Key Controls:

- Appointment of Joint Accountable Officer with Liverpool University Hospitals NHS FT
- Robust engagement with ICS discussions and developments through CEO and Chair
- Evidence of cash support for the Trust's 2023/24 position
- Chair of the Maternity Gold Command for Cheshire and Merseyside
- C&M Maternal Medicine Centre
- Liverpool Trusts Joint Committee
- Neonatal partnership in place with Alder Hey, with developing partnership board arrangements
- Partnership Board in place with LUHFT and involvement in wider Estates Plan
- Crown Street Community Diagnostic Centre Partnership
- Positive and developing relationship with Merseycare NHS FT
- Women's Services ICB Sub-Committee, chaired by ICB Chair
- Women's Services Programme Board established to oversee delivery of short-, medium- and long-term actions relating to the isolated site risks.
- Signed up to CMAST Joint Working Agreement and Committee in Common
- Participation in CMAST networks and workstreams
- Health care partnership are using existing memorandum of understanding in relation to staff movement between local hospital at time of staffing need.
- LWH have provided assistance to LUFT by taking over LWH non obstetric Ultrasound scanning activity
- LWH identified as Gynaecology Oncology Hub for Cheshire and Mersey.
- Effective relationships with Higher Education institutions for research activity and staff development

		Assurance Level	Assurance Rating	Overall Assurance Rating		
Key Assurances:	Quarterly Partnership Reporting to Board	**2**			**Gaps in Control / Assurance:**	Governance arrangements are developing (Action 6.2) Some partnership arrangements are not yet underpinned by formal governance arrangements and/or service level agreements. (Action 6.2)
	LNP Assurance meeting	**2**				
	The ICB is providing oversight on the programme of work to address the clinical sustainability challenges related to the isolated site.	**2**				
	The majority of dialogue with regulators will be led by the ICB in future. Chair and CEO will maintain ongoing dialogue with relevant key stakeholders at both national and regional level, as appropriate. Trust Communications Team has established good links with respective teams at Place and the ICB and will support any future communication and engagement activities regarding the programme.	**2**				
	Partnership with Liverpool University Hospitals in place and strengthening. Shared dashboard and risk register under development. Shared review of relevant SIs	**2**				
	Active engagement with commissioners ongoing via newly established sub-committee of ICB	**2**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
6/1	Continue to provide updates to the Board regarding the development of the ICS, highlighting when decision points are likely	CEO	On-going		
6/2	Underpin all partnership arrangements with formal governance and service level agreement where appropriate	CFO	April 2023	Limited progress made towards putting SLA documentation in place. AHCH Tors and workplan in development. Suggested to be area of work within the Trust's Improvement Programme.	

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2757		
4 Major					
3 Moderate					
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
High Scoring (15+) Divisional Risks		
2757	Condition: Trust wide Pathology services are dependent on third party providers	15

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BAF Risk 7 – *Failure to meet patient waiting time targets*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Inadequate clinical systems, processes and governance to ensure delivery of national waiting time standards. Insufficient management capacity. External factors that cannot be easily influenced.	The event occurs when the demand for services exceeds the Trust's capacity to deliver timely care, leading to increased waiting times for patients. This can manifest in various ways, such as delayed appointments, extended waiting lists, or increased waiting times for diagnostic tests or treatments.	Prolonged waiting times at Liverpool Women's NHS Foundation Trust can result in patient dissatisfaction, negative feedback, and loss of confidence in the Trust's services. Delays in accessing care can compromise patient outcomes, leading to increased pain, discomfort, and complications. Breaches of regulatory targets and standards, such as NHS maximum waiting time targets, may trigger regulatory scrutiny and financial penalties. The Trust may incur additional costs and resource utilization to address the backlog, impacting its budget and sustainability. Persistent waiting time issues can also damage the Trust's public perception and relationships with stakeholders.

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	Every patient will have an outstanding experience	✓		**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Quality Committee**	**Lead Director:**	**Chief Operating Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**	**4**	**4**		**3**	**March 2024**	Our risk appetite for experience is **low.** Liverpool Women's NHS Foundation Trust has a low-risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality and sustainability of the Trust and its patients, may affect the experience of our patients, the reputation of the Trust or the reputation of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Senior Management Team. Despite retaining this a 'low' risk appetite the Quality Committee agreed that the Trust would need to be more ambitious in its attempts to better understand the views of patients and local communities.
Consequence	**4**	**4**	**4**		**4**		
Risk Level	**16**	**16**	**16**		**12**		

Rationale for risk score and quarterly update – September

Following the operational pressures faced as a result of the COVID pandemic, a large number of patients had their treatment and appointments delayed as a result of changes to clinical capacity. This has led to an increasing number of patients waiting beyond 52 weeks to receive their treatment. Continued rises in referrals from Primary Care and an increasing backlog of patients to be seen has led to increased delays in care and deterioration of Trust performance in relation to national Referral to Treatment (RTT) standards.

Key Controls and Assurance Framework

Key Controls:

- Fortnightly Access Board meetings with Divisional Operational Teams and Information present monitoring key performance
- Daily monitoring of performance through Power BI dashboards – daily and weekly updates on key performance metrics
- Weekly Patient Tracking List (PTL) meetings with Divisional Operational teams and Patient Access
- Elective Recovery Programme in place with workstreams to improve performance and reduce waits
- Theatre Utilisation Group
- Sub-specialisation of Gynaecology and sub-specialty recovery plans in place to monitor actions/risks at a sub specialty level and establish performance trajectories to deliver improvements
- Controls in place to monitor length of stay for women in induction of labour
  - Daily safety huddles
  - IoL metrics included on Executive and SLT live dashboards

	• External validation programme of work reviewing all admitted and non-admitted pathways to ensure RTT guidance being applied correctly – audited by MIAA. • Review of Medical & Nursing job plans to ensure capacity in place to treat patients in a timely manner				• C&M weekly maternity escalation cell • Cancer Committee – meets bi-monthly to review Cancer performance and track actions to improve performance. Tier 2 multi partner cancer oversight meets monthly to oversee a cancer action plan. • Increased staffing capacity in MAU	
		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**		
Key Assurances:	Access Board reporting	**2**			**Gaps in Control / Assurance:**	Work underway to explore most effective Gynae ED model Work against checklists within 'Further Faster - Gynaecology Handbook'
	Escalation through to FPBD and Board	**2**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
7/1	Continue to provide updates to the Board regarding the Elective Recovery Plan through Divisional Performance Reviews and to FPBD on a monthly basis through the Integrated Performance Report	Deputy COO	On-going		
7/2	Access Policy review and delivery of SOP's via Waiting List Management audit action plan	Patient Access Lead	April 2024		
7/3	Work to reconfigure the MLU estate to maximise efficiencies for IoL.	FH Div Manager	~~September 2023~~ **April 2024**		
7/4	Work against checklists within 'Further Faster - Gynaecology Handbook'	COO	July 2024		

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2316, 2667		
4 Major			2087		2770
3 Moderate					
2 Minor			~~2084~~		
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
2087	Condition: 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.	12
~~2649~~	~~Condition: There is little evidence to support Audim audits are being undertaken as required in line with National Standards of Healthcare Cleanliness (2021)~~	~~9~~
~~2084~~	~~Condition: 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~~
High Scoring (15+) Divisional Risks		
2770	Condition: Risk to Anaesthetics capacity for out of hours emergency Obstetrics and Gynaecology procedures	20

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Appendix 1 – System BAF risk mapping

	LWH BAF 1				LWH BAF 2				LWH BAF 3				LWH BAF 4				LWH BAF 5				LWH BAF 6				LWH BAF 7			
	Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities				Inability to ensure the on-going sustainability of clinical services and prevent patient harm by maintaining a high standard of care at the current Crown Street site.				Failure to deliver an excellent patient and family experience to all our service users				Impact to the safety of patient care services due to the lack of effective Digital Systems adoption, Strategy implementation and Cyber Security breaches influenced through cyber threats, staffing and financial resources.				Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term				The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative				Failure to meet patient waiting time targets			
	Target 12 (I3 x c4)				Target 15 (I3 x c5)				Target 8 (I2 x c4)				Target 15 (I3 x c5				Target 12 (I3 x c4)				Target 6 (I2 x c3				Target 12 (I3 x c4)			
	Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
LWH BAF	16	16	12		20	20	20		12	8	8		20	16	16		16	16	20		9	6	6		16	16	16	
LUHFT BAF	8 (8)				1 (9)				6 (10)				10 (10)				5 (9)				11 (9)				2 (9)			
					3 (12)				7 (10)								9 (12)											
					4 (9)				12 (7)																			
					13 (9)																							
WC BAF	5 (12)	5 (12)			2 (9)	2 (9)			1 (12)	1 (12)			11 (15)	11 (15)			3 (9)	3 (9)										
	8 (9)	8 (9)			4 (9)	4 (9)			6 (12)	6 (12			12 (12)	12 (12)			7 (9)	7 (9)										
	9 (12)	9 (12)			10 (12)	10 (12)																						
LHCH BAF	4 (12)	4 (16)			8 (9)	8 (9)			1 (6)	1 (6)			9 (12)	9 (12)			3 (12)	3 (12)			7 (4)	7 (4)			2 (12)	2 (12)		
					6 (12)	6 (12)											5 (12)	5 (12)										
AHH BAF	2.1 (15)	2.1 (20)			1.1 (9)	1.1 (9)							4.2 (16)	4.2 (16)			3.4 (16)	3.4 (16)			3.2 (12)	3.2 (12)			1.2 (15)	1.2 (20)		
	2.2 (9)	2.2 (9)			1.3 (12)	1.3 (12)															3.5 (16)	3.5 (12)						
	2.3 (15)	2.3 (15)																										
CCC BAF	10 (12)	10 (16)			1 (15)	1 (10)							13 (12)	13 (9)			3 (16)				6 (12)	6 (8)						
	11 (16)				2 (12)	2 (12)							14 (12)	14 (12)														
MC BAF	P1 (16)	P1 (16)			S3 (12)	S3 (12)			S1 (12)	S1 (12)			R2 (12)	R2 (12)			R1 (12)	R1 (12)			F2 (16)	F2 (12)			S4 (16)	S4 (16)		
									S2 (12)	S2 (12)																		
									P2 (12)	P2 (12)																		
ICB BAF	P9 (16)	P9 (12)			P1 (16)	P1 (16)			P4 (15)	P4 (10)			P2 (12)	P2 (6)			P7 (20)	P7 (16)							P3 (25)	P3 (15)		
					P8 (12)	P8 (12)			P5 (20)	P5 (20)															P6 (20)	P6 (16)		

LUHFT BAF Risks Summary	
1	If we do not enhance the systems and processes employed to deliver planned care at elective activity plans level, we will not reduce patient delays, negative impact on health outcomes, negative impact on finances, and potential increase in demand for social care
2	If we do not introduce innovative solutions to address the safety concerns within Urgent & Emergency Care, we may not see improvements in the delivery of safe care and the health and safety of staff.
3	If we do not embed the plans to achieve improvements in the fundamentals of nursing care (falls, pressure ulcers, nutrition and hydration), we may not achieve a reduction in length of patient stay and positive health outcomes for patients.
4	If corporate and quality governance arrangements do not meet the requirements of the Well-Led Framework, the Trusts assurance and escalation processes may not be fit for purpose, impacting on the provision of high quality, sustainable, harm free care.
5	If we do not support the wellbeing and resilience of our people, then our ability to recruit and to provide safe staffing levels in order to provide safe, caring and effective care may be compromised
6	If we do not address Equality Diversity & Inclusion (EDI) inequalities affecting our workforce, we may fail to improve the experience of staff from diverse background and fail to recruit, promote and retain diverse talent.
7	If we are unable to embed agreed leadership behaviours throughout the organisation, we may fail to strengthen our current leadership capability, which will have a negative impact on our ability to recruit and retain the best people.
8	If we do not deliver the agreed financial plan this may result in a detrimental impact on medium/long term sustainability and effective system collaboration.
9	If we are unable to develop cyber secure and compatible patient information systems due to resourcing and lead time limitations, this may result in detrimental impact on service continuity and consistency.
10	If we are unable to build and sustain effective partnerships with other health, care, voluntary sector and other key organisations, this may impact adversely on our ability to deliver the Trust strategy and the Liverpool Clinical Services Review
11	If we are unable to fulfil our responsibilities as an anchor organisation to the wider community, this may result in missed opportunities to support the Liverpool system and its people to improve health outcomes and address health inequalities.
12	If we do not deliver agreed milestones in line with the Research Strategy to become a clinically research active organisation, this may reduce the patient access to clinical research and reduce opportunities to improve patient care and treatment options.
13	If we do not deliver agreed milestones in line with the Research Strategy to become a clinically researchactive organisation, this may reduce the patient access to clinical research and reduce opportunities to improve patient care and treatment options

WC BAF Risks Summary	
1	Impact on patient outcomes and experience
2	Inability to develop further regional care pathways
3	Inability to deliver financial plan for year
4	Inability to deliver the operational plan
5	Inability to attract, retain and develop sufficient numbers of qualified staff
6	Inability to improve equitable access to services
7	Inability to secure capital funding to maintain the estate to support patient needs
8	Inability to develop a national training offer
9	Inability to develop and attract world class staff
10	Inability to grow an innovative culture
11	Inability to prevent Cyber Crime
12	Inability to deliver the Digital Aspirant plan and associated benefits

LHCH BAF Risks Summary	
1	Failure to maintain safety and quality and avoid harm would result in poorer patient & family experience
2	Inability to deliver annual planning activity and performance targets could result in poorer patient outcomes, inability to address the backlog of patients waiting and result in financial consequences to the Trust.
3	Inability to achieve the five year capital programme within a challenging and uncertain operating environment and deliver an Estates Strategy that supports the provision of outstanding services
4	Challenges in recruiting, developing, retaining and ensuring the wellbeing of a high quality, diverse and inclusive workforce would affect our ability to deliver world class care
5	Failure to deliver financial plans and changes in the funding regime could impact sustainability for the Trust and system partners
6	Inability to delivery the Research and Innovation agenda to exploit future opportunities
7	Failure to be recognized as an Anchor Institution, demonstrating social value, sustainable green strategy and contribution to population health may increase costs in the longer term and disappoint public, staff and regulatory expectations
8	System architecture is still maturing and may present tensions for our LHCH leadership role, alignment of priorities with the ICS and system partners, and ensuring wider view to Cheshire & Merseyside and beyond.
9	Failure to ensure strong digital transformation and IT service resilience could erode LHCH's position as a world-class provider of specialist care delivering services for patient needs

Alder Hey BAF Risks Summary	
1.1	Inability to deliver safe and high-quality services
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care

Clatterbridge Cancer Centre BAF Risks Summary	
1	Quality governance
2	Demand exceeds capacity

Merseycare BAF Risks Summary	
S1	There is a risk we will not deliver the best clinical practice to the people we serve, due to the Trust not understanding thehealth needs of it's local population, resulting in increased risk in the identification and reduction of safety and quality issues and the continuesimprovement of medical care and leadership.
S2	There is a risk that Mersey Care will not improve the quality of our health services, due to us not considering the wider issuesthat impact on health and wellbeing, resulting in the unfair and unjust differences in access and outcomes for the communities we serve.

1.3	Building and infrastructure defects that could affect quality and provision of services		3	Insufficient funding		S3	There is a risk that the care for people with complex health and social needs will be fragmented and poorly coordinated, due to a focus on treatment which misses opportunities for earlier intervention, resulting in poorer coordination and less integration of wholeperson care at all ages. Executive Lead Trish Bennett
1.4	Access to Children and Young People's Mental Health		4	Board governance		S4	There is a risk of delivering the winter/resilience plan, due to demand exceeding expected levels, reduction in workforce capacity and data inaccuracies impacting decision making, resulting in the Trust not being able to address the immediate challenges of winter and the significant changes to the acute bed base across the system.
2.1	Workforce Sustainability and Development		5	Environmental sustainability		P1	There is a risk of reduced health and wellbeing of staff, due to workforce pressures and the Trust not address sickness absence and vacancy hot spots within our services, resulting in a working environment that struggles to be restorative, safe, supportive and inclusive.
2.2	Employee Wellbeing		6	Strategic influence within ICS		P2	There is risk that the trust fails to tackle the rising demand, due to a lack of insight into the experiences of our service users and communities, resulting in great inequality in access and enabling people to have greater control of their care.
2.3	Workforce Equality, Diversity & Inclusion		7	Research portfolio		R1	There is a risk to the modernisation of our inpatient and community estates, due to changes to the financial framework withinthe NHS meaning that the Trust will have less autonomy in prioritising its investments, resulting in potentially less capital for buildings thatsupport new models of care
3.1	Failure to fully realise the Trust's Vision for the Park		8	Research resourcing		R2	There is a risk that the Trust doesn't utilise the benefits of digital technology, due to the challenges in balancing growingdemand for finite resources and moving away from a 'one size fits all', technological solutions, resulting in delays in transforming the way wedeliver clinical excellence, population health, and care coordination within our services.
3.2	Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships		9	Leadership capacity and capability		F1	There is a risk that the trust will not increase its research capacity and capability, due to us not capitalising on new interventions with, academic and industry partners in real-world settings, resulting in us not advancing research and innovation in mental health and our understanding of how mental, physical, and social conditions are interlinked.
3.4	Financial Environment		10	Skilled and diverse workforce			
3.5	System working to deliver 2030 Strategy		11	Staffing levels			
4.1	Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People		12	Staff health and wellbeing			
4.2	Digital Strategic Development & Delivery		13	Development and adoption of digitisation			
			14	Cyber security			
			15	Subsidiaries companies and Joint Venture			

C&M ICB BAF Risks Summary

P1	The ICB is unable to meet its statutory duties to address health inequalities
P2	The ICB is unable to address inadequate digital and data infrastructure and interoperability which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities
P3	P3: Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. This may result in inability to meet increased demand, increase in backlogs of care, resulting in poor access to services, increased inequity of access, and poor clinical outcomes
P4	Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience
P5	Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience
P6	Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population
P7	The Integrated Care System is unable to achieve its statutory financial duties
P8	The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services

P9	**Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives**						
P10	**ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population**						

Commentary

In development.

Appendix 2 – Corporate Risks and High Scoring Divisional Risks

Ref	Description	Severity	Likelihood	Risk Rate Score	Directorate	Review Date	Next Review Date	BAF Link(s)
Corporate Risk Register								
2732	Condition: Following the CQC review (January 2023) it was again identified and highlighted within the CQC initial report regarding the lack of medical cover out ofhours within GED	4 Major	4 likely	16	Gynaecology		28/01/2024	
2641	Condition: There is a significant risk to the dietetic service and delivery of patient care at LWH	4 Moderate	5 Almost Certain	15	Clinical Support Service	19/12/2023	18/01/2024	1 & 2
2087	Condition: 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.	4 Major	3 Possible	12	Maternity	07/12/2023	06/03/2024	1, 2 & 3
~~2469~~	~~Condition: 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 - see risk 2274.~~	~~3 Moderate~~	~~2 Unlikely~~	~~6~~	~~Facilities & Estates~~	~~12/07/2023~~	~~12/10/2023~~	~~2~~
2301	Condition: There is both an operational and a financial risk related to the position in relation to contracts and SLAs for services provided to and by the Trust.	4 Major	3 Possible	12	Financial Services	10/01/2024	09/04/2024	5
2329	Condition: There is a risk to the Trust is not meeting it requirements for the safe and proper management of medicines	4 Major	3 Possible	12	Pharmacy	03/01/2024	02/02/2024	2
2223	Condition: LWH has been involved in a police investigation of public and media interest as a Neonatal Nurse on the Local Neonatal Unit at Chester who has alleged involvement in the murder and harm of babies.	3 Moderate	4 Likely	12	Neonatal	04/12/2023	03/03/2024	
1966	Condition: Risk of safety incidents occurring when undertaking invasive procedures.	4 Major	3 Possible	12	Governance	08/01/2024	07/02/2024	2
2085	Condition: 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 co-morbidities, and meeting the pre-operative assessment standards of the Association of Anaesthetists of GB & Ireland (AAGBI) and the Royal College of Anaesthetists (RCoA), to asses patients' clinical risk and plan for additional requirements for their safety and provide an optimal experience.	4 Major	3 Possible	12	Theatres & Anaesthesia	08/12/2024	01/02/2024	2
2232	Condition: There is a risk that due to a number of causes the Trust is unable to meet the safety requirements related to Blood Transfusion	5 Catastrophic	3 Possible	15	Pathology	29/12/2023	28/03/2024	2
2491	Noncompliance with mandated level of fit mask testers qualification, accreditation and competency.	5 Catastrophic	3 Possible	15	Governance	08/01/2024	08/03/2024	1
~~2488~~	~~Condition: Failure to meet clinical demand for red blood cells~~	~~3 Moderate~~	~~3 Possible~~	~~3~~	~~Clinical Support Service~~	~~12/07/2023~~	~~12/10/2023~~	~~2~~
2296	Condition: 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.	3 Moderate	3 Possible	12	Pathology	04/12/2023	27/06/2024	2
~~2603~~	~~Condition - Current Intranet in poor condition and no longer fit for purpose.~~	~~3 Moderate~~	~~3 Possible~~	~~9~~	~~Human Resources~~	~~14/08/2023~~	~~14/12/2023~~	~~4~~
~~1704~~	~~Effective management systems are not in place or sufficient to ensure all employees complete and keep up to date with their mandatory training requirements.~~	~~4 Major~~	~~3 Possible~~	~~12~~	~~Human Resources~~	~~21/06/2023~~	~~19/09/2023~~	~~1~~
2549	Condition: Staff shortages in the Ultrasound Team within the Imaging Department due to Vacancies and 5 staff members leaving in May & June 22	4 Major	4 Possible	12	Clinical Support Service	28/12/2023	27/03/2024	1
2086	Condition: Uncertainty about provision of adequate on-site Blood bank stocking all major blood products necessary to support the needs of the Maternity service.	3 Moderate	3 Possible	9	Maternity	19/09/2023	19/03/2024	2
2321	Condition: Due to the Trust not being located next to or with acute services, it is unable to meet the National Recommendations for Maternal Medicine.	4 Major	3 Possible	12	Maternity	13/09/2023	19/02/2024	2

1635	Risk of delays to treatment due to significant problems with the junior doctor rotas- vacancies and maternity leave. This is placing severe strain on the ability to fulfil the on-call rota as well as covering in hours duties. There is an increased reliance on locums, causing financial pressures. The risk include potential gaps in the rota which may put patients at risk, regular locum use which may result in potential compromise to the quality of the service provided and risk to the training provision of junior doctors if they are being moved around to fulfil the basic rota.	4 Major	4 likely	16	Human Resources	03/11/2023	01/02/2024	1, 2 & 5
~~2084~~	~~Condition: 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.~~	~~2 Minor~~	~~3 Possible~~	~~6~~	~~Gynaecology~~	~~05/07/2023~~	~~05/10/2023~~	~~1, 2 & 3~~
2088	Condition: Lack of on-site specialist staff and services	4 Catastrophic	5 Almost Certain	20	Neonatal	21/12/2023	10/07/2024	1 & 2
2323	Condition: The Trust is currently non-compliant with standards 2,5,6 of the seven-day service standards	5 Catastrophic	3 Possible	15	Governance	10/01/2024	18/10/2023	2
~~2395~~	~~Condition: Ambulatory gynaecology demand is exceeding current capacity~~	~~3 Moderate~~	~~5 Almost Certain~~	~~15~~	~~Gynaecology~~	~~07/08/2023~~	~~07/10/2023~~	~~2~~
2606	Failure to comply with national infection trajectory specifically in relation to E. coli bacteraemia	2 Minor	5 Almost Certain	10	Governance	13/09/2023	13/09/2024	2
2607	There is a risk of disruption to services as a result of industrial action from a number of trade unions in relation to matters relating to pay and conditions of service. Exemptions and derogations are to be agreed at a local level, if these are in line with previous years, maternity and neonatal services would be exempted, some activity across gynaecology and fertility will be stood down. We are working in partnership at a system level to agree a shared approach to managing industrial action, as well as ongoing liaison with our staff side colleagues.	4 Major	3 Possible	12	Human Resources	08/01/2024	07/02/2024	1
~~2708~~	~~The Child Protection Information Sharing (CPIS) System is not being accessed for every unplanned care attendance anyone aged under 18 or all pregnant women. This will lead to children, young people and unborn infants not being identified as being on a child protection plan or being a looked after child.~~	~~3 Moderate~~	~~4 Likely~~	~~12~~	~~Safeguarding~~	~~05/07/2023~~	~~04/08/2023~~	~~2~~
~~2709~~	~~Families and children are at risk of not receiving a co-ordinated approach to early help. The trust is not in a position to evidence early help work undertaken by Front Line Staff leading to the LA and Safeguarding Children Partnership Board raising concerns against the Trust that multi agency policy is not being appropriately implemented.~~	~~3 Moderate~~	~~3 Possible~~	~~9~~	~~Safeguarding~~	~~07/09/2023~~	~~07/12/2023~~	~~2~~
~~2710~~	~~Safeguarding information contained on Bulletin Board within Meditech and the associated safeguarding flags cannot be migrated onto Digicare. This will lead to front line staff being required to check the old system when patients attend and transcribe information onto new record. This is open to human error risk.~~	~~4 Major~~	~~3 Possible~~	~~12~~	~~Safeguarding~~	~~01/08/2023~~	~~04/01/2024~~	~~2~~
~~2726~~	~~Lack of administration, analyst and surveillance support for IP&C Team due to an open vacancy since 19/05/2023. Risk of compliance in regards to the Hygiene Code for the provision of suitable accurate information on infections (reporting locally, to ICB and into the HCAI DCS system)~~	~~2 Minor~~	~~2 Unlikely~~	~~4~~	~~Infection Control~~	~~06/09/2023~~	~~06/10/2023~~	~~2~~
High Scoring Divisional Risks								
2768	Condition: Shortage of middle grade and Consultant level Anaesthetics medical workforce	4 Major	5 Almost Certain	20	Clinical Support Services	NEW	NEW	
2760	Condition: Lack of on-site leadership and governance structure for MRI and CT	4 Major	4 Likely	16	Clinical Support Services	NEW	NEW	
2770	Condition: Risk to Anaesthetics capacity for out of hours emergency Obstetrics and Gynaecology procedures	4 Major	5 Almost Certain	20	Clinical Support Services	29/12/2023	28/01/2024	
2759	Condition: Risk of sustainability of HSSU service	4 Major	4 Likely	16	Clinical Support Services	NEW	NEW	
2758	Condition: Lack of on-site Imaging Medical Cover, currently dependant on 3 external providers for Radiologist support	4 Major	4 Likely	16	Clinical Support Services	NEW	NEW	
2048	Condition: Risk to patients and staff of not having availability of a chaperone when performing intimate examinations in the main department or Community sites.	3 Moderate	5 Almost Certain	15	Clinical Support Services	28/12/2023	27/03/2024	
2757	Condition: Trust wide Pathology services are dependent on third party providers	3 Moderate	5 Almost Certain	15	Clinical Support Services	NEW	NEW	
2730	Condition: Trust has insufficient internally generated capital to expand ambulatory estate	4 Major	4 Likely	16	Corporate	NEW	NEW	

2752	Condition: Staff are not trained in supporting people with a learning disability / autism in line legislative requirements. Recommended training is Oliver McGowan Mandatory Training, however other training can be delivered but must be in line with code of practice (including co delivered face to face with person with lived experience both LD and Autism)	4 Major	5 Almost Certain	20	Corporate	08/01/2024	07/02/2024	
2684	T5, T8, Compact fluorescent lamps are becoming obsolete from October 2023 to February 2024. Stocks of lamps will become depleted and then non-existent.	4 Major	4 Likely	16	Estates and Facilities	11/12/2023	10/03/2024	
2418	Condition: Lack of support and appropriate care for patients presenting with mental health conditions	4 Major	4 Likely	16	Governance	15/08/2022	13/11/2022	
2386	Condition: Data Loss Prevention	3 Moderate	5 Almost Certain	15	Information Governance	27/12/2023	26/03/2024	
2531	Condition - Inadequate and unsustainable IT Helpdesk Provision	4 Major	4 Likely	16	IT	27/12/2023	26/01/2024	
2372	Condition: Inability to safely provide a joint obstetric/endocrine/diabetes ANC across BOTH Aintree University Hospital and LWH sites for women with pre-existing and gestational diabetes	4 Major	4 Likely	16	Family Health	12/01/2024	12/03/2024	
2746	Condition: Lack of DSN due to short and long term sickness leading to no DSN support for the women with diabetes in pregnancy - failure to comply with local and national guidelines	4 Major	4 Likely	16	Family Health			
2772	Lack of IT equipment available on Mat Base to enable staff to complete contemporaneous documentation.	4 Major	4 Likely	16	Family Health			
2430	Condition: Network outlier for pre-term mortality - rate is higher than the national average	4 Major	4 Likely	16	Family Health	12/09/2023	12/03/2024	
2667	Delay in access to timely radiography out of hours	5 Catastrophic	3 Possible	15	Family Health	22/11/2023	20/02/2024	
2769	Risk of inability to use laboratory and procedure rooms at the Knutsford site.	5 Catastrophic	3 Possible	15	Hewitt			
~~2722~~	~~Condition: There is a risk to the division being overspent against budget due to unfunded cost pressures identified as part of the annual planning process.~~	~~4 Major~~	~~4 Likely~~	~~16~~	~~Clinical Support Services~~	~~02/10/2023~~	~~31/12/2023~~	~~5~~
~~2735~~	~~Condition: Lack of emergency call bells in part of the Imaging department.~~	~~5 Catastrophic~~	~~4 Likely~~	~~20~~	~~Clinical Support Services~~	~~18/09/2023~~	~~18/10/2023~~	~~2~~
~~2178~~	~~Condition: Lack of a robust system to ensure that ultrasound scanning performed by non-Sonographer practitioners is monitored and reviewed/audited and appropriate subsequent action taken.~~	~~5 Catastrophic~~	~~4 Likely~~	~~20~~	~~Clinical Support Services~~	~~02/10/2023~~	~~31/12/2023~~	~~2~~
~~2724~~	~~Condition: 20-minute appointment slots at dating scans is insufficient for all required duties. Out of area patient's growth charts and care summary reports not generated.~~	~~3 Moderate~~	~~5 Almost Certain~~	~~15~~	~~Clinical Support Services~~	~~27/09/2023~~	~~26/12/2023~~	~~2~~
~~2728~~	~~Cause: Current ambulatory estate is insufficient to meet demand for ambulatory activity~~	~~4 Major~~	~~4 Likely~~	~~16~~	~~Corporate Services~~	~~- / /~~	~~- / /~~	~~2 & 7~~
~~2572~~	~~Condition - there is a lack of strategic leadership and robust procedures to ensure the safety of people and assets within the Crown Street and Knutsford sites.~~	~~4 Major~~	~~4 Likely~~	~~16~~	~~Corporate Services~~	~~06/09/2023~~	~~06/10/2023~~	~~2~~
~~2598~~	~~Condition: Risk relating to the Trusts Emergency Response~~	~~5 Catastrophic~~	~~3 Possible~~	~~15~~	~~Corporate Services~~	~~22/06/2023~~	~~20/09/2023~~	~~2~~
~~2599~~	~~Condition: Risk relating to the Trusts Internal Security (Premises)~~	~~5 Catastrophic~~	~~3 Possible~~	~~15~~	~~Corporate Services~~	~~22/06/2023~~	~~20/09/2023~~	~~2~~
~~2604~~	~~Condition: Risk relating to Trust Security Systems~~	~~5 Catastrophic~~	~~3 Possible~~	~~15~~	~~Corporate Services~~	~~06/09/2023~~	~~06/10/2023~~	~~2~~
~~2743~~	~~In ability to comply with National guidance for the management of women with pre-existing and pregnancy related diabetes leading to poor outcomes and failure of implementation of SBL3~~	~~4 Major~~	~~4 Likely~~	~~16~~	~~Family Health~~	~~- / /~~	~~- / /~~	~~2~~
~~2732~~	~~Following the CQC review (January 2023) it was again identified and highlighted within the CQC initial report regarding the lack of medical cover out of hours within GED.~~	~~4 Major~~	~~4 Likely~~	~~16~~	~~Gynaecology~~	~~13/10/2023~~	~~12/11/2023~~	~~1 & 2~~
~~2725~~	~~The division have identified cost pressures of approx. £2.35m that are unfunded for 2023/24. This is now a significant pressure to the division and the overall Trusts financial position. A large proportion of the pressures are staff already in substantive roles (for several years) and further inflationary costs.~~	~~4 Major~~	~~4 Likely~~	~~16~~	~~Gynaecology~~	~~11/09/2023~~	~~10/11/2023~~	~~5~~

~~2485~~	~~Condition: Limited access to MRI scan (currently 5-6 weeks wait) needed for cancer patient pre treatment (both surgical and radiotherapy treatment). MRI requested and undertaken at CCC as per pathway, as expertise in reporting is there and feeds into specialist MDT. Of note MRI added into clinical pathway as part of BGCS stratification for surgery during the first wave of COVID pandemic - this is considered best practice.~~	~~4 Major~~	~~4 Likely~~	~~16~~	~~Gynaecology~~	~~/ /~~	~~/ /~~	~~2 & 7~~

Changes to Risk Summary (Quarterly)

Since the November 2023 meeting, there have been the following developments in various risks.

De-Escalated Risk:
One risk, Gynaecology Medical (Risk 2084), with an initial score of 6 and a target score of 2, has been de-escalated by the Risk Manager and Divisional Manager. The de-escalation, dated 09/01/2024, is attributed to the Divisional Governance - Oncology gaining access to theatre sessions at LUFT, with the risk now de-escalated to the Divisional Level. Although there is no change in the current risk score, further actions or a review for closure are recommended.

Closed Risks:
A Gynaecology Ambulatory risk (Risk 2395) with a score of 15 at closure has been closed on 22/11/2023, merged with another risk due to duplication. Another risk, Pathology (Risk 2488), related to the clinical demand for red blood cells, has a score of 3 and has been recommended for closure. The rationale involves the low supply of red blood cells and a review on 29/12/2023, with plans to move it from the corporate to the service risk register.

New Risks:
A new risk, Gynaecology Emergency (Risk 2732), has been added to the register with a current score of 16. This risk stems from the identified lack of medical cover after 10 p.m. within GED, impacting patient outcomes and resulting in increased incidents. The risk has been escalated with a corporate business case being developed to request additional specialty doctors.

Additionally, Clinical Support Services propose the inclusion of an extreme risk (Risk 1960) related to Imaging onto the Corporate Risk register. This risk, with a current score of 20, highlights a lack of robust governance for ultrasound processes across the trust. The rationale for escalation includes ongoing actions and controls established in the previous year, yet the risk persists, and improvements are challenging for CSS alone. The risk is associated with potential serious incidents, claims, loss of reputation, and regulatory sanctions. The risk manager suggests further review and appropriate articulation on the risk register.

Appendix 3 - 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

Liverpool Women's
NHS Foundation Trust

Jargon Buster

We know that the language used in healthcare can sometimes be quite confusing, especially when acronyms are concerned. To make life a little easier, we will try to ensure that we spell out acronyms in full at first mention and then put the abbreviation in brackets, for example, Strategic Clinical Network (SCN) in our reports and minutes.

We've also put together a list of acronyms that you might see throughout our documentation. If you spot a gap, please email our Trust Secretary on mark.grimshaw@lwh.nhs.uk.

The following webpage might also be useful - https://www.england.nhs.uk/participation/nhs/

A		
A&E	Accident & Emergency	hospital department specialising in the acute care of patients who arrive without a prior appointment with urgent or emergency trauma
AC	Audit Committee	a committee of the board – helps the board assure itself on issues of finance, governance and probity
AGM	Annual General Meeting	a meeting to present and agree the trust annual report and accounts
AGS	Annual Governance Statement	a document which identifies the internal controls in place and their effectiveness in delivering effective governance
AHP	Allied Health Professionals	health care professions distinct from dentistry, optometry, nursing, medicine and pharmacy e.g. physiotherapists, radiographers, speech therapists and podiatrists
AHSC	Academic Health Science Centre	a partnership between a healthcare provider and one or more universities
AHSN	Academic Health Science Network	locally owned and run partnership organisations to lead and support innovation and improvement in healthcare
ALOS	Average Length of Stay	the average amount of time patients stay in hospital
AMM	Annual Members Meeting	a meeting that is held every year to give members the opportunity to hear about what the trust has done in the past year; could be part of the AGM
AO	Accountable Officer	senior person responsible and accountable for funds entrusted to their trust; for NHS provider organisations this person will be the chief executive
ALB(s)	Arms Length Bodies	an organisation that delivers a public service but is not a ministerial government department; these include HEE, HSCIC, HRA, HTA, NHSE, NICE, Monitor, NHSBSA, NHSBT, NHSI, NHSLA, MHPRA, CQC, PHE (See individual entries)
	Agenda for Change	the NHS-wide grading and pay system for NHS staff, with the exception of medical and dental staff and some senior managers; each relevant job role in the NHS is matched to a band on the Agenda for Change pay scale

B		
BAF	Board Assurance Framework	the key document used to record and report an organisation's key strategic objectives, risks, controls and assurances to the board
BCF	Better Care Fund	this fund creates a local single pooled budget to incentivise the NHS and local government to work more closely together in local areas
BMA	British Medical Association	trade union and professional body for doctors
BAME	Black Asian Minority Ethnic	terminology normally used in the UK to describe people of non-white descent
BoD	Board of Directors	executive directors and non-executive directors who have collective responsibility for leading and directing the trust
	Benchmarking	method of gauging performance by comparison with other organisations

C		
CAMHS	Child and Adolescent Mental Health Services	specialise in providing help and treatment for children and young people with emotional, behavioural and mental health difficulties
CapEx	Capital Expenditure	an amount spent to acquire or improve a long-term asset such as equipment or buildings. Typically, capital is raised via a loan, but it can come from reserves and is paid back/written off over a number of years from revenue income. This is a contrast with revenue spend which is always from in-year income
CBA	Cost Benefit Analysis	a process for calculating and comparing the costs and benefits of a project
CBT	Cognitive Behavioural Therapy	a form of psychological therapy used mostly in depression but increasingly shown to be a useful part of the treatment for schizophrenia
CCG	Clinical Commissioning Group	groups of GPs, clinicians and managers who are responsible for commissioning local health services in England (all GP practices must belong to a CCG)
CDiff	Clostridium difficile	a bacterial infection that most commonly affects people staying in hospital
CE / CEO	Chief Executive Officer	leads the day-to-day management of a foundation trust, is a board member and the accountable officer for the trust.
CF	Cash Flow	the money moving in and out of an organisation
CFR	Community First Responders	a volunteer who is trained by the ambulance service to attend emergency calls in the area where they live or work
CHC	Continuing Healthcare	Whereby those with long-term or complex healthcare needs qualify for social care arranged for and funded by the NHS
CIP	Cost Improvement Plan	an internal business planning tool outlining the Trust's efficiency strategy
CMHT	Community Mental Health Team	A team of mental health professionals such as psychiatrists,

		psychologists, social workers, community psychiatric nurses and occupational therapists, who work together to help people manage and recover from mental illness.
CoG	Council of Governors	the governing body that holds the non-executive directors on the board to account for the performance of the board in managing the trust, and represents the interests of members and of the public
COO	Chief Operating Officer	a senior manager who is responsible for managing a trust's day-to-day operations and reports to the CEO
CPD	Continuing Professional Development	continued learning to help professionals maintain their skills, knowledge and professional registration
CPN	Community Psychiatric Nurse	a registered nurse with specialist training in mental health working outside a hospital in the community
CQC	Care Quality Commission	The independent regulator of all health and social care services in England
CQUIN	Commissioning for Quality and Innovation	a sum of money that is given to providers by commissioners on the achievement of locally and nationally agreed quality and improvement goals
CSR	Corporate Social Responsibility	A business practice which incorporates sustainable goals, usually positive impacts on environmental, economic and social factors, into a business model
CT	Computed Tomography	A medical imaging technique
CFO	Chief Finance Officer	the executive director leading on finance issues in the trust
CNST	Clinical Negligence Scheme for Trusts	The Clinical Negligence Scheme for Trusts (CNST) handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) in England currently belong to the scheme.
	Caldicott Guardian	A board level executive director responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian

D		
DBS	Disclosure and barring service	conducts criminal record and background checks for employers
DBT	Dialectical behavioural therapy	A type of psycho-therapy, or talk therapy, which has been developed from CBT to help those experiencing borderline personality disorder
DGH	District General Hospital	major secondary care facility which provides an array of treatment, diagnostic and therapeutic services, including A&E
DHSC	Department of Health and Social Care	the ministerial department which leads, shapes and funds health and care in England
DN	Director of Nursing	The executive director who has professional responsibility for services provided by nursing personnel in a trust

DNA	Did Not Attend	a patient who missed an appointment
DNAR	Do Not Attempt Resuscitation	A form issued and signed by a doctor, which tells a medical team not to attempt CPR
DPA	Data Protection Act	the law controlling how personal data is collected and used
DPH	Director of Public Health	a senior leadership role responsible for the oversight and care of matters relating to public health
DTOCs	Delayed Transfers of Care	this refers to patients who are medically fit but waiting for care arrangements to be put in place so therefore cannot be discharged
	Duty of Candour	a legal duty on hospital, community, ambulance and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm

E		
E&D	Equality and Diversity	The current term used for 'equal opportunities' whereby members of the workforce should not be discriminated against because of their characteristics. This is promoted by valuing diverse characteristics in a workplace.
ED(s)	Executive Directors *or* Emergency Department	senior management employees who sit on the trust board *or* alternative name for Accident & Emergency department
EHR	Electronic Health Record	health information about a patient collected in digital format which can theoretically be shared across different healthcare settings
EOLC	End of Life Care	support for patients reaching the end of their life
EPR	Electronic Patient Record	a collation of patient data stored using computer software
ESR	Electronic staff record	A collation of personal data about staff stored using computer software

F		
FFT	Friends and Family Test	a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care
FOI	Freedom of Information	the right to ask any public sector organisation for the recorded information they have on any subject
FT	Foundation Trust	a public benefit corporation, which is a legal body established to deliver healthcare to patients / service users and has earned a degree of operational and financial independence
FTE	Full Time Equivalent	a measurement of an employees workload against that of someone employed full time e.g. 0.5 FTE would be someone who worked half the full time hours
FTSU	Freedom to speak up	An initiative developed by NHS Improvement to

		encourage NHS workers to speak up about any issues to patient care, quality or safety
	Francis Report	the final report, published in 2013, of the public inquiry into care provided by Mid Staffordshire NHS FT chaired by Sir Robert Francis QC

G

GMC	General Medical Council	the independent regulator for doctors in the UK
GDP	Gross Domestic Product	the value of a country's overall output of goods and services
GDPR	General Data Protection Regulations	The legal framework which sets the guidelines for collecting and processing personal information from individuals living in the European Union

H

HCAI	Healthcare Associated Infection	these are infections that are acquired in hospitals or as a result of healthcare interventions; MRSA and Clostridium difficile can be classed as HCAIs if caught whilst in a healthcare setting
HCA	Health Care Assistant	staff working within a hospital or community setting under the guidance of a qualified healthcare professional
HDU	High Dependency Unit	an area in a hospital, usually located close to the ICU, where patients can be cared for more extensively than on a normal ward, but not to the point of intensive care, e.g. patients who have had major surgery
HEE	Health Education England	the body responsible for the education, training and personal development of NHS staff
HR	Human Resources	the department which focusses on the workforce of an organisation including pay, recruitment and conduct
HRA	Health Research Authority	protects and promotes the interests of patients and the public in health research
HSCA 2012	Health & Social Care Act 2012	an Act of Parliament providing the most extensive reorganisation of the NHS since it was established, including extending the roles and responsibilities of governors
HSCIC	Health and Social Care Information Centre	the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care
HTA	Human Tissue Authority	regulates the removal, storage, use and disposal of human bodies, organs and tissue for a number of scheduled purposes such as research, transplantation, and education and training
HWB / HWBB	Health& Wellbeing Board	a local forum to bring together partners from across the NHS, local government, the third sector and the independent sector, led by local authorities
	Health Watch	A body created under the Health and Social Care Act 2012

		which aims to understand the needs and experiences of NHS service users and speak on their behalf.

I		
IAPT	Improved Access to Psychological Therapies	an NHS programme rolling out services across England offering interventions approved by the National Institute of Health and Care Excellence for treating people with depression and anxiety disorders
IG	Information Governance	ensures necessary safeguards for, and appropriate use of, patient and personal information. Key areas are information policy for health and social care, IG standards for systems and development of guidance for NHS and partner organisations
ICP	Integrated Care Pathway	a multidisciplinary outline of care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through diagnosis and treatment to positive outcomes
ICS	Integrated Care system	Groups of NHS providers, commissioners and local authorities working together to improve health and care in the local area
ICT	Information Communications Technology	an umbrella term that includes any communication device or application, encompassing: radio, television, cellular phones, computer and network hardware and software, satellite systems, as well as the various services and applications associated with them
ICU *or* ITU	Intensive Care Unit Intensive therapy unit	specialist unit for patients with severe and life threatening illnesses
IP	Inpatient	a patient who is hospitalised for more than 24 hours
IT	Information Technology	systems (especially computers and telecommunications) for storing, retrieving, and sending information
IV	Intravenous	treatment which is administered by injection into a vein

K		
KLOE(s)	Key Line of Enquiries	detailed questions asked by CQC inspectors which help to answer the five key questions to assess services: are they safe, effective, caring, responsive and well-led?
KPIs	Key Performance Indicators	indicators that help an organisation define and measure progress towards a goal
	King's Fund	independent charity working to improve health and health care in England

L		
LD	Learning Disability	a disability which affects the way a person understands information and how they communicate
LGA	Local Government Association	the national voice of local government in England and Wales. It seeks to promote better local government and maintains communication between officers in different local authorities to develop best practice
LOS	Length of Stay	a term commonly used to measure the duration of a single episode of hospitalisation

M		
M&A	Mergers & Acquisitions	mergers bring together two or more bodies to form a new legal entity and disband the merging bodies. acquisitions are take-overs of one body by another
MD	Medical Director	a member of the board who has a clinical background and has professional responsibilities for doctors and dentists in the trust
MHPRA	Medicines and Healthcare Products Regulatory Agency	an executive agency of DHSC which is responsible for ensuring that medicines and medical devices work and are acceptably safe
MIU	Minor Injuries Unit	A unit which treats injuries or health conditions which are less serious and do not require the A&E service
MoU	Memorandum of Understanding	describes an agreement between two or more parties
MRI	Magnetic Resonance Imaging	a medical imaging technique
MRSA	Methicillin-Resistant Staphylococcus Aureus	a bacterium responsible for several difficult-to-treat infections in humans
MSA	Mixed Sex Accommodation	wards with beds for both male and female patients

N

NAO	National Audit Office	an independent Parliamentary body in the United Kingdom which is responsible for auditing central government departments, government agencies and non-departmental public bodies. The NAO also carries out Value for Money audits into the administration of public policy
NED	Non Executive Director	directors who are appointed, but not employed by the trust; they have no executive responsibilities and are responsible for vetting strategy, providing challenge in the boardroom and holding the executive directors to account
NHSBSA	NHS Business Services Authority	a Special Health Authority of DHSC which provides a range of services to NHS organisations including: NHS Prescription Services, NHS Pensions, Help With Health Costs, Student Services, NHS Dental Services, European Health Insurance Card, Supplier Management (including NHS Supply Chain) and NHS Protect
NHSBT	NHS Blood and Transplant	a Special Health Authority of DHSC responsible for providing a reliable, efficient supply of blood, organs and associated services to the NHS
NHSE	NHS England	an executive non-departmental public body with a mandate from the Secretary of State to improve health outcomes for people within England
NHSI	NHS Improvement	The Independent regulator of NHS Foundation Trusts
NHSLA	NHS Leadership Academy	national body supporting leadership development in health and NHS funded services
NHSP	NHS Professionals	provides bank (locum) healthcare staff to NHS organisations
NHSX		A unit designed to drive the transformation of digital technology in the NHS
NICE	National Institute for Health and Care Excellence	provides national evidence-based guidance and advice to improve health and social care
NIHR	National Institution for Health Research	The largest funder of health and social care research in the UK, primarily funded by the Department of Health and Social Care
NMC	Nursing and Midwifery Council	nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
	Never Event	serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. NHS England defines the list of never events every year

	NHS Digital	The information and technology partner to the NHS which aims to introduce new technology into services
	NHS Providers	NHS Providers is the membership organisation for NHS public provider trusts. We represent every variety of trust, from large acute and specialist hospitals through to community, ambulance and mental health trusts.
	Nolan Principles	key principles of how individuals and organisations in the public sector should conduct themselves comprising of: selflessness, integrity, objectivity, accountability, openness, honesty, leadership. Set by the Committee for Standards in Public Life, an independent advisory non-departmental public body set up to advise the prime minister on ethical standards
	NHS Resolution	not-for-profit part of the NHS which manages negligence and other claims against the NHS in England on behalf of their member organisations. Also, an insurer for NHS bodies
	Nuffield Trust	independent source of evidence-based research and policy analysis for improving health care in the UK, also a charity

O

OD	Organisational Development *or* Outpatients Department	a systematic approach to improving organisational effectiveness *or* a hospital department where healthcare professionals see outpatients (patients which do not occupy a bed)
OOH	Out of Hours	services which operate outside of normal working hours
OP	Outpatients	a patient who is not hospitalized for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment
OPMH	Older People's Mental Health	mental health services for people over 65 years of age
OSCs	Overview and Scrutiny Committees	established in local authorities by the Local Government Act 2000 to review and scrutinise the performance of public services including health services
OT	Occupational Therapy	assessment and treatment of physical and psychiatric conditions using specific activity to prevent disability and promote independent function in all aspects of daily life

P		
PALS	Patient Advice & Liaison Service	offers confidential advice, support and information on health-related matters to patients, their families, and their carers within trusts
PAS	Patient Administration System	the automation of administrative paperwork in healthcare organisations, particularly hospitals. It records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient
PbR	Payment by Results or 'tariff'	a way of paying for health services that gives a unit price to a procedure
PCN	Primary care network	A key part of the NHS long term plan, whereby general practices are brought together to work at scale
PDSA	Plan, do, study, act	A model of improvement which develops, tests and implements changes based on the scientific method
PFI	Private Finance Initiative	a scheme where private finance is sought to supply public sector services over a period of up to 60 years
PHE	Public Health England	a body with the mission to protect and improve the nation's health and wellbeing and reduce health inequalities
PHSO	Parliamentary and Health Service Ombudsman	an organisation which investigates complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England
PICU	Psychiatric Intensive Care Unit *or* Paediatric Intensive Care Unit	a type of psychiatric in-patient ward with higher staff to patient ratios than on a normal acute admission ward *or* an inpatient unit specialising in the care of critically ill infants, children, and teenagers
PLACE	Patient-Led	Surveys inviting local people going into hospitals as
	Assessments of the Care Environment	part of a team to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance
PPI	Patient and Public Involvement	mechanisms that ensure that members of the community --- whether they are service users, patients or those who live nearby – are at the centre of the delivery of health and social care services
PTS	Patient Transport Services	free transport to and from hospital for non-emergency patients who have a medical need

	Primary Care	the first point of contact with the NHS for most people and is delivered by a wide range of independent contractors, including GPs, dentists, pharmacists and optometrists, it also includes NHS walk-in centres and the NHS 111 telephone service

Q

QA	Quality assurance	monitoring and checking outputs to make sure they meet certain standards
QI	Quality improvement	A continuous improvement process focusing on processes and systems
QIA	Quality Impact Assessment	A process within NHS trusts which ensures the quality of service is systematically considered in decision- making on service changes
QUI	Qualities and Outcomes Framework	The system for performance management and payment of GP's in the NHS

R

R&D	Research & Development	work directed towards the innovation, introduction, and improvement of products and processes
RAG	Red, Amber, Green classifications	a system of performance measurement indicating whether something is on or better than target (green), below target but within an acceptable tolerance level (amber), or below target and below an acceptable tolerance level (red)
RGN	Registered General Nurse	a nurse who is fully qualified and is registered with the Nursing and Midwifery Council as fit to practise
RoI	Return on Investment	the benefit to the investor resulting from an investment of some resource. A high RoI means the investment gains compare favourably to investment cost. As a performance measure, RoI is used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments.
RTT	Referral to Treatment Time	the waiting time between a patient being referred by a GP and receiving treatment

S		
SALT	Speech and Language Therapist	assesses and treats speech, language and communication problems in people of all ages to help them better communicate
SFI	Standing Financial Instructions	Policy used for the regulation of the conduct of an NHS trust in relation to all financial matters
SHMI	Summary Hospital Level Mortality Indicator	reports mortality at trust level across the NHS in England using standard and transparent methodology
SID	Senior independent Director	a non-executive director who sits on the board and plays a key role in supporting the chair; the SID carries out the annual appraisal of the chair, and is available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair
SIRO	Senior Information Risk Officer	a senior manager who will take overall ownership of the organisation's information risk policy
SITREP	Situation Report	a report compiled to describe the details surrounding a situation, event, or incident
SLA	Service Level Agreement	an agreement of services between service providers and users or commissioners
SoS	Secretary of State	the minister who is accountable to Parliament for delivery of health policy within England, and for the performance of the NHS
SRO	Senior Responsible officer	A leadership role which is accountable for the delivery and outcome of a specific project
STP	Sustainability and Transformation Partnership	Partnerships formed between local councils and NHS services to help plan and run services, and agree system-wide priorities
SUI	Series Untoward Incident / Serious Incident	A serious incident which resulted in one or more of the following: unexpected or avoidable death, a never event, a prevention of organisation's ability to continue to deliver healthcare services, abuse, or loss of confidence in a service
SWOT	Strengths, Weaknesses, Opportunities, Threats	a structured planning method used to evaluate the strengths, weaknesses, opportunities and threats involved in a project or in a business venture
	Secondary Care	NHS health service provided through hospitals and in the community

T		
TTO	To Take Out	medicines to be taken away by patients on discharge

	Tertiary Care	healthcare provided in specialist centres, usually on referral from primary or secondary care professionals

V

VTE	Venous Thromboembolism	a condition where a blood clot forms in a vein. This is most common in a leg vein, where it's known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE)
VfM	Value for Money	used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it both acquires and provides, within the resources available to it

W

WLF	Well Led Framework	a set of indicators that seek to identify how well led an organisation is, also used as a framework for board governance reviews
WRES	Workforce Race Equality Standard	a metric to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of black and minority ethnic (BME) board representation
WTE	Whole-time equivalent	See FTE

Y

YTD	Year to Date	a period, starting from the beginning of the current year, and continuing up to the present day. The year usually starts on 1st April for financial performance indicators