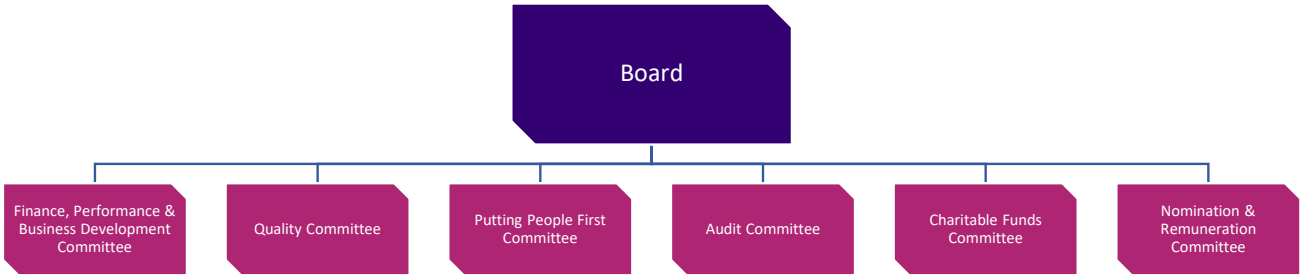
Liverpool Women's
NHS Foundation Trust

Trust Board

2 September 2021, 09.00am
Virtual Meeting



Liverpool Women's NHS Foundation Trust

Trust Board

Location	Virtual Meeting
Date	2 September 2021
Time	9am

AGENDA					
Item no. 21/22/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
064	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	09.00 (5 mins)
065	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
066	Minutes of the previous meeting held on 1 July 2021	Confirm as an accurate record the minutes of the previous meeting(s)	Written	Chair	
067	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
068	Patient Story	To receive a patient story	Verbal	Chief Nurse & Midwife	09.05 (15 mins)
069	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	09.20 (10 mins)
070	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	09.30 (10 mins)
QUALITY & OPERATIONAL PERFORMANCE					
071a	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	09.40 (80 mins)
071b	Safeguarding Annual Report 2020/21	For assurance and approval	Written	Chief Nurse & Midwife	
071c	Freedom to Speak Up i) Whistleblowing / Freedom to Speak up Annual Report 2020/21 ii) Freedom to Speak Up Vision and Strategy 2021-24	For assurance and approval	Written	Chief People Officer	
071d	Integrated Governance Report	For assurance	Written	Chief Nurse & Midwife	
071e	Bi-Annual Safe Staffing	For assurance	Written	Chief Nurse & Midwife	

071f	Chair's Reports from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
BREAK – 10 mins					
PEOPLE					
072a	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	11.10 (30 mins)
072b	Equality Diversity and Inclusion Update, including WRES and WDES 2021 Data	For assurance	Written	Chief People Officer	
072c	Chair's Report from the Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
BREAK – 15 mins					
Board Thank You – 5 mins					
FINANCE & FINANCIAL PERFORMANCE					
073a	Finance Performance Review Month 4 2021/22	For assurance - To note the current status of the Trusts financial position	Written	Chief Finance Officer	12.00 (45 mins)
073b	Future Generations Programme: Expression of Interest to Build a New Liverpool Women's Hospital	For approval	Written	Chief Finance Officer	
073c	Chair's Report from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
073d	Chair's Report from the Audit Committee • Bribery Briefing note	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
BOARD GOVERNANCE					
074a	Well-Led Governance Review – Action Plan	For approval	Written	Trust Secretary	12.45 (30 mins)
074b	Board Assurance Framework	For assurance	Written	Trust Secretary	
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
075a	R&D Annual Report	For assurance	Written	Medical Director	Consent
075b	Health & Safety Annual Report	For assurance	Written	Chief Operating Officer	
075c	Constitution Amendment	For approval	Written	Trust Secretary	
075d	Membership Strategy	For approval	Written	Trust Secretary	

075e	Corporate Governance Manual – 2021 Update	For approval	Written	Trust Secretary	
075f	Updated LHP Members Agreement following formal dissolution of LHP Ltd.	For approval	Written	Chief Executive	
CONCLUDING BUSINESS					
076	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	13.15 (5 mins)
077	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
078	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
Finish Time: 13.20					

Date of Next Meeting: 4 November 2021

13.20 – 13.30	*Questions raised by members of the public*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Liverpool Women's
NHS Foundation Trust

Meeting attendees' guidance

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

Before the meeting

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

General considerations:

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

*some members may send a nominated representative who is sufficiently senior and has the authority to make decisions. Refer to the terms of reference for the committee/subcommittee to check whether this is permitted.

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

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

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

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

At the meeting

General Considerations:

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

- General Participants:
  - Focus on the meeting at hand and not the next activity
  - Actively and constructively participate in the discussion
  - Think about what you want to say before you speak; explain your ideas clearly and concisely and summarise if necessary
  - Make sure your contributions are relevant and appropriate
  - Respect the contributions of other members of the group and do not speak across others
  - Ensure you understand the decisions, actions, ideas and issues agreed and to whom responsibility for them is allocated
  - Do not use the meeting to highlight issues that are not on the agenda that you have not briefed the chair as AoB prior to the meeting
  - Re-group promptly after any breaks
  - Take account of the Chair's health, safety and fire announcements (fire exits, fire alarm testing, etc)
  - Consent agenda items, taken as read by members and the minutes will reflect recommendations from the paper. Comments can still be made on the papers if required but should be flagged to the Chair at the beginning of the meeting.

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

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

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

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

Attendance

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

After the meeting

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

Standards & Obligations

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

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

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

Page 129 Handbook to the NHS Constitution 26th March 2013

Liverpool Women's NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held virtually at 09.30am on 1 July 2021

PRESENT

Robert Clarke	Chair
Kathryn Thomson	Chief Executive
Jenny Hannon	Director of Finance
Gary Price	Chief Operating Officer
Jo Moore	Non-Executive Director/Vice Chair
Louise Martin	Non-Executive Director
Lynn Greenhalgh	Medical Director
Dr Susan Milner	Non-Executive Director/SID
Ian Knight	Non-Executive Director
Prof Louise Kenny	Non-Executive Director
Tony Okotie	Non-Executive Director
Marie Forshaw	Director of Nursing & Midwifery
Michelle Turner	Chief People Officer

IN ATTENDANCE

Dawn Valentine Gray	Macmillan Nurse, Gynae-Oncology (item 47 only)
Prof. Colin Morgan	Consultant Neonatologist / Deputy Director for Starting Well (item 50b only)
Dr Timothy Neal	Director of Infection, Prevention & Control (item 50d only)
Angela Winstanley	Quality & Safety Midwife (until item 50g)
Eva Horgan	Deputy Director of Finance
David Dodgson	Financial Controller (Board Thank You only)
Chris Gough	Financial Accountant (Board Thank You only)
Stephen Chapman	Security Officer (Board Thank You only)
Jodie Reardon	Health Care Assistant (Board Thank You only)
Kathryn Sandison	Administrator (Testing & Surveillance Team) (Board Thank You only)
Kirsty McCartney	Switchboard (Board Thank You only)
Andrew Weeks	Consultant Obstetrician (Board Thank You only)
Lesley Mahmood	Member of the public
Felicity Dowling	Member of the public
Teresa Williamson	Member of the public
Mary McDonald	Appointed Governor
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Tracy Ellery	Non-Executive Director

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

Jo Moore - Non-Executive Director / Vice Chair	✓	✓	✓									
Tracy Ellery - Non-Executive Director	✓	✓	✓									
Louise Martin - Non-Executive Director	✓	✓	✓									
Ian Knight - Non-Executive Director	✓	✓	✓									
Tony Okotie - Non-Executive Director	A	✓	✓									
Prof Louise Kenny - Non-Executive Director	✓		✓									
Jenny Hannon – Chief Finance Officer	✓	✓	✓									
Marie Forshaw – Chief Nurse & Midwife	✓	A	✓									
Gary Price - Chief Operating Officer	✓	✓	✓									
Michelle Turner - Chief People Officer	✓	A	✓									
Dr Lynn Greenhalgh - Medical Director	✓	✓	✓									
Present (✓) Apologies (A) Representative (R) Non attendance (NA)												

21/22/	
043	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. Apologies were noted as above and there were no declarations of interest.
044	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
045	**Minutes of the previous meetings held on 6 May 2021** The minutes of the Board of Directors meetings held on 6 May 2021 were agreed as a true and accurate record.
046	**Action Log and matters arising** The Trust Secretary drew attention to Action 21/22/008a 'Performance Report', noting that whilst progress had been made to develop the reporting of areas of statutory compliance, this would only be complete for September 2021 (action marked as complete on tracker).
047	**Patient Story** The Macmillan Nurse (Gynae-Oncology) attended to present the story of a patient who had required symptomatic support at the Trust during chemotherapy treatment. Emotional support had also been provided via face-to-face and telephone contacts. Subsequent scans showed a progression of disease and the patient moved into palliative care, again with emotional support provided from the Macmillan nurse. The patient opted to stay at the Trust for their palliative care (Mulberry Suite), due to the personal relationships that had developed during their care. Despite challenges relating to the Covid-19 pandemic, arrangements were made for safe visiting. The patient's daughter had a significant birthday and the Trust ensured that a celebration could be held with important memories made. The patient unfortunately passed away at the Trust with their husband present at their side. The Chair remarked that 'going the extra mile' did not adequately describe the support that the Trust's teams provided to the patient and their family. The Chief Executive extended a thank you to the team and noted that the Mulberry Suite was a special place. The Trust was currently exploring options to carry out refurbishment to make further improvements. The Medical Director stated that the story showed the power of face-to-face contact, something that had been made challenging during the pandemic. Attention would need to be given in terms of how to prioritise face-to-face care when developing Covid-19 recovery plans. The Medical Director also

	queried the on-going support for families. The Macmillan Nurse explained that the team signposted to available services. The Chair and Board members thanked the patient's family for enabling the story to be shared and the teams involved in the care. *Dawn Valentine Gray left the meeting*
048	**Chair's announcements** The Chair noted the following issues: • A Council of Governor meeting had been held on 13 May 2021 and another was scheduled for 22 July 2021. Part of the meeting on the 22 July 2021 would consider the outcomes from the Chair and Non-Executive Director appraisal process. • An Integrated Care System Assembly meeting had been held for Chairs and Non-Executive Directors. The Trust had been well represented at the event. • The Chair had attended an inclusive leadership talk by John Amaechi, OBE. A key lesson from the event was the importance of individuals ensuring that they "treated others as they would want to be treated". The Board noted the Chair's update.
049	**Chief Executive's report** The Chief Executive presented the report which detailed local, regional and national developments. The Trust had held a 'Diversity Day' which had been attended by John Barnes who spoke to staff about his experience of racism and outlined his support for the Trust's 'Be Kind' campaign. The Chief Operating Officer reported that the Covid-19 pandemic continued to present significant challenges. As community infections and the requirement for people to isolate was increasing, this was impacting on the availability of staff. The Trust had recently taken the unusual step to divert maternity patients to neighbouring units and this was due to a mixture of staffing issues and the acuity of patients presenting. The Trust was working closely with partner organisations to ensure the safety of maternity services across Cheshire & Merseyside. The Trust Secretary noted that the Board approved the application of the Trust Seal on a lease pertaining to the use of Mulgrave Street Car Park with Liverpool City Council via email. The Board was asked to ratify this decision. The Board of Directors: • noted the Chief Executive update. • Ratified the decision to approve the application of the Trust Seal on a lease pertaining to the use of Mulgrave Street Car Park with Liverpool City Council
050a	**Quality & Operational Performance Report** The Board considered the Quality and Operational Performance Report. Non-Executive Director, Ian Knight noted a deterioration in mandatory training compliance and queried what had caused the change of trajectory from a trend of recent improvement. The Chief People Officer noted that the staffing challenges in maternity was having an impact on compliance as it was difficult to release staff for training. The Trust was taking a risk-based approach to targeting training to ensure that safety was maintained. Improvements in mandatory training compliance were being seen in other areas. The Chair asked if there was any alternative action that could be taken to improve sickness and mandatory training performance. The Chief People Officer asserted that all NHS organisations were similarly challenged and that attempts were being made to look across networks for alternative

	approaches e.g., online training. However, it was noted that different approaches for specialist clinical training were limited. Non-Executive Director, Louise Martin, queried how the Trust's target for complaints had been set. The Director of Nursing & Midwifery noted that it was most likely a nationally mandated target but undertook to seek clarification. **Action: To seek clarification on the setting of the Trust's complaints target.** The Trust Secretary noted that an updated Oversight Framework had been produced by NHS Improvement / England with an accompanying suite of metrics. This was being reviewed and would be assessed against the current Key Performance Indicators reported to the Board and its Committees. **Chair's Log: For relevant Committee's to review the new Oversight Framework KPIs relevant to their area of oversight.** The Chief Operating Officer outlined the Trust's progress for Covid-19 recovery performance. An area of pressure related to day case capacity and in response, the Trust was looking to increase ambulatory capacity. Recovery trajectories were being monitored weekly at the Executive Team and whilst the Trust was performing moderately, there were challenges. In terms of cancer performance, it was explained that the Trust was looking to work towards pre-Covid-19 cancer pathways by Quarter 3 2021/22. Work was progressing with partners across the region towards this aim and it was noted that positive progress was being seen in diagnostic performance. The Chair queried whether there were any other areas of challenge that would prevent the Trust reverting to pre-Covid-19 cancer pathways. The Chief Operating Officer noted that staffing challenges would continue to put challenges on recovery. The Director of Nursing & Midwifery added that increased pressure on obstetric theatres was also impacting theatre utilisation. **Chair's Log: Quality Committee to review progress towards and potential challenges to reverting to pre-Covid-19 cancer pathways.** A suite of metrics for tracking estates and facilities performance was in progress and was being overseen by the Finance, Performance & Business Development Committee. There was a challenge relating to a Planned Preventative Maintenance backlog that was being managed. The Board of Directors: • Received and noted the Quality & Operational Performance Report.
050b	**Starting Well Programme** Prof. Colin Morgan attended to outline the 'Starting Well' Programme – a key project being managed by Liverpool Health Partners. Prof. Colin Morgan explained that promoting a healthy lifestyle, mitigating and preventing adversity, promoting positive mental health and tackling chronic inflammatory and infection-related disorders were part of the Programme's mission to better the lives of women, children and young people across the region and beyond. A life course approach was key. It was asserted that good maternal health increased the chances for a safe delivery and good birth weight, both crucial factors for a positive start to life. Promoting a healthy lifestyle decreased the risk of adverse health factors for children as they grew up. It was noted that there were several themes underpinning the project, each with research and / or public health endeavours attached. The Chair asked how the Trust could best support the Programme. Prof. Colin Morgan explained that the Trust had an opportunity for leading on regional training pathways and for ensuring that research was 'mainstreamed' into day-to-day operations.

	Dr Susan Milner, Non-Executive Director, remarked that it was encouraging to see the joined-up approach as outlined in the Programme. Prof. Colin Morgan agreed that the Programme would help to connect clinicians to the public health agenda in a more meaningful way. The Medical Director noted that similar discussions were being held as part of the Integrated Care System (ICS) discussions where it had been noted that improvements were required in linking provider trusts to public health processes. The Chair noted that it would be important for the Trust to consider what population health outcomes it was trying to influence and to return to the topic at a future Board discussion. The Board of Directors: • Noted the presentation and thanked Prof. Colin Morgan for attending the meeting.
050c	Lessons Learnt from Mortality Q4 and Annual Report The Medical Director explained that the report had been collated from the quarterly adult, stillbirths & neonatal mortality reports provided to the Quality Committee. It was stated that there were processes in place for review in all three types of death at the Trust. Unlike other Trusts, every death in the Trust, including expected adult deaths, were reviewed. Attention was drawn to the fact that there had been two unexpected gynaecology deaths recorded during the year. One of these had occurred as part of the mutual aid offer between the Trust and Liverpool University Hospitals NHS Foundation Trust. Several key lessons had been learned and these would be applied to future work in relation to system working and recovery. It was reported that Neonatal mortality rate had seen an increase in the last year and an external review had been commissioned by the team to review processes. This has started and was expected to complete by Quarter 2 2022/23. The Trust Secretary noted that receipt of the report supported the Trust's CNST compliance. The Chair remarked that future reports could be strengthened by more clearly identifying the lessons learned at the front of the paper. The Board of Directors: • Noted the report and the assurance that there were adequate processes in place for learning from deaths. *Dr Timothy Neal joined the meeting*
050d	Annual Report of the Director of Infection Prevention and Control 2020/21 Dr Timothy Neal, Director of Infection Prevention and Control (DIPC) attended to present the report. Dr Timothy Neal reminded the Board of their responsibilities regarding infection prevention and control and continued to provide an outline of Trust performance during 2020/21. It was noted that the Covid-19 pandemic had resulted in a highly challenging period for infection, prevention and control, with policies and procedures needing to be developed, written and amended throughout the year. There had been three nosocomial infections during the reporting period and 85 patients in total cared for at the Trust whilst Covid-19 positive. Dr Timothy Neal thanked the Board for enhancing resources and support in response to the demands from the pandemic. One MRSA infection had been reported during the year and whilst the number of Gram-negative sepsis cases had reduced by 50% since 2016/17, general instances of congenital infections had plateaued and therefore required further work during 2021/22. Dr Timothy Neal continued to outline the Trust's processes for monitoring water safety explaining that the delivery of safe water was the responsibility of the estates function whilst the safe use of

	water was a clinical matter. A system for monitoring water flushing had been implemented in year and the average rate of compliance required improvement. The most recent monthly figure showed 92% demonstrating a positive trajectory. In relation to the monitoring of water, the Trust had a zero-non-compliance rate and no outlet had been found with Pseudomonas aeruginosa present. Rates of Pseudomonas were also monitored with babies throughout the year. Attention was drawn to the forward plan for 2021/22. Prof. Louise Kenny, Non-Executive Director, commended the IPC team for maintaining a low number of nosocomial infections despite a relatively high footfall throughout Trust premises. Dr Timothy Neal stated that front line staff and greeters at the Trust entrances should also be commended for their efforts. Non-Executive Director, Louise Kenny thanked Dr Timothy Neal for proactively engaging with water safety issues but noted an on-going concern with statutory compliance, particularly in relation to staffing availability and frequency of oversight arrangements. Dr Timothy Neal acknowledged that it was important for water safety groups to meet on a regular basis to provide oversight and intervention when necessary. It had been agreed to increase the frequency in 2021/22 to quarterly meetings from bi-annual. The Board of Directors received and approved the Annual Report of the Director of Infection Prevention and Control 2020/21 and approved its publication on the Trust website. *Dr Timothy Neal left the meeting* *Angela Winstanley joined the meeting.*
050e	**Maternity Staffing** The Director of Nursing & Midwifery noted that due to current levels of activity alongside some staffing challenges, the Maternity Service had been required to notify pregnant women on a few occasions in recent weeks that their admission to the Trust could be impacted. Whilst service diverts were a relatively common occurrence in the NHS, it was rare that the Trust had been in the position to divert maternity services. The Board considered the report that provided an update regarding the Trust's maternity staffing issues, explaining the context to current establishment numbers, the drivers behind the current challenges, and outlined the immediate and longer actions being put into place in response. The Chair remarked that the paper discussed actions for recruitment but provided less information regarding retention. The Director of Nursing & Midwifery noted that the Trust was looking at expanding training opportunities and that efforts were made to retain staff at all times. The Chief People Officer highlighted that it was important for staff to have clarity regarding their progression pathway and to offer opportunities relating to research. **Chair's Log: For the Putting People First Committee to explore the progression pathway and development opportunities for the midwifery role.** Non-Executive Director Louise Martin noted that maternity activity had reduced from previous years and queried whether this would have an impact on funding. The Director of Finance noted that the Trust was seeing a higher level of acuity and this was reflected in the tariff. A Birthrate Plus study was currently underway that would provide the Trust with intelligence regarding the appropriate level of staffing resource against activity and acuity. The Board of Directors: • Received the update.

050f	**Maternity Incentive Scheme (CNST) Position Paper** The Chief Operating Officer explained that the paper provided the final position in respect to compliance against each of the ten maternity incentive scheme safety actions. Should the Board provide their approval, the Chief Executive would progress with the Trust's submission on 15 July 2021. It was noted that the implementation of the Saving Babies Lives Care Bundle 2 (SBLCBV2) had presented a challenge to the Trust since the last update paper provided on 10th June 2021. The Trust guideline for the screening and management of Foetal Growth Restriction (FGR) had needed to be updated to meet the SBLCBV2 requirements. This had been disseminated to all clinical stakeholders, with ratification at the Family Health Divisional Board and at the Maternity Clinical Meeting. The updated guideline was included Appendix E. It demonstrated compliance with the requirements that all women, deemed at High Risk of FGR, as per SBL risk factors were managed in line with SBL pathways. Non-Executive Director Tony Okotie noted that there was a lesson to be learned regarding the clarity of assurances provided to the Board and its Committees. The Board of Directors • Noted the Trust's compliance position • Instructed the CEO to sign the Board Declaration Form. *Angela Winstanley left the meeting.*
050g	**Chair's Reports from the Quality Committee** The Board considered the Chair's Reports from the Quality Committee meetings held on 24 May 2021 and the 21 June 2021. Committee Chair and Non-Executive Director, Tony Okotie highlighted that the meeting held on 21st June 2021 had received a report on lessons learned from cerebral palsy incidents that was commended as a quality piece of work. It was agreed that the report would be circulated to all Board members for information. **Action: To circulate the cerebral palsy lesson learning report to all Board members.** The Board of Directors: • Received and noted the Chair's Reports from the Quality Committee meetings held on 24 May 2021 and the 21 June 2021 In summarising the Quality and Operational Performance section of the meeting, the Chair noted the importance of the Trust's growing role in public health and the strong assurances received regarding infection prevention and control.
	Board Thank you *David Dodgson, Financial Controller, Chris Gough, Financial Accountant, Stephen Chapman, Security Officer, Jodie Reardon, Health Care Assistant, Kathryn Sandison, Administrator (Testing & Surveillance Team), Kirsty McCartney, Switchboard and Andrew Weeks, Consultant Obstetrician joined the meeting.* The Director of Finance presented a Board Thank You to the finance team noting that it had been a challenging year with a high level of complexity and uncertainty. This has been overlayed by a need to 'joint-run' planning and year-end processes, the latter of which had been complicated by more onerous value for money requirements. The Chief Operating Officer presented a Board Thank You to staff who had been involved in the 'front of house' efforts in relation to the Trust's Covid-19 response. This included security, 'greeters' at the

	entrance, and switchboard. The first impression given by the Trust had been hugely important in 'setting the tone' for infection prevention and control measures and for on occasion, diffusing challenging situations. The Chief People Officer noted that the Trust had recently implemented 'Schwartz Rounds' as part of efforts to provide psychological care and support to staff. A Board Thank You was presented to Dr Andrew Weeks who had provided leadership to a wider team when establishing and overseeing the Schwartz Rounds. *David Dodgson, Financial Controller, Chris Gough, Financial Accountant, Stephen Chapman, Security Officer, Jodie Reardon, Health Care Assistant, Kathryn Sandison, Administrator (Testing & Surveillance Team) Kirsty McCartney, Switchboard and Dr Andrew Weeks, Consultant Obstetrician left the meeting.*
051a	**Workforce Performance Report** The Board received the Workforce Performance Report. The Chair noted that workforce issues had been discussed in the context of several other items during the meeting which highlighted the importance of people when driving quality improvement. It was noted that Information Governance training compliance had reached 95% to support the Trust's Data Security and Protection Toolkit submission. The Board of Directors: • Noted the Workforce Report.
051b	**Chair's Report from the Putting People First Committee** The Board considered the Chair's Report from the Putting People First Committee meeting held on 17 May 2021. Committee Chair and Non-Executive Director, Jo Moore noted that a junior doctor exception report had been noted by the Committee regarding missed breaks. The Committee requested further information on the issue and discussed how to better hear the voice of junior doctors at meetings, noting the importance of supporting this staffing group. An improved internal audit outcome for mandatory training was noted – now 'moderate' assurance, previously 'limited'. A discussion was held regarding the workforce and cultural aspects of the Ockenden Report and the Family Health Division was asked to continue to work against the issues identified. The challenges regarding maternity staffing were reviewed and a recommendation made to increase the relevant BAF risk score (discussed further in item 53b). Non-Executive Director Tony Okotie queried whether the issue relating to the junior doctor exception report was linked to the maternity staffing challenges. The Chief People Officer stated that this was currently unknown, but work was progressing to review the potential corollaries of maternity staff shortages on other staffing and service areas. The Board of Directors: • Received and noted the Chair's Reports from the Putting People First Committee meeting held on 17 May 2021.
052a	**Finance Performance Review Month 2 2021/22** The Director of Finance explained that since the Month 1 report, the Trust had secured an additional £4.9m of System funding through Cheshire and Merseyside Health and Care Partnership (C&M HCP). Along with other changes, this meant that the Trust now had a breakeven plan for the first six months of 2021/22 (H1). This was a challenging but achievable plan and would leave the Trust in a better position for the second half of the year (H2), which was yet to be agreed. It was noted that there remained some uncertainty regarding Elective Recovery Fund (ERF) calculations and as a result, estimates were being utilised when forecasting Trust financial performance. The importance of

	ensuring good progress was being made against the Trust's Cost Improvement Programme (CIP) was noted. Non-Executive Director, Louise Martin queried the nature of the 'estates rationalisation' CIP item. The Director of Finance explained that this related to the rationalisation of estate in locations other than the Crown Street site. The Board of Directors: • Noted and received the Month 2 2021/22 Finance Performance Review
052b	Chair's Reports from Finance, Performance and Business Development Committee The Board considered the Chair's Reports from the Finance, Performance & Business Development Committee meetings held on 24 May 2021 and the 21 June 2021. Committee member and Non-Executive Director, Ian Knight highlighted that the Committee would be closely monitoring progress against the Trust's CIP over the next few months. Clarity was provided on the status of the Community Diagnostic Hub. Whilst the Committee had approved the direction of travel and for a bid to be submitted, the detailed business case had not yet been received and would follow to a future meeting. Once the final business case had been received this would be reported through the usual governance route – Committee and then Board – for final consideration and, if deemed appropriate, approval. The Director of Finance noted that the Community Diagnostic Hub would support both the community and the Trust's services. Further clarity on the revenue implications was awaited. The Board of Directors: • Received and noted the Chair's Reports from the FPBD Committee meetings held on 24 May 2021 and 21 June 2021.
052c	Chair's Report from the Charitable Funds Committee The Board considered the Chair's Report from the Charitable Funds Committee meeting held on 14 June 2021. Non-Executive Director, Tony Okotie noted that an increase in fundraising activity had been noted by the Committee and that a benchmarking exercise for charity resources was in progress. The Chief People Officer noted that it was not unusual for NHS charities to compete for the same funding and therefore this presented both an opportunity for collaboration and a risk in terms of the availability of funding. The Board of Directors: • Received and noted the Chair's Report from the Charitable Funds Committee meeting held on 14 June 2021.
053a	Well-Led Governance Review – Action Plan The Chair noted that the fieldwork for the external Well-Led review undertaken by Grant Thornton was completed in April 2021 and a final report had been shared with the Trust and made available for Board members to view. The recommendations from the external review had been compiled into an action plan and combined with outstanding actions from the Trust's internal assessment. Grant Thornton had also undertaken a site visit to several clinical areas during April 2021 and several recommendations also flowed out of this process. These had also been captured into the overall action plan. It was agreed that Executive Leads, Operational Leads and Non-Executive Leads would review their aligned areas in detail with an aim of completing the majority of actions by the September 2021 Board. To support this process, it was also agreed that Committees would receive their aligned actions for additional oversight. Chair's Log: For Committees to receive aligned well-led actions for oversight and comment.

	The Board of Directors: • Received the well-led action plan
053b	**Board Assurance Framework – 2021/22 Update** The Board received the Board Assurance Framework (BAF) that had been updated to align the key risks with the Trust's recently agreed strategic aims and to improve the layout in response to comments received from Board members and the recent external well-led review. It was noted that the BAF items had been considered by the respective Committees and it was noted that there had been two points of discussion raised by the Putting People First Committee regarding items 1.1 'Failure to be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)' and 1.2 'Failure to recruit and retain key clinical staff'. In relation to item 1.1, a discussion was held as to whether the current wording would result in Trust having to score the risk disproportionately high, albeit there remained a desire to maintain the intended ambition. It was agreed that the July 2021 Putting People First Committee meeting would debate the wording and provide a recommendation to the Board. With regards to item 1.2, the acute challenges in relation to maternity staffing had been discussed and the recommendation was to score the item at '20' rather than '16' as had been initially suggested. The process for reviewing and discussing the BAF at the Board and its Committees was discussed. It was agreed that detailed discussions at Board would take place on a quarterly basis (with the BAF made available as a reference document to each meeting) and that the Committees would review their aligned BAF items at each meeting. The Board of Directors: • Agreed the layout and content of the BAF • Agreed the proposed scores, including the increase to '20' for item 1.2
054	**Governance and Performance Framework** The Board approved the Governance and Performance Framework.
055	**Review of risk impacts of items discussed** In summarising the meeting, the Chair highlighted the following key considerations: • The growing importance of the Trust's role in the wider public health agenda • Continuing pressures relating to maternity staffing • Continuing financial uncertainty
056	**Chair's Log** The following Chair's Logs were noted: • For relevant Committee's to review the new Oversight Framework KPIs relevant to their area of oversight. • Quality Committee to review progress towards and potential challenges to reverting to pre-Covid-19 cancer pathways. • For the Putting People First Committee to explore the progression pathway and development opportunities for the midwifery role. • For Committees to receive aligned well-led actions for oversight and comment.
057	**Any other business & Review of meeting** The Chief Executive noted that there was an NHS Big Tea Party on 5 July 2021 to celebrate the NHS and raise funds for NHS charities. The Board was encouraged to participate.

	The Chair noted that health inequalities and engagement with the public health agenda had been a theme throughout the meeting and queried how the Board could best engage with the issue, particularly defining the Trust's Corporate Social Responsibility and its role in 'place'. It was agreed that a small working group consisting of Non-Executive Directors, Executive Directors and Senior Managers could be set up to develop a scope for the scheme of work. **Action: To establish a Board working group to explore the Trust's role in 'place' and the Corporate Social Responsibility agenda.** **Review of meeting** The Chair suggested that the Board should write to the Gynaecology Division to commend them for their approach demonstrated through the Patient Story item.

Liverpool Women's NHS Foundation Trust

Action Log

Trust Board - Public
September 2021

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
1 July 2021	21/22/57	Any other business & Review of meeting	To establish a Board working group to explore the Trust's role in 'place' and the Corporate Social Responsibility agenda.	Chief People Officer	Sept 21	On track	Membership agreed. Date for first meeting being identified.
1 July 2021	21/22/50g	Chair's Reports from the Quality Committee	To circulate the cerebral palsy lesson learning report to all Board members.	Medical Director	Aug 21	Complete	Circulated on 2 August 2021
1 July 2021	21/22/50a	Quality & Operational Performance Report	To seek clarification on the setting of the Trust's complaints target.	Chief Nurse & Midwife	Sept 21	On track	Provisional discussions held to reduce 15 complaints /mth to 6-7 /mth following CNM discussion and approval. This would reflect an average over past 3 years that informs a refreshed target.
6 May 2021	21/22/27b	Chair's Report from Finance, Performance and Business Development Committee	For a future Board workshop training on revised performance reports.	Chief Operating Officer	Oct 21	On track	To be considered as part of the Board Development Programme
6 May 2021	21/22/26a	Staff Listening Events	For the Executive Team to consider attendance, staff engagement and meeting location of future Listening Events.	Chief People Officer	Sept 21	On track	Proposal to Exec Team meeting 1.9.21 & to PPF Sept meeting.

			Board oversight of delivery against the 30/60/90 day actions as agreed at the Listening Event held in April 2021.	Chief People Officer	Sept 21	On track	Update to go to Sept PPF and to Board via Chairs Report
6 May 2021	21/22/25a	Performance Report	To ensure good practice of communicating safe staffing levels and service needs to front line staff is modelled across all departments.	Chief Nurse & Midwife	Sept 21	Complete	Daily Trustwide staffing meeting held then reports into daily Huddle. Staffing levels captured in Power BI twice a day. Mat 104 bleep holder captures staffing 6 times a day. Matrons walk their areas where staffing challenges and current position is discussed.
1 April 2021	21/22/005	Patient Story	For the Executive Team to receive assurance regarding the progress of the outreach work in the Trust's wards by the Honeysuckle Team.	Chief Nurse & Midwife	July 21	Complete	Presentation received on the 14th July 2021
4 February 2021	20/21/270	Ockenden Report Update	For the MVP Chair to be invited to attend a future Board meeting to discuss the patient's perspective on maternity services.	Chief Nurse & Midwife	Sept 21	On track	Invite to be extended following agenda setting process for the September 2021 Board.

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Received	22.07.2021	Board to receive overview of Maternity Oversight Arrangements	Audit Committee	Sept 21	Closed	Update in CEO Report.

		Lead Officer: COO				
Delegated	01.07.2021	For Committees to receive aligned well-led actions for oversight and comment. Lead Officer: Committee Executive Leads	FPBD / QC / PPF	July 2021	Closed	
Delegated	01.07.2021	To explore the progression pathway and development opportunities for the midwifery role. Lead Officer: Chief Nurse and Midwife	Putting People First Committee	September 2021	Open	
Delegated	01.07.2021	To review progress towards and potential challenges to reverting to pre-Covid-19 cancer pathways. Lead Officer: Chief Operating Officer	Quality Committee	September 2021	Open	
Delegated	01.07.2021	For relevant Committee's to review the new Oversight Framework KPIs relevant to their area of oversight. Lead Officer: Committee Executive Leads	FPBD / QC / PPF	September 2021	Open	
Delegated	06.05.2021	For the FPBD Committee to receive a detailed variation review of the capital plan 2020/21. Lead Officer: Director of Finance	Finance, Performance & Business Development Committee	July 2021	Closed	Committee referred to the update included in M12 finance paper, see finance report appendix pack.
Delegated	06.05.2021	For the Quality Committee to review progress on ensuring that there was improved practice of lesson learning and evidence that proposed actions from the Lesson Learning report had been put into place. Lead Officer: Director of Nursing & Midwifery	Quality Committee	September 2021	Closed	Note action timeframe moved to August 2021 to allow for a focussed workshop approach by Quality Committee on 23rd August 2021.

Delegated	04.03.2021	For the quality impacts of robotic assisted surgery to be monitored by the Quality Committee within six months from implementation. Lead Officer: Chief Operating Officer	Quality Committee	September 2021	Open	Remitted to Quality Committee for action
Delegated	03.12.2020	Gynaecology staffing challenges 'deepdive' Lead Officer: Chief People Officer / Director of Nursing & Midwifery	Putting People First Committee	March 2021	Closed	Discussion held at March 2021 PPF meeting as part of the Gynaecology divisional reporting.

Liverpool Women's
NHS Foundation Trust

CEO Report

Trust Board
September 2021

Chief Executive Report

Executive Summary:

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

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

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

Section A - *Internal*

COVID-19: Recovery and Restoration

The following provides the headlines from work underway to progress the recovery and restoration of services:

- IPC Measures remain in place for staff and patients in all LWH services
- Command and Control in place with Executive Oversight
- June 21 - new NHS Oversight Framework published with key priorities for year ahead
- Maternity: Establishment of regional C&M Maternity Cell (Chaired by LWH), review and update of regional escalation policy
- Gynaecology : Elective services restored with a challenge of backlog (8.5k patients- 10.5k patients through pandemic), patients clinically reviewed and prioritised. National ask to eliminate long (>52 week waiters)
- June 2021 - a challenge with elective care due to increased sickness absence
- Inpatient elective activity overperforming year to date
- Day case activity behind plan with a focus on increasing throughput through Ambulatory day case a priority
- Oncology has seen a sustained increased in referrals (120%) vs 19/20 for past 6 months. National ask to get back to pre pandemic performance by Q3 2021/22

Section A - *Internal*

Maternity Executive Oversight

Following a request from the Audit Committee, the following provides an overview of work being undertaken during the weekly Maternity Oversight Meetings, established to support Family Health Division with the following challenges in Maternity:

- Staffing challenges due to sickness and vacancy
- Patient flow needing to be improved
- Support our leaders
- Supporting listening to staff issues/ concerns and feedback

Workforce
- 30+ new midwives to commence in September and October (agency support in interim)
- 3 new Consultant Obstetricians recruited to
- 1 new digital midwife post
- Transformation post commenced

Patient Flow
- Flow coordinator role
- Digital tools developed to predict activity and demand
- Review of estate

Wellbeing
- Wellbeing sessions established (currently under review)
- increased presence of OD team in Maternity
- Increased executive visibility and opportunities for staff to feedback

Monthly Transformation Board established to oversee strategic programmes
- Maternal Medicine Networks for C&M
- Perinatal Mental Health Wok programme
- CNST Year 4

Section A - *Internal*

Enforcement Undertakings

Following an investigation in November 2015, NHS Improvement acknowledged that the Trust had taken steps to address its financial challenges however they wished to determine what additional support they could offer the trust as it seeks to reduce its financial deficit and ensure long term sustainability. On 8 April 2016 NHS Improvement took action, under the license for providers, and the Trust entered into an enforcement undertaking which requires specific actions to be taken in order that the Trust can return to a sustainable position.

In a letter dated 18 August 2021, NHS Improvement / England confirmed that there are no longer reasonable grounds to suspect that the Trust is in breach of licence. Further detail on this outcome will be reported to a future Finance, Performance and Business Development Committee.

Cyber Metrics

NHSX CEO Matthew Gould circulated several key cyber metrics relating to the Trust along with some key leadership questions for the Board to consider. The metrics provide an indication of how well the Trust is performing in each of the 3 critical areas:

1) Backups (Trust performing higher than average for two metrics)

2) Unsupported systems (Trust performing in line with the average for two metrics)

3) Responding to High Severity Alerts (Trust performing higher than average for two metrics and in line with average for one metric)

- Also noted that standards were exceeded for the Data Security Protection Toolkit 2020/21.

The following high-level questions were identified:

- Does your organisation's High-Level Risk Register and/or Board Assurance Framework cover cyber security with a clear link to patient safety? How often does the board review your organisation's cyber security risk? How involved is your SIRO in agreeing cyber risk appetite?
- How can the Board or wider local system help address root causes of failure to progress the areas below or other cyber vulnerabilities?
- How does the Board get assurance that the DSPT self assessment is a true reflection of state of cyber security in the organisation?

The Trust Secretary and Chief Information Officer are meeting later in the month to discuss how best to provide a line of sight regarding cyber security risk to the Board.

Section A - *Internal*

Data Quality Kite Mark

In response to a recommendation from the External Well-Led Review, steps have been taken to implement a data quality kite mark into the performance report template.

The over-arching principles to assigning a DQKM will be:

1. DQKMs will be assigned on a KPI basis and reviewed according to agreed timescales, based on the type and source of data

2. The Information Team and KPI owner will together assess and assign the DQKM

3. The DQKM will be available against each KPI within every performance report

4. The DQKM score will be held in the KPI dictionary and the assessment for each will be available in Power BI for review

5. The DQKM will be scored 0 – 5 based on the domains below

6. Where a DQKM is assessed as 5 or below a plan to improve these will be included within the data health check section of the performance report and outline the impact of the gaps in data quality assurance

Source	Is the source of the data fully documented and understood?		The data source is well documented with documented procedures on how and when to extract the data
			The data source is poorly documented and could be inconsistently extracted
Timeliness	Is the data up to date and available in line with national guidelines?		The data is reflective of the most recently approved submission or publication
			Data is not available for the current month due to processing or validation issues
Complete	Is the indicator a reflection of the performance for all in scope activity?		The data includes all in scope activity according to the KPI definition. There are no known gaps in data.
			Data is not reflective of all Trust activity within scope of the KPI. Data processing issues result in unnecessary exclusions

Granularity	Is the data available at a granular level for divisions?		The data is aggregated using raw data and made available at the lowest appropriate hierarchical level
			Data is extracted at an aggregate level from the source system or is not easily accessible for continuous monitoring
Audit / Validation	Has data been validated or audited prior to submission		Data has been subject to validation or audit relevant to the size and complexity of the KPI. The process for this is documented.
			Data is not validated or audited to a level where assurance can be derived from this. There is no process for this to happen.

Monitoring

DQKMs will be visible on the performance report and the KPI dictionary will highlight the latest review date. The data health check section of the performance reports will provide more detail on when DQKMs become out of date based on assigned review dates in addition to the actions required to improve those that are non-compliant.

In addition to the regular reviews by the Information Team and KPI Owner at least 5 DQKMs will be peer reviewed per year for those that form part of the NHSI oversight framework.

Chief Executive Report

Section A - *Internal*

Change of Job Titles

To create consistency across the Executive Team and to align with the national direction of travel, the following amendments to job titles were agreed by the Nomination & Remuneration Committee in July 2021:

- Director of Nursing & Midwifery – now Chief Nurse & Midwife
- Director of Finance – now Chief Finance Officer

New Divisional Manager for Gynaecology – Matt Butcher

We are pleased to welcome Matt Butcher to LWH who has started his role as the new Divisional Manager for Gynaecology this week. This role was recently vacated by Dan Nash who moved into the new position of Deputy Chief Operating Officer.

Matt joins us from Manchester NHS Foundation Trust (Wythenshawe) having previously worked at the Countess of Chester NHS Foundation Trust. Matt has worked in various operational roles over the years including medical and surgical specialities.

Matt commented: “I’m really excited to have started this week at Liverpool Women’s and has been great to meet so many people so far. I look forward to meeting more new colleagues over the coming weeks and working closely with our Gynaecology division.”

Employee & Team of the Month

Congratulations to our June 2021 winners

- Employee of the Month – Jane Calveley, Acting Co-Ordinator Testing & Surveillance Team
- Team of the Month – NICU BCG Team

The Women’s View – Issue 06

Issue 06 of The Women's View is now available for download.

Section B - *Local*

Cheshire & Merseyside Acute & Specialist Trust Provider Collaborative

Linda Buckley has been appointed as the Managing Director for the Cheshire & Merseyside Acute & Specialist Trust Provider Collaborative (CMAST). Linda is currently Director of Strategic Transformation / Locality Director with NHSE/I, and most recently has also been providing assistance to the Hospital Cell.

Monthly C&M Cancer Alliance Board Report

This included a report on the impact of COVID-19 on cancer inequalities which is attached to this report as Appendix A.

Living Well Director Announcement

Liverpool Health Partners (LHP) has announced the appointment of its new Living Well Programme Director, Professor Matt Ashton. Prof Ashton will work alongside Programme Manager Elizabeth Collins to develop a strategy for the programme, to be launched before the end of 2021.

Dr Dawn Lawson, Chief Executive of LHP, said: “I am delighted to welcome Matt Ashton as our new Living Well Programme Director.”

Section C - *National*

Tripartite annual seasonal flu letter

Please see Appendix B for a letter received from the Department for Health and Social Care and Public Health England regarding the national influenza immunisation programme 2021 to 2022. Due to the length of the letter, this is an abridged version – the full version is available to Board members via Virtual Boardroom or Microsoft Teams.

The Trust's flu planning is well underway with a plan to commence in early October 2021. Confirmation is awaited as to whether a covid booster programme will run alongside the flu vaccination programme. Plans are in place to deliver as a combined model or as two individual programmes if required. The Trust has a good track record of high uptake of both the seasonal flu and the covid vaccine.

Maternity self-assessment tool

The National Maternity Self- Assessment Tool provides support to all trusts seeking to improve their maternity service rating from 'requires improvement' to 'good', as well as a supporting tool to support trusts looking to benchmark their services against national standards and best practice guidance. This was updated and relaunced on the 9 August 2021. Work will progress to utilise the tool with outcomes reported to a future Quality Committee.

Working together at scale: Guidance on Provider Collaboratives

In June 2021 NHS Improvement / England (NHSI/E) published the ICS Design Framework, providing a broad overview of the future role, functions and governance arrangements for the proposed NHS Integrated Care Boards (ICB), their relationships with ICS partners and anticipated timetable for their establishment.

During August they published 'Working together at scale: Guidance on Provider Collaboratives'. Provider collaboratives are a key component of system working, with opportunities to tackle unwarranted variation in standards of care and health inequalities, and to build resilience across systems to support staff more effectively. The guidance sets out the minimum expectations for how providers should work together to deliver benefits for patients, staff and communities. It offers principles to support local decision-making and suggest the functions and forms that systems and providers may wish to consider. This and other guidance will also be available on the dedicated workspace for ICS Guidance [https://future.nhs.uk/ICSGuidance/grouphome] on the FutureNHS Collaboration Platform.

Section C - *National*

Consultation Race Equality Strategy

The race equality strategy is aligned with the work undertaken on Model Employer , the NHS Long Term Plan and the People Plan 2020/21. The new strategy is expected to be published in October 2021.

As defined by the Equality Act 2010, race covers everyone, including colour, nationality, ethnic or national origins.

All NHS staff, including bank and agency staff, professional bodies and staff-side representatives are invited to contribute and share their thoughts via an online form by 12 September 2021.

In addition, NHSEI are planning a series of virtual listening events where Chatham House rules apply. If you would like to attend one of the listening sessions, or have any questions please contact Olivia.King6@nhs.net, Workforce Race Equality Standard strategy policy lead, NHSEI.

Appendix A

Cheshire & Merseyside Cancer Alliance

Cancer Inequalities in Cheshire and Merseyside: Covid-19 impact analysis

July 2021

Version 1.1

Contents

i. Introduction
ii. Impact on cancer referrals
iii. Impact on cancer treatments
iv. Next steps

Section I: Introduction

The Covid-19 pandemic has presented the NHS with perhaps its most challenging period in its 73 year history. Clinical and non-clinical healthcare professionals have gone to extraordinary lengths to maintain cancer services in Cheshire and Merseyside throughout the crisis.

This document explores available data to understand the impact of the pandemic on cancer services and specifically to see whether the impact has been felt disproportionally by different patient groups. It looks at the impact on suspected cancer referrals and treatments for new cancers, analysed by geography, tumour group, age, gender, deprivation and ethnicity. It does not yet include an analysis of the impact on the stage of disease at the point of diagnosis as cancer registration data for 2020/21 is not yet available[1].

The findings will inform the focus of ongoing work to fully recover cancer services in an equitable way.

[1] The latest published cancer staging data is for April – June 2019. Provisional ('rapid') registration data for 2020 is available but has not been used for analysis due to a very high proportion of records with unknown stage which makes analysis problematic, especially when split by characteristics such as deprivation, ethnicity, gender and age.

Section II: Impact on cancer referrals

At the start of the pandemic the number of people seeking advice from their GP regarding symptoms that could be cancer, and hence the number of urgent suspected cancer referrals to hospitals, fell dramatically. Referrals were lower than expected between April and September 2020 but have since recovered and are now approximately 20% greater in number each week than before the pandemic. This is positive because it means that the public's confidence to seek medical advice from their GP about potential signs of cancer has, in general, been restored. However, there are some differences at tumour level. Referrals for suspected urological cancers (primarily suspected prostate cancer), suspected lung cancers and suspected haematological (blood) cancers remain lower than expected.

Although referral rates have, in most cases, returned to at least pre-pandemic levels, the impact of the dramatic fall in referrals at the beginning of the crisis means that the total number of referrals received in the year from April 2020 to March 2021 was 8% lower than the previous 12 month period (i.e. the year before the pandemic). The biggest shortfalls are in the tumour groups that still have not returned to normal referral levels, i.e. urological, lung and haematology and, to a lesser degree, skin (although skin referrals are now 28% higher than pre-Covid-19). Whilst 8% is the average shortfall in referrals in 2020/21 compared to 2019/20 across Cheshire and Merseyside, there is variation by CCG. NHS Halton CCG has seen the greatest shortfall with 17% fewer referrals across the year.

During 2020/21, the reduction in referrals was significantly greater amongst people living in the most deprived areas, with a 9% reduction in Quintile 5 (most deprived) compared to a 5% reduction in Quintile 1 (least deprived). However, by April 2021 referrals from all five deprivation quintiles had returned to pre-pandemic levels.

The proportional impact on referrals during 2020/21 increased with age. Referrals for patients aged 0-49 reduced by 1%, compared to a 13% drop for those aged over 80. Referrals for men fell by 11% compared to 5% for women.

The impact of Covid-19 on referrals from different ethnic backgrounds is more difficult to assess due to small numbers in some ethnic communities. Suspected cancer referrals for people from ethnic diversity groups fell by 6% during 2020/21 compared to 2019/20, and by 8% for White British. Referrals for people of all ethnic backgrounds have now returned to at least pre-pandemic levels.

Section III: Impact on cancer treatments

In total, 14% fewer patients were treated for a new cancer in 2020/21 compared to 2019/20 in Cheshire and Merseyside. Beneath this headline figure there are differences between CCGs, tumour groups and routes to diagnosis, but no statistically significant variation by gender, deprivation, age or ethnicity.

In all cases, first treatment rates have now returned to pre-Covid-19 levels.

In Cheshire and Merseyside, 13,384 new patients were treated for cancer between April 2020 and March 2021. This was 14% fewer than were treated in the previous year. The reduction varies by CCG with NHS Liverpool CCG and NHS St Helens CCG experiencing the biggest reductions (19% and 22% respectively).

Treatments for prostate cancer reduced by the greatest proportion, dropping 30% in 2020/21 compared to 2019/20. Breast (-24%) and other urological cancers (excluding prostate) (-20%) saw the next largest proportional reductions.

The route to diagnosis had a big impact upon the number of first treatments delivered in 2020/21. For several months the cancer screening programmes were paused in Cheshire and Merseyside due to the pandemic, as they were across England, other than for high risk patients. Consequently, the number of new cancer patients diagnosed and referred for treatment by the screening programmes reduced by 52% compared with 2019/20. In comparison, the number of patients diagnosed and treated following an urgent suspected cancer referral from a GP fell by 9% (which is in line with the previously mentioned 8% drop in GP referrals).

There was a 14% reduction in the number of first treatments for patients in the most deprived neighbourhoods (Quintile 5) during 2020/21 compared to a 9% reduction in the least deprived (Quintile 1). The smallest reduction (5%) was in the second most deprived neighbourhoods (Quintile 4). The differences are not considered statistically significant primarily because the number of first treatments are relatively small compared to the number of referrals.

Three percentage points separate the reduction in treatments for males and females. This is not considered to be statistically significant.

With regard to the age of patients, the greatest reduction in first treatments during 2020/21 was seen in the 60 to 69 year olds (13%) and the smallest reduction was in the 50 to 59 year olds (6%). The variation is not considered statistically significant.

Approximately 4% fewer patients from ethnic diversity groups received first treatments in 2020/21 compared to 2019/21. Eleven percent fewer White British patients received first treatments in the same period. The difference is not considered statistically significant due to the small numbers in the non-White British group.

Section IV: Next steps

The Cancer Alliance will continue to monitor the ongoing impact of Covid-19 on cancer services and follow the mantra of 'building back fairer'[1] in acknowledgement that inequalities existed before the pandemic and these still need to be addressed.

In partnership with Macmillan, the Cancer Alliance has established a dedicated health inequalities and patient experience team. The initial focus of the team is to provide structure, learning and support to ensure that addressing health inequalities is core to all Alliance-sponsored activities. A key aim is to build a network of diverse community links, to consult with, in all stages of project development and delivery. For example, the health inequalities team is currently working with NHS E/I NW on a social media campaign co-designed with members of local Muslim communities, aimed at increasing participation in the bowel cancer screening programme.

[1] Build Back Fairer: The COVID-19 Marmot Review, Sir Michael Marmot et al, The Health Foundation, Dec 2020

Cheshire & Merseyside Cancer Alliance

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Cheshire and Merseyside Cancer Alliance is an NHS organisation that brings together NHS providers, commissioners, patients, cancer research institutions and voluntary & charitable sector partners to improve cancer outcomes for our local population.

Appendix B

Department of Health & Social Care | Public Health England | NHS

17 July 2021

Dear Colleague,

The national influenza immunisation programme 2021 to 2022

1. Last year saw the roll out of the biggest NHS influenza vaccination programme ever, with the aim of offering protection to as many eligible people as possible during the COVID-19 pandemic. We would like to extend a huge thank you to all those involved for your hard work during very challenging times which led to the best influenza vaccine uptake rates ever achieved.

2. As a result of non-pharmaceutical interventions in place for COVID-19 (such as mask-wearing, physical and social distancing, and restricted international travel) influenza activity levels were extremely low globally in 2020 to 2021. As a result, a lower level of population immunity against influenza is expected in 2021 to 2022. In the situation where social mixing and social contact return towards pre-pandemic norms, it is expected that winter 2021 to 2022 will be the first winter in the UK when seasonal influenza virus (and other respiratory viruses) will co-circulate alongside COVID-19. Seasonal influenza and COVID-19 viruses have the potential to add substantially to the winter pressures usually faced by the NHS, particularly if infection waves from both viruses coincide. The timing and magnitude of potential influenza and COVID-19 infection waves for winter 2021 to 2022 are currently unknown, but mathematical modelling indicates the 2021 to 2022 influenza season in the UK could be up to 50% larger than typically seen[1] and it is also possible that the 2021 to 2022 influenza season will begin earlier than usual. Influenza vaccination is therefore an important priority this coming autumn to reduce morbidity and mortality associated with influenza, and to reduce hospitalisations during a time when the NHS and social care may also be managing winter outbreaks of COVID-19.

Eligibility

3. The national influenza immunisation programme aims to provide direct protection to those who are at higher risk of influenza associated morbidity and mortality. Groups eligible for influenza vaccination are based on the advice of the Joint Committee on

[1] Modelling on influenza activity in the 2021/22 season. University of Warwick [unpublished]. Referenced in JCVI statement (30/06/2021) JCVI interim advice: potential COVID-19 booster vaccine programme winter 2021 to 2022

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Vaccination and Immunisation (JCVI) and include older people, pregnant women, and those with certain underlying medical conditions.

4. Since 2013, influenza vaccination has been offered to children in a phased roll-out to provide both individual protection to the children themselves and reduce transmission across all age groups to protect vulnerable members of the population.

5. The expanded influenza vaccination programme that we had last year will continue in 2021 to 2022 as part of our wider winter planning when we are likely to see both influenza and COVID-19 in circulation. This means that as a temporary measure the offer for 50 to 64 year olds will continue this year to protect this age group, as hospitalisation from COVID-19 also increases from the age of 50 years onwards.

6. As a temporary measure, the programme will also be extended this year to 4 additional cohorts in secondary school so that all those from years 7 to year 11 will be offered vaccination. Vaccinating children reduces transmission of influenza and JCVI have recommended that expanding into secondary schools would be cost-effective, particularly if COVID-19 is still circulating[2].

7. Therefore, those eligible for NHS influenza vaccination in 2021 to 2022 are:
    - all children aged 2 to 15 (but not 16 years or older) on 31 August 2021
    - those aged 6 months to under 50 years in clinical risk groups
    - pregnant women
    - those aged 50 years and over
    - those in long-stay residential care homes
    - carers
    - close contacts of immunocompromised individuals
    - frontline health and social care staff employed by:
        - a registered residential care or nursing home
        - registered domiciliary care provider
        - a voluntary managed hospice provider
        - Direct Payment (personal budgets) and/or Personal Health Budgets, such as Personal Assistants.

8. All frontline health and social care workers are expected to have influenza vaccination to protect those they care for.

9. The influenza chapter in ‘Immunisation against infectious disease’ (the ‘Green Book’), which is updated periodically, gives detailed descriptions of the groups outlined above and guidance for healthcare workers on administering the influenza vaccine.

[2] Draft minute of the meeting of the Influenza sub-committee of the Joint Committee on Vaccination and Immunisation held on 26 August 2020

Vaccines for the national immunisation programme

10. Influenza viruses change continuously and the World Health Organization (WHO) monitors the epidemiology of influenza viruses throughout the world, making recommendations about the strains to be included in vaccines, with recommendations now confirmed for 2021 to 2022[3].

11. Every year JCVI reviews the latest evidence on influenza vaccines and recommends the type of vaccine to be offered to patients[4]. Providers should ensure that they have ordered adequate supplies of the recommended vaccines for their different adult patient groups, as set out in 2 letters from NHS England and Improvement (NHSEI) on 3 February and on 1 April 2021[5].

12. In summary the recommended vaccines are:

- for those aged 65 years and over – the adjuvanted quadrivalent influenza vaccine (aQIV), with the cell-based quadrivalent influenza vaccine (QIVc) or the recombinant quadrivalent influenza vaccine (QIVr) offered if aQIV is unavailable
- for under-65s (including those at risk, pregnant women and 50 to 64 year old cohort) offer QIVc or QIVr, as an alternative if these are not available, the egg-grown quadrivalent influenza vaccine (QIVe) should be considered for use

13. Public Health England (PHE) procures vaccines for the children's programme and these can be ordered through Immform. The live attenuated influenza vaccine (LAIV) should be offered to eligible children aged 2 years and over, unless contraindicated. QIVc, which is now licensed for all children aged 2 years and above, will be available to order for children in at risk groups who are contraindicated to receive LAIV, and as an alternative offer for children aged 2 and over whose parents object to LAIV on the ground of its porcine gelatine content. Children in clinical risk groups aged 6 months to less than 2 years should be offered QIVe.

14. LAIV is offered to children as it is generally more effective in the programme than the injected vaccines. It is also easier to administer and considered better at reducing the spread of influenza to others, who may be vulnerable to the complications of influenza.

15. In order for providers to receive payment for administration and reimbursement of vaccine they will need to use the specific influenza vaccines recommended in the NHSEI letters referred to in paragraph 11.

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[3] WHO Consultation and Information Meeting on the Composition of Influenza Virus Vaccines for Use in the 2021 to 2022 Northern Hemisphere Influenza Season
[4] Joint Committee on Vaccination and Immunisation: Advice on influenza vaccines for 2021 to 2022
[5] NHS England: Achievements and developments during 2020 to 2021 flu season

16. Last season due to supply constraints the alternative offer for children whose parents/guardians objected to LAIV on grounds of porcine gelatine content was only able to be made from November onwards. This season no supply constraints are anticipated and the alternative offer should be made routinely from the start of the season where applicable.

Achieving high vaccine uptake levels

17. Last season saw the most successful programme ever. Despite the challenges due to the COVID-19 pandemic, at the end of February 2021 NHS services had vaccinated a record 80.9% of those aged 65 years and over in England. This is the highest uptake ever achieved for this group and exceeds the WHO uptake ambition of 75%. For frontline healthcare workers, 2 and 3 year olds, and at risk groups the highest ever recorded levels of influenza vaccine uptake were also achieved. [6].

18. All providers should have planned their influenza vaccine ordering to at least equal the high levels of uptake achieved in 2020 to 2021. The ambitions we are setting for the 2021 to 2022 programme are set out below. We want to build on the momentum of last year's achievements and the successful roll-out of the COVID-19 vaccination programme, achieving even higher uptake this year. You many need to order additional vaccine to support you in reaching these ambitions.

19. The high ambitions reflect the importance of protecting against flu this winter and should be regarded as a minimum level to achieve. The different ambitions across the cohorts reflect what is regarded as achievable so, for instance, for those aged 65 and over the high ambition reflects the already high uptake levels achieved last year whereas for school-aged children the large expansion into secondary school this year will be challenging in itself.

Table 1. Vaccine uptake ambitions in 2021 to 2022

Eligible groups	Uptake ambition
Routine programme for those at risk from influenza	
Aged 65 years and over	At least 85%
Aged under 65 'at risk', including pregnant women	At least 75% in all clinical risk groups
Aged 50 to 64 years	At least 75%
Children's programme	

[6] Seasonal flu vaccine uptake in GP patients: winter season 2020 to 2021
Seasonal flu vaccine uptake in children of school age: winter season, 2020 to 2021
Seasonal flu vaccine uptake in healthcare workers: winter season, 2020 to 2021

Preschool children aged 2 and 3 years old	At least 70% with most practices aiming to achieve higher.
School-aged children	At least 70% to be attained across all eligible school years.
Reducing levels of inequality	
All ages	No group or community should have a vaccine uptake that is more than 5% lower than the national average. See paragraph 18 for more details.
Health and social care workers	
Frontline health care workers	100% offer with an 85% ambition
Frontline social care workers	100% offer with an 85% ambition

* In addition to occupational health schemes, all frontline social care workers can access a free vaccination from their GP or local pharmacy through the complementary scheme.

20. In 2020 to 2021, published monthly data included a breakdown by ethnic group for the first time, and this was included in the 2020 to 2021 annual report[7] and this will continue in 2021 to 2022. Other inequalities work led by PHE will continue to monitor and enhance the tools available and will include data on Index of Multiple Deprivation (IMD) which can be used to provide the best measure of relative deprivation as a snapshot in time (see Appendix I). We need to ensure those who are living in the most deprived areas, from ethnic minority and other underserved communities, have equitable uptake compared to the population as a whole. It will therefore require high quality, dedicated and interculturally competent engagement with local communities, employers, faith and advocacy groups. Providers are expected to ensure they have robust plans in place for tackling health inequalities for all underserved groups to ensure equality of access.

21. GP practices and school-based providers must actively invite 100% of eligible individuals (for example, by letter, email, phone call, text) and ensure uptake is as high as possible. The benefits of influenza vaccination among all eligible groups should be communicated and vaccination made as accessible as possible. Community pharmacy service providers do not have a fixed patient list from which to undertake call and recall activities. However, they should proactively offer influenza vaccination to any patient they identify as being eligible to receive it should the patient present in the pharmacy for any reason.

22. NHSEI will be recommissioning of a National Call and Recall service for the 2021 to 2022 season. This national call and recall service will supplement rather than replace

[7] Seasonal influenza vaccine uptake in GP patients: winter season 2020 to 2021 (24/06/2021) https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-winter-2020-to-2021

local contractual call and recall mechanisms which must still continue as contracts dictate.

Frontline health and social care workers

23. All frontline health and social care workers should receive a vaccination this season. This should be provided by their employer, in order to meet their responsibility to protect their staff and patients and ensure the overall safe running of services. Employers should commission a service which makes access easy to the vaccine for all frontline staff, encourage staff to get vaccinated, and monitor the delivery of their programmes.

24. For healthcare workers providers should use the current definition as set out in chapter 12 of the Green Book.

25. As in previous years, NHS Trusts should complete a self-assessment against a best practice checklist which has been developed based on 5 key components of developing an effective flu vaccination programme. The completed checklist should be published in public board papers at the start of the flu season. (See Appendix H.)

26. Where employee led occupational health services are not in place NHS England and Improvement (NHSEI) will continue to support vaccination of social care and hospice workers employed by registered residential or domiciliary care providers as well as those employed through Direct Payment and/or Personal Health Budgets to deliver domiciliary care to patients and service users. Vaccination will be available through community pharmacy or their registered general practice. This scheme is intended to complement, not replace, any established occupational health schemes that employers have in place to offer flu vaccination to their workforce.

27. Since last year, the Community Pharmacy Seasonal Influenza Advanced Service Framework enables community pharmacies to vaccinate both residential care or nursing home residents **and** staff in the home setting in a single visit.

28. Good practice guidance material can be found at Increasing Health and Social Care Worker Flu Vaccinations: Five Components and marketing resources will be available to download and order from the PHE Campaign Resource Centre.

Influenza and COVID-19 vaccination

29. At present, the Green Book chapter on the COVID-19 vaccine states that administration of the COVID-19 vaccine should ideally be scheduled with an interval of at least 7 days to another vaccination (including influenza) in order to avoid incorrect attribution of potential adverse events[8]. Booster vaccines for COVID-19 are currently under

[8] COVID-19: the Green Book, chapter 14a

consideration, with trials underway to ascertain whether co-administration of COVID-19 and influenza vaccines will be permissible, subject to the advice of JCVI. Early evidence on the concomitant administration of COVID-19 and influenza vaccines used in the UK, supports the delivery of both vaccines at the same time where appropriate[9].

30. Planning for influenza vaccination should continue as usual for this autumn, with further advice issued should co-administration with COVID-19 vaccination be recommended so that where appropriate both vaccines could be given at the same time.

Timing

31. Vaccination should be given in sufficient time to ensure patients are protected before influenza starts circulating. If an eligible patient presents late for vaccination it is generally appropriate to still offer it. This is particularly important if it is a late influenza season or when newly at risk patients present, such as pregnant women who may not have been pregnant at the beginning of the vaccination period. The decision to vaccinate should take into account the fact that the immune response to vaccination takes about 2 weeks to fully develop.

32. Last year the school age immunisation national service specification had a requirement that, to provide early protection, the provider would complete the influenza vaccination as early as possible after the influenza vaccine became available and at the latest by 15 December for all eligible children. In order to facilitate the service expansion alongside the continuation and catch up of the routine school age immunisation programmes this season the completion date for school age influenza vaccinations has been extended until the end of January 2022 although providers are encouraged to complete as soon as possible.

33. Parents of any child at risk from influenza because of an underlying medical condition can choose to receive influenza vaccination in general practice, especially if the parent does not want their child to have to wait for the school vaccination session (which may be one of the later sessions). GP practices should invite these children for vaccination, making it clear that parents have the option to have their child vaccinated in general practice.

List of appendices

34. Detailed planning information is set out in the following appendices:

[9] National Immunisation Schedule Evaluation Consortium (NISEC) data [unpublished], referenced in the JCVI Interim Statement regarding a potential COVID-19 Booster vaccine programme for winter 2021 to 2022 (30/06/2021)

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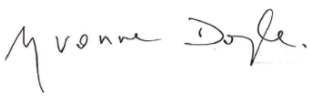
Conclusion

35. We would like to take this opportunity to thank you all for your hard work in delivering the influenza immunisation programme. We have some of the best influenza vaccine uptake rates in Europe and we achieved record levels in 2020 to 2021. This winter, it remains a key intervention to reduce pressure on the NHS and social care.

36. This Annual Influenza Letter has the support of the Chief Pharmaceutical Officer, the NHS Chief Nursing Officer for England and the Public Health England Chief Nurse.

Yours sincerely,



Prof Chris Whitty
Chief Medical Officer for England

Prof Yvonne Doyle
Public Health England Medical Director & Director for Health Protection

Prof Stephen Powis
NHS England & NHS Improvement, National Medical Director

Appendix G: Pregnant women

Rationale

1. All pregnant women are recommended to receive the inactivated influenza vaccine irrespective of their stage of pregnancy.

2. There is good evidence that pregnant women are at increased risk from complications if they contract influenza[14,15]. In addition, there is evidence that having influenza during pregnancy may be associated with premature birth and smaller birth size and weight[16, 17] and that influenza vaccination may reduce the likelihood of prematurity and smaller infant size at birth associated with an influenza infection during pregnancy[18]. Furthermore, a number of studies show that influenza vaccination during pregnancy provides protection against influenza in infants in the first few months of life[19, 20,21,22,23].

3. A review of studies on the safety of influenza vaccine in pregnancy concluded that inactivated influenza vaccine can be safely and effectively administered during any trimester of pregnancy and that no study to date has demonstrated an increased risk of either maternal complications or adverse fetal outcomes associated with inactivated influenza vaccine.[24]

When to offer the vaccine to pregnant women

14 Neuzil KM, and others. (1998) Impact of influenza on acute cardiopulmonary hospitalizations in pregnant women. American Journal of Epidemiology. 148:1094-102
15 Pebody R and others. (2010) Pandemic influenza A (H1N1) 2009 and mortality in the United Kingdom: risk factors for death, April 2009 to March 2010. Eurosurveillance 15(20): 19571.
16 Pierce M, and others (2011) Perinatal outcomes after maternal 2009/H1N1 infection: national cohort study. BMJ. 342:d3214.
17 McNeil SA, and others. (2011) Effect of respiratory hospitalization during pregnancy on infant outcomes. American Journal of Obstetrics and Gynecology. 204: (6 Suppl 1) S54-7.
18 Omer SB, and others (2011) Maternal influenza immunization and reduced likelihood of prematurity and small for gestational age births: a retrospective cohort study. PLoS Medicine. 8: (5) e1000441.
19 Benowitz I, and others (2010) Influenza vaccine given to pregnant women reduces hospitalization due to influenza in their infants. Clinical Infectious Diseases. 51: 1355-61.
20 Eick AA, and others. (2010) Maternal influenza vaccination and effect on influenza virus infection in young infants. Archives of Pediatrics and Adolescent Medicine. 165: 104-11.
21 Zaman K, and others. (2008) Effectiveness of maternal influenza immunisation in mothers and infants. New England Journal of Medicine. 359: 1555-64.
22 Poehling KA, and others. (2011) Impact of maternal immunization on influenza hospitalizations in infants. American Journal of Obstetrics and Gynecology. 204:(6 Suppl 1) S141-8.
23 Dabrera G, and others. (2014) Effectiveness of seasonal influenza vaccination during pregnancy in preventing influenza infection in infants, England, 2013 to 2014. Eurosurveillance. Nov 13;19.
24 Tamma PD, and others. (2009) Safety of influenza vaccination during pregnancy. American Journal of Obstetrics and Gynecology. 201(6): 547-52.

4. The ideal time for influenza vaccination is before influenza starts circulating. However, even after influenza is in circulation vaccination should continue to be offered to those at risk and newly pregnant women. Clinicians should apply clinical judgement to assess the needs of an individual patient, taking into account the level of flu-like illness in their community and the fact that the immune response following influenza vaccination takes about 2 weeks to develop fully.

Data review and data recording

5. Uptake of vaccine by pregnant women, along with other groups, will be monitored. GPs will need to check their patient database throughout the duration of the influenza vaccination programme in order to identify women who become pregnant during the season. GPs should also review their records of pregnant women before the start of the immunisation programme to ensure that women who are no longer pregnant are not called for vaccination (unless they are in other clinical risk groups) and so that they can measure the uptake of influenza vaccine by pregnant women accurately.

Maternity services

6. All pregnant women are able to access influenza immunisation from their GP practice or a community pharmacy. In addition, Maternity Service Providers may also vaccinate pregnant women via a national Service Specification as commissioned by NHSEI.

7. Midwives need to be able to explain the benefits of influenza vaccination to pregnant women and offer them the vaccine, or signpost women back to their GP or community pharmacy if they are unable to offer the vaccine.

8. Where maternity providers or pharmacies provide the influenza vaccine, it is important that the patient's GP practice is informed in a timely manner (within 48 hours) so their records can be updated accordingly, and included in vaccine uptake data collections. Maternity providers should ensure they inform GPs when a woman is pregnant or no longer pregnant.

Liverpool Women's NHS Foundation Trust

Trust Board

Operational Performance Summary
September 2021

Trust Board Performance Report

Executive Director: Gary Price, Chief Operating Officer
Report produced by Digital Services

Liverpool Women's NHS Foundation Trust

This report has been produced to provide an exception position against the Trust's key performance standards. It outlines the measures being undertaken to improve performance where required. The paper includes information on key workforce metrics and access targets.

Delivering high quality, timely and safe care is the key priority for the organisation. This report provides an overview of the Trust's performance against the key standards. It highlights those areas where the targets have not been met in month and subsequent actions taken to improve this position.

How to interpret the report:

Green: KPI **meeting** target
Red: KPI is **failing** against the target
Purple: KPI is **outside** of control limits
Black: KPI does not have a target set

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

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

Data Quality Kitemark

The DQ Kitemark is included to identify the confidence levels around data quality. Each metric is measured using five domains: Source, Timeliness, Completeness, Granularity, Validation. Where KPIs do not meet the requirements for each of the domains an action plan will be included within the data health check section for detail around where improvements are required.

The Kitemark is a score out of 5 with compliance against each domain scoring 1.

Digital.Information Data Health Check

All denominators have been reviewed and there has been no unexpected variation in these. There are no KPIs where known data issues have affected performance.

Exec Lead	KPI	Month	Target	KPI Meeting Target	Denominator Check
Chief Operating Officer	18 Week RTT: Admitted Completed Pathways	June 2021	>= 90%	No	As Expected
Chief Operating Officer	18 Week RTT: Incomplete Pathway > 52 Weeks	June 2021	0	Control Limit Breached	N/A
Chief Operating Officer	18 Week RTT: Incomplete Pathways	June 2021	>= 92%	No	As Expected
Chief Operating Officer	18 Week RTT: Non-Admitted Completed Pathways	June 2021	>= 95%	No	As Expected
Chief Operating Officer	A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	July 2021	>= 95%	Yes	As Expected
Chief Operating Officer	Advice and Guidance	July 2021			N/A
Chief Operating Officer	All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	June 2021	>=85%	No	As Expected
Medical Director	Caesarean Section - Emergency Rate	July 2021	<=16.6%	Control Limit Breached	As Expected
Chief Operating Officer	Cancer: 104 Day Breaches	June 2021	0	No	N/A
Chief Operating Officer	Cancer: 2 Week Wait	June 2021	>= 93%	Yes	As Expected
Chief Operating Officer	Cancer: 28 Day Faster Diagnosis	June 2021	>= 75%	No	As Expected
Chief Operating Officer	Cancer: 31 Days for Subsequent Treatment (Surgery)	June 2021	>=94%	No	As Expected
Chief Operating Officer	Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	June 2021	>=96%	No	As Expected
Chief Operating Officer	Cancer: 62 Day RTT Consultant upgrade (Non-urgent suspected cancer referrals)	June 2021	>= 85%	No	As Expected
Chief Operating Officer	Cancer: 62 Day Screening Referrals (Numbers)	June 2021	< 5	Yes	N/A
Chief Operating Officer	Cancer: 62 Day Screening Referrals (Percentage)	June 2021	>=90%	Yes	As Expected
Director of Nursing & Midwifery	Complaints: Number Received	July 2021	<= 15	Yes	N/A
Chief Operating Officer	Diagnostic Activity Levels	July 2021			N/A
Chief Operating Officer	Diagnostic Tests: 6 Week Wait	July 2021	>= 99%	No	As Expected
Chief Operating Officer	Elective activity levels - Daycase	July 2021			N/A
Chief Operating Officer	Elective activity levels - Inpatient	July 2021			N/A
Chief Operating Officer	Elective activity levels - Outpatient Follow Up	July 2021			N/A
Chief Operating Officer	Elective activity levels - Outpatient New	July 2021			N/A
Director of Nursing & Midwifery	Emergency Care: % of 0 day LOS admission	July 2021			As Expected
Director of Finance	Financial Sustainability Risk Rating: Overall Score	July 2021	3	Yes	N/A
Director of Nursing & Midwifery	Friends & Family Test: A&E % positive	July 2021	95%	No	As Expected
Director of Nursing & Midwifery	Friends & Family Test: In-patient/Daycase % positive	July 2021	0.95	Control Limit Breached	As Expected
Director of Nursing & Midwifery	Friends & Family Test: Maternity % positive	July 2021	95%	No	As Expected
Medical Director	Infection Control: Clostridium Difficile	July 2021	1	Yes	N/A
Medical Director	Infection Control: MRSA	July 2021	0	Yes	N/A

Digital.Information Data Health Check

All denominators have been reviewed and there has been no unexpected variation in these. There are no KPIs where known data issues have affected performance.

Exec Lead	KPI	Month	Target	KPI Meeting Target	Denominator Check
Medical Director	Intensive Care Transfers Out (Rolling 12 Months)	July 2021	8 per annum	No	N/A
Director of Workforce	Mandatory Training Compliance	July 2021	>= 95%	Control Limit Breached	N/A
Medical Director	Neonatal Deaths per 1000 live Births	July 2021			N/A
Medical Director	Never Events	July 2021	0	Yes	N/A
Director of Nursing & Midwifery	NHSE / NHSI Safety Alerts Outstanding	July 2021	0	Yes	N/A
Medical Director	Number of deaths - Gynae	July 2021			N/A
Chief Operating Officer	Overall size of Elective Waiting List	June 2021			N/A
Chief Operating Officer	Proportion of patient activity with an ethnicity code	July 2021			As Expected
Director of Workforce	Proportion of Temporary Staff	July 2021	TBA		N/A
Director of Nursing & Midwifery	Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	July 2021	1	Yes	As Expected
Director of Nursing & Midwifery	Serious Untoward Incidents: Number of SUI's with actions outstanding	July 2021	0	Yes	N/A
Director of Nursing & Midwifery	Serious Untoward Incindents: New (Rolling per year)	July 2021	24 /year	Yes	N/A
Director of Nursing & Midwifery	Serious Untoward Incindents: Open	July 2021	<5	No	N/A
Director of Workforce	Sickness Absence Rate	July 2021	<= 4.5%	No	As Expected
Director of Workforce	Turnover Rate	July 2021	<= 13%	Control Limit Breached	N/A
Medical Director	Venous Thromboembolism (VTE)	July 2021	>= 95%	Control Limit Breached	As Expected

WE SEE Summary

WE SEE Positive Developments

Workforce

- Overall Trust clinical mandatory training improved from 80% in M3 to 82% in M4

Efficient

- As at Month 4, the Trust remained in surplus Year to Date (YTD) despite generating a small deficit (£0.1m) in month

Safety

- The Trust's IPC performance remains strong
- Improved oversight of the Trust's statutory requirements regarding Estates and Facilities now in place at the FPBD Committee.

Effective

- We continue to see good performance in an historical context for our 31 day DTT and sustained performance against 2WW.

Experience

- Number of complaints received is below target
- Whilst below target, Friends and Family Test results show signs of improvement

WE SEE Areas of Challenge

Workforce

- Mandatory training compliance fell from 87% to 80% from June 2021 to July 2021
- The Trust's sickness rate increased marginally between June 2021 and July 2021

Efficient

- Shortfalls on the Cost Improvement Programme (CIP) and Elective Recovery Fund (ERF), as well as pay overspends, mean that delivery against plan remains reliant on non-recurrent items

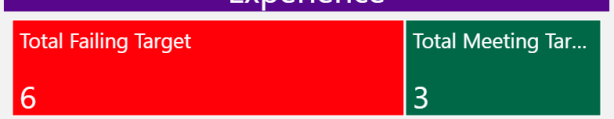
Safety

- The Trust has been challenged in relation to maternity staffing levels – resulting in an on-going impact on Continuity of Carer performance.

Effective

- We continue to face challenges as expected within our Elective Care Waiting Time Standard KPI's in response to Covid-19
- Cancer wait times remain challenging with sustained high levels of referrals

Experience



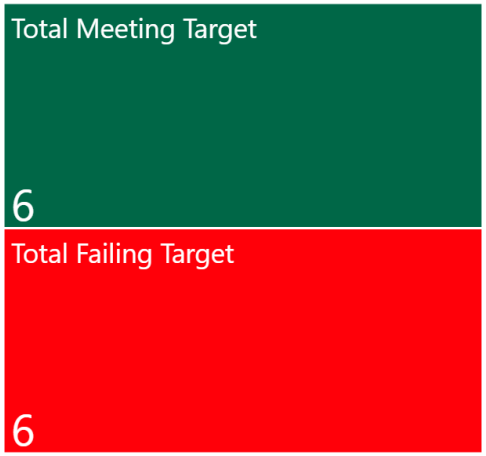
- Friends and Family Test performance remains below target across all relevant KPIs

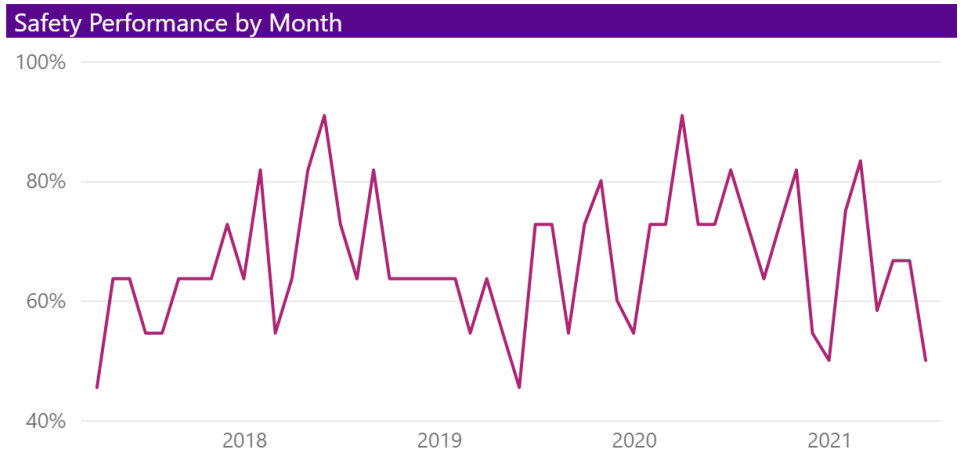
Liverpool Women's
NHS Foundation Trust

Operational & Quality Performance

Trust Board
September 2021

To deliver **Safe** services



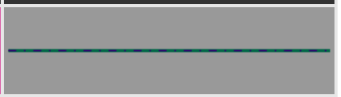
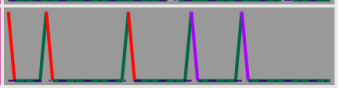
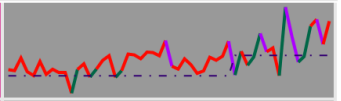
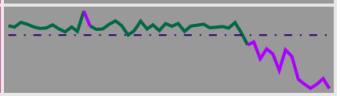


Continuity of Carer targets have changed with Trust's required to have a plan for the majority of women to be under this pathway of care by March 2022 and for this to be achieved by March 2023. The Trust has a plan in place and CoC targets will be updated accordingly for future reports.

It is encouraging to continue to see positive results in relation to the Trust's infection, prevention and control (IPC) regime.

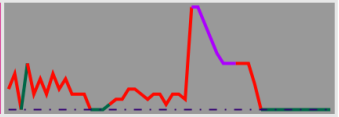
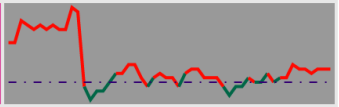
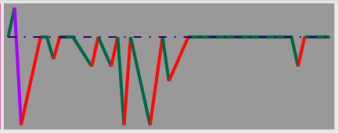
The Finance, Performance & Business Development Committee have started to receive statutory key performance indicators relating to Estates and Facilities. Any areas of concern will be escalated to the Board via the Chair's Report. A summary of performance can be found in this section of the report.

To deliver Safe services

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Sparklines
Director of Nursing & Midwifery	NHSE / NHSI Safety Alerts Outstanding	July 2021	0	0	0			
Medical Director	Infection Control: Clostridium Difficile	July 2021	0	0	0			
	Infection Control: MRSA	July 2021	0	0	0			
	Never Events	July 2021	0	0	0		5	
Medical Director	Caesarean Section - Emergency Rate	July 2021	20.66%	+4.06%	16.60%	692	5	
	Venous Thromboembolism (VTE)	July 2021	84.58%	-10.42%	95.00%	1167		

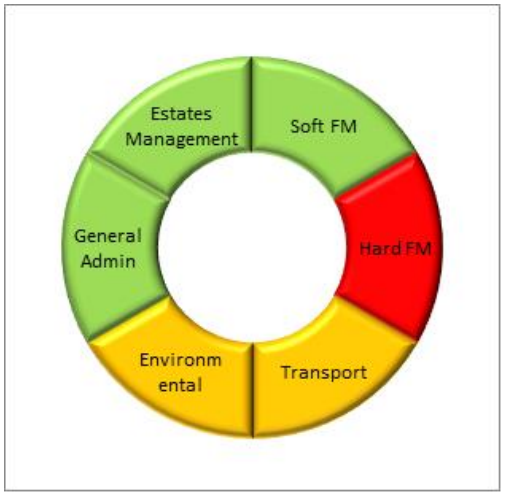
KPI	What is the reason for failure against this target?	How is this being fixed?	When will target be achieved?	Why this timeframe?	Patient Harm?	Mitigating Actions?
Caesarean Section - Emergency Rate						

To deliver Safe services - Serious Untoward Incidents

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Sparklines
Director of Nursing & Midwifery	Serious Untoward Incidents: Number of SUI's with actions outstanding	July 2021	0	0	0			
	Serious Untoward Incindents: Open	July 2021	8	+3	5			
Director of Nursing & Midwifery	Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	June 2021	100.00%	+0.00%	100.00%	1		

KPI	What is the reason for failure against this target?	How is this being fixed?	When will target be achieved?	Why this timeframe?	Patient Harm?	Mitigating Actions?
Serious Untoward Incindents: Open	There were a number of serious incidents declared within maternity (not linked) and extensions to 2 serious incident investigations within gynaecology.	There have been a number of immediate actions taken following declaration of the serious incidents, detailed within the 72 hour reviews.	Immediate actions have been taken and implemented. Longer term actions will be detailed within the final reports and associated action plans.	As detailed within the 72 hour report - immediate actions taken. Longer term actions following completion of the SI report will be implemented within the agreed timescales as signed off by the relevant SI panel chair.	Yes	These investigations have been progressed. Since this data, a further maternity incident has been submitted, and the 2 gynaecology investigations have been submitted. There were also no new serious incidents in July.

To deliver Safe Services – Estates and Facilities



Hard FM

Electrical infrastructure upgrade: 96% completed – Biomedical Science Monitoring installation, nearly completed, once complete function testing to be undertaken during the night.

Water safety PPM's:
July = 93% completion rate.
Very good improvement in the figures this month which was as a result of some overtime working by the team.

Other Hard FM PPM's:

Work is continuing to record PPM's on backtraq, with significant progress made during this reporting period – it is pleasing to report that all 39 AHU's have been serviced by the in house team. Faults reported on two needing parts which have been ordered.

To continually improve and maintain compliance in water safety and other PPM's it is becoming increasingly evident that additional resources are required. A detailed report with recommendations will be available by the end of September.

To deliver Safe Services – Serious Incidents

Overview

There were no new SI's reported in July making a total of 5 SI's reported for the year to date for 2021/22. Compared to 2020/21 period the Trust has had a slight decrease on the previous 4 years of reporting as can be seen below with the exception of 2018/19.

Year Comparison

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

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

To deliver Safe Services – Serious Incidents

HSIB Cases Reported and NHSR Early Notification Scheme

During July 2021 there has been 1 case which met the HSIB criteria and have been reported to HSIB and NHSR as per procedure. The main theme of the incidents reported is in relation to; cooled babies, there have been small numbers of neonatal death and Hypoxic Ischaemic Encephalopathy (HIE):

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

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

Duty of Candour

All Serious Incidents which have been declared to date, have had full duty of candour completed in line with Trust policy. The results of the 20-21 audit of duty of candour demonstrated 100 % in respect of all Serious Incident Investigations.

Overdue Actions for reported SIs

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

To deliver Safe services - Safer Staffing

Gynaecology: July Fill Rate

Fill–rate – The fill rate for Registered Nurses in July for days is 65.16%, the fill rate does not include the Band 4 AP who will be on duty supporting the Registered Nurses on the Night shift there were 3 Registered Nurses and 2 HCA on all shifts, the establishment is under review
Attendance/ Absence – 8.25% sickness, 87% LTS, 13% STS, 1.61WTE Maternity leave
Vacancies – 3 RN vacancies
Red Flags – none raised.
Bed Occupancy – 43.69% a review of the bed numbers recorded on Meditech is being undertaken

Neonates: July Fill Rate

Fill-rate – Throughout July the NICU has continued to maintain safe staffing and fill rates are reflective of acuity and occupancy. However, this has required increased use of Bank and the flexibility of staff swapping and changing shifts.
Attendance/Absence – July sickness ran at 8.03%, this was up on June by 1.97%. Short term sickness sits at 40% with long term sickness making up 60%. Covid sickness and covid special leave made up approximately 3.2% this is up from 1.5% in the previous month. While we have had some positive staff the main covid issue has been around contacts and children who have been contacts. There are 13 FTE on maternity leave and turnover sits at 10% well below the Trust target.
Vacancies – Band 6 post have been recruited to internally and band 5 post which have been recruited previously will commence in September 21
Red Flags – No red Flags
Bed Occupancy – Unit occupancy has run at 74.5% just below the expected 80%. IC ran at 86.6%, HD 54%, LD 71.9%, and TC at 36%, IC occupancy was higher than expected this month.

Maternity: July Fill Rate

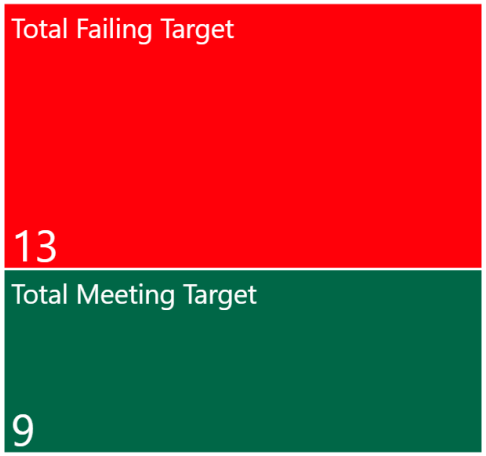
Fill-rate – Maternity continues to experience staffing challenges, with reasons including current vacancy position, maternity leave, turnover and Covid-19 related absence. Maternity reviews its safer staffing levels daily by reviewing activity and acuity and deploys staff to the areas of highest acuity area to maintain safety.
Attendance/Absence – July total sickness within maternity is recorded at 12.28% which is a 2.15% increase from the previous month. Covid-19 related sickness is 3.56%, Covid-19 special leave at 1.94% and maternity sickness is reported at 7.52%, which is a 0.34% increase from the previous month of 9.26%. 66% of sickness is long term sickness. The cumulative total sickness for the year is 10.36% with 12.01WTE staff currently on maternity leave.
Vacancies – There has been 1 Band 6 WTE midwife commence in post in July 2021. A Further 28.97 WTE Band 5 midwives and 4.84 WTE Band 6 midwives are undergoing the recruitment process with a planned commencement date of September/ October 2021. Further recruitment is in progress with interviews scheduled for 18.08.21. 3 external midwives have been recruited as bank midwives via the rolling bank recruitment advert.
Red flags – 30 red flags were reported in July. 10 related to delays in induction of labour, 7 related to staffing, 8 delays in transfer/ delay between admission and triage, 2 for acuity, 2 omitted medicines and 1 inability to accept an intrauterine transfer.
Bed Occupancy – The maternity ward has been required to increase its bed availability by 4 beds to accommodate the clinical antenatal and postnatal requirements. The bed occupancy report will be updated to reflect the changes. Jeffcoate postnatal ward remains closed due to reduced staff.

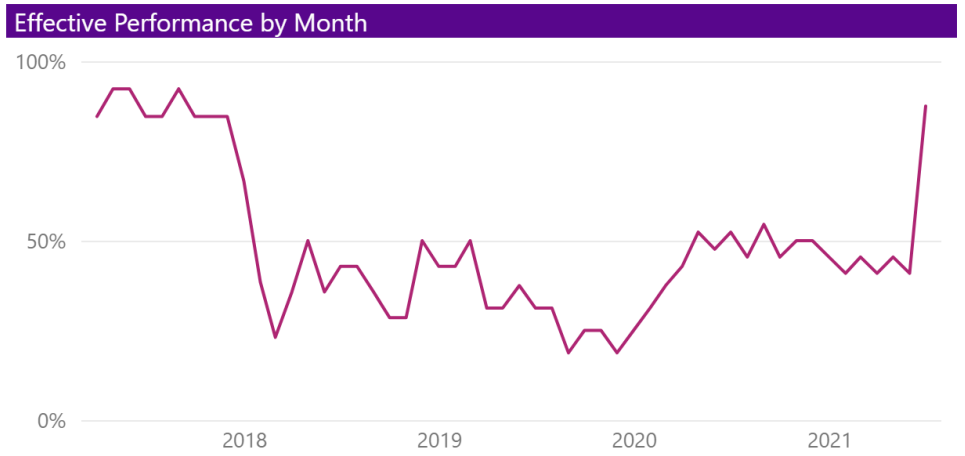
To deliver Safe services - Safer Staffing

July 2021

WARD	Fill Rate Day%	Fill Rate Day %	Fill Rate Night %	Fill Rate Night %
	RN/RM	Care staff	RN/RM	Care staff
Gynae Ward	65.16%	106.45%	95.70%	212.90%
Induction & Delivery Suites	79.78%	106.45%	79.14%	94.62%
Maternity & Jeffcoate	72.35%	93.91%	71.43%	96.36%
MLU	60.00%	80.65%	60.65%	90.32%
Neonates (ExTC)	96.77%	62.90%	96.60%	69.35%
Transitional Care	74.19%	106.45%	141.94%	38.71%

To participate in high quality research in order to deliver the most **E**ffective outcomes





We continue to face challenges as expected within our Elective Care Waiting Time Standard KPI's in response to Covid-19. We slipped in performance against our planned trajectories for 52 week waiting for June 2021 and anticipate this to continue in July 2021 due to sickness absence. We have see an increase in referrals in from primary care as expected , supporting our RTT performance which remains at 68%.

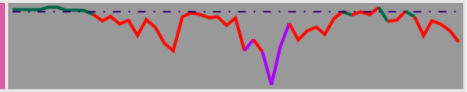
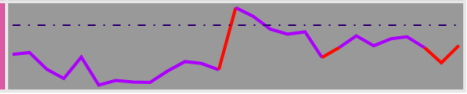
Cancer wait times remain challenging with sustained high levels of referrals with 342 received in for 2ww compared to 223 in 2019 (an increase of 153%) we continue to see good performance in an historical context for our 31 day DTT and sustained performance against 2WW. 62 day remains a challenge with work with external providers on-going to help resolve some diagnostic pathway issues. Gynaecology Pathway review commissioned by cancer alliance to be undertaken in 21/22 financial year.

To participate in high quality research in order to deliver the most Effective outcomes

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denomina...	DQ Kite Mark	Sparklines
Medical Director	Intensive Care Transfers Out (Rolling 12 Months)	July 2021	9	+1	8			
Chief Operating Officer	18 Week RTT: Admitted Completed Pathways	June 2021	78.40%	-11.60%	90.00%	250	5	
	18 Week RTT: Incomplete Pathways	June 2021	67.37%	-24.63%	92.00%	11445	5	
	18 Week RTT: Non-Admitted Completed Pathways	June 2021	73.88%	-21.12%	95.00%	2427	5	

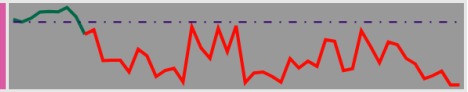
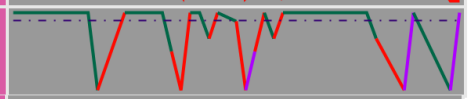
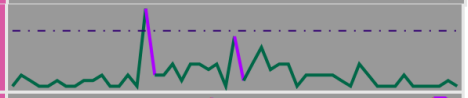
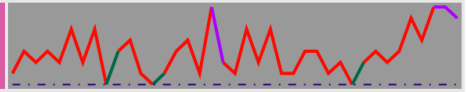
KPI	What is the reason for failure against this target?	How is this being fixed?	When will target be achieved?	Why this timeframe?	Patient Harm?	Mitigating Actions?
18 Week RTT: Incomplete Pathway > 52 Weeks - Gynaecology	We are performing to our planned trajectories for 52 week waiting patients (197 against plan of 199). We have 52 week breaches due to the covid 19 pandemic causing a cessation in elective services.	Elective capacity been made available as much as possible, once shielding staff have returned capacity will return to maximum as soon as possible	Trajectory is for end of Q4	Covid 19 and high numbers in backlog	No	Elective capacity been made available as much as possible but staff shielding has impacted our elective capacity. Clinical Validation Programme undertaken and patients have been treated in line with prioritisation, also reopened capacity to maximum as soon as feasible
18 Week RTT: Incomplete Pathways - Gynaecology	Covid 19 pandemic stopped routine elective activity during the first wave and second wave causing a backlog in access for routine patients,	Clinical Validation Programme undertaken and patients have been treated in line with prioritisation, also reopened capacity to maximum as soon as feasible	Unable to answer	covid 19 pandemic and uncertainties surrounding impact moving forward	No	Elective capacity been made available as much as possible throughout the covid 19 response it continue to impact our elective capacity, patients are being treated in accordance with priority status guidance.
18 Week RTT: Non-Admitted Completed Pathways	Covid 19 pandemic stopped routine elective activity during the first and second wave of pandemic causing a backlog in access for routine patients	we have utilised virtual and telephone clinics to mitigate reduction in F2F capacity. F2F capacity returning to pre-covid levels	Unable to answer	covid 19 pandemic and uncertainties surrounding the impact moving forward	No	we have utilised virtual and telephone clinics to mitigate reduction in F2F capacity, enabling the service to maximise capacity for patients

To participate in high quality research in order to deliver the most Effective outcomes - Cancer Waiting Times

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Previous Year Value	DQ Kite Mark	Sparklines
Chief Operating Officer	Cancer: 2 Week Wait	June 2021	96.20%	+3.20%	93.00%	342	5	
	Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	June 2021	68.00%	-28.00%	96.00%	25	5	
	Cancer: 28 Day Faster Diagnosis	June 2021	65.18%	-9.82%	75.00%	336	5	

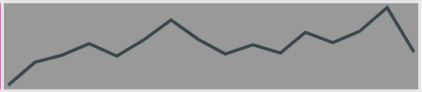
KPI	What is the reason for failure against this target?	How is this being fixed?	When will target be achieved?	Why this timeframe?	Patient Harm?	Mitigating Actions?
Cancer: 28 Day Faster Diagnosis	Performance 66% against a target of 75%. We have seen an improvement towards this target. The main delays with the patient pathway continue to be caused by hysteroscopy capacity. A longer wait for hysteroscopy then delays the diagnosis or exclusion of cancer within 28 days. In May there were 101 requests for hysteroscopy and the average wait for request to perform was 29 days as above We continue to review hysteroscopy capacity to increase both for out-patient hysteroscopy and ambulatory hysteroscopy. The bigger delay sits with ambulatory procedure. Out patient hysteroscopy has been impacted by long term sickness. This has now resolved. Clinical sessions are also being converted to out-patient hysteroscopy to create capacity and the impact can be seen by the improving percentage against target.	as detailed.	Unable to confirm at this time	Unable to confirm due to ongoing issues with Covid.	No	We are following a number of routes to increase ambulatory capacity including extending sessions/converting rooms/ introducing new clinicians.
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	There are continued delays in accessing the investigations needed following pre-op. We are seeing a lot more patients requiring ECHO and Spirometry which are all outsourced. There are also significant delays in accessing CT and MRI. We achieved 68% against a KPI target of 96%. We are experiencing delays around investigations needed following pre-op assessment at LWH with a higher number of patients requiring Echocardiogram and spirometry which are all outsourced. There are issues with capacity within these organisations. There is also the impact of the reduction in theatre sessions due to theatre staffing issues. Although every effort is taken to protect the oncology theatre sessions.	as detailed.	unable to answer at this time due to ongoing impact of Covid both within LWH and external hospitals who provide these diagnostic tests.	as above.	No	The cancer team, and particularly the early diagnosis support workers liaise regularly with local hospitals to escalate delays and to attempt to obtain earlier appointments. There is work ongoing to agree an SLA with LHCH. An escalation SOP has been developed to strengthen communication between LWH and CBH, however the capacity issues in CBH have been severe. As above No Yes

To participate in high quality research in order to deliver the most Effective outcomes - Cancer Waiting Times

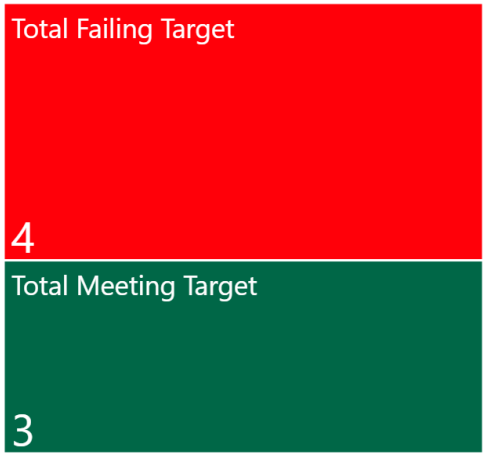
KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Sparklines
Chief Operating Officer	All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	June 2021	20.00%	◆ -65.00%	85.00%	10	5	
	Cancer: 62 Day Screening Referrals (Percentage)	May 2021	100.00%	● +10.00%	90.00%	1	5	
Chief Operating Officer	Cancer: 62 Day Screening Referrals (Numbers)	June 2021	0	● -5	5		5	
	Cancer: 104 Day Breaches	June 2021	6	◆ +6	0		5	

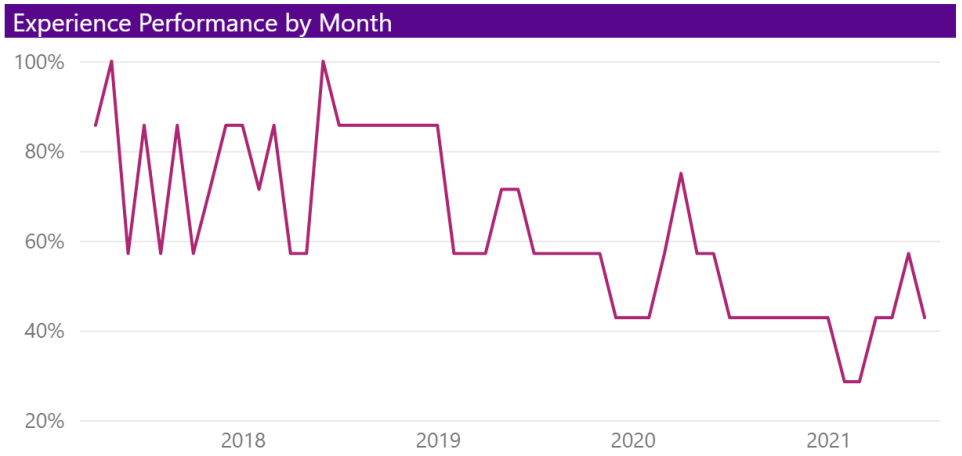
KPI	What is the reason for failure against this target?	How is this being fixed?	When will target be achieved?	Why this timeframe?	Patient Harm?	Mitigating Actions?

To participate in high quality research in order to deliver the most Effective outcomes

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Sparklines
Chief Operating Officer	Advice and Guidance	July 2021	61	61				
	Diagnostic Activity Levels	July 2021	1759	1759				
	Elective activity levels - Daycase	July 2021	456	456				
	Elective activity levels - Inpatient	July 2021	152	152				
	Elective activity levels - Outpatient Follow Up	July 2021	5003	5003				
	Elective activity levels - Outpatient New	July 2021	3398	3398				
	Overall size of Elective Waiting List	June 2021	11609	11609				
Chief Operating Officer	Proportion of patient activity with an ethnicity code	July 2021	95.59%	95.59%		15200		

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



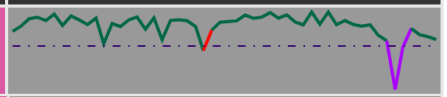
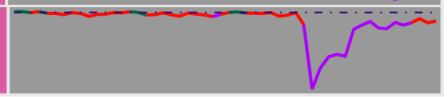


We have seen an increase in delays for complaint response times – predominantly driven by staff being unavailable during sign off stages. A weekly complaints meeting has been reinstated to receive regular updates.

There has been an increase in the number of theatre sessions being cancelled due to staff shortages. Vacancies have been filled but training is required to enable this to have an impact.

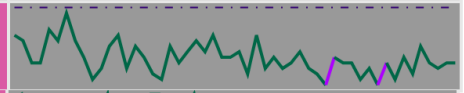
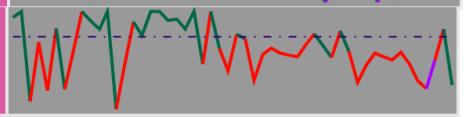
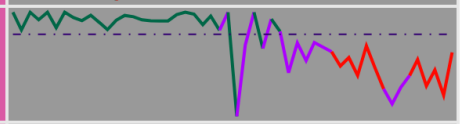
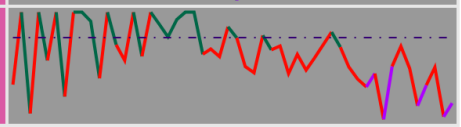
The pandemic continues to impact patient experience and friends and family performance remains below target. Weekly updates are now being provided to enable greater oversight and to generate timely actions.

To deliver the best possible Experience for patients and staff

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Sparklines
Chief Operating Officer	A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	July 2021	95.95%	+0.95%	95.00%	1036	5	
Chief Operating Officer	Diagnostic Tests: 6 Week Wait	July 2021	90.95%	-8.05%	99.00%	652		

KPI	What is the reason for failure against this target?	How is this being fixed?	When will target be achieved?	Why this timeframe?	Patient Harm?	Mitigating Actions?
Diagnostic Tests: 6 Week Wait	Diagnostic Waiting Times Numerator 593, Denominator 652, Achievement 90.95%, Target 99.00% Dexa Numerator 45, Denominator 45, Achievement 100.00% Imaging Numerator 474, Denominator 478, Achievement 99.16% Cystoscopy Numerator 5, Denominator 11, Achievement 45.45% Cystometry Numerator 69, Denominator 118, Achievement 58.47% Capacity within the gynaecology services has led to the failure of this KPI.	See above Additional capacity within gynaecology is also being identified	Q3	Gynaecology consultant has been appointed to support additional capacity	No	The CSS Operational Service Manager is validating the PTL on a weekly basis and working with service leads / admin leads across the Trust to identify capacity and try to mitigate the number of month end breaches

To deliver the best possible Experience for patients and staff

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Sparklines
Director of Nursing & Midwifery	Complaints: Number Received	July 2021	5	-10	15		5	
Director of Nursing & Midwifery	Friends & Family Test: In-patient/Daycase % positive	July 2021	85.45%	-9.55%	95.00%	110	5	
	Friends & Family Test: A&E % positive	July 2021	90.91%	-4.09%	95.00%	33	5	
	Friends & Family Test: Maternity % positive	July 2021	82.03%	-12.97%	95.00%	128	5	

KPI	What is the reason for failure against this target?	How is this being fixed?	When will target be achieved?	Why this timeframe?	Patient Harm?	Mitigating Actions?
Friends & Family Test: A&E % positive	90.91% against the target of 95% improvement made on last month	as above	aiming month on moth for improvements, this is an agenda item on the clinical governance meeting and discussed review in Q2	time to monitor and address locally	No	department manager and matron to monitor weekly and promote feedback mechanisms with patients, discuss in huddle with staff to promote feedback from patient

KPI Lineage

Metric Description	Board	FPBD	Quality	PPF	Senate	Family Health Division	CSS Division	Gynaecology Division	Maternity Clinical	Neonates Clinical (MDT)
18 Week RTT: Admitted Completed Pathways	Y	Y	Y		Effective		D	Y		
18 Week RTT: Incomplete Pathway > 52 Weeks	Y	Y	Y		Effective		D	D		
18 Week RTT: Incomplete Pathways	Y	Y	Y		Effective		D	D		
18 Week RTT: Non-Admitted Completed Pathways	Y	Y	Y		Effective		D	D		
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Y	Y	Y		Experience			Y		
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Y	Y	Y		Effective			Y		
Caesarean Section - Emergency Rate	Y				Safety				Y	
Cancer: 104 Day Breaches	Y	Y	Y		Effective			Y		
Cancer: 2 Week Wait	Y	Y	Y		Effective			Y		
Cancer: 28 Day Faster Diagnosis	Y	Y	Y		Effective		Y	Y		
Cancer: 31 Days for Subsequent Treatment (Surgery)	Y	Y	Y		Effective			Y		
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Y	Y	Y		Effective			Y		
Cancer: 62 Day RTT Consultant upgrade (Non-urgent suspected cancer referrals)	Y	Y	Y		Effective			Y		
Cancer: 62 Day Screening Referrals (Numbers)	Y	Y	Y		Effective			Y		
Cancer: 62 Day Screening Referrals (Percentage)	Y	Y	Y		Effective			Y		
Clinical Mandatory Training Compliance	Y		Y	Y	Workforce	D	D	D		
Complaints: Number Received	Y		Y		Experience	D	D	D		

KPI Lineage

Metric Description	Board	FPBD	Quality	PPF	Senate	Family Health Division	CSS Division	Gynaecology Division	Maternity Clinical	Neonates Clinical (MDT)
Diagnostic Tests: 6 Week Wait	Y	Y			Experience		Y	Y		
Financial Sustainability Risk Rating: Overall Score	Y	Y			Efficient					
Friends & Family Test: A&E % positive	Y		Y		Experience			Y		
Friends & Family Test: In-patient/Daycase % positive	Y		Y		Experience			Y		
Friends & Family Test: Maternity % positive	Y		Y		Experience				Y	
Infection Control: Clostridium Difficile	Y		Y		Safety					
Infection Control: MRSA	Y		Y		Safety					
Intensive Care Transfers Out (Rolling 12 Month)	Y		Y		Effective					
Mandatory Training Compliance	Y		Y	Y	Workforce	D	D	D		
Never Events	Y		Y		Safety		D	D		
NHSE / NHSI Safety Alerts Outstanding	Y		Y		Safety				Y	
Proportion of Temporary Staff	Y			Y	Workforce		Y	Y		
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescale	Y		Y		Safety		Y			
Serious Untoward Incidents: Number of SUI's with actions outstanding	Y		Y		Safety		Y	Y		
Serious Untoward Incindents: New	Y				Safety		Y	Y	Y	
Serious Untoward Incindents: Open	Y		Y		Safety					
Sickness	Y		Y	Y	Workforce	D	D	D		
Turnover	Y			Y	Workforce					
Venous Thromboembolism (VTE)	Y				Safety			Y		

Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/71b*	Date: 02/09/2021		
Report Title	Safeguarding Annual Report 2020/21			
Prepared by	*Mandy McDonough, Associate Director of Nursing and Midwifery for Safeguarding*			
Presented by	*Matthew O'Neill, Safeguarding Assurance and Governance Lead*			
Key Issues / Messages	*The Safeguarding Annual Report for Children, Young People and Adults is to provide an overview of Safeguarding activity within the Trust for the period 1st April 2020 to the 31st March 2021 and to assure our Board of Directors that the Trust has effective systems and processes in place to safeguard patients who access services provided by Liverpool Women's NHS Foundation Trust.*			
Action required	Approve ☒	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	For the Board to receive and approve the Annual Safeguarding Report 2020/21.			
Supporting Executive:	***Marie Forshaw, Chief Nurse & Midwife***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 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
Quality Committee	22 June 2021	Associate Director of Nursing and Midwifery for Safeguarding	The Committee noted the report and recommended it for approval to the Board.

EXECUTIVE SUMMARY

The Safeguarding Annual Report for Children, Young People and Adults is to provide an overview of Safeguarding activity within the Trust for the period 1st April 2020 to the 31st March 2021 and to assure our Board of Directors that the Trust has effective systems and processes in place to safeguard patients who access services provided by Liverpool Women's NHS Foundation Trust.

Safeguarding remains a fundamental component of all care within the Trust and we have again this year responded effectively and efficiently to the challenges of safeguarding both our patients and our staff in what has been a most challenging year.

The Hospital Safeguarding Board (HSB) and Safeguarding Operational Group (SOG) have continued to provide the Board of Directors, Clinical Commissioning Group (CCG) and External Safeguarding Boards with assurance of our ability to respond effectively and demonstrate accountability, for all aspects of safeguarding children, young people and adults.

The report will outline the progress against the 2019/20 priorities and set out the key priorities for the coming 12 months. These are central to supporting core safeguarding activities and demonstrate the organisations compliance with Section 11 of the Children Act (2004) and the Care Act (2014).

Recommendation

For the Board to receive and approve the Annual Safeguarding Report 2020/21.

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

Attached at Appendix A is a reminder of the Board Responsibilities for Safeguarding Arrangements.

REPORT

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Introduction

The term “safeguarding” covers everything that assists children, young people and adults at risk to live a life that is free from abuse and neglect and which enables them to retain independence, wellbeing, dignity and choice. Safeguarding also encompasses prevention of harm, exploitation and abuse through provision of high quality care, effective responses to allegations of harm and abuse, responses that are in line with multi-agency procedures and lastly, using learning to improve services to our patients.

Liverpool Women's NHS Foundation Trust understands and acknowledges that safeguarding is everybody’s business and everyone working in healthcare has a responsibility to help prevent abuse and to act quickly and proportionately to protect children, young people and adults when abuse is suspected.

At Liverpool Women’s we are committed to safeguarding all patients who access hospital services, including community services. Although responding effectively and efficiently to the complex challenges of safeguarding it can often be a challenging process. Regardless, safeguarding is a fundamental component of all care provided within Liverpool Women's NHS Foundation Trust and is firmly embedded within the core duties of the organisation.

This reporting period (2020/2021) has been an exceptional year in terms of challenge with safeguarding children, young people and adults becoming more important than they have ever been. During the COVID-19 pandemic, with lockdowns and social distancing measures in place across the UK, it became more difficult to maintain regular contact with individuals and check on their welfare.
However, during all the uncertainty, it was particularly important to safeguard children who may be at an increased risk of abuse, harm and exploitation from a range of sources. It was also equally important to safeguard families, with parents facing

significant pressures to continue to protect and promote the welfare of their children, parents who may have already been struggling; thus with additional pressure their likelihood of significant harm may increase.

During this time by their resilience, creativity and adaptability to maintain support for vulnerable children and families, our staff at Liverpool Women's have shown an extraordinary ability and resourcefulness in their response to the COVID-19 pandemic.

This year the Trust Safeguarding Team has continued to provide a range of activities to support key areas of Safeguarding work, embrace change and respond to emerging themes both local and nationally to ensure all safeguarding processes are robust and effective.

In response to the COVID-19 restrictions, changes required to relevant safeguarding processes have been established, with robust governance and assurance processes embedded to monitor.

Statutory Framework and National Policy Drivers

In order to carry out safeguarding duties, it is vital to understand the local and national safeguarding policies. The government regularly revisit safeguarding legislation and policy to strengthen procedures and make guidance as clear as possible.

In order to appropriately safeguard children, the Trust is statutorily obliged to comply with Section 11 of the Children Act (2004), which outlines the requirement for clear lines of accountability for the provision of services that safeguard and promote the well-being of children. *Working Together to Safeguard Children* (2018) establishes a clear legal framework for all statutory agencies to maintain the rights of those with care and support needs who are at risk of harm, abuse or neglect.

Following the introduction of the Care Act in 2014, Liverpool Women's has also been required to demonstrate compliance with the following regulations:

1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)
2. Care Quality Commission (Registration) Regulations 2009 (Part 4)

The regulations below relate to Safeguarding and must be considered in how the Trust assures itself that there are effective and robust safeguarding processes and practices in place:

Regulation 9: Person-centred care
Regulation 10: Dignity and respect
Regulation 11: Need for consent
Regulation 12: Safe care and treatment
Regulation 13: Safeguarding service users from abuse and improper treatment

Liverpool Women's NHS Foundation Trust is fully aligned to the regulatory requirements but also takes into consideration the revised NHS England published guidance to all NHS organisations on their responsibilities to safeguard children and

adults at risk. The *'Framework for Safeguarding Vulnerable People in the Reformed NHS (2019)'* clearly outlines the statutory duties that all NHS bodies have to safeguard and promote the welfare of children and adults, with a particular emphasis placed on the provision of greater assurance to the Board of Directors and external partners, that those at the greatest risk of abuse, regardless of age, continue to be protected within our services.

There is a clear distinction between Providers' responsibilities to deliver safe and high-quality care and Commissioners' responsibilities to assure themselves of the safety and effectiveness of the services they have commissioned.

Our Regulators and Commissioners have a role to actively monitor the performance and quality of our service, with the responsibility to intervene if there is a decline in the quality of the service we deliver or they suspect a breach of our standards.

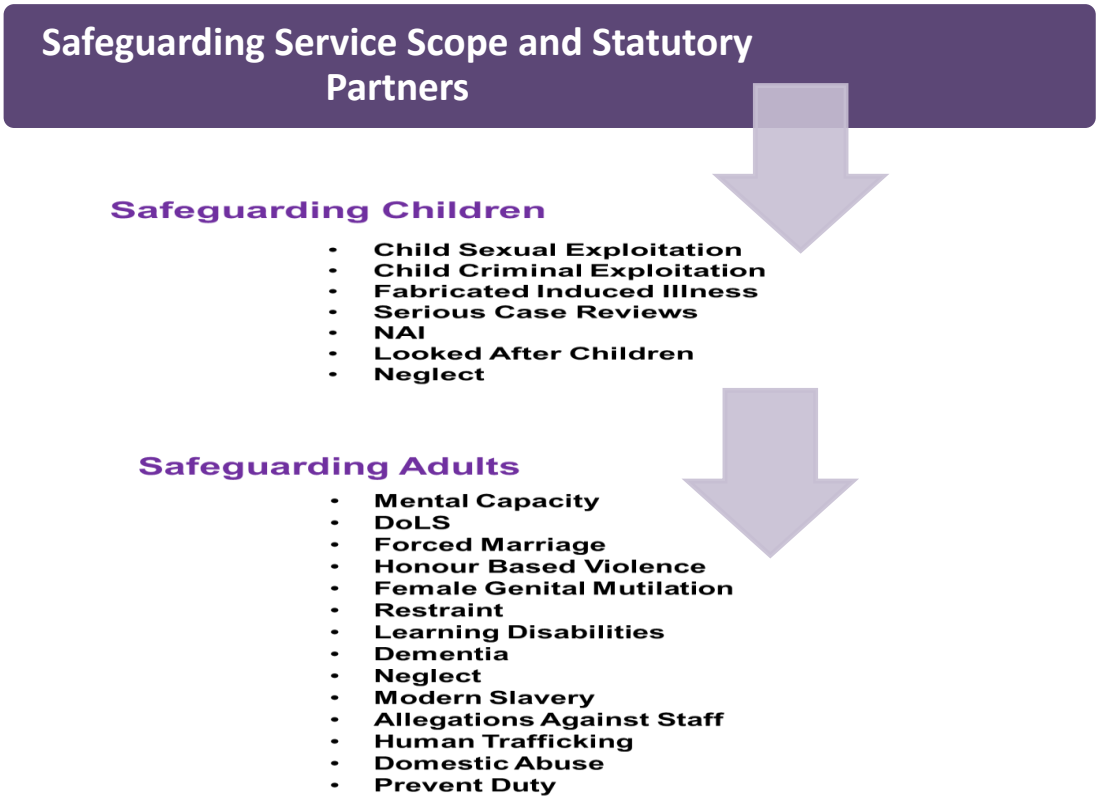
In partnership with NHS England the Clinical Commissioning Groups (CCG), the Safeguarding Boards, our partner statutory agencies (below) and other provider organisations, Liverpool Women's continue to work in partnership to ensure that we protect the health and well-being and the rights of those identified as vulnerable.

Safeguarding Arrangements at Liverpool Women's

Liverpool Women's takes care of more than 50,000 patients from Liverpool, the surrounding areas and across the UK. Along with hospital based contact, delivering around 8,500 babies and performing some 10,000 gynaecological procedures annually, the Trust provides care for patients within the community and at the Aintree Centre for Women's Health; which is based at Liverpool University Hospitals NHS Foundation Trust (Aintree site).

Supporting that activity, the Safeguarding Team is an established, fully integrated, multi professional service, comprising of Senior Health and Social Care Professionals with experience in Midwifery, A&E, Critical Care, Elderly and Social Care; and who are able to act both strategically and operationally in preventing and investigating potential abuse.

The following reflects our scope of Service:



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

Supported by the Associate Director of Nursing and Midwifery for Safeguarding, Amanda McDonough, the Director of Nursing and Midwifery, Marie Forshaw has executive responsibility for safeguarding arrangements within the Trust. Gaynor Thomason was the Interim Executive Director of Nursing and Midwifery prior to Marie Forshaw's successful appointment in January 2021.

As outlined in the *Intercollegiate Safeguarding Competencies for Adults (2018)* and *Children (2019)* all NHS providers must identify a Named Doctor a Named Nurse for Safeguarding Children and Young People, a Named Professional for Adults and a Named Midwife, (if the organisation provides maternity services); to provide expert advice and support to Trust employees and promote good practice within their organisation as per Children Act (1989/2004) and the Care Act (2014).

From April 2020 - March 2021 the Liverpool Women's Named Professionals were;

- Named Nurse & Midwife for Children – Amanda McDonough
- Named Nurse for Safeguarding for Adults – Carl Griffiths
- Specialist Nurse & Midwife for Children and Adults – Maria Clegg
- Trust Prevent Lead – Matt O'Neill
- Named Doctor for Safeguarding Children – Dr Helen Chitty
- Named Doctor for Safeguarding Adults – Dr Gillian Fowler

Summary of Current Position

Throughout the reporting period for 2020/21, despite the constraints of working in a pandemic and the many changes that has brought about, significant progress has been made with the safeguarding children, young people and adult's work plans. This has ensured that the Trust has remained compliant with its overall objective to:

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

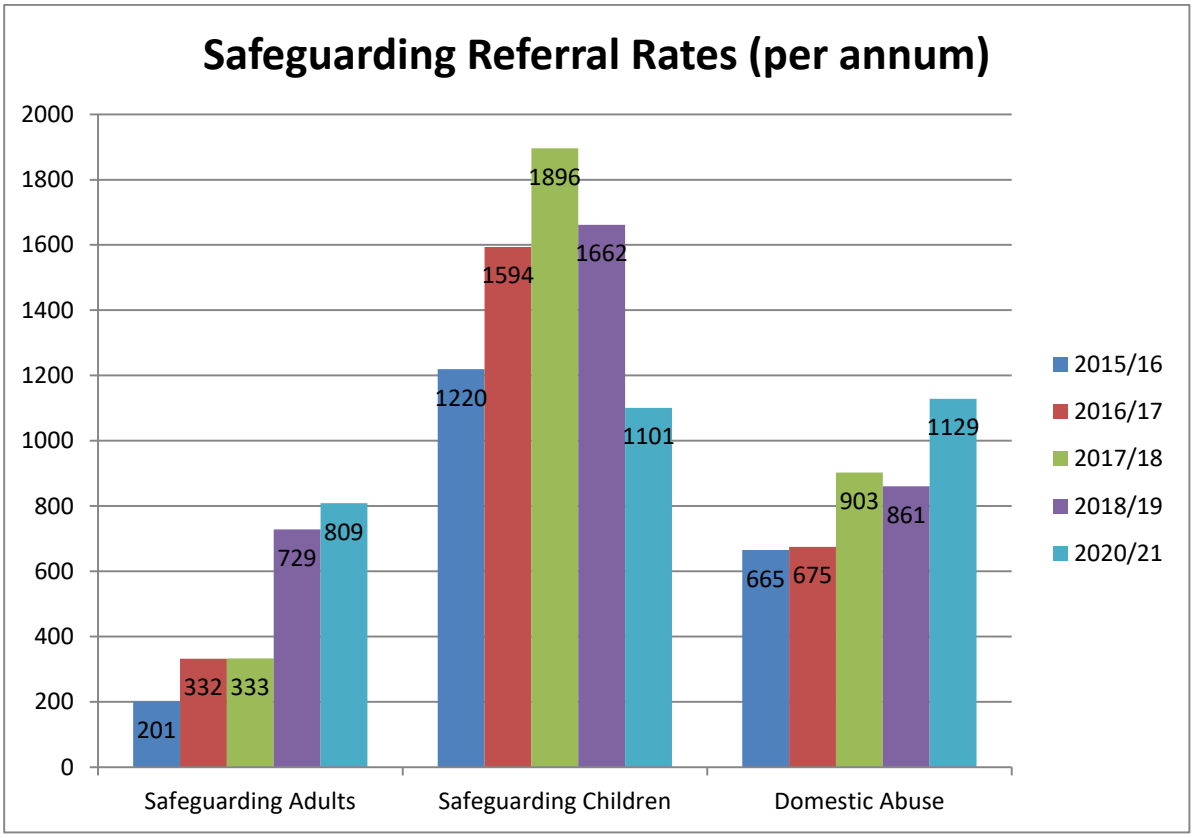
A number of key areas of priority were identified and outlined in the 2019/20 Safeguarding Annual Report and below is our progress against those priorities:

Number	Objective	RAG Status
1	Ensure that all safeguarding processes currently in place are replicated robustly within electronic health records (K2/PENS) and enable greater confidential sharing of safeguarding information across the workforce (replicated but ongoing minor issues currently working on)	
2	Building on the recognised good practice of Liverpool Women's when recognising and responding to domestic abuse as a healthcare issue; plan and host a series of Webinars aimed at Commissioners, managers and other professionals working in the NHS, Police, Social Care / Local Authorities and the wider public, private, voluntary and community sectors	
3	Complete a full review and update the Corporate Safeguarding strategy (2017-2020)	
4	Complete an annual full self-assessment against the Section 11 standards detailed in Working Together (2018)	
5		

	Complete a further full self-assessment against the Learning Disability improvement standards detailed within the NHS Improvement guidance (July 2018) and develop a standalone Strategy for Supporting Patients with Additional Needs with an embedded operational work plan.	
6	Progress the arrangements for patients, detained under the Mental Health Act 1983 with a view as to providing further assurance that the Trust are meeting its statutory obligations	
7	The Mental Capacity (Amendment) Act (2019) is due to be implemented in October 2020. If Government delay the implementation, due to COVID-19, Safeguarding will be required to monitor the progress of this in readiness for any required changes around the Liberty Protection Safeguards; then complete a scoping exercise and develop an implementation plan.	

The key objectives for 2021/22 will be summarised at the end of this report.

Safeguarding Performance Data Overview



Overall, 2020/21 saw an increase in the safeguarding operational workload. Compared to 2019/20, the amount of safeguarding referrals received by the service increased by 158.

As expected, we saw an increase in the amount of domestic abuse referrals. This was expected with the national lockdown measures due to a raised awareness and an increase in Police call-outs and subsequent referrals.

In this reporting period we have made some changes to the process for 'Routine Enquiry' to every contact and delivered more bespoke domestic abuse training to individual clinical areas. We have also seen an increase in over the phone advice

when clinicians have had to change processes because of lockdown measures; which will account for an increased knowledge and referrals.

Although there has again this year been a reduction in the amount of Safeguarding Children referrals; the quality of referrals has improved. This is reflected in the high conversion rate of referrals to Local Authority Single Assessments as demonstrated in 2019/20 Safeguarding Children audit.
The improved quality can be attributed to staff learning from the feedback process which is firmly embedded into the referrals, alongside the changes made to the Safeguarding Children Level 3 Training; which now includes more specific training around applying the 'Levels of Need' for a child.

We believe another contributory factor for the reduction in Safeguarding Children referrals, may be as a result of data inaccuracy, as alongside this we have seen a slight increase in the Safeguarding Adults referrals.

Following a deep dive of referral data, it was found that some of the referrals have been categorised as Safeguarding Adults (pregnant women) when they should be Safeguarding Children as it's the unborn that there are concerns about. As a consequence of this finding, all referrals are re-categorised on completion to ensure the data is accurate.

Safeguarding Children

COVID-19 and the impact on other agencies including Children Services both in the delivery of services and workforce availability have presented many challenges within this past year for the Safeguarding Team.

Despite those challenges Liverpool Women's Hospitals NHS Foundation Trust has continued to support the statutory requirements with the roles of the Associate Director of Nursing and Midwifery for Safeguarding who is the Trust's Named Nurse and Midwife for Safeguarding Children and Dr Helen Chitty who is the current Named Doctor for Safeguarding Children.

As a statutory partner of Liverpool, Sefton and Knowsley Safeguarding Children Boards/Partnership Boards, Liverpool Women's has continued in our commitment to those boards, fulfilling our role in relation to safeguarding practices.

As in previous years, for this reporting period, through audit the Trust has demonstrated full compliance with the Trust Safeguarding Children Policy.

Key points from the audit highlighted that Liverpool Women's staff are able to identify and report safeguarding concerns and follow the appropriate information sharing protocols to assist multiagency working.

Our staff are confident with the Local Authority Plans (Child Protection Plan) for the unborn they have concerns about and with support from the Safeguarding Team are able to ensure the plan is adhered to, actions are implemented and there is a safe discharge.

Overall, through the findings Liverpool Women's are able to demonstrate compliance with the Trust's statutory duty in relation to safeguarding children specifically.

National and Local Safeguarding Reviews (previously Serious Case Reviews)

Within the reporting period, Liverpool Women's Hospitals NHS Foundation Trust has responded to all scoping requests for information from all associated Safeguarding Children Boards/ Partnership Boards. In total we have contributed to eight Critical Incident Groups (CIG) and one Rapid Review.

Following consideration, all cases in relation to young children did not result in a Safeguarding Child Practice Review. However it was acknowledged that themes identified as part of a previous review, lack of escalation, lack of professional curiosity and disguised compliance; were themes included within previous learning/training.

The Trust was not requested to actively participate in any National and Local Safeguarding Reviews in this reporting period.

Throughout the reporting period, the Trust has attended Safeguarding Board/Partnership learning events to ensure relevant actions and lessons have been implemented; and further disseminated across the Trust.

Child Exploitation (CE)

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

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

Bespoke enhanced CSE/CE Training continues to be delivered by the Safeguarding Team to the Trust's unplanned care settings such as Bedford Clinic, Maternity Assessment Unit and the Gynaecology Emergency Room.

The Liverpool Multi Agency Criminal Exploitation (MACE) panel which is made up of a range of statutory, voluntary and community sector agencies enables regular information/intelligence sharing and action planning to tackle CE. MACE is the governance structure to ensure all medium/high concerns about child exploitation have been assessed and responded to in a timely way. It provides the forum to share wider intelligence of the CE risks and needs across Merseyside and enables greater intelligence to enhance safeguarding and disrupt perpetrators.

Regular attendance from service providers mean there can be an immediate response to ensuring an appropriate provision is provided. It provides an opportunity to identify any child who presents as a victim of exploitation and a risk towards other children to ensure risk is identified and managed appropriately. Liverpool Women's refer and provide information as appropriate to the Liverpool MACE. The information we receive is added to our systems and can be accessed by our staff to alert them of known CE nominals and they are supported.

Early Help

Although the Early Help agenda sits within the Family Health portfolio, Safeguarding have oversight of all the referrals in order to quality assure the correct levels of need. The Early Help Assessment Tool (EHAT) is used for identifying children/young people and families who would benefit from the provision of additional services as universal services do not meet any identified needs. The assessment promotes a coordinated service response to meet those needs and to significantly improve the outcomes for the child.

Historically Liverpool Women's have had some difficulties in the completion of Early Help documentation in relation to the information required and have explored many different options including whether a midwifery reduced version or pre-EHAT would be more appropriate.

This approach was highlighted and following on from a successful 12 month pilot, Liverpool now have a dedicated Early Help Team. Midwifery Services are now able to make referrals to the Early Help Service using the pre EHAT form for families that are in need of an Early Help Assessment and Team around the Family plan. Midwifery staff can record vital information and observations obtained through routine midwifery care and share with external partners/agencies. This has been successful in reducing referrals that do not meet the appropriate level of need (Level 4) going through to Children's Services.

Overall the Early Help Team has seen a significant demand for service during 2020/21 with an 18% increase of complex family circumstances at Level 3 and Level 2. The demand was anticipated from the previous year and it is believed that it will continue to increase. Merseyside Police are amongst the highest referrers which may be as a result of the pandemic given that as family stresses increase, the Police may the first statutory agent a family have contact with.

During this reporting period Liverpool Women's have directly referred 26 women/families to the Early Help Hub (*Liverpool area only*); which highlights an increase from the previous year and shows a reduction in cases going to Children's Services.

Looked After Children (LAC)

A 'Looked after Child' (LAC) is a child who has been in the care of their Local Authority for more than 24 hours.

Healthcare services have a responsibility to keep children safe. As such if a LAC accesses the Trust via unscheduled care, staff will be aware as they have access the Child Protection Information Sharing (CP-IS); which connects Local Authority Children's Social Care systems with those used by NHS unscheduled care settings and Maternity Units. Access to information is instant and enables vulnerable children to be identified wherever they are cared for in England.

Staff notify the Safeguarding Team of this young person's admission or attendance in order for any relevant information sharing with the Local Authority. LAC inpatients (on

the Neonatal Unit) are supported by the Neonatal Discharge Co-ordinator who liaises with appropriate professionals (LAC Nurses).

Voice of the Child

Actively involving children to communicate their experiences of care, with a particular emphasis on how a service has helped to improve their health and wellbeing, is essential in ensuring that the care we provide is improving children's lives and keeping them safe. Failure to listen to children and ensure that their views are taken into account in child protection cases has been highlighted in many National and Local Safeguarding Reviews (previous Serious Case Review) findings.

However, this is difficult in Provider organisations that predominantly deliver healthcare to adults and babies. Liverpool Women's are able to evidence compliance with the Voice of the Child agenda as if an unborn is perceived to be 'at risk' when there are known Safeguarding concerns and the concerns relate to any present and/or future risk; in accordance with statutory guidance (Section 17, of the Children Act 1989, 2004) there must be a Child Protection Referral to Children's Social Care. This referral process is our Midwives and Nurses 'acting by proxy' and is the voice of the child (for the unborn).

Safeguarding Supervision

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

Supervision provides a framework for examining a case from different perspectives and enables staff members to deal with the stresses inherent in working with vulnerable children, young people and adults at risk and their families. In a safe environment, it allows staff to explore their own role and responsibilities in relation to

the families they are working with and facilitates good quality, innovative and reflective practice.

Although Liverpool Women's have a number of trained Safeguarding Supervisor's (*including the Safeguarding Team*) who continue to provide Supervision for all Trust staff that hold a child protection caseload; due to changes in workforce, we require more Supervisors. Discussions with Family Health are ongoing regarding staff release to complete the course.

Domestic Abuse

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

During the national lockdown, it was recognised that the measures that were put in place to tackle coronavirus (COVID-19) could possibly have a detrimental impact for victims of domestic abuse.

In order to pre-empt any potential impact and appropriately respond to the potential increase in domestic abuse cases and lockdown measures, the Safeguarding Team put the following measures in place:

- Continued to communicate with our partners at a local and national level to promote positive and sustained services for the victims of domestic abuse
- Routine Enquiry processes were increased to be completed at every contact from staff (Request for specific field for this in the Community Midwife contacts (MediTech)
- Added a separate safeguarding section to the Routine Enquiry Standard Operating Procedure (SOP) for Maternity
- Provided virtual and written guidance to managers on enhancing their diligence to the signs of domestic abuse with staff due to a noted increase in staff disclosures
- Amended the Trust SOP for imaging of obstetric patients to include Routine Enquiry as the Sonographers are scanning women with no partner present so this is a rare and opportune time for a disclosure to be made
- Additional services offered to high risk patients; to mirror National Campaign the Associate Director of Nursing and Midwifery for Safeguarding and Head of Midwifery introduced code words and access for patients suffering from abuse to Midwifes/Safeguarding Staff

- Completed weekly audits in relation to activity to identify any trends or increased referrals

Initially the volume of domestic abuse reporting in Merseyside didn't significantly increase despite the government and national media reporting an increase by up to 25%. This data was provided by national charities and support service and enabled Merseyside Police to work closely with them to understand the gaps in reporting and why there are calls to organisations outside of the Police.

Enquiries established that the contacts to the National Domestic Abuse Helpline included calls that were not simply calls from victims and survivors of crime, but from agencies seeking advice and guidance. As such, the Police requested that national charities and support services encourage people to come forward to the Police to report any domestic abuse concerns.

In April, the Home Office worked with a number of these key partners and charities and continuing with the support for victims of domestic abuse, the #YouAreNotAlone campaign was relaunched.

Alongside this campaign, as part of the North West Population Health and Protection Network (NWPHPN), the Associate Director of Nursing and Midwifery for Safeguarding presented *Domestic Abuse - a Pandemic within a Pandemic* at the NHSE/I virtual event 'taCkling dOmestic Violence In a panDemic'.

The webinar was developed and delivered by NWPHPN for network members and was developed to appropriately reflect on the impact of COVID-19 on safeguarding in the context of domestic violence.

The NWPHPN felt that it was important to remember that domestic violence was a global pandemic long before the COVID-19 outbreak. But the pandemic exacerbated

domestic abuse and created an escalation in violence. Around the globe, governments were asking residents to stay home to protect themselves and others. However for domestic violence victims, the vast majority of whom are women, home was a dangerous place. As the traditional routes to help and support such as Schools, A&E, GPs and workplaces were either closed or less accessible, there were less opportunities to identify the early warning signs of abuse and more individuals isolated.

The webinar was designed to help build a conversation about what needs to happen to address the issue. With a target audience of NHS trusts, Public Health Teams, voluntary sector organisations and stakeholders with an interest in safeguarding in relation to domestic violence, the event highlighted the on-going challenges and enabled access to available resources and assets. It also once again puts Liverpool Women's at the forefront of leading change in relation to safeguarding practice.

Across Merseyside there was a coordinated partnership approach to tackling domestic abuse through the Strategic Domestic Violence and Abuse Group (SDVAG) which comprised of a variety of criminal justice agencies, Local Authorities and Health representatives. The SDVAG raised awareness of domestic abuse services available to victims via social media and Police/Local Authority internet sites. The Associate Director of Nursing and Midwifery for Safeguarding represents Liverpool Women's at the SDVAG.

During this reporting period the Safeguarding Team have completed their annual Domestic Abuse Audit. The Trust Domestic Abuse Policy and national guidance clearly identifies that a proactive approach to the identification of domestic abuse is necessary, and therefore it is essential that routine enquiry is completed.

The findings of the audit demonstrated that Liverpool Women's staff are adhering to the Trust Domestic Abuse Policy and responding effectively to disclosures/ known domestic abuse in the majority of cases.

Of all the cases audited there was evidence that in 75% of the cases routine enquiries had been completed. 15 % of the cases had clear evidence that it was not safe to

complete enquiries and 10% of the cases reviewed had no evidence that routine enquiries had been completed.

Although the audit shows that staff remain compliant with the policy, remain aware of the risks posed by domestic abuse and the need to provide a safe environment to complete enquiries; the results differ from previous year's findings. The audit identifies missed opportunities to identify domestic abuse; all cases in GED/MAU. This enables the Team to focus specific Domestic Abuse Training in those areas, to enhance their training requirements and ensure we reduce the missed opportunities.

Overall in Merseyside, domestic abuse incidents increased by only 5%. The weekly average prior to pandemic was 680, which rose to 714 post lockdown. Moving forward into 2021/2022, we know that it is likely that many families in the UK will be suffering from job losses and financial struggles. Finances, addiction, mental health and poverty can be exacerbating factors and as such we are fully prepared for an increase in reporting and will monitor capacity and resources into tackling domestic abuse in the event of significant rises.

Multi-Agency Risk Assessment Conference's (MARAC)

All healthcare providers are required to provide health information relevant to cases being discussed at the Multi Agency Risk Assessment Conference (MARAC) and attend the meetings where victims who have been referred by the individual Trusts are being discussed.

Liverpool Women's continues to work in collaboration with our external statutory partners by referring and attending when required at the MARAC; enabling maximum information sharing between relevant agencies within an agreed protocol. This ensures that those identified as most at risk from violence and abuse, are managed jointly with a management plan that provides a professional, co-ordinated approach to reducing the perceived risk.

During the COVID-19 pandemic, the MARAC continued to function well through telephone conferences and Microsoft Teams ensuring appropriate information sharing and joint working with partners and specialist services. The Trust continued to provide all appropriate health information/intelligence to Liverpool (North and South), Sefton and Knowsley MARAC's.

Moving forward, the long awaited Domestic Abuse Bill is due to receive Royal Assent in April 2021. We anticipate that the Bill will explicitly recognise children as victims if they see, hear or experience the effects of abuse and will include changes to the legal definition of domestic abuse to incorporate a range of abuses beyond physical violence, including emotional, coercive or controlling behaviour, and economic abuse. It is hoped that the Bill will provide protection to the many people who experience domestic abuse and strengthen measures to tackle perpetrators.

Domestic Homicide Reviews (DHRs)

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

In this reporting period, the Trust has had requests for information and involvement in three potential DHR's; two of which did not proceed to a full review.

The third case, was an 18 year old female who was killed by her partner in January 2021 and had a 4 month old baby, born with us in September 2020.

Following consideration by the Community Safety Partnership it has been decided that this case meets the criteria for a full DHR and this recommendation will go to the Chair of the Safeguarding Adult's Board and to the Home Office.

The 'Protecting Vulnerable People Agenda'

The Pan Merseyside Harmful Practices Group meet on a quarterly basis and lead on raising awareness among professionals and practitioners of harmful practice; such as Forced Marriage, Honour Based Violence and Female Genital Mutilation. The Safeguarding Team represent Liverpool Women's at that meeting in order to share good practice and disseminate any local and national learning.

Human Trafficking / Modern Slavery

Our work with Merseyside Police Human Trafficking Team has continued throughout 2020/21. This is an important piece of collaboration (developed by Liverpool Women's and Merseyside Police in 2018) as it ensures that the robust processes in place as standard; which includes 'real time' access to operational data and intelligence, enables timely identification of individuals involved.

Up to date intelligence and knowledge around the particulars of 'trafficked' cases ensures Liverpool Women's are able to advocate for this vulnerable cohort of women when referring to the Local Authority and supports victims being safeguarded with evidenced outcomes.

Safeguarding Adults

Although some of the referrals from our staff were found to have been categorised incorrectly and should have been a Safeguarding Child referral; this year has continued to see a rise in the number of Safeguarding Adult referrals received by the Safeguarding Team. The majority did not meet the criteria for Section 42 enquiries, but instead related to concerns of self-neglect, an increase in care needs following admission, a perceived complexity to establishing capacity to consent and the identification of patients with additional needs requiring significant reasonable adjustments needing to be implemented.

This increase can be attributed to the significant impact on the Safeguarding Adults landscape, seen nationally, during the COVID-19 pandemic.

In the early stage of the pandemic, safeguarding issues were not being identified and reported due to decreased face-to-face contact between people who were shielding due to their care and support needs and their families, friends, neighbours or professionals.

The Coronavirus Act 2020 made some changes to The Care Act 2014, enabling local authorities to prioritise services to ensure the most urgent and serious care needs were met. This led to non-essential services being either stopped or reduced and the subsequent gaps allowed for opportunities for exploitation or abuse. This was because those most vulnerable to abuse were typically more isolated and social contact of any kind was often welcomed without sufficient caution.

The propensity for self-neglect due to age, infirmity, mental health problems and OCD also increased due to a combination of heightened anxiety, isolation and the temporary reduction or cessation of both statutory and voluntary sector support services as Local Authorities struggled to adapt to lockdown and the changes that brought about.

In general, safeguarding concerns dropped markedly during the initial weeks of the COVID-19 lockdown period gradually increasing as the restrictions eased, which then led to concerns that were normally identified in the community; instead being noted on attendance or admission to Hospital.

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

Unlike other pieces of legislation, both the MCA and DoLS were not amended by the Coronavirus Act 2020. However the Government did issue additional guidance during the pandemic, which was to promote a pragmatic approach in exceptional circumstances.

This included assessing capacity remotely by telephone or video link, promoting that any best interest's decision can only be made between the options available and that treatment in a care home or hospital did not require a DoLS authorisation; providing the same treatment would be given to a person without a mental disorder.

This meant that a patient who met the criteria for being deprived of their liberty would only receive the protection of DoLS in circumstances whereby the level of restrictions in place to maintain their safety were increased in comparison to a patient being treated without a cognitive impairment.

As in previous years, for this reporting period, through audit the Trust has continued to demonstrate full compliance with Trust policy when establishing a person lacks capacity to provide consent for serious medical treatment.

In addition, when making a decision to proceed in the individual's best interest, compliance with Section 1(5) of the Act was demonstrated including the requirement for statutory checks i.e. powers of attorney, taking into account the persons wishes and feelings and a rationale as to why the choice was the least restrictive option available.

Compared to the 2019-20 audit, this was a significant improvement in compliance which may be related to the gradual improvement in MCA training compliance, increasing from 51% in March 2020 to 76% in April 2021.

This year has also seen a rise in the complexity of cases requiring specialist support from the Safeguarding Team; on many occasions providing specific directions to clinical staff in respect to documenting capacity assessments and best interest decisions and on occasion, compliance could be viewed as being solely dependent on safeguarding support.

In addition, as part of the pilot Safeguarding Quarterly Review, cases perceived by clinicians to be complex and requiring significant support from the safeguarding team were analysed.

These cases all related to proposed gynaecology/oncology investigations and treatment, with the complexity deriving from issues, such as a disagreement over withdrawing life sustaining treatment, the patient refusing to engage in assessments or the need to liaise with external professionals.

It was noted that in these situations, whilst the clinicians responsible were confident assessing capacity and making best interest decisions they were less so in the presence of dispute, need for advocacy or behaviour that challenged the established pathway for treatment.

As a consequence, a survey is required to be completed by the Safeguarding Team to ascertain the views of senior Trust Consultants in respect to their confidence in using the Act and the potential requirement for additional training.

Learning Disabilities, Autism & Dementia

Liverpool Women's continue to work in collaboration with external health providers and service users to implement the aims of the NHS Long Term Plan (NHS England/Improvement (NHSE/I) 2018) to develop a clearer and more widespread focus on the needs of people with a Learning Disability, Autism and Dementia.

The NHSI Learning Disability Improvement Standard's (2018) combined with the Dementia-Friendly Hospital Charter 2020; which supports the Prime Minister Challenge on Dementia 2020, continues to inform the Trust direction for measuring the quality of service and ensure consistency across the NHS in how we approach and treat people with Learning Disabilities, Autism or both.

As part of our contractual agreement; the Trust continues to participate in the NHSE/I learning disabilities improvement standards annual survey. However, following the publication of the 2018/19 report and despite previous concerns being raised with NHSE/I regarding the difficulty in interpreting the data to inform individual service participating NHS Acute Trusts a decision was taken to create a bespoke internal audit framework using the criteria of both Standards.

It is hoped this will provide assurance that Liverpool Women's have the right structures, processes, workforce and skills to deliver the outcomes that people with Learning Disabilities, Dementia and Autism, receive and deserve.

Despite the impact the pandemic has had on the Safeguarding Team and the operational workload, developments to improve the service offered to those with additional needs continued throughout the year.

These included the introduction of screening and implementing reasonable adjustments when booking an appointment, the development of a front facing webpage containing relevant guidance to patients with additional needs and their carers including access to the Trust Virtual Reality (VR) Programme.

This programme allows users to experience a sense of presence in the Trust via a computer-generated three-dimensional environment thereby providing a de-sensitisation strategy for patients who may find hospital admissions challenging as well supporting those patients who have difficulty reading through a 'voice over' component explaining key aspects of the patient journey therefore complying with the Accessible Information Standard for Trusts.

The innovative programme; enabling our patients with additional needs an ability to prepare for their admission in the safe and familiar surroundings of their own home, was a finalist in the Health Service Journal (HSJ), Patient Safety Awards 2020.

Although we didn't win the HSJ Patient Safety Awards for 2020 the Trust was recognised with a "Highly Commended" initiative. This is an exceptional piece of work that will undoubtedly help improve the safety and experience of patients and their carers. This facility will become available to patients and carers in April 2021.

Reasonable Adjustments during the Pandemic

The COVID-19 crisis has been shown to have significantly impacted on people with a Learning Disability and or Autism resulting in exclusion, inequality and the associated restrictions leading to a lack of control, confinement, isolation, fear and stress.

It found 451 per 100,000 people registered as having a learning disability died with COVID-19 between 21 March and 5 June, a death rate 4.1 times higher than the general population after adjusting for other factors such as age and sex.

But as not all deaths in people with learning difficulties are registered on these databases, researchers estimated the real rate may have been as high as 692 per 100,000, 6.3 times higher.

A review of available data on the deaths of people identified as having learning disabilities in England during the COVID-19 pandemic, commissioned by PHE,

identified people registered as having a Learning Disability had a death rate 6.3 times higher than the general population after adjusting for other factors such as age and sex.

Deaths were also spread much more widely across the age spectrum, with far greater mortality rates in younger adults, compared to the general population. The death rate for people aged 18 to 34 with learning disabilities was 30 times higher than the rate in the same age group without disabilities, researchers found.

As a consequence of the restrictions enforced by Government policy and the reduction in primary care attendances through the majority of the pandemic there was a subsequent reduction in those patients referred with a learning disability, autism and or dementia compared to the previous year.

However, this has led to an increase in the presenting complexities requiring adjustments to be made to the admission process. Despite this Liverpool Womens have continued to promote the entitlement to reasonable adjustments being made to reduce barriers to accessing healthcare throughout the pandemic and have continued to work with external partners, patients and their families.

Moving forward

We will embed and continue to build upon the significant progress made to date. However in order to ensure we continue to improve patient outcomes, patient experience and partnership working; the Safeguarding Team will be developing a three year strategic plan. The plan will detail how we will respond to the profile of our local population and work with our patients, carers, staff and partners to deliver high quality, person-centred care for people with additional needs and their carers/families.

Mental Health

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

In response to the review of existing processes in the Trust, completed by the Safeguarding Team in the previous year, discussions continue with a Mental Health provider to agree a Service Level Agreement to underpin compliance with the Act.

To promote Mental Health awareness for Trust staff the updated Mandatory Safeguarding online training package, due to be rolled out in Summer 2021, has been amended to include guidance on the types of mental illness patients may present with, the causes of mental illness, the stigma and misconceptions commonly associated with mental illness and tips on how to listen and engage.

In the interim and whilst awaiting an agreed way forward, the Safeguarding Team have continued to provide guidance and support on a case by case basis.

This year has seen a slight reduction in the number of referrals relating to mental health concerns. The majority of referrals relate to adults with additional needs or have on-going mental health needs and require specialist advice and support during their admission; or a review of their established package of care to facilitate a safe discharge.

The numbers of referrals that progress to further enquiries being made by Merseyside Police or the Local Authority, remain minimal.

In addition, there has been a reduction in referrals requesting support to identify appropriate reasonable adjustments for patients in compliance with the Equality Act (2010).

This reduction demonstrates a greater awareness from front line staff around the diverse nature of safeguarding adults and the importance of recognising potential vulnerabilities and seeking specialist advice to ensure compliance with the statutory

guidance. Staff awareness can be attributed to embedding the skills required to complete the assessments with key groups such as the Enhanced Midwifery Team and the Pre-Operative Assessment staff in Gynaecology.

Regardless of this year's slight reduction, the Safeguarding Team have continued to take a proactive approach to working collaboratively with both the patient and external partner agencies in agreeing appropriate safeguarding arrangements in line with statutory guidance.

Prevent

The aim of PREVENT is to reduce the threat of terrorism by stopping people becoming terrorists or supporting terrorism. The Health Service is a key partner in PREVENT and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients.

Liverpool Women's NHS Foundation Trust as a Health Provider continues to ensure our workforce is aware to identify any service users who are vulnerable to radicalisation. As a Trust we liaise directly with both the Merseyside Police Prevent Team as well as the Local Authority Prevent Engagement Officer to help support the agenda as well as our local community.

In 2020/21, we were not requested to attend a Channel Panel and completed zero direct referrals in relation to Prevent. We are fully compliant with the NHS Commissioning Services for Prevent and we continue to provide data around the Prevent agenda to both the Home Office and Liverpool CCG on a quarterly basis.

Safeguarding Governance

Risk

During 2020/21 there were two open service level risks identified within the Safeguarding Service:

1. Risk ID 2302 - Safeguarding training below target compliance
2. Risk ID 2308 – Reduction in Safeguarding Service staffing

Risk 2302

In September 2019, the Hospital Safeguarding Board agreed that as the Trust had not achieved the internal and commissioning training compliance targets for an extended period of time the Safeguarding Service completed a risk assessment. The group agreed with the score of 10 (2*5), as well as the controls in place and the risk was added to the Risk Register (Service Level).

Risk controls continued to be facilitated and tested to ensure the risk was managed appropriately however, despite an increase, the Safeguarding Level 3 compliance rates never achieved internal or commissioning targets in 2020/21. In Quarter 1, Safeguarding Level 1 and 2 Children and Adults training achieved the 90% compliance threshold and did not drop below 90% during 2020/21.

Additional controls were added for example Safeguarding Level 3 compliance was agreed to be embedded within the divisional performance reports as well as weekly sessions being provided by the Safeguarding Service.

Risk 2308

Prior to our impending CQC Inspection in 2019 the Safeguarding Team agreed to second a member of the Team to assist and support another division (Gynaecology) for a 3 month period. Due to the reduced staffing and potential service impact, Safeguarding completed a risk assessment and placed the risk on the risk register

(2*5=10). The seconded team member was successful in obtaining a permanent position within the Gynaecology service allowing for Safeguarding to successfully recruit to the positon of Safeguarding Specialist Nurse in April 2020. Subsequently this risk was closed in June 2020.

Performance

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

For 2020/21 Liverpool Clinical Commissioning Group (LCCG) provided an overall limited assurance rating to the Trust Safeguarding Service. Similar to the previous year the only area of limited compliance was the adult and children safeguarding training. All other areas of Safeguarding again achieved significant assurance.

LCCG acknowledged and were satisfied that the Trust Safeguarding Team had a detailed recovery action plan and trajectory in place that had oversight from the Director of Nursing and Midwifery, that training programmes have continued to be reviewed and staff training compliance is reported to Quality Committee via the Hospital Safeguarding Board.

LWH	Q1 (2020/21) Assurance rating	Q2 (2020/21) Assurance rating			Q3 (2020/21) Assurance rating			Q4 (2020/21) Assurance rating		
Training	*Due to COVID-19 there was an agreement with all Providers for the KPI Framework not to be followed for Quarter 1*			↔			↔			↔
Local Authority Children				↔			↔			↔
Local Authority Adults				↔			↔			↔
MCA / DoLS				↔			↔			↔
Commissioning Standards				↔			↔			↔

Section 11 Children Audit

Following the changes to safeguarding arrangements in 2018/19, Liverpool, Knowsley, Sefton and St Helens Safeguarding Children's Partnerships (Boards) utilised a Pan-Merseyside approach based on one single Section 11 submission. However in 2020/21 this approach is no longer in operation and Liverpool Women's NHS Foundation Trust have not been required to provide assurance around this process.

Section 11 Audit

In 2019, following on from the published Working Together to Safeguard Children (2018), an evaluation of Merseyside's Section 11 Audit compliance against the new standards was completed by the partnership.

Given that the previous process evaluated Liverpool Women's latest policy and practice in relation to a new set of standards, the Liverpool Children's Safeguarding Partnership (LSCP) Board agreed to complete a 'light touch' scrutiny process for agencies in 2020/21. This process required agencies to provide updates to policy and practices where the quality of provision in respect of the standards have altered significantly. However, as Liverpool Women's met with the required compliance scrutiny in 2019/20, this was not required.

The process for assessing compliance with standards for the year 2021/22 will require full evidence and site visits in accordance with the Board's decision to assess compliance on a two yearly basis going forward. Results of 2021/22 scrutiny will be reported in the LSCP Annual report in Summer 2022.

Policies

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

Updated documents in 2020/21:

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

Main changes to safeguarding policy for 2020/21 were:

- ✓ Amendments to all policies where COVID-19 has impacted and altered practice e.g. routine enquiry to ascertain patient safety from domestic abuse
- ✓ The updated the Harmful Practices and Female Genital Mutilation (FGM); within the Trust Domestic Abuse policy
- ✓ Further guidance around Dementia and Autism was included within the review of the Supporting Patients with Additional Needs policy

Audits

Forward Plan No.	Title	Auditor / Audit Supervisor	Summary / Findings
2020-019	Trust compliance with the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS)	Carl Griffiths Matt O'Neill	The audit found full compliance with Trust policy, in respect to establishing a lack of capacity, a decision made in Best Interest and the identification, authorisation and notification of the outcome of deprivations of liberty within LWH. It was noted that there was a reduction in admission rates, compared to 2019/20, for patients with a cognitive impairment which correlated with the national picture of delays accessing primary care as a consequence of the COVID-19 pandemic. Furthermore there appeared to be a dependence on the use of the paper based Consent Form 4 as opposed to the online template available on the PENS system. As a consequence the Gynaecology Division, with the support of Safeguarding, will be encouraged to promote the use of the MCA & Best Interest template on PENS to support the move to a paperless service along with all clinical divisions continuing to promote the need to complete the online mandatory training MCA module for identified staff groups.

2020/055	Safeguarding children procedures in accordance with statutory guidance audit	Maria Clegg Matt O'Neill	Audit displayed very high standard of compliance with Child policy and procedures. Staff routinely complete appropriate actions once safeguarding concerns are disclosed/identified. Compliance with following safeguarding plans of care was also a positive finding. One action identified was further training to staff on how to apply the Levels of Need framework consistently so the appropriate actions are applied in a timely manner.
2020/033	Auditing the compliance against Domestic Abuse Protocol/Procedure	Jayne Reid/ Matt O'Neill	High standard of compliance with policy and procedures. Findings of the audit demonstrated that LWH staff are adhering to the Trust Domestic Abuse Policy and responding effectively to disclosures/ known domestic abuse in the majority of cases. A significant increase in the amount of safety planning at the point of disclosure as well as the high compliance with appropriate referrals was very well received. Some additional work is still needed to ensure the areas are self-sufficient out of hours and that staff are referring to the Local Authority appropriately without the need for safeguarding input.

Assurance

Hospital Safeguarding Board (HSB)

Within this reporting period, the HSB has had much focus on the monitoring of progress against the training compliance and the recovery plan. We have also completed a review of the Terms of Reference in which the body of work encompassed within the HSB was clarified ensuring the following items are continually discussed and monitored:

- Partnership Working
- Risks & Serious Incidents
- Legislation and National / Local guidance changes
- Training
- Serious Case Reviews (SCRs) & Domestic Homicide Reviews (DHRs)
- CCG Key Performance Indicators (KPIs)
- Governance
- Assurance
- Effectiveness
- Performance
- COVID-19 pandemic

Safeguarding Operational Group (SOG)

The Safeguarding Operational Group (SOG) supports the HSB. It's primary purpose is to ensure that safeguarding children and adults is a Trust wide priority and the work from the external boards and HSB is disseminated across the Trust..

Following annual review of the meeting, it was identified that certain work streams were slow to progress and there was an inconsistency in meeting attendance. Safeguarding have now completed a review of the Terms of Reference and agreed for the Safeguarding Service Manager to act as chair of the group for the next 12 months, with a clear work plan. This will be reviewed again in 2021/22.

Safeguarding Training

At the end of the reporting period for 2020/21, the Trusts compliance levels for Safeguarding training are:

Session	CCG Compliance Threshold (%)	Compliance as of April 2021 (%)
Safeguarding Children Level 1	90%	**91.8%**
Safeguarding Children Level 2	90%	**91.8%**
Safeguarding Children Level 3	90%	**82.8%**
Safeguarding Children Level 4	90%	**100%**
Safeguarding Adults Level 1	90%	**91.8%**
Safeguarding Adults Level 2	90%	**91.8%**
Safeguarding Adults Level 3	90%	**83.4%**
Safeguarding Adults Level 4	90%	**100%**
MCA & DoLS (Advanced) *	90%	**76.5%**
Prevent (Basic Awareness)	90%	**91.8%**
Prevent (WRAP)**	90%	**84.0%**

**for MCA/DoLS Level 2 training and no programme available locally/nationally, Liverpool Women's created a bespoke package of training which was launched early 2020 to all staff via ESR. Compliance was reset to zero.*

***for WRAP training, early 2020/21 the Trust TNA was amended and dropped the compliance below 90% and compliance has slowly increased back towards the target during this reporting period. This is a once only training competency.*

As previously reported, due to the lack of regulatory compliance, Risk 2302 was raised with controls embedded to provide assurance; alongside actions to support the clinical divisions to increase compliance.

Key Objectives for 2021/22

2020/21 has shown us more than any other previous that Safeguarding needs to continually evolve and the complexity of decision making increases around newly recognised forms of harm and abuse, structures and process need to continually develop in response.

Alongside a pandemic it again has been another year of significant and scrutiny. However, throughout this reporting period and despite a pandemic, the Trust has successfully demonstrated that robust mechanisms remain in place and we are able to adapt those mechanisms as appropriate to safeguard children, young people and adults from abuse.

For 2021/22, aside from further embedding of existing overall process, the following key areas / objectives for improvement have been identified as priorities:

2021/22 Priorities:

Number	Objective
1	Develop a standalone Strategy for Supporting Patients with Additional Needs with an embedded operational work plan
2	Progress the arrangements for patients, detained under the Mental Health Act 1983 with a view as to providing further assurance that the Trust are meeting its statutory obligations
3	Engage with EPR developers to enhance the system(s) functionalities around safeguarding to better assist staff
4	As part of the Liverpool MARAC Steering Group, working closely with our Commissioners, implement any changes required to Liverpool Women's processes and policy for Domestic Abuse
5	Source further NHSE/I Safeguarding Supervision Training for Liverpool Women's staff and further develop our Supervision processes

Conclusion

Despite the number of challenges during 2020-2021 for the Safeguarding Service, this Annual Report demonstrates how the Trust continues to adapt to changing priorities and has achieved its statutory duties in order to effectively safeguard patients and staff that use our services. This would not have been possible without the hard work, tenacity and commitment of the Safeguarding Team and all Trust staff who work tirelessly in ensuring, 'Safeguarding is Everyone's Business'.

The Safeguarding Team have an understanding of purpose, roles and responsibilities not only to each other but to how this fits into the wider organisation and most importantly our patients who access services within our Trust.

The Trust Board understands the areas which require focus and are fully sighted on these.

Overall the Trust is again in a strong position moving forward into the coming year and as the Associate Director of Nursing and Midwifery for Safeguarding I look forwards to the coming year in leading and supporting the service to further strengthen the arrangements in place to support the safeguarding agenda and the Trust on its journey to become 'Outstanding' as rated by the Care Quality Commission.

**Picture taken prior to COVID-19*

Staff Briefing

NHS
Liverpool Women's
NHS Foundation Trust

Board Responsibilities for Safeguarding Arrangements at Liverpool Women's

The Board must demonstrate:

- They have the appropriate core competencies in safeguarding. Completion of the Level 1 Safeguarding Children & Adults Training, will ensure an understanding of the common presenting features of abuse and neglect and the context in which it presents to health care staff

- They understand the statutory role as a Provider Organisation within Safeguarding;
  which is to ensure Liverpool Women's has the right systems and processes in place to make sure children and adults are protected from abuse and neglect; and there is commitment to external partners and legislative requirements

- Liverpool Women's has strong leadership within Safeguarding including the relevant statutory staff's roles and responsibilities with an:

  - ✓ **Executive Accountable Officer– DoNM Marie Forshaw**
  - ✓ **Non-Executive Director (NED) – Susan Milner**
  - ✓ **Safeguarding Service Lead for Children and Adults – ADN Mandy McDonough**
  - ✓ **Named Nurse for Safeguarding Children - ADN Mandy McDonough**
  - ✓ **Named Midwife for Safeguarding Children - ADN Mandy McDonough**
  - ✓ **Named Nurse for Safeguarding Adults – Carl Griffiths**

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/71c(i)*		**Date: 02/09/2021**	
Report Title	Whistleblowing / Freedom to Speak up Annual Report 2020/21			
Prepared by	***Freedom to Speak Up Guardian***			
Presented by	***Michelle Turner, Chief People Officer / Deputy Chief Executive***			
Key Issues / Messages	***This is the annual report completed by the Freedom To Speak Up Guardian to provide the Board with assurance regarding Whistleblowing. It includes details of those issues that have been formally raised with the Trust and how they have been dealt with.***			
Action required	Approve ☐	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to accept the assurance provided by this report and endorse the further actions proposed.			
Supporting Executive:	***Michelle Turner, Chief People Officer / Deputy Chief Executive***			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*			
Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☒

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Audit Committee	22 July 2021	CPO	Noted and recommended to the Board
Quality Committee	26 July 2021	CPO	Noted and recommended to the Board

EXECUTIVE SUMMARY

This is the annual report completed by the Freedom to Speak Up Guardian to provide the Board with assurance regarding Whistleblowing. It includes details of those issues that have been formally raised with the Trust and how they have been dealt with.

MAIN REPORT

1. Introduction

The Trust is committed to developing and maintaining an open and constructive culture whereby all staff feel comfortable in raising any concerns they might have regarding the Trust and the services that it provides. All staff should feel able to raise concerns in the knowledge that they will be taken seriously, that their concerns will be addressed, and without any fear of reprisal of detriment. While this commitment is based in, and underpinned by our statutory and legal obligations, the Trust's Whistleblowing Policy & Procedure encapsulates it in a form that is easily accessible for all staff.

This report is produced on an annual basis to give the committee assurance that the policy is in place, and that it is both appropriate and regularly updated. It also provides a summary of whistleblowing cases over the previous financial year to further provide assurance that the policy is being appropriately implemented.

2. Issues for Consideration

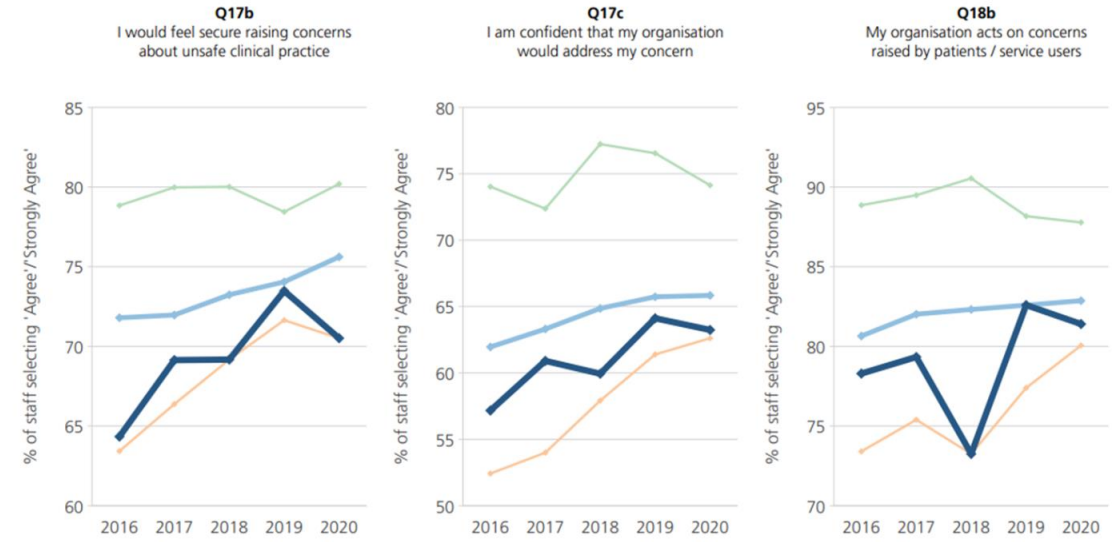
2.1. Trust Policy

The Trust's policy has been reviewed and updated. The staff side were consulted as part of this process and they were happy with the content and form of the policy.

2.2. Assurance: Annual Staff Survey Results

The National NHS Staff Survey includes three questions that specifically relate to issues around raising concerns.

The table below shows the Trust's results from the previous surveys, together with comparisons against the national comparator (in our case Acute Specialist Trusts) and the Trust's previous results:



	2016	2017	2018	2019	2020
Best	78.8%	80.0%	80.0%	78.4%	80.2%
Your org	64.3%	69.1%	69.2%	73.5%	70.5%
Average	71.8%	72.0%	73.2%	74.0%	75.6%
Worst	63.4%	66.4%	69.2%	71.6%	70.5%

	2016	2017	2018	2019	2020
Best	74.0%	72.4%	77.2%	76.5%	74.1%
Your org	57.2%	60.9%	59.9%	64.1%	63.2%
Average	62.0%	63.3%	64.9%	65.7%	65.8%
Worst	52.4%	54.0%	57.9%	61.4%	62.6%

	2016	2017	2018	2019	2020
Best	88.9%	89.5%	90.5%	88.2%	87.8%
Your org	78.3%	79.3%	73.3%	82.6%	81.4%
Average	80.6%	82.0%	82.3%	82.6%	82.9%
Worst	73.4%	75.4%	73.3%	77.4%	80.1%

Source: raw data for 2020 NHS Staff Survey supplied by Quality Health

These figures continue to show the majority of our staff are clear about how to report any unsafe clinical practice, although they all show a dip in our results from last year, taking them further away from the national averages we have been working towards. Those dips aren't huge, but it is something that we will need to address. The results regarding staff feeling secure and confident about raising concerns again showed a small dip following the significant increase from the previous year. All scores continue to show an improvement on the initial base score in 2016.

Formal Concerns Raised with the Trust (Inc. Whistleblowing Declarations / CQC notifications)

Seven cases were formally raised with the Trust during the period April 2020 to March 2021:

1. an anonymous concern raised with regards to issues on Mat Base, re) morale, staff shortages, management and lack of resources – review conducted including drop in sessions and confidential meetings with staff in that area – findings were fed back to both managers and staff, with a number of agreed actions put in place.

2. an anonymous concern raised in relation to Continuity of Care, specifically around issues of training and communication – drop in sessions and confidential meetings offered to staff – a number of agreed actions were put in place.

3. a bank sonographer complained about alleged bullying– some work was done locally with that team, and we are now commissioning an external review of working practices & leadership in imaging via the Society of Radiographers.

4. an anonymous letter alleged that two midwives had been working whilst off sick – the matter was investigated, and the allegation was found to be unsubstantiated.

5. an allegation was made to the NMC that a named midwife had failed to preserve patient safety by not sharing information to colleagues – the matter was investigated, and the allegation was found to be unsubstantiated.

6. an allegation was made to the NMC that a named midwife had acted outside the scope of her competence and not in a manner consistent with the values of the organisation – requested information was shared with the NMC who subsequently informed the Trust that they were not pursuing the matter.

7. an allegation was made to the NMC that a named midwife had attended work whilst under the influence of alcohol (this was a historical incident dating back to 2016) - requested information was shared with the NMC who subsequently informed the Trust that they were not pursuing the matter – the member of staff had left the Trust's employment some time ago.

2.3. Freedom to Speak Up Guardian (F2SUG)

The chart below demonstrates the Guardian contacts per Quarter and the main themes; this recording is in line with National Guardian requirements and reported externally**.**

	Total number of concerns raised	Concerns where staff wanted to remain Anonymous	Concerns with element of Patient Safety/quality	Concerns with element of Bullying and Harassment	Concerns where concerns about detriment	Comments
Q1 2020/21	11	0	2	0	0	Decrease of 4 from 2019/20
Q2 2020/21	14	0	7	0	0	Increase of 6 from 2019/20
Q3 2020/21	34	2	26	2	0	Increase of 26 from 2019/20
Q4 2020/21	13	1	2	6	0	Increase of 3 from 2019/20

In the last 12 months a total of **72** contacts were made to the Freedom to Speak up Guardian (F2SUG) requesting support to raise concerns or where staff want to speak to someone in a safe space to discuss work related issues. This is increase of **112 %** (38) contacts recorded in the previous 12 months. Concerns throughout the year were raised from a wide variety of staff, with concerns raised by staff of all grades and from all services and teams have spoken to the Freedom to Speak up Guardians. The trend data would seem to indicate that staff continue feel confident to raise concerns in their own name.

Where staff want to speak to someone in a safe space to discuss work related issues, these contacts are usually related to Grievance or Interpersonal issues within teams where no formal action is required by the Guardian. They are recorded and monitored with the individual to ensure if required to ensure appropriate avenues are able to be accessed by the staff member.

The large increase in concerns in Q3 related to many concerns raised by Maternity staff relating to the impending introduction of the continuity of carer program. Many staff felt that such a big change during a pandemic was creating risks to bit patients and staff. The concerns were raised and addressed with the Director of Nursing and Midwifery at the time and a program of work were put in place to follow these concerns up.

Concerns continued to be raised throughout the year relating to the uncertainty around the COVID-19 Pandemic and the constant changes that this brought about. Much of the work undertaken by the Guardian in relation to these issues meant the concerns were able to be dealt with at the initial discussion. This was by reviewing the trust guidance and discussing their anxieties this with them. Many of the concerns were being influenced by national media coverage and hearsay.

In Q2 a member of the midwifery team raised concerns about the preceptorship and how this was affecting new midwives and retaining them. The Guardian supported the member of staff to engage with the senior managers in Maternity and discussed the issues. As a result of the staff members insight they were invited to be part of the review group aimed at providing the best possible preceptorship program.

Throughout the year there have been cases where the root cause seems to be an issue with how change is managed and implemented. During the past year services and staff had had to be very flexible and agile to cope with the ever-changing circumstances, but on occasion how this has been implemented meant staff felt frustrated and concerned about the impact of these on patients and themselves. As part of the leadership courses being undertaken during 2021/22 the Freedom to Speak Up module will include advice and guidance on change management and the impact this has on the concerns of staff.

Towards the end of Q4 the second Guardian role was recruited to so we now have the full complement of guardians again.

After many years in the pipeline, during Q4 2020/21 the National Guardian Office launched their freedom to speak up training that is available for anyone who works in healthcare. Developed in association with Health Education England, the training is spit into 3 modules

- **“Speak Up”**
  This is core training for all workers and covers what speaking up is, why it matters and it helps staff understand what they can expect from speaking up
- **“Listen Up”**
  This is for Managers at all levels and focuses on listening to concerns and understanding the barriers to speaking up. This should be completed in conjunction with *Speak Up* as to ensure they understand what speaking up is and how they should respond when someone speaks up to them.
- **“Follow Up”**
  For senior leaders, including executive and Non-Executive Directors, lay members and governors. This final module, Follow Up, for senior leaders – including executive and Non-Executive Directors, lay members and governors – will be launched later this year. Senior leaders will be expected to complete all three modules, *Speak Up*, *Listen Up* and *Follow Up* to ensure they have a full understanding of the speaking up process.

Induction and training activities have continued to be undertaken during this year in both virtual, recorded and face to face formats where possible.

Concerns throughout the year were raised from a wide variety of staff, with concerns raised by staff of all grades and from all services and teams have spoken to the Freedom to Speak up Guardians. The trend data would seem to indicate that more staff feel confident to raise concerns in their own name.

Feedback to the Guardians is collected at the end of an episode of raising concerns with staff feedback being wholly positive. There has been no negative feedback this year related to the support offered by the Guardians.

The F2SUG is an active member of the North West Regional F2SU Guardians network and have presented at regional events. This work helps to standardise Guardians works across a wider footprint and to create a support structure for Guardians to enable training, learning and debriefing after difficult cases.

The Freedom to Speak up Guardian continues to be heavily involved in the Fair and Just culture project within the Trust and is a certified manager in this methodology. The project has essential links in with the aims and ambitions of the nation Guardian program.

The F2SUG continues to monitor training, policies and processes undertaken by the Guardians to ensure any national changes are implemented where apprpriate. F2SUG continue to have a presence on all inductions and leadership courses within the Trust.

The National Guardians office continues to undertake case reviews within NHS Trusts and make recommendations for improvement where they see for. These reports are then shared with the F2SUG's. They are then used within LWH for self-reflection and review of any areas of learning. , we have used these for LWH to ensure we are working within the best practice guidance of the National Guardians Office.

2.4. Freedom to Speak Up Index

Working with NHS England, the National Guardian's Office (NGO) has brought together four questions from the NHS Staff Survey into a 'Freedom to Speak up (FTSU) Index'. These questions ask whether staff feel knowledgeable, secure and encouraged to speak up, and whether they would be treated fairly after an incident. The FTSU Index seeks to allow trusts to see how an aspect of their FTSU culture compares with other organisations so learning can be shared, and improvements made. This is the third year in a row that we are publishing the FTSU Index. This year's index is based on the results from the 2020 NHS Staff Survey.

The FTSU index was calculated as the mean average of responses to the following four questions from the 2020 NHS Staff Survey:

- *% of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 16a)*

- *% of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 16b)*

• *% of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 17a)*

• *% of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 17b)*

There was an additional question included in the 2020 NHS Staff Survey which focused on workers feeling safe to speak up more generally:

• *% of staff "agreeing" or "strongly agreeing" that they would feel safe to speak up about anything that concerns them in their organisation (question 18f)*

Question 18f was not included in this year's FTSU Index – to allow for comparability to previous years – but has been analysed alongside the index score.

The overall Index score for 2021 at LWH was 77.8% which is below the national average of 79.2% and a 2% decrease on the year before. This follows a 4% increase in the report from 2020.

The specific speak up question (18f) scored 66.7% and was above average nationally, which was 65.6%

2.5. Freedom to Speak up survey

To help us expand on the findings of the national report we have conducted an LWH specific local survey in relation to Freedom to Speak Up, which we will conduct on a regular basis throughout the year in conjunction with our Communications Team. This survey was conducted electronically with LWH staff between 2nd June – 11th June 2021.

Aim of survey was to understand people's knowledge of Freedom to Speak up within the Trust and if they know how to contact the Freedom to Speak up guardians. It also purposefully asked if information is visible enough and if it has been seen across the Trust recently to support the upcoming promotional campaign.

132 responses received (approx. 10% sample of all staff).

Over three quarters are aware we have Freedom to Speak up Guardians within the Trust (77.3% / 22.7% respectively).

Less are aware of the role of the guardians and why they are there for them (63.6% / 36.4%)

With just over half saying they are aware of how to contact the guardians (56.5% /42.5%)

60% said they would feel comfortable contacting a guardian with a concern they may have although comments received included:

- *Don't feel safe to speak up due to potential implications on me as a result*
- *Worry about confidentiality*
- *Feel raising concerns will impact on career progression*

75% said F2SU information is NOT visible enough with 81% saying they haven't seen any information displayed across the Trust in the last week.

- One comment said they had a look on Intranet for information and found details
- Another said the only guardian they are aware of has either left or on long term sick

There were 17 free text comments, the main themes of which included:

- Difficult to get privacy to speak with them
- Regular communication needed from guardians and visiting areas to raise profile
- Positive feedback towards a guardian but concerns not addressed and anonymity a concern

2.6. Actions for the Coming Year Ahead

Launch new promotional campaign with a stronger visual identify across the trust to help with the visibility of the service provided

Embed the national training modules across the trust and encourage all staff to complete to their relevant job level. This will add to the work that is done at induction and other awareness activity.

Continue to engage with staff, to be visible within the Trust, support training for staff and managers around Speaking up.

Work towards our staff supporters being “Freedom to Speak up Champions” within the trust to provide contact and signposting information

Conduct a refreshed Freedom to Speak Up review tool review for 2021 with the Board and work on any associated actions that result from this.

Launch the Freedom to Speak up Strategy

Conduct review of the Freedom to Speak up Guardian structure to support the future plans and strategy.

Explore how to enable the Freedom to Speak Up data to be triangulated with other data through the Trust’s Integrated Governance report

Implement new communication tools, such as inputting into the learning newsletter from Governance that is looking to be introduced, to enhance visibility

Support the Leadership and Management Programme by providing specific Freedom to speak up workshops to identified future leaders. This will focus on how concerns are received by managers and the expected actions they are required to take.

Continue to meet with staff groups to publicise the role of the Freedom to Speak up Guardian both internally and externally to the Trust.

Continue to support the Fair and Just Culture work program within the Trust and embed its principles into all aspects of Trust business.

Continue to work with Reginal and National Guardians to improve communication and standards of working and reporting of Concerns Raised.

Work with HR colleagues on analysis of the any Staff Survey's to identify pockets of concern and prioritise these areas for contact and support.

Continue to Work with the Divisional Leads to identify any trends and themes in concerns raised.

3. Conclusion

This paper demonstrates that the Trust is working to increase the reach and visibility of the freedom to speak up service. It demonstrates the continued feedback approach being adopted to ensure the service keeps pace with the needs of the staff in the organisation.

It also provides assurance that any concerns that have been raised have been dealt with appropriately.

4. Recommendation(s)

The Board is asked to accept the assurance provided by this report and endorse the further actions proposed.

Liverpool Women's
NHS Foundation Trust

Freedom to Speak Up

Vision and Strategy
2021-2024

Context & Mission

Sir Robert Francis's 'Freedom to Speak Up' review in February 2015 highlighted the need for the creation of the National Guardian and Freedom to Speak Up Guardians at every Trust in England as a 'vital step towards developing the right culture and environment for speaking up'.

The National Guardian's Office, produces leadership, guidance and information in relation to national best practice for Speaking Up and how organisations can develop and enrich their speaking up arrangements, to better support staff to do so.

The National Guardian's stated mission is to make speaking up business as usual throughout the healthcare sector.

What is Freedom to Speak Up?

When things go wrong we need to make sure that lessons are learnt and improvement made. If we think that something is wrong, it is important that we feel able to speak up so that potential harm is avoided.

Even when things are going well, but could be made better, we should feel able to say something and should expect that what we say is listened to and used as an opportunity for improvement.

Speaking up is about all those things.

Workers may use terminology such as 'raising concerns', 'whistleblowing', 'raising a grievance', 'complaining', 'making a suggestion for improvement'.

All of these things are speaking up.

Our Vision

At Liverpool Women's Hospital (LWH we are committed to creating an open, fair, just & kind culture throughout the organisation from front line to Board level.

We want to ensure that all staff, including agency workers, temporary workers, students, volunteers, governors and other stakeholders are encouraged and **feel safe** to '**Speak Up**'.

Our Freedom to Speak Up culture will actively encourage:

Courage – speaking truthfully and challenging appropriately
Impartiality – remaining objective and unbiased
Empathy – listening well to diverse voices and acting with sensitivity
Learning -seeking and providing feedback, and looking for opportunities to improve.

Our Board and senior leadership team will support this vision by:

- Actively championing Speaking Up
- Providing timely and easy access to the Senior Independent Director when requested
- Ensuring all methods of raising concerns are promoted seeking innovative ways to make speaking up accessible to all staff at all times
- Raising the profile and visible leadership of Freedom to Speak Up
- Modelling the behaviours to promote a positive culture in the organisation
- Providing the time and resources required to deliver an effective Freedom to Speak Up function
- Seeking assurance from Guardians across a range of indicators about the underlying culture in relation to speaking up across the Trust
- Utilise data effectively including triangulation of Speak Up data with quality and engagement metrics
- Ensuring the policy and procedures are being effectively implemented
- Leading the development of a Fair and Just Culture with LWH
- Ensuring that F2SUGs have access to all the information they require (maintaining confidentiality) to adequately assess and understand the cultural drivers in relation to speaking up
- Providing learning to support leaders to recognise and utilise the potential for speaking up to drive improvement
- Provide access to training for all workers, including leaders, to promote a speak up, listen up, follow up culture
- Ensuring that those who speak up are supported, cared for and suffer no detriment.

Role of the Freedom to Speak Up Guardians at LWH

The Trust's Guardians will fully engage with the National Guardian's Office and the local network of Freedom to Speak Up Guardians in our region to learn and share best practice.

There are 10 principles of the F2SU Guardian role defined by the National Guardian's office

1. **Fairness -** F2SU Guardian teams appointed or selected in a fair and transparent way
2. **Conflict -** F2SU Guardians should guard against potential conflicts caused by holding additional roles
3. **Reach -** The F2SU message should reach everyone
4. **Diversity -** All staff groups, especially the most vulnerable, need routes to enable them to speak up, staff networks can support this
5. **Communication -** F2SU messages should be included in training and feedback and how it generates change should be disseminated regularly
6. **Partnerships -** F2SU Guardians need to develop strong partnerships with teams and individuals throughout their organisation
7. **Leadership -** All leaders in the organisation should demonstrate their commitment to F2SU and CEOs and NEDs will meet regularly with the F2SU Guardian/s
8. **Openness -** F2SU Guardians should present regular reports to their Board of Directors in person
9. **Feedback -** F2SU Guardians should gather feedback on their performance
10. **Time -** F2SU Guardians should have sufficient time and resource to meet the needs of workers in the organisation

Our F2SU Guardians will work together to:

- Engage with Trust leadership and the wider workforce to raise the profile of raising concerns in our organisation.
- Meet with staff, utilising a variety of events, processes and media to ensure that all staff are aware of how to raise a concern.
- Provide confidential access, advice, support and feedback to every section of the workforce in relation to concerns they have about patient safety.
- Provide training to all staff in how to raise and receive a concern.
- Provide adequate information, which has been appropriately triangulated, to PPF and Board to enable them to make informed opinions on the culture of speaking up with LWH

Strategy

We will prioritise the following actions to deliver our F2SU Vision:

Leadership

- Annually review our position against the National Guardian's Office expectations for Boards
- Provide support for the Guardian/s and ambassadors in their roles with access to executive and non-executive leads
- Participate in the relevant Integrated Care System programs in line with The NHS People Plan. For example workforce race equality and F2SU joint training
- Ensure Visible leadership of F2SU by promoting all methods access and communication

Governance

- Ensure policies, procedures and reporting arrangements are in place and reviewed annually, taking into consideration national, regional and local learning
- Ensure systems are in place to record disclosures and that they protect a person's confidentiality when a concern is raised
- Annual review and audit of the Trust's F2SU strategy and policy
- Annual audit of staff awareness of F2SU processes
- Report outcomes through the appropriate channels
- Provide an annual report for the Trust Board and presented in person by the Guardian/s

Learning

- Deliver the national training program at three levels; all staff, managers and the Board
- Share good practice and learning from concerns raised through a variety of fora, with the key aim of fostering openness and transparency
- Review and strengthen plans to address learning from NGO case reviews
- Review internal cases management through reflection
- Seek opportunity to triangulate learning from F2SU concerns with patient safety, patient experience and HR data

Culture

- Develop a communications and training plan which raises the profile and understanding of our speaking up arrangements and learning
- Ensure people who raise concerns are supported through the process, receive feedback and are thanked for their action
- Ensure that all staff are treated fairly and consistently when speaking up or raising concerns, including those who are being spoken about
- Develop a plan to ensure that staff from minority groups feel able to access speaking up support
- Ensure that all staff will have completed F2SU training and know how to speak up, and if in a line manager role, will know how to listen up and take action

Monitoring Impact

- The Putting People First committee (PPF) will have oversight of the Strategy and the supporting workplan will be reviewed twice yearly by the PPF Committee and annually by the Board of Directors.
- Annual Freedom to Speak up report / presentation to the Trust Board
- Annual Raising Concerns Report (including Freedom to Speak Up) to be presented to Putting People First Committee and Audit Committee
- Divisional Boards will receive and review Divisional F2SU quarterly reports and Divisional Performance Reviews. This will be incorporated into the PPF and Board reports.
- Feedback obtained from those that speak up; about their experience of speaking up will be collated and used to inform appropriate changes
- Regular testing of staff awareness and confidence in Speak Up processes will be undertaken at regular intervals throughout the year and as part of the Annual Staff Survey.

Draft F2SUG Strategy Action Plan 2021-24

	On target to achieve		*Minor Delay*		*Behind Schedule*		*Completed*

Action	Action Description	Lead	Target Date	Progress / Completion	RAG
a) Identify the baseline for knowledge of speaking up across the Trust – use the intelligence gathered to inform future engagement with staff.	Regular all staff surveys to be undertaken at 6 month intervals and scores tracked to identify any areas of improvement	**KR**	**Jan 2022**	Initial survey undertaken in June 2021 for baseline.	
b) F2SUG to work at Regional and National Level to celebrate and inform speaking up	Attend quarterly Reginal events including Regional conference Read and review Bulletins from NGO and share any relevant information	**KR**	**Ongoing**		
c) Read and Evaluate the Case Studies produced by the NGO	Develop a gap analysis and action plan for improvement on LWH current performance and development needs in relation to Case Studies. Report findings, developments to PPF in bi annual report. Escalate any urgent issues to Executive and NED for Speaking Up	**KR**	**Ongoing**		
d) Development of a Bi-annual Divisional Reports to raise the profile of speaking up at Divisional level.	Identify the • Number/ type of concerns raised per division per quarter. • Learning achieved • Areas of concern for Guardians • Silent areas	**KR**	**April 2022**		

	• Survey results of F2SUG • Team meetings attended, other engagement and education events attended.				
e) Ensure feedback and findings gathered from speaking up cases feed into wider Trust governance reports	Feedback framework to be designed to ensure trands and findings from sepak up cases feed into reviews with Incidents, Patient feedback, staff surveys etc.	**KR**	**Apr 2022**		
f) Ensure the Trust Policy on Speaking up reflects the best practice National Speaking up Policy Guidance	Review current policy against National Speaking up Policy Guidance Undertake Gap analysis Revise policy to reflect national guidance Ratify policy via usual channels	**KR**	**Apr 2022**		
g) Ensure all Trust Induction Sessions have a spot for the F2SUG role and Speaking Up at LWH	Review all Trust induction programs and ensure F2SUG are represented on each one including student nurse/midwife and Junior Doctor Induction programs. Ensure promotional materials are available in induction packs	**KR**	**Complete**	Allocated time on all inductions completed. Video induction recorded and made available where needed.	
h) Gap analysis of current training program against National Guidelines on Speaking up Training from NGO	Review the F2SUG input into the Trust Leadership program to ensure it is up to date and congruent with national best practice. Ensure the training program for staff meets the minimums standards of the NGO Guidance. Development of on line and virtual	**KR**	**Jan 2022**	Online training developed as per Action q) currently in the process of adding this to the Trust training provisions through Education Governance.	

	training programs to promote learning.				
i) Development of closer links with other staff support services such as Mental Health First Aiders and Dignity at Work Advisors	Support the development of a comprehensive advice system for all staff. Support other internal staff support services and engage in greater cross working	**KR**	**Ongoing**		
j) Develop ways to celebrate speaking up across the Trust and externally	Celebrate annual Speaking up Month (October) have plans in place to raise the profile of speaking up Develop (where appropriate) lessons learnt from speaking up cases within the Trust, maintaining confidentiality.	**KR**	**Oct 2022**		
k) Regular meetings between the F2SUG's and CEO/Chair, NED and Exec for Speaking up are diarised	Ensure meetings are regular and given priority within diaries	**KR**	**Nov 2021**	NED Meetings arranged	
l) Development of a minimum Data set for reports to Board and PPF which will provide assurance about the Speaking up arrangements in the Trust	Ensure compliant with NGO advice in Guidance for Boards on F2SU in NHS Trusts and NHS Foundation Trusts Ensure data set is triangulated properly to give informed advice to Board and PPF Agree with Trust Secretary frequency of reports to Board and PPF	**KR**	**OCT 2022**		
m) Development of a feedback mechanism to allow learning, improvement and development of the F2SUG service	Design a feedback / evaluation form for all contacts for the F2SUGs within LWH to include • Ease of use • Support Offered / Given	**KR**	**April 2022**		

	• Any Detriment • Overall Satisfaction • E&D Data • Use again? Ensure this feedback is added to the annual F2SUG reports to PPF and Board				
n) Annual Self-Assessment against national best practice to be developed	To be completed annually and action plans developed for any areas of non-compliance with expectation.	**KR**	**Ongoing**		
o) Development with HR leads a system to review impact of speaking up on workforce	Review current arrangements and revise the information this is telling us. To include :- • Sickness • Recruitment • Termination • Exit Interview • Staff Survey results	**KR**	**April 2023**		
p) Review of all Promotional Materials	Review current promotional materials, cross reference with survey responses (above) and refresh and develop new methods of promotion of Speaking Up across the Trust. Development of a Trust Leaflet on Guidance about How to speak up and How to receive a concern at LWH.	**KR**	**April 2022**	New branding promotional materials sourced and distributed.	
q) Development of an online training program in how to raise and receive a concern.	Working with Learning and Development Leads, IT leads; NGO and Regional Guardians	**KR**	**Completed**	Online training program now complete- Implementation picked up in action g)	

	develop a comprehensive on line training program for all staff. Develop an evaluation process for evaluation of learning Build in annual reviews				

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Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/71d*		2 September 2021	
Report Title	**Integrated Governance Assurance Report 2021/22 – Quarter 1**			
Prepared by	***Allan Hawksey, Acting Associate Director of Quality and Governance***			
Presented by	Marie Forshaw, Chief Nurse & Midwife			
Key Issues / Messages	Report provides information of oversight and assurance monitoring of Integrated Governance and highlights key risks to the Trust.			
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 requested that the Trust Board review the contents of the paper and take assurance that there are adequate governance processes in place and the positive progress in managing risk has been made with Senior Management having oversight of such risks.			
Supporting Executive:	***Marie Forshaw, Chief Nurse & Midwife***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

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REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Improvement Group	20/08/21	Deputy Medical Director	The Group took assurance from the report

EXECUTIVE SUMMARY

The following Integrated Governance Assurance report covers Quarter 1 of 2021/22. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of Integrated Governance across the Trust.

Key findings in this report:

- There has been an increase in the total number of incidents reported during Quarter 1 by 279 compared to Quarter 4 in 2020/21 and an increase of 910 compared to the same quarter in 2020/21.
- The no harm category has decreased by 163 incidents, low/minor harm increased by 205 incidents and moderate harm decreased by 7 incidents overall.
- Clinical management is the highest cause group for reported incidents related to delays of greater than 30 minutes between presentation and triage, failure to follow clinical guidelines, treatment and procedures being delayed or failing and communication issues, predominantly across maternity services (delivery suite) but also across the Trust.
- There remains a significant issue (reported in Q3 and Q4) relating to blood sampling errors, with samples not being processed due to inadequate / inappropriate labelling. The Trust Transfusion practitioner in continuing to undertake a weekly safety round in all clinical areas on the subject as well as discussing errors with individual staff.
- Lessons learned remain a priority for the Governance Team who are actively working to continue to develop an evolving system of dissemination in order to improve quality, reduce risk and develop staff engagement through use of engagement and learning events, the Trust Wide shared learning desktop icon and the roll out of the new staff app which is expected to be fully functional as a priority.

Dashboard of key figures relating to Incidents, complaints and claims Q1

- Increase of 279 incidents compared to Quarter 4 – Increase of 910 incidents compared to Q1 20-21
- Decrease of 163 no harm incidents, increase of 205 low / minor harm incidents and a decrease of 7 moderate harm incidents
- Overall increase in total number of patient safety incidents due to increased incident reporting, however a significant reduction for moderate levels of harm.
- Increase of 3 controlled drug incidents.

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Key themes and issues highlighted:

- Clinical management – treatment procedures / delays
- RTT 52-week breaches – reduced Trust capacity
- Investigations – blood labelling sampling errors
- Admission / discharge / transfers – ability to discharge, admit patients and transfer internally
- Staffing levels – Covid impact and sickness

- Decrease in formal complaints (-4) – fewer formal investigations required
- Increase in closures (+7)
- Increase in PALS complaints (+76))
- 10 clinical negligence claims – increase of 3 from Q4

Key risks to the Trust:

- At the time of writing this report the key risks to the organisation relate to the continued impact of Covid-19 and on Trust capacity to treat patients appropriately within 52-week performance targets.
- Blood sampling errors continue to be reported on a daily basis relating to inappropriate and insufficient labelling errors and other errors associated with obtaining such samples. This remains a focus for the Trust transfusion lead in working with staff to support and educate staff in improving standards.
- The key areas, which continue to be part of the themes and trends, though out incident and complaints continues to be, clinical treatment / management and communication.

Achieved

- Engagement of staff
- Improved compliance with Safe and Secure Storage of Medicines
- New CQC compliance Module, Action Planning Module and Clinical Audit Module on Ulysses developed and ready for implementation.
- Safety and Governance in relation to Covid-19
- Continued availability and use of PPE
- Fit Testing staff for FFP3 mask completed for all nominated clinical staff
- Increase in incident reporting over the year

Requires Improvement

- Lesson learnt from Complaint's / PAL's need to be implemented in a timelier manner
- Prescribing errors Trust wide
- Insecure storage and retention of patient medication
- Verbal communication and accuracy documentation
- Full use of Ulysses system in progress
- Further improvements to learning being disseminated Trust wide required.
- Risk register content continues to require improvement and development but is progressing
- Care of the 16-17 year old

Risks

- Lack of learning being disseminated divisionally and Trust wide
- Poor verbal and written communication
- Multiple IT systems – Managed risk
- Non - compliance with Medicines Safe and Secure Requirements
- Lack of adherence to recommendations, requiring further education of staff
- Medicines Safety
- Clinical management and treatment

- A key area, which continues from triangulation, is poor or lack of communication, with patients, between staff and in written documentation (as per Q3)
- Governance work on greater dissemination of lessons learnt has significantly progressed with the continuation of Trust Wide learning and engagement events, the introduction of a Trust Wide Shared Learning icon on all staff computers (which is regularly updated) and a section on the new staff app called Learning Together which is due to launch imminently.
- Medicines Safety Group – work continues to ensure all new and closed medication incidents are reviewed and scrutinised by the group weekly, chaired by the Gynaecology Head of Nursing (this reports to the Medicines Management Committee).

Recommendation: It is it is requested that the Trust Board review the contents of the paper and take assurance that there are adequate governance processes in place and the positive progress in managing risk has been made with Senior Management having oversight of such risks.

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MAIN REPORT

The following report provides information in relation to five key aspects of an integrated Governance structure, Incidents, Complaints, Clinical Audit, Claims and triangulation of themes.

Incidents

Total incidents

- 1691 reported in total
- Increase of 279 incidents compared to Quarter 4 – Increase of 910 incidents compared to Q1 20-21

Top 5 cause groups

- Clinical management – 194 (+24)
- 52 week breaches – 174 (+57)
- Investigations – 164 (-40)
- Admission / discharge / transfer – 127 (+40)
- Communication – 126 (+4)

Top 5 Incident locations

- Maternity - 763 (+143)
- Gynaecology – 380 (+21)
- Neonatal -153 (+8)
- Theatres and Anaesthesia – 99 (+47)
- Patient Administration – 69 (+31)

Patient Safety Incidents

Total Patient Safety Incidents

- 1402 reported in total (+357 from Q4)
- No harm 537 (-163)
- Low / minor harm – 445 (+205)
- Moderate harm 7 (-7) – Joint highest cause groups: Admission / discharge / transfer (2), Clinical management (2), Diagnosis (1), Infection (1) and Resuscitation (1)
- 5 Formal reviews undertaken (2 still under review), 1 case of appropriate care with 4 cases demonstrating potential for improvement by reflections and discussions with staff.

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Clinical Management Incidents

Clinical Management Incidents

- Highest cause group Q1
- 194 Incidents reported in total
- Delay >30 Mins Between Presentation And Triage (30)
- Failure To Follow Clinical Guidelines (14)
- Shoulder Dystocia (10)
- Treatment / Procedure - Delay/Failure (10)
- Communication issue (9)

Top 5 Location Clinical Management Incidents

- Delivery Suite (57)
- MAU - Maternity Assessment Unit (41)
- Maternity Base (15)
- Midwifery Led Unit(MLU) (12)
- Community (8)

Impact of Clinical Management Incidents

- Near miss (5)
- No harm (73)
- Low harm (41)
- Moderate Harm (2) – (did not result in an SI)

Medication Incidents

Medication Incidents

- 118 (+28) incidents reported in total
- 12 (+3) related to a controlled drug (CD).
- 3 CD incidents within Gynaecology
- 3 occurred within Pharmacy
- 5 occurred on Maternity Base
- 3 occurred within Neonatal
- 1 occurred within Gynaecology
- 4 medication incidents assessed as near miss
- 34 as no harm.
- 53 as low / minor
- No incidents assessed as moderate harm.

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Serious Incidents

Serious Incidents

- 5 (-1) serious incidents reported
- 4 (-1) serious incidents submitted to the CCG
- No never events
- All incidents requiring duty of Candour have been completed
- New serious incidents relate to 5 Maternity cases – 2 cooled babies and admission to NICU (HSIB cases), 1 regarding failure to escalate deteoriation of mother and baby during labour, 1 relating to the diversion of maternity services, 1 for post-delivery failure to recognise perforation.

Complaints and PAL's

Complaints and PALS

- 13 (-4) formal complaints
- Clinical Treatment and Communication are the key themes
- 15 complaints closed down
- 718 (+76) PALS contacts
- Communications, appointments and access to treatment or drugs remain key themes
- PALS+ 11 (-21) contacts
- Patient care, values and behaviours (staff) and communication are key themes

Effectiveness and Audit

Effectiveness and Audit

- 3 audits completed in Q1
- Shared learning from clinical audit outcomes were disseminated at local meetings to promote awareness of the importance of robust documentation.
- Communication with staff about indications for intrapartum antibiotics through a Lesson of the Week.
- Change in EPR (K2 Athena) system to include a clear process for GBS documentation.
- In addition, continuing the development of Saving Babies Lives Care Bundle V2 Power BI dashboard, and continuing to work with regional strategic clinical team to align LWH guidance for fetal surveillance competency assessment, training requirements, escalation process and management of staff who are non-compliant.

- Ensuring information team are able to retrieve risk status data from K2, ensuring second scope of K2 work includes ability to document risk status for FGR is built into the risk assessment, and evaluating K2 risk assessments and status with K2 Midwife after completion of the second scope of work.
- Scenario-based learning was added to Safeguarding Children training to increase staff confidence in assessing level of need.
- Further work required in respect of Staff engagement with the early help agenda (EHAT), how Staff facilitate the offer of early help and document this.

Claims cases and Inquests

Legal

- 10 clinical negligence claims in Q1
- Increase of 3 from Q4 20/21, and 3 from Q1 20/21
- 4 clinical negligence claims were settled in Q1
- No claims were raised as a result of any Serious Incident investigations
- No new public liability of employer liability claims
- 1 request for inquest statements – The Trust is indirectly involved in the case.

April

In April 3 gynaecology claims settled

May

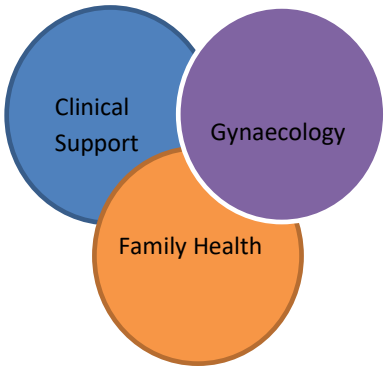
In May 1 claim settled during trial.

1 neonatal claim settled upon serving the Letter of Response.

Inquests

The Trust have been asked to provide statements for an inquest that the Coroner is investigating regarding a lady that was operated on at the Trust under an arrangement with another local Trust.

Triangulation and key trends



- Medication errors relating to prescribing and administration across all divisions (as per Q4)
- Blood sampling errors relating to Inappropriate or insufficient labelling across all divisions (as per Q4)
- Communication issues both with patients and with the teams across all divisions (as per Q4)
- Clinical treatment / management and communication remain the highest categories of formal complaints and a significant proportion of PALS contacts.
- Risk 2329 (Pharmacy) on the Corporate Risk Register relates to the safe and proper management of medicines – Owned by the Medical Director and managed by the Deputy Chief Pharmacist
- Risk 2232 (Pathology) on the Corporate Risk Register relates to the safety requirements regarding blood transfusion including sample labelling – Owned by the Trust Transfusion Lead (Consultant) and managed by the Trust Transfusion Practitioner.

Quality Improvement Projects

- There are 39 current ongoing projects, 7 new projects listed for July
- Overarching QI project on Ulysses is addressing the Trust wide issue of clinical investigations; this covers the blood sampling issues, scan requests and reporting on ICE and moving onto new systems. The project lead is Lynn Greenhalgh with a fortnightly task and finish group established utilising an MDT approach
- CSS have 8 current ongoing QI Projects, 2 for Theatres/Anaesthesia (Measurement of blood loss in theatres and Outcomes of high-risk patients sent to the RLUH for surgery). The other 6 projects are for Genetics with 2 on-track and 4 overdue. The overdue projects are being addressed by the project leads and these should move to being on track by the end of July.
- Family Health there are a total of 19 projects. Maternity have 9 projects, 2 are on-going, 7 are overdue all project leads have been contacted and offered training and support to ensure the updates are actioned. (1- Management of pain post caesarean section; patient experience survey has been presented at the QI Great Day in April this project is ongoing. 2 - Service evaluation prior to, during and post the implementation of Birmingham Specific Obstetric Triage System into the Maternity Assessment Unit – this is ongoing.)
- Neonatal have 9 projects listed all are overdue, these are currently being addressed 2 have been completed and closed without uploading the project evidence. 2 projects have had junior doctors leave and these are being re-assigned to ensure completion (1-Lumbar punctures on the NICU this has been closed but awaiting further evidence to be uploaded. 2- Avoiding Term Admissions to NICU, this project has been re-assigned and will be updated by end of July on Ulysses)

CONCLUSION

This report is to provide assurance as to the Governance System in place in LWH and that staff are being open by reporting incidents, clinical and non-clinical, to ensure patients and staff safety is maintained.

The report which has been presented has clearly identified themes within incidents and complaints and the triangulation of these across the divisions.

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RECOMMENDATIONS

It is it is requested that the Trust Board review the contents of the paper and take assurance that there are adequate governance processes in place and the positive progress in managing risk has been made with Senior Management having oversight of such risks.

Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/71e*		Date: 02/09/2021	
Report Title	Bi-Annual Safer Staffing Paper; Nursing and Midwifery			
Prepared by	***Nashaba Ellahi, Deputy Chief Nurse & Midwife***			
Presented by	***Marie Forshaw, Chief Nurse & Midwife***			
Key Issues / Messages	***The bi-annual Nursing and Midwifery staffing report is provided to the Board of Directors through the Putting People First (PPF) Committee. The report sets out the LWH position in the context of the National Nursing and Midwifery workforce challenges.***			
Action required	Approve ☐	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board of Directors are asked to: ***1. Accept the assurance of the current nurse/ midwife staffing levels*** ***2. Note the content of the report and the assurances, provided that nurse/midwife staffing levels agreed are safe and appropriate at present.*** ***3. Note the risk to the organisation of the number of nursing and midwifery staff > 50 years of age.*** ***4. Be sighted on the national shortage of nurses and midwives, current vacancies in Maternity and Theatres and actions being taken in divisions.***			
Supporting Executive:	***Marie Forshaw, Chief Nurse & Midwife***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1.2 Failure to recruit and retain key clinical staff 3.1 Failure to deliver an excellent patient and family experience to all our service users	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Putting People First Committee	July 2021	CN&M	Outlined in the report.

EXECUTIVE SUMMARY

The bi-annual Nursing and Midwifery staffing report is provided to the Board of Directors through the Putting People First (PPF) Committee. The report sets out the LWH position in the context of the National Nursing and Midwifery workforce challenges. This report covers the period from January 2021 to June 2021 (where data has been available). The report provides assurance that there are robust systems and processes in place throughout the year to monitor and manage nursing & midwifery staffing requirements. This report also includes AHP staffing. The report will emphasise a focus on re-set (post peak of Covid-19) highlighted within the recommendations of this paper.

The report has been presented and discussed at Putting People First Committee (PPF) in July 2021 where the key issues reported were:

- Vacancy rates at LWH are 5% for Registered Nurses, Midwives and ODPs with the vacancy rate remaining static in LWH since previous report (December 2020).
- Vacancy rates at LWH are 10% for HCSW which is an improvement on previous report of 21%
- Nursing and Midwifery Turnover rates are at 10% in June 2021
- The Age profile for LWH is 29.7 % of the Nursing and Midwifery workforce are > 50 years of age. This is a very small reduction from previous report
- Recording the highest volume of staff in the past 12 months on Maternity Leave in June 2021 (35 headcount)
- Actual versus planned staffing over last 6 months highlights fill rates have fluctuated, with some figures reflecting more recently the challenges experienced with Covid-19, sickness and absence and vacancies
- The previous results of the Safer Care Nursing Staffing Tool (SCNT) were unable to define the correct establishment needed for the gynaecology ward. Further communication regarding use of SNCT is underway with NHS/I
- Staff have worked flexibly over the last six months (and previously) with deployment of staff from one area to another to support safer staffing across the organisation as required overseen by Heads of Nursing and Midwifery.

MAIN REPORT

1.0 Introduction

1.1 Getting the right numbers of nurses, midwives and care staff in place is essential for the delivery of safe and effective patient care. It is a requirement for the Executive Nurse Director, on behalf of the Board of Directors to review the nursing and midwifery staffing numbers twice per year.

1.2 NHSI have developed recommendations to support Trusts in making informed, safe, and sustainable workforce decisions (October 2018). The document builds on the National Quality Board's (NQB) guidance (2013, 2016). NQB's guidance states that providers:

- Must deploy sufficient suitable qualified competent, skilled, and experienced staff to meet the care and treatment needs safely and effectively.
- Should have a systematic approach to determining the number of staff and range of skills required to
  meet the needs of the people using the service and keep them safe at all times.
- Must use an approach that reflects current legislation and guidance where it is available.

1.3 The Bi-annual Nursing and Midwifery review and annual budget setting ahead of Q4 and Q1 staffing report considers relevant guidance and resources available to support organisations. The relevant literature endorses supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (National Quality Board, 2016) through effective staffing (NICE, 2014; NICE, 2015; NHSI, 2018).

1.4 Liverpool Women's Hospital reports the following in line with recommendations:

- Six monthly Trust Board report: Bi- annual Nursing & Midwifery Staffing Review.
- Monthly Board level reporting detailing planned and actual staffing (fill rates) for the previous month, reported through the Integrated Performance Report
- Monthly staffing report to Unify and published on the Trust's website.
- Nursing/ Midwifery staffing levels each shift (planned and actual) displayed at ward level.
- Evidence based tools, professional judgement and outcomes are used in the safe staffing processes within Divisions as an integral part of detailed six-monthly staffing reviews.
- Updated annual workforce plan that is signed off by the Executives.
- Any service change, including skill mix change has a full quality impact assessment review signed off by
  the DONM and MD.

1.5 This bi-annual comprehensive report is provided to the Board of Directors on Nursing and Midwifery staffing. The report details the Trust's position against the requirements of NICE guidance for adult wards (2014); NICE guidance for maternity settings (2015), NQB Safer Staffing Guidance (2016) and NHSI, Developing Workforce Safeguards (2018).

1.6 The report will provide analysis of the Trusts workforce position at the end of June 2021 and the actions being taken to mitigate and reduce the vacant position.

1.7 Workforce planning has been undertaken prior to budget setting by each division. This has been signed off by Divisions and Trust Board in April 2021.

1.8 Each Division has undertaken a review of their workforce.

1.9 The staffing and acuity measures are modelled based on activity and professional judgement. BirthRate plus reviews acuity versus staffing requirements utilising the BirthRate Plus tool which provides a calculation of plus or minus depending on clinical activity and staffing. In addition, the maternity delivery suite utilises an acuity tool every four hours to assist with staffing and Maternity Led Unit reviews acuity and staffing every two hours due to status a low risk birth suite. Following the initial findings of the Ockenden Report a gap analysis of the maternity workforce has been compiled and is reported to Board monthly. Supporting safe care in maternity is the adoption of the helicopter view through the 104 bleep. The helicopter bleep has oversight of the acuity and dependency and utilises professional judgement in addition to actual staffing to determine appropriate midwifery staffing across all areas. The bleep holder additionally reviews issues such as staff breaks, patient ratio on ward and captures staff moves.

1.10 The Neonatal unit utilises an acuity model of staffing, which is reviewed 12 hourly and staffing flexed in accordance with patient need. British Association of Perinatal Medicine (BAPM) standards have been utilised to provide the benchmark for staffing within the Neo-natal Unit. Theatre staffing review is based on AFPP (Association of peri-operative practitioners) guidelines. The SCNT (Safe Care Nursing Tool) which

is a measure of acuity is currently being considered for use in Gynaecology in-patients with initial discussions being held with NHSE/I. Acquisition of appropriate license being the first step ahead of any training and use thereafter. The tool is not suitable for day- case patients.

1.11 The performance indicators such of fill rates, attendance/absence, vacancies, red flags and bed occupancy is reported monthly at Trust Board. The information is presented within the Integrated Performance Reports.

2.0 National Context

2.1 The shortfall in nurse numbers and midwives across the UK is well-recognised. The National Audit Office (March 2020) highlighted the shortfall in nurse vacancies to be 43,590 vacancies (12%). With the NHS in England short of almost 2,500 midwives according to the latest Royal College of Midwives analysis of birth figures published in August 2020 by the Office for National Statistics (ONS).

2.2 The people plan sets out areas of focus for the future nursing and midwifery workforce which includes:

- Increasing the pipeline supply
- Reducing vacancies (target 5% by 2028)
- Career development and progression
- Expanding the nursing workforce (including nursing associate role and International Recruitment)

3.0 LWH Nursing and Midwifery Workforce position

3.1 At the end of June 2021 there were a total of 37.85 wte Nursing, Midwifery, and ODP vacancies across LWH. This is an increase of 2.49 wte since December 2020 (previous reporting period).

3.2 June 2021 saw the vacancies improve in HCSW with a current vacancy of 19.91wte, an improvement from 37.63wte in December 2020 (previous reporting period)

3.3 The Trustwide vacancy rate in June 2021 as a percentage for Nursing, Midwifery and ODP is 5% (previously reported 5%); HCSW vacancy rate is 10% (previously reported 21%).

3.4 The Nursing and Midwifery turnover is 10% at the end of June 2021. The last six months saw a spike in January 2021 of 13% which has since stabilised and remains under the Trust turnover target.

3.5 The Nursing and Midwifery staff on Maternity Leave demonstrates a variable but relatively stable combined position of between 29-31 staff on maternity leave over the past 6 months except for June when the position rose to 35. Maternity leave has previously not been funded within budgets, but where possible has been recruited to by divisions. The Deputy Director of Nursing and Midwifery in conjunction with the Deputy Director of Finance will support divisional teams to actively recruit against maternity leave and turnover to avoid sub-optimal gaps and therefore unnecessary workforce challenges.

3.6 The age profile of Nurses and Midwives across LWH. 201.95 wte of our N&M workforce are >50 years of age which equates to 29.7% of LWH workforce, which demonstrates a small reduction from the previous 6 months.

3.7 Sickness absence saw a rise to 10.15% in January 2021 and notably the highest recorded since the start of the pandemic, however June 2021 has seen a rise after a previous reduction and now at 7.86%. Covid-19 related sickness absence in the last six months, saw January 2021 with the highest peak at 5.33% with June 2021 position highlighting a small upward turn after previously being under 1% (1.51% in

June). Current position of Trustwide sickness (June 21) is highlighting short term sickness is at 32%, but long-term sickness remains the greatest challenge at 68%.

4.0 Summary from Divisional staffing reviews.

4.1 Gynaecology services

4.2 The Gynaecology Nursing team currently incorporates:

- Gynaecology Emergency Department (GED) & Early Pregnancy Assessment Unit (EPAU)
- In-patient ward (24 beds)
- High Dependency Unit (2 beds)
- Day Case Surgery Unit (6 trolleys)
- Outpatient department (includes Colposcopy and Ambulatory care) based at Crown Street and Aintree
- A Colposcopy and Hysteroscopy Unit both on site and at Aintree
- The Bedford unit
- Hewitt Fertility Centre based at Crown Street and Knutsford

4.3 The breakdown of staffing establishment is as follows: (utilising May's budget statements):

- GED/EPAU: Nursing establishment for GED and EPAU is set at 44.02 WTE, Registered Nurses 26.93 WTE, Healthcare Support 12.81 WTE
- In-patient ward: Nursing establishment is set at 30.64WTE, Registered Nurses 18.36 WTE, an over establishment was agreed of 2.83WTE to support with Maternity leave and career break, Healthcare Support is set at 10.08WTE.
- HDU: Nursing establishment for HDU is set at 6.77 WTE,
- Day Case Surgery Unit: 4.08WTE and 1.86WTE Support Workers fully stablished Out-patients Department: Nursing establishment is set at 36.56WTE and fully established
- Bedford Unit: The nursing establishment is set at 10.28 WTE 7.86 RN and 2.42 HCA
- Hewitt Fertility Centre: The establishment for the Hewitt Centre is set 33.63 WTE Registered Nurses, 12.08 WTE Health Care Assistants, within this establishment there are 1.92 WTE Nurse consultants and 1 WTE ANP with 1 WTE trainee ANP

4.5 Current vacancies

4.6 Current position in June 2021 across Gynaecology division highlights wte vacancies as follows: 1 HCA, 8 RN and 1 Ward Manager

4.7 Sickness Absence

4.8 January 2021 saw sickness rise from previous six months in Gynaecology (9.39%) and Hewitt Fertility Centre (4.42%), June position highlights Gynaecology at 8.22% and Hewitt Fertility Centre which has shown a significant rise after showing some improvement at 6.35% with further work to be undertaken to be under Trust target. Gynaecology noted as area of highest sickness absence, with the division giving a focus on managing this in line with policy.

4.9 In addition to sickness absence, the division has also been impacted by Covid-19 special leave which includes those staff who were shielding (and unable to work from home). During the third period of shielding which ran from 6th January-31st March 2021 it was noted that related absence peaked to 7.99%

in January 2021 within Gynaecology/Hewitt Fertility Centre combined. Following a significant period away from work, the division introduced a 'Welcome Back' training day which was held in Gynaecology to support staff returning from shielding in April 2021. This position improved when shielders returned, however the current combined Gynaecology/Hewitt Fertility Centre position of 5.61% in June 2021 remains high.

4.10 Turnover

4.11 January 2021 saw the highest turnover position (Gynaecology 22%; Hewitt Fertility Centre 25%). This position is based on 'avoidable' turnover, therefore excludes retirements and dismissal from the calculation. Since January we can see that there has been a marked improvement in turnover with the data reflecting either a marginal above target position or one which is below. In addressing the high turnover from January 2021 gynaecology inpatient ward has embedded actions to support improvement. This has included the introduction of a Ward Based Matron, increased support for new starters as part of a recruitment and retention strategy adopted for the unit, recruiting to turnover which was previously not undertaken and recruitment of additional experienced HCA staff to support nurse retention and staff experience. The staffing model will reflect a HCA and RN per team. The changes and improvements made is reflected in our current turnover position with June 2021 position seeing Gynaecology at 9%. The Hewitt Fertility Centre has a current position of 16% turnover (June) with further work to support improvement.

4.12 Age Profile within the workforce

4.13 Largest staff group who can potentially retire under terms and conditions is within 56-60 age group with Gynaecology at 16.88wte (20staff); Hewitt Fertility Centre at 4.09wte (6staff). This is closely followed by those in 51-55 age group with Gynaecology at 16.67 (17staff); Hewitt Fertility Centre at 3.43 (4staff).

4.14 Currently there is one Colposcopy Lead Nurse requesting retirement in October 2021, this leaves a gap in the leadership role as the division has not previously placed direct focus on succession planning, therefore in the absence of anyone internally being able to assume the duties through acting up or a successful internal appointment, the post will be externally advertised.

4.15 One Nurse Consultant has expressed the desire to retire in the very near future and a further Nurse Consultant has requested to reduce her hours to support an improved home and work life balance.

4.16 The division will take action to prevent any gaps in the expertise required by advertising for a qualified ANP who will work alongside the Nurse Consultants to bridge any potential gap in service delivery.

4.16 Workforce challenges identified:

- Awaiting a start date for Children's Nurse Specialist to support the management of under 18s in adult settings
- Specialist nurse group identified as greatest area of risk from age profile
- Efficient and effective use of staff resource in HDU/In-patient ward, highlights current model for areas demonstrates a lack of role rotation between areas, development of a range of staff in advanced skills to support safe care across both areas. Further work to be undertaken to review bed occupancy across both areas, use of CPD/HEE monies to develop staff and review of current workforce model of a stand-alone HDU establishment. Consideration through consultation the

adoption of a similar model to Maternity in managing patients and HDU requirements within a combined establishment
- Early Pregnancy Unit based in Gynaecology Emergency Department with plans to re-locate to Bedford Unit to support succession planning in scanning for early pregnancy

4.17 Actions being taken to address workforce challenges:

- The Triumvirate, alongside HR and Finance Business partners to create a succession plan which includes a detailed business case for succession planning in specialist nursing teams across Gynaecology as part of a wider workforce review
- ANP recruitment to support the Nurse Consultant succession plan, covering Gynaecology
- Introduction of an educator post in Hewitt Fertility Centre to support on-going and specialist fertility training.
- On-going recruitment to vacancies and deep dive into areas of highest sickness to ensure managing sickness absence in line with policy
- Implement rotational post for Band 5 across gynaecology. Adverts will all include rotational post offer.
- MSc cancer module discussions being progressed with Liverpool John Moore's and Edgehill Universities with development of a Level 6 Gynaecology Nursing module and Nurse Sonographer module.
- In conjunction with HR Business Partners and OD&L, develop staff through appraisal process (PDR), including talent management and developing future leaders through career conversations
- Appropriate use of CPD/HEE spend noted in Divisional Training Needs Analysis with HoN oversight to support clinical, academic, and managerial development
- Review of HDU/In-patient ward bed modelling, occupancy, and staffing review to be undertaken identifying proposals for consideration and adoption.

5.0 Clinical Support Services

5.1 The Clinical Support Services Division provides the services required across Liverpool Women's Hospital to enable the delivery of safe effective care. The services provided include, theatres for gynaecology and obstetrics, imaging, including radiology and sonography, physiotherapy, dietetics, blood transfusion and genetics. The Dietitians are not employed directly and therefore staffing information is not covered in this paper.

5.2 Theatres

5.3 Staffing within in theatres comprises of registered nurses, operational department practitioners and there are 3 registered nurses with advanced skills working as surgical first assistants and 1 surgical care practitioner educated at master's level. Current vacancies within theatres are 18 WTE. Recently theatres recruited further theatre scrub and healthcare support workers to open a second theatre out of hours for obstetrics theatres and as demand for caesarean births has increased we are developing a business case to fund additional theatre lists for obstetrics and the staffing required. In December theatres operationalised the expansion of robot assisted surgery for women with gynaecological conditions and over the past six months we have been training an expanding team of surgeons and surgical first assistants to operate using Robotics.

5.4 Imaging

5.5 The imaging department provides a service with the facility to provide diagnostic Scanning services for women requiring gynaecology and obstetrics appointments. There are currently 2.0 WTE vacancies for sonographers within the imaging department. Recruitment is taking place and the department is recruiting two more trainees, reducing the vacancies in the team further. There are currently 2 WTE sonographers on maternity leave. A workforce review is planned within the imaging department which will assess current workforce issues.

5.6 Capacity and demand is currently being reviewed in the service to understand if we have sufficient resource in the core establishment as there has been an increase in agency spend which is being monitored and bank rates are under review.

5.7 There have been recruitment and retention challenges and the trust has carried out listening events with staff to understand concerns raised in the team regaining moral, training opportunities and career progression. The trust has planned a cultural mapping exercise for the service to review the current culture in the teams and see what improvements can be made.

5.8 Genetics

5.9 The Merseyside and Cheshire Clinical Genetics Service is primarily involved with the diagnosis and genetic counselling of families with possible or known inherited disorders. There are also 0.4 WTE vacancies within the Genetic Counsellor team, recruitment into these vacancies is to commence soon.

5.10 Table showing summary of vacancies for CSS

Department	Staff Group	Band	WTE
Theatres	Nursing / ODP	6	1.0
	Nurse / OPD	5	13.74
	HCA	2	4.3
Genetics	Counsellor	6	0.4
Imaging	Sonographers	7	1.5
	HCA	2	0.54

5.11 Current vacancy levels above are below the National vacancy target in all areas except theatres who have a high number of vacancies.

5.12 Workforce KPIs

5.13 The divisional workforce KPIs presented exclude the medical workforce.

5.14 Sickness Absence

5.15 Having peaked in January 2021, sickness absence has continued on a downward trend, reducing to 4.5% in March 2021, though increasing again in June 2021 to 4.98% (combined overall sickness absence). Absence remains higher in the admin and theatre teams with attention focused in those areas, which is showing an improvement.

5.16 In addition to sickness absence, the division has also been impacted by Covid-19 special leave which includes those shielding (and unable to work from home), peaking at 4.54% during the third period of shielding which ran from 6th January - 31st March 2021, with the impact concentrated in theatres. Following a significant period away from work, individual return plans were agreed with those who had been shielding to support their return to the hospital site in April. Current sickness absence in division due to Covid-19 is at 2.10% in June 2021, however this remains significantly higher in theatres scrub (6.57%) and theatre pre-op (7.01%).

5.17 Turnover

5.18 The reported turnover figure provides a rolling 12-month position, and is based on 'avoidable' turnover, so excludes retirements and dismissal from the calculation, for example. Turnover remains above the 13% target. Within this reporting period, divisional turnover is at 17% with higher turnover noted in areas of theatres and physiotherapy.

5.19 Age profile

5.20 Those in the age bands of 56 and over within registered and unregistered Nursing and Allied Health Professionals in June 2021 equates to 7.36wte which is 13.64% of the total workforce in CSS. Given the distribution of ages within the services, the services encourage new entrants to enable cross working/learning from the experienced workforce. This allows the transfer of skills and supports succession planning.

5.21 PDR Compliance & Mandatory Training

5.22 The division is under the agreed targets for Mandatory training and PDRs and are taking actions to understand the reason for this and taking steps to improve.

5.23 Workforce challenges identified, and actions being taken to address workforce challenges:

- Vacancies are higher than desired in theatres, recent progress has been made with recruitment of band 6 scrub nurses and team leaders, a review of the correct staffing number and skill mix is underway benchmarking current staffing, existing staffing model against the Association of Peri-operative practitioners (AFPP) guidance. A recruitment drive for band 5 staff is planned.

- The age profile for the Division highlights the need to continue to build on student training provision and the recruitment of newly qualified staff to build our workforce for the future.

- Focussed divisional oversight during Quarter 2 on improving training in the areas of: Core Mandatory Training, Clinical Mandatory Training, Specialty Specific (Local) Training and PDR Compliance

6.0 Maternity

6.1 The maternity service at LWH, had 7349 births for the period of April 2020 to March 2021, the maternity service offers a wide range of tertiary maternity services to the women of Liverpool and beyond. The 2021 – 2022 budgets were set in line with the agreed ward or service level rotas which were updated early 2021. This establishment and rota work were 'signed and rolled over' as the divisional team recognised the potential operational delivery and staffing requirements of the implementation of the National maternity

transformation work – Continuity of Care (COC). The resultant overall WTE budget was also reviewed to ensure workforce requirements were in line with the national Maternity workforce tool, Birthrate plus.

6.2 Maternity has recognised the requirement, for an updated Birthrate plus report, to ensure effective workforce planning for the forth coming year, to include the staffing requirements of the national mandated 100% compliance rate of COC.

6.4 There is a funded establishment of 371.6wte, across the service, consisting of 291.95wte midwives and 79.65wte maternity support workers, ranging in band 2-4, for the purposes of Birthrate plus calculation only bands greater than 3 can be utilized in a staffing establishment calculation. We are presently undertaking the data collection required for our full Birthrate plus report, draft findings are expected into the division, in the late summer.

6.5 Covid-19 has had a huge impact on staffing within maternity services, both in registered and unregistered staff, with staff feedback including, burnout, stress and staffing issues. This feedback follows the national pattern within maternity services, with many midwives deciding to retire early, leave the profession, or reduce working hours to achieve a different work/home life balance. The division are currently working with the HR Business Partner to review flexible work patterns, and support the continued delivery of COC, which will offer midwives flexibility with working hours.

6.6 Maternity is currently reporting a sickness rate of 10.13%, which equates to 12.76wte LTS and 8.23wte STS lost to the rota in June. An in-depth review of sickness has been undertaken by the divisional HR Business Partner which highlights management of sickness is in line with policy.

6.7 Sickness remains a challenge as the breakdown of maternity sickness demonstrates a long-term sickness rate of 7.31%. Work remains ongoing within the division to support managers to address. Staff supporters continue to be visible and in place for all staff, with resilience sessions held to provide further care. The maternity ‘wobble room’ remains available for staff to take a break or used to seek support.

6.8 Maternity leave has also seen an increase within the service, we remain committed to recruiting to all maternity leaves. In June 2021, Trust Board approved an additional over-recruitment of 10.0wte Midwives to cover anticipated maternity leave.

6.9 Maternity has undertaken a successful recruitment to address all absence from rotas, including LT sick cover in addition to vacancies. We are presently expecting 32.0wte newly qualified (NQ) midwives from within the CM region, to commence in September 2021 (this has reduced from initially recruited numbers due to regional post availability). The division has recognised that the introduction of a large cohort of NQ midwives poses a risk to the skill mix across the service, and for this reason Maternity has been granted approval to recruit to two band 7 Professional Midwifery Advocate (PMA)/Preceptorship Midwives to support the transition from NQ status to band 6 midwife. Furthermore, the division has successfully strengthened the Pre-registration Practice Education Facilitator (PEF) role by securing funding for 1.0wte PEF. The additional recruitment will support the changes in Standards for Student Supervision and Assessment (SSSA) requirements.

6.10 Despite the above we recognise short and long-term sickness (Covid and Non-Covid) and current vacancy position has been a challenge noting the effect of this has resulted in a number of maternity diverts.

6.11 Divisional on-going actions to support recruitment, retention, and attraction:

- Collaborating at a regional level to offer rotational programmes for experienced midwives giving them opportunities to gain advanced competencies in a tertiary unit. These midwives will be paid a retention premium to come from their substantive employers for 6 months
- Collaborating at NW level to engage in joint domestic and international recruitment
- Enhanced support and onboarding package for newly qualified staff starting in September with additional PEF support
- Individual and team coaching for maternity matrons and ward managers, reviews of roles and structures as well as support for the Divisional Leadership Team through the reach for the stars programme
- Opportunity for all midwives to engage in the Leadership Programme and have access to a mentor
- Dedicated wellbeing programme for maternity
- Development of new roles including digital midwife

7.0 Neonatal Services

7.1 Overview of the Neonatal Workforce

7.2 The workforce with the Neonatal Intensive Care Unit (NICU) comprises of both registered and non-registered nurses. The registered staff are made up of Advanced Neonatal Nurse Practitioners (ANNP) and Nurses from a background Adult, Children, and midwifery training. Over 70% of the nurses on the unit have completed a speciality course in the care the preterm and sick babies this allows them to be registered as nurses who are qualified in speciality (QIS).

7.3 However, the Trust continues to be very successful in the recruitment of staff and have one of the lowest vacancy rates in the country. The Trust have also had great success with internal recruitment and the launch of our talent pool. Turnover remains below the national average at 7% and the Trust have reduced the aging age profile of the unit, 68% of staff 45 years or under.

7.4 Staffing

7.5 Neonatal Nursing has become one of the most prescribed areas of nursing over the last years. In line with other intensive care specialities BAPM has set clear standards around the minimum number of nurses required to care for our client group. This is set in the national specification for neonatal care and is clearly defined by the specialist commissioners in hospital contracts.

7.6 Neonatal Units have also seen the introduction of the safer staffing guidance for Neonatal services, this reflects the requirements of the BAPM guidance but also addresses ways in which professional judgement should be used to ensure safer staffing on units. This way of working has been in use on the NICU since early 2017 and has helped ensure the Trust maintain safe and appropriate levels of staffing.

7.8 The above requirements have been included in the Neonatal staffing budgets for 2020-21. These budgets are rota based as reviewed and agreed by the Head of Neonates and the Deputy Director of Nursing & Midwifery.

7.9 Advanced Clinical Practice (ACP)

7.10 The role of the ANNP is widely acknowledged as being essential to the provision of safe and effective care to sick and vulnerable newborn infants. There have been ANNPs in post on the neonatal unit at LWH since 1995. Currently there are 28 qualified ANNPs (25.28 WTE) plus 4 in training. The team is well established with levels of experience within the existing team of ANNPs ranging from 1-year post qualification to 26 years post qualification. The team has been led by an 8b ANNP Nurse consultant appointed in 2016.

7.11 As the ANNP team expanded rapidly from 12 ANNPs in 2016 to 26 ANNPs by 2019, the need for a second tier of leadership was recognised. A second 8b nurse consultant was appointed in 2019, but the two Nurse consultant model of leadership was unsuccessful, and the second 8b Nurse consultant left the trust in 2020. A decision was made to divide the second 8b salary and uplift several the existing 8a senior tier 2 ANNPs to 8b lead ANNP role. Five 8b lead ANNPs (4.36 WTE) were appointed in May 2021. This reflects the ambition of the new national framework for ACP.

7.12 Trainee ANNPS

7.13 There are currently 4 Trainee ANNPS in post. The current trainees are all senior nurses recruited from the existing nursing team. The Trainees will complete their university program me including a nonmedical prescribing qualification in July 2022.

7.14 Staffing Tool

7.15 Previously commissioners have used the Dining Tool to calculate staffing requirements of the Neonatal units, however, this has now moved to the new National Clinical Reference Group (CRG) Workforce tool. The CRG Workforce Calculator (2020) has been adapted from the CRG Workforce Calculator (Dinning) Tool (2013) and has been developed with the National Lead Nurses Group. It is intended to support neonatal nurse managers and their colleagues by providing a consistent method for the calculation of nursing establishment requirements which meet national standards i.e. NHSI (2018); NHSE Neonatal Service Specification e08 (2015); DH (2009); BAPM (2010); NICE (2010) This tool uses activity against standards to calculate the cot nursing need of a unit. The expectation is every year this tool will be completed and reported into the North West Neonatal Operational Delivery Network (NWNODN) to ensure there is a clear national picture. the tool is completed using the year's activity and budgeted and actual staffing.

7.18 Workforce KPI's

7.19 Turnover

7.20 The turnover remains low on the NICU at an average of 7%; this is assisted with good morale, proactive training and the possibilities of internal promotion. Vacancy has been actively managed over the last 6 months, with all band 6 post being recruited to internally and all band 5 posts being filled at interview. Talent pools are running for band 5-6 promotion, band 6-7 talent pool being established and nurse to ANNP talent pool established. There are 3.0 WTE current 8a vacancies, which will go out to advert after vacancy panel approval on 30th Jun 2021.

7.21 Age profile

7.22 The unit has reduced the age profile of the unit, with most of our staff in the under 45 categories. With a reduced age profile, the service can see that the length of service of the majority of our team is under 10 year, meaning that the service is aware of the training and development needs of the team. Also, in having a younger workforce, the service is cognisant that maternity rates may be higher over the coming years. On average the service has 8.5wte on maternity leave at any one time. Going into Quarter 3 of this year we are expecting to have upwards of 14.0wte on maternity leave.

7.23 Sickness

7.24 Sickness within the Neonatal Service has run at an average of 5.2% over the last 12 months, of this there has been an average split of 50/50 between long-term and short-term sickness. All sickness has been managed in line with Trust policy and with the support of the HR Business Partner. Covid-19 sickness and Covid-19 special leave has had an impact on staffing. Most episodes have been more due to the need for team members to isolate or because those within their bubble have become positive. The service has had some members of staff who have been affected with Long Covid, two are now back in work and the other remains supported by their team leader and HR support

7.24 There has been active management and a downward trend in long term sickness across the service and that short-term sickness sits in the most part at less than 3%. The main causes of sickness on the neonatal service are around stress /anxiety/mental health, flus/colds, gynae and GI sickness. Occupational Health referrals are completed where appropriate and staff signposted to NHS Resilience HUB. Again, where appropriate adjusted working patterns and support are put in place by team leaders and Matron.

7.25 Achievements of Neonatal Nursing & ANNP teams

- Positive external recruitment of speciality and ANNP trained staff
- Presentations at local, regional, national and international conferences
- Positive rotational posts between Alder Hey and LWH
- Development of talent pools
- QI project implementation led by nursing teams
- Development of the Lead ANNP role
- Development of the TNA role
- Amazing kindness and teamwork throughout the pandemic
- Outstanding memory making with families during palliative care
- Development of staff council and newsletter
- Parent teaching programme
- Introduction of Less Invasive Surfactant Administration (LISA)

7.26 Recommendation for 21/22

- To work with the NWNODN to secure funding for the development of protected quality roles
- To further develop talent pools for all staff within the neonatal service
- To work with staff council to promote the health and well-being of all staff within neonatal services
- To continue to challenge staff to develop and grow within our services
- More focus on developing the leadership and management skills of the senior leadership teams
- Increasing the profile of the senior leadership team and the work undertaken within neonatal service at LWH.

8.0 Recruitment

8.1 Trust wide proactive recruitment campaigns continue to attract experienced nurses and midwives as well as newly qualified Nurses and Midwives. The Trust utilises links with Universities and social media as part of recruitment strategies. The HON/ M have introduced keep in touch strategies for those in the recruitment process. There is a regional drive to improve HCSW recruitment with £54k support from NHSE. LWH are part of this programme to fill all HCSW vacancies. The Trust has successfully recruited 27 staff (22.97wte) with a current Trustwide vacancy position remaining of 19.91wte

8.2 LWH continues to support Student placements and is committed to increasing placements as appropriate to support succession planning for the future. The Trust currently takes up to 30 student nurses on placement and 121 student midwives, with growth in student midwife numbers expected in September 2022. LWH currently has one OPD apprentice who is in the 3rd year of training. All students have recommenced placements. As part of the workforce review it has been identified that a further PEF is required to support the increase in student capacity within Maternity with funding secured to support this.

8.3 Trainee Nursing associates commenced in September 2020 who will complete their training on June 2022. They are current healthcare support workers who are undertaking a foundation degree and will become a Band 4 Registrant at the end of their training. They have been supported by the gynaecology division as part of their recruitment and succession planning for the future. Neonates are considering 2 staff being recruited into the TNA programme in January 2022.

9.0 Retention and Turnover

9.1 Retention is a key element of the workforce plans for the Trust. At the end of June 2021, the Nursing and Midwifery turnover rate was 10%. This is a 1% increase from the last report reflecting December 2020 position.

9.2 To support staff, competency frameworks have been developed for Bands 8C- Band 5 with plans for Matron's to participate in the Trust Leadership Programme commencing in September 2021.

9.3 Deputy Director of Workforce to support Head of Midwifery with a review into recruitment, attraction and retention across Midwifery which will support flexible working patterns, draw in experienced midwives, newly qualified staff and specialist practitioners, supporting succession planning and the Trust delivery of low and high risk maternal care. Paper reflecting intentions and approach to be presented in Quarter 2 at PPF by Family Health Division.

9.4 Trust Board have requested a deep dive into retention and turnover through Putting People First Committee

10.0 Health Care Support Workers

10.1 There are 19.91wte HCSW vacancies across the Trust (June 2021) an improvement on previously reported position, however, in maternity some of these vacancies are considered within a review of establishment undertaken due to the drop-in births.

10.2 LWH is part of a national programme to recruit to HCSW vacancies with support from NHSE. Funding has been secured and utilised to support with the recruitment, training, and pastoral support.

11.0 Care Hours Per Patient Per Day (CHPPD)

11.1 In May 2014, guidance was published from NHSE that required all Trusts to publish staffing fill rates of RN/RM and Care Staff by hours and percentages (Actual versus Planned) via the Unify Return- Safe Staffing Fill Rate. From April 2016 all Trusts were required to report this monthly.

11.2 CHPPD was introduced as a measure for the deployment of nursing, midwifery, and healthcare support staff on acute and acute specialist inpatient wards. CHPPD is now the national principal measure. CHPPD relates only to hospital wards where patients stay overnight.

11.3 CHPPD is calculated by taking all the shift hours worked over the 24-hour period by Registered nurses/ midwives and nursing assistants and dividing this by the number of patients occupying a bed at midnight. The data is aggregated each day over the month. In maternity only, the mothers are included in the census.

11.4 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.

11.5 The lack of national CHPPD benchmarks limits the validity of the data to inform safer staffing decisions at present. 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 considered alongside measures of quality and safety.

11.6 Whilst CHPPD is a simple measure, this must be reviewed alongside patient acuity and dependency data as CHPPD is not a metric to neither determine registered nurse/ midwife requirements nor provide assurance for safe staffing.

12.0 Safe Care-Planned versus actual

12.1 Planned versus actual staffing levels are reported monthly via Unify. Currently the data is gathered manually with discussions relating to possible future reporting via Health Roster in 2021-2022.

12.2 The planned versus actual fill rates from January 2021- June 2021 highlights that the fill rate is better at nights than days, with fill rates for care staff generally higher when RN/RM fill rates are notably reduced, which reflects how safe care overall is being managed with adjustments to skill mix.

12.3 The fill rates are reported monthly within the Integrated Board Reports

13.0 Safe Care-Acuity and Dependency

13.1 The previous results of the Safer Care Nursing Staffing Tool (SCNT) were unable to define the correct establishment needed for the gynaecology ward due to the mix of day cases and in-patients but gave an indication for the HoN to use as part of the workforce review. Further communication regarding future consideration is underway with NHS/I.

13.2 The tool is not designed to capture acuity and dependency data from wards with less than 10 beds, day case rates, maternity areas, or departments.

14.0 Red Flags, Escalation and Patient Experience

14.1 Where a shortfall in Registered Nurses/ Midwives occurs, the Trust has a process to mitigate in real time through interventions by senior nurses/ midwives in line with an escalation process to enable the delivery of safe and effective patient care.

14.2 NICE guidance recommends that the trust have a mechanism to capture “red flag” events. The trust has incorporated these into the Trust incident reporting system. Incidents can be reviewed against acuity and dependency, planned and actual staffing levels for the day. Triangulation of data assists in informed decision making related to staffing.

14.3 From January 2021-June 2021 (Q4&Q1) a total of 193 Red flags were raised. Of these 70 incidents reported on staffing levels. There were 2 reportable incidents in Q1, one related to Maternity diverts (3 separate diverts initiated) and the other related to staff breach of Covid-19 regulations in Maternity.

14.4 Maternity services (DS, MAU, MLU and Mat Base) dominated the top reporting areas of staffing incidents in Q4 and Q1. Community added to the list of high reporting of staffing related incidents in Q1. Gynaecology saw high reporting of staffing incidents in Q4 (8) which reduced in Q1 (2).

14.5 There were two formal complaints during Q4 and Q1 that had some concerns raised about staffing. The first one was in Maternity and had a direct complaint about staffing numbers, however on investigation it was found that the staffing numbers were sufficient, so this part of the complaint was not upheld.

14.6 The second complaint was in Gynaecology where a patient complained that her call bell was left unanswered for long periods and the patient was left alone for long periods on numerous occasions for long periods which may relate to staffing issues, however this is currently still under investigation and therefore a causal link has not yet been identified .

14.7 Complaints can be received by the Trust later that may relate to Q4 and Q1 reporting period which the Trust are currently unaware of, therefore caution is applied in noting the 2 cases highlighted for this period may alter. Future reporting will seek to include and review both PALs and PALs+ to identify any themes or trends that could be linked to staffing issues and included in this paper.

14.8 There were 9771 Trust responses to Friends and Family Test from January – June 2021. 1588 responses positively mentioned staff. 70 responses were displeased with staff with 21 of the 70 responses specifically mentioning staffing levels.

14.9 Staffing levels are also triangulated with complaints and adverse incidents to provide assurance on patient safety and are reported through the appropriate senates. Staff are encouraged to complete an incident report when staffing levels are below the required parameters. Each division puts plans in place when staffing falls below the required parameters with oversight by the Head of Nursing/ Midwifery. Daily staffing huddles take place for the site to review staffing levels and oversee the support required for the shortfalls and escalation as necessary.

15.0 E-Roster

15.1 The Trust has rolled out Health Roster v11, there is still some work to do with embedding usage of the system. Health roster sign off meetings will commence with DDON/M, monitoring the roster performance KPI’s with the HON/M and Matrons. This will be led initially by the DDoN/M, supported by

DDoW, DDoF and E-roster Manager to embed new process adoption and standards before being handed back to divisional senior management teams to manage

16.0 Temporary staffing

16.1 Currently the Trust uses its own internal Bank system. A contract for the use of NHSP will likely commence in November 2021. Ahead of this will be the start of an implementation process led by the DDoN/M in July 2021. There will be stakeholder engagement throughout the implementation process with a task and finish group and cross divisional representation to ensure safe transition and use of NHSP.

17.0 Summary

17.1 LWH can demonstrate how it manages safe staffing levels through workforce reviews, use of acuity tools, and
professional judgement.

17.2 Vacancy rate for Registered Nursing, Midwifery and ODP at LWH is 5 % which is the same as previously reported
(December 2020). Vacancy rate for HCSW has improved at 10% (previously 21%)

17.3 Total turnover for Nursing and Midwifery is 10% in June 2021. However, it is to be noted the services over the
Trust target of 13% in June 2021 are Hewitt Fertility Centre and Surgical Services.

17.4 29.7% of the Nursing and Midwifery workforce are > 50 years of age therefore recruitment and retention need
to remain a high focus.

17.5 Recording the highest volume of staff in the past 12 months on Maternity Leave in June 2021 (35 headcount)

17.6 There has been a fluctuation in sickness rates in the last six months with January 2021 seeing the highest rate
of 10.15% and June 2021 reflecting 7.86%

17.7 COVID-19 related absence has decreased since January 2021 where it was at its highest in the last six months
(5.33%) to 1.51% in June 2021.

17.8 The Divisional triumvirate structure monitors workforce data monthly.

17.9 Staff have worked flexibly during COVID-19 and at times of increased staffing challenge to support safe care Trustwide.

18.0 Conclusion and Recommendations

18.1 The Board of Directors are asked to:

Be sighted on the national shortage of nurses and midwives.

- *Note the content of the report and the assurances provided that nurse/midwife staffing levels are challenging yet managed by HoN's/HoM safely and appropriately to mitigate any shortfalls*

- *Note the risk to the organisation of the number of nursing and midwifery staff > 50 years of age (29.7%)*
- *Note the current impact of sickness Covid-19 and Non Covid-19 related absence on staffing and fill rates*
- *Note Unify fill rates are collected manually with need for a digital solution*
- *Note NHSP contract agreed to supply Bank and Agency staff to support fill rates. Implementation commences in July led by DDoN/M; full implementation of contract expected end of November 2021*
- *Note changes to e-roster oversight and sign off process to commence in July 2021*
- *Support DDoN/M to obtain the SNCT licence for the organisation to aid a nurse staffing review of Gynaecology in-patients in the next 6-12 months*
- *Support the DDoN/M in a request to recalculate headroom for the organisation yearly in view of the large number of long serving NHS staff (10 years or more), new starters/leavers and increased training requests ahead of budget setting so local adjustments to headroom can be agreed*
- *Support the DDoN/M to make improvements to simplify future bi-annual staffing reports and avoid variance and duplication of information in divisional reporting with use of a staffing template aligned to the reporting of mandatory information*
- *Support the DDoN/M to work with colleagues in the development of a Trust wide recruitment calendar that underpins the workforce strategy for recruitment and retention that can be reported on in Putting People First committee*
- *Approve a refresh of reporting schedules to allow full Quarter reporting in bi-annual papers, resulting in Q4&Q1 reporting to PPF committee in September and Trust Board in October; Q2&Q3 reporting to PPF committee in March and Trust Board in April each year*

Quality Committee Chair's Highlight Report to Trust Board
26 July 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Recent activation of the internal major incident plan and maternity diverts due to staffing pressures and high levels of activity and acuity. The subsequent pressure and ability within the region to accept maternity diverts was considered. It was noted in response to the escalation that Cheshire and Merseyside had initiated a maternity cell to address system pressures. The Committee queried the health and wellbeing of front-line staff at this time and noted the services available to support them. • Concern raised regarding the impact of the Oversight Framework and developing Integrated Care Systems, in particular in relation to a continuation of mutual aid requests and potential impact on timely delivery of care to Trust patients and resilience of staff. • Challenges working with external partner agencies in relation to Safeguarding concerns during 2020/21 had been highlighted. This had been escalated and meetings with relevant bodies requested to review past cases and agree forward actions to improve partnership working. The Chief Executive requested further escalation if the matter was not resolved.	• Committee noted a change in national timetabling for delivery of the Continuity of Carer pathway. Firm plans to be in place as of March 2022 and become implemented default model as of 2023. • A persistent theme in relation to electronic systems linking patient care between MAU and other Trust services was noted within the Integrated Governance and Assurance report. The Committee raised the action to the Digital Hospital Sub-Committee to consider the tracking process.
Positive Assurances to Provide	**Decisions Made**
• Received the first Chair Reports from the inaugural meetings of the Research Development and Innovation Sub-Committee and the Maternity Transformation Board. • Assured by the update provided by the Maternity Executive Oversight Group that it was appropriately challenging operational issues and supporting progress forwards towards an outstanding maternity service. • The Executive Safety Champion Lead noted that the Safety Champion Group continued to meet and included representation from the Maternity Voices Partnership. No issues escalated. • Noted the action plan underway as an output from the Board Well led governance review. Leads would be asked to update actions ahead of submission to the Trust Board in September 2021. • Assured by the contents of the CQC Insight Tool report. The tool comprised information about the Trust which would be analysed by the CQC to monitor services at provider, location, and core service level.	• Committee reviewed the Quality related BAF risks. No changes to existing risks were identified as a result of business conducted during the meeting. It was noted that BAF risk 5.2 had been reviewed in detail by the Executive Lead and gaps in control identified and addressed. • Approved the Trust Safeguarding Sub-Committee terms of reference. • Agreed to add the CQC Insight Tool to the Committee workplan. • Approved the Safeguarding Annual Report 2020/21 and the Complaints Annual Report 2020/21.

• Noted that the Trust response to the Ockenden review had been submitted. Awaiting formal outcome from the review team. • Assured by the Serious Incident and Learning quarterly report noting key risks in relation to 52-week performance and blood sampling errors. Positive progress against medication incidents was noted. A streamlined version highlighting key trends and effective learning would be shared with Trust Board in September 2021. • Committee assured by the refocus and prioritisation applied to LocSSIPs. • Committee received an overview in respect to the planned delivery of the Clinical and Quality Strategy for 2021/22 and beyond. The Committee noted that five key workstreams had been agreed to achieve the strategy priorities and the associated timescales. The Committee felt assured by the update noting that the proposed actions would strengthen the process of efficient reporting to inform annual reports and external regulators. The Committee would receive the workplan for approval at its meeting in September 2021. • Assured by the contents of the Safeguarding Annual Report, it was requested that an anonymised case be presented to a future meeting. • Assured by the contents of the Complaints Annual Report. Further work to effectively track social media comments was noted together with the Communications Team and other health providers. • Received and assured by the contents of the Medicines Management Assurance Report and NICE Annual report. • Noted MIAA findings report on the Trust CQC Action plan had been to Audit Committee and would be presented to a future Committee meeting.	
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Good quality of report papers. • Effective timekeeping.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
76.	Board Assurance Framework	Assurance	**83.**	Integrated Governance Assurance Report Quarter 1	Assurance
77.	Sub Committee Chair Reports	Assurance	**84.**	Local Safety Standards for Invasive Procedures (LocSSIPs) Assurance Report Quarter 1	Assurance
78.	Well led governance review recommendations aligned to Quality Committee	Information	**85.**	Review of Quality Strategy Quarter 1	Assurance
79.	Quality Performance Report Month 3 2021/22	Assurance	**86.**	Safeguarding Annual Report 2020/21	Approval
80.	CQC Insight Tool	Information	**87.**	Complaints Annual Report 2020/21	Approval

81.	Ockenden Report	Assurance	**88.**	Medicines Management Assurance Report Quarter 1	Assurance
82.	Serious Incident and Learning Update Quarter 1	Assurance	**89.**	National Institute for Health and Care Excellence (NICE) Annual Report	Assurance

3. 2021 / 22 Attendance Matrix

Core members	Apr		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie, Chair	✓	✓	A	✓	✓								
Susan Milner	✓	✓	A	✓	✓								
Ian Knight	✓	✓	✓	✓	✓								
Louise Kenny	✓	✓	✓	✓	✓								
Marie Forshaw	✓	✓	✓	✓	✓								
Gary Price	✓	✓	A	✓	✓								
Lynn Greenhalgh	✓	✓	A	✓	A								
Jenny Hannon	✓	✓	A	✓	✓								
Michelle Turner	✓	✓	✓	✓	✓								
Christopher Lube	✓	✓	✓	✓	NM								

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

Quality Committee Chair's Highlight Report to Trust Board
23 August 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Received an insightful staff story related to a safeguarding case where an inherent jurisdiction had been placed. The Committee noted the partnership working required between multiagencies to deliver safeguarding appropriately. The empathy and compassion displayed by the LWH team to ensure safe delivery of baby and safe patient care despite the planned future outcome was noted. The difficulties to communicate effectively and agree the clinical plan provided by the Trust was highlighted. This had been escalated to the Commissioners to assist the Trust to improve multiagency engagement. The comprehensive planning and debrief support available to staff was positively noted as a difficult process for staff to undertake. • Noted that the Trust reported all investigations of maternity incidents that meet the criteria for Each Baby Counts programme to the Healthcare Safety Investigation Branch (HSIB). The Trust also investigates all incidents internally to resolve issues quickly and act on learning. It was noted that the Trust had been advised that only one investigation should be conducted led by HSIB. The Committee was asked to note the possible impact on rapid learning. • Significant work required to close the action: Control of Substances Hazardous to Health (COSHH) Reporting and Audit on the Trust CQC action plan was noted. It was reported that the team were working through the detail but no timeframe could yet be assigned. The Committee would be further updated on this action.	• Committee noted a further MIAA review of Learning had been commissioned to be undertaken in Autumn 2021. • Received an update to the MIAA review of the Trust CQC action plan. The results of the MIAA review highlighted that there was evidence of full implementation for 23 actions with a further 11 actions being partially compliant. MIAA had proposed 9 main recommendations to clear the 11 actions. Work undertaken had resulted in the closure of 3 actions; 6 remain open. Of these 6; one action required significant work, however the remainder of 5 are anticipated to be closed by September 2021. Work with IM&T to explore digital solutions such as the creation of 'SharePoint' as a data repository for easier collation of evidence was noted. • Consideration how to present the updated Oversight Framework metrics within the Board performance report going forward.
Positive Assurances to Provide	**Decisions Made**
• Assured by the investigation report into the e-RS waiting list incident. Actions including strengthening of asset owner registers, raising staff awareness of NHS Digital Alerts, and Access Recovery Board oversight of e-RS alerts were noted. • Committee received a review against the MIAA recommendations from the Learning from Serious Incidents and Never Events audit. The Committee was assured by the significant work undertaken to ensure the areas of improvement had been progressed. • Assured by the internal audit process conducted to highlight weaknesses which could be addressed. • Assured by the positive trend of improvement across the suite of quality metrics.	
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Lesson learning approach undertaken at the meeting had been positive and beneficial. • Internal audit process effectively utilised for both the CQC action plan and Learning from SI & NEs.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
98.	Patient / Staff Story: Safeguarding Story	Information	**101.**	Health and Safety Investigation Branch (HSIB) Referrals	Information
99.	Concise Investigation Report: ERS waiting lists	Assurance	**102.**	Mersey Internal Audit Agency Care Quality Commission Audit Update	Information
100.	Learning Lessons Follow up Report	Assurance	**103.**	Quality Performance Report Month 4, 2021/22	Assurance

3. 2021 / 22 Attendance Matrix

Core members	Apr		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie, Chair	✓	✓	A	✓	✓	**A**							
Susan Milner	✓	✓	A	✓	✓	✓							
Ian Knight	✓	✓	✓	✓	✓	✓							
Louise Kenny	✓	✓	✓	✓	✓	✓							
Marie Forshaw	✓	✓	✓	✓	✓	A							
Gary Price	✓	✓	A	✓	✓	✓							
Lynn Greenhalgh	✓	✓	A	✓	A	✓							
Jenny Hannon	✓	✓	A	✓	✓	✓							
Michelle Turner	✓	✓	✓	✓	✓	✓							
Nashaba Ellahi	NM	NM	NM	✓	✓	✓							
Christopher Lube	✓	✓	✓	✓	NM	NM							

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

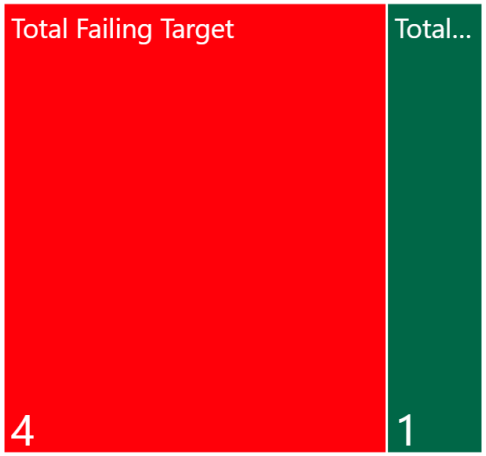
Liverpool Women's NHS Foundation Trust

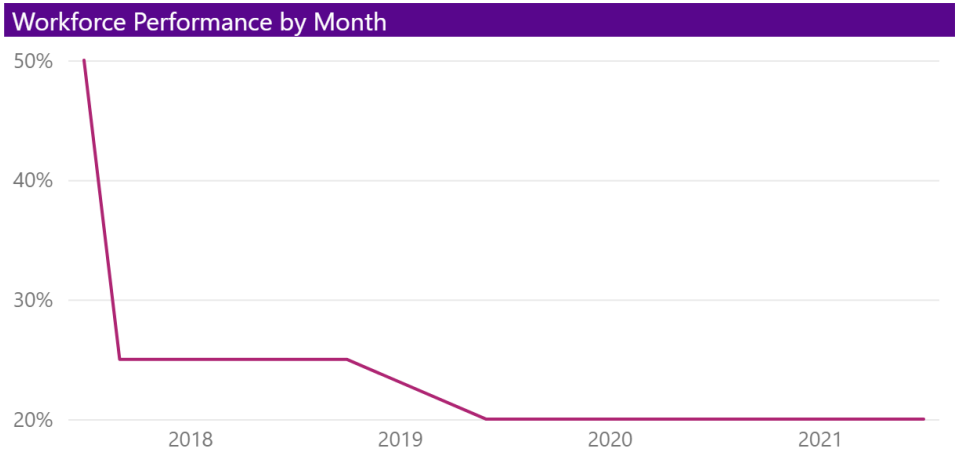
Workforce Performance

Trust Board

September 2021

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





Leadership

- The first LWH Leadership Forum takes place on 31st August which is an opportunity for Executive Directors and Senior Leaders to come together to progress the Trust Strategy. The forums are designed to aid self-development, peer support and networking across the organisation and the system. Each Forum will have targeted areas of focus, but can be reviewed to support the requirements of the group.
- North West Leadership Academy are delivering a series of bespoke leadership bitesize sessions for Medical colleagues over the Autumn and sessions have been opened out to other Trust leaders
- PDRs for Band 7s and above in Nursing and Midwifery are now nearing completion meaning talent and succession plans in these areas will be clearly identified and N&M leaders can be prioritised for access to the brand new LWH Leadership Programme which will be launched in October and then rolled out to the rest of the Trust

Flex for the Future

- LWH has successfully bid to take part in a national flexible working programme with NHSI. A project team consisting of a Matron, Ward Manager, Clinical Fellow, E-Roster Manager and the Deputy Director of Workforce has been identified to lead this project which will establish and implement targeted flexible working solutions for LWH based on best practice nationally.

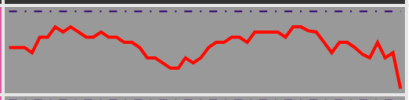
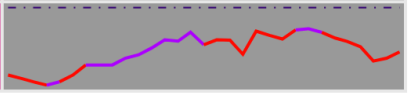
Wellbeing

- Over 1700 Wellbeing bags have been delivered to staff over the last month, this coincided with the launch of the LWH 'We Care' wellbeing strategy, Boo consulting are continuing to work with colleagues in maternity to deliver resilience, wellbeing support and Coaching. We will shortly be welcoming ex-professional rugby players from Rugby Cares to deliver targeted mental health support throughout September and October and will soon be in receipt of our 2 /3 Sleep Pods, plus the refurbishment of staff rooms programme will commence.

NHSP Implementation

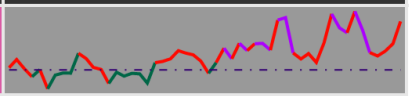
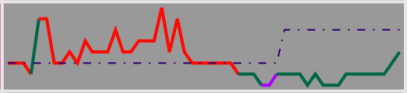
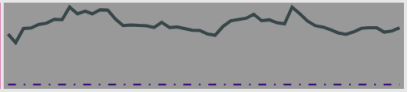
- The implementation process has started and a project go live date of 22nd November has been identified. This project is being supported and underpinned by the E-Rostering Review meetings which are ensuring that rosters are efficient, safe and compliant to minimise the use of bank and agency staffing. The revised bank rates agreed in the summer will be reviewed as part of the implementation process.

To develop a well led, capable, motivated and entrepreneurial Workforce - Mandatory Training

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Trend
Director of Workforce	Mandatory Training Compliance	July 2021	80.00%	-15.00%	95.00%			
	Clinical Mandatory Training Compliance	July 2021	81.88%	-13.12%	95.00%			

KPI	Month	What is the reason for failure against this target?	How is this being fixed?	When will target be achieved?	Why this timeframe?	Mitigating Actions?
Clinical Mandatory Training Compliance	July 2021	The overall Trust clinical mandatory training compliance increased by 2% from 80% in month three, to 82% in month four. This is now 13% under the Trust's target rate of 95% and rated as amber. In the largest clinical areas, compliance increased by 1% in Gynaecology, and by 3% in Maternity, although it remained unchanged in Neonates. At the divisional level, compliance increased by 2% in both the Gynaecology Division and Clinical Support Services, and by 1% in both Family Health and the Corporate Division.	The HR and L&D teams continue to provide support, information and training to managers across the Trust. There have been a number of compliances added to the system for clinical mandatory training to support central recording. There are some courses which are below compliance which are mainly those that are face to face or via workbooks - this is being looked at locally to review the figures and seek solutions to improve. Safeguarding level 3 online learning has been redeveloped and now requires additional e-learning modules.	By the end of quarter three (December 2021).	While every effort is being made to improve and maintain compliance rates, it is difficult to accurately predict when the target figure of 95% will be achieved, particularly in light of the continuing covid 19 global pandemic and the pressures it has created both operationally and in terms of staffing. High sickness levels will also be having an impact. Nevertheless, every endeavour continues to be made to bring the figure within Trust target through effective collaboration between line managers, Human Resources and Learning & Development.	Local managers continue to monitor the training compliance of their staff, to ensure that patient safety and the quality of the service provided are maintained.
Mandatory Training Compliance	July 2021	The overall Trust mandatory training compliance fell by 7% from 87% in month three, to 80% in month four. This is now 15% under the Trust's target rate of 95% and rated as amber. In the largest clinical areas, compliance fell by 4% in Gynaecology, by 8% in Maternity, and by 10% in Neonates. At the divisional level, compliance fell by 5% in the Gynaecology Division, by 9% in Family Health, by 7% in Clinical Support Services, and by 4% in the Corporate Division.	The HR and L&D teams continue to provide support, information and training to managers across the Trust. Further ways of making mandatory training more accessible are being explored including widening the provision for e-learning. Efforts are also being made to ensure that training which has to be face to face can be delivered in an appropriate and safe environment.	By the end of quarter three (December 2021).	While every effort is being made to improve and maintain compliance rates, it is difficult to accurately predict when the target figure of 95% will be achieved, particularly in light of the continuing covid 19 global pandemic and the pressures it has created both operationally and in terms of staffing. Nevertheless, every endeavour continues to be made to bring the figure within Trust target through effective collaboration between line managers, Human Resources and Learning & Development.	Local managers continue to monitor the training compliance of their staff, to ensure that patient safety and the quality of the service provided are maintained.

To develop a well led, capable, motivated and entrepreneurial Workforce

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Trend
Director of Workforce	Sickness Absence Rate	July 2021	7.67%	+3.17%	4.50%	42194		
	Turnover Rate	July 2021	11.00%	-2.00%	13.00%			
	Proportion of Temporary Staff	July 2021	7.00%	+7.00%	0.00%			

KPI	Month	What is the reason for failure against this target?	How is this being fixed?	When will target be achieved?	Why this timeframe?	Mitigating Actions?
Sickness Absence Rate	July 2021	The single month sickness absence figure increased by 1.46% from 6.21% in month three, to 7.67% in month four. This is now 3.17% above the Trust's target figure of 4.50% and is therefore rated as red. In the largest clinical areas, sickness absence increased by 0.08% in Gynaecology, by 2.15% in Maternity, and by 1.97% in Neonates. At divisional level, sickness increased by 0.16 in the Gynaecology Division, by 2.11% in Family Health, by 0.34% in Clinical Support Services, and by 2.13% in the Corporate Division. Overall, there was an increase in short term sickness, which accounted for 37% of the total figure in month four, compared to 32% in month three. In terms of diagnosis, the top three most common remain unchanged: cold/cough/flu is the most prevalent diagnoses, followed by anxiety/stress/depression, and then gastrointestinal problems. The figure for sickness specifically resulting from covid 19 increased from 1.34% in month three to 1.91% in month four.	The HR Department are continuing to provide support for managers in managing sickness absence and in supporting staff through this difficult time. A range of measures are in place specifically to address the situation with regards to covid 19. These are available to all staff and include risk assessments, on-site testing for staff (and family members) with suspected symptoms, asymptomatic testing, and vaccinations. So far, 86.75% of staff have been vaccinated (88.22% of BAME/vulnerable staff have been vaccinated). A lot of work has also been done in pulling together and communicating to staff a whole range of available support, with a particular focus on health and wellbeing.	By the end of quarter three (December 2021).	Efforts to reduce sickness absence are on-going, but it is difficult to accurately predict when the target figure of 4.50% will be achieved, particularly in light of the continuing covid 19 global pandemic and the pressures it has created both operationally and in terms of staffing. Nevertheless, every endeavour continues to be made to bring the figure within Trust target through effective collaboration between line managers, Human Resources and Occupational Health.	Local managers continuously monitor sickness absence and adjust rotas and work schedules as appropriate.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/72b*		**Date: 02/09/2021**	
Report Title	Equality Diversity and Inclusion Update, including WRES and WDES 2021 Data			
Prepared by	***Rachel Cowley, Head of Culture and Staff Experience***			
Presented by	***Michelle Turner, Chief People Officer / Deputy Chief Executive***			
Key Issues / Messages	***This report fulfils the mandatory requirement for the Board of Directors to review the annual data relating to the Workforce Race Equality Standard (WRES) and the Workforce Disability Standard (WDES) (for the year ending 31st March 2021), presents a range of other ED&I information and updates the Board of progress against our strategic aims as outlined in the Trust Strategy 2021-2025.***			
Action required	Approve ☐	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to note the contents of the report, be assured that appropriate actions are being taken, and support the ongoing work on the ED&I agenda.			
Supporting Executive:	***Michelle Turner, Chief People Officer / Deputy Chief Executive***			

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

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1.1 Failure to be recognised as one of the most inclusive organisations in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	Comment: This report is a key source of assurance against this BAF risk area.
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

This paper:

- Fulfils the mandatory requirement for the Board of Directors to review the annual data relating to the Workforce Race Equality Standard (WRES) and the Workforce Disability Standard (WDES) (for the year ending 31st March 2021).
- Presents a summary of the Gender Pay Gap information for the year ending 31st March 2020 (GPG data is always presented a year behind).
- Provides the Board with an overview of the ED&I activity undertaken in the last 12 months and planned activity for the forthcoming year.
- Focuses on the workforce ED&I agenda but also provides information on progress with the patient ED&I agenda with a more detailed update to come to board at a later date following the establishment of the ED&I Manager in post.
- Updates the Board of progress against our strategic aims as outlined in the Trust Strategy 2021-2025.

MAIN REPORT

Introduction

LWH consistently benchmarks positively in the national NHS Staff Survey in relation to the ED&I agenda (specifically in relation to career progression opportunities, bullying and harassment and involvement in employee relations issues). Whilst there have been examples of good work in both the patient and staff agendas over the last few years, it was recognised that there was insufficient infrastructure and a lack of co-ordinated focus, and over the last 5 years the LWH workforce has not become more representative of the communities we serve.

It was in this context that the Board spent some focused development time on the ED&I agenda in late 2020, there was universal agreement that we had the opportunity to be transformative in both the staff and patient agendas, and consequently some ambitious strategic aims were agreed which form the basis of all ED&I activity going forward.

- *Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)*
- *Treble number of staff from ethnic minority backgrounds in leadership roles (Band 7 and above) by 2022*
- *Ensure our workforce matches the ward of Riverside in terms of % of staff from ethnic minority backgrounds by 2025*

Operationally, ED&I is overseen by the ED&I Committee which meets on a quarterly basis and feeds into the Putting People First Committee. The Committee is now chaired by the Deputy Director of Nursing and Midwifery and has a refreshed membership. It is essential that ED&I is not ‘owned’ by the ED&I lead and hence this committee is vital to deliver the workplan for both the staff and patient agenda and spread awareness within departments.

ED&I during Covid

The national focus and spotlight on health inequalities for diverse communities, in particular the poorer health outcomes aligned to Covid for individuals from ethnic minority backgrounds has been a call to

action for the NHS as a whole and has provided a much-needed focus via the NHS People Plan on how we create a more diverse workforce from board to ward level.

As the Board are aware, Covid was an enabling factor in engaging with our staff from ethnic minority backgrounds and we set up a BAME network in summer 2020, something that had been attempted on a number of previous occasions. This group, along with an ethnic minority representative on Covid Oversight Committee has been a source of direct and indirect feedback about the impact of the pandemic on our BAME colleagues. BAME staff were prioritised for risk assessments with over 98% compliance and were also offered Vitamin D testing. The good relations and momentum built during this period provides a solid basis for co-ordinated work going forward.

Key ED&I achievements in past 12 months

Key achievements and progress in relation to our ED&I agenda over the past 12 months include:

- Appointment of two individuals with ED&I all or part of their job role.
- Establishment of both a BAME and Disability Staff Network.
- The first 'Great Day' dedicated to ED&I with focused training for our medical and clinical colleagues on ED&I delivered by a consultant from LUHT along with John Barnes MBE as a Guest Speaker who shared his own lived experiences.
- Worked with the University of Liverpool to produce a training video on micro-aggressions in the clinical environment.
- Working with Navajo to establish a baseline position for Liverpool Women's in relation to LBTQ staff and patient and identification of areas for action.
- Through the new ED&I Manager, introduction meetings have taken place with key community groups in L8 including the Pakistani Centre, Caribbean Centre, BAME Life Skills Worker, Somalian community and Chinese Community. This has led to:
  - health fairs in the local Pakistani Centre, focusing on diet, perinatal mental health and physiotherapy
  - Sharing information and signposting relating to maternity care for asylum seekers.
- Appointment of a second Freedom to Speak Up Guardian from an ethnic minority background
- It was agreed that BAME nurses and midwives would be prioritised for talent management and in October 2020 all N&M leaders were asked to have a 'Career Conversation' with their staff and identify support needed for progression. Due to the pressures of Covid, limited progress has been made but this is a priority for the next 6 months and has full support of the Director of Nursing and Midwifery. One example of good practice is in Neonatal who are revising their recruitment and selection processes for progression from Band 5 to Band 6 based on feedback from overseas nurses in the team.
- The Board have committed to engagement in mentoring and reverse mentoring opportunities and communication of these opportunities has been reiterated.
- We are working in partnership with Microsoft and the IT department on a project how Liverpool Women's can improve Digital Inclusion through technology, for both patients, translation opportunities and improved staff support for those with neurodiversity

- We have undertaken celebration and educational pieces on Easter, Lent, Passover, Ramadan, Pride and learning disabilities week with the aim of raising awareness and increasing engagement.

- Appointment to four new senior roles with a focus on ED&I for staff and patients:
  1. Head of Culture and Staff Experience (Band 8b) commenced 1st April 2021 = 40% of role is D&I focused for staff experience
  2. Equality, Diversity and Inclusion lead (Band 7), commenced 1st June 2021, 100% of role D&I focused for both patient experience and staff experience
  3. Patient Experience Matron (Band 8a), currently at interview stage, 30% of role is D&I focuses for patient experience
  4. Diversity Midwife (Band 7), currently at advertisement stage, 100% of role is D&I focus for patient experience

- We have made an application to become members of 'Inclusive Companies'. Benefits of membership include:
  - Access to the Inclusive Top 50 UK Employers Survey & Index to help establish a baseline of how inclusive Liverpool Women's is and what areas require improvement
  - Unlimited access to all Inclusive Companies events, webinars and training opportunities throughout the year available to all employees – improving education and understanding
  - Access to the Inclusive Companies Network and participation in monthly Round Table discussions with fellow Inclusive Companies members, to share best practice and learning
  - Access to a members hub which can be shared internally so Liverpool Women's staff can access toolkits, case studies, exclusive reports and webinar recordings
  - 12 Months unlimited job listings on Inclusive jobs website
  - One quarter page advert in Inclusive Companies directory

Summary of WRES and WDES data

In summary from the latest Workforce Race Equality Standard (WRES) submission, it can be evidenced that the workforce remains largely static in relation to the demographics of employees, with a minimal decrease from 8.5% to 8.4% of ethnic minority staff. This compares to Liverpool City which has an ethnic minority population of 11.1% (March 2021 data) and the NHS as a whole which has 22.1% of staff from an ethnic minority background (January 2021 data).

In 'Our Strategy 2021-2025' the Trust has committed to treble number of staff from ethnic minority backgrounds in leadership roles (Band 7 and above) by 2022. This aspiration excludes Medical staff where there are no issues with representation as 47% of medical staff are from an ethnic minority background. As at March 21, there were 19 staff from ethnic minority backgrounds in Band 7 and above roles (both clinical and non-clinical) compared with 16 last year. To achieve the strategic commitment, the Trust needs to recruit a minimum of 38 staff with an ethnic minority background at band 7 and above and focus on retention of all currently in roles.

In summary from the latest Workforce Disability Equality Standard (WDES) submission, it can be evidenced that the workforce remains largely static in relation to the demographics of employees, with a minimal decrease from 3.0% to 2.91% of disabled staff (equating to 45 staff).

There remains an important issue of staff data disclosure on ESR, in particular staff not wanting to disclose disability and ethnicity when they commence in post on ESR. Through the ED&I Manager, we

are gathering feedback from staff to understand why this may be the case, to supplement our annual data collection / refresh exercises.

It is recognised that some of the work planned last year around further analysis, focus groups to better understand this data, unfortunately did not take place due to staff members not being in post and covid pressures, but is a focus area for the ED&I workplan this year.

WRES Data 2021

Band distribution has not changed with the majority of ethnic minority staff holding clinical Band 5, Band 6 and Band 7 posts. The highest banded non-clinical role remains the same as 2020, one individual at Band 8a. The highest banded clinical role (excluding medics) remains one individual at Band 8b.

Medical staff figures remain static at 34 staff disclosed ethnic minority background on ESR in both 2020 and 2021.

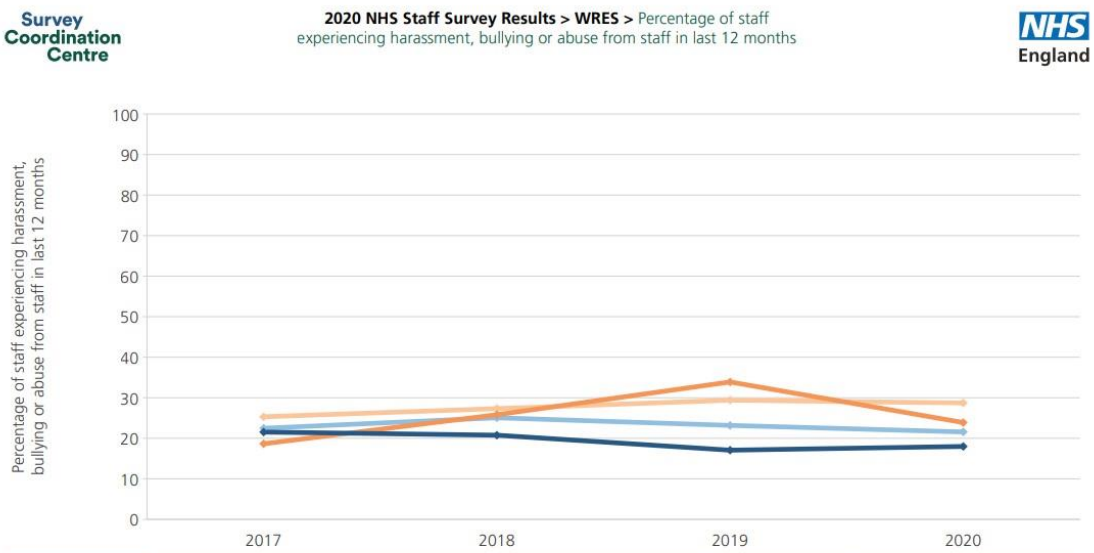
There are 12 staff from Agenda for Change payscales who have not disclosed on ethnicity on ESR and 3 staff from Medical grades who have not disclosed ethnicity on ESR.

Board member and non-Executive Director data for ethnic minority staff remains static at 1 person in a non-Executive Director role.

Relative likelihood of being appointed from interview if an applicant is of ethnic minority background has increased from 41.67% in 2020 to 52.70% in 2021.

For the last 3 years there have been no staff from ethnic minority background staff entering the formal disciplinary process. In the last 3 years there have been an average of 8 disciplinary investigations per year.

The number of BAME staff reporting harassment, bullying or abuse from staff has reduced from 33.9% to 23.9% however this remains both a concerning figure and higher than the figure reported by white colleagues. There have been no complaints of B&H raised to HR in the last 3 years by BAME staff.



	2017	2018	2019	2020
White: Your org	21.5%	20.8%	17.1%	18.0%
BME: Your org	18.6%	25.8%	33.9%	23.9%
White: Average	22.5%	25.1%	23.2%	21.6%
BME: Average	25.3%	27.3%	29.4%	28.7%

There has been a minor reduction in the number of ethnic minority staff believing the Trust provides equal opportunities for career progression, from 87.9% to 84.2% compared to 90.7% of white staff this year.

WDES Data 2021

There are 285 staff from Agenda for Change payscales who have not disclosed disability status on ESR (status unknown) and 20 staff from Medical grades who have not disclosed on ESR.

In terms of band distribution, there are 2 disabled staff above band 8a in non-clinical roles, and 1 disabled staff above band 8a in clinical roles. This is an increase from a zero return for previous reporting year. There are no staff disclosing a disability in medical roles. This issue has been discussed at JLNC and will continue to do so. LWH is currently supporting a number of junior doctors with mental health issues that would be covered in the Equality Act, there is clearly a cultural issue with disclosure, particularly of mental health issues that requires further analysis and exploration.

In terms of recruitment, non-disabled candidates are 1.67 times more likely to be appointed from shortlisting stage than disabled candidates which is a positive position compared to previous year where non-disabled candidates were 2.32 times more likely to be appointed. 25 disabled staff applied for a job at the Trust in 20/21 which is a decrease from the previous year (32) and 12 were appointed, which overall is a positive picture. The Trust has been re-accredited as a Disability Confident Employer and more work will be undertaken to assess these candidates experiences of the recruitment process through the 90 Day Listening Events and targeted requests for feedback.

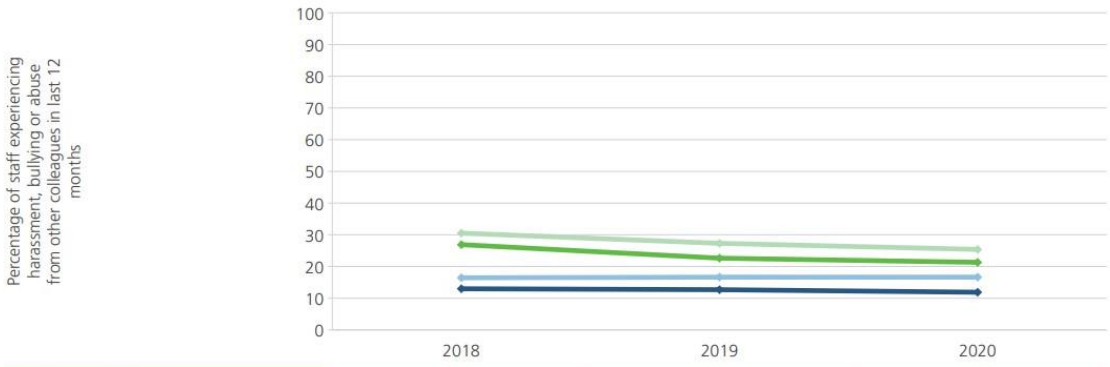
In the reporting period, 3 disabled staff and 1 non-disabled staff entered into the formal capability process. As with any formal process, reasonable adjustments would be made to support staff with disabilities.

21.3% state they have experienced bullying, harassment or abuse in the workplace compared to non-disabled colleagues (11.9%), though this is lower than the national average for disabled staff (25.4%). Disabled staff are slightly more likely to report it (55.8%) than non-disabled (46.8%).

Survey Coordination Centre

2020 NHS Staff Survey Results > WDES > Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months

NHS England



	2018	2019	2020
Staff with a LTC or illness: Your org	26.9%	22.6%	21.3%
Staff without a LTC or illness: Your org	13.0%	12.7%	11.9%
Staff with a LTC or illness: Average	30.5%	27.3%	25.4%
Staff without a LTC or illness: Average	16.4%	16.6%	16.6%
Staff with a LTC or illness: Responses	145	137	122
Staff without a LTC or illness: Responses	701	662	648

Average calculated as the median for the benchmark group

A positive improvement from 83% in previous year, 89.3% of disabled staff believes the Trust provides equal opportunities for career progression compared to 90.3% of non-disabled employees.

Gender Pay Gap Reporting

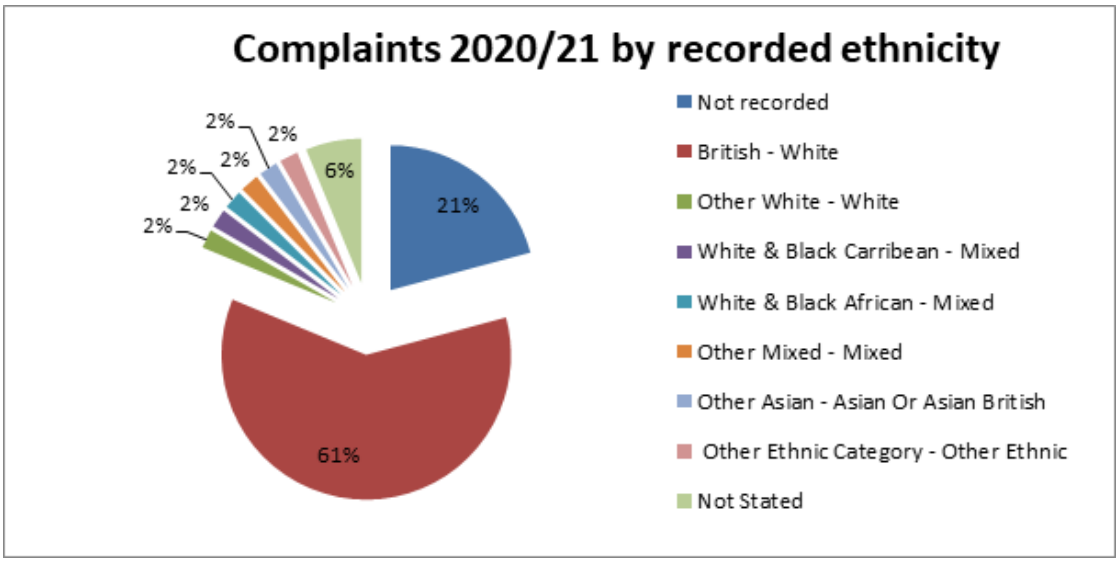
Gender pay gap information is required to be submitted in October 2021 (based on March 2020 data). Initial data gathering shows female employees continue to make up the majority of the workforce (91%). There is a *mean* gender pay gap of 22.5% and a *median* gender pay gap of 9% which represents minimal change from last year. The role distribution at LWH means there are small numbers of male employees concentrated at the top and bottom of the payscales and a large number of female nurses and midwives in the middle. Further work will be undertaken to analyse the gender split in key leadership roles

Patient ED&I

Whilst this paper focuses on workforce ED&I indicators, the appointment of an ED&I Manager is already having a real impact in building relationships with some of our local communities and we recognise there is work to do in terms of capturing and tracking all of our patient interventions.

To note, that patient ED&I data is currently not captured by protected group for the Friends and Family Test but this is being looked at as the Trust recognises the importance of analysing data in this way. Currently we have complaints data broken down by ethnicity, going forward this needs to be looked at in the context of the ethnic mix of our overall patient group to see if there is a disproportionate bias towards complaints by BAME patients.

Ethnicity of complainants in 2020/21



The percentage of complainants recorded as “British – White” in 2020/21 has reduced from 82% in 2019/20 to 62% this year. The number of complainants noted as being “not recorded” has increased from 9% in 2019/20 to 21% this year.

Examples of good practice on the patient ED&I agenda over the last 12 months include:

- **Virtual Clinics:** The trust implemented Attend Anywhere to facilitate virtual patient consultations. On completion of a virtual appointment call the patient is asked to leave feedback before closing the Attend Anywhere system. The trust set up a form that is integrated into the system which allows patients to provide feedback on their experience. The feedback is then collated into a report which is updated daily to support identification of themes and trends. Any feedback/ themes/ trends that require further action are collated by the Deputy Head of Patient Experience for subsequent reporting through to the Trusts relevant internal committees.
- **Picture Cards with COVID-19 symptoms at the main entrance:** There are a number of patients who attend the trust whose first language is not English. The trust also sees a number of asylum seekers and refugees whose first language is not English. At the beginning of the COVID-19 pandemic staff were deployed to the main entrance to ask key COVID-19 symptom questions and to take temperatures of patients on arrival. It became clear early on that patients whose first language was not English who did not have anyone accompanying them to their appointment were experiencing difficulty understanding the questions about symptoms. In view of the diverse population and number of languages spoken the trust felt introducing picture cards with all of the symptoms on would better support patients whose first language isn’t English to point to the picture cards if they were experiencing any of the symptoms rather than translate a number of patient information leaflets that may not meet everyone’s’ communication needs. The Patient Experience Team worked with the Communications team to develop the picture cards. The Clinicians at the front entrance were shown the picture cards and started to use them immediately.

EDI focus for next 12 months

There are lots of planned actions over the next 12 months which will address concerns raised in WRES and WDES 2021 data, as well as strengthen the overall ED&I agenda. These include:

- Complete a deep dive by end of 2021 into turnover from staff with ethnic minority backgrounds and ensure exit interviews have been completed for leavers with ethnic minority backgrounds
- Data cleanse campaign to commence in January 2022 for improvement of disclosure on ESR for all protected characteristics
- Re-instate 'First impressions' questionnaires and welcome meetings and ensure data about people's recruitment experiences is captured and tracked. was ceased as a result of covid, reintroduce in a covid safe format (paper/electronic survey)
- Embed reverse mentoring and coaching opportunities for disabled and ethnic minority staff
- Embed career conversations for disabled and ethnic minority staff
- Embed Health and Wellbeing conversations for all staff, refreshing the Covid Risk Assessments, ensuring all staff from protected characteristics or with long term health conditions have completed a refreshed Covid Risk Assessment by the end of 2021.
- Ringfenced places on Liverpool Women's new Leadership Development Programme for staff from an ethnic minority background
- Review of Friends and Family Test protected characteristic data for improved patient experience
- Continue to strengthen links with diverse community groups, working in partnership to improve positive relationship for staff and patients, as well as improved access for patient care
- Sharing of staff experience stories of staff from protected characteristics, listening and learning how the Trust can improve and embed an inclusive culture
- Review of the current Equality Impact Assessment (EIA) process, simplification of document and sufficient guidance and education on how to complete – anything that impacts on staff and patient experience should have a completed EIA at the beginning mid-point and end of the planning phases (every project, process, transformation, CIP, policy, etc)
- Extension of e-learning package to design and deliver specific ED&I training and education to all staff – improved knowledge will result in benefits for better staff and patient experience
- Education and celebration of the key ED&I events: Black History Month, Disability History Month, LGBT+ History Month and key faith observance days/festivals
- Exploration of how the Trust attracts local population to work at Liverpool Women's, utilising widening participation programmes and alternative ways to advertise and promote our job opportunities
- Exploration and implementation of more diverse recruitment and selection processes, which includes:
  - Recruitment and selection training for members of inclusion staff networks, to ensure sufficiently skilled interview panel members from diverse backgrounds can support recruitment decisions
  - ED&I panel representative to clarify with appointing manager rationale if staff with disclosed disabilities and ethnicity are not chosen for appointment

Recommendation

The Board is asked to note the contents of the report and note that there has been some good progress in the last 12 months, and a sustained focus is in place to meet the ED&I ambitions set out in the Trust Strategy.

Putting People First (PPF) Committee Chair's Highlight Report to Trust Board
19 July 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Committee received a detailed assurance paper in relation to the clinical workforce in maternity. Immediate and short term actions in place to improve the position and weekly executive oversight meetings to oversee progression against the actions noted. Committee moderately assured due to the residual risk. • The Committee was moderately assured by the Medical Workforce Assurance Report and agreed that an action plan should be developed to take forward actions to address the risks identified. • The Committee received limited assurance from the Corporate Services Workforce Assurance Report due to an inconsistent narrative via multiple authors. It was agreed that the narrative would be improved to ensure a consistent and unified report within the next iteration.	• Supported the development of a Medical Workforce Strategy • Pilot launch of a 'three key message' approach noted, which includes a 1) Trust wide message, 2) a Divisional wide message and 3) a local team message rolled out on a weekly basis. The implementation of the three key messages should improve the flow of staff messages particularly for those who do not have regular access to e-mails. • Noted and supported actions to be undertaken to review Nursing, Midwifery and AHP staffing within the Trust which included commissioning a Safer Nursing Care Tool; recalculation of the headroom; and development of a recruitment calendar. The Committee also agreed with the action to simplify future bi-annual staffing reports to avoid variance and duplication of information to the Committee. • Trust's Disciplinary Policy currently subject to a fundamental review in conjunction with the staff side and operational managers. • Received the Well-Led Review Action Plan and noted that the Chief People Officer and Committee Chair would update the PPF aligned actions and circulate to Committee members for approval ahead of Trust Board meeting 02 September 2021.
Positive Assurances to Provide	**Decisions Made**
• Received a positive staff story from an oversees trainee doctor, of her experience learning at the Trust and embedding into UK culture during the past six years. The Committee thanked the doctor for sharing her story and becoming an integral part of the team and wished her well for the future as she is due to leave the Trust to return home. • NHS System Oversight Framework 21/22: There are a number of key people metrics within the Oversight Framework that trusts will be expected to deliver. These metrics are captured within the Trust Putting People First Strategy and Equality Objectives and a sustained focus was already in place on all areas. The CPO identified one area which required further focus in relation to increasing flexible working across all areas. A review of rostering practices was the first step towards addressing this action. • Received Month 3 KPI report detailing compliance with mandatory training, sickness and turnover rates. The Committee had been assured by actions in place within the clinical divisions to improve compliance levels in relation to mandatory training. • Positively assured by the Staff Listening Events Update noting swift action taken and communication back to staff following the recent Listen and Learn event. • Received assurance from the Bi-Annual Safer Staffing Report. • Received the Whistleblowing/ Freedom to Speak up Annual Report 2020/21 noting that all concerns raised had been dealt with appropriately. The Committee noted the proactive approach to increase the visibility and access to the freedom to speak up service. • The Committee was assured by the Analysis of Disciplinary, Grievance and DAW Cases during the period 2020/21.	• Reviewed the PPF aligned BAF risks. Agreed to revise the narrative and risk score of BAF risk 1.1 and present to the Board in September 2021. Subject to the changes to BAF risk 1.1 the committee approved the PPF BAF risks. • Committee agreed to amend the Committee workplan to allow full Quarter reporting within the Bi-annual Safer Staffing Report, resulting in Q4&Q1 reporting to PPF committee in September 2021 and Q2&Q3 reporting in March 2022.

Comments on Effectiveness of the Meeting / Application of QI Methodology
• Lengthy meeting due to the number of reports however the meeting had kept to time as planned • There had been good challenge and robust discussion • It was agreed that the Maternity BAF Risk report had created an important discussion.

2. Summary Agenda

No.	Agenda Item	Purpose	Rating	No.	Agenda Item	Purpose	Rating
28.	Board Assurance Framework (BAF): Workforce related risks	Assurance		35.	Staff Listening Events Update	Assurance	
29.	Clinical Workforce Update in response to BAF risk – Maternity Services	Assurance		36.	Bi-Annual Safer Staffing Review	Assurance	
30.	Staff Story: Trainee Doctor	Information		37.	Freedom to Speak Up (FTSU) Update • Whistleblowing/ Freedom to Speak up Annual Report 2020/21 including FTSU Index & Progress Plan • Trust Strategy	Assurance	
31.	Service Workforce Assurance & Risk Report: Medical Workforce	Assurance		38.	Disciplinary and Grievance processes annual review	Assurance	
32.	Service Workforce Assurance & Risk Report: Corporate Services	Assurance		39.	Well Led review recommendations aligned to PPF	Information	
33.	Chief People Officer Report	Information		40.	Subcommittee chairs reports	Assurance	
34.	Workforce KPI Dashboard Report	Assurance					

3. 2021 / 22 Attendance Matrix

Core members	May	Jun	Sep	Nov	Jan	Mar
Jo Moore	✓	A				
Dr Susan Milner	A	✓				
Tracy Ellery	A	✓				
Louise Martin	Non member	✓				
Michelle Turner	✓	✓				
Marie Forshaw	✓	✓				
Gary Price	✓	✓				
Claire Scott	A	✓				
Liz Collins	✓	✓				
Medical Staff Chair – vacant	Vacant	Vacant				

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**2021/22/73a**		**Date: 02/09/2021**	
Report Title	**Finance Performance Review Month 4 2021/22**			
Prepared by	***Eva Horgan, Deputy Director of Finance***			
Presented by	***Jenny Hannon, Chief Finance Officer***			
Key Issues / Messages	***To take assurance from the Month 4 finance 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 – Y ***If no – please outline the reasons for deviation.***			
	The Board is asked to note the Month 4 Financial Position			
Supporting Executive:	***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)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks*	Comment:

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The Trust remains on track year to date and forecast to deliver the April to September (H1) plan. However, shortfalls on the Cost Improvement Programme (CIP) and Elective Recovery Fund (ERF), as well as pay overspends, mean this remains reliant on non-recurrent items. There is less certainty about October to March (H2).

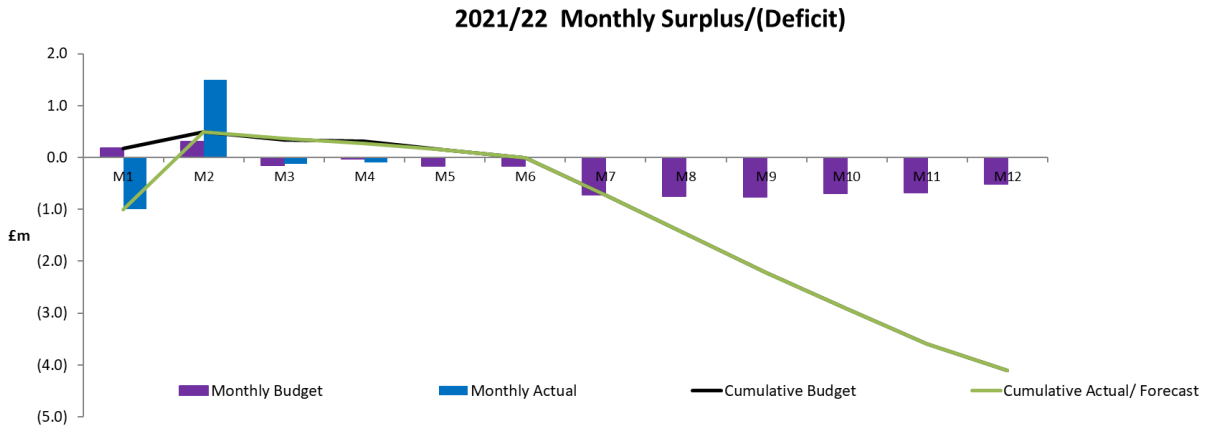
As at Month 4, the Trust remained in surplus Year to Date (YTD) despite generating a small deficit (£0.1m) in month. The cash position reduced from the previous month as the Trust awaits payment for the ERF earned to date. CIP and ERF are behind plan. Capital spend is behind plan but expected to increase.

	Plan	Actual	Variance	RAG	*R*	*A*	*G*
Adjusted Surplus	£0.3m	£0.3m	-£0.0m	↓	*>10% off plan*	*0-10% off plan*	*Plan or better*
H1 Surplus FOT	£0.0m	£0.0m	£0.0m	↔			
NHS I/E Rating	3	3	0	↔	*4*	*3*	*2+*
Cash	£4.5m	£3.2m	-£1.3m	↓	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement	£0.5m	£0.3m	-£0.2m	↑	*>10% off plan*	*0-10% off plan*	*Plan or better*
Recurrent CIP Achievement	£0.5m	£0.3m	-£0.2m	↑	*>10% off plan*	*0-10% off plan*	*Plan or better*
Elective Recovery Fund (net)	£1.3m	£1.0m	-£0.2m	↓	*>10% off plan*	*0-10% off plan*	*Plan or better*
Non - Recurrent Items	£0.0m	£1.0m	£1.0m	↓	*>£0*	-	*£0*
Capital Spend YTD	£3.4m	£1.2m	-£2.2m				

Note that NHSI/E have indicated the release of new system oversight metrics which will be detailed in due course.

1. Summary Financial Position

At Month 4 the Trust is reporting a Year to Date (YTD) surplus of just under £0.3m, slightly behind the surplus plan. There is a small deficit target in month due to the phasing of Elective Recovery Fund. Note that H2 is still a deficit plan at present but it is anticipated this will be revised once H2 planning is complete.



2. Divisional Summary Overview

In a change from 2020/21, divisions do now have income targets which are based on their agreed activity plans costed using payment by results (PbR) tariffs, although this is reconciled at a trust wide level to the blocks and top ups actually received. Elective Recovery Fund (ERF) income has been estimated and included in the trust wide position but not at divisional level.

Direct Covid-19 costs (e.g. cover for staff absence) are still recorded separately and do not impact the divisional positions. These are now budgeted for per the revised plan.

Family Health: The division was £165k overspent YTD in Month 4, a deterioration of £69k since Month 3, largely due to a significant pay overspend, particularly on agency midwives.

Gynaecology: The division is £918k overspent YTD, primarily relating to activity and income being behind plan.

Performance on the ERF reduced as detailed in section 3 below, with activity significantly behind plan in daycases and outpatients (although ahead on inpatients).

There remain overspends on pay, particularly on medical staffing (£63k YTD) and agency (£80k YTD).

Clinical Support Services: There was an underspend in month (£80k) bringing the YTD underspend to £180k.

Agency: Agency spend across the Trust is now a concern and at risk of breaching the agency ceiling which has been re-introduced in NHSI/E monitoring. Total agency spend was £513k YTD, largely related to the high cost of agency midwives. Work is going on to resolve this on a number of fronts including the procurement team working on rates with agencies, the introduction of NHS Professionals to manage temporary staffing and divisions looking at usage to try to bring this down.

3. Elective Recovery Fund

The Elective Recovery Fund has been put in place to incentivise providers to undertake more elective activity and to pay for the additional costs associated with this. It is measured using a baseline of 2019/20 data and uses SUS[1] data which is not finally validated until three months after the activity is complete. The Trust has now received confirmation of Month 1 ERF which was higher than anticipated at £504k. The YTD ERF has been estimated at just under £1m which is £291k behind plan as shown in the table below; note that there is still some risk to this beyond Month 1.

It is important to note that the whole system needs to achieve in order for individual trusts to achieve, and that a number of gateway criteria also need to be met, as well as the activity targets.

The target is measured using a baseline of a percentage of 2019/20 activity – with activity above 70% of the 2019/20 baseline being funded in Month 1 and above 75% in Month 2. Activity is funded at tariff up to 85% and at 120% tariff above this in Quarter One.

Note that the thresholds were changed in July and from Month 4, ERF will only be earned on activity above 95% on 2019/20, and 120% of tariff will only be earned above 100% on 2019/20, not 85%. This means there is a risk that Cheshire and Merseyside will not achieve as a whole in Quarter 2 (Q2), and the Trust has had to reduce projections for Q2 against the original plan.

Note that the ERF is measured on a financial baseline not activity.

A summary of the Trust's estimate for Month 4 YTD is given below (noting again that this is not guaranteed and is subject to amendment). Further detail is given in the appendix.

	2019/20		2021/22				
Point of Delivery	**Activity**	**Costed Activity £000**	**Activity**	**Costed Activity £000**	**ERF £000**	**% Activity**	**% Costed Activity**
Daycases	1,956	1,169	1,172	913	249	60%	78%
Elective Inpatients	480	1,372	484	1,720	313	101%	125%
Outpatient First	12,540	1,760	12,407	2,033	381	99%	116%
Outpatient Follow Up	19,428	1,631	16,322	1,697	351	84%	104%
Other					*-299*		
Total		**5,932**		**6,362**	**995**		**107%**

4. Women's Health and Maternity (WHAM)

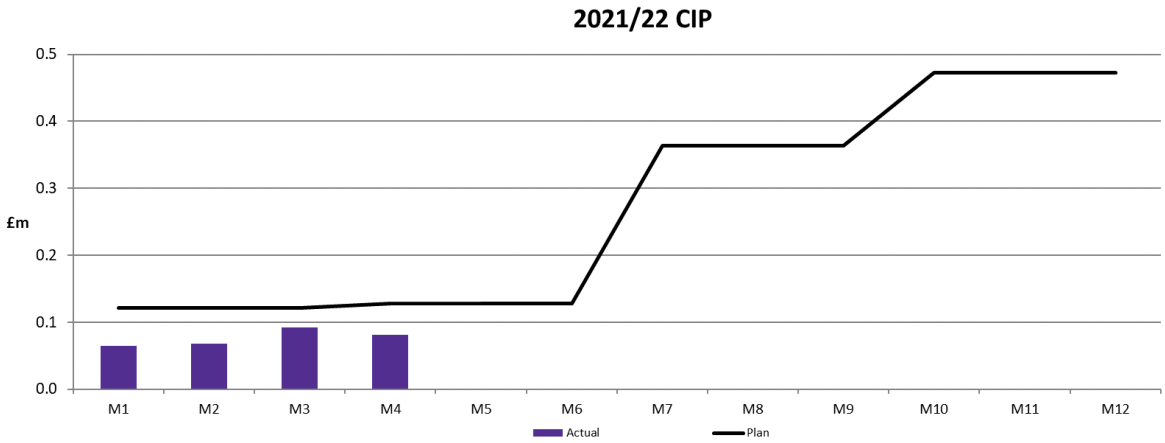
The financial plan and budget for the Women's Health and Maternity Programme (WHAM), incorporating the Local Maternity System (LMS), have been provisionally agreed and most funding has now transferred from the CCG and other sources. A full plan and budget will be agreed at the HCP Board in September and reported to the Trust Board after this.

[1] https://digital.nhs.uk/services/secondary-uses-service-sus

5. CIP

CIP is still behind plan and this is being managed with divisions individually and via the Senior Management Team meeting, which is being refocussed to give greater time to CIP and Transformation.

The graph below shows performance to Month 4.



6. COVID-19

The Trust spent £460k on direct Covid-19 related costs YTD to Month 3, against a plan of £688k. A budget is in place for 2021/22 in line with the plan agreed with the HCP. Further detail is given in the Appendix.

7. Cash and Borrowings

Cash reduced in Month 4 to £3.2m. Now that further system monies and a breakeven plan have been agreed, cash is less of a risk for H1.

Close monitoring of the cash position has been in place for some time and will continue; this includes review of each payment run and detailed daily cashflow forecasts.

8. Capital Expenditure

Capital expenditure was relatively low again in month. It is expected to increase in coming months as plans are finalised for the ongoing Crown Street Enhancements.

The Trust is also awaiting the outcome of proposals for a potential Community Diagnostic Hub at Crown Street. If successful this could mean there will be significant capital funding on top of existing plans to spend in 2021/22.

9. BAF Risk

There are no proposed changes to the risk at this time.

10. Conclusion & Recommendation

The Board is asked to note the position.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M4

YEAR ENDING 31 MARCH 2022

Liverpool Women's NHS Foundation Trust

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NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M04
YEAR ENDING 31 MARCH 2022

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	2,907
(b) PDC + Interest Payable + Loans Repaid	762
CSC Ratio = (a) / (b)	**3.82**
NHSI CSC SCORE	**1**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25	
LIQUIDITY	
(a) Cash for Liquidity Purposes	(13,285)
(b) Expenditure	40,842
(c) Daily Expenditure	335
Liquidity Ratio = (a) / (c)	**(39.7)**
NHSI LIQUIDITY SCORE	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)	
I&E MARGIN	
(Surplus) / Deficit (Adjusted for donations and asset disposals)	(281)
Total Income	(43,749)
I&E Margin	**0.6%**
NHSI I&E MARGIN SCORE	**1**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)	
I&E MARGIN VARIANCE FROM PLAN	
I&E Margin (Actual)	0.60%
I&E Margin (Plan)	0.70%
I&E Variance Margin	**-0.10%**
NHSI I&E MARGIN VARIANCE SCORE	**2**
Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%	
Note: NHSI assume the score of the I&E Margin variance from Plan is a 1 for the whole year and year to date budget. This is because NHSI recognise the fact that an organisation would not "plan" to have a variance from plan and have not applied a calculated ratio to the budgeted columns of this metric.	
AGENCY SPEND	
YTD Providers Cap	597
YTD Agency Expenditure	500
	-16%
NHSI 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.

Liverpool
NHS Fo

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M4
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE	Month 4			YTD			H1 FOT		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income									
Clinical Income	(10,527)	(10,086)	(441)	(42,260)	(41,606)	(654)	(63,026)	(62,183)	(843)
Non-Clinical Income	(576)	(621)	46	(2,304)	(2,143)	(161)	(3,456)	(3,147)	(309)
Total Income	**(11,103)**	**(10,707)**	**(396)**	**(44,564)**	**(43,749)**	**(815)**	**(66,482)**	**(65,330)**	**(1,152)**
Expenditure									
Pay Costs	6,288	6,449	(160)	24,906	25,310	(404)	37,465	38,655	(1,189)
Non-Pay Costs	2,562	2,126	436	10,248	9,210	1,039	15,370	13,179	2,191
CNST	1,581	1,581	0	6,323	6,323	0	9,484	9,484	0
Total Expenditure	**10,431**	**10,155**	**276**	**41,477**	**40,842**	**635**	**62,319**	**61,318**	**1,001**
EBITDA	**(671)**	**(552)**	**(119)**	**(3,086)**	**(2,907)**	**(179)**	**(4,163)**	**(4,012)**	**(150)**
Technical Items									
Depreciation	501	469	32	1,985	1,876	109	2,985	2,882	103
Interest Payable	3	4	(0)	13	14	(1)	20	21	(2)
Interest Receivable	0	0	0	0	0	0	0	0	0
PDC Dividend	195	181	14	780	747	33	1,170	1,121	49
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	0	0	0	0	0
Total Technical Items	**699**	**654**	**45**	**2,778**	**2,638**	**140**	**4,174**	**4,024**	**150**
(Surplus) / Deficit	**28**	**102**	**(74)**	**(308)**	**(269)**	**(39)**	**12**	**12**	**(0)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **2a**
INCOME & EXPENDITURE HOSTED SERVICES: M4
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE £'000	Month 4 Budget	Month 4 Actual	Month 4 Variance	YTD Budget	YTD Actual	YTD Variance
Income						
Clinical Income	0	(71)	71	0	(337)	337
Non-Clinical Income	0	0	0	0	0	0
Total Income	**0**	**(71)**	**71**	**0**	**(337)**	**337**
Expenditure						
Pay Costs	0	36	(36)	0	154	(154)
Non-Pay Costs	0	35	(35)	0	183	(183)
Total Expenditure	**0**	**71**	**(71)**	**0**	**337**	**(337)**
(Surplus) / Deficit	**0**	**(0)**	**0**	**0**	**(0)**	**0**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M4
YEAR ENDING 31 MARCH 2022

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget
Pay Costs							
Board, Execs & Senior Managers	359	335	24	1,414	1,323	91	4,288
Medical	1,690	1,686	4	6,654	6,456	198	19,953
Nursing & Midwifery	2,685	2,678	7	10,638	11,122	(484)	31,754
Healthcare Assistants	484	461	23	1,938	1,860	78	5,565
Other Clinical	396	389	7	1,563	1,533	30	4,838
Admin Support	616	622	(6)	2,466	2,516	(49)	7,309
Agency & Locum	58	278	(220)	233	500	(267)	610
Total Pay Costs	**6,288**	**6,449**	**(160)**	**24,906**	**25,310**	**(404)**	**74,317**
Non Pay Costs							
Clinical Suppplies	774	705	69	3,067	2,822	245	8,219
Non-Clinical Supplies	590	499	91	2,371	2,093	278	6,897
CNST	1,581	1,581	0	6,323	6,323	0	18,968
Premises & IT Costs	710	622	88	2,851	2,621	229	7,994
Service Contracts	488	300	188	1,960	1,673	286	5,631
Total Non-Pay Costs	**4,143**	**3,707**	**436**	**16,571**	**15,532**	**1,039**	**47,708**
Total Expenditure	**10,431**	**10,155**	**276**	**41,477**	**40,842**	**635**	**122,025**

Note that the values above exclude £337k in relation to hosted services.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
COVID EXPENDITURE: M4
YEAR ENDING 31 MARCH 2022

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	H1 FOT Budget	H1 FOT Actual	H1 FOT Variance
Pay Costs									
Board, Execs & Senior Managers	0	0	0	0	1	(1)	0	1	(1)
Medical	0	3	(3)	0	4	(4)	0	4	(4)
Nursing & Midwifery	45	50	(5)	215	123	92	305	227	77
Healthcare Assistants	27	11	15	113	46	67	166	76	90
Other Clinical	0	(0)	0	0	2	(2)	0	4	(4)
Admin Support	21	18	3	93	105	(12)	134	191	(56)
Agency & Locum	15	12	3	60	45	15	90	69	21
Total Pay Costs	**107**	**93**	**14**	**481**	**326**	**155**	**695**	**572**	**123**
Non Pay Costs									
Clinical Suppplies	9	8	1	57	32	25	76	102	(26)
Non-Clinical Supplies	0	0	(0)	6	(9)	15	6	(8)	14
CNST	0	0	0	0	0	0	0	0	0
Premises & IT Costs	33	16	17	144	99	45	210	221	(11)
Service Contracts	0	11	(11)	0	11	(11)	0	11	(11)
Total Non-Pay Costs	**42**	**35**	**7**	**207**	**134**	**73**	**292**	**326**	**(34)**
Total Expenditure	**149**	**128**	**21**	**688**	**460**	**228**	**987**	**898**	**89**

Note that the values above include £8k YTD related to Vaccination and LAMP Testing expenditure which should both be reimbursed.

NHS
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LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M4
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE	MONTH			YEAR TO DATE			H1 FOT			YEAR
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Budget
Maternity										
Income	(4,000)	(4,065)	65	(16,001)	(15,834)	(167)	(24,002)	(24,020)	18	(48,003)
Expenditure	1,955	2,117	(162)	7,820	8,030	(210)	11,729	12,390	(660)	23,382
Total Maternity	**(2,045)**	**(1,948)**	**(98)**	**(8,182)**	**(7,804)**	**(377)**	**(12,272)**	**(11,630)**	**(642)**	**(24,622)**
Neonatal										
Income	(1,743)	(1,751)	7	(6,973)	(7,028)	55	(10,460)	(10,516)	56	(20,920)
Expenditure	1,236	1,216	21	4,946	4,789	157	7,418	7,166	252	14,808
Total Neonatal	**(507)**	**(535)**	**28**	**(2,028)**	**(2,239)**	**212**	**(3,042)**	**(3,349)**	**307**	**(6,112)**
Division of Family Health - Total	**(2,552)**	**(2,483)**	**(69)**	**(10,209)**	**(10,044)**	**(165)**	**(15,314)**	**(14,979)**	**(335)**	**(30,734)**
Gynaecology										
Income	(2,041)	(1,987)	(54)	(8,166)	(7,640)	(525)	(12,248)	(11,418)	(830)	(24,547)
Expenditure	1,104	1,182	(79)	4,405	4,649	(244)	6,612	7,008	(396)	13,144
Total Gynaecology	**(938)**	**(805)**	**(133)**	**(3,760)**	**(2,991)**	**(769)**	**(5,636)**	**(4,411)**	**(1,226)**	**(11,402)**
Hewitt Centre										
Income	(771)	(745)	(25)	(3,059)	(2,928)	(131)	(4,589)	(4,398)	(190)	(9,449)
Expenditure	699	713	(14)	2,797	2,815	(18)	4,196	4,201	(5)	8,140
Total Hewitt Centre	**(71)**	**(32)**	**(39)**	**(262)**	**(112)**	**(149)**	**(393)**	**(198)**	**(195)**	**(1,310)**
Division of Gynaecology - Total	**(1,009)**	**(837)**	**(172)**	**(4,022)**	**(3,104)**	**(918)**	**(6,029)**	**(4,609)**	**(1,420)**	**(12,712)**
Theatres										
Income	0	0	0	0	0	0	0	0	0	0
Expenditure	823	861	(38)	3,290	3,260	30	4,936	4,908	28	9,779
Total Theatres	**823**	**861**	**(38)**	**3,290**	**3,260**	**30**	**4,936**	**4,908**	**28**	**9,779**
Genetics										
Income	(13)	20	(33)	(50)	(23)	(27)	(75)	(42)	(33)	(150)
Expenditure	144	131	13	575	502	73	862	764	98	1,725
Total Genetics	**131**	**151**	**(20)**	**525**	**478**	**46**	**787**	**722**	**65**	**1,575**
Other Clinical Support										
Income	(367)	(424)	57	(1,469)	(1,559)	91	(2,203)	(2,286)	83	(4,451)
Expenditure	636	554	82	2,530	2,518	12	3,802	3,799	3	7,353
Total Clinical Support	**269**	**131**	**138**	**1,062**	**959**	**103**	**1,599**	**1,513**	**86**	**2,902**
Division of Clinical Support - Total	**1,223**	**1,143**	**80**	**4,877**	**4,697**	**180**	**7,322**	**7,143**	**178**	**14,256**
Corporate & Trust Technical Items										
Income	(2,167)	(1,826)	(341)	(8,846)	(9,073)	227	(12,905)	(14,836)	1,930	(18,803)
Expenditure	4,534	4,105	429	17,892	17,254	638	26,939	27,292	(354)	52,095
Total Corporate	**2,367**	**2,279**	**87**	**9,046**	**8,181**	**865**	**14,033**	**12,457**	**1,576**	**33,292**
(Surplus) / Deficit	**28**	**102**	**(74)**	**(308)**	**(269)**	**(39)**	**12**	**12**	**(0)**	**4,102**
Of which is hosted;										
Income	0	(71)	71	0	(337)	337	0	(2,186)	2,186	0
Expenditure	0	71	(71)	0	337	(337)	0	2,187	(2,187)	0
Total Corporate	**0**	**(0)**	**0**	**0**	**(0)**	**0**	**0**	**1**	**(1)**	**0**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
CIP: M4
YEAR ENDING 31 MARCH 2022

Scheme	Month 4			YTD		
	Target	Actual	Variance	Target	Actual	Variance
Procurement and Non Pay	89	46	(43)	346	176	(170)
Estates Utilisation	0	0	0	0	0	0
Staffing and Skill Mix	17	17	0	67	67	0
Outpatients Utilisation	0	0	0	0	0	0
Medicines Management	0	0	0	0	0	0
Service Developments	21	18	(3)	79	62	(17)
Strategic Review	0	0	0	0	0	0
Theatre Efficiency	0	0	0	0	0	0
Technology Driven Efficiences	0	0	0	0	0	0
	127	**81**	**(47)**	**493**	**306**	**(187)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
BALANCE SHEET: M04
YEAR ENDING 31 MARCH 2022

BALANCE SHEET £'000	YEAR TO DATE Opening	M04 Actual	Movement
Non Current Assets	90,086	89,445	(641)
Current Assets			
Cash	4,235	3,156	(1,079)
Debtors	4,976	8,981	4,005
Inventories	410	398	(12)
Total Current Assets	**9,621**	**12,535**	**2,914**
Liabilities			
Creditors due < 1 year - Capital Payables	(3,447)	(850)	2,597
Creditors due < 1 year - Trade Payables	(13,728)	(15,009)	(1,281)
Creditors due < 1 year - Deferred Income	(3,136)	(5,894)	(2,758)
Creditors due > 1 year - Deferred Income	(1,592)	(1,587)	5
Loans	(2,136)	(2,136)	0
Provisions	(4,090)	(3,829)	261
Total Liabilities	**(28,129)**	**(29,305)**	**(1,176)**
TOTAL ASSETS EMPLOYED	**71,578**	**72,675**	**1,097**
Taxpayers Equity			
PDC	62,927	63,755	828
Revaluation Reserve	7,522	7,522	0
Retained Earnings	1,129	1,398	269
TOTAL TAXPAYERS EQUITY	**71,578**	**72,675**	**1,097**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CASHFLOW STATEMENT: M04
YEAR ENDING 31 MARCH 2022

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	1,030
Depreciation and amortisation	1,877
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	(1,017)
Net cash generated from / (used in) operations	**1,890**
Interest received	0
Purchase of property, plant and equipment and intangible assets	(3,797)
Proceeds from sales of property, plant and equipment and intangible assets	0
Net cash generated from/(used in) investing activities	**(3,797)**
PDC Capital Programme Funding - received (Approved Emergency Capital of £1,600k)	828
PDC COVID-19 Capital Funding - received	0
Loans from Department of Health Capital - repaid	0
Loans from Department of Health Revenue - received	0
Loans from Department of Health Revenue - repaid	0
Interest paid	0
PDC dividend (paid)/refunded	0
Net cash generated from/(used in) financing activities	**828**
Increase/(decrease) in cash and cash equivalents	**(1,079)**
Cash and cash equivalents at start of period	4,235
Cash and cash equivalents at end of period	**3,156**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid
Loans from Department of Health - Capital (ITFF) - 2.0% Interest Rate	5,500	(3,364)
Loans from Department of Health - Capital (Neonatal) - 2.54% Interest Rate	14,572	(14,572)
Loans from Department of Health - Revenue - 1.50% Interest Rate	14,612	(14,612)
Total	**34,684**	**(32,548)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 9
CAPITAL EXPENDITURE: M04
YEAR ENDING 31 MARCH 2022

CAPITAL EXPENDITURE £'000		Year to Date Plan	Year to Date Actual	Year to Date Variance	FOT Plan	FOT Actual	FOT Variance
Estates	Estates - Business as Usual	232	11	221	700	650	50
	Estates - Prior Year	0	22	(22)	0	6	(6)
	Estates Total	**232**	**33**	**199**	**700**	**656**	**44**
Capital Projects	Crown Street Enhancements	2,572	667	1,905	4,513	4,513	0
	Medical Equipment - CSE	0	7	(7)	7	7	0
	Capital Projects Total	**2,572**	**674**	**1,898**	**4,520**	**4,520**	**0**
IM&T	IM&T - Business as Usual	70	0	70	130	130	0
	IM&T - Business as Usual (Staff)	284	243	41	850	800	50
	Meditech Expanse (EPR)	108	67	41	408	384	24
	Prior Year - Homeworking Equipment	0	70	(70)	0	140	(140)
	Prior Year - Business as Usual	0	90	(90)	0	72	(72)
	IM&T Total	**462**	**470**	**(8)**	**1,388**	**1,526**	**(138)**
Medical Equipment	Medical Equipment - Neonates	0	0	0	78	78	(0)
	Medical Equipment - Maternity	0	0	0	35	35	0
	Medical Equipment - Gynae	0	0	0	51	51	(0)
	Medical Equipment - HFC	0	17	(17)	124	106	18
	Medical Equipment - Imaging Installatic	0	0	0	0	60	(60)
	Medical Equipment - Theatres	0	0	0	14	14	0
	Medical Equipment - Resus	0	0	0	10	10	0
	Medical Equipment Total	**0**	**17**	**(17)**	**302**	**344**	**(42)**
Other	Intranet Redevelopment	22	0	22	22	22	0
	Phone Upgrade HFC	30	0	30	30	30	0
	E-rostering	49	6	43	49	35	14
	Total Other	**101**	**6**	**95**	**101**	**87**	**14**
	Mitigating pressures	0	0	0	0	(122)	122
	Total Mitigating pressures	**0**	**0**	0	**0**	**(122)**	**122**
Grand Total		**3,367**	**1,200**	**2,167**	**7,011**	**7,011**	**(0)**

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***21/22/73b***		**Date: 02/09/2021**	
Report Title	**Future Generations Programme: Expression of Interest to Build a New Liverpool Women's Hospital**			
Prepared by	***Jennifer Huyton, Head of Strategy and Transformation***			
Presented by	***Jenny Hannon, Chief Finance Officer***			
Key Issues / Messages	***The Trust will be submitting an expression of interest, in order to be considered in the selection process to become one of eight proposed new hospital building schemes in England.***			
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.***			
	Recommendation: *The Board is asked to review the proposal outlined in this report and approve the submission of an expression of interest to build one of eight new hospitals in England.*			
Supporting Executive:	***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)	
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:

2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site 4.1 Failure to ensure our services are financially sustainable in the long term	
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
FPBD	26/07/21	CFO	Intention to submit expression of interest discussed.

EXECUTIVE SUMMARY

In July 2021, the government announced a plan to build eight new hospitals in England, inviting expressions of interest from Trusts who meet specific criteria. The Trust intends to submit an expression of interest to build a new Liverpool Women's Hospital, co-located with an adult acute site, in order to address the long-standing clinical safety and sustainability issues which arise from its current isolated location. If successful, the proposal will deliver a broad range of local and system-wide benefits.

This paper outlines the background, summarises the proposal and describes the anticipated benefits.

MAIN REPORT

Introduction & Background

Liverpool Women's first formally identified its clinical sustainability challenges in 2014, based on emerging views from clinicians that clinical services were unsustainable in their current form, primarily due to being located on an isolated standalone site.

The Trust's Future Generations programme was established at the end of 2014 to undertake a review of the Trust's clinical services. The over-arching conclusion of the programme was that the best available option to the Trust to ensure future sustainable and safe services was to build a new hospital, co-located with an adult acute site. This plan was articulated in the Trust's 'Future Generations 2016 - 2020' clinical strategy.

Since the publication of the strategy, the plan has been further developed, tested, and verified in partnership with stakeholders from across the system. There is widespread support for the clinical case for change however the Trust has not yet secured capital funding to consult on and implement its plans.

Selection Process for Eight New Hospitals in England

On 15 July 2021, the government announced the launch of a selection process for eight new hospitals in England, stating:

"The Government is now launching the next phase of implementation of its Health Infrastructure Plan. The Department of Health and Social Care is inviting expressions of interests from mental health, community and acute NHS trusts in England who wish to be considered for inclusion in this next wave of the programme, identifying a further 8 new hospitals to deliver on our commitment to fund and build a total of 40 new hospitals by 2030. Together with eight pre-existing schemes which have been included in the national programme, these 48 hospitals represent the biggest hospital building programme in a generation.
This is the first of a two-stage selection process, starting with an 'expression of interest' phase which is open to all trusts. It will be followed by a more detailed process for long-listed schemes later in the year. We aim to make a final decision in spring 2022. This process will also inform the ongoing pipeline of investment through this programme, subject to future funding settlements."

The scheme must meet one of the following criteria:

- A whole new hospital site on a new site or current NHS land (either a single service or consolidation of services on a new site).
- A major new clinical building on an existing site or a new wing of an existing hospital (provided it contains a whole clinical service, such as maternity or children's services).
- A major refurbishment and alteration of all but the building frame or main structure, delivering a significant extension to useful life which includes major or visible changes to the external structure.

Trusts are asked to outline how the scheme supports key strategic goals, including:

- better outcomes for people and smarter use of infrastructure – how the scheme supports the NHS Long Term plan aims, for example joined up, person centred and high-quality clinical care. This might include a brief description of the clinical and service model case for change and/or how the scheme would support service delivery and benefit the local population.
- stronger and greener NHS buildings – how the scheme would support modern fit for purpose and efficient use of estates and increase service resilience. For instance, you might wish to describe how the scheme will address estates quality or safety issues (for example backlog maintenance, specifically critical infrastructure risk and impact on services), support COVID-19 recovery (for example ensuring greater flexibility and productivity in the use of space) improve efficiency of the estate and/or support net-zero carbon/ sustainability objectives.
- fairer and more efficient use of resource – how would this scheme enable more efficient, levelled-up investment and support the local community. This might include how the scheme would support wider health and care service models (for example supporting services to be delivered through primary and community settings and/or better join up amongst services); and how this makes efficient use of assets and land. This could also include a description of any savings you foresee from investing in this way.

The Trust's proposal for the future of women's and neonatal services in Liverpool meets the criteria outlined above, and clearly supports the key strategic goals listed. Therefore, the Trust intends to submit an expression of interest, the contents of which are described in the remainder of this paper. The deadline for submissions is 9 September 2021.

Case for Change/Proposal in Summary

The consequences of carrying risk within maternity services were clearly demonstrated by Donna Ockenden's recent report into maternity services at the Shrewsbury and Telford Hospital NHS Trust. Liverpool is already one of the most socio-economically deprived areas of the country, with poorer health outcomes and increasing inequality; in 2020, life expectancy fell to 76.7 years in Liverpool compared to 79.8 in England, widening the gap from 2.8 to 3.1 years. The current configuration of services in Liverpool is a barrier to addressing these health inequalities and ensuring that safe and sustainable care can be provided in the long term.

On the Crown Street site the Trust does not have critical care facilities and lacks rapid access to other specialist surgical and medical services in case of urgent need. There is also lack of access to onsite gynaecology and maternity services for inpatients at other acute hospitals, for example pregnant women admitted to major trauma services or ITU due to COVID-19.

The scheme comprises a new build hospital, co-located with and linked by footbridge to an adult acute site, to facilitate urgent transfer of patients and staff between buildings. The purpose of the scheme is to address the issues which arise as a result of the Trust's current location, isolated from adult acute services. Costs of the scheme were previously estimated at £150m; however cost estimates are currently being refreshed and it is anticipated that there will be some increase in costs due to time elapsed and recent changes impacting the construction industry.

The proposal will facilitate closer links with research facilities at Liverpool University, as well as with cancer services at the Clatterbridge Cancer Centre. To date, plans include reference to:

- Increased provision of digital access to care
- Increasing provision of services in the community, delivering services closer to people's homes, and improving access to care
- Provision of a free-standing midwife led unit, facilitating increased choice in location of birth for women.

There is no proposed reduction in beds or direct clinical space; a smaller footprint (compared to the current site) is achieved through reduced administrative and non-direct clinical space, with assumptions made regarding some sharing of facilities with the co-located site.

Engagement and Support

The Trust's plans have been developed with full engagement from system partners, have been clearly articulated as part of the 'Future Generations' programme and widely shared and publicised over the last seven years. Widespread engagement has been carried out with system partners, with extensive and support received.

Clinical staff have been instrumental in developing the proposal and in collating and subsequently escalating supporting evidence (for example non-compliance with clinical standards, incident reporting and managing escalating clinical risk) over the last seven years.

Patients and the wider community have influenced plans from the outset and have been widely engaged.

Benefits

The proposal will deliver a broad range of system-wide benefits, outlined below.

Addressing Clinical Risk, Health Inequalities, and Improving Women's Services

The proposal will address quality and safety issues, delivering compliance with key clinical standards and service specifications. It will ensure tertiary services are retained in the region, enabling delivery of a broader range of specialist maternity and gynaecology services in Liverpool, while at the same time improving access and clinical outcomes for patients across the whole of Cheshire and Merseyside. The proposal will secure the region's largest maternity and gynaecology services for the long-term, consequently securing services across the region as a whole.

Delivery of a co-located Liverpool Women's Hospital will enable the system to address health inequalities and ensure women's services are given equal priority in healthcare in line with the government's proposed Women's Health Strategy, by:

- Delivering cohesive, joined up services across the Liverpool and Cheshire and Merseyside health economies, increasing opportunities for mutual aid and COVID-19 recovery.
- Improving prospects for research, development, and innovation, creating opportunities for Starting Well initiatives and early intervention within the first 1001 days of life.
- Ensuring women from ethnic minority backgrounds, who face additional maternity risks and experience poorer maternal and neonatal outcomes, can access appropriate standards of care, and achieve equitable maternity outcomes
- Improving access to care closer to people's homes, through delivery of a broader range of community services, digital innovation, and increased choice in birth location.

It is also expected that the proposal will drive significant improvements in patient experience; for example, patients requiring inpatient care in other Trusts across Liverpool who are also pregnant (such as pregnant women admitted to ITU due to COVID-19), would be able to access 24/7 midwifery and obstetric care.

Facilitating System Reconfiguration

While no longer being suitable for complex, high risk acute service provision, the Crown Street site provides an ideal location for high volume, low complexity (HVLC) and community services across a broad range of specialties. If the proposal is successful, the site at Crown Street will become available for use by the wider health and care system, enabling it to be repurposed for the benefit of the local community, Liverpool and wider Cheshire and Merseyside system. This provides an opportunity to secure and expand the range of services provided in Toxteth, as well as expanding service provision on the site to a much wider population (no longer restricting service provision to women and neonates).

Repurposing the current site as described above will also greatly improve system resilience and the ability to deliver improved elective recovery. It will facilitate city-wide estate reconfiguration of services, improving efficiency and utilisation of public estate and potentially addressing backlog maintenance issues on other sites.

Improved Financial Sustainability

If successful, the proposal is expected to deliver improved financial sustainability for the Trust and the Liverpool system. Likely annual revenue savings resulting from co-location with adult acute services have been previously estimated at approximately £3m per year, drawn from the following areas:

- Reduction in patient transfer costs
- Co-location benefits within clinical support services (e.g., pharmacy, physiotherapy, imaging, pre-op)
- Facilities management.

As well as the ability to re-utilise the remaining estate within the Cheshire and Merseyside health and care system.

Delivery of National Programmes
The proposal will also facilitate delivery of a range of national programmes aimed at improving health care outcomes and reducing inequalities, including:

- Maternity transformation programme.
- Ockenden recommendations.
- Networked Maternal Medicine Services.
- NHS Long Term Plan ambitions for maternity, neonatal and cancer services, as well as ambition for digital access to care.
- COVID-19 recovery.
- Community Diagnostic Hub programme.

Conclusion and Recommendation
The Trust's proposal to build a new Liverpool Women's Hospital, co-located with an adult acute site, meets the criteria and supports delivery of the strategic aims set out by the government in their plan to build eight new hospitals in England.

The Board is asked to review the proposals outlined above and approve the submission of an expression of interest to build one of eight new hospitals in England.

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
26 July 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Committee noted Trust finances remained on track and forecast to deliver the April – September 2021 plan. However, risks in relation to shortfalls on the Cost Improvement Programme (CIP) and Elective Recovery Fund (ERF) and pay overspending were highlighted as potential impacts during quarter 2 and had been factored into the forecast. • Uncertainty in relation to the ERF funding noted. • The Recovery and Restoration update highlighted risks in relation to the capacity plans to deliver activity dependant significantly on sickness absence (which had increased through June and July 2021) and the need to support more urgent demands, e.g. oncology and the subsequent impact on achieving the 52 week position. • It was agreed that Mutual aid requests from the system required careful consideration against the capacity of the Trust workforce and Trust waiting lists. • No financial plan agreed for the period October 2021 to March 2022 • Received indicative timescales for Planning H2 from NHSE/I noting that planning would run into the same time period (up until November 2021). The importance for the Trust to have a clear grip on costs and issues and ability to clearly articulate the need to resource at the correct level to deliver safe services was noted. It had been indicated that the H2 position would be more constrained with an increased requirement for Cost Improvement Programmes, reduced Elective Recovery Income, and targeted system reductions in allocations for specific areas. Covid allocations would also reduce.	• Relaunch of the Future Generations programme and an opportunity to bid for capital funding. Recommence public dialogue in relation to Future Generations starting with Trust Board in September 2021. • Noted the actions aligned to the Committee within the Well-Led review action plan. Executive Leads, Operational leads and Non-Executive Director leads would work on significantly updating the action plan and the evidence of completion ahead of the Board meeting in September 2021.
Positive Assurances to Provide	**Decisions Made**
• Assured by Month 3 Finance performance position, noting a Year-to-Date surplus of just under £0.4m, slightly ahead of the surplus plan. • Noted an improved cash position in Month 3 and was assured by system support and a breakeven plan that the risk had been reduced for H1 (April – Sept 2021). • Assured by the Treasury Management report Quarter 1 that good treasury management was in place. It was noted that the Trust had not excluded disputed prior year invoices from the Better payment practice code metric although guidance advised that these should be excluded. The approach undertaken had been to resolve issues swiftly but exclusion within future reporting would be considered.	• Reviewed the FPBD related BAF risks. The Committee considered BAF risk 2.2: Failure to develop our model of care to keep pace with developments and respond to a changing environment in relation to the Trust's use of multiple systems. It was agreed that the risk should be reviewed ahead of the next report to accurately reflect the position. No further changes to existing risks related to FPBD were identified as a result of business conducted during the meeting.

• Noted the position in relation to the National Cost Collection exercise 2020/21 including the change in governance and that a further paper with analysis of the outputs would be provided when available. The Trust Costing Assurance Programme Report 2020/21 was circulated post meeting. • Assured by the operational report, noting continued improved monitoring of Estates and Facilities metrics. • Received a detailed presentation on the Continuity of Carer (CoC) Pathway noting a shift in national timescales to final implementation of CoC for all patients by March 2023.The benefits to both patients and staff was noted. Appropriate allocation of funding nationally to support delivery of CoC was discussed. • Works progressing on Phase 1 of the Crown Street Enhancement Programme. A project risk register was in place and regularly reviewed by the Programme Board. • Positive assurance from the Digital Services Update. The Trust had successfully submitted the Data Security and Protection Toolkit as standards met which was reassigned as standards exceeded by NHS Digital. • Positive assurance received from the bi-annual review of the Digital Generations Strategy noting demonstrable progress against each of the four themes. • Assured that high-level mitigations and controls were in place and ongoing engagement between NHS Digital and Digital Services department to remove Windows 7 from the Trusts estate by the end of December 2021.	
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Good discussion and challenge. • Allocate more time at the beginning of the agenda	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
63.	Board Assurance Framework Review	Information	71.	Crown Street Enhancements Program	Assurance
64.	Finance Performance Report Month 3 2021/22	Assurance	72.	Review of Strategic Progress	Assurance
65.	Treasury Management Quarterly Report /22	Assurance	73.	Digital Services Update including Information Governance Update	Information
66.	Costing Assurance Programme, National Cost Collection Exercise Update & Publication of NCC 2019/20 data	Information	74.	Digital Generations Strategy 2020-2024 Bi-annual review	Assurance
67.	Operational Performance Report Month 3 2021	Assurance	75.	Windows 7 Removal Plan	Information
68.	Recovery and Restoration Trajectory Update	Assurance	76.	NHSI Enforcement Undertaking Review	Information
69.	Continuity of Carer Update	Assurance	77.	Well Led review recommendations aligned to FPBD	Information
70.	Planning and CIP Update	Information	78.	Sub-Committee Chairs Reports	Assurance

3. 2021 / 22 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tracy Ellery	✓	✓	✓	✓							
Jo Moore	A	✓	✓	A							
Ian Knight	✓	✓	✓	✓							
Louise Martin	Non member		✓	✓							
Jenny Hannon	✓	✓	✓	✓							
Kathryn Thomson	✓	✓	✓	✓							
Gary Price	✓	✓	✓	✓							
Marie Forshaw	✓	✓	✓	✓							

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

Audit Committee Chair's Highlight Report to Trust Board
22 July 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Divisional Presentation for Family Health had been deferred to the next meeting in October 2021 due to on-going pressures in the Division. It was stated that there remained a need for the Board to receive assurance on the how the challenges in the Division were being managed (remitted as Chair's Log). • The Committee was informed from the MIAA audit of the Trust's CQC action plan that 11 out of the 34 actions were only partially complete. An action was remitted to the Quality Committee to receive assurance regarding the close out of the 11 'partially complete' CQC actions and on the initial process for sign off of completed actions. • The Freedom to Speak Up Annual Report was received and whilst there were no significant concerns raised, the Trust had identified several improvement actions to further promote the Guardian role.	• The Trust's Bribery Act 2010 Statement had been updated (briefing included as Appendix A). • Following a request at the March 2021 Committee meeting, a proposal to strengthen the Trust's Conflicts of Interest controls was received. The tests outlined in the proposal would be undertaken over August – September with outcomes reviewed by a scheduled MIAA internal audit. • The Committee agreed to establish an Audit Panel (or equivalent) to review and progress the procurement process of updating (or replacing) the Trust's external audit provision ahead of making a recommendation to the Council of Governors.
Positive Assurances to Provide	**Decisions Made**

• Clear progress to close out internal and external audit recommendations in a timely way was noted.
• Seven internal audit reports were received: Consultant Appraisals report (Substantial assurance)
  ○ Learning from Serious Incidents report (Moderate assurance)
  ○ Mandatory Training report (Moderate assurance)
  ○ Critical Application Review – K2 Athena report (Moderate assurance)
  ○ CQC Action Plan Follow Up report (Ungraded)
  ○ Data Security and Protection Toolkit (re June 2021 submission) report (Substantial assurance)
  ○ Facilities Management report (Substantial)
• The Committee noted that the substantial assurance opinion on the Data Security and Protection Toolkit was a positive outcome for the Trust as a number of organisations had been challenged to meet the requirements.
• Robust planning was being put into place with the internal auditor to prepare for Q2 and Q3 audits.
• Noted that there had been a reduction in the number of waivers during 2020/21. Whilst this could be explained by an overall reduction in procurement due to the Covid-19 pandemic,
	• The Committee agreed updated Anti-Fraud, Bribery and Corruption Policy & Response Plan but requested that it was formatted in line with the Trust's policy guidance ahead of final ratification.
	• The Committee reviewed an updated Corporate Governance Manual and recommended approval to the Board.
	• The Committee considered the updated layout of the Board Assurance Framework and the underpinning processes. No suggested amendments were made.
	• The Committee reviewed the effectiveness of the internal and external auditor.

there was confidence that there had been fewer waivers due to improved controls and processes.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- The Chair noted that Non-Executive Director, Ian Knight would be leaving the Trust ahead of the next scheduled Audit Committee. Ian's replacement on the Committee had yet to be agreed but it was likely that a Non-Executive Director from the current cohort would join to provide continuity.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
021	Follow up of Internal Audit and External Audit Recommendations	To receive and review an update of actions taken.	028	Conflicts of Interest - Controls	To receive update
022	MIAA Internal Audit Reports a) Internal Audit Progress Report i. Consultant Appraisals report ii. Learning from Serious Incidents report iii. Mandatory Training report iv. Critical Application Review – K2 Athena report v. CQC Action Plan Follow Up report vi. Data Security and Protection Toolkit (re June 2021 submission) report vii. Facilities Management report b) Follow Up of Audit Recommendations Report c) Anti-Fraud Progress Report 2021/22 Insight d) Insight Update	To note the contents and any recommendations from the report.	029	Corporate Governance Manual review	To receive and note amendments to the Corporate Governance Manual
023	External Auditor Update	To receive update	030	Chairs reports of the Board Committees a) Finance, Performance and Business Development Committee b) Quality Committee c) Putting People First Committee d) Charitable Funds Committee	Review of Chair's Reports for overarching assurance.
024	Waivers Q4 Full Year 2020/21 and Q1 Financial Year 2021/22	The Committee is asked to note the Register of Waivers and receive assurance that contracts requiring a waiver are managed appropriately within the Trust's SFI's	031	Board Assurance Framework (BAF)	To receive assurance on the process being undertaken to assess assurances regarding the Strategic Risks impacting on the

					Trust's strategic objectives
025	Whistleblowing / Freedom to Speak up Annual Report	The committee is asked to accept the assurance provided by this report	031	Review of effectiveness of Internal Audit and External Audit	To discuss
026	Settlement Agreement Report 2020/21	The committee is asked to note that the Trust entered into the Settlement agreements	032	Appointment process for External Auditor	To discuss
027	**Divisional Governance Arrangements – Family Health**	To receive update	20/21/97	Board Assurance Framework (BAF)	For assurance

3. 2021 / 22 Attendance Matrix

Core members	June	July	October	January	March
Tracy Ellery	✓	✓			
Ian Knight	✓	**A**			
Susan Milner	✓	✓			

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

To: Trust Board

CC: Director of Finance

From: Virginia Martin, Anti-Fraud Specialist, MIAA

Date: 24/08/2021

Re: Bribery Act 2010 & Trust Anti-Bribery Strategy

1 Introduction and Background

1.1. The Bribery Act 2010, which came into force on 1st July 2011, reformed the criminal law of bribery making it easier to tackle this offence proactively in the public and private sectors. In addition to the main offences under Sections 1, 2 and 6 of the Act, which carry custodial sentences of up to 10 years and potentially unlimited fines, it introduced a corporate offence (under Section 7), exposing commercial organisations to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

1.2. Any organisation that is incorporated under the law in the United Kingdom falls under Section 7 of the Act, including NHS bodies such as CCGs, NHS trusts, foundation trusts, and special health authorities are all deemed to be relevant corporate bodies. Applicable organisations must ensure 'adequate preventative procedures' are in place for acts of bribery and corruption committed by 'persons associated' with them, in the course of their work, else the organisation will become liable.

1.3. 'Persons associated' can mean employees, temporary and agency personnel, contractors, agents, suppliers, partners and Joint Ventures, as well as other individuals or organisations (whether incorporated or not) that may provide a service.

1.4. For the purposes of the Bribery Act, a 'trade' or 'profession' is considered a business. This means that, whether individually or in partnership, GPs, pharmacists, dental practitioners, opticians, finance professionals etc will also be subject to, and personally liable under, the Bribery Act.

2 Definition

2.1. Bribery is generally defined as an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to

gain a personal, commercial, regulatory and/or contractual advantage, on behalf of oneself or another.

3 Risks of Non-Compliance

3.1. There are a number of risks entailed in breaching the Bribery Act. These include:

3.1.1. Criminal justice sanctions against directors, board members and other senior staff (under Section 14);

3.1.2. Damage to the organisation's reputation;

3.1.3. Conviction of bribery or corruption may lead to the organisation being precluded from future public procurement contracts. *[Under the Public Contracts Regulations 2006 (which gives effect to EU law in the UK), a company is automatically and perpetually debarred from competing for public contracts where it is convicted of a corruption offence. There are no current plans to amend the 2006 Regulations for this to include the crime of failure to prevent bribery. Organisations which are convicted of failing to prevent bribery are not automatically barred from participating in tenders for public contracts; however, there is discretion to exclude organisations convicted of this offence if it is deemed appropriate].*

3.1.4. Potential diversion and/or loss of resources;

3.1.5. Unforeseen and unbudgeted costs of investigations and/or defence of any legal action;

3.1.6. Negative impact on patient/stakeholder perceptions.

4 Bribery Act Offences

4.1. In summary, there are 5 key offences under the Act:

4.1.1. **Section 1** - Offering, promising or giving a bribe to another person to perform a relevant 'function or activity' improperly, or to reward a person for the improper performance of such a function or activity.

4.1.2. **Section 2** - Requesting, agreeing to receive or accepting a bribe to perform a function or activity improperly, irrespective of whether the recipient of the bribe requests or receives it directly or through a third party, and irrespective of whether it is for the recipient's benefit.

4.1.3. **Section 6** - Bribing a foreign public official (probably of limited applicability to most NHS organisations/staff).

4.1.4. **Section 7** - Failure of a commercial organisation to prevent bribery (the corporate offence). This is a 'strict liability'* offence and an organisation can be found guilty of 'attempted' or 'actual' bribery on the organisation's behalf, even if the organisation and its officers were not aware of the bribery itself. It should be noted that a corresponding Section 1 or Section 6 offence needs to be proven for a section 7 offence to apply.

** Strict liability offences do not require proof of intention or recklessness – in other words, it is not necessary for the prosecution to show that the organisation intended to make the bribe in bad faith, or that it was negligent as to whether any bribery activity took place.*

4.1.5. **Section 14** - where an offence under sections 1, 2 or 6 is committed with the consent or connivance of a 'senior officer' of an organisation, that person (as well as the organisation) is guilty of the offence and liable to be proceeded against and punished accordingly.

4.2. An organisation has a defence to the corporate offence if it can show that it had in place 'adequate procedures' as part of a cohesive and integrated corporate Anti-Bribery Strategy designed to prevent bribery by, or of, persons associated with the organisation.

5 Adequate Procedures

5.1. The Act is not prescriptive as to what constitutes 'adequate procedures', although both the Ministry of Justice (MOJ) and NHS Counter Fraud Authority (NHSCFA) have provided guidance as to what form these procedures might take, depending on the nature, size and type of organisation. Adequate procedures need to be applied proportionally, based on the level of risk of bribery across the organisation, and form part of an NHS body's overall governance arrangements.

5.2. Adequate procedures relate to relevant compliance protocols and transparent procedures and measures which an organisation can put in place to prevent bribery by individuals associated with it. These might include training, briefings or new internal controls and procedures. Whether the procedures are adequate will ultimately be a matter for the courts to decide on a case by case basis.

5.3. The MOJ suggests that an effective Anti-Bribery Strategy framework could be informed by six principles:

5.3.1. **Principle 1 – Proportionate Procedures.** An organisation's procedures to prevent bribery by persons associated with it are proportionate to the bribery risks it faces and to the nature, scale and complexity of the organisation's activities. They are also clear, practical, accessible, effectively implemented and enforced.

5.3.2. **Principle 2 – Top-Level Commitment.** The top-level management of an organisation (be it a board of directors, the owners or any other equivalent body or person) are committed to preventing bribery by persons associated with it. They foster a culture within the organisation in which bribery is never acceptable.

5.3.3. **Principle 3 – Risk Assessment.** The organisation assesses the nature and extent of its exposure to potential external and internal risks of bribery on its behalf by persons associated with it. The assessment is periodic, informed and documented.

5.3.4. **Principle 4 – Due Diligence.** The organisation applies due diligence procedures, taking a proportionate and risk based approach, in respect of persons who perform

or will perform services for or on behalf of the organisation, in order to mitigate identified bribery risks.

5.3.5. **Principle 5 – Communication (including Training).** The organisation seeks to ensure that its bribery prevention policies and procedures are embedded and understood throughout the organisation via internal and external communication, including training, which is proportionate to the risks faced.

5.3.6. **Principle 6 – Monitoring & Review.** The organisation monitors and reviews procedures designed to prevent bribery by persons associated with it and makes improvements where necessary. It considers independent assessment and/or certification of its arrangements.

6 Existing Counter Measures & Action Required

6.1. Bribery should be seen as another business risk to the organisation and should be treated accordingly. It is the responsibility of everyone in the organisation playing their part to ensure both the likelihood of bribery occurring, and its adverse impact if it does, are kept to an absolute minimum. However, as with the counter fraud strategy, the implementation of an anti-bribery agenda backed by a zero tolerance culture should be driven from the very top of the organisation, at Board level.

6.2. MIAA's Internal Audit and Counter Fraud Services directly assist and support the Trust and its senior management with maintaining adequate procedures on an ongoing basis, primarily through existing Internal Audit and Counter Fraud plans.

6.3. However, changes to the environment in which the Trust operates, such as the introduction of new legislation and global pandemics, as well as organisational and operational changes for the Trust over time, can result in alterations to risk exposure. As a consequence, this brings the need for a more thorough review of the appropriateness of the anti-bribery measures in place.

6.4. The most significant change to the Trust's operating environment in recent times is the COVID-19 global pandemic, which has affected all organisations, and the NHS in particular. It is therefore timely for the Trust to reflect on whether changes in recent years, particularly the response to the COVID-19 pandemic, have had impact on the Trust's bribery risks, such as procuring PPE from non-typical sources and restricted procurement processes.

6.5. An anti-bribery review has been conducted by MIAA, which was primarily structured around the MOJ's six principles, and also gave consideration to the Trust's response to the COVID-19 pandemic, to identify and evaluate any additional or increased bribery risks for the Trust.

6.6. The anti-bribery review resulted in a report on findings and an action plan, aimed to support the Trust to strengthen controls and arrangements around bribery, thereby improving the adequacy of procedures in place. The actions proposed are not

exhaustive and should be subject to periodic review in light of experience, practice and any relevant developments, internally or externally.

6.7. A key step in this process is ensuring that the Anti-Bribery Strategy is driven from the very top of the organisation. To this end, it is requested that the Board note this paper, and continue to support the Trust's Top-Level Commitment with respect to adopting and applying bribery counter measures on an organisation-wide basis.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/74a*		**Date: 02/09/2021**	
Report Title	Well-Led Framework – Action Plan			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***This report presents the updated combined action plan from the internal and external well-led inspections. Areas that remain outstanding are highlighted with proposed actions outlined.***			
Action required	Approve ☐	Receive ☒	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to note the updated combined well-led framework action plan.			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*			
Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☒

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

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Comment: The Trust's progress against the NHSI well-led framework will be a key source of information for a future CQC well-led inspection.
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment: N/A

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Trust Board	Several times	Trust Secretary	Since April 2020, the Board has received updated regarding the Trust's progress against the well-led framework
Committees	July 2021	Trust Secretary	FPBD, Quality and PPF Committees all considered the well-led actions during their July 2021 meetings.

EXECUTIVE SUMMARY

This report presents the updated combined action plan from the internal and external well-led inspections. Areas that remain outstanding are highlighted with proposed actions outlined.

MAIN REPORT

INTRODUCTION

The Trust undertook a self-assessment against the Well-Led Framework during January to March 2020. This resulted in an overall view of performance which was agreed by the Board in April 2020. The next step was to develop an action plan and work against this ahead of the procurement of an external review during 2020/21. This action plan was agreed in July 2020 and it was noted that regular updates on progress would be provided to the Board. The most recent of these updates was provided in February 2021.

The fieldwork for the external Well-Led review undertaken by Grant Thornton was completed in April 2021 and a final report WAS shared with the Trust in June 2021 and shared with the Board ahead of the July 2021 meeting.

The high-level output from the external review was as follows:

NHSI Well-Led framework			
#	Question	Trust rating 2020	GT rating 2021
1	Is there the leadership capacity and capability to deliver high quality, sustainable care?		
2	Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?		
3	Is there a culture of high quality sustainable care?		
4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?		
5	Are there clear and effective processes for managing risk, issues and performance?		
6	Is appropriate and accurate information being effectively processed, challenged and acted on?		
7	Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?		
8	Are there robust systems and processes for learning continuous improvement and innovation?		

Grant Thornton also undertook a site visit to several clinical areas during April 2021 and several recommendations also flowed out of this process. These, together with the actions from the external and internal assessment were combined into an overall action plan (Appendix 1).

KEY ISSUES

Since presenting the combined action plan to the Board in July 2021, Executive leads have worked to close out the recommendations, liaising with Non-Executive leads where appropriate, either through Committee meetings, separate meetings or via email.

As can be seen, positive progress has been made against the identified actions with the majority either noted as being 'blue' (complete with evidence) or 'green' (evidence available that a plan for completion in line with the deadline is in place). Two main issues remain outstanding, and these cut across several of the 'amber' or 'red' areas:

1) There is a requirement to ensure that there is consistent practice at Divisional governance meetings so that risks are regularly checked, lessons are learned, and feedback is effectively cascaded. The efficacy of Divisional governance arrangements has also been highlighted in recent Board Committee meetings where there have been discussions regarding the strength of challenge and the impact on the strength of assurances provided. Nevertheless, there is clear evidence that progress is being made Trust-wide in the practice of learning lessons – a key theme identified in the internal and external reviews.
2) Whilst progress has been made to improve the Trust's Quality Improvement process, there remains room for further development. In response to this, the Trust have engaged MIAA to provide additional support and the action plan for this can be seen below:

<u>Method of Delivery with Timescales and Products</u>

Deliverable Outputs: Complete the Clinical Quality Strategy to include ambitions and measurable objectives as follows;

Ref	Deliverable	Method of Delivery	Product/ Output
1	• Support increased communications to ensure lessons learnt are shared across the organisation • Work with staff to develop 'buy in' of QI process – involvement in strategy and methodology development • Engage with ward staff to assess what is being done currently • Streamline QI project requests. • Review QI training provision	Consultancy support: utilisation of one-to-one meetings, focus groups, action groups, presentations, questionnaires, and production of documents. **Timescale- 6th September 2021-31st March 2022**. A project working group will be formed to oversee the project. Before development begins there will be a review of existing documents, pathways and practices. **Establishing methods for communicating learning across the organisation.** Focus sessions with key staff from each division will take place to explore how previous learning has been shared, what worked well and what could have been better. Case studies will be used to map the communication pathway to identify areas that need strengthening. Following that an Action group will be formed to lead the development of new processes that are required. This will support the implementation of improvements to increase communications to ensure lessons are leant and learning from QI projects are shared. The method will also ensure ownership by the Trust of the processes created.	• Established method for the communication of learning and outcomes of QI projects- November 2021 • Finalised process for embedding learning from serious incidents throughout services. January 2021. • Training Plan and -January 2021

		Development of a Training Plan: Engagement with staff via questionnaires and focus sessions with key staff members and leads to identify the challenges to taking up training, explore content context, and methods of delivery that compliment service delivery. If appropriate methods will be tested and refined before a final training plan is presented. Engaging with staff to build the training plan will provide insight that allows a realistic training plan to be developed. **Development of Quality Improvement Framework:** The proposed model of delivery will be to engage with staff to co-produce a Quality Improvement framework and processes to be used across the organisation. Co-production of the framework and processes will: support staff "buy in", increase staff understanding of the framework (which will contribute to greater success in training staff) and increase the success of the framework from theory to practice. The bottom-up approach will provide vital information to build QI processes that can be embedded into pathways and day-to-day service delivery. Engagement will vary and include, questionnaires, facilitated workshops and one-to-one meetings.	• Completed and signed off QI Framework March 2021
2	• Deliver QI masterclasses and bespoke workshops, to support the development of QI Champions to ensure MIAA support is sustainable once the project comes to cessation.	Workshops. November 2021- March 2022 (See Appendix B for workshop outline). With some coaching where required.	Up to 20 members of staff trained to Champion QI and the use of essential QI tools.
3	• Provide a report on actions taken as part of MIAA's involvement and the agreed framework the Trust have committed to take forward.	Document. March 2022.	Document. March 2022.

RECOMMENDATION

The Board is asked to note the updated combined well-led framework action plan.

Well-Led Action Plan – Combined

KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?								
Lead Executive: Chief Executive **Management Lead: Trust Secretary** **NED Lead: Trust Chair**								
Origin	**Ref.**	**Risk Level**	**Action / Recommendation**	**Timescale**	**Lead**		**Comments**	**Evidence**
External Review	1.1	Medium	The Chair should hold a session with the Non-Executive Directors to discuss the benefits and perception of robust challenge.	October 2021	Chair		Action to be merged with Action 4.6. Non-Executive Directors to lead a session with the Council of Governors on how they seek assurance and provide effective challenge. To be scheduled for October 2021.	N/A
External Review	1.2	Medium	An Executive Director session should be scheduled to enable an open discussion around the best-fit of portfolios.	May 2021	CEO		This session was held at an Executive Away Day in May 2021. Since the addition of the CIO to the Executive Team, the summary document has been updated.	Executive Accountabilities Summary document
External Review	1.3	Low	As part of its talent management approach the Trust should develop appropriate succession plans for all senior leadership positions and identify potential vulnerabilities so that targeted training can be provided to individuals and their teams in conjunction with the Trust's leadership programme	September 2021	CEO		An initial outline of succession planning is scheduled for the July 2021 Nomination & Remuneration Committee. This will be further developed at a September 2021 Nomination & Remuneration Committee with respective Directors presenting on their portfolios.	1 July and 2 September Nomination & Remuneration Committee agendas.
External Review	1.4	Medium	A programme of quality visits should be established. • all NEDs and Executive Directors should participate in a structured programme of visits; • information should be provided to Board members prior to the visit to optimise the approach e.g. key performance metrics; any notable successes; key challenges and any hot issues; • any emerging issues that require follow-up should be logged centrally and receipt of any response from the areas visited should be monitored; • outcomes of quality visits should be summarised for feedback at the Quality Committee.	September 2021	DONM		Process agreed and schedule developed with dates to be circulated to NEDs for final agreement.	Quality Visit Reporting template Senior Leadership Quality Visit templat
Internal Assessment	1.5	N/A	Ensure that safeguarding issues are highlighted more prominently in Board and Committee papers	Sept-21 (Jan-21)	TS / Chair / Committee Chairs		New Safeguarding Quarterly Report developed that will be received by the Quality Committee with issues escalated to the Board through the Chair's Report.	
Internal Assessment	1.6	N/A	To share findings from the external well-led review once complete and ensure that progress against the action plan is reported through the public Board.	Jul-21	TS		The external well-led review action plan was shared at the public Board. The final well-led review was made available to Board members.	July 2021 Board papers
Internal Assessment	1.7	N/A	To seek Committee feedback into the effectiveness reviews from all members – take into consideration the recommendations from the MIAA Audit Committee Effectiveness Review.	Mar-21	TS		The 2021 Committee Effectiveness Review mirrored the effectiveness review process undertaken by the Audit Committee in Oct 2020.	Committee Annual Reports provided to the March 2021 Board
Internal Assessment	1.8	N/A	Consider how to formalise feedback from the Shadow Board process – continue opportunity for growth and development of individuals.	~~Oct-20~~ September 2021	TS / Chair		New Leadership Forum – 1st one taking place on 31 August 2021 - opportunity for Executive Directors and Senior Leaders to come together to progress the Trust Strategy. The forums are designed to aid self-development, peer support and networking across	Leadership Forum agenda and schedule.

							the organisation and the system. Each Forum will have targeted areas of focus but can be reviewed to support the requirements of the group.	
Internal Assessment	1.9	N/A	Effective assurance minute writing guidance to be produced for all relevant administrative staff.	July -21	TS		This has been incorporated into the Governance and Performance Framework. This is supported by group training delivered by the Corporate Governance team. Training has been undertaken for the majority of administrative staff during December 2020 and follow up sessions will continue on an on-going basis.	Training presentation Governance and Performance Framework
Clinical Visit	1.10	N/A	Access to the Clinical rooms and Patient Own Drug (POD) lockers at the patient's bedside are restricted by the use of Digi-Locks, however there is variance in the frequency the Digi Lock codes are changed, with some areas reporting they have no programme in place to change Digi-Lock codes (Action required)	September 2021	DONM		Evidence attached.	Digi locks.docx
Clinical Visit	1.11	N/A	All CD medication was securely stored. However, in the Delivery Suite and Obstetric Theatre Recovery we observed CD registers are stored outside of CD cupboards. (Action required)	September 2021	DONM		This inspection highlighted the CD register for the diamorphine fridge which is accessed frequently by 3 theatres in obs recovery and less frequently in gynae recovery. **Actions** All staff have been informed via email (18/08/21) and safety huddle and weekly safety and governance meeting held 19/08/21 A combination lock has been ordered and will be installed to the outer door of the CD cabinet to enable storage of the register when not in use and emergency access.	scan_08_19_2021_09_55_30_604.pdf Controlled Drugs Book.msg
Clinical Visit	1.12	N/A	All IV fluids were found to be in date and were clearly separated. However, some areas routinely decanted IV fluids from the original packaging, which is not in-line with best practice. We spoke to the Ward Managers about solutions for this using the current configuration of cupboards. (Action required)	September 2021	DONM		Awaiting confirmation of completion	
Clinical Visit	1.13	N/A	IV fluids were securely stored in the clinical room. However, in some areas we found IV fluids stored on open shelving in the clinical room and this may allow unrestricted access to IV fluids from unregistered staff. (Action required)	September 2021	DONM		Awaiting confirmation of completion	
Clinical Visit	1.14	N/A	All areas hold daily Safety Huddles that are used to update staff on current situation and any identified or potential risks, however in most areas there is no current record of issues discussed in the huddles. (Action required)	September 2021	DONM		NICU- • 7@7 Nursing team – LOTW, Unit update Board in each room on update • MDT Handover every morning • Lunchtime MDT Huddle with Maternity Team • Further huddles added if acuity requires	NICU Board.png LESSON OF THE WEEK.docx
Clinical Visit	1.15	N/A	Midwives are able to request a rotation into the delivery suite or obstetric theatres to maintain their skills. However, there is no established rotation program for midwives. We were told it is staff's professional responsibility to maintain their practice and this is not monitored centrally. (Action required)	September 2021	DONM		Information incorrect, maternity has an established rotation programme (theatre skills are NOT required as part of the midwifery MT programme), Band 5 as part of preceptorship programme rotate to all clinical areas, Band 6 rotation due to staffing pressures with COVID was halted – post mass recruitment (Sep/oct), this programme will recommence – this will sit alongside the COC offer to staff.	Rotation evidence.ods Preceptorship at Liverpool Women's I Rotation Programme for Midv Rotation letter Rotation named plan

Clinical Visit	1.16	N/A	The ward environments are observed to be physically clean and evidence is maintained to demonstrate the completion of daily cleaning. However on Delivery Suite; Gynaecology Ward; Gynaecology Emergency Department; and Maternity Base we found variable use of 'Clinell' stickers that are used to indicate if equipment had been cleaned and ready for use. On two occasions we identified equipment that should be cleaned daily displaying 'Clinell' stickers that suggested they had not been cleaned for several days. (Action point)	September 2021	DONM		Evidence attached.	General Rapid Improvement Enviro
KLOE 2. Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?								
Lead Executive: Chief Finance Officer Management Lead: Strategic Finance Manager NED Lead: Jo Moore								
Origin	**Ref.**	**Risk Level**	**Action / Recommendation**	**Timescale**	**Lead**	Progress	Comments	**Evidence**
External Review	2.1	Low	The Trust needs to progress its plans to increase staff 'buy in' to ensure that the Strategy, and links to its enabling strategies and the Trust's vision and values, are accessible and understood by its staff. Measures should be developed to allow monitoring of progress and this should be reported to the PPF Committee.	September 2021	CPO		Our Strategy 2020-25 was launched in May 2021 in various formats to cater for different audiences in the most effective way to meet their needs. As well as a full strategy document, we developed a strategy 'on a page' to condense the key messages down in a simple way. These were shared Trust wide via an Executive Team briefing to all staff and published on our public facing website. We have also consolidated our strategy documents to make them all visible in one accessible place with an over-arching 'Our Future' theme. This groups together Our Strategy 2021-25, our Clinical & Quality Strategy 2020-25, and our Future Generations Strategy 2020-25. Divisional operational plans aligned to Trust Strategy Trust wide Medical Workforce Plan in development (to PPF in outline in September 21 and for approval November 21) Vision & values/ behavioural framework/draft going out for discussion/consultation during September having been socialised with the Great Place to Work group, under the BE KIND brand Following the launch of Our Strategy 2020-25, the Executive Team agreed for regular briefings to be given Trust wide on progress to increase understanding of its delivery. The next of these updates is planned for late August 2021.	https://www.liverpoolwomens.nhs.uk/about-us/corporate-documents/
External Review	2.2	Medium	Milestones and measures to demonstrate achievement should be documented as part of the Leadership and Talent Strategic Framework. Progress should be presented to the PPF Committee.	September 2021	CPO		Paper due to PPF in September 21	Not yet available.
Internal Assessment	2.3	N/A	Strategy re-fresh to be undertaken with public facing document also produced. This will be socialised with the public, stakeholders, and staff. Strategy to ensure that it; a) References operational priorities – e.g. RTT, GIRFT b) is aligned to newly published Long-Term Plan; c) Clearly articulates short- and medium-term plans linked to	Apr-21	DoF / CPO		Strategy Updated and launched on 6 May 2021	Trust website

			overarching strategy, and; d) Shows how it has used NHSI Strategy tool					
Internal Assessment	2.4	N/A	Ensuring there is a clear link to strategy when producing annual service plans	Apr-21 (Sep-20)	DoF		Annual Service Plans were paused due to the Covid-19 in 2020/21 but this was incorporated into planning 2021/22.	Annual Plan to FPBD
Internal Assessment	2.5	N/A	To undertake testing on whether more junior staff in all areas can articulate the Trust strategy	September 2021	CPO		See 2.6	
Internal Assessment	2.6	N/A	Ensure that there are documented links from overarching strategy to individual performance target levels	September 2021 (Sep-20)	CPO		PDR window introduced in line with publication of the Trust corporate objectives, creating a 'golden thread'. Corporate Strategy on a page to be developed/shared Divisional operational plans to link back to corporate strategy/vision and to be communicated as part of divisional PDR process from April-June annually	Appendix 1 Career Conversation self refe PDR Workbook 2021.docx Strategy on a page - https://www.liverpoolwomens.nhs.uk/media/3812/our-strategy-one-page-v3.pdf
Internal Assessment	2.7	N/A	To ensure that there is a post implementation review process for strategy	Apr-21 (Jun-21)	DoF		A formal process is being introduced for annual strategy post implementation reviews to be scrutinised and reported through the relevant Board Committee structures. This is to be added as part of the annual workplan for each committee. The overarching corporate strategy will further be aligned to the Board's review of the setting of and performance against the Trust's annual Corporate Objectives. The Trust's Digital Strategy has recently undergone its first review of progress – this will form a model for reviewing strategies going forward.	Digital Strategy review – reported to FPBD in January 2021.
Internal Assessment	2.8	N/A	Clear links to strategy in divisional priorities with references to strategy delivery in Divisional Performance meetings	September 2021 (Oct-20)	COO		This was intended to be achieved with the plans on a page, however Covid-19 affected the practicalities of completing this and the national H1 and H2 planning timelines. The Trust performance reports for each Division are now however reported and measured on under the WESEE headlines Each Division to undertake refreshed strategic objectives in September 2021 now that Trust strategy has been refreshed in Summer 2021 with KPIs for each to be monitored at performance meetings.	Divisional Performance meetings

KLOE 3. Is there a culture of high quality, sustainable care?

Lead Executive: Chief Nurse & Midwife Management Lead: Deputy Chief Nurse & Midwife NED Lead: Tony Okotie

Origin	Ref.	Risk Level	Action / Recommendation	Timescale	Lead	Progress	Comments	Evidence
External Review	3.1	Medium	To further develop the FTSU agenda the Board should consider: • reviewing the WTE allocation to the FTSU Guardian;	September 2021	CPO		• Guardians are currently paid an additional allowance (£7k pa) and provided with flexibility by line manager to support their Guardian activity. This has been reviewed with Guardians who indicate this works well. The Trust is	

			• the use of a FTSU Champions model or use of the Trust's staff supporters to assist staff with accessibility closer to grade, locality and professional group; • relaunching the Trust's FTSU arrangements, using posters within services to advertise the role and provide contact details.; • including data on ethnicity and gender in FTSU reports to gain a broader understanding of potential underlying issues; • ensuring the FTSUG is linked in to discussions with the Trust's Fair and Just Culture programme of work				currently out to advert to replace its second Guardian role and will discuss with the successful candidate and their line manager the most effective way of undertaking the role. • The Great Place to Work group has brought together the Guardians with staff supporters, mental health first aiders and other staff. All staff supporters will be equipped to signpost to Guardians and to promote the role of the Guardian. • Guardian service relaunched with widespread awareness raising campaign. • Future F2SUG reports to include gender and ethnicity information • Guardian trained in Fair & Just Culture methodology and member of Steering group	
External Review	3.2	Low	The NED aligned to the FTSU agenda should access the FTSU training available from the National Guardian's Office to maximise the support offered to the FTSU Guardians	September 2021	CPO		NED invited to undertake training.	Training not yet attended.
External Review	3.3	Low	The Trust should consider the line management and reporting arrangements for the Freedom to Speak Up Guardian to ensure staff do not associate raising concerns as part of an HR process	July 2021	CPO		Recommendation considered and reviewed with Guardian but no issues found with current F2SU reporting arrangements. Will review annually.	N/A
External Review	3.4	Medium	The Trust should undertake a random sample of completed appraisal paperwork to review the quality and inclusion of the required parameters. This could inform future training requirements to continue to improve staff experience and outcomes in this area	September 2021	CPO		Review of B7 N&M leaders appraisal quality & experience (this group have undertaken appraisal in a defined window). Paper summarising findings/actions to improve to September 2021 PPF	Awaiting paper to September 2021 PPF.
External Review	3.5	Medium	The Trust should undertake 'pulse' surveys with staff on a quarterly basis to measure how staff are feeling in the areas where work is being undertaken to address the results of the staff survey.	September 2021	CPO		• Let's Talk (pulse) Survey issued quarterly. The response rate for most recent survey on 8 August was 17%. • Quarterly reports into Divisional Boards with their specific feedback from reviews • Bi annual report to PPF and Board on Staff Engagement – activities/progress (April/October)	
Internal Assessment	3.6	N/A	It is recognised and evidenced through the staff survey that the quality of appraisals needs improving. A review of appraisal process and documentation / conversation needs to happen with a talent management conversation as a separate discussion. To start in September 2020.	September 2021 (Mar-21)	CPO		- see 2.6 Talent management conversations rolled out.	 Appendix 1 Career Conversation self refe  PDR Workbook 2021.docx
Internal Assessment	3.7	N/A	Focus areas remain incident reporting / learning from incidents (safety culture) where we have improved year on year but below average and the best performing Trusts. Embedding learning from incidents/ complaints is a key part of N, M& AHP strategy and the Quality strategy with focused actions to achieve this. Continued and improved recognition awards both internal and external.	Apr-21 (Sep-20)	DoN&M		Good progress has been made in this area (see follow up report to Quality Committee in August 2021). Further audit scheduled in September 2021. **Suggested to remove from this action plan as will be tracked by Quality Committee.**	
Internal Assessment	3.8	N/A	LWH still receive some complaints from staff via CQC, there are some complex dignity at work investigations. To improve there needs to be a more consistent approach across all teams needs to be evident utilising the fair and just culture approach.	September 2021	CPO		• Fair and Just project embedded in substantive role of Head of Talent and Culture. Work progressing in accordance with work-plan including integration within HR policies and procedures, and incident investigations. • 20 senior leaders undertaken Fair & Just Culture training (July 21)	

							• 200 leaders will have had Fair & Just Culture training by October 21 • Next phase of work to focus on how to transact the fair & just culture at ward and departmental level. • Guardian role promoted (see above) • Anonymous concerns email box to commence in September 21 with monthly updates into the wider organisation from senior leadership team	
Internal Assessment	3.9	N/A	There needs to be more evidence of embedding lessons learnt and sharing across the trust. There is evidence of divisional lessons learnt but lack of Trust wide evidence and utilising quality improvement methodology to sustain this	Apr-21 (Sep-20)	MD		<u>Trust wide Learning</u> Weekly 'Safety Check Ins' have been instituted chaired by the MD. These comprise of one 10 minute lesson on medicines safety or IPC safety and a second 10 minute lesson on lessons learnt from an incident. These are recorded and staff can listen to them via a link. A Mortality Review Group is being established to strengthen Trust wide learning from patients who sadly die. This will review all deaths in the Trust and the clinical review that has been undertaken into each death. The views of the parents or families of the deceased person will be sort and the lessons learnt incorporated into the quarterly paper to Quality Committee and the annual paper to Trust Board. The learning from these meetings will feedback to the clinicians via the GREAT day Mortality and morbidity meeting which currently happens quarterly. The GREAT day has continued throughout COVID and has moved online which has resulted in improved access to the day and with an increase in attendance. Embedding lessons learnt – see 3.7	See 3.7
Internal Assessment	3.10	N/A	More work needs to be undertaken with the reporting of incidents. Although staff do speak out regarding concerns to CQC, Freedom to speak up more needs to be done to give staff the confidence to report incidences internally and that they have feedback regarding the issues raised.	September 2021 (Sep-20)	CPO		The Risk and Patient Safety Manager continues to work with the Governance managers on ways in which we can improve incident reporting levels. The Serious Incident process includes a feedback process to staff.	
Internal Assessment	3.11	N/A	Although there are some effective systems and processes in place for documenting lessons learnt/ action plans this is not readily available for teams in an electronic format (reminder) for them to monitor out of date actions. Also, lessons learnt is not embedded at 'shop floor' level.	Apr-21 (Sep-20)	DoN&M		See 3.7	
Internal Assessment	3.12	N/A	To ensure that there is a clear mechanism for the triangulation of information to inform the Trust's Training Needs Analysis and that the Educational Governance Group provides sufficient oversight.	September 2021 (Sep-20)	CPO		The divisional structure is providing improved input and oversight regarding the Trust's Training Needs Analysis (TNA). To be explored whether lesson learning can be used to help inform the TNA. Suggested item for PPF Committee in September 2021.	

Internal Assessment	3.13	N/A	Training and appraisal performance needs to be consistently above 95% in all areas	Nov-20	COO & CPO		Robustly monitored via Divisional Board and Divisional Performance Review. Compliance trajectories in place. This is being monitored closely at the Putting People First Committee **Suggested to remove from Action Plan as issue being monitored in other fora.**	

KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Lead Executive: Chief Executive Management Lead: Trust Secretary NED Lead: Tracy Ellery

Origin	Ref.	Risk Level	Action / Recommendation	Timescale	Lead	Progress	Comments	Evidence
External Review	4.1	Low	On an annual basis NEDs who Chair Committees should observe the sub-meetings/groups that feed into their Committee to gain a view on how business is undertaken	July 2021	TS		Invites sent out to NEDs to attend sub-committees. Feedback to be provided either directly to Executive Lead and/or via the Chair's Report at the parent Committee.	Pairings agreed and circulated via email.
External Review	4.2	Low	Consideration should be given to undertaking a grading review for key staff in the Division of Clinical Support Services.	September 2021	COO		The Divisional Manager Job Description is undergoing an Agenda for Change Job Review process to be completed September 2021	Updated Job Description
External Review	4.3	Medium	The Trust should consider the line management arrangements of its Governance Managers and consider integrating these posts into the Divisions to create greater ownership and management of the governance agenda in each Division.	September 2021	DONM		In progress – evidence attached	4.3 - Allan.docx
External Review	4.4	Medium	The Trust should consider providing clarification to the Divisional Senior Leadership teams regarding the expected operational and professional reporting lines and accountabilities	September 2021	COO		The Divisional teams have met with the Executive team to clarify the roles and responsibilities of the Divisional Managers. The Divisional Managers have been written to reinforce this	Letter to DMS
External Review	4.5	Medium	The Chief Operating Officer should schedule a series of weekly 1-2-1 meetings with each Divisional General Managers to discuss performance and related issues. Regular meetings should also be scheduled collectively with the three Divisions so that the adjacent portfolios and interdependencies can be discussed.	July 2021	COO		Meetings now in place	Meeting action logs from Operational Meetings
Internal Assessment	4.6	N/A	The level of challenge between Governors and Non-Executive Directors can be strengthened in order for the former to demonstrate discharge of holding to account responsibilities.	October -21 (Jan-21)	TS		See 1.1.	
Internal Assessment	4.7	N/A	A review of Board agendas from 2017-2020 demonstrates that there is an imbalance in the Board time allocated to current performance and the time allocated to strategic discussion during meetings held in public. Whilst this is developing in right direction, further emphasis can be given to strategic discussion.	Apr-21 (Jan-21)	TS		External Well-Led review noted effective balance of items.	External well-led review.

KLOE 5. Are there clear and effective processes for managing risks, issues and performance?

Lead Executive: Chief Operating Officer Management Lead: Head of Governance & Quality NED Lead: Susan Milner

Origin	Ref.	Risk Level	Action / Recommendation	Timescale	Lead	Progress	Comments	Evidence
External Review	5.1	Low	The scheduling of the monthly Performance Review meetings should be reviewed to allow chairing to be undertaken as intended by the CEO.	~~July 2021~~ September 2021	TS		Scheduling has been amended in line with Governance and Performance Framework. This will enable the CEO to chair the meetings.	

External Review	5.2	Low	An action log should be developed for each Division to record and monitor required actions following Performance Reviews.	July 2021	COO		Action Logs in place from July meetings onwards	Action logs available
External Review	5.3	Low	The timetabling of Performance Review meetings should be reviewed to align scheduling to the availability of the very latest data	~~July 2021~~ September 2021	COO		Scheduling to be amended in line with Governance and Performance Framework See 5.1	See 5.1
External Review	5.4	Medium	The Divisions should ensure that adequate time is timetabled to allow a regular and thorough review of their risk registers.	September 2021	COO		Review of Divisional Governance meetings to be undertaken to ensure consistency of practice.	N/A
External Review	5.5	Medium	The CRR should be updated to ensure all fields are populated and that risk ownership, treatment, scores and appetite is appropriately stated	July 2021	DONM		CRR updated	May 2021 CRR agenda
External Review	5.6	Low	The Trust should consider extending reporting information on post implementation reviews for schemes that may be considered higher risk to the Quality Committee.	July 2021	DoF		Detail provided to the Quality Committee in July 2021	Quality Committee July 2021 papers
External Review	5.7	Medium	The Trust should consider adopting a triumvirate approach to its QIA sign-off process to include the Director of Nursing/Midwifery, Medical Director and the Chief Operating Officer to allow consideration of potential impact on adjacent portfolios.	July 2021	DoF		COO has been involved throughout. Meeting scheduled to get formal sign off.	QIA documents.
KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?								
Lead Executive: Chief Finance Officer Management Lead: Chief Information Officer NED Lead: Ian Knight								
Origin	**Ref.**	**Risk Level**	**Action / Recommendation**	**Timescale**	**Lead**	**Progress**	**Comments**	**Evidence**
External Review	6.1	Low	The Trust should consider the inclusion of a Data Quality Indicator as part of the redesign of its performance report	September 2021	TS		The new performance report includes a kite mark. Detailed plan provided to the Trust Board in September 2021 in the CEO report.	September 2021 Board papers
KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?								
Lead Executive: Chief People Officer Management Lead: Deputy Director of Workforce NED Lead: Chair								
Origin	**Ref.**	**Risk Level**	**Action / Recommendation**	**Timescale**	**Lead**	**Progress**	**Comments**	**Evidence**
External Review	7.1	Medium	The Trust should regularly survey its staff to ascertain the direction of travel and impact of the actions taken on the areas for improvement indicated by the 2020 Staff Survey results.	September 2021	CPO		Covered under 3.5	See 3.5.
External Review	7.2	Medium	The Chair should work with the Lead Governor to establish activities that will gain useful information on patient experience. The following activities should be established as soon as Covid-19 restrictions are eased. • A buddy scheme whereby a Governor and NED pair up and meet informally could enhance the ability of the Council in its role in holding the NEDs, individually and collectively, to account for the performance of the Board of Directors. • 'Meet the Governor' or Governor drop in sessions could be scheduled once Covid-19 restrictions allow to gather valuable patient/visitor feedback for the Trust to consider to improve/transform its services. • The nationally available Governor training should be made available to all Governors.	October2021	TS		Nationally available training as been circulated and booked onto for governors e.g. finance training. The value of a NED/Governor 'buddy scheme' has been considered and it is felt that there are alternative options to develop the relationship between NEDs and Governors to enhance the holding to account role. This includes 1) exploring options to strengthen the processes at Governor sub-group meetings 2) holding an 'informal session' at the end of the year for governors and NEDs to discuss key priorities and strategic issues 3) joint training sessions (see 1.1.). Thought will be given to methods to best gather member feedback, particularly once Covid-19 restrictions ease. Many of these are captured in the Membership Strategy 2021-25.	National training feedback from Peter Norris to CoG FOPG Membership Strategy 2021-25.

KLOE 8. Are there robust systems and processes for learning, continuous improvement and innovation?

Lead Executive: Medical Director Management Lead: Deputy Medical Director NED Lead: Louise Kenny

Origin	Ref.	Risk Level	Action / Recommendation	Timescale	Lead	Progress	Comments	Evidence
External Review	8.1	High	The Quality Improvement Framework document should be progressed to publication as soon as possible. It should include detailed milestones, monitoring of achievement against the milestones and reporting arrangements for assurance on direction of travel and outcomes	July 2021	DONM		Document remains in draft.	Quality Improvement Framework.docx
External Review	8.2	Medium	The Trust needs to develop its training plan and increase and record the pace of training for the roll out of its PDSA model. Training rates should be reported to the Quality Committee.	July 2021	DONM		This is currently ad hoc due to staffing constraints From December 2021 QI is on the Trust Training Programme collaboration with OD Training figures will go through both QIG and Safety & Effectiveness Additional support is needed from Divisions There are also self study links for QI on Trust intranet and there is a basics to QI module on ESR that are available to all staff – this needs promoting more widely.	
External Review	8.3	Medium	The Trust should consider how to and publicise to staff the outcomes of the completed QI projects. This will raise confidence in the approach and reaffirm the use of the PDSA model.	July 2021	DONM		This needs Divisional support – all matrons were trained in PDSA in 2019 and therefore should be part of the improvement drive	
External Review	8.4	Medium	Following the CCG learning panel event the Trust should establish and document its plans to embed the way it learns incidents throughout its services, from front-line service areas through to the Board	July 2021	DONM		This should commence through Divisional Boards and triangulated with Governance to ensure risk, Patient Safety, Health and Safety and QI are integrated in Lessons Learnt for wider dissemination	
Internal Assessment	8.5	N/A	The Trust requires strengthened articulation of a quality improvement preferred methodology and strategy either within the existing quality strategy or in a new QI strategy.	Nov-20 (Sep-20)	MD		The approach to QI is referenced within the Clinical & Quality Strategy. The Trust's QI methodology is set out in a package on the Trust's intranet and is available to all staff. A consolidated QI document remains in development and requires approval by the Executive team. Expected by the middle of February 2021.	QC Progress Report - Clinical and Quality S Evidenced through QIG, Safety and Effectiveness Sub-committee two preferred methods are Service Evaluations and PDSA Both reporting through digital platforms
Internal Assessment	8.6	N/A	Theme of Quality Improvement to be used for a 'Great Day' to help communicate the Trust's agreed approach from the Quality Improvement Strategy.	Feb-21	MD		QI 'Great Day' held on 30th April 2021	
Internal Assessment	8.7	N/A	Review of the work-plan of the Divisional partnership board meetings, Senates and Board committees to ensure that learning from external sources is reflected.	September-21 (Sep-20)	TS/MD		Learning from External reports is a standing item on the Safety and Effectiveness Sub – committee. Each Divisional Board has will have this as an agenda item from September.	
Internal Assessment	8.8	N/A	Governance team to evidence activity around improvement using PDSA cycles being discussed and supported in Divisions and Senates and develop a training and implementation plan if one is needed.	Jan-21 (Sep-20)	DoN&M		See 8.1	
Internal Assessment	8.9	N/A	Governance department to produce a co-ordinated planned roll-out of improvement methodology teaching to encompass all key groups as agreed with the executive group	Jan-21 (Oct-20)	DoN&M		See 8.1	

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***21/22/7***		**Date: 02/09/2021**	
Report Title	**Board Assurance Framework**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***The report outlines any updates relating to the Board Assurance Framework and any key areas for consideration for the Board.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y ***If no – please outline the reasons for deviation.***			
	The Board requested to review the BAF risks and agree their contents and actions.			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

BAF discussed at FPBD, PPF, Quality and Audit Committees since previous version presented to Board on 1 July 2021.

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.

Board members will be aware that the BAF has recently been updated to align with the Trust's 'Our Strategy' document and was discussed for the first time under the new format at the Board on 1 July 2021.

The BAF items are aligned to the Board's assurance committees and these were reviewed and discussed during July 2021. The outcomes of these discussions are detailed in the report below and on the BAF itself.

MAIN REPORT

Introduction

The following report provides an update to Board members on the latest review of the BAF items.

The report is intended to allow the members of the Board to review any proposed changes or additions and agree them moving forward. The report is also an opportunity for the Board to make informed judgements as to the level of assurance that they can take and to identify any further action required to improve the management of the identified risks.

Process for reviewing BAF areas during the meeting

As the Board works through the agenda, members are requested to consider the BAF areas contained in Appendix 1 and the associated interdependent 15 and above risks / CRR risks. Keeping these risks in mind should support consideration of whether any assurances provided through the reports received could contribute to mitigation (or escalation) of the BAF risks. These can be noted when the BAF itself is discussed.

In addition, members should consider whether as a result of the review of assurances and/or identification of risks, whether there is a need to commission additional assurance to be reported to future Board and / or Committee meetings. In particular, the Board needs to ask itself whether it is attaining adequate assurance against its highest scoring risks i.e., are these areas of risk driving the Board and Committee agendas? Any information that has been discussed in the meeting that needs to be shared with other corporate governance meetings should be included in the Chair's Log.

Changes to BAF

N.B. following comments from the 1 July 2021 Board meeting, risk descriptors have been added to the BAF.

1.1 Failure to be recognised as one of the most inclusive organisations in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)

- Discussion was held at the July 2021 PPF Committee meeting on whether the wording of this BAF area best reflected the risk to the aligned strategic aim. One point of view was that the Trust should be ambitious in this area and should not seek to qualify the language being used to describe the BAF item. Alternatively, it was stated that the main aim of the BAF was to provide the Board with an accurate view of risk to the delivery of the Trust strategy and with the ambitious nature of this area, there could be a need to score the item artificially high as there was a low likelihood of achieving the aim as currently expressed. It was agreed to propose the highlighted (above) amendment to the Board.
- Refinements have been made to the content of the BAF (demonstrated via track changes)
- Several new actions have been added to the first strategic threat.

1.2 Failure to recruit and retain key clinical staff

- Following consideration of this BAF item at all Board Committees and the Board itself, it was agreed to increase the score to '20' from the initial proposed score of '16'. This was to reflect the acute staffing challenges facing the Trust, particularly in the maternity service.
- Refinements have been made to the content of the BAF (demonstrated via track changes)

2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site

- This remains a long term, strategic aim for the Trust
- It is likely that the identified actions (and their timescales), transposed from the previous BAF, will require a thorough review ahead of the September 2021 FPBD Committee meeting to ensure that they provide an accurate position on expected progress. This will need to take into consideration the discussion at the Board regarding the New Hospital Expression of Interest.

2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment

- No significant changes to report, however, in discussions with the Medical Director, it was highlighted that the Trust's multiple system issue remained a significant risk to the organisation. It is suggested therefore, that the Board reflect on whether the current score (8) is an accurate reflection of this position.

2.3: Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system

- No significant changes to report.

3.1: Failure to deliver an excellent patient and family experience to all our service users
• No significant changes to report.
BAF Risk 4.1: Failure to ensure our services are financially sustainable in the long term
• This remains one of the highest scoring risks for the Trust. • Noted that a thorough review of the controls, assurances, gaps and actions is required for the long-term financial element of this BAF item. This will be completed ahead of the September 2021 Committee meeting.
BAF Risk 4.2: Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS
• Noted that this risk remains challenging to score accurately whilst guidance around the development of the ICS remains uncertain. The Trust retains strong partnerships and relationships in the system.
5.1: Failure to progress our research strategy and foster innovation within the Trust
• No significant changes to report.
5.2: Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership
• Further work regarding ward accreditation programme required. Due dates on actions amended accordingly. • Amendment to the ownership of QI related actions to Head of Patient Safety from Head of Governance.

New Risks or Strategic Threats

Since the report was last circulated and discussed at the Board, no new risks or strategic threats have been added to the BAF. There are however plans to discuss in further detail 1) the risk of the Trust running multiple clinical systems and 2) whether cyber security should be recognised on the BAF rather than the Corporate Risk Register. The Board is asked to provide a preliminary view on these issues.

Closed Risks or Strategic Threats

Since the report was last circulated and discussed at the Board, no risks closed on the BAF.

On-going report

It was agreed in July 2021 that substantive reviews of the BAF would take place on a quarterly basis and these would report to the Board at the next opportunity. Committees will continue to review their aligned BAF risks at each meeting.

A schedule of review meetings with the Trust Secretary and Executive Leads have been established with these taking place in October 2021 (and quarterly thereafter) with outcomes reporting to the respective Committees and then through to the Board.

Conclusions

Board members are asked to comment on the current content and where required make further recommendation for change and agree the current BAF risks.

Recommendation

The Board requested to review the BAF risks and agree their contents and actions.

Liverpool Women's NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK 2021/2022

Trust Board - September 2021

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
DoF	Director of Finance
DoNM	Director of Nursing & Midwifery
MD	Medical Director

Key to lead Committee Assurance Ratings	
	Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity - no gaps in assurance or control AND current exposure risk rating = target OR - gaps in control and assurance are being addressed
	Amber = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy
	Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each BAF Risk and also to identify any further action required to improve the management of those risks.

Board Assurance Framework: Legend	
Strategic Priority	The 2021/25 strategic priority that the BAF risk has been aligned to.
BAF Risk:	The title of the strategic risk that threatens the achievement of the aligned strategic priority
Rationale for Current Risk Score:	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk.
Strategic Threat:	What might cause the BAF risks to materialise
Provider Licence Compliance:	NHS Improvement provider licence conditions that align to the BAF risk providing assurance on compliance.
Controls:	The measures in place to reduce the risk likelihood or risk consequence and assist secure delivery of the strategic priority.
Assurances:	The measures in place to provide confirmation that the controls are working effectively in supporting the mitigation of the risk.
Gaps in Controls / Assurance:	Areas that require attention to ensure that systems and processes are in place to mitigate the BAF risk Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the BAF risk.
Required Action:	Actions required to close the gap in control/ assurance
Lead:	The person responsible for completing the required action.
Implemented By:	Deadline for completing the required action.
Monitoring:	The forum that will monitor completion of the required action.
Progress:	A RAG rated assessment of how much progress has been made on the completion of the required action.

Risk Descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long- term incapacity/disabilit y Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day)	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days)	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff

			Low staff morale Poor staff attendance for mandatory/key training	Loss of key staff Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10– 25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?
The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Board Assurance Framework Dashboard 2021/2022									
SA	**BAF Risk**	**Committee**	**Lead**	**July 2021**	**Q2**	**Q3**	**Q4**	**Q 2 Q movement**	**2021/22 Target**
SA1 Workforce	1.1 Failure to be recognised as one of the most inclusive organisations in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	PPF	CPO	12 (l3 x c4)				⇔	8 (l2 x c4)
	1.2 Failure to recruit and retain key clinical staff	PPF	CPO	20 (l5 x c4)				⇔	12 (l3 x c4)
SA2 Safe	2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site	FPBD	MD	15 (l3 x c5)				⇔	15 (l3 x c5)
	2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment	FPBD	COO	12 (l3 x c4)				⇔	8 (l2 x c4)
	2.3 Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	Quality	COO	20 (l4 x c5)				⇔	15 (l3 x c5)
SA3 Experience	3.1 Failure to deliver an excellent patient and family experience to all our service users	Quality	DoNM	12 (l3 x c4)				⇔	8 (l2 x c4)
SA4 Efficient	4.1 Failure to ensure our services are financially sustainable in the long term	FPBD	DoF	20 (l5 x c4)				⇔	16 (l4 x c4)
	4.2 Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	FPBD	DoF	8 (l2 x c4)				⇔	8 (l2 x c4)
SA5 Effective	5.1 Failure to progress our research strategy and foster innovation within the Trust	Quality	MD	8 (l2 x c4)				⇔	4 (l1 x c4)
	5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Quality	DoNM	12 (l3 x c4)				⇔	8 (l2 x c4)

BAF HEAT MAP

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2.1	2.3	
4 Major		4.2 5.1	1.1 2.2 3.1 5.2		1.2 4.1
3 Moderate					
2 Minor					
1 Negligible					

Strategic Objective	SA1: To develop a well led, capable, motivated and entrepreneurial WORKFORCE
Committee:	Putting People First Committee
Risk Appetite:	Moderate

Principal risks (BAF)	Risk Score
1.1 Failure to be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	12 (3 x 4)
1.2 Failure to recruit and retain key clinical staff	20 (4 x 5)

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

Ref	Corporate Risk Register / High Scoring (15+) Risks	Risk Score
2443	Inability to recruit specialised allied health professions in a timely manner	16
1705	Insufficient midwifery staffing levels as recognised by birth rate place plus.	20
2424	Unable to meet safe staffing levels in line with BAPM requirements	15
2087 **(CRR)**	Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	12
2244 **(CRR)**	The functions and assurances provided by the Resuscitation Team had stopped (or been partially completed on an ad hoc basis) since April 2016. Some ILS courses have been provided via Whiston Hospital; however, they could not deliver any further courses until January 2019 at the earliest. This has led to a depletion of certificated skills within the Trust's nursing and ODP staff.	9
2323 **(CRR)**	The Trust is currently non-compliant with standards 2,5,6 of the seven-day service standards (due to insufficient consultant numbers)	15

BAF Risk 1.1: Failure to be recognised as one of the most inclusive organisation in the NHS with zero discrimination for staff and patients (zero complaints from patients, zero investigations)	**Lead Director:** CPO **Op Lead:** Deputy Director of Workforce	**Review Date:**	**Ulysses Ref:**

Strategic Priority: SA1: To develop a well led, capable, motivated and entrepreneurial workforce

Lead Committee: Putting People First

Provider Licence Compliance link(s):

N/A

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
12 (3 x 4)				⟷	8 (2 x 4)

Rationale for current risk score:

The Trust has several strong controls in place against this risk and can demonstrate effective performance in comparison with other NHS trusts. However, this is an ambitious aim within the Trust's 2021-25 strategy and will require significant cultural change to achieve together with a continued and unrelenting focus. The Trust can also make progress on the mechanisms that it has in place to hear the views and voices from its diverse staffing and patient communities and ensure that these voices have an impact on service improvement and development. Whilst there is evidence that the Trust has responded well to challenge that the pandemic has posed to the Trust in terms of patient and staff inequalities, this will continue to be a challenge over the year.

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
Unable to create a workforce representative of the community we serve	Monitoring of applications for employment within the Trust throughout the recruitment & selection process over a 12-month period via TRAC reporting	Monitored by the EDI Lead and reported through the ED&I Action Plan	None	
	Opportunities for all staff groups to attend/participate in 'shadow board'	Shadow Board attendance list and minutes.	None	
	Links with community leaders established to improve under-representation	PPF Strategy and action plan – monitored by PPF Committee	To ensure that there are robust processes in place to target advertising, work shadowing opportunities, pre-application training and offering career advice **(Actions 1.1 / 1 and 1.1 / 2)**	
	Annual review of all employee relation casework to determine if staff are reporting any form of discrimination and to ensure that process is fairly/consistently applied across all staff groups (benchmark against local and national data, where possible)	WRES submitted in September 2019 and reported a 100% reduction of BAME employees undergoing a formal process as at March 2019	None	
	All HR policies have up to date equality impact assessments at the point of review, in line with the policy schedule	Policy schedule is currently on track with EIA's being requested as required	None	
	HR policies reviewed in line with fair and just culture	Policy review process reported to PPF	None	
	WDES and WRES action plan delivery in line with timescales presented from NHS England	WDES and WRES Action Plan submissions	None	
	Demographic tracking for training access	In place and monitored by Head of L&D OD	None	
	Establishment of BAME and Disability Networks and work in collaboration with local Trusts to promote staff networks	Progress reported to PPF Committee	None	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status	
1.1 / 1	Reciprocal mentoring scheme to be developed	Head of Culture, Inclusion, Wellbeing and Engagement	September 2021	E&D Sub-Committee		
1.1 / 2	Robust targeting of job adverts	Head of Culture, Inclusion, Wellbeing and Engagement	September 2021	E&D Sub-Committee		
1.1 / 3	Review of the current Equality Impact Assessment (EIA) process, simplification of document and sufficient guidance and education on how to complete, ensuring this is a meaningful form that is completed at the beginning stages of every project/transformation/CIP/Procedure	Head of Culture, Inclusion, Wellbeing and Engagement	December 2021	E&D Sub-Committee		
1.1 / 4	Extension of e-learning package to design and deliver specific EDI training and education to all LWH staff	Head of Culture, Inclusion, Wellbeing and Engagement	December 2021	E&D Sub-Committee		
1.1 / 5	Education and celebration of the key EDI events: Black History Month, Disability History Month, LGBT+ History Month and key faith observance days/festival	Head of Culture, Inclusion, Wellbeing and Engagement	December 2021	E&D Sub-Committee		
1.1 / 6	Exploration of how we attract local population to work at LWH, utilising widening participation programmes and alternative ways to advertise and promote our job opportunities	Head of Culture, Inclusion, Wellbeing and Engagement	December 2021	E&D Sub-Committee		
1.1 / 7	Ensure all BAME colleagues have a career conversation with their Manager	Head of Culture, Inclusion, Wellbeing and Engagement	November 2021	E&D Sub-Committee		
1.1. 8	Exploration and implementation of more diverse recruitment and selection processes including diverse interview panels and alternative recruitment methods	Head of Culture, Inclusion, Wellbeing and Engagement	March 2022	E&D Sub-Committee		

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**

Unable to effectively engage with our patient and staff groups to understand further the needs of individuals with protected characteristics and respond proactively to identified needs	Patient stories on ED&I related matters being received by staff at Divisional Board, In the Loop etc	Divisional Board minutes, In the Loop recordings, other staff communications	Need to review internal communications and key Trust meetings to ensure that stories and the experience from under-represented groups is being heard, with action taken if necessary. **(Action 1.1 / 3)**
	Patient information leaflets are up to date and accessible for all protected groups	Annual audit of patient leaflets to ensure accessibility and usability	To check where this assurance is currently being monitored and reported.
	Enhanced communication and patient experience for people with disabilities coming for care at the Trust as part of Reasonable Adjustment activities	Personalised Maternity Care Budgets/ Maternity Early Adopter and Pioneer site – LMS Cheshire and Mersey Patients with learning difficulties, mental health or autism spectrum are allowed relatives to stay with them throughout their stay. Pro-active admissions for these groups with preadmission and discharge planning Admission procedures and assessments e.g. MUST /VTE/ FALLS / risk assessment Maternity Pre-operative assessments	None
	Barriers removed to access/health inequalities to maternity services for all with specific focus to migrant and asylum-seeking women	Barriers identified and measures put in place to remove e.g. Presence of representatives from MRANG in the antenatal clinic to support asylum seekers	Further work required to ensure that the Trust is adequately engaging with its communities and understanding how best to deliver and tailor its services. For this feedback to generate actions to build trust. **(Actions 1.1 / 4 and 1.1 / 5)**

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.1 / 9	Review internal communications and key Trust meetings to ensure that stories and the experience from under-represented groups is being heard, with action taken if necessary.	Head of Audit, Effectiveness and Patient Experience	September 2021	Patient Involvement & Experience Sub-Committee	
1.1 / 10	Need to ensure that the Trust is adequately engaging with its communities and understanding how best to deliver and tailor its services. For this feedback to generate actions to build trust.	Head of Audit, Effectiveness and Patient Experience	September 2021	Patient Involvement & Experience Sub-Committee	
1.1 /11	To review complaints data to explore trends relating to patients with protected characteristics	Head of Audit, Effectiveness and Patient Experience	September 2021	Patient Involvement & Experience Sub-Committee	

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
COVID-19 impact further increasing health inequalities for staff and patients	Staff working from home wherever possible, use of virtual meetings and enhanced IT provision Clear staff absence process and monitoring with increased flexibility Clear criteria as to elements of activity and types of patients the Trust can assist with Regular staff communications Listening Event for BAME staff completed to consider what further action the Trust could take to ensure BAME staff are protected as much as possible Risk Assessments undertaken for shielding & vulnerable staff including BAME, Pregnant workers, Age and Gender Comprehensive testing programme for symptomatic staff & household, antibody testing programme and have commenced asymptomatic testing for staff in high risk clinical areas Lateral Flow Testing at Home ongoing for all staff Trust offering vaccination reserve list to family members of staff who meet priority groups Staff Flu Vaccination Campaign completed within timeframe to required target level Covid - 19 Staff vaccination programme in place over 83% of staff have had vaccine.2nd dose programme to commence on 19th March 2021 Staff who have not had a first dose or have declined are being supported by local managers and HR in relation to any concerns about the vaccine Clear communication to patients via direct communications and social media. Review of national guidance re:activity delivery via Clinical Advisory Group Visiting Policy amended to reduce risk of spread PALS service continuing Family liaison service established to supplement PALS Service. Baby swabbing offer to new parents on leaving the hospital to provide assurance regarding hospital acquired infection. In patient swabbing in place monitored for completion at day 3 and day 5 as per national requirement Trust following National Guidance on Maternity partner support	Reduced footfall though the Trust - activity and visitors (comms) Close monitoring of guidelines and mandatory requirements with assurance reported to Extraordinary Board on 18 June 2020 Corporate BAU largely maintained despite remote working. Regular Covid-19 response reports to the Public Board EPRR Meetings continued Weekly monitoring of vaccine uptake in staff Weekly monitoring of swabbing of in patients	The age profile of individuals being infected with Covid-19 appears to be extending and there is an increase in the younger population with Covid-19. This includes the main age group of women attending maternity services. There is a possible increase in numbers of ladies and partners attending LWH who may be Covid-19 positive but asymptomatic. Impact on whole system during 'wave Three'	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.1 / 6	Close working with Cheshire and Mersey procurement via Covid Supply Response (CSR)	Head of Procurement	September 2021	EPPR	

BAF Risk 1.2: Failure to recruit and retain key clinical staff

Lead Director: CPO
Op Lead: Deputy Director of Workforce

Review Date:

Ulysses Ref:

Strategic Priority: SA1: To develop a well led, capable, motivated and entrepreneurial workforce

Lead Committee: Putting People First

Provider Licence Compliance link:

N/A

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
20 (4 x 5)				⟷	12 (3 x 4)

Rationale for current risk score:

Whilst the Trust has a significant number of controls and sources of assurance, the Trust does have acute and chronic staffing challenges in several areas and a higher than target sickness rate. The particularly acute issues with maternity staffing are the main driver behind this risk being scored a '5' for likelihood. There are also the following issues to consider: Insufficient numbers of doctors in training; ageing workforce; national shortage of nurses and midwives; isolated site and associated clinical risk impacting on recruitment and retention of specialist consultant staff; pension tax changes impacting on the retention of consultant medical staff (early retirement or reduction in working time).

There are examples of positive assurance in how the Trust has responded to the pandemic in relation to staff wellbeing but there remains some significant challenges during the 'recovery stage' and will require Board oversight and attention.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust.	Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff.	Monthly KPI's for controls.	Quality of appraisal.	
	Behavioural framework developed in partnership with staff in 2021			
	Consultant revalidation process.	Outcomes reported to PPF and the Board	None	
	Reward and recognition processes linked to values.	Monthly KPI's for controls.	None	
	Pay progression linked to mandatory training compliance	Monthly KPI's for controls.	None	
	Targeted OD intervention for areas in need to support.	PPF Committee	Staff survey engagement score not improved in year Mandatory training currently below target. Sickness absence above target. **(Action 1.2 / 1)**	
	New Leadership Programme and Talent Management framework in placeprogramme.	Leadership & Talent Strategy	Recommendation from Well-Led Review that additional measurables applied to this strategy to measure progress. Poor attendance at non-mandatory training e.g. leadership training. Requirement for further development of middle management	
	Programme of health and wellbeing initiatives.	Reported to PPF Committee	Ongoing challenges of engaging effectively with all staffing groups due to rota patterns.	
	All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities.	Monthly KPI's for controls.	None	
	Workforce planning processes in place to deliver safe staffing.	Divisional Board and Divisional Performance Reviews	Further evidence required that robust plans are being reviewed regularly at Divisional Board level	
	Shared decision making with JLNC and Partnership Forum.	Chair's Report to PPF Committee	None	
	Putting People First Strategy	Progress reported to PPF Committee	None	
	Guardian of Safe Working.	Report form Guardian of Safe Working	None	
	PDR training programme in place and PDR window for band 7 and above in N&M commenced in 2021	Monthly KPI's for controls.	None	
	Two Freedom to Speak Up Guardians	Bi-annual Speak Up Guardian Reports.	Consideration to be given to well-led review recommendation regarding development of a 'Champion's Network'.	
	Whistle Blowing Policy	Annual Report to PPF and Audit Committee	None	
	Engagement Tool Implemented.	Quarterly internal staff survey (Go Engage System)	None	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.2 / 1	PPF deep dive into service level workface risks	Deputy Director of Workforce	On-going	PPF Committee	
1.2 / 3	Executive team and staff side walkabouts – to consider amending this process in line with recommendations from the Well-Led external review	Deputy Director of Workforce	1 September 2021	PPF Committee	
1.2 / 4	Fair & Just Culture Programme Delivery - Year 3 Action plan now developed and in place - key elements include training and engagement activities for colleagues at all levels.	Deputy Director of Workforce	30th June 2021	PPF Committee	

	1.2 / 5	To respond to well-led review recommendation regarding additional measurables for talent & leadership programme	Deputy Director of Workforce	1 September 2021	PPF Committee		
	1.2 / 6	Consideration to be given to well-led review recommendation regarding development of a 'Champion's Network'. There is now a Great Place to Work Network	Deputy Director of Workforce	1 September 2021	PPF Committee		

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Covid-19 pandemic has the potential to impact staff wellbeing, particularly in relation to morale and a result of changed ways of working.	Staff working from home wherever possible, use of virtual meetings and enhanced IT provision Clear staff absence process and monitoring with increased flexibility Clear criteria as to elements of activity and types of patients the Trust can assist with Regular staff communications Listening Event for BAME staff completed to consider what further action the Trust could take to ensure BAME staff are protected as much as possible Risk Assessments undertaken for shielding & vulnerable staff including BAME, Pregnant workers, Age and Gender	PPF Committee Feedback from staff side	'Staff recovery' will be as important as 'service recovery' post pandemic. This must remain as a key area of attention for the organisation.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes.	Annually agreed funding contract with HEE	PPF Committee, HEN Visit	None	
	Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer.	Lead Employer notifies the Trust of Gaps in local rotations, giving the Trust autonomy to recruit at a local level into these gaps	None	
	Effective electronic rota management system for AFC staff implemented with doctors implemented by early 2022	PPF Committee	Further utilisation of the rota management system. E-Roistering System not fully utilised	
	Director of medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN	Quarterly reporting by Guardian of Safe Working, GMC Survey	None	
	Guardian of Safe Working Hours appointed in 2016 under new Junior Doctor Contract.	Quarterly reporting by Guardian of Safe Working.	None	
	Acting down policy and process in place to cover junior doctor gaps	Quarterly reporting by Guardian of Safe Working.	None	
	National Revalidation process ensuring competent staff.	Revalidation report to PPF Committee	None	
	Shared decision making and review of risk with JLNC.	Chair's Report to PPF Committee	None	
	Succession Planning and Talent Programmes	PPF Committee	None	
	NHSE Retention Improvement Programme	PPF Committee	None	
	NHSI Sickness Improvement Programme	PPF Committee	None	
	NHSE/I leadership programme to reduce sickness	PPF Committee	None	
	Shared appointments with other providers	PPF Committee	None	
	Secured operating time at the LUH	PPF Committee	None	
	Increased consultant recruitment with incentives Neonatal Partnership	PPF Committee	None	
	Maternity introduction of ACP Midwives	PPF Committee	Maternity Staffing requirements require further analysis.	
	~~Policy to mitigate impact on LTA and AA on senior staff in place~~	~~PPF Committee~~	~~None~~	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
	Await outcome of Business case sent to NHSI to develop E-Rostering System Collaborative - The Trust has been successful in its business case and a procurement process has commenced and will be concluded by February 21 This will be concluded for O&G doctors by September, others by early 2022	Deputy Director of Workforce	September 2021	PPF Committee	
1.2 / 1	To provide evidence that robust workforce plans are being reviewed regularly at Divisional Board	Deputy Director of Workforce	1 September 2021	PPF Committee	
1.2 / 2	Robust Maternity Staffing plans to be developed	Head of Midwifery	1 September 2021	Quality Committee	

Strategic Objective	SA2: To deliver SAFE services
Committee:	Quality Committee & Finance, Performance & Business Development Committee
Risk Appetite:	Low

Principal risks (BAF)	Risk Score
2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site	15 (3 x 5)
2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment	12 (3 x 4)
2.3 Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	20 (4 x 5)

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

Ref	Corporate Risk Register / High Level (15+) Risks	Risk Score
1961	Risk to patient safety, including risk of misdiagnosis, inaccurate reporting of imaging findings, and lack of evidence that imaging has been performed on PACS.	16
2397	Following a recent serious incident, there is a risk that patients will not be informed of abnormal imaging results from LWH or external organisations when the results are received at the Trust	16
2341	There is a risk that during the Covid-19 pandemic, adult patients who suffer a cardiac arrest will receive suboptimal resuscitation	16
2386	Risk of personal and sensitive information being compromised or being misused	15
2316	Risk of women needing to access emergency care with pregnancy complications and not being able to access advice or care at the point needed. Impact on the safety of patients, (physical/psychological harm)	16
2446	A number of patients who had been waiting for Gynaecology surgery (P4) and had pre-operative scans that were missed / not reviewed in time, subsequently had escalation of diagnosis and further management plan.	16
2084 **(CRR)**	Uncertainty of adequacy of 24/7 access to specialist input to support changing patient profiles and needs, new guidance and the Chief Medical Officer's recommendation of the specialist multidisciplinary team approach to treatment planning and co-ordination, including pre-operative, surgical and up to level 3 post-operative care for improved patient safety and improved outcomes.	6
2085 **(CRR)**	Uncertainty around access to dedicated diagnostic capacity and physiological measurement needed to support needs of a changing patient demographics and an increase in complex multiple comorbidities, and meeting the pre-operative assessment standards of the AAGBI and the RCoA, to asses patients' clinical risk and plan for additional requirements for their safety and provide an optimal experience.	12
2086 **(CRR)**	Uncertainty about provision of adequate on-site Blood bank stocking all major blood products necessary to support the needs of the Maternity service.	9
2296 **(CRR)**	The LWH laboratory autoview analyser (the machine used to process Blood Group and Save samples on site) will no longer be supported as of 1st March 2020. This machine cannot continue to be used after this date.	16
2321 **(CRR)**	Due to the Trust not being located next to or with acute services, it is unable to meet the National Recommendations for Maternal Medicine	15

BAF Risk 2.1: Failure to progress our plans to build a new hospital co-located with an adult acute site	**Lead Director: Medical Director** **Op Lead: Head of Transformation & Strategy**	**Review Date:**	**Ulysses Ref:**

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

Integrated Care Condition

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
15 (3 x 5)				⇔	15 (3 x 5)

Rationale for current risk score:

The Trust's services being located on an isolated site away from an acute centre, remains the most significant risk to the organisation. The Trust can demonstrate strong controls in relation to developing the clinical evidence base for the move and has achieved buy in from significant stakeholders. There remains however, a lack of system support outside of the C&M region to secure the capital case.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Inability to effectively communicate the case for change with regulators, key partners and the local community and receive buy-in to move project forward.	Continuing dialogue with regulators	CEO and Chair maintaining on-going dialogue	Lack of system support outside of Cheshire and Mersey to secure the capital case H&CP submissions for capital bids not successful despite system agreement of clinical case	
	Future Generations Strategy Update	Available on the Trust website	None	
	Active management with all commissioners	Good meetings with CCG via Clinical Quality and Performance Group (CQPG)	None	
	Progress being made in relation to building relationships with LUFT	Partnership Board meetings and involvement in wider Estates Strategy	None	
	Future Generations project group established with the Trust	Reports to the Quality Committee	Only recently re-started.	
	External validation of case for change	Output from Clinical Summit report (2019)	Outcomes from the clinical summit to be actioned Business Case for new build required Public consultation required Lobby systems and MPs for active support External review/testing of counterfactual case	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.1 / 1	To commence public consultation (external control of this action by NHSE/I)	Medical Director	October 2021	Board	
2.1 / 2	Agree Business Case for new build	Head of Transformation & Strategy	April 2022	Board	
2.1 / 3	Outcomes from the clinical summit to be actioned	Head of Transformation & Strategy	August 2021	Board	
2.1 / 4	Management of Future Generations Strategy through Project Management Office	Head of Transformation & Strategy	August 2021	Board	
2.2 / 5	Lobby systems and MPs for active support	Head of Transformation & Strategy	August 2021	Board	
2.2 / 6	External review/testing of counterfactual case	Head of Transformation & Strategy	August 2021	Board	

BAF Risk 2.2: Failure to develop our model of care to keep pace with developments and respond to a changing environment	**Lead Director:** COO **Op Lead:** Deputy COO	**Review Date:**	**Ulysses Ref:**

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
12 (3 x 4)				⟷	8 (2 x 4)

Rationale for current risk score:

The lack of an EPR (and as a corollary, having in place a disparate number of systems), remains a significant risk to the organisation. However, there is evidence of robust mitigating controls and progress being made in the procurement and subsequent embedding of an expanded Meditech system. The Trust can demonstrate evidence of being open and responsive to change in service development and delivery but further work can be done to strengthen the approach to horizon scanning and longer term, strategic planning at a Divisional level.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Trust's current clinical records system (paper and Electronic) are sub-optimal.	Approved Digital Generations Strategy	Quarterly risk assessments completed	None	
	Approved Meditech Expanse Business Case		None	
	Maintenance of present system	FPBD Committee overview and scrutiny	None	
	Development of individual / service solutions e.g. PENs (Gynaecology) and Staff training	Digital Hospital Committee oversight Approved EPR Business case which define clear direction and preferred solution.	Staff fatigue and loss of confidence. Ability of clinical staff to engage with the system development due to time and financial impact	
	Incident reporting		None	
	Tactical solutions including the implementation of K2 Athena system	EPR programme board chaired by MD	Optimisations to K2 system and refinements which are required	
	Exchange/LHCRE enables for patent information sharing	Independent lessons learnt Positive review	Not all Trust using LHCRE for patient information exchange	
	Virtual Desktop technology to aid staff working flexibly.		None	
	Additional network resilience for LUHFT supplied systems (K2/PENS/CRIS) to reduce risk of unplanned systems downtime	MIAA Critical Application Audit (rolling programme across trust systems) Reporting into Audit Committee and Digital Hospital Group	None	
	PACS upgrade removes a separate login for that system, reducing multiple systems issues.		None	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.2 / 1	Develop staff communication plan for new system	CIO	May 2021	Digital Hospital Committee oversight	
2.2 / 2	Ongoing review of systems and mitigations quarterly (report to FPBD & QC)	CIO	February 2022	FPBD and Quality Committees	
2.2 / 3	Issue appropriate communication to all staff in relation to digital development by multiple means and forms	CIO	April 2022	Digital Hospital Committee oversight	
2.2 / 4	Develop a business case for appropriate digital training capabilities for the Trust	CIO	April 2022	Digital Hospital Committee oversight	
2.2 / 5	Develop a digital clinical leadership business case	CIO	September 2021	Digital Hospital Committee oversight	
2.2 / 6	Implement required system optimisations as identified by Maternity and other Trust stakeholders	CIO	April 2022	Digital Hospital Committee oversight	
2.2 / 7	Task and Finish group to explore mitigations and identify new solutions to ensure the results of clinical investigations are reviewed and actioned. Ensuring documentation of this process can be provided	CIO	April 2022	Digital Hospital Committee oversight	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Clinical service strategies that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities	Operational 'Plans on a page' for Divisions	Divisional Board meetings	To improve horizon scanning processes to constantly review and update plans on a page To understand commissioning priorities emerging from developing ICS	
	Operational planning process	Operational plans and budgets	None	
	Availability of data on service trends and demographics	Divisional Boards	To ensure that Divisions are fully utilising data to understand changing service demands	
	Workforce plans	Divisional Boards	To ensure that workforce plans are informed by trends and data led intelligence.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status

	2.2 / 8	Use of effective horizon scanning at Divisional Boards to review and update 'plans on a page' – to include emerging intelligence around commissioning priorities from developing ICS	Deputy COO	September 2021	Executive Team		
	2.2 / 9	To ensure that Divisions are fully utilising data to understand changing service demands	Deputy COO	September 2021	Executive Team		
	2.2 / 10	To ensure that workforce plans are informed by trends and data led intelligence.	Deputy COO	September 2021	Executive Team		

BAF Risk 2.3: Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	**Lead Director: Medical Director** **Op Lead:** Deputy Medical Director	**Review Date:**	**Ulysses Ref:**

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Quality Committee

Provider Licence Compliance link:

N/A

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
20 (4 x 5)				⇔	15 (3 x 5)

Rationale for current risk score:

The Trust's services being located on an isolated site away from an acute centre, remains the most significant risk to the organisation and to patient safety. Good progress is being made on mitigating measures to make the Crown Street site safer with a number of significant capital projects either completed, underway or planned. It should be acknowledged that the impact of this risk cannot be fully mitigated whilst the Trust operates on an isolated site.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Location, size, layout and accessibility of current services do not provide for sustainable integrated care or safe and high-quality service provision.	Programme for a partnership in relation to Neonates with AHCH has been established.	Neonatal partnership updates provided to the Board	None	
	£15m capital investment in neonatal estate to address infection risk	IPC Reports	None	
	Transfer arrangements well established for neonates and adults	Transfers out monitored at HDU Group	None	
	Formal partnership and board established with Liverpool Universities Hospitals with respect to: -Diagnostics -Medical and surgical expertise -Intensive care facilities -Theatre access at Liverpool Universities Hospitals for women with Gynae cancers		Onsite and partnership mitigations cannot fully address the clinical risk - this can only be achieved through co-location	
	Blood product provision by motorised vehicle from nearby facility.	Serious incidents, should they occur are tracked and reported through the governance framework,	None	
	Investments in additional staffing inc. towards 24/7 cover	Staff Staffing levels reports to board	Emerging clinical standard leading to potential loss of services and increase in difficulty in relation to recruitment of consultants	
	Enhanced resuscitation training provision	Training compliance rates reported to PPF Committee	None	
	Crown Street Enhancement Group developed and has commenced meeting		Financial and workforce constraints for delivery of additional facilities on site. - No blood bank on site -No 24/7 cover on site - No CT	
	Divisional Operational Plans completed	Divisional Boards	None	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.3 / 1	Divisional plans to be developed to support long term clinical sustainability via operational plan - Action in final stages of completion.	Head of Transformation & Strategy	July 2021	Trust Executive	
2.3 / 2	Agree funding for mitigations on site (Blood Bank, MRI, Diagnostics, CT and Staffing) for inclusion in 20/21 operational plan	Head of Transformation & Strategy	July 2021	FPBD Committee	
2.3 / 3	Project to establish 24/7 transfusion services, robotics surgical service and CT imaging at the Crown Street site. To include construction work and associated estate reconfiguration	Head of Transformation & Strategy	July 2021	FPBD Committee	

Strategic Objective	SA3: To deliver the best possible EXPERIENCE for patients and staff
Committee:	Quality Committee
Risk Appetite:	Low

Principal risks (BAF)	Risk Score
3.1 Failure to deliver an excellent patient and family experience to all our service users	12 (3 x 4)

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

Ref	Corporate Risk Register / High Level (15+) Risks	Risk Score
2418	Lack of support and appropriate care for patients presenting with mental health conditions	16
2430	Network outlier for pre-term mortality - rate is higher than the national average	16
2427	Covid lockdown between March 2020 and July 2020 and then September 2020 and subsequently December 2020 to March 2021, resulting in prolonged wait for elective surgery for benign gynaecologic procedures	16
2350	Due to the need to reduce patient attendance / stop elective activity and adhere to social distancing as a result of Covid-19 a number of services within Gynaecology have had to cease or changes the way in which they are delivered	15
2304	Failure to achieve 31 day and 62 day national cancer targets, and having monthly 104 day breaches	16
1966 **(CRR)**	Risk of safety incidents occurring when undertaking invasive procedures	12
2088 **(CRR)**	Lack of on-site specialist paediatric care and support services Neonatal surgery provision and Level 3 neonatal intensive care unit and lack of on-site provision for CT & MRI scanning and Blood bank and Transfusion Lab.	12

BAF Risk 3.1: Failure to deliver an excellent patient and family experience to all our service users	**Lead Director: CN&M** **Op Lead:** Deputy Director of Nursing & Midwifery	**Review Date:**	**Ulysses Ref:**

Strategic Priority: SA3: To deliver the best possible EXPERIENCE for patients and staff

Lead Committee: Quality Committee

Provider Licence Compliance link:

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
12 (3 x 4)				⟺	8 (2 x 4)

Rationale for current risk score:

The Trust has strong evidence in relation to its response to the Covid-19 pandemic and continues to receive positive feedback from significant patient surveys. To improve further, it is imperative that the organisation ensures that it can listen to patient voices and the local community and ensure that services are responsive and can cater to differing needs. The evidence for how effective the organisation is undertaking this can be strengthened from the current position.

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
Unable to recover services to pre-Covid-19 levels and beyond	Commitment to deliver Business as Usual wherever possible	Situation continues to be monitored at Oversight and Scrutiny Group weekly and 3 times a week at the Command and Control meeting.	National mandates and what the Trust is required to recover and trajectories. Day case efficiency currently 70% backlog and ineffective in dealing with backlog. Insufficient Theatre staffing due to vacancies and not having a full complement of anaesthetists. Test, Track and Trace system impact on staffing	
	Corporate controls remain in place	Annual Governance Statement and performance reports		
	On-going regulatory compliance	As above		
	Recovery plans in development to include areas of good practice which should be maintained	Cancer services activity in Feb 2021 above activity in 2020		
	Maternity escalation and incineration process in place to support staff taking on back and extra shifts at times of short staffing	Safe Staffing report		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
Unable to adequately listen to patient voices and our local communities to ensure that services are responsive and cater to differing needs.	Patient Experience Strategy	Experience Senate (now Patient Involvement & Experience Sub-Committee)	Updated Strategy in development. There is a need to ensure that the Trust is adequately hearing from all demographic areas and ensuring that services are tailored to meet differing needs as much as is practicable. Improvements required in how Divisions utilise patient views and feedback to drive quality improvement.	
	Family Liaison Service	Experience Senate (now Patient Involvement & Experience Sub-Committee)		
	PALs and Complaints data	Experience Senate (now Patient Involvement & Experience Sub-Committee)		
	Friends and Family Test	Experience Senate (now Patient Involvement & Experience Sub-Committee)		
	National Patient Survey	Experience Senate (now Patient Involvement & Experience Sub-Committee)		
	Healthwatch feedback	Experience Senate (now Patient Involvement & Experience Sub-Committee)		
	Social media feedback	Experience Senate (now Patient Involvement & Experience Sub-Committee)		
	Membership feedback	Council of Governors		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
3.1 / 1	To finalise updated Patient Experience Strategy	Head of Audit, Effectiveness and Patient Experience	September 2021	Patient Involvement & Experience Sub-Committee	
3.1 / 2	To ensure that the Patient Involvement & Experience Sub-Committee monitors the objectives within the updated Patient Experience Strategy	Head of Audit, Effectiveness and Patient Experience	September 2021	Patient Involvement & Experience Sub-Committee	
3.1 / 3	To build relationships with local community leaders and mechanisms for hearing feedback on the Trust's services	Head of Audit, Effectiveness and Patient Experience	September 2021	Patient Involvement & Experience Sub-Committee	
3.1 / 4	To appoint a Non-Executive Director with a focus on community engagement	Trust Secretary	September 2021	Board	
3.1 / 5	To ensure that Divisions are adequately utilising patient feedback to drive quality improvement initiatives	Deputy COO	September 2021	Patient Involvement & Experience Sub-Committee	

Strategic Objective	**SA4: To be ambitious and EFFICIENT and make the best use of available resources**
Committee:	**Finance, Performance and Business Development Committee**
Risk Appetite:	**Moderate**

Principal risks (BAF)	Risk Score
4.1 Failure to ensure our services are financially sustainable in the long term	20 (5 x 4)
4.2 Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	8 (2 x 4)

Ref	Corporate Risk Register / High Level (15+) Risks	Risk Score
None identified to date		

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

BAF Risk 4.1: Failure to ensure our services are financially sustainable in the long term	**Lead Director: DoF** **Op Lead:** Deputy Director of Finance	**Review Date:**	**Ulysses Ref:**

Strategic Priority: SA4: To be ambitious and EFFICIENT and make the best use of available resources

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
20 (5 x 4)				⟷	16 (4 x 4)

Rationale for current risk score:

The Trust has a well-defined and evidence backed case that whilst it remains on a single site, long-term financial sustainability will be compromised. Progress has been made to identify strategic solutions to this issue, but these remain unresolved. Whilst plans are in place, there also remains significant on-going uncertainty regarding the financial regime, introduction of Integrated Care Systems and consequent change in commissioning landscape and the impact of changing clinical requirements with resource implications. That said, these changes could also present opportunities for the Trust that the Board should remain aware of. The Trust can demonstrate robust short-term and 'business as usual' financial controls – evidenced by feedback from internal and external audit.

Strategic Threat *(what might cause this to happen)*	**Controls** ⇨ *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** ⇨ *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
The Trust is not financially sustainable in the long term	5 Year financial model produced giving early indication of issues	5 Year plan approved (BoD Nov 2014) Long Term Plan Submission Nov 19	Whilst plans are in place, there remains significant on-going uncertainty regarding the financial regime, introduction of Integrated Care Systems and consequent change in commissioning landscape and the impact of changing clinical requirements with resource implications.	
	Business case to Trust Board which identifies a solution which minimised deficit, including relocation to an acute site and merger	Future Generations Clinical Strategy and Business Plan (BoD Nov 15 – refreshed in 2020) Sustainability and Transformation Plan (FPBD, Jul 16) PCBC Approval (FPBD, Oct 16)	Implementation of business case is dependent on decision making external to the Trust (CCG, NHSE/I) National CDEL Issue Lack of capital nationally	
	Early and continuing dialogue with NHSE/I	NHSE/I use of resources rating above 3 over 5 year period	None	
	Active engagement with CCG resulting in a pre-consultation Business Case	CCG Pre Consultation Business Case approved by CCG Committees in common	None	
	Agreement for merger proposals with partner Trusts approve by three BoD's	Strategic Outline Case for merger approved by three Trust Boards (BoD, Jun 16) SOC for preferred option approved by Board - Sept 17	Merger dependent on external partners	
	Review of open claims and legal processes	Completed annually	None	
	Engagement in place with Cheshire and Mersey Partnership to review system solutions	Submission of Cheshire and Mersey STP capital bid Summer 2018 ranked no1 of schemes	Position potentially superseded by development of ICS	
	Clinical Engagement and support for proposals	Northern Clinical Senate Report supporting preferred option	None	
	Reduction in CNST Premium	Interim budget approved by the Board in April 2021	Important to continue to enhance safety and quality to reduce claims	
	Reduction in back office overheads costs.	Oversight on costs at FPBD and Board	None	
	Application for emergency capital for mitigations on site	Approved with work now underway	None	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
4.1 / 1	Business Case 4 - Revision of SOC following unsuccessful STP capital bid - Target has been put back based on initial feedback from TU readiness assessment - system buy in to be initial focus ahead of SOC update	Deputy Director of Finance	March 2023	FPBD Committee	
4.1 / 2	Business Case 2 - Public consultation by CCG following development of preferred option (Subject to capital bid)	Deputy Director of Finance	March 2022	FPBD Committee	
4.1 / 3	Business Case 3 - Decision making business case produced in partnership with CCG and final decision following outcome of public consultation required	Deputy Director of Finance	October 2022	FPBD Committee	
4.1 / 4	Business case - to support the application for capital to support the relocation required	Deputy Director of Finance	December 2021	FPBD Committee	
4.1 / 5	Merger 1 - Agree in principle to proceed to merger	Deputy Director of Finance	December 2021	FPBD Committee	
4.1 / 6	Merger 2 - Establish Merger Project (internal group)	Deputy Director of Finance	December 2021	FPBD Committee	
4.1 / 7	Merger 3 - Develop Strategic case working with external organisations	Deputy Director of Finance	December 2021	FPBD Committee	
4.1 / 8	Merger 4 - Develop and complete business case in conjunction with external organisations	Deputy Director of Finance	November 2021	FPBD Committee	
4.1 / 9	Merger 5 - Merger / acquisition approval process with external organisation	Deputy Director of Finance	September 2023	FPBD Committee	
4.1 / 10	Shared Exec Model 1 - Develop Shared Exec Model - Work in partnership with external body (LUHFT) in order to develop and assess options for a shared executive model which will deliver financial savings	Deputy Director of Finance	December 2021	FPBD Committee	
4.1 / 11	Shared Exec Model 2 - Agree Model - Review and agree preferred model in conjunction with external organisation (LUHFT)	Deputy Director of Finance	December 2021	FPBD Committee	
4.1 / 12	Shared Exec Model 3 - Implement Shared Exec Model - Detailed implementation plan to be developed in conjunction with external organisation (LUHFT) to implement agreed shared exec model.	Deputy Director of Finance	June 2022	FPBD Committee	

	4.1 / 13	Procurement 1 - OJEU - Undertake most appropriate formal procurement process to appoint primary building contractor & architect	Deputy Director of Finance	June 2023	FPBD Committee		
	4.1 / 14	Procurement 2 - PQQ Stage - Procurement team to complete Pre Qualification Questionnaire stage	Deputy Director of Finance	September 2023	FPBD Committee		
	4.1 / 15	Procurement 3 - ITPD Stage - Procurement team to complete Invitation to Participate in Dialogue stage	Deputy Director of Finance	April 2024	FPBD Committee		
	4.1 / 16	Procurement 4 - Financial Close - Procurement team to complete financial close stage	Deputy Director of Finance	July 2024	FPBD Committee		
	4.1 / 17	Procurement 5 - Contract Award - Trust to approve contract award	Deputy Director of Finance	September 2024	FPBD Committee		
	4.1 / 18	Business Case 1 - Work in partnership with CCG to refresh PCBC document, including stakeholder engagement and refresh of data.	Head of Transformation & Strategy	December 2021	FPBD Committee		
	4.1 / 19	Business Case 5 - Approval for funding from NHSI/E based on refreshed SOC	Deputy Director of Finance	April 2023	FPBD Committee		

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
Risk that the Trust will not deliver a breakeven position or have sufficient cash resources in the 2021/22 financial year	Monthly reporting and monitoring of position including taking corrective action where required. Sign off of budgets by budget holders and managers, and holding to account against those budgets Divisional performance reviews Working within ICS/system to ensure issues understood and Trust secures required amount of available funding.	FPBD Committee Internal Audit External Audit	Lack of contractual income position due financial framework in place following the Covid-19 pandemic, gap in baseline position and block payment compared to actual activity and cost, risk to CIP and income streams, timing of recovery and uncertainty over future regime.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
4.1 / 20	Ensure regular reporting in place and corrective action taken where needed	Deputy Director of Finance	March 2022	FPBD Committee	
4.1 / 21	Ensure full CIP programme in place with relevant QIAs etc	Deputy Director of Finance	March 2022	FPBD Committee	

BAF Risk 4.2: Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	**Lead Director: COO** **Op Lead:** Deputy COO	**Review Date:**	**Ulysses Ref:**

Strategic Priority: SA4: To be ambitious and EFFICIENT and make the best use of available resources

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

Integrated Care

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
8 (2 x 4)				⟷	8 (2 x 4)

Rationale for current risk score:

The Trust has well defined partnerships and relationships with a number of key stakeholders. These have been strengthened and added to during the Covid-19 pandemic response. The regulatory and system landscape remains uncertain and the Board will be looking for additional clarity on future arrangements (and the Trust's assured role in this) in order to mitigate this risk and work towards the target score and improve the overall assurance rating on the controls.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Conflicting priorities, financial pressures (system financial plan misalignment) and/or ineffective governance resulting in a breakdown of relationships amongst ICS and ICP partners and an inability to influence further integration of services across acute, mental, primary and social care	Robust engagement with ICS discussions and developments through CEO and Chair	CEO Report updates to the Board Board workshop discussion – June 2021	Governance arrangements are developing **(Action 4.2 / 1)**	
	Evidence of cash support for the Trust's H1 breakeven position	Interim Trust budget agreed by the Board	Developments for H2 currently unknown	
	Neonatal partnership in place with Alder Hey	Regular updates to the Board	None	
	Partnership Board in place with LUHFT and involvement in wider Estates Plan	Updates provided to the Quality Committee and Board	None	
	Positive and developing relationship with Merseycare NHS FT	Updates provided to the FPBD Committee	None	
	LMS Hosting Arrangement	Updates provided to the Board	Governance arrangements are developing **(Action 4.2 / 2)**	
	Finance Directors Group	Updates provides to the Executive Team and through the governance structure when appropriate	None	
	Health care partnership are using existing memorandum of understanding in relation to staff movement between local hospital at time of staffing need.	Agreed at Board	None	
	LWH have provided assistance to LUFT by taking over Non Obstetric Ultrasound scanning activity	Mutual aid reported through to the Quality Committee and Board	None	
	LWH identified as Gynaecology Oncology Hub for Cheshire and Mersey.		None	
	Theatre sessions provided at LWH for other Trusts such as Colorectal for LUFT		None	
	Provision of mutual aid to NWAST by supporting staff testing on LWH site for them		None	
	Provision of Mutual aid to NWAST for staff Covid-19 vaccinations		None	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
4.2 / 1	Continue to provide updates to the Board regarding the development of the ICS, highlighting when decision points are likely	CEO	On-going	Board	
4.2 / 2	Development and embedding of governance arrangements for the LMS	COO	September 2021	Board	

Strategic Objective	SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes
Committee:	Quality Committee
Risk Appetite:	High

Principal risks (BAF)	Risk Score
5.1 Failure to progress our research strategy and foster innovation within the Trust	8 (2 x 4)
5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	12 (3 x 4)

Ref	Corporate Risk Register / High Scoring (15+) Risks	Risk Score
2336	There is risk to the Trust, as it is not currently meeting the CQC Regulations and national guidance in relation to the care of children aged 18 and below within the Gynaecology services	15
2232 **(CRR)**	There is a risk that due to a number of causes the Trust is unable to meet the safety requirements related to Blood Transfusion	15
2295 **(CRR)**	Inability to achieve and maintain regulatory compliance, performance and assurance.	8
2329 **(CRR)**	There is a risk to the Trust is not meeting it requirements for the safe and proper management of medicines	12

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

BAF Risk 5.1: Failure to progress our research strategy and foster innovation within the Trust	**Lead Director: MD** **Op Lead:** Director of Research	**Review Date:**	**Ulysses Ref:**

Strategic Priority: SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

N/A

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
8 (2 x 4)				⟷	4 (1 x 4)

Rationale for current risk score:

The Trust has a well-established and successful research process and has been particularly active in the support provided to the wider system during Covid-19. To strengthen this area and further mitigate this risk, the Trust should look to widen participation in research across the organisation making links explicit with quality improvement activity. There is also an opportunity to further enhance the Trust's research profile in the local system but also nationally and internationally.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
If high quality research staff cannot be engaged and retained, then research activities will not be fulfilled leading to withdrawal of funding or damage to reputation	Excellent support continues to be provided to medical staff in identifying and nurturing talent, ensuring projects suggested by new researchers are feasible and of high quality and establishing mentorship for individuals who wish to have a research component as part of their future career.	The Trust in-house research management infrastructure continues to operate in a robust and efficient manner. Its performance can be demonstrated via various internal and external reporting mechanisms.	Further support and development of the non-medical workforce in respect of research is required	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.1 / 1	To explore methods of providing further support and development for the non-medical workforce in relation to the research agenda.	Medical Director	October 2021	Research and Development Sub-Committee	
5.1 / 2	To collaborate with the Professor of Midwifery	Medical Director	October 2021	Research and Development Sub-Committee	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Continued engagement with the City-wide integrated approach to innovation is necessary in order to further promote, develop and innovation ideas from the Trust's workforce.	Engagement with Liverpool Health Partners	Regular innovative ideas are identified and supported, for example Life Start Trolley, Butterfly Pillow, Butterfly Shelf, parenteral nutrition product, speculum for the diagnosis of urogenital atrophy. Such ideas are supported in-house and via outsourced expert help and advice.	Further development of this strategic principle is required to enable the Trust to empower its staff in engaging with a City-wide integrated approach to innovation.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.1 / 3	To progress engagement with Liverpool Health Partners and other city-wide partners to further the Trust's research agenda	Medical Director	October 2021	Research and Development Sub-Committee	
5.1 / 4	Continue progress towards university hospital status application	Medical Director	October 2021	Research and Development Sub-Committee	
5.1 / 5	Continue Trust engagement with population health and longitudinal studies / workstreams	Medical Director	On-going	Research and Development Sub-Committee	

BAF Risk 5.2: Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	**Lead Director: CN&M** **Op Lead:** Deputy DoN&M	**Review Date:**	**Ulysses Ref:**

Strategic Priority: SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes

Lead Committee: Quality Committee

Provider Licence Compliance link:

General Licence Condition 7

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
12 (3 x 4)				⟷	8 (2 x 4)

Rationale for current risk score:

The Trust has a current rating of 'requires improvement' for well-led from the most recent CQC inspection and also received a warning notice regarding medicine management. Good assurance is in place regarding the Trust's response to this with only two actions remaining outstanding and the warning notice being withdrawn. Further work required to refine process and to ensure that the Trust remains 'inspection ready' at all times.

The Trust was subject to an external wee-led review and themes relating to effective lesson learning and establishing a quality improvement methodology were identified, mirroring findings from the CQC inspection and feedback from commissioners. Progress has been made in relation to both of these areas but this needs to go further to achieve the target score.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
If the Trust fails to comply with the CQC fundamental standards and if actions arising from the CQC visit are not implemented at sufficient pace then clinical standards may not be met leading to significant patient harm, deterioration in patient outcomes, a failure to maintain a CQC rating of 'good' and a serious reputational risk to the Trust.	Action plan process in place with monthly review at Executive and Board level Widespread communication about CQC report and actions arising CQRG monitoring Majority of actions implemented with clear timeline in place for implementation of outstanding two actions	Quality Committee Executive Team oversight Divisional Board and performance review meetings MIAA internal audit report on CQC action plan	None Further work required to refine ward accreditation process	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 1	To implement updated Ward Accreditation programme	Deputy Director of Nursing & Midwifery	October 2021	Quality Committee	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective understanding and learning following significant events	Regular dialogue with regulators Incident reporting and investigation policies and procedures. MDT involvement in safety HR policies in relation to issues relating to professional and personal responsibility Mandatory training in relation to safety and risk Serious Incident Feedback form Serious Incident panels Safety is included as part of executive walk rounds. Risk Management Strategy	CQPG Meetings Reporting of incidents and management of action plans through Safety & Effectiveness Sub-Committee Reflection of risks and Corporate Risk Register and Board Assurance Framework CQC Assessment Annual Quality Account Report	'Moderate Assurance' from recent MIAA Audit External criticism from regulators and commissioners Lack of testing of action plans following audits to ensure they lead embedded change Inconsistent completion and dissemination of actions and improvement plans Inconsistent implementation of lessons learnt and lack of evidence Pace of implementing change Lack of consistent between divisional governance meetings (noted in recent well-led report) Well-led external review recommendation regarding walkaround process	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 2	To ensure that Divisional Governance meetings are consistent and seek evidence of actions / lessons being embedded	Deputy COO	September 2021	Safety & Effectiveness Sub-Committee	

	5.2 / 3	Develop better reporting from the Ulysses System There is a continuing commitment to improving reporting using Ulysses. A recent development has been the agreement to cross-tabulate incidents and complaints using Ulysses using a formal process.	Head of Governance & Quality	June 2021	Safety & Effectiveness Sub-Committee		
	5.2 / 4	Business case for the provision of Human Factors Training to be developed and submitted to education governance committee	Medical Ed Lead	September 2021	Safety & Effectiveness Sub-Committee		
	5.2 / 5	New risk management and patient safety training package to be developed	Head of Governance & Quality	June 2021	Safety & Effectiveness Sub-Committee		
	5.2 / 6	Root Cause Analysis training for staff to be reviewed and updated and to recommence via teams	Head of Risk	June 2021	Safety & Effectiveness Sub-Committee		
	5.2 / 7	Governance team to review current compliance level and to make changes to ensure trajectory is met	Head of Risk	July 2021	Safety & Effectiveness Sub-Committee		
	5.2 / 8	The governance team will work with the communications team to identify if it is possible to have a link on desktop of computer with a link to lesson learnt section of web page	Head of Risk	June 2021	Safety & Effectiveness Sub-Committee		
	5.2 / 9	The use of the action planning module is to be embedded across all divisions. Governance team to use weekly meeting for review actions and ensure shared. Governance team to ensure oversight and reporting of progress	Head of Risk	June 2021	Safety & Effectiveness Sub-Committee		
	5.2 / 10	Governance team to monitor compliance levels with risk management training and highlight staff who are non compliance to the Divisions and provide compliance update to Safety and Effectiveness Sub-committee.	Head of Risk	July 2021	Safety & Effectiveness Sub-Committee		

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective and / or ill-defined quality improvement methodology will result in the Trust missing opportunities to improve the safety, effectiveness and experience of care.	Quality Improvement training materials available on Trust Intranet	Training levels reported to the Quality & Clinical Audit Group	Quality Improvement methodology document not finalised Opportunities to engage individuals in QI training limited, particularly during pandemic	
	Quality Improvement projects tracked	Safety & Effectiveness Sub-Committee	Evidence of QI projects being undertaken but not 'formalised'	
	Quality Account tracking key projects	Annual Quality Account	None	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 11	Finalise and disseminate Quality Improvement Methodology document	Head of Patient Safety	August 2021	Quality Committee	
5.2 / 12	Increase levels of QI training	Head of Patient Safety	September 2021	Quality Committee	
5.2 / 13	Simplify process to encourage staff to record QI projects within formal framework	Head of Patient Safety	September 2021	Quality Committee	

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/75a*		**Date: 02/09/2021**	
Report Title	Research & Development Annual Report 2020/21			
Prepared by	*Louise Hardman, R&D Manager* *Mark Turner, Director of R&D*			
Presented by	*Lynn Greenhalgh, Medical Director*			
Key Issues / Messages	***This report provides an opportunity to demonstrate our commitment to continuous, evidence-based research and celebrate our achievements.***			
Action required	Approve ☐	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to note the Trust's Research & Development Annual Report for 2020/21.			
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* 5.1 Failure to progress our research strategy and foster innovation within the Trust	Comment: This report is a key source of assurance against this BAF risk area.
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	June 2021	Medical Director	Recommended to the Board for assurance purposes.

EXECUTIVE SUMMARY

Welcome to Liverpool Women's NHS Foundation Trust's Research & Development Annual Report for 2020/21. This provides an opportunity to demonstrate our commitment to continuous, evidence-based research and celebrate our achievements.

Key Themes

The national strategy for research in the NHS remains focused on the clinical and economic imperatives for Trusts to continue to improve their performance in initiating and delivering research. This will accelerate the benefits of research for patients and develop the UK's competitive advantage in the life sciences.

Locally, research activity benefits the Trust's clinical capabilities and deliverables, which means that the Trust can implement evidence-based interventions in a timely manner, thus improving the quality of health care for our patients and enhancing patient choice. Research fosters personal development and attracts high calibre staff. As a result, more of our nursing and midwifery staff than ever before are benefiting professionally from their participation in delivering research. As well as the work of individuals, engagement with Cochrane reviews, NICE, and CRNs has positioned the Trust as a national leader in its clinical work-streams.

Summary Report

Key findings from the report can be summarised as follows:

Performance

- A total of 1,316 individuals were recruited to participate in research
- The Trust conducted 118 clinical research studies across all speciality areas, with a further 28 studies in set up at the year end, including 6 industry studies and 2 COVID-19 research studies
- Approximately 187 clinical staff contributed directly to research
- 109 publications have resulted from involvement in research during the year
- Due to the unprecedented effect of COVID-19 on usual research activity, the 2021/22 NWC CRN baseline funding allocation has been matched with the 2020/21 allocation
- Excellent performance at research leadership in all medical speciality areas
- Full contribution to the research component of the Government's COVID-19 strategy

Innovation

- Further programme of work to assess the performance of the new parenteral nutrition product that comprises a specific amino acid formulation concentration.
- In association with Robinson Healthcare, the development of a speculum to assist in the diagnosis of urogenital atrophy for use in both primary and secondary care.
- Development of a tactile sensory array 'intelligent mattress' to deliver moving stroking touch to preterm babies in the NICU at velocities and forces that research has shown is optimal for c-tactile afferents

Strategy

- The Trust played a full part in the alignment of research activity across the city during the pandemic and was fully embedded in the integrated “command and control” structures that will evolve after the pandemic.
- Continued collaborations with Liverpool Health Partners and Health Education Institutions
- Excellent performance demonstrated against the eight strategic principles in the first three years of the five-year strategy.
- Since the last strategy was defined further opportunities have been identified.

Conclusions

Delivery of the Trust’s Research Strategy as of 2020/21 has been successful as detailed in the main body of the report. COVID-19 research was conducted effectively. However, performance and delivery of research not related to COVID-19 has been impacted by the pandemic.

Recommendations

The Board is asked to note the Trust’s Research & Development Annual Report for 2020/21.

Abbreviations

AHP	Allied Health Professionals
BAME	Black, Asian, and minority ethnic
CCG	Clinical Commissioning Group
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
CRN	Clinical Research Network
DfID	Department for International Development
HEI	Higher Education Institutes
HFC	Hewitt Fertility Centre
HLO	High Level Objective
HTA	Health Technology Assessment
LCR	Liverpool City Region
LHP	Liverpool Health Partners
LMICs	Low and middle income countries
MRC	Medical Research Council
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NWC CRN	North West Coast Clinical Research Network
PCT	Patent Cooperation Treaty
PDA	Patent ductus Arteriosus
PMDD	Premenstrual dysphoric disorder
PPH	Post-partum haemorrhage
PTSD	Post-traumatic stress disorder
RLBUHT	Royal Liverpool & Broadgreen University Hospitals Trust
SPARK	Single Point of Access for Research and Knowledge
SPs	Strategic principles
UKARCOG	UK Audit and Research Collaborative in Obstetrics and Gynaecology
UoL	University of Liverpool
WHO	World Health Organisation

Report

The Trust's vision is to be the recognised leader in healthcare for women, babies and their families. To achieve this vision, the Trust aims to foster a research culture, to support its existing strengths and to explore new directions in its research efforts. Therefore, a new Research and Innovation Strategy was produced and approved by the Trust Board in March 2018. The following eight Strategic Principles (SPs) were devised:

(SP1) Research activities will become an integral part of the Trust's clinical activities
(SP2) All of the Trust's clinical staff will contribute to the research agenda and relevant non-clinical staff will support research activity
(SP3) The Trust will support and build upon its present research strengths
(SP4) New areas of research that the Trust supports will link to the healthcare challenges of our local population of women and their newborn babies
(SP5) A contribution to research internationally will be supported, particularly when social and economic disadvantage is linked to poor outcomes
(SP6) The Trust will continue to underpin high quality research by training researchers and managing research infrastructures
(SP7) The Trust will work with local, national and international research partners to achieve its vision and aims
(SP8) Innovation will be encouraged and receive corporate support

The strategy document described the ways in which these eight Strategic Principles were to be pursued in a five-year cycle between 2018 and 2023.

A dashboard of progress against each of these strategic principles has been presented on a regular basis to the Effectiveness Senate, Quality Committee, and also documented within R&D Annual Reports.

In the latter quarter of 2020/21 a post implementation review of the strategy was undertaken in order to summarise performance against these strategic principles during the first three years of the five-year strategy.

March 2018 to February 2021 Post Implementation Review

The post implementation review process, involved evaluation of each strategic principle to assess performance against four key questions:

- Did the strategic principle achieve its objective, have positive impact?
- Did the strategic principle have any adverse unforeseen impact?
- Did the strategic principle achieve any additional benefits?
- Did the strategic principle highlight any risk?

	Yes	Partly	No	N/A	Total
Did the strategic principle achieve its objective, have positive impact?	6	2	0	0	8
Did the strategic principle have any adverse unforeseen impact?	0	0	8	0	8
Did the strategic principle achieve any additional benefits?	1	0	7	0	8
Did the strategic principle highlight any risk?	0	0	8	0	8

From the table above it can be observed that:

- 6 strategic principles have achieved their objectives (SPs 1, 2, 3, 4 ,5 and 7)
- 2 strategic principles have partially achieved their objectives (SPs 6 and 8)
- 1 strategic principle achieved additional benefits (SP 7)
- 0 strategic principles failed to achieve their objectives
- 0 strategic principles were found to highlight other risks

The finding of the review can be summarised as follows:

1. Excellent progress can be demonstrated against 6 of the 8 strategic principles, however, the Trust should continue to develop and build on its current strengths

2. Further support and development of the non-medical workforce in respect of research is required

3. Continued engagement with the City-wide integrated approach to innovation is necessary in order to further promote, develop and support innovative ideas from the Trust's workforce

The Trust can take assurance that excellent performance can be demonstrated against the eight strategic principles during the first three years of the five year strategy.

Following Trust-wide review of its Committee structure, a restructured R&D Sub-Committee with direct reporting into the Quality Committee will be established early in 2021/22. The Sub-Committee's remit will include overseeing the development and implementation of a refreshed research strategy.

1. Research Activity at Liverpool Women's NHS Foundation Trust during 2020/21

Our commitment to conducting clinical research demonstrates our dedication to improving the quality of care we offer and to making our contribution to wider health improvements. Our healthcare providers stay up to date with new and innovative treatment options and are able to offer the latest medical treatments and techniques to our patients.

This section summaries the research performance of the Trust, the content of which is detailed in section 2.

1.1 Research Activity Summary for 2020/21

As reported in the Trust's Quality Report for 2020/21 we have continued our efforts to contribute to quality National Institute for Health Research (NIHR) studies and to maintain our numbers of participants recruited to NIHR studies (recruitment accruals). We have also continued to focus our efforts on collaborative research with academic partners to ensure the research we conduct is not only of high quality, but is translational, providing clinical benefit for our patients in a timely manner.

In response to the outbreak of SARS-CoV-2 and the subsequent statement by the Department of Health and Social Care, the set-up of all new clinical research projects and the participation of individuals in the majority of active clinical research projects were halted in March 2020. Exception was made to those studies where discontinuing them would have a detrimental effect on the ongoing care of individual participants involved. Following this decision, the Trust prioritised the delivery of COVID-19 research activity, a key element of the Government's overall response to the pandemic.

As the peak incidence of individuals admitted to hospital with COVID-19 reduced significantly towards the end of May 2020, attention was given to the identification of which of the portfolio of clinical research studies could start to reopen at the Trust. The policy was in line with Department of Health and Social Care and NIHR guidance, "Supporting the restart of paused NIHR research activities". The decision to recommence recruitment or the setup of clinical research studies was dependent upon the following principles:

- Changing national, regional or local guidance
- Delivery and prioritisation of the COVID-19 portfolio of research
- Re-pause of non-COVID-19 research should further waves of infection occur
- Collaborative decision involving the Sponsor, funder and investigator aligned with the Trust's clinical service
- The restart of an individual study could be restricted due to dependence upon other organisations, ie those that provide diagnostic and laboratory services
- Study restart was proportionate, commencing with those that could be easily reactivated
- Limitations with respect to social distancing, patient concerns, remote contact, continued staff absence due to shielding and illness was factored
- Consideration given to the possibility of closing those studies that had been consistently underperforming and could no longer be accommodated by the clinical service

During the latter half of 2020/21 the Trust focused its efforts in restarting contribution to quality National Institute for Health Research (NIHR) studies whilst balancing the prioritisation of the delivery of COVID-19 research activity.

Despite the challenges faced by the Trust, the number of patients receiving relevant health services provided or sub-contracted by Liverpool Women's NHS Foundation Trust in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 1,316 of which, 880 were recruited into NIHR portfolio studies.

Liverpool Women's was involved in conducting 118 clinical research studies across our speciality areas of maternity, neonates, gynaecology oncology, general gynaecology, reproductive medicine, anaesthetics and genetics during 2020/21. This figure also included 15 COVID-19 related studies that were opened and delivered at the Trust during the year. At the end of 2020/21 a further 28 studies were in set up, including 6 industry studies and a further 2 COVID-19 research studies.

There were approximately 187 clinical staff contributing to research approved by a research ethics committee at Liverpool Women's during 2020/21. These staff contributed to research covering a broad spectrum of translational research from basic research at the laboratory bench, through early and late clinical trials, to health systems research about healthcare delivery in the community.

Some members of staff were either funded directly by research income, or the individuals were named on grant applications. Many other members of staff contributed to research within their general job plans. These were named on delegation logs for study activity, for such tasks as the administration of trial medication and performing other interventions including surgery, radiology; collation of questionnaires; dispensing of trial medication; collection and processing of research tissue and blood samples.

Specific examples of the co-operation of clinical staff in helping with research delivery have been:

- An antenatal study investigating the best way to care for women with babies who appear to be bigger than expected and whether labour should be started a little earlier for these women.
- A study assessing at how many weeks of pregnancy is it best to deliver the baby of women who have high blood pressure (hypertension) during their pregnancy in order to minimise the risk of harm to the mother and to her baby.
- A Hewitt Fertility Centre collaboration with ExamenLab Ltd, Belfast investigating the impact of the quality of sperm on fertilisation, embryo quality, pregnancy and miscarriage.
- Co-operation from obstetric, maternity and theatre staff in the delivery of a research study investigating the physiological and pathological effect of different agents, novel substances and biomarkers on myometrial contractility.
- A trial investigating whether infants born at 30+0 to 32+6 weeks gestation who are given full milk feeds initiated in the first 24 hours after birth reduces the length of hospital stay in comparison to IV fluids with gradual milk feeding.
- An ectopic pregnancy diagnosis study undertaken in the emergency room the aim of which is to develop a metabolomics profile analysis in biofluids to detect an ectopic pregnancy in symptomatic women in early pregnancy.

Our research has contributed to the evidence-base for healthcare practice and delivery, and in the last year, 109 publications have resulted from our involvement in research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

1.2 Contribution to National Institute for Health Research

The Trust does not provide funding for research projects. Trust research is funded by the National Institute for Health Research (NIHR), grants (e.g. MRC, HTA and charitable organisations), and industry. All income received is accounted for by the salary costs of the growing research delivery team, research costs and consumables. End of year financial reports are provided to the various funders in order to reconcile funds received against expenditure.

The Trust's annual business planning in collaboration with the North West Clinical Research Network (CRN) took place in March 2021. The CRN provides a large proportion of the funding that supports the research function at the Trust. Due to the unprecedented effect of COVID-19 on usual research activity, the Trust was informed that the 2021/22 baseline funding allocation would be matched with the 2020/21 allocation.

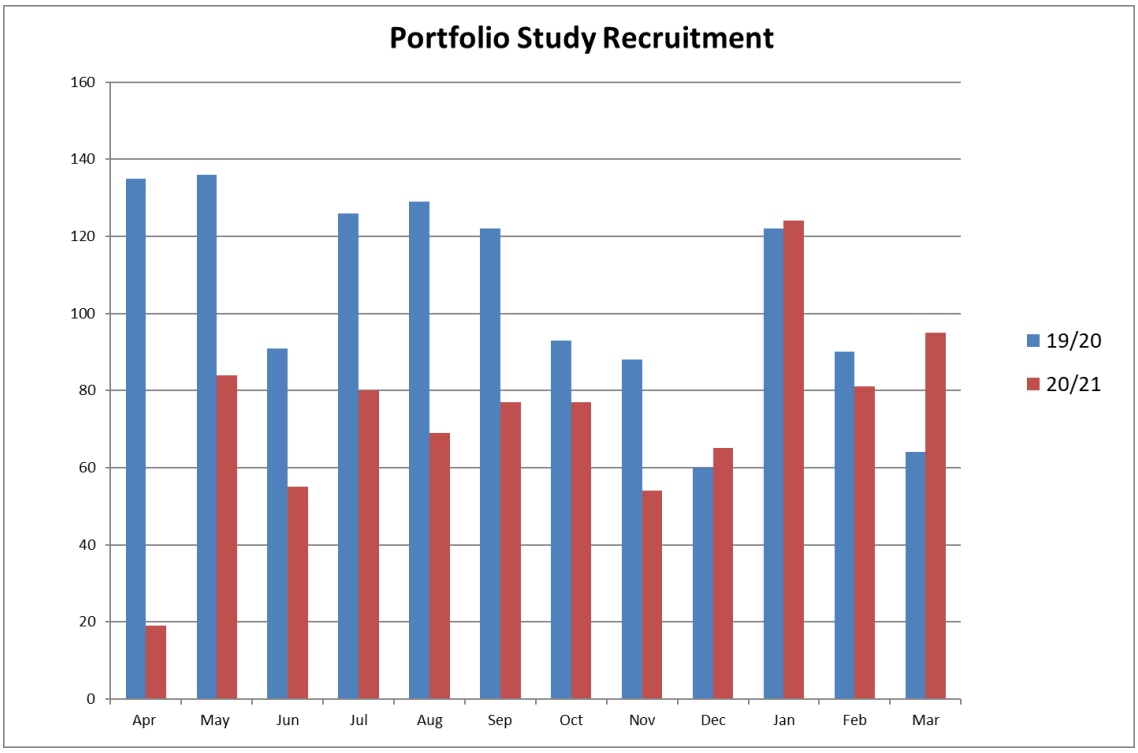
As a government funded initiative, the NIHR Clinical Research Network (CRN) has produced a number of high-level objectives against which Trusts are measured. These objectives allow the CRN to track progress and improvements. The R&D department report performance against these objectives on a monthly basis.

Current and historic performance strengthens the Trust's reputation as a high performing research institution. The following sections illustrate the Trust's 2020/21 performance in comparison with the high level objective metrics set by the Department of Health that apply to this organisation.

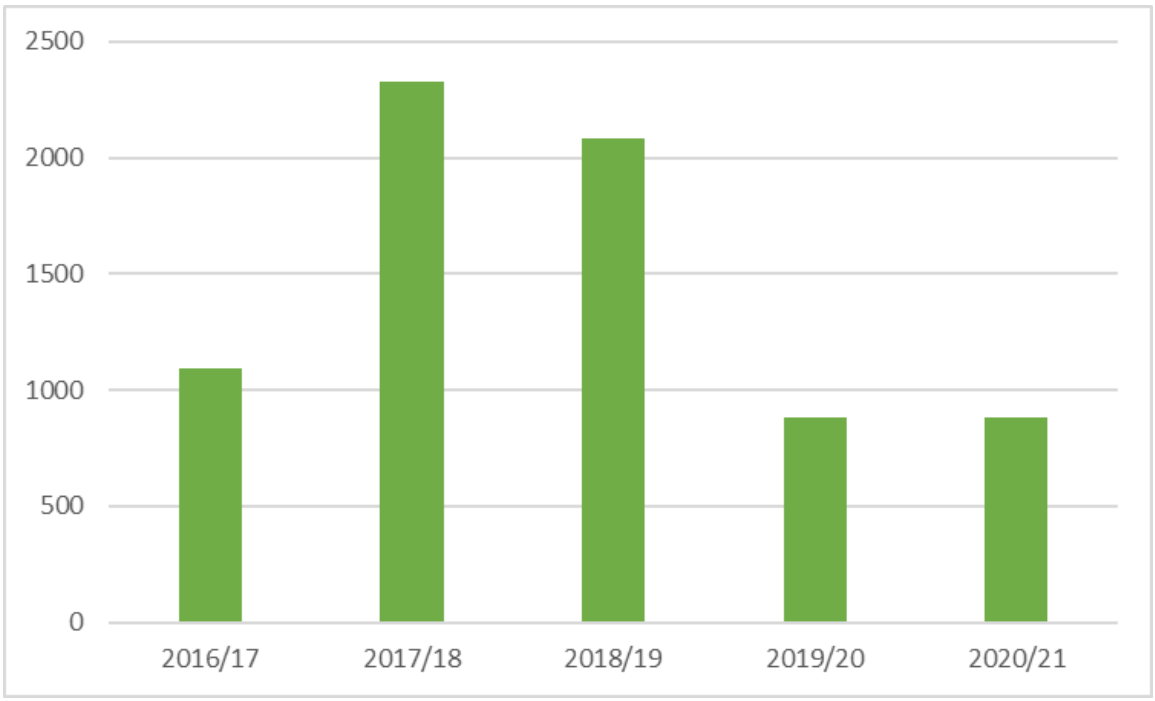
The impact of COVID-19 on the majority of research studies during 2020/21 has resulted in a poorer performance across all HLOs in comparison with previous years. This has been acknowledged by the National Institute of Health Research and will be taken into account when reviewing the Trust's overall performance for the year.

1.2.1 High Level Objective 1 - Number of participants recruited to NIHR research studies

Although during 2020/21 COVID-19 significantly impacted upon the Trust's usual research activity, contribution to COVID related research studies and the proactive efforts to restart non-COVID research resulted in regaining a position comparable with 2019/20. The table below demonstrates the Trust's overall performance of recruitment of participants to NIHR portfolio research studies during 2020/21 in comparison with 2019/20.



The following graph shows a comparison with NIHR portfolio research activity from 2016/17 through to 2020/21 which demonstrates continuing good performance in the number of individuals recruited to NIHR portfolio research during 2020/21. The reduction in the overall recruitment number during the last two years can be attributed to the closure of a large interventional trial and the impact of COVID-19.



If there is a national NIHR portfolio study that the Trust is not recruiting to, which meets our clinical areas of expertise, the Trust can be assured that the feasibility, questions of local leadership, equipoise will have been explored and we are confident there is good reason for not being a participating site. However, we remain vigilant in managing our portfolio, continually exploring feasibility of new studies and anticipating and preparing for replacement studies where studies are due to close following completion of recruitment

1.2.2 High Level Objective 2a – the proportion of commercial contract studies delivering to recruitment target during planned recruitment period

Performing well in industry studies demonstrates that the Trust can deliver research that meets the most stringent regulatory requirements and highlights the continuing commitment to build strong alliances with colleagues outside the Trust to make women and children's research a strong focus for continued investment by the healthcare industry.

During 2020/21, although no commercial studies closed to recruitment in-year, two commercial studies were active and at the year-end a further six were in set up.

1.2.3 High Level Objective 2b – the proportion of non-commercial studies delivering to recruitment target during planned recruitment period

Despite the impact of COVID-19 during 2020/21, performance in respect to this metric has improved, increasing from 46% to 71% in comparison with 2019/20.

1.2.4 High Level Objective 9a – Commercial studies - Date site selected to first recruit – ambition of 80 days

During 2020/21, no commercial studies were opened in-year. However, at the year-end six commercial studies were in set up.

1.2.5 High Level Objective 9b – Non-commercial studies - Date site selected to first recruit – ambition of 60 days

The Trust's performance generally demonstrates a consistent ability to deliver against target, with it taking a median of 54 days from the date selected as a research site to recruiting the first patient (quickest 9 days, longest 90 days).

1.2.6 Performance in Initiating and Delivering Clinical Research

Trusts holding NIHR contracts are required to provide and publish, on a quarterly basis, outcomes with regard to performance in initiating and delivering clinical research trials, including commercial trials. The Department of Health use this reporting mechanism to assess the performance of Trusts. Consequences for unsatisfactory performance may result in a proportion of a Trust's Research Capability Funding (RCF) allocation being withheld.

All NHS providers are required to submit information in two specific areas:

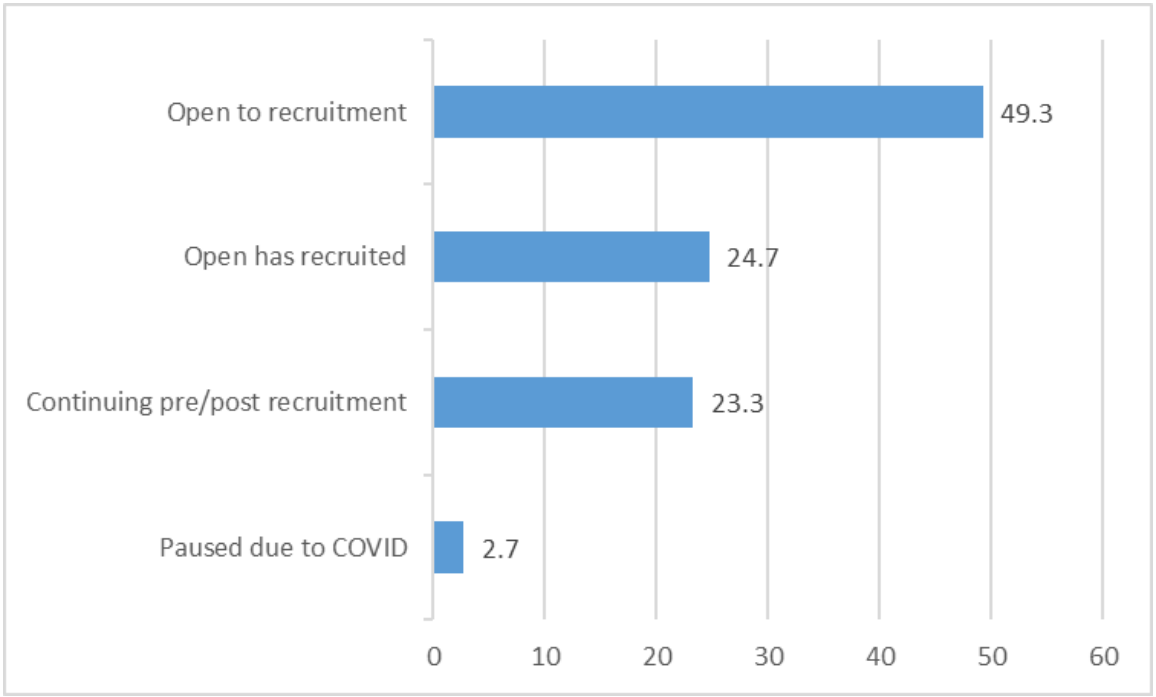
- Initiating clinical research
- Delivering commercial contract clinical research to time and target.

The collection of NHS provider data on initiating and delivering clinical research, is a separate exercise from the ongoing collection of performance data by the NWC CRN against the NIHR HLOs. The overall aim of both exercises is to increase the number of patients participating in research and enhance the nation's attractiveness as a host for research.

Although the national reporting deadlines were initially delayed during 2020/21, the reporting of all outstanding data relating to the Trust's performance has now been submitted and published in line with NIHR Central Commissioning Facility guidance.

1.2.7 Non-COVID Research Re-start

In line with Department of Health and Social Care and NIHR guidance, "Supporting the restart of paused NIHR research activities", (https://www.nihr.ac.uk/news/supporting-the-restart-of-paused-nihr-research-activities/24890) organisations were set a target of 80% of NIHR portfolio research to be restarted by 31st March 2021. At the year-end the Trust's progress was excellent, with only 2.7% of research remaining paused:



1.2.8 COVID-19 Clinical Research

Although the Trust did not provide frontline NHS clinical services for the treatment of COVID-19, since April 2020 15 COVID related studies have been opened and a further study is currently in set-up. A total of 184 participants were recruited to these research studies (recruitment data to health worker studies is unavailable).

COVID-19 clinical research study activity to date at the Trust is as follows:

Project Short title	Study Type	Status
UKOSS COVID 19 in Pregnancy	Urgent Public Health	Open
RECOVERY - Randomised Evaluation of COVID-19 Therapy	Urgent Public Health	Open
COVID-19 ISARIC/WHO Clinical Characterisation Protocol for Severe Emerging Infections (CCP-UK)	Urgent Public Health	Open
Pregnancy and Neonatal Outcomes in COVID-19	Urgent Public Health	Closed to recruitment
COVIDA - A digital wellbeing tool to assess the psychological impact of the COVID-19 pandemic on NHS healthcare professionals	Non-Urgent Public Health	Open
Oxford Astra Zeneca Vaccine Trial	Urgent Public Health	In follow up
The COVID-19 Resilience Project - Studying the impact of COVID-19 on the NHS workforce to guide trauma-informed & psychologically-informed support provision	Non-Urgent Public Health	Open
Impact of detectable anti SARS-COV2 antibody on the incidence of COVID-19 in healthcare workers (SIREN)	Urgent Public Health	In follow up
UKCOGS - UK Covid and Gynaecological Cancer Study Phase 1 – Audit / Phases 2 & 3 - Research	Non Urgent Public Health	Open
Communication Assessment in personal Protective Equipment (CAPE)	Non Urgent Public Health	Completed
When pandemic and everyday ethics collide: supporting ethical decision-making in maternity care and paediatrics during the Covid-19 pandemic	Non Urgent Public Health	Open
SARS-CoV2 viability in the Abdomen or Pelvis and the FEasibility of SURGERY	Non-urgent Public Health	Open
COVID-PREP: COVID-19 Pregnancy Testing Programme	Non-Urgent Public Health	In Set-up
Facilitating Accelerated CLinical evaluation Of Novel diagnostic tests for COVID-19 (FALCON C-19)	Urgent Public Health	Closed to recruitment
ASPIRE-COVID-19 CENTRE: Achieving Safe and Personalised maternity care in response to epidemics - Case studies of eight NHS Trusts in England	Non-Urgent Public Health	Open
COMCOV II Vaccine Trial	Urgent Public Health	In follow up

The "Communication Assessment in personal Protective Equipment (CAPE)", designed and undertaken by Dr Alexander Malin a Clinical Fellow in Anaesthesia investigated the effects of personal protective equipment (PPE) including face masks and visors on verbal communication. As the use of PPE increased in frequency due COVID-19 the study sought to assess how much PPE can limit verbal communication as well as identifying potential methods to overcome these barriers. Dr Malin presented his findings at the combined Mersey & North Anaesthetic Trainee regional meeting and was awarded second place out of 26 presentations. He was also awarded the Jackson Rees Medal from the Liverpool Society of Anaesthetists.

In response to a surge in COVID-19 research activity in Liverpool as a result of the second/third waves, the Trust became actively involved in supporting the Liverpool School of Tropical Medicine with the delivery of the Astra Zeneca / Oxford and the COMCOV II vaccine trials. Research nurses were also deployed to Liverpool University Hospitals NHS Foundation Trust in order to provide support to interventional COVID research trials**.**

2. Performance at Research Leadership

2.1 Maternity

- A new collaborative world-leading programme of research focused on improving the health and wellbeing of children and their families within the Liverpool City Region (LCR) has been awarded funding from the Wellcome Trust. The 'Children Growing-up in Liverpool (C-GULL)' research study is led by Professor Louise Kenny. The data resource will be used to better understand and improve the lives of LCR children and their families. This will be the first newly established longitudinal birth cohort to be funded in the UK for almost 20 years.

  Currently, Liverpool ranks badly in terms of the highest rates of child mortality and conditions such as asthma, type 2 diabetes, epilepsy and risk factors for poor health such as obesity, poor nutrition and low levels of physical activity. To help develop a better understanding of these issues, researchers will collect information from 10,000 babies and their families, starting in pregnancy and over the first years of life, allowing changes in their health and development to be monitored and recorded over time. The information gathered will provide important evidence for policy, practice and research that will ultimately help improve child health and development in the area.

  Due to COVID-19 the launch of C-GULL was delayed. However, initiation of the programme at Liverpool Women's Hospital is planned for early 2021/22, which will bring together citizens, researchers and clinicians across the Liverpool City Region and wider to make one of the largest family studies in the UK.

- COPE: The Carboprost or Oxytocin Postpartum haemorrhage Effectiveness study. The grant award of approximately £1.8 million in response to a commissioned call by the NIHR HTA, supports a 4 year study, which aims to recruit 3,948 women in up to 40 UK hospitals. The study will randomize women following the doctor's decision to give treatment to stop the bleeding caused by PPH. Professor Weeks is the trial lead, with trial management provided by a team from the Clinical Trials Research Centre (CTRC) at the University of Liverpool. Despite the

difficulties facing the team during the pandemic, efforts to set up the trial across the UK commenced in the latter half of 2020/21. It is anticipated that the first patient at LWH will be recruited during the first half of 2021.

- Dr Andy Sharp was successful in securing a grant award of approximately £250,000 funded by the NIHR Research for Patient Benefit programme. PLANES: Placental Growth Factor Led Management of the Small for Gestational Age Fetus, is a feasibility study which aims to establish whether the management and care given to pregnant women who are carrying a small baby can be improved by the use of a blood test (sFlt-1/PlGF ratio). The test could reveal whether the mother's placenta is working as well as it should. The research is expected to commence during Summer 2021.

- During 2019/20, the Trust was awarded approximately £341,765 by the NIHR Health Technology Assessment programme. The funding will support delivery of the FERN – Intervention or Expectant Management for Early Onset Selective Fetal Growth Restriction in Monochorionic Twin Pregnancy research study. It is anticipated that the clinical research study will commence during Summer 2021.

- Professor Zarko Alfirevic holds the post of Associate Pro-Vice Chancellor (Clinical) at the University of Liverpool. Professor Andrew Weeks is currently the lead within the CRN NWC Clinical Research Advisory Group. Dr Andy Sharp holds the post of CRN NWC Specialty Lead for Reproductive Health and Childbirth. Dr Sharp is also the system lead for Obstetrics and Gynaecology at the University of Liverpool.

- Dr Angharad Care and Dr Kate Navaratnam both hold the position of Clinical Lecturer at the University of Liverpool. These appointments are excellent examples of how both the Trust and the University have supported the career advancement of talented individuals.

2.2 Gynaecology

- Professor Hampangama continues with her ground breaking endometrial research supported by specific grant funding awards. During 2018/19, she secured grant funding of £197,039 from the Wellbeing of Women, to support ExPeDITe: Ectopic Pregnancy DIagnosis sTudy. The research study aims to develop metabolomic profile analysis in biofluids to detect an ectopic pregnancy in symptomatic women in early pregnancy. If successful, the results of the research could help to improve the way an ectopic pregnancy is diagnosed and reduce the health risks and stress to women.

- Professor Hapangama together with Drs John Kirwan, Sian Taylor, Purushothaman Natarajan and Lucy Dobson have designed a research study to see whether it is possible to develop an acceptable and easy to collect biomarker-based screening test, to identify those with an increased risk of endometrial cancer among women presenting with abnormal post/peri-menopausal bleeding. If successful it could mean many women could have an early test, at their convenience, to rule out endometrial cancer without needing to be referred to hospital, waiting for a scan, or having more invasive tests.

- Following the procurement of the da Vinci Robotic System at the Trust, the first dedicated women's hospital in Europe to be able to provide minimally invasive surgery to our patients, Mr

Thangesweran Ayakannu has begun a programme of research commencing with a study to determine if surgery by robot-assisted techniques results in better clinical outcomes and is associated with improved quality of life for patients with organ-specific endometrial cancer.

- Dr Nicola Tempest holds the position of Clinical Lecturer at the University of Liverpool. She continues with her contribution to ground breaking research conducting a study examining the current self-management strategies used to ease chronic pelvic pain and the acceptability of using cannabidiol.

2.3 Neonates

- Dr Elaine Neary was successful in securing funding as part of the NIHR Research Scholars Programme to support her research project "Using Novel Echocardiographic Techniques to Facilitate Identification of Preterm Neonates at Risk of Developing Significant Chronic Pulmonary Hypertension".

- Dr Nim Subhedar was successful in securing a place in the NIHR Clinician Researcher Programme. The programme provides funding of £10,000 a year with the aim of supporting established clinicians interested in pursuing and leading their own clinical research.

- Professor Mark Turner is scientific leader of a €140 million pan-European paediatric clinical research network and leads on building interfaces between similar initiatives in Europe, North America and Japan, with clinicians and colleagues in regulators and the Pharmaceutical industry.

- A collaborative study run by the National Perinatal Epidemiology Unit Clinical Trials Unit, funded by the Health Technology Assessment programme within the NIHR and led in Liverpool by Dr Nim Subhedar, aimed to establish whether or not a large Patent Ductus Arteriosus (PDA) in very premature babies should be treated with ibuprofen within 72 hours of birth. The trial closed to recruitment in December 2020.

2.4 Genetics

- Dr Jenny Higgs holds the post of CRN NWC Specialty Lead for Genetics.

- The overall genetics research portfolio is continuing to grow, particularly in respect to rare disease studies. Although the numbers of patients participating in such research studies are small, the time and effort involved in identifying individuals who meet the research study criteria is considerable. Our committed genetics research team have compiled a catalogue of approximately 30 genetic research studies open at the Trust. The catalogue has greatly helped in identifying the type of study each patient would be eligible to take part.

- Dr Vicki McKay has been successful in generating a number of important collaborations in order to further her research work into aortic disease and genetic syndromes. Collaborations include: aortic surgery and genetic syndromes (LHCH and UoL), defining surveillance for aortic disease (University of Leicester), aortic surgery and psychological impact (St Bart's), quality and efficiency in cardiovascular genetics (University of Chester).

2.5 Hewitt Fertility Centre

Joint Hewitt Fertility Centre and R&D monthly meetings are continuing to take place and have been instrumental in continuing to drive forward the HFC research agenda.

- Mr Andrew Drakeley has been successful in securing funding for the STOP-OHSS (Shaping and Trialling Outpatient Protocols for Ovarian Hyper-Stimulation Syndrome): A feasibility study and randomised controlled trial, with internal pilot, to assess the clinical and cost-effectiveness of earlier active management of OHSS. Dr Drakeley is a co-applicant in this NIHR HTA funded project. The first phase of the trial commenced in the last quarter of 2020/21.

- Mr Andrew Drakeley has also been successful in securing funding for the LOCI Trial: Letrozole or Clomifene, with or without metformin, for ovulation induction in women with polycystic ovary syndrome. Dr Drakeley is a co-applicant in this NIHR HTA funded project. The trial opened to recruitment in the last quarter of 2020/21.

- A collaborative research project between the Trust and ExamenLab Ltd, Belfast commenced recruitment in January 2021. The aim of the research is to study the associations between sperm quality and the impact that this has on fertility diagnosis, fertility treatment, embryo quality, pregnancy and miscarriage. It is hoped that findings can be used to improve infertility treatment or current therapies.

- In 2019, Dr Daphne Chong, Sub-speciality Trainee in Reproductive Medicine was awarded a £5,000 Ferring STIRMAS research grant. The grant will be used to support her research project which aims to evaluate the biospecimens for oocyte and embryo growth in low and high responding patient groups undergoing IVF treatment, in order to identify specific differences in the microenvironment which could be used for the development of potential predictive biomarkers that predicts the outcome of fertility treatment.

2.6 University of Liverpool

- ***Harris Wellbeing Pre-term Birth Centre***

  In collaboration with the Centre for Women's Health Research, the Trust continues to host the Harris Wellbeing Pre-term Birth Centre, led by the Director, Professor Zarko Alfirevic and Co-Director, Professor Susan Wray. The Centre's focus is developing personalised treatments for all pregnant women who experience or are at risk of preterm birth. The Centre acts as an international hub for research, promotes best clinical practice related to preterm birth, and provides cutting-edge research training for early career researchers committed to preterm birth research. In light of the COVID-19 pandemic an additional no cost extension was approved by Wellbeing of Women and a revised end date of 30/09/2021 was agreed. Four work packages are currently underway details are as follows:

  Biomarker of preterm birth - the central component within this work package has been a biomarkers of preterm birth cohort study, which recruited 298 women with previous preterm birth (under 34 weeks) and 270 women with previous healthy pregnancies. The final analysis stage will be focused on linking detailed pregnancy outcome data to the results obtained from blood and

vaginal secretions samples to assess how the data interact, and whether or not there are any indicators that can predict, and prevent, preterm birth in a better way.

Muscles - Researchers continue to explore the timing and dosage of different drugs applied to uterine tissues as well as investigating how the uterine environment (pH, levels of oxygen) affects their actions. Findings from studies exploring the effects of combining different drugs on contractions are in preparation for publication. Other work has included a gene study to explore differences in the womb of women carrying twins to those carrying just one (singleton) baby. The results of the study showed there was very little difference between singleton and twin pregnancies except for between preterm singletons and term twins where there is likely to be the most difference in the amount of stretch on the uterus. A methodology paper identifying the most appropriate genes to use as reference genes in studies exploring gene expression in human myometrium was published, which will make a useful contribution to the uterine research field

Evaluating different preventative strategies by research synthesis - the final deliverable of this work package is the publication of a network meta-analysis. The work is now complete and has been submitted for publication in British Medical Journal (BMJ). The review included over 100 randomised clinical trials to summarise evidence for treatments for women with high risk of preterm birth due to short cervix or prior history of preterm birth.

Drug delivery - Dr Andrew Sharp and Dr Sarah Arrowsmith, along with Dr Tom McDonald from the University of Liverpool's Chemistry department have submitted an application to The Engineering and Physical Sciences Research Council (EPSRC) to study different formulations of current therapies as nanomedicines in the uterus, to find more effective treatments, as well as look more closely as its actions in the cells of the uterus to gain a better understanding of how these nanomedicines work. They anticipate that these new formulations would offer a safer and more effective treatment for preterm labour.

Other notable work - The Harris Centre is committed to ensuring synergy between patients and research and has an established Patient and Public Involvement/Engagement Group 'Liverpool Babies' who contribute to the ongoing cycle of clinical research development, management, delivery and dissemination. As part of the University of Liverpool's response to COVID-19, the Liverpool Babies group have been instrumental in the design of a new research study COVID-PREP 'Pregnancy Testing Programme'. The study will determine the proportion of women booking in their first trimester of pregnancy (n=16,000) who have positive SARS-CoV-2 serology in order to correlate the risk with respect to maternal and neonatal outcomes.

- ***Perinatal Mental Health***

Pauline Slade, Professor of Clinical Psychology at the University of Liverpool continues to lead on a number of ground-breaking psychological research projects, namely:

- *Perinatal Access to Resources and Support: a Feasibility Study with External Pilot (PeARS):* The study, funded by CLAHRC, aimed to check the feasibility of a simple intervention based on three evidence based components to improve uptake of perinatal support for women in neighbourhoods with high deprivation. Outputs to date include four presentations and one paper.

- *Fear of Childbirth: Developing an evidence-based, usable and acceptable tool for UK maternity services (FOCUS*): The project, funded by Liverpool CCG aimed to develop a clear definition of the fear of childbirth construct; evaluate the utility and acceptability of existing measures for fear of childbirth with a UK sample; and, determine and implement where necessary, any requirement for modifications to current measures for fear of childbirth, for use with a UK sample. Outputs to date include three presentations and four papers.

- *Programme for the prevention of posttraumatic stress disorder in midwifery (POPPY):* The project, funded by Health Education North West, developed and evaluated the feasibility of an educational and supportive package for midwives, aimed at reducing the probability that work-related events are perceived as traumatic, that posttraumatic stress responses develop, and to ensure that access to psychological input for those with clinical PTSD is facilitated. Outputs to date include twelve presentations and three papers. In February 2021, the team were invited to submit case studies for maternity staff support systems for consideration by the World Health Organisation.

- *Psychological health and relationship Experiences After vaginal Childbirth: The effects of experiencing perineal cuts or tears (PEACH):* The aim of this study, funded by the University of Liverpool, was to explore the effects of different degrees of perineal trauma on women's experiences of childbirth, perineal pain and their psychological and emotional health in the first nine months after they had given birth. Outputs to date include one presentation and two papers.

- *Preventing Post Traumatic Stress Disorder: the Stress and Wellbeing after Childbirth Study (STRAWB2)":* This definitive trial, funded by the NIHR Research for Patient Benefit programme (£348,363), compared self-help material with usual care for women screened to be at risk of developing Post-Traumatic Stress Disorder (PTSD) after childbirth. The trial successfully recruited to time and target and within budget. Outputs to date include seven presentations and one paper.

- *Post-traumatic stress disorder following childbirth*: A systematic review of clinical effectiveness of psychological interventions, and metasynthesis of barriers and facilitators to uptake of care. Outputs to date include one paper.

- *Coping with the Uncertainties of Childbirth (CUBS):* The feasibility and acceptability of a single-session of Acceptance and Commitment Therapy (ACT) intervention to support women self-reporting fear of childbirth in a first pregnancy. The study has recently been completed and a paper has been submitted for publication.

- *INDIGO* – the study funded by the Welling of Women and in collaboration with Professor Andrew Weeks sought to better understand the trauma-based experiences that obstetricians and gynaecologists face, and the contributing factors that these experiences have on burnout. The results of the study are currently being adapted into joint RCOG / RCM guidelines led by Professors Weeks and Slade.

2.8 International Research

- The Centre for Women's Health Research (based at Liverpool Women's Hospital) hosts the **Cochrane Pregnancy and Childbirth Cochrane Centre**. The Cochrane Centre is an independent, international not-for-profit organisation, dedicated to making healthcare readily available worldwide. Pregnancy and Childbirth is one of 53 Cochrane Review Groups and was the first group to be formed. It produces and disseminates systematic reviews of healthcare interventions and promotes the search for evidence in the form of clinical trials and other studies of interventions. Cochrane produces high quality systematic reviews which are published monthly as part of the Cochrane Library. Sub-sets of Cochrane reviews published in the Cochrane Library are also published in the WHO Reproductive Health Library. The Group have also produced a Cochrane Pocketbook which allows doctors, midwives, students and parents to quickly access the best evidence for the care of pregnant women.

- The **Sanyu Research Unit** which was established in 2012, is directed by Professor Andrew Weeks and has a specific remit to improve maternal and newborn health by developing and evaluating innovative, cost-effective technologies and approaches that can be adapted in both high and low resource settings. Due to its co-location at the Trust, it is in the ideal situation to undertake maternal health research here in the UK. This important proof of concept research can be translated into either research studies in Low and Middle Income Countries (LMICs) to provide appropriate context to the clinical setting or translated directly into clinical practice. Some of the activities on-going within Sanyu during 2020/21 are:

  - *MOLI Study* (funded jointly by MRC/Wellcome/DfID: £1,160,007). This mixed methodology trial consists of a cohort study followed by an open label randomized trial comparing oral misoprostol alone with oral misoprostol followed by oxytocin in women induced for hypertension of pregnancy. In January 2020, the study started recruitment within three public hospitals location in Nagpur, India. Due to the COVID-19 pandemic recruitment was suspended for a number of months. However, to date 143 patients have been recruited to the cohort study and 98 to the randomised study.

  - *Baby Saver Tray* (funded by Sir Halley Stewart Trust: £14,000 and Canada Grand Challenges $100,000 CAD). Infant mortality and morbidity in LMICs is a major health problem. Evidence based practice suggests that keeping the mother and baby as close as possible during the immediate post-partum period, which includes delaying cord clamping, will bring benefits for both mother and baby. The Baby Saver Tray (BST) led by Mr James Ditai at the Sanyu Africa Research Institute, Mbale, Uganda, follows on from Professor Weeks' earlier development work on the BASICS trolley at the Trust. A feasibility study to test the device was conducted between August 2020 and February 2021 in Uganda.

  - *The Babygel Study* (funded by European and Developing Countries Clinical Trials Partnership (EDCTP), €5.9m/£5.2m). The principal objective of this study is to determine whether the provision of alcohol-based hand rub (ABHR) to pregnant women for postnatal household use is effective for the prevention of severe illness or death during the first 3 months of life. Over 60 months, pregnant women will be recruited from homes within 72 study villages in Mbale region, Eastern Uganda. Start of recruitment was delayed until January 2021 due to the COVID-19 pandemic.

- *Maternal Self-Assessment Tool* – As the global provision of post-natal care is poor, particularly in Uganda where it has the poorest coverage in the continuum of care, the study will look to optimisation of immediate maternal post-natal care in healthcare facilities through the development and validation of a maternal self-assessment tool for post-natal Ugandan women.

- *Uterine Acidosis Study* - Despite the implementation of various therapeutics and surgical measures to reduce the rates of post-partum haemorrhage (PPH), PPH remains the main cause of maternal morbidity and mortality in low resource settings. This study will investigate the effect of uterine acidosis on myometrial contractility and post-partum haemorrhage at caesarean section.

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- Dr Carol Kingdon, Reader in Medical Sociology at the University of Central Lancashire is research active within the area of Midwifery and Maternal Child Health. She has contributed to a global series on optimising caesarean section use published in The Lancet. This research has also informed the new World Health Organisation Guideline recommendations on non-clinical interventions to reduce unnecessary caesarean sections. Other international projects undertaken during 2020/21 include:

  - *ASPIRE-COVID-19: Achieving safe and personalised maternity care in an epidemic*. Funded by UKRI-COVID-19 Economic and Social Research Council. The aim of this study is to document organisational changes in, responses to, and outcomes of, maternity and neonatal care provision in the context of the COVID-19 pandemic; undertake a case-specific and cross-case analysis of the findings; identify 'best practice' in terms of optimising safe and personalised maternity and neonatal care; create a model of what works in a pandemic, and a toolkit to help organisations to respond rapidly in the context of safe and personalised care

  - *Assisted Vaginal Delivery (AVD) to facilitate complicated deliveries and reduce unnecessary caesarean sections*: a systematic review. Funded by UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), Department of Reproductive Health and Research (RHR), World Health Organization.

  - *Q-Moli:* An alongside qualitative study exploring patients' and health care professionals' expectations and experiences of labour induction with misoprostol and oxytocin for hypertension in pregnancy in India. Funded by MRC/DfID/ Wellcome Trust Joint Global Health Trials Fund.

  - *QUALI-DEC:* Reducing unnecessary caesarean section through QUALIty DECision-making by women and providers in low and middle income countries (Argentina, Burkino Faso, Thailand, Vietnam). Funded by EU Horizon 2020. Technical Advisory Board member.

- Professor Mark Turner is the scientific leader of CONECT 4 Children, an academic consortium that has been selected to work with a consortium of 10 large pharmaceutical companies on a €140 million, 6 year project to develop a sustainable pan-European research network that integrates research activity in 20 countries, 24 European Reference Networks, 25 clinical specialties, and liaises with networks in 6 other high income countries. He also is also Co-Director (Europe) of the International Neonatal Consortium which has developed global standards for

research about medicines in neonates and is using real world data from 300,000 babies to develop a disease progression model for chronic lung disease of prematurity and reference ranges for laboratory values in neonates.

3. Innovation

Searching for and applying innovative approaches to delivering healthcare must be an integral part of the way the NHS does business. Doing this consistently and comprehensively will dramatically improve the quality of care and services for patients.

During 2020/21 the Trust has continued to benefit from outsourced expert support from the 2Bio Impact Science team. 2Bio's service model is based on identifying problems and solutions; developing, testing and implementing the solutions and then supporting their adoption and dissemination.

Projects

- Research led by Professor Colin Morgan has led to the development of an idea for a new parenteral nutrition product that comprises a specific amino acid formulation concentration. The research team, together with the R&D Department and a team of expert patent attorneys worked to further protect the IP by formally submitting an international patent allowed the team to publish the preliminary data without other parties using the information for commercial gain whilst additional scientific analysis is undertaken. A programme of further work to examine the changes in gene expression present in arginine supplemented infants <30 weeks' gestation between day 3 and day 10 of postoperatively is being planned. The changes in gene expression will be compared with those seen between day 3 and day 10 in unsupplemented preterm and term infants.

- Following the appointment to the post of Consultant in Sexual and Reproductive Health, Dr Paula Briggs in association with Robinson Healthcare, has developed a speculum to assist in the diagnosis of urogenital atrophy for use in both primary and secondary care. The validation of this objective method of diagnosing urogenital atrophy and assessing response to treatment will facilitate ongoing research in relation to this condition.

- The Trust has entered into preliminary discussions in respect of a collaboration with Liverpool John Moores University. An 'intelligent mattress' has been developed that will deliver the c-tactile afferents preferred forces and velocities of gentle massaging touch that a preterm would have experienced in-utero. A programme of research will be designed aiming to address the question of how to maximise preterm infants' neurodevelopmental outcomes. The hypothesis is that this 'Mattress' device promotes experiences that are conducive to normal development. An application to the NIHR Invention for Innovation funding programme is in development.

4. Summary of Local and National Partnerships

4.1 Health Education Institutions

Although the Trust has a long history of significant collaborations with the University of Liverpool, concerted efforts have been made to develop existing partnerships with other HEIs.

Discussion between researchers at LWH and **Liverpool John Moores University** have continued with the aim of igniting new collaborations/joint working, identifying combined research strengths, exploring important research questions and strengthening existing networks. Some of the early indications of success have been:

- Proposal to develop a tactile sensory array 'intelligent mattress' to deliver moving stroking touch to preterm babies in the NICU at velocities and forces that research has shown is optimal for c-tactile afferents.

- Professor Andrew Weeks in association with Professor Valerie Fleming will explore postnatal depression in a large cohort of Ugandan women, as a part of the EDCTP BabyGel project. 6000 women will be recruited over 2 years with postnatal assessments of depression undertaken during the antenatal and postnatal periods.

- A research study looking at the role of physical activity on metabolic health during pregnancy, specifically trying to understand the role of obesity and health status during pregnancy and whether these are related to habitual physical activity levels.

Following the appointment of Dr Julie Abayomi as Associate Head of Applied Health & Social Care at **Edge Hill University**, the Trust has been able to further strengthen its research partnership with the institution, for example:

- Dr Abayomi in collaboration with Hazel Billson, Maternal & Women's Health Dietitian (LWH) and Dr Andy Sharp (LWH/UoL) will undertake a study examining dietary intake and weight changes of women with a multiple pregnancy. Funding of £12,158 has been successfully obtained from the British Dietetic Association.

- In January 2021, the University confirmed funding for two PhD studentships; one to research the dietary intake and weight change & physical activity of BAME pregnant women, then comparing observational data to pregnancy outcome data; and the other to evaluate the Mamafit programme with regard to diet, physical activity & perinatal mental health in pregnant/postnatal women. Due to the impact of COVID-19, these projects will be delayed until later in 2021.

4.2 Liverpool Health Partners (LHP)

The overarching aim of Liverpool Health Partners is to bring together leading organisations within the City region in order to develop world-leading research which:

- addresses the needs of the local population
- plays to region's strengths and fulfils its research potential

- establishes an optimal collaborative framework through which LHP partners can work with one another and with other relevant stakeholders to shape and deliver the strategies for LHP's programmes.

In order to achieve these aims and objectives specific programmes and themes have been strategically formulated with key, relevant expertise to positively impact the population, locally and globally, namely:

- *Programmes*: Starting Well; Living Well; Aging Well

- *Themes*: Maternal & Neonatal Health; Babies, Children & Young People; Physical, Mental & Social Wellbeing; Infection; Pharmacology & Therapeutics; Cardiovascular Disease; Cancer; Neuroscience; Digital & Health Informatics

The positive benefits that have been derived from the partnership are that for the first time there is a possibility of having a City-wide strategic view with interactions from across all organisations, each having an equal share with respect to shaping the vision. The Trust has been actively involved with the Starting Well programme, with Professor Colin Morgan having been appointed as the Deputy Programme Lead. The programme has already been the catalyst for extremely useful dialogue between colleagues with specific specialisms, such as:

- Preparation of a multi-centre neurosurgical RCT of ventricular lavage in PHVD – lead at LWH: Dr Mani Chandrasekaran
- Development of neonatal neuroimaging protocols for clinical trials and neurodevelopmental studies in anticipation of the new NICU ward opening at Alder Hey thus enabling close alignment of research from birth to childhood between Alder Hey and the Trust – lead at LWH: Dr Mani Chandrasekaran
- Hugh Greenwood funding award for the "MicroRNAs as biomarkers and new molecular targets for the prediction of spontaneous preterm birth pilot study" – lead at LWH: Dr Angharad Care
- PhD student project addressing geographical inequalities in neonatal and infant mortality using linked routine data – LWH lead: Dr Nim Subhedar
- Clinical Research Fellowship to support "An exploratory study of Arginine Supplementation and the Postoperative Immune REsponse (ASPIRE) in neonates" – LWH lead: Professor Colin Morgan

Discussions with regard to the development of pain and mental health, perinatal mental health and recurrent miscarriage research collaborations will continue into 2021/22.

The response to the COVID-19 pandemic has demonstrated a willingness to pool and manage collective resources. The Strategic One Liverpool Partnership for COVID (STOP COVID), a city-wide framework which aims to support, accelerate and assess research-based innovations within the Liverpool City region has initiated a single approval route for all grant applications for COVID related research, to ensure that the University and NHS partners where applicable have the capacity to undertake research safely. The accompanying Gold / Silver / Bronze research command and control process has provided a structured approach to cross-organisational discussion and decision. This has created an opportunity to learn from the experience, build upon the platform of excellent collaboration and develop improved future ways of working.

4.3 Development of the Nurse, Midwife and Allied Health Professional Research Workforce

The Trust's new Nursing, Midwifery and Allied Health Professional Strategy was launched in January 2020. Within the strategy it was recognised that healthcare institutions that embrace research can demonstrate better clinical outcomes and therefore it is important that nurses, midwives and AHP's are included in efforts to foster a research culture.

During 2020/21, the following projects have been developed:

- Gillian Houghton, Consultant Midwife is the lead for a number of research programmes of work at the Trust, including:

  - Principal Investigator for the Optibreech Study – which has involved setting up a Breach Birth Team in preparation for a national RCT
  - Principal Investigator for "ASPIRE-COVID-19: Achieving safe and personalised maternity care in an epidemic".
  - Collaboration with the Department of Psychology at both The University of Liverpool and Liverpool John Moore's University on several fear of childbirth workstreams. A screening tool for tokophobia and interventions to support women with high levels of fear are currently being developed.
  - Working with Liverpool and Lancashire Maternity Voices Partnerships to develop a research tool to explore women's views of information provision and decision making on induction of labour

- Cheryl McNamara, Advanced Nurse Practitioner, Emergency Room - "Can women identify their fertile period during the menstrual cycle?"
- Katy Stevenson, Embryology STP – "Evaluation of clinical outcomes following a reduction in 37°C incubation time during semen preparation for IVF treatment".
- Shani Tatton, Embryology STP – "Development of a traffic light system for retrospective use and as a prognostic tool".
- Andrew Allen, Andrology STP – "Inter and Intra-Individual variability in sperm morphology assessment using both 'wet' and stained preparations".
- Olivia Sanys, Andrology STP – "Can the MiOXSYS™ improve the diagnostic accuracy of routine semen analysis at the Hewitt Fertility Centre?"
- Sofya Mahmud, Embryology STP – "Validation of computer-assisted algorithms using Artificial Intelligence (AI) for embryo selection".
- Lowri Underhill, Embryology STP- "Have clinical outcomes improved following changes to vitrification/warming at the Hewitt Fertility Centre?" +
- Bethany Muller, Embryology STP – "Assessment of insemination concentration for conventional in vitro fertilisation".
- Tamanda Timvere-Hartley, Andrology STP – "Introduction and use of Computer Aided Semen Analysis (CASA) in therapeutic semen analysis at the Hewitt Fertility Centre"

For the past 5 years, the research and development department has hosted student research midwives and nurses within a dedicated research placement. By sensitising these students to

research within their training, it will thus help develop potential researchers of the future. Due to the COVID-19 pandemic this indicative was suspended during 2020/21.

4.5 Research Training

During 2020/21, the Trust hosted 21 students undertaking a research project as part of a higher educational degree.

5. Opportunities for Strengthening RD&I Across the Trust

There is scope to strengthen research, development and innovation within each Division by instituting RD&I leads within each clinical area. Regular review of divisional reports by the R&D Sub-Committee and the Quality Committee will ensure oversight of progress within each area.

In order to increase capacity and strengthen the support for the delivery of research across the Trust, continued and increased collaboration with the Harris–Wellbeing Preterm Birth Centre / Centre for Women's Health Research should be encouraged. A number of activities can be successfully and conveniently supported, all to the Trust's benefit, for example:

- Management and coordination of RD&I studies and evaluations led by the Trust, ensuring adherence to research governance and quality assurance requirements
- Management of RD&I data within the Trust and beyond, particularly building upon the work of CIPHA (Combined Intelligence for Population Health Action)

The Trust needs to develop a comprehensive approach to innovation. Effective innovation will need to combine expertise in commercial processes, market assessment, intellectual property, patents etc and integrate with three essential components:

- Identification of clinical needs
- Effect product development
- Deployment of products into clinical practice

At present the Trust provides support for product development by buying in expertise for commercial processes, intellectual property etc, and so there is a need to upgrade this approach, for example:

- Undertaking scoping opportunities within the organisation, with a realistic assessment of likelihood of clinical impact and commercial success
- Identifying the Trust's appetite for novelty, investment, and risk
- Specifying the Trust's preferences for in-house expertise, outsourcing, and collaboration – and then identifying and deploying the resources to meet these requirements

6. Report Conclusions

Research continues to demonstrate favourable outcomes to the Trust, its staff and its patients. The governance arrangements for research within the Trust are operating well. Good management of

research performance has produced measurable results which must be maintained in order to maximise the benefit of external support. Positive improvements continue to be made in accordance with the overarching Trust research strategy.

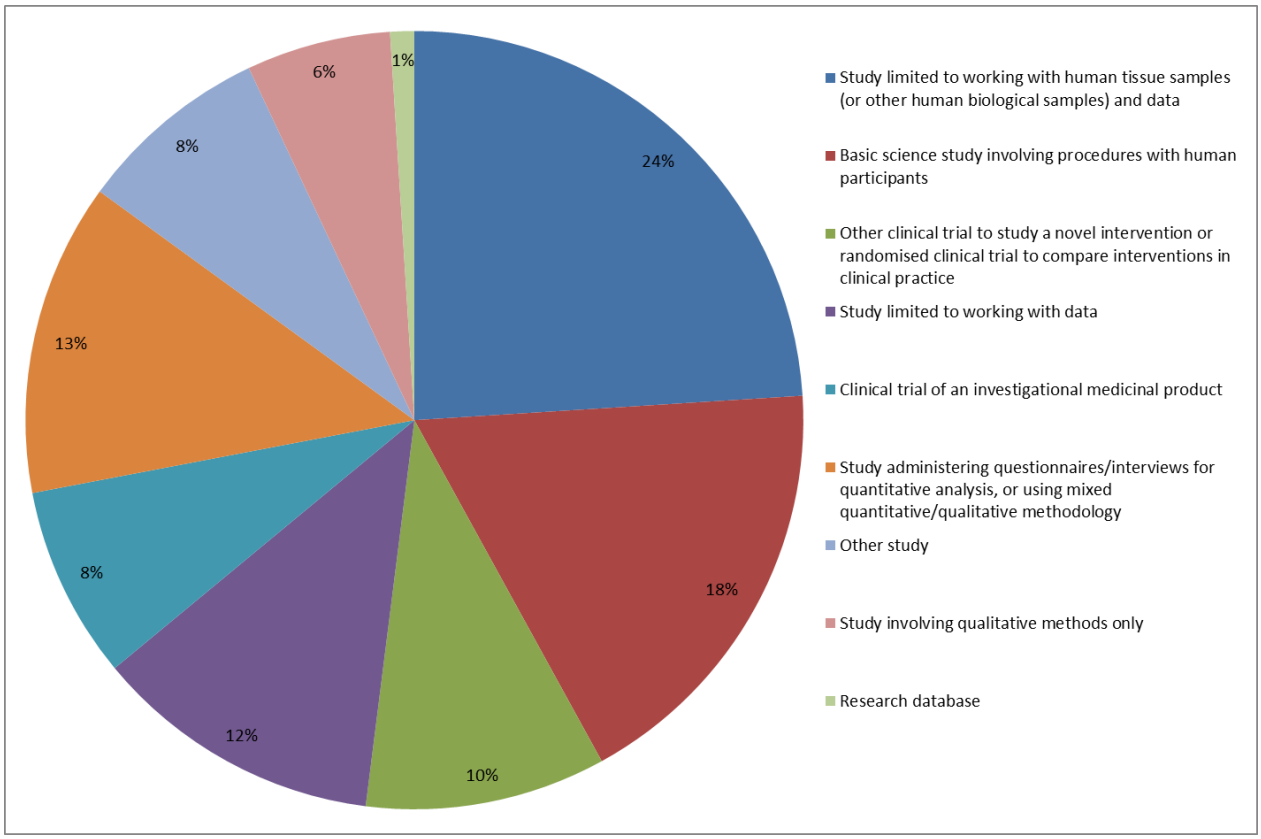
External partnerships can be demonstrated as being very helpful in driving forward the Trust's own research agenda. In particular, partnerships with Higher Education Institutes continues to be an effective way to host high quality, high impact research. Therefore, efforts should be made to maintain and increase such collaborations.

Although the implementation of the City-wide joint research service has been at times challenging, by actively engaging and driving forward discussions and decisions, the changes have enabled and strengthened the Trust's ability to deliver and lead research. As evidenced by the City-wide response to the COVID-19 pandemic, lessons can be learned, and experience built upon to improve collaboration and achieve the Trust's own research aims.

The considerable opportunities for strengthening RDI across the Trust need to be evaluated.

APPENDIX 1 – Additional Information

Tables 1 & 2 – Projects active at LWH by study type



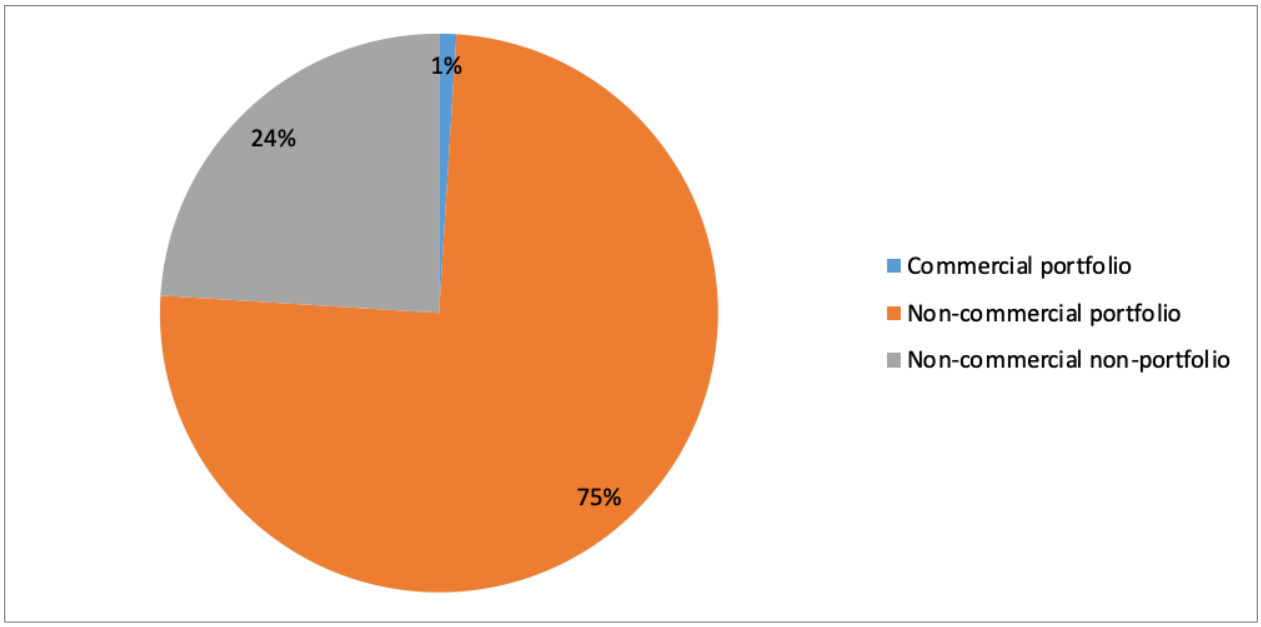


Table 3 – Studies by speciality at LWH

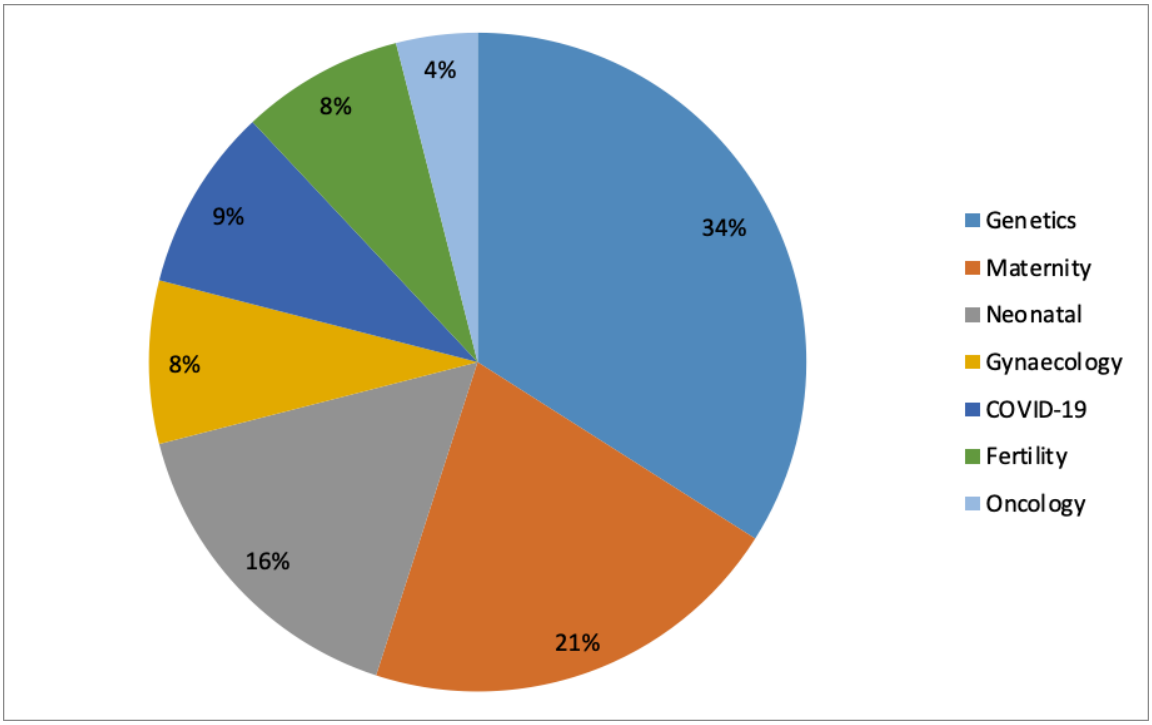
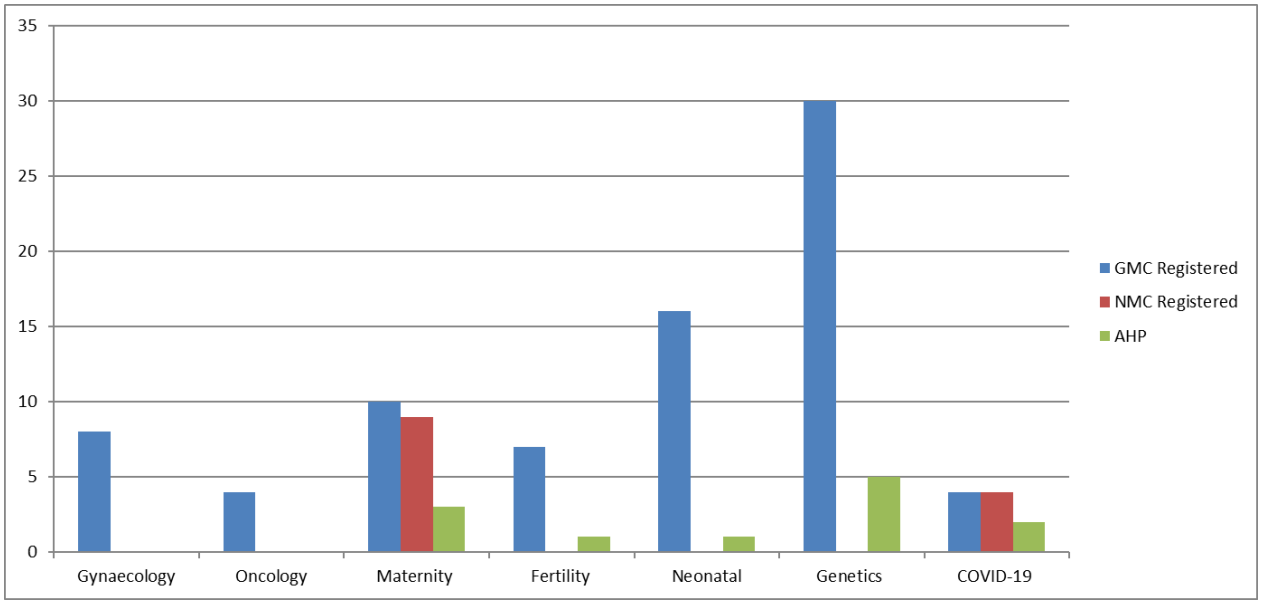


Table 4 – Lead inviestigator by job type at LWH



Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/75b*		Date: 02/09/2021	
Report Title	Annual Health and Safety Report 2020/21			
Prepared by	*Tracy Bryning, Health and Safety Manager*			
Presented by	*Gary Price, Chief Operating Officer*			
Key Issues / Messages	*This report gives an overview of compliance and governance assurance regarding the Health and Safety arrangements, activities, performance and improvements for Liverpool Women's NHS Foundation Trust (LWH) for the financial year 2020/2021.*			
Action required	Approve ☐	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to note the Trust's Health & Safety Annual Report for 2020/21.			
Supporting Executive:	*Gary Price, Chief Operating Officer*			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	June 2021	COO	Recommended to the Board for assurance purposes.

EXECUTIVE SUMMARY

This report gives an overview of compliance and governance assurance regarding the Health and Safety arrangements, activities, performance and improvements for Liverpool Women's NHS Foundation Trust (LWH) for the financial year 2020/2021.

The opening months of 2020 were challenging in light of the covid-19 pandemic and constantly changing guidance, collaborations between the HSE, PHE and TUC. A gap highlighted in the Trust's arrangements for fit mask testing was adequately addressed with the purchase of highly accurate Porta count quantitative fit testing machine in addition to the four qualitative testing kits already utilised. The need for additional and updated health and safety related policies and standard operating procedures in reflection of the pandemic were addressed in a timely manner and remain under regular review.

All areas were required to undertake covid secure risk assessments in order to ensure that all covid related risks were reduced and achieve a covid secure certificate. Managers are responsible for the regular review and update of these risk assessments and we are required by the Health and Safety Executive to publish each risk assessment. A dedicated Health and Safety intranet page was created, accessible to all staff, where relevant health and safety guidance, documents and risk assessments are maintained.

Trust wide risk assessments remain an ongoing process including where significant changes have been made to process, accommodation or new practices. The introduction of the Alcumus Sypol COSHH management software across the Trust has been successful and replaces a precarious paper-based system of COSHH risk assessments.

The work plan in Section 10 details plans for future improvements and activities, demonstrating the Trust's commitment to effective health and safety management and continuing improvements in health and safety performance.

Whilst slower progress has been made in this reporting period, hindered by the pandemic, in relation to the overall health and safety management system, there remains some scope for improvement, particularly in relation to risk assessment reviews, audit and communication.

Key Objectives and Current Situation

1. Health and Safety

1.1 Risk Assessments & Audits

i. Mandatory annual health and safety workplace assessments were interrupted by the onset of the pandemic at the beginning of 2021, when historically Trust wide annual health and safety workplace audits would have been completed. Managers were expected to complete comprehensive covid secure risk assessments of all areas, as directed by the Health and Safety Executive. An overarching organisational covid secure risk assessment was also completed.

ii. The Health and Safety Manager has recently revised a rolling programme for these audits which allows her to be able to undertake the workplace audit in association with the service/departmental manager; enabling some issues to be addressed on the spot, supporting the manager and enhancing their knowledge of health and safety by discussing any gaps found and why they have to be prioritised. This method also enabled the Health and Safety Manager to engage in all areas across the sites and departments.

iii. A suitable solution for electronic risk management of health and safety documentation has been procured, led by the Head of Governance and Quality, who has invested in the Risk and Safety Management Module within Ulysses. The Health and Safety Manager has worked with the Governance Officers to develop the module in readiness to share with all areas. This new safety management software system was close to being deployed on in April, 2020; however the decision was taken to delay the training and access to the module due to the on-going covid-19 situation. This project has been made a priority action for early 2021/22.

The benefits of this investment include:

- Ulysses is fully supported by both I.T. and the Governance Risk Team
- All staff are familiar with its functionality
- There are no limits to user licences
- Training is fully supported
- It is fully customisable and we would benefit from other users development of the module
- It can manage any of our risk assessments; staff will be able to use their existing log in details to complete annual departmental audits and actions, risk assessments, etc.
- The module links to relevant incidents, risk register entries or risk assessments and provides an overall compliance dashboard for each individual element e.g. fire, water, COSHH, DSE, injuries, sharps and so on
- Easy to interrogate from a reporting perspective and matches corporate reporting for incidents, risks, safeguarding, legal, alerts and complaints

1.2 Fit Mask Testing

i. **Overview**

The Risk and Patient Safety Manager took the lead for ensuring all staff who required to be fit mask tested were tested and assisted in the procurement of appropriate forms of mechanical and non-mechanical hoods, ventilators, masks and fit mask testing equipment. To facilitate this testing, the Trust has invested in external training to grow the number of fit testers to 32. During the last 12 months, there have been 972 fit tests completed, with 760 total passes across the Trust.
To facilitate this testing, the Trust has invested in external training to grow the number of fit testers to 32. During the last 12 months, there have been 972 fit tests completed, with 760 total passes across the Trust.

We have invested in a new highly accurate Porta count quantitative fit testing machine, in addition to the 4 qualitative testing kits.

ii. **Issues**

- Expanding testing capacity across the Trust and training staff.
- Identifying those staff who may be involved in Aerosol generating procedures via their managers and ensuring those staff are tested around their clinical availability.
- Staff uptake on testing and managers ensuring staff attend for their test
- Developing a system of centrally recording which staff have been tested on what masks – central spreadsheet held by governance and sent to the Divisions
- Shortage of certain 3M masks and sourcing alternative suitable masks for staff to be retested on in sufficient quantities by working with procurement.
- Sourcing alternative provision when staff fail on all available masks - The Trust has 9 hooded respirators and 38 half-face respirators available for staff who do not fit any of our masks. There are currently 8 staff using a hooded respirator and 23 staff using a half-face respirator.

iii. **Next-steps**

- Ensuring that momentum is maintained with a 12 month rolling programme of continuous testing.
- The Trust is currently working to ensure fit testing compliance is mandated for relevant staff on ESR.
- Fit testing will be returned to the divisions to ensure testing and compliance and this will be overseen centrally by governance.

1.3 PPE

i. In response to the covid 19 pandemic and the need for continuous provision of appropriate PPE (personal protective equipment) for all staff, the Head of Governance & Quality, in collaboration with the Purchasing and Infection Prevention Control Teams, led on establishing central PPE store rooms and in ensuring safe levels of stock with a robust internal requisition and distribution process established.

ii. A daily Command and Control Meeting was established and held at 0930 daily. An Executive Oversight Meeting was held weekly. In addition, a Clinical Advisory Group was established and held daily by senior clinicians.

iii. It was recognised that reopening elective work would have an impact on PPE stock levels; however, the Trust has remained in a good position with regards to PPE stock levels and has been proactive in ordering.

iv. Where PPE has been donated, e.g. visors, a robust QA process was put into place by the Governance Team. The Trust took the decision not to adopt second use of PPE, as PHE guidance had suggested.

v. In response to the higher risk to BAME staff members'; staff who are deemed to be at higher risk, should they contract the virus, have been offered appropriate support. An Individual Risk Assessment to ensure staffs safety, so far as is reasonably practicable, was designed to identify risks and controls, including reasonable adjustment that may have determined home working as the safest option or temporary displacement to alternative duties. Advisory letters were sent to all those deemed at higher risk.

1.4 COSHH

i. **Alcumus Sypol COSHH Management Software**

The introduction of the Alcumus Sypol COSHH management software, in August 2020, across the Trust has been largely successful and replaces the former precarious paper based system of COSHH risk assessments.

The Health and Safety Manager, who is Co-ordinator for the Alcumus Sypol System, is monitoring usage of the system and in establishing meaningful compliance reports for system users and managers.

ii. Increased use of Formalin

Due to impacts of the pandemic upon specimen collection and transportation there was a need to increase the organisations use of Formalin. Formalin is used as a fixative and preservative for anatomical (histology) samples. Our usage increased from approximately 10 litres per week to 50 to 60 litres per week due to the large amount of Formalin required to completely submerge placentas in the liquid.

Formalin is a known carcinogenic which is harmful if harmful if ingested, inhaled or absorbed through skin. Inhalation may be fatal. It is, therefore, essential that strict handling procedures are adhered to, staff are trained in its safe use and on how to manage a spillage or exposure.

A Formalin standard operating procedure was created in response to the increased use of this high risk chemical. Following a number of reported incidents in the use of Formalin the Health and Safety Manager determined that a more formal Formalin policy was required and this is currently in partial draft format.

A Trust wide Specimen Collection, Handling and Transportation Policy is in draft format at this time. There are many strands and services that this policy is required to cover. A Task and Finish Group has been established to complete the policy and to ensure the safe collection, handling and transportation of specimens. The Director of Operations for the Trust will sponsor this policy.

1.5 DSE

i. Annual DSE (display screen equipment) risk assessments are required to be undertaken for all DSE users across the Trust on annual basis or when there is a significant change in software, hardware or a person's individual circumstances, as is a requirement of the Display Screen Regulations 1992 (amended 2002). The Trust Health and Safety Manager has proposed that these individualised risk assessments are captured via ESR as a competency and this will enable the Trust to produce reliable evidence of compliance. This proposal is currently being taken forward.

ii. The Trust has always promoted the requirement to complete DSE risk assessments for those staff who are permitted to work from home. In response for a need to establish a safe home working environment for a large number of staff, in response to the safety guidance relating to reducing the risks associated with covid 19, an updated home working risk assessment was created and included guidance for safe home working. These risk assessments were supported by the Health and Safety Manager, Managers, HR, IT and the Purchasing Team to ensure appropriate equipment was quickly made available for all home workers to ensure their safety so far as is reasonably practical.

2. Health and Safety Training

Health and Safety legislation requires employers to provide adequate health and safety training and employers have a general duty to provide information, instruction and training and to provide a safe place of work, under Section 2 of the Health and Safety at Work Act (1974).

2.1 Manual Handling (People and Inanimate Objects)

The Manual Handling Operations Regulations (1992) sets out a hierarchy of measures to reduce the risks of manual handling in the workplace, so far as are reasonably practicable. These measures include access to specialist advice, access to suitable and sufficient training programs, provision of people and inanimate object handling equipment to reduce the risks and adequate risk assessments.

LWH has maintained a service level agreement (SLA) with Aintree Hospitals' Head of Compliance & Safety to provide update training for our manual handling cascade trainers and delivery of training for newly nominated manual handling cascade trainers. The SLA includes provision of ad hoc guidance and advice from Aintree's Manual Handling Advisor.

An e-learning package for Moving and Handling Level 1 certificate is now accessible to all staff to support safe moving and handling practices.

2.2 First Aid

First Aid training continues to be provided externally via the Health and Safety Training Manager. In April 2020, the Trust's register of first aiders and appointed persons for first aid was revalidated in light of the covid pandemic. New HSE guidance led to the First Aid SOP being updated to reflect new PPE and CPR safety guidance for first aiders and in managing the scene of an accident to reduce numbers of persons present, to ensure social distancing and infection control procedures.

2.3 Health & Safety Related Training

Towards the end of the reporting period, face to face Health and Safety related training was reduced, observing strict safety rules. Staff were able to complete Health and Safety Awareness training, DSE Assessor Training and COSHH Awareness training.

2.4 Executive Health & Safety Training

As part of the Health and Safety Regulations and the Care Quality Commission Well Led Domain, a training session has been designed for executives and executive directors.

It is was intended to deliver this essential training on an annual basis to ensure that the board members remain up to date with their legal responsibilities under the Health and Safety at Work Act. The annual update for early 2020 was delayed due to the then unfolding covid-19 conditions. Training was delivered in January 2021 via Microsoft Teams.

2.5 Training Needs Analysis 2021/22

The Health and Safety Training Needs Analysis has been completed and submitted for 2021/22 and includes provision for the delivery of the following health and safety related training in additional to mandatory health and safety training requirements:

- DSE (Display Screen Equipment) Assessor Training
- COSHH (Control of Substances Hazardous to Health) Awareness Training
- Health and Safety Awareness Training for Managers, Supervisors, Team Leaders
- First Aider Training and Update Training
- Manual Handling Cascade Trainers Training – new and refresher training
- Medical Gases update training for Officers and Trainers
- Ligature Response and Ligature First Aid
- Ulysses Health and Safety Risk Management Module
- Fire Warden Training
- Ligature Rescue Training

Failure of staff to attend a Health and Safety funded training place without contact or acceptable mitigation will result in a cross charge being made to the service area.

3. <u>Policies & Standard Operating Procedures</u> (SOP's)

i. The current Slips, Trips and Falls SOP is to be converted back to a policy as per regulatory guidance. Direction has been given that two policies are required, one for the management of clinical related clips, trips and falls; the other for the management of non-clinical slips, trips and falls.

ii. A review of the Transportation of Formalin SOP was undertaken by the Health and Safety Manager and deemed to be insufficient. Incidents reported via the Ulysses incident reporting system in relation to the use of formalin require that a formal policy, named Formalin Policy, is required. The new policy is currently near to completion.

iii. New HSE guidance led to the Display Screen Equipment SOP for home based workers being updated to reflect new covid secure safety guidance for all staff.

iv. To meet the actions required in response to a CAS alert concerning national food allergy incidents it was identified that the Trust did not have a food safety policy. The Health and Safety Manager has drafted this new policy which is currently being reviewed by the OCS Catering Manager and Trust Patient Facilities Manager.

4. Ulysses Health and Safety Risk Management Module

A suitable solution for electronic risk management of health and safety documentation has been procured, led by the Head of Governance and Quality, who has invested in the Risk and Safety Management Module within Ulysses. The Health and Safety Manager had worked closely with the Governance Support Team to develop the module in readiness to share with all areas.

This new safety software system was ready to be deployed on 1st August, 2020; however the decision was taken to delay the training and access to the module due to the on-going covid-19 situation. The system will now be introduced in May 2021 following some minor adjustments.

The benefits of this investment include:

- Ulysses is fully supported by both I.T. and the Governance Risk Team
- All staff are familiar with its functionality
- There are no limits to user licences
- Training is fully supported
- It is fully customisable and we would benefit from other users development of the module
- It can manage any of our risk assessments; staff will be able to use their existing log in details to complete annual departmental audits and actions, risk assessments, etc.
- The module links to relevant incidents, risk register entries or risk assessments and provides an overall compliance dashboard for each individual element e.g. fire, water, DSE, injuries, sharps and so on
- Easy to interrogate from a reporting perspective and matches corporate reporting for incidents, risks, safeguarding, legal, alerts and complaints

5. Health & Safety Management System

Employers have a duty to consult with their employees, or their representatives, on health and safety matters. Communication is key to an effective health and safety system and industry best practice is to apply a reflective and collaborative learning stance to health and safety incident investigation. It is good practice for large organisations to establish and maintain a Health and Safety Committee, where the Committee should provide a link between staff doing the work and the people directing it.

The Health and Safety Committee continues to meet on a quarterly basis with the caveat to be able to call an extraordinary meeting. The Health and Safety Committee will be known as the Health and Safety Group from April 2021 in line with the new meeting governance restructure.

6. Reported Non Clinical Health and Safety Incidents

In the reporting period 2020/21 there were seventy eight non-clinical health and safety related incidents reported which sees a decrease in reported incidents of forty one incidents from the 2019/20 period. There is concern of an under reporting of non-clinical incidents in this reporting period.

Table 1 – Non Clinical Health & Safety Incidents by Cause

	SERVICE AREA					
	MATERNITY (FAMILY)	NICU	GYNAECOLOGY & HEWITT	CORPORATE FUNCTIONS	CLINICAL SUPPORT SERVICES	TOTAL
STAFF INCIDENTS						
COLLISION	1					1
COSHH (INCLUDING SPLASH)			2		1	3
ILL HEALTH		1				1
INJURY	7	4	2	1	1	15
MOVING & HANDLING			3			3
NEEDLESTICK INJURIES	8	10	8		3	29
SLIPS, TRIPS, FALLS	6	2	3		2	13
TOTAL STAFF INCIDENTS	22	17	18	1	7	65
ORGANISATIONAL INCIDENTS						
EQUIPMENT	1	1		1	1	4
ENVIRONMENT			1		2	3
TOTAL ORGANISATION	1	1	1	1	3	7
PATIENT/VISITOR INCIDENTS						
SLIPS, TRIPS, FALLS	2		2			4
INJURY	1			1		2
TOTAL PATIENT INCIDENTS	3		2	1		6
OVERALL TOTALS	26	18	21	3	10	78

The three primary causes of incidents are categorised as needlestick incidents, injury and slips trips falls. Further analysis of these cause groups are detailed in the following tables and narrative.

6.1 Needlestick Injuries

Inoculation incidents may be subdivided into two categories. Those resulting from percutaneous exposure which occurs as a result of a needlestick or a medical sharp contaminated with blood or bodily fluid; and those resulting from mucocutaneous exposure which occur when bodily fluids come in to contact with open wounds or mucous membranes such as the mouth and eyes. There are more than twenty pathogens that can be transmitted following a needlestick (NSI) or sharps injury. The most common are Hepatitis B, Hepatitis C and HIV and, therefore, are a significant occupational hazard to healthcare professionals.

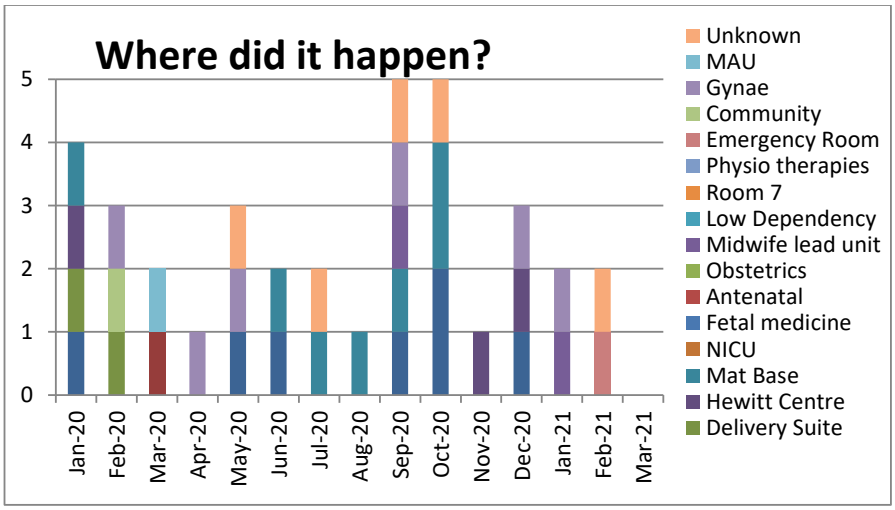
The total number of needlestick injury incidents formally reported via the Ulysses reporting system in 2020/21 was twenty nine including two near miss events, an increase of three from 2019/20 reporting period. However, as in previous years reports, there is conflicting data between staff presenting to Occupational Health following a needlestick injury with a discrepancy of eight more staff known to Occupational Health than is reflected in formal incident reports.

From a Ulysses extract, fourteen of these incidents involved percutaneous exposure to hollow bore needles, three from a suture needle, two from scalpels/blades, five from a cfm (cerebral fluid monitoring) needle and three from cannula. There were two near miss incidents recorded due to poor disposal.

An annual summary of needlestick injuries includes cause, equipment failure and where preventative impovements can be made has been shared with all clinical Heads, Infection Control Team and the Medical Director.

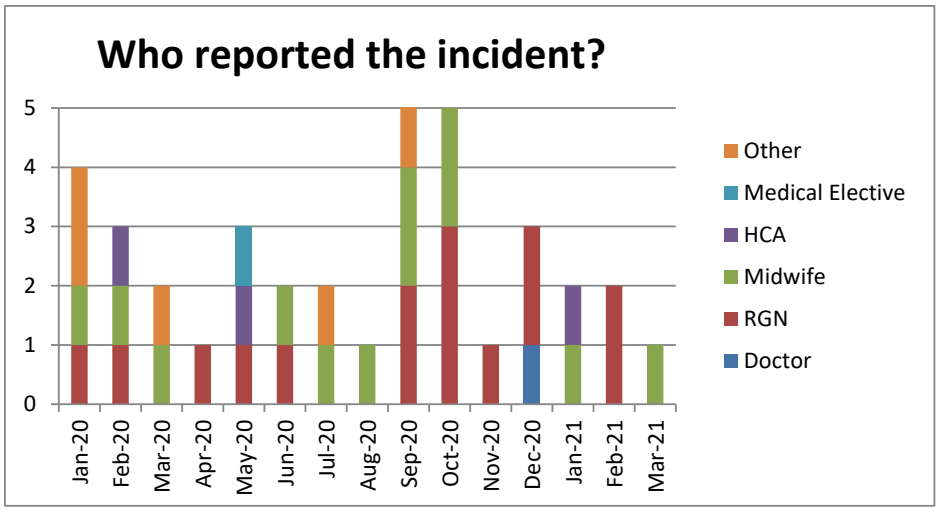
Staff in all clinical areas have been reminded of how to locate the relevant policy on how to manage a needlestick injury or exposure to potention BBV's. The policy can be accessed from any p.c. desktop in the Trust. Further work is underway to rename the Inoculation Injury and Blood Bourne Viruses Policy to *Sharps Injury and Bodily Fluids Exposure Policy* which will have a formal relaunch in early May 2021.

Table 2 – Needlestick Incidents by Service 2020/21



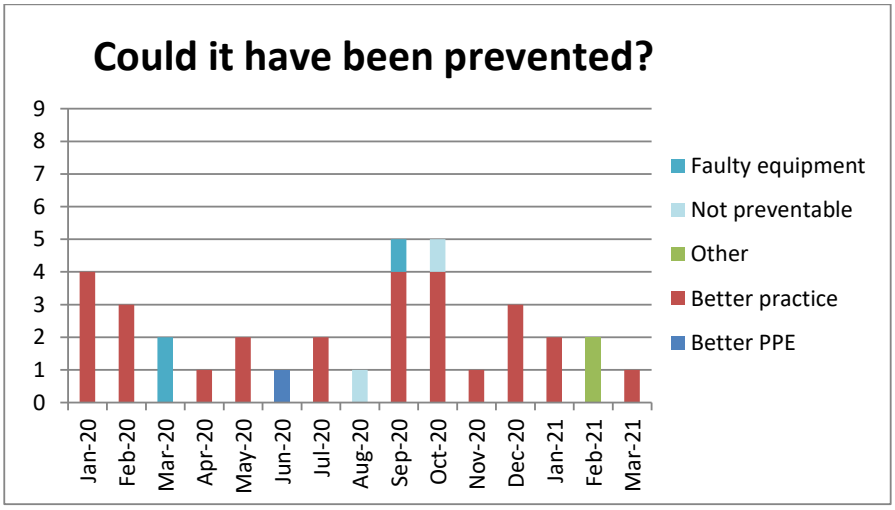
The Neonatal Unit have reported the highest number of needlestick injuries at ten incidents, five of which were attributed to CFM needles. Historically CFM needlestick injuries have been a significant cause of injury for our staff. It was reported at January's Health and Safety Committee that the Neonatal Unit are to trial using CFM pads once training is completed.

Table 3 – Staff Reporting a Needlestick Injury to Occupational Health in 2020/21



The majority of needlstick injuries were sustained by nursing staff, fifteen in total.

Table 4 – Could the injury have been prevented 2019/20



Twenty eight incidents were attributed to poor practice, three incidents could have been avoided with better PPE and two were deemed to be not preventable.

There was one incident of bodily fluids being splashed into staff's eyes, a significant reduction of eight such incidents from the previous year's report.

All incidents were of a low risk nature and the Inoculation Injury and BBV Policy was followed in each case. However, several staff reported issues in locating the relevant policy and associated forms, finding managing needlestick injuries difficult outside of daytime working hours. The Health and Safety Manager found that there were two policies in circulation with conflicting titles, one being very out of date. Relevant communications were sent to all staff to remind them of the location of the policy and forms. Occupational Health have reviewed and renamed the policy and included flowcharts early in the policy to guide staff on what actions are required.

The use of the Sharpsmart disposal system continues and is still offering good value. Ongoing audits are carried out at factory level where the containers are opened, photographed and

checked for non-compliant contents. The onsite audits look at usage and whether the documentation is correct and complete.

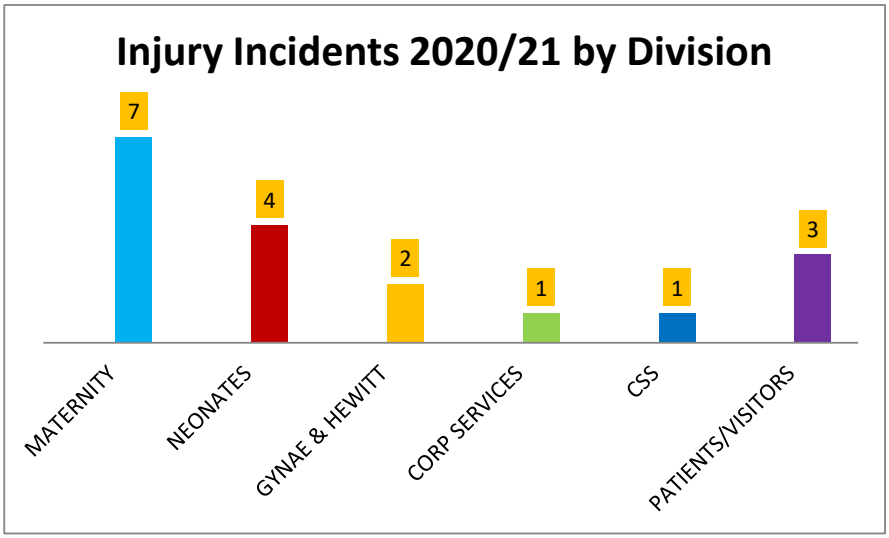
Ongoing training continues to be delivered by the auditor whenever any 'bad practices' are observed or evidenced.

No issues have been raised over any safety aspects of the system.

6.2 Personal Injury

Table 5 – Injury Incidents by Division

There were a total of eighteen personal injuries in this reporting period. There were no identifiable themes.



All incidents of personal injury were dealt with appropriately. One incident was RIDDOR reportable to the HSE involving a staff member falling from a truck in the site loading bay.

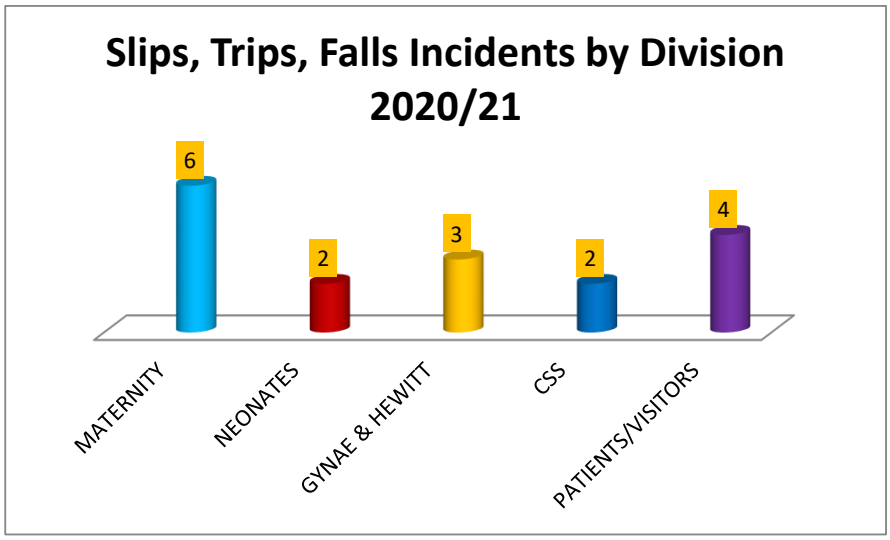
6.3 Slips, Trips & Falls

There were a total of eighteen slips, trips and falls incidents reported during 2020/21 a significant decrease of twelve incidents from the previous reporting period 2019/20. The majority of slip, trips and falls incidents were reported by Maternity Services (six).

There were several reports of slips occurring due to wet floors or spillages. All staff have been reminded to be mindful of any spillages and the need for these to be cleaned immediately. The importance of using wet floor warning signs has been reiterated.

One patient related slip occurred due to ice in a patient car park. The manager initiated an investigation to question whether the areas have been gritted and whether that was sufficient. The outcome of this was that the areas had been gritted including sideways and road. The company responsible for gritting explained that movement of vehicles on salted areas helps the de-icing process and pavements can take longer where footfall is reduced.

Table 6 – Slips, Trips, Fall incidents by Division



7. RIDDORS (Reporting of Injuries, Diseases and Dangerous Occurrences)

The Trust is required to submit RIDDOR reportable incidents to the HSE within prescribed timescales. Persistent late reporting exposes the Trust to potential prosecution for non-compliance with the regulations.

This incident was in unique, accidental circumstances. Staff member received appropriate care and support.

Department	Cause Group	Reportable Injury/Occurrence or Over 7 Day Absence
Purchasing	Injury	Over 7 day absence – soft tissue injuries

8. Legal Claims

There were nine non-clinical/health and safety related personal injury and public liability claims made in 2020/21. Five claims have been settled and the remainder are on-going.

The Health and Safety Manager is to issue appropriate guidance to staff with regards to managing the scene of a serious accident or health and safety related incident as often photographs and even forensic evidence may be vital in establishing the root cause of the event, and assist in reducing or eliminating risk of further occurrence and may also be needed for HSE or legal proceedings.

9. Health & Safety Executive (HSE) Priority Objectives 2021/22

The HSE priority themed objectives for 2021/22 are aimed at reinforcing their existing commitment to:

- lead and engage with others to improve workplace health and safety
- provide an effective regulatory framework
- secure effective management and control of risk
- reduce the likelihood of low-frequency, high-impact catastrophic incidents

- enable improvement through efficient and effective delivery

10. Health and Safety Work Plan for 2020/21

Health & Safety Work Plan 2021/22		
Actions	**Responsible Persons**	**Completion Date**
Continue to work with Head of Governance & Quality to establish a robust safety management system, as per HSG65	Health & Safety Manager	On-going
Continue to address gaps in the health and safety checklist	Health & Safety Manager	On-going
Further review, audit and develop health and safety policies and SOPs	Health & Safety Manager	On-going
Monitor health and safety incidents. Support divisional representatives to provide quarterly incident reports to the Health & Safety Committee. Monitoring and acting upon incident trends.	Health & Safety Manager	On-going
Provide an annual Health and Safety Report to the Health & Safety Group, Quality Committee and Safety Senate	Health & Safety Manager	On-going
Report RIDDORs to the HSE	Health & Safety Manager	On-going
To continue to modernise Health & Safety annual workplace audits and introduce electronic solutions through the roll out of the Ulysses Health and Safety Risk Management Module	Health & Safety Manager	June 2021
Continue to review and improve upon health and safety training provision	Health & Safety Manager	On-going
Introduce a Chemical Clearance Programme in collaboration with Purchasing Team following the roll out the Sypol COSHH Management database	Health & Safety Manager	July 2021
To keep the Trust up to date with changes in Health and Safety legislation and significant HSE projects or guidance	Health & Safety Manager	On-going

11. Recommendations

The Quality Committee, Corporate Risk Committee and Health and Safety Committee are requested to consider and accept the following recommendations:

- Support the continuing review of the Trust's Health and Safety Management System arrangements
- Support the continuing development and promotion of a positive Health and Safety Management System and culture
  Encourage managers and staff to commit to attendance of Health and Safety related training courses

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***2021/22/75c***	**Date: 02/09/2021**		
Report Title	**Constitution Amendment**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***Following a recent process to extend the terms of office for Non-Executive Directors, it was noted that the Trust's constitution was not fully aligned to the Code of Governance. This report outlines a suggested amendment. Amendments to the Constitution must be made jointly by the Board and the Council of Governors. The Council of Governors approved the proposed amendment at their meeting on 22 July 2021.***			
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.***			
	For the Board to consider, and if deemed appropriate, approve the suggested amendments to the Constitution.			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Liverpool Women's NHS Foundation Trust

Committee or meeting report considered at:	Date	Lead	Outcome
Council of Governors	22 July 2021	Trust Secretary	The Council of Governors approved the proposed amendments

EXECUTIVE SUMMARY

This report outlines the proposed amendments to the Trust's Constitution.

MAIN REPORT

Making amendments to the Constitution

The Trust's Constitution states that:

44.1 The Trust may make amendments of its constitution only if:

44.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments; and

44.1.2 More than half of the members of the Board of Directors of the trust voting approve the amendments.

44.2 Amendments made under paragraph 44.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

44.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

44.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and

44.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

Proposed Amendments

Non-Executive Director Term of Office

During a recent discussion regarding the extension of Non-Executive Director terms of office, it was noted that the Constitution currently contains the following provision (ANNEX 6 – ADDITIONAL PROVISIONS – BOARD OF DIRECTORS):

8. The Chair and the non-executive Directors are to be appointed for a period of office not exceeding three years and in accordance with the terms and conditions of office, including remuneration and allowances, decided by the Council of Governors at a General Meeting. Any re-appointment of a non-executive Director by the Council of Governors shall be subject to a satisfactory appraisal carried out in accordance with procedures which the Board of Directors have approved. Re-appointment will be for a further term of up to three years. The Council of Governors may determine, in exceptional circumstances, that a non-executive Director may be re-appointed for a third term.

Whilst the Trust's Constitution is not specific regarding the length of a third term, the NHS Code of Governance includes the following provision:

B.7.1. In the case of re-appointment of non-executive directors, the chairperson should confirm to the governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years (e.g., two three-year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-executive directors may, in exceptional circumstances, serve longer than six years (e.g., two three-year terms following authorisation of the NHS foundation trust) but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive's independence.

Whilst not specifically stated in the Constitution, the Trust has taken decisions in the past to comply with this provision. It is recommended that paragraph 8 of the Constitution is amended to the following to align with the NHS Code of Governance:

8. The Chair and the non-executive Directors are to be appointed for a period of office not exceeding three years and in accordance with the terms and conditions of office, including remuneration and allowances, decided by the Council of Governors at a General Meeting. Any re-appointment of a non-executive Director by the Council of Governors shall be subject to a satisfactory appraisal carried out in accordance with procedures which the Board of Directors have approved. Re-appointment will be for a further term of up to three years. The Council of Governors may determine, in exceptional circumstances, that where a non-executive has served six years, they may be subject to annual re-appointment up to a maximum of nine years in total served.

General Housekeeping

In 2018, it was agreed to replace 'Monitor' with 'NHS Improvement' – there remains some instances where this change has not been made. This iteration updates these throughout the whole document.

The full Constitution document, with tracked changes, is available to the Board of Directors via the supporting documents section on Virtual Boardroom and the 'Trust Board' Microsoft Teams room.

Potential future amendments

With the on-going development of Integrated Care Systems, it is possible that the Trust's Constitution will require review to ensure that it is aligned. The Council of Governors and Board of Directors will be kept informed.

Next Steps

Should the Board agree the amendments, the amendment will be presented to the Annual Members' Meeting for final approval.

If agreed, the constitution will be finalised and reported to NHS Improvement.

Recommendation

For the Board to consider, and if deemed appropriate, approve the suggested amendments to the Constitution.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***2021/22/75d***	**Date: 02/09/2021**		
Report Title	**Membership Strategy 2021-25**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***Following work undertaken by a Task and Finish group led by governors and overseen by the Council of Governors Communications and Membership Engagement Group, an updated Membership Strategy for 2021-25 has been developed. This was approved by the Council of Governors at their meeting on 22 July 2021. The Trust's Membership Strategy requires approval from both the Council of Governors and 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.***			
	For the Board to consider, and if deemed appropriate, approve the Membership Strategy 2021-25.			
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* 3.1 Failure to deliver an excellent patient and family experience to all our service users	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

Liverpool Women's NHS Foundation Trust

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Communications & Engagement Sub-Group	Dec 20 – June 21	Trust Secretary	The Group has reviewed several iterations of the draft strategy, providing comment and amendment.
Council of Governors	22 July 2021	Trust Secretary	The Council of Governors approved the Strategy.

EXECUTIVE SUMMARY

This report introduces the updated Membership Strategy 2021-25

MAIN REPORT

Background

The December 2019 Communications and Membership Engagement Group was informed of a proposal to include membership engagement within a revised Trust Communications & Engagement Strategy from 2020/21 rather than creating a separate standalone Membership Strategy. The intention was to learn the lessons from the 2017-20 Membership Strategy and focus on 3-5 key activities during the year ahead that could be clearly monitored, and impact measured.

Due to the COVID-19 outbreak and pandemic, progress on the revised LWH Communications & Engagement Strategy was limited and as a result a year extension to the current document was agreed. Whilst membership engagement had been referenced within the extended document, the detail was not as extensive as would have been in place in a fully revised document. It was therefore agreed to include an addendum to 2017-20 Membership Strategy to provide this detail ahead of a comprehensive refresh in April 2021.

The addendum outlined several membership engagement objectives for 2020/21. The COVID-19 pandemic meant that a focus on realistic and achievable goals was even more important. The effects of lockdown and social distancing limited engagement options and in a time of increased pressure, it was vital that NHS resources were utilised effectively and for a clear purpose. However, the pandemic also engendered an unprecedented amount of goodwill from the public towards the NHS and interest in health and healthcare services has never been higher. Therefore, it was agreed that it would be worthwhile to progress with membership engagement activity that reflected the current challenges and enabled for effective planning ahead of a post COVID-19 environment. A key objective within the addendum was the development of a 'membership charter' to provide clarity on the 'offer' of membership. It was also recognised that some of our members would want to be more actively involved whereas some may prefer to only receive information from the Trust.

Steps were taken in January 2021 to ask members what level of involvement they wished to have – they could choose to be "Informed" or to be "Involved".

- Be informed: members receive regular information about the Trust, such as invitation to the members annual meeting, receive notices of election and receive the Trust's quarterly newsletter.
- Be Involved: Includes the above plus participation in surveys, questionnaires focus group discussions and behind the scenes events.

There was a recognition that the Membership Strategy would require a comprehensive review and refresh heading into 2021/2022. This work has been undertaken via a governor's task and finish group with

oversight provided by the Governors' Communications & Membership Engagement Group.

Development of the Strategy

The task and finish group established to help develop the strategy held three meetings, inviting officers from the Trust to provide their views. Key themes identified from the discussions were as follows:

- the importance of ensuring that there is a consistent 'golden thread' joining all the documents within the Trust's strategic framework, including the membership strategy.
- the importance of the membership strategy in being a key mechanism that will help the Trust to communicate the overall strategic direction to members (public and staff) and the wider community.
- That it is important for the membership strategy to state that effective communication with members is 'two-way' – and that listening is just as important as communicating Trust messages. Noted that 'listening' tends to be most effective when targeted and led by intelligence.
- Noted that healthcare is increasingly being delivered across partnerships and outside of established organisational boundaries. The membership strategy will need to consider this aspect and recognise the importance of building relationships with organisations that have a footprint across the system e.g. Healthwatch.
- The Trust has been challenged in engaging with 'hard to reach' groups and membership has a role to play in improving this.
- The importance of ensuring that the updated membership strategy could clearly articulate the purpose of membership and how it could and did provide added value to the Trust.
- there is an opportunity to ensure that intelligence from patient engagement was utilised by the Communications and Engagement Group to target membership engagement activity.

This information was reported to the Communications & Engagement Sub-Group and a draft strategy developed. Members were then asked for their views on the emerging themes. Whilst the response rate was disappointing, interesting suggestions were received from those who did respond. These were incorporated into the Strategy.

Key Aspects

The Strategy is clear that membership engagement cannot be an isolated task and should be embedded into wider patient / public engagement and involvement activity. There is also an opportunity for membership to play a significant role in helping the Trust to engage with all aspects of the community.

Underpinning the overall objectives and priorities are annual actions that will be reviewed and updated each year. The first year's actions are very much focused on providing a 'baseline' whether that be through establishing effective reporting and intelligence gathering mechanisms or building relationships and partnerships with key organisations.

Recommendation

For the Board to consider, and if deemed appropriate, approve the Membership Strategy 2021-25.

NHS
Liverpool Women's
NHS Foundation Trust

Membership Strategy

2021–2025

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Our Vision

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

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

Our Values	Care	Ambition	Respect	Engage	Learn

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

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

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

Our Core Focus

- Our first priority should be our people; making sure we have the best staff enabled to provide the best care. Our people are our most important asset and our success hinges on getting this right.
- Safety is of paramount importance to everyone; staff and patients. Patients have told us that each and every person they meet while using our services has a role in making them feel safe.
- Experiences in healthcare can be life-changing, and making sure that every patient has the best experience possible is equally important to our staff and the people using our services. We know that having the best people as part of our team is central to making sure this is achieved.

Why we need a Membership Strategy

This membership strategy outlines the Trusts vision for membership over the period 2021-2025 and builds on the work of our previous strategy. We want to work with our members to build a membership strategy that incorporates the core focus from the Corporate Strategy and responds to the local needs and national priorities, including the NHS Long Term Plan.

Through this strategy we will set out the methods that will be used to continue to develop an effective, responsive and representative membership that will assist in ensuring the Trust "to be the recognised leader in healthcare for women, babies and their families".

Through our membership, the Trust can be closer to the people who access our services and more accountable to them than ever before. We intend to see our members becoming an increasingly active and valued component, building on existing partnerships and supporting new ones.

The Trust's formal accountability relationship with Members can be found in Appendix 2.

Developing our Membership Strategy

Our members are vital to the development of our strategy and feedback was sought through an online survey. Whilst responses were limited, views were captured and the suggestions for improving and developing our membership over the next five years have been incorporated into the Strategy.

Ahead of seeking views from the membership, the Council of Governors established a task and finish group to explore the most effective direction of travel for the new 2021-2025 Membership Strategy and to ensure that it is aligned with the overall strategic direction of the Trust (below).

To offer a service that supports the Trust to give an outstanding experience to women, babies and families whilst promoting LWH as the recognised leader in women's health and other specialist care that we provide.

Reflection on 2017-2020 Membership Strategy

The previous Membership Engagement Strategy ran from 2017-20. Whilst there had been some notable membership engagement successes (e.g. 'Get Involved' campaign in Liverpool City Centre in August 2018), much of the activity in the strategy was tied to the on-going progress of the Trust's Future Generations' strategy[1] which had been slowed due to issues outside of the Trust's control.

Work to update the Membership Strategy began in December 2019 and it was agreed that a number of objectives set at the launch of the 2017-2020 strategy remained pertinent and relevant for taking forward the Trust's approach to public and membership engagement. It was intended to refresh the strategy on this basis and incorporate it into a wider Trust Communications and Engagement Strategy. As this work progressed, the COVID-19 pandemic began.

The pandemic created a number of challenges for effective public and member engagement, most notably through the effects of lockdown. Whilst foundation trusts are now entering into an uncertain landscape as the post COVID-19 pandemic recovery progresses, there are also undoubted opportunities that can be maximised. For instance, the pandemic has engendered an unprecedented amount of goodwill from the general public towards the NHS and interest in health and healthcare services will never be higher. Also, trusts have been required to find innovative ways to maintain services and administrative functions, mainly through the use of 'virtual meetings'. The use of technology has proven to be successful and there is wide agreement that this can be implemented to widen the reach of engagement.

As the pandemic forced a pause in the onward development of the Trust's updated membership engagement approach, it was agreed to develop an 'addendum' to the 2017-20 Membership Strategy. The addendum included several actions, each with an aim of continuing the key issues from the 2017-20 Strategy and also looking ahead to 'ready' the Trust's membership database and processes to support an updated Strategy. A key part of this was an attempt to increase the number of members who had provided the Trust with an email address. This attempt also included giving members the option of new categories of engagement - developed to allow members to specify the level of engagement they wished to have with the Trust.

An important action as part of the addendum was to think about the relationship that members had with the Trust and the expectations that both parties should have as part of this. This reflection led to the development of a 'Membership Charter' – a document that provides a framework and the underpinning principles to this Strategy and membership engagement.

[1] https://www.liverpoolwomens.nhs.uk/media/3647/future-generations-2020-25-strategy.pdf

Membership Charter

We aim to ensure that our members have every opportunity to play a meaningful part in shaping our vision, determining, and developing our standards and building on the high quality of care for which we are recognised.

Our vision is of a broad base membership reflecting the diversity of the communities that we strive to serve.

What members should expect from the Trust:
As a Member of the Foundation Trust, you:

- Will receive communications regarding the Trust and the services it provides to keep you up-to-date.
- Will have the opportunity to 'have your say' about the Trust and have the chance to understand or question any planned changes to the organisation that matter to you and others.
- Will be invited to attend free events for Members, such as 'behind-the-scenes' tours of the Hospital. We also run talks for our Members, this is where staff from different departments provide an overview of their work.
- Are welcome to attend our quarterly Council of Governors meetings and also our Annual Members Meetings, meet staff and Governors, and hear first-hand about the Trust's ongoing work and plans.
- Have the opportunity to access a wide range of NHS staff discounts through joining the website 'Health Service Discount' (https://healthservicediscounts.com/).

The Role of Trust Members:

- Be a voice of your community, telling us about the needs and expectations of your local community relating to the services of the Trust.
- Take an interest in the work of the Trust and help signpost members of the public to accurate sources of information.
- Encourage others to become members of the Trust
- You will be able to vote for Governors in elections that happen in your constituency.
- As well as voting, you can run for Governor when the opportunity arises and represent the voice of the Members in your constituency.

Our Members & the Landscape

Our members join the Trust to have their voices heard and to help us better understand the views of those who access our services so that we can improve the quality, responsiveness, and development of services.

Members may only join the Trust in one category of membership. No skills or experience are required to be a member of our Foundation Trust, but members should be interested in our services and compassionate towards the people who access them. We are committed to encouraging everyone who is eligible to become an active member of the Trust.

The Governor Constituencies for the Trust can be found in Appendix 3

Membership Breakdown

Public members	9328	Staff Classes	1551
Out of Trust Area	36	Doctors	101
Central Liverpool	2,734	Nursing	417
Knowsley	1,099	Midwifery	331
North Liverpool	1,536	Scientists/Technicians & AHPs	330
Sefton	1,212	Non-Clinical & Clinical Support Staff	372
South Liverpool	1,308		
Rest of England	1,403	**Total Membership**	**10,879**

Membership Involvement Levels

The Trust recognises that members will have differing levels of interest, time and availability for involvement. Members choose the degree to which they would like to be involved at the point at which they sign up as a member. This is set across two tiers;

Be Informed
Receive regular newsletters
Receive regular communications
Receive invitation to the Annual Members Meeting

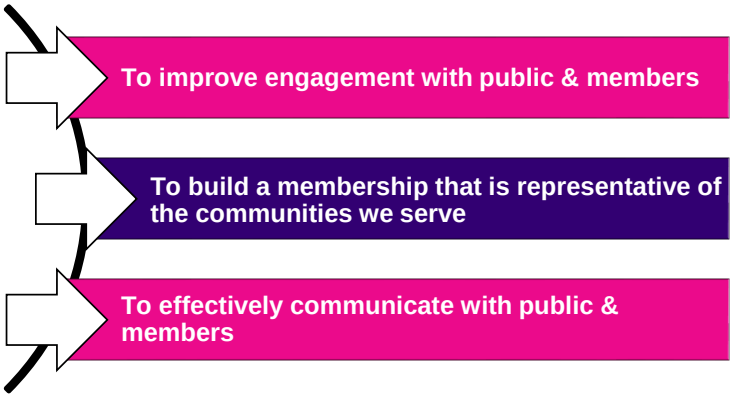
Be Involved (as above plus)
Participate in survey, questionnaires, consultations
Participate in focus/discussion/advisory groups
Volunteering for the Trust

All members retain their statutory rights e.g. to vote or stand as a governor in Council of Governors elections.

Objectives for 2021-2025

This section outlines the membership objectives that we have set ourselves to achieve our strategy; and our priorities for delivery over the next four years, in order to provide focus and clarity.

There are three objectives to the 2021-2025 membership strategy:



These objectives form the framework by which we hold ourselves to account. They recognise and build on the systems and processes which the Trust has in place to grow, engage and involve its membership.

Objective 1: To improve engagement with public and members

Aim: For members to feel part of the Trust and be aware of opportunities and how to be involved in helping to improve the way services are provided.

As a Foundation Trust we are accountable to our local population and an active and engaged membership helps us work together with our communities. We understand that the value of membership is not in the numbers of people who have joined but in the quality of members who are engaged. We recognise it is more beneficial to build an engaged and active membership rather than a large but passive one, and this is reflective of how our current members feel.

We want to broaden our membership and include voluntary and third sector organisations through Associate memberships; this will enable us to build a greater awareness and support for women's health in the community.

Through innovative engagement approaches we want all our members to feel involved and supported to add value to the Trust; this will also help us to support our governors in representing the interests of members and the public.

We have identified five priorities that will help us achieve improved engagement with public and members, these are:

1. To improve engagement with public & members	
Priorities*	1.1 Maintain an Events Calendar to identify and plan effectively for membership engagement events
	1.2 Development of events that are tailored to members
	1.3 Build on existing relationships with the patient experience team and the Trust Charity
	1.4 To link in with the Corporate strategy plans & the Communications & Marketing Strategy to enhance engagement with patients/public/members
	1.5 Strengthen links with pan-region organisations such as Healthwatch and explore opportunities for cross-Trust membership engagement.

Objective 2: To build a membership that is representative of the communities we serve

Aim: To ensure our membership reflects the broad diversity of our local communities.

It is important to regularly analyse our membership to make sure we understand its composition and take steps to ensure, as far as possible, it is representative of the people we serve. From our analysis we understand there are some groups who are less well represented and we want to try new ways of engaging with them.

We will strategically align our recruitment and engagement programme to coincide with other key events throughout the year. These opportunities will help us to raise awareness amongst seldom heard communities and address under-representation.

Using the data we hold on our members we have identified five priorities to support us to deliver objective 2.

2. To build a membership that is representative of the communities we serve	
Priorities*	2.1 Analyse our membership on a regular basis to ensure that progress is being made in increasing representation
	2.2 Analyse membership events to ensure that attendance was as representative as possible, reflecting on methods to improve this if required.
	2.3 Develop relationships with schools to increase young people representation and engagement
	2.4 Develop enhanced links with organisation aligned to underrepresented groups to improve recruitment, engagement and involvement with these demographics
	2.5 Ensure that intelligence from patient engagement is utilised by the Communications and Engagement Group to target membership engagement activity

Objective 3: To effectively communicate with public and members

Aim: For members to feel well informed and receive communications that are targeted towards their interests.

Members are a vital link between the Trust and our communities. We want to establish methods for two-way communication and respond to the increased demand of the digital landscape to meet the expectations of those who interact with us.

We need to adapt our communications to meet expectations and introduce new techniques to enable members' opinions to be heard.

3. To effectively communicate with members	
Priorities*	3.1 Continue building and maintaining an accurate database
	3.2 Identify opportunities for two-way communication between members and governors
	3.3 Continue providing appropriate information to members
	3.4 Communicate the benefits of membership
	3.5 Target communications with the desired audience

*Each of these priorities have underpinning actions that will be reviewed and updated on an annual basis. These are included in Appendix 1.

Work to Support Strategy Objectives

Strengthening the links between Members & Governors

The Trust will promote governors ability to represent the interests of the membership and the wider public by:

- Investing in development days with a particular focus on public and membership engagement and accountability.
- Keeping members well informed about their Governor representative e.g. governor profiles in the Women's Voice publication
- Bringing Governors together with members at public meetings and inviting members to attend the Council of Governors
- Encouraging Governors to participate in the Trusts well established site visits to speak with service users and carers about their experience.
- Involving governors in membership recruitment (membership toolkit)
- Publishing Council of Governors papers publicly
- Enabling members to evaluate the effectiveness of Governors in representing their interests.

Strengthening the link between Governors & the Board

The Trust will promote the ability of Governors to hold Non-Executive Directors to account for the performance of the Board through:

- Facilitating communication between Governors and the Non-Executive Directors whom they hold to account through
    - Attending Board of Directors meetings
    - The attendance by designated Non-Executive Directors at Governor Committees and Working Groups
    - Regular access to the Trust Chair

Membership Strategy Governance

The Council of Governors is supported by the Communications and Membership Engagement Group in the process of recruiting, engaging and communicating with the Trust's membership and representing the interests of patients, carers, families and the general public in the areas served by the Trust.

The Communications and Membership Engagement Group will review and develop underpinning annual objectives to support the strategic priorities. The Group will review progress against the objectives on a quarterly basis reporting back on progress at the Council of governors through a written or verbal update from the committee Chair. An annual report of progress against this strategy will also be available at the Annual Members Meeting.

Continuous Learning & Feedback

To ensure that both members and the Trust get the best out of membership, we will build mechanisms for learning and improvement into all membership initiatives. Members will be able to provide feedback at any stage by emailing communications@lwh.nhs.uk

The Trust will also actively seek to learn lessons through:

- An annual membership survey
- An annual Governor survey
- Feedback from Governors through the annual Chair's appraisal process
- Feedback forms at events
- Membership database reports (e.g. meeting attendance, membership growth, membership demographics)

Appendix 1

Strategy Year One – Underpinning Actions

Objective 1: To improve engagement with public and members

Aim: For members to feel part of the Trust and be aware of opportunities and how to be involved in helping to improve the way services are provided.

To improve engagement with public & members		Underpinning Actions 2021-22
Priorities*	1.1 Maintain an Events Calendar to identify and plan effectively for membership engagement events	1.1a Develop Events Calendar and report it quarterly to the Communications and Engagement Group to support planning for membership engagement events 1.1b Ensure that links are in place with services who are planning themed engagement events so that there can be a link with membership involvement. 1.1c Divisions and services across the Trust will be required to inform of upcoming events they have planned outside of the Communications events calendar with a request for timely notice if anything is planned to ensure this is shared with the public and members of the Trust
	1.2 Development of events that are tailored to members	1.2a Develop mechanism to seek views from members on the types of events that they would be interested in e.g. Behind the Scenes events 1.2b Explore holding events outside of the Trust e.g. in Community hubs, places of worship, youth clubs etc.

	1.3 Build on existing relationships with the patient experience team and the Trust Charity	1.3a Ensure that intelligence from the patient experience team and the Trust Charity is fed back to the Communications and Engagement Group
	1.4 To link in with the Corporate strategy plans & the Communications & Marketing Strategy to enhance engagement with patients/public/members	1.4a Work with the Transformation Team to identify opportunities for engagement regarding the Trust Strategy for members.
	1.5 Strengthen links with pan-region organisations such as Healthwatch and explore opportunities for cross-Trust membership engagement.	1.5a Establish relationship with Healthwatch representatives and explore mechanisms for sharing intelligence regarding patient experience. To also consider whether joint events could be held. 1.5b Build relationships with women's groups – A helpful stakeholder list has been developed for local groups who have an interest in women's health and wellbeing. Relationships with these groups (particularly young people) will be developed and maintained and they will be invited to get involved in any public facing events/activities in the future. 1.5c Liverpool network development – Collaborative and engaging relationships have been forged with partner organisations during COVID-19. LWH will build on this for the future by becoming more proactively engaged with Liverpool wide partners in health, local authority, education, enterprise and local communities.

Objective 2: To build a membership that is representative of the communities we serve

Aim: To ensure our membership reflects the broad diversity of our local communities.

To build a membership that is representative of the communities we serve		Underpinning Actions 2021-22
Priorities*	2.1 Analyse our membership on a regular basis to ensure that progress is being made in increasing representation	2.1a Regular reports to the Council of Governors will include: • Membership totals within all constituencies; • Membership churn, i.e. the number of 'joiners' and 'leavers' within the public membership constituencies per month; and • Diversity reports, i.e. comparisons of the Trust's public membership demographics to those within the local population. • Reports on events to note the demographics of attendance (where possible)
	2.2 Analyse membership events to ensure that attendance was as representative as possible, reflecting on methods to improve this if required.	*See 2.1a above*
	2.3 Develop relationships with schools, colleges and universities to increase young people representation and engagement	2.3a Work with the Learning & Development Facilitator to develop opportunities to liaise with schools, colleges and universities to encourage membership engagement and recruitment. 2.3b To research issues of interest to young people and how they would wish to be engaged with.

	2.4 Develop enhanced links with organisation aligned to underrepresented groups to improve recruitment, engagement, and involvement with these demographics	2.4a Identify key community leaders in the City / wider C&M region and attempt to establish opportunities for engagement
	2.5 Ensure that intelligence from patient engagement is utilised by the Communications and Engagement Group to target membership engagement activity	2.5a Ensure that themes from patient complaints and compliments is reported to the Communications and Engagement Group 2.5b Communications and Engagement Group to utilise patient and service user feedback to target and focus membership activity.

Objective 3: To effectively communicate with public and members

Aim: For members to feel well informed and receive communications that are targeted towards their interests.

To effectively communicate with members		Underpinning Actions 2021-22
Priorities*	3.1 Continue building and maintaining an accurate database	3.1a Undertake an annual refresh of the database to ensure it remains up-to-date.
	3.2 Identify opportunities for two-way communication between members and governors	3.2a Ensure that feedback time from members to governors is built into events 3.2b Support Governors in actively engaging with their constituents e.g. signposting relevant events, providing a steer from the Communications and Engagement Group on topics of interest. 3.2c Identify opportunities for members to become involved in inspections / patient experience programmes

		3.2d Explore filming governor profiles for use on social media to support engagement and interest in standing for election.
	3.3 Continue providing appropriate information to members	3.3a Ensure that Council of Governor meetings are advertised to members and that papers are published on the Trust website in advance of meetings 3.3b Continue to make membership information available electronically via the Trust's website, intranet, and social media platforms. 3.3c Ensure that membership information is widely available in all major trust sites, i.e. reception areas, wards, café/restaurant etc.
	3.4 Communicate the benefits of membership	3.4a Include membership forms within regular correspondence e.g. appointment letters 3.4b Ensure that a 'you said, we listened' approach is taken to membership engagement
	3.5 Target communications with the desired audience	3.5a Identify public events associated with Trust services across the public constituencies, in which to promote FT membership, its benefits and to recruit public members associated with these areas and constituencies 3.5b On an ongoing basis, develop and implement targeted campaigns to recruit people interested in health services.

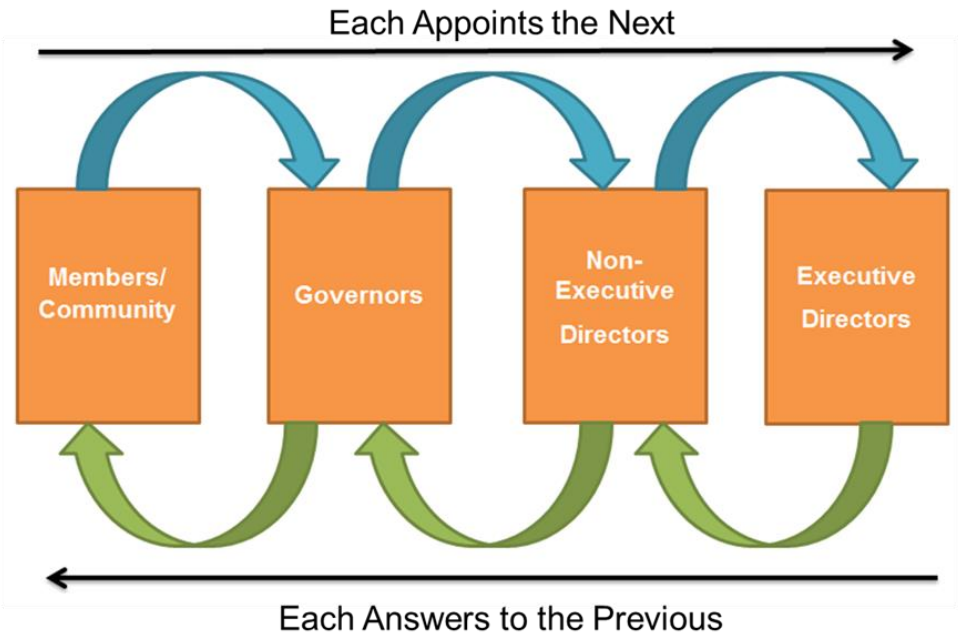
Appendix 2

Accountability to our Members

The Health and Social Care Act (2012) states that the fundamental duty of a Foundation Trust Board is to promote the success of the organisation so as to maximise its benefits to members of the Trust and the wider public. To ensure we are doing this as a Trust we have clear lines of communication between the Board and Members. This enables the Board to have a continuous "line of sight" to the views and priorities of members and the public, and so that members and the public are assured that the Board is performing as an effective steward of public assets. Much of the accountability of the Board to its members is through the Council of Governors, which has two fundamental statutory duties –

- To represent the interest of the membership and the wider public; and
- To hold the Trusts Non-Executive Directors to account for the performance of the Board.

Foundation Trust Accountability Chain



It is vital to ensure that the links between members and governors, and governors and the Board are robust so that a gap does not emerge between member and public interests and Board decisions. Focusing on strengthening these key links is the Foundation Trust Governance model and therefore a priority area within this strategy.

Appendix 3

Council of Governors

The Council is chaired by the Trust Chair, who ensures that the council is made aware of the relevant issues in sufficient depth to enable them to fulfil the needs of public accountability.

The Council of Governors (Council) ensures that the interests of the community served by the Trust are appropriately represented.

The Council is made up of the following representative constituencies:

14 Public Governors - elected by the Trust's public membership who represents the local community, as follows:

- Central Liverpool – four Public governors
- North Liverpool - two Public governors
- South Liverpool - two Public governors
- Sefton – two Public governors
- Knowsley – two Public governors
- The rest of England and Wales – two public governors

5 Staff Governors - elected by the trust's staff members, who they represent, as follows:

- Doctors – one Staff governor
- Nurses – one Staff governor
- Midwives – one Staff governor
- Scientists, technicians and allied health professionals – one Staff governor
- Administrative, clerical, managers, ancillary and other support staff – one staff governor.

8 Appointed Governors - nominated by partner organisations who work closely with the trust, as follows:

- Liverpool City Council – one Appointed Governor
- Sefton Borough Council – one Appointed Governor
- Knowsley Borough Council– one Appointed Governor
- University of Liverpool– one Appointed Governor
- Faith Organisations – one Appointed Governor
- Community & Voluntary Organisations – one Appointed Governor
- Liverpool Hope University/ Liverpool John Moores University/ Edge Hill University - one Appointed Governor
- University of Liverpool/ Liverpool Hope University/ Liverpool John Moores University/ Edge Hill University – one student Appointed Governor

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***21/22/75e***	**Date: 02/09/2021**		
Report Title	**Corporate Governance Manual – 2021 Update**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***Amendment to the Corporate Governance Manual was last presented and agreed at the Board in September 2020.*** ***A review of the document has been undertaken with input from the Trust Secretary, Finance Team and Head of Procurement and this was reviewed and discussed by the Audit Committee on 22 July 2021.***			
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 is asked to adopt the updated Corporate Governance Manual.			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Audit Committee	22 July 2021	Trust Secretary	The Audit Committee approved the suggested amendments to the CGM. A financial limit to reportable waivers was suggested but not accepted by the Committee.

EXECUTIVE SUMMARY

Amendment to the Corporate Governance Manual was last presented and agreed at the Board in September 2020.

A review of the document has been undertaken with input from the Trust Secretary, Finance Team and Head of Procurement and this was reviewed and discussed by the Audit Committee on 22 July 2021.

Amendments to the document are shown utilising track changes.

MAIN REPORT

The following table provides a summary of the amendments that have been made to the Manual since July 2020:

Version control	
Changes made	**Date**
Public Contracts Regulations 2015 to the procurement of services and supplies threshold changed to £122,976 rather than £189,330.	**August 2021**
Removal of references to 'OJEU'	**August 2021**
Updated Committee Structures	**July 2021**
References to Nominations Committee (Executive Directors) and the Remuneration and Terms of Service Committee and replaced by Nomination & Remuneration Committee	**July 2021**
Alignment with new Corporate branding	**July 2021**
Change of job titles: • **Director of Finance changed to Chief Finance Officer** • **Director of Nursing & Midwifery to Chief Nurse & Midwife**	**July 2021**
Approved committee membership, Committee Structure and terms of reference added.	**July 2021**
TABLE A – Delegated Authority • **Removal of Head of Estates – replaced where appropriate with Director of Estates** • **19c – removal of references to outdated legislation** • **35a – inclusion of the ability of Executives to nominate a Deputy to enter the Trust into contracts.**	**July 2021**

• **35c – addition of Divisional Managers as having operational responsibility to nominate officers to oversee and manage contracts on behalf of the Trust** • **35h – removed – duplication with 35g**	
References to 'CONCODE' removed throughout the document.	**July 2021**

Areas to note

Communication of changes to the Corporate Governance Manual

In line with the procedure for amending the manual, it is incumbent on the Chief Executive and the Trust Secretary to ensure that all directors, governors and Trust staff are made aware of the manual and their responsibilities in respect of it. A key part of this is to ensure that an up-to-date version of the manual will at all times be available on the Trust's intranet and website.

As noted in last year's update, there is recognition that the Corporate Governance Manual can be an unwieldy document to access and understand. It had been proposed that an abridged version be produced, focusing on providing clarity to managerial staff on the extent of and limits to their respective responsibilities and accountabilities. Owing to challenges during the pandemic, this abridged version has yet to be completed but remains an area of development.

Contract process

On reviewing the Corporate Governance Manual in July 2020, it was noted that there was room for interpretation in terms of who had authority to enter the Trust into contracts. Even contracts with a low financial cost (seeming or otherwise) can have significant commercial implications for the Trust. It was therefore agreed to limit the entering of the Trust into contracts, regardless of value, to Executive Director level who can then specifically nominate a deputy. The option to nominate a deputy has been added to the Delegated Authority Table. In terms of nominating officers to oversee and manage contracts on behalf of the Trust this has been expanded from Chief Finance Officer, Chief Operations Officer or Head of Procurement to include the Divisional Managers.

A potential additional control of introducing a contract award process i.e. a contract award recommendation paper required prior to contract signatures, or at least for those above a £40k value. Was discussed but rejected by the Audit Committee in July 2021. It was felt that the processes within the SFIs and Scheme of Delegation were sufficiently robust without this additional level of approval.

Additional amendment since the July 2020 Audit Committee

Since the Audit Committee reviewed the document changes to Public Contracts Regulations were announced and these became active from 16 August 2021. NHS Foundation Trusts are required to apply the lower financial threshold for the application of the Public Contracts Regulations 2015 to the procurement of services and supplies.

To confirm the threshold from 16 August 2021 will be; £122,976 rather than £189,330. All references to these figures have been updated in the CGM.

Also, specific references to 'OJEU' have been removed as these no longer exists post Brexit. This portal / approach has been superseded by a new e-tendering platform called 'Find a Tender' called (FTS).

Recommendation

The Board is asked to adopt the updated Corporate Governance Manual.

Liverpool Women's
NHS Foundation Trust

This is how we do it ….

Corporate Governance Manual

July 2021
V10.0

Version control			
Version	**Section**	**Changes made**	**Date**
10.0	**Throughout**	**Public Contracts Regulations 2015 to the procurement of services and supplies threshold changed to £122,976 rather than £189,330.**	**August 2021**
10.0	**Throughout**	**Removal of references to 'OJEU'**	**August 2021**
10.0	**5.0, Table A**	**TABLE A – Delegated Authority** • **Removal of Head of Estates – replaced where appropriate with Director of Estates** • **19c – removal of references to outdated legislation** • **35a – inclusion of the ability of Executives to nominate a Deputy to enter the Trust into contracts.** • **35c – addition of Divisional Managers as having operational responsibility to nominate officers to oversee and manage contracts on behalf of the Trust** • **35h – removed – duplication with 35g**	**July 2021**
10.0	**Throughout**	**References to 'CONCODE' removed throughout the document.**	**July 2021**
10.0	**4.1**	**Updated Committee Structures**	**July 2021**
10.0	**3.3.4**	**References to Nominations Committee (Executive Directors) and the Remuneration and Terms of Service Committee and replaced by Nomination & Remuneration Committee**	**July 2021**
10.0	**Throughout**	**Alignment with new Corporate branding**	**July 2021**
10.0	**Throughout**	**Change of job titles:** • **Director of Finance changed to Chief Finance Officer** • **Director of Nursing & Midwifery to Chief Nurse & Midwife**	**July 2021**
10.0	**4.0**	**Approved committee membership, Committee Structure and terms of reference added.**	**July 2021**

9.0	**6.15.1.3**	**Reference to Nomination & Remuneration Committee updated to align with updated Nomination & Remuneration Committee Terms of Reference.**	**September 2020**
9.0	**8.0**	**Board Code of Conduct Updated**	**September 2020**
8.0	**6.0 (6.27.1.6.6)**	**Reasons for a single tender action to be reported to the Audit Committee and through the Board of Directors in the Chair's Report.**	
8.0	**6.0 (6.27.1.6.6)**	**All requests to waive tenders to the Audit Committee quarterly and not directly to the Board of Directors**	**July 2020**
8.0	**5.0, Table B**	**OJEU threshold updated from £181,302 to &189,330**	**July 2020**
8.0	**5.0, Table B (4)**	**Provision 'Requisitioning stock and non-stock items / services against a budget, in line with EU procurements thresholds (subject to periodic review) and quotation and tendering procedures set out under Section 6' amended to 'Approving requisitions, authorising invoices and recommending contract awards'.**	**July 2020**
8.0	**5.0, Table A (35, h)**	**Removal of the provision - 'Decide if late tenders should be considered'.**	**July 2020**
8.0	**5.0, Table A (35, a)**	**Provision added – 'Entering into contracts on behalf of the Trust, regardless of value'**	**July 2020**
8.0	**5.0, Table A (35, b)**	**Removal of Head of Estates from Operational Responsibility**	**July 2020**
8.0	**5.0, Table A (30, e)**	**Insertion of '…in line with national requirements' following the 'prompt payment of accounts' section**	**July 2020**
8.0	**5.0, Table A (34, w)**	**Authority to authorise overtime – limited to Clinical Directors and Chief Operating Officer. To encourage preferred option of utilising the Bank rather than overtime.**	**July 2020**
8.0	**5.0, Table A (34, nn)**	**Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances – provision removed.**	**July 2020**
8.0	**5.0, Table A (34, x)**	**Reference 'authorised approvers' in place of budget holders.**	**July 2020**
8.0	**5.0, Table A (34, k)**	**Addition of '…at recruitment stage' to the provision of the granting of additional increments.**	**July 2020**
8.0	**5.0, Table A (34, q)**	**Remove section on 'Authorise car users' – Trust no longer has a car lease scheme.**	**July 2020**
8.0	**5.0, Table A (34, p)**	**Renewal of fixed term contract – role of Vacancy Control Panel stated.**	**July 2020**

8.0	**5.0, Table A (17, l)**	**Reference to 'All corporate posts to be reviewed by the Vacancy Control Panel and all clinical posts by the Executive team' added to operational responsibility.**	**July 2020**
8.0	**5.0, Table A (33, c)**	**Operational responsibility for Informing staff of their duties in respect of patients' property noted as being Head of Governance and Quality rather than Head of Legal Services.**	**July 2020**
8.0	**5.0, Table A (34, i)**	**Removal of line managers from being authorised to book agency staff. In relation to Nursing and Midwifery agency staff, line managers to be replaced with Heads of Nursing / Midwifery.**	**July 2020**
8.0	**5.0, Table A (34, i)**	**Deputy Chief Nurse and Midwife or Matron listed as having operational responsibility for approving bank usage.**	**July 2020**
8.0	**5.0, Table A (17, i)**	**Responsibility to Identify and implement cost improvements and income generation activities in line with the Operational Plan identified as being all budget holders.**	**July 2020**
8.0	**5.0, Table A (throughout)**	**References to 'business plan' removed from budget section and replaced with operational plan.**	**July 2020**
8.0	**5.0, Table A (17, b)**	**Operational responsibility for budget submissions to the Board identified as Deputy Chief Finance Officer (from Chief Finance Officer)**	**July 2020**
8.0	**5.0, Table A (throughout)**	**Removal of reference to Corporate Administration Manager**	**July 2020**
8.0	**5.0, Table A**	**Caldicott Guardian changed from Chief Nurse and Midwife to Medical Director**	**July 2020**
8.0	**5.0, Table A (throughout)**	**Removal of references to Hewitt Centre Managing Director**	**July 2020**
8.0	**Throughout**	**Change of job titles:** • **Director of Operations changed to Chief Operating Officer** • **Director of Workforce & Marketing to Chief People Officer**	**July 2020**
8.0	**4.2**	**Trust Board Terms of Reference added**	**July 2020**
8.0	**4.0**	**Approved committee membership, Committee Structure and terms of reference added.**	**July 2020**
7.0	**4.0**	**Approved committee membership, Committee Structure and terms of reference added.**	**July 2019**
7.0	**5.0, Table A**	**Section 13 - Conflicts of interest definition of decision-making staff in compliance of the Trust's policy 'Managing conflicts of Interest'**	**July 2019**

7.0	**5.0, Table A**	**Section 22 – Gifts and Hospitality- Threshold increased in line with the Trust Policy 'Managing conflict of Interest' from £25 to £50.**	**July 2019**
6.0	**4.0**	**Approved committee membership and terms of reference added.**	**05.07.18**
5.2	**5.0 Table B**	**OJEU threshold has changed and been updated. Threshold value amended from £164,176 (ex VAT) to £181,302 (ex VAT).**	**09.01.2018**
5.1	**4.0**	**Change of name of Governance and Clinical Assurance Committee to the Quality Committee Amended Terms of Reference of the Quality Committee and Remuneration and Nominations Committee Amended Integrated Structure Charts**	**08.01.2018**
4.1	**4.0**	**Board approved Terms of reference added**	**07.07.17**
	Table B – Delegated Financial Limits	**Threshold value amended from £172,514 ex VAT when in fact it should be £164,176 ex VAT.**	**15.06.17**
4.0	**4.0**	**Board approved Terms of reference added**	**30.01.17**
	5.0	**Table B – Delegated Financial Limits**	**30.01.17**
	6.0	**Amendments to Standing Financial Instructions.**	**30.01.17**
	All	**Changes to names throughout the document, i.e. Trust regulator name, job titles of directors, heads of departments. Full reformat required to provide consistency.**	**30.01.17**
3.0	**4.0 Terms of reference**	**Board approved Terms of reference added**	**27.07.15**
	Table A	**Amended job titles of Directors. Amended waiving requirements to include delegated authority to authorise the use of a waiver. Amended thresholds to reflect the revised EU threshold.**	**27.07.15**
	6.0	**Prudential Borrowing Code removed as is no longer a requirement The approval limits for Charitable Expenditure updated.**	**27.07.15**
2.0	**4.0 Terms of reference**	**Board approved Terms of reference added**	**03.10.14**
1.1	**6.12.3 6.13.3.2 Table A Table B**	**Minor amendments approved by Board of Directors in April 2014.**	**05.04.14**

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1. Foreword

1.1. Liverpool Women's NHS Foundation Trust (the Trust) is a public benefit corporation that was established in accordance with the provisions of the National Health Service Act 2006. As a body corporate the Trust has specific powers to contract in its own name and to act as a corporate trustee.

1.2. Corporate governance is the system by which an organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability and probity. Effective corporate governance, along with clinical governance, is essential for a Foundation Trust to achieve its clinical, quality and financial objectives. Fundamental to effective corporate governance is having the means to verify the effectiveness of this direction and control. This is achieved through integrated governance.

1.3. The NHS Act 2006 and subsequent regulations set out the legal framework within which the Foundation Trust operates. The Trust's Constitution sets out who can be members of the Foundation Trust and how it should conduct its business. The Licence is provided by NHS Improvement (the independent regulator of Foundation Trusts) and identifies the conditions of operation. The Accounting Officer Memorandum requires Foundation Trust Boards of Directors to adopt schedules of reservation and delegation of powers and to set out the financial framework within which the organisation operates.

1.4. This corporate governance manual comprises:

- Schedule of matters reserved to the Board of Directors
- Matters delegated by the Board of Directors to its committees
- Scheme of delegation
- Standing Financial Instructions
- Standing Orders for the Board of Directors
- Code of Conduct for the Board of Directors
- Council of Governors' Code of Conduct
- Code of Conduct for NHS Managers
- Standards of Business Conduct for NHS Staff
- Standing Orders for the Council of Governors.

1.5. Compliance with these documents is required of the Foundation Trust, its Executive and Non-Executive Directors, Governors, officers and employees, all of whom are also required to comply with:

- The Trust's Constitution and Provider Licence
- The Accounting Officer Memorandum.

1.6. The Trust must also have agreed its own Standing Orders as a framework for internal governance. Standing Orders for both the Board of Directors and Council of Governors are included in this corporate governance manual.

1.7. All of the above-mentioned documents together provide a regulatory framework for the business conduct of the Foundation Trust.

1.8. The Foundation Trust Board of Directors also has in place Audit, Nomination and Remuneration committees and an established framework for managing risk.

1.9. It is essential that all Directors, Governors, officers and employees know of the existence of these documents and are aware of their responsibilities include within. A copy of this

manual is available on the Trust's website and intranet and has been explicitly brought to the attention of key staff within the organisation and to all staff via the internal communication routes.

1.10. Any queries relating to the contents of these documents should be directed to the Chief Finance Officer, Trust Secretary or myself who will be pleased to provide clarification.

Kathryn Thomson
Chief Executive
July 2021

2. Definition and interpretation

2.1. Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this corporate governance manual bear the same meaning as in the NHS Act 2006 and the Constitution. References to legislation include all amendments, replacements, or re-enactments made.

2.2. Headings are for ease of reference only and are not to affect interpretation. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

2.3. In this corporate governance manual, the following definitions apply:

	Definition
The 2012 Act	The Health and Social Care Act 2012
The 2006 Act	The National Health Service Act 2006
The 1977 Act	The National Health Service Act 1977
Accounting Officer	The person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act; they shall be the Officer responsible and accountable for funds entrusted to the Foundation Trust in accordance with the NHS Foundation Trust Accounting Officer Memorandum. They are responsible for ensuring the proper stewardship of public funds and assets. The NHS Act 2006 designates the Chief Executive of the NHS Foundation Trust as the Accounting Officer
Agenda Item	• Board of Directors - an item from a Board member (notice of which has been given) about a matter over which the Board has powers or duties or which affects the services provided by the Foundation Trust • Council of Governors – an item from a Governor or Governors (notice of which has been given) about a matter over which the Council has powers or duties or which affects the services provided by the Foundation Trust
Appointing organisations	Those organisations named in the constitution who are entitled to appoint governors
Authorisation	An authorisation given by NHS Improvement under Section 35 of the 2006 Act
The Board	The Board of Directors of the Foundation Trust as constituted in accordance with the Trust's constitution
Bribery Act	The Bribery Act 2010
Budget	A resource, expressed in financial or workforce terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Foundation Trust
Budget holder	The Director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation
The Chair	Is the person appointed by the Council of Governors to lead the Board and ensure it successfully discharges its overall responsibility for the Foundation Trust as a whole. It means the Chair of the Foundation Trust, or, in relation to the

	Definition
	function of presiding at or chairing a meeting where another person is carrying out that role as required by the Constitution, such person
Chief Executive	The chief officer of the Foundation Trust
Committee	A committee or subcommittee created and appointed by the Foundation Trust
Constitution	The constitution of the Foundation Trust as amended from time to time. Describes the type of organisation, its primary purpose, governance arrangements and membership
Contracting and procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets
Council of Governors	The Council of Governors of the Foundation Trust as constituted in accordance with the Trust's constitution
Director	A member of the Board of Directors
Chief Finance Officer	The chief finance officer of the Foundation Trust
External auditor	The person appointed to audit the accounts of the Foundation Trust, who is called the auditor in the 2006 Act
Financial year	Successive periods of twelve months beginning with 1 April
Foundation Trust	Liverpool Women's NHS Foundation Trust
Foundation Trust contract	Agreement between the Foundation Trust and Clinical Commissioning Groups and/or others for the provision and commissioning of health services
Funds held on Trust	Those trust funds which the Foundation Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under the 2006 Act. Such funds may or may not be charitable
Governor	An elected or appointed member of the Council of Governors
Legal advisor	A properly qualified person appointed by the Foundation Trust to provide legal advice
Licence	The document issued by the sector regulator setting out the conditions of operation for a Foundation Trust
NHS Improvement (previously known as Monitor)	The independent regulator (NHS Improvement) took over the responsibilities of its predecessors responsibilities from [1 April 2016]
Meeting	• Board of Directors – a duly convened meeting of the Board of Directors • Council of Governors - a duly convened meeting of the Council of Governors
Member	A member of the Foundation Trust
Motion	A formal proposition to be discussed and voted on during the course of a meeting
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions
Non commissioner contract	Agreements with non Clinical Commissioning Group t organisations covering the variety of services that the Foundation Trust provides and charges for

	Definition
Officer	An employee of the Foundation Trust
Partner	In relation to another person, a member of the same household living together as a family unit
Protected property	Property identified in the Licence as being protected. This will generally be property that is required for the purposes of providing the mandatory goods and services and mandatory training and education
Registered medical practitioner	A fully registered person within the meaning of the Medicines Act 1983 who holds a licence to practice under that Act
Registered nurse or midwife	A nurse, midwife or health visitor registered in accordance with the Nurses, Midwives and Health Visitors Act 1997
Secretary	The Secretary appointed under the constitution, the Secretary of the Foundation Trust or any other person appointed to perform the duties of the Secretary, including a joint, assistant or deputy secretary
Standing Financial Instructions	(SFIs) regulate the conduct of the Trust's financial matters
Standing Orders	(SOs) incorporate the Constitution and regulate the business conduct of the Foundation Trust

3. Schedule of matters reserved to the Board of Directors

3.1. General enabling provisions

3.1.1. The Board of Directors may determine any matter it wishes, for which it has authority, in full session within its statutory powers. In accordance with the Code of Conduct and Accountability adopted, the Board explicitly reserves that it shall itself approve or appraise, as appropriate, the following matters detailed in paragraph 3.3 below. All Board members share corporate responsibility for all decisions of the Board and the Board remains accountable for all of its functions, even those delegated to individual committees, subcommittees, directors or officers.

3.2. Duties

It is the Board's duty to:

- Act within statutory financial and other constraints
- Be clear what decisions and information are appropriate to the Board of Directors and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these
- Ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account
- Establish performance and quality measures that maintain the effective use of resources and provide value for money;
- Specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities;
- Establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.

3.3. Reserved matters

3.3.1. Standing Orders

Approval of and changes to Board standing orders.

3.3.2. Matters of Governance

- Approval of and changes to the schedule of matters reserved to the Board of Directors
- Approval of and changes to the standing financial instructions
- Suspension of Board standing orders
- Ratify or otherwise instances of failure to comply with standing orders brought to the Chief Executive's attention in accordance with Standing Orders
- Ratification of any urgent decisions taken by the Chair and Chief Executive, in accordance with the standing orders
- Approval of and changes to codes of conduct
- Approval of the Trust's risk assurance framework
- Approval of the Board's scheme of reservation and delegation
- Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Foundation Trust and approval of any changes
- Approval of the remit and membership of Board committees, including
- Approval of terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board of Directors
- To confirm the recommendations of committees where they do not have executive powers

- To receive reports from committees including those which the Foundation Trust is required by the National Health Service Act 2006 or other regulation to establish and to take appropriate action thereon
- Audit arrangements
- Clinical audit arrangements
- The annual audit letter
- Annual report (including quality report/accounts) and statutory financial accounts of the Trust
- Annual report and accounts for funds held on trust (charitable funds)
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a corporate trustee for funds held on trust
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a bailer for patients' property
- Disciplining Board members or employees who are in breach of statutory requirements or Standing Orders.

3.3.3. Important regulatory matters

- Compliance with the Trust's Licence or any document which replaces it, its constitution and all statutory and regulatory obligations
- Directors' and officers' declaration of interests and determination of action if required
- Arrangements for dealing with complaints
- Disciplinary procedures for officers of the Trust.

3.3.4. Appointments and dismissals

- Appointment and dismissal of committees (and individual members) that are directly accountable to the Board of Directors excluding the Audit Committee, the Nomination & Remuneration Committee. This does not imply that individual members of all Committees can be dismissed
- Appointment, appraisal, disciplining and dismissal of Executive Directors
- Confirm the appointment of members of any committee of the Foundation Trust as representatives on outside bodies
- Appoint, appraise, discipline and dismiss the Trust Secretary
- Approve proposals received from the Nomination & Remuneration Committee regarding the Chief Executive, Directors and senior employees.

3.3.5. Strategic direction

- Strategic aims, direction and objectives of the Foundation Trust
- Financial plans and forecasts
- Approval of the Trust's annual plan, strategic developments and associated business plans
- Approval of annual revenue and capital budgets
- Approval of all Trust strategies to include, but not be limited to the risk management strategy and human resources strategy
- Approval of capital plans including:
    - Proposals for acquisition, disposal or change of use of land and/or buildings
    - Private finance initiative (PFI) proposals
    - Individual contracts, including purchase orders of a capital or revenue nature in accordance with Delegated Financial Limits, Table B, section 2.
- Approve proposals for action on litigation against or on behalf of the Foundation Trust where the likely financial impact is as shown in the Delegated Financial Limits, Table B, section 2 or contentious or likely to lead to extreme adverse publicity, excluding claims covered by the NHS risk pooling schemes.

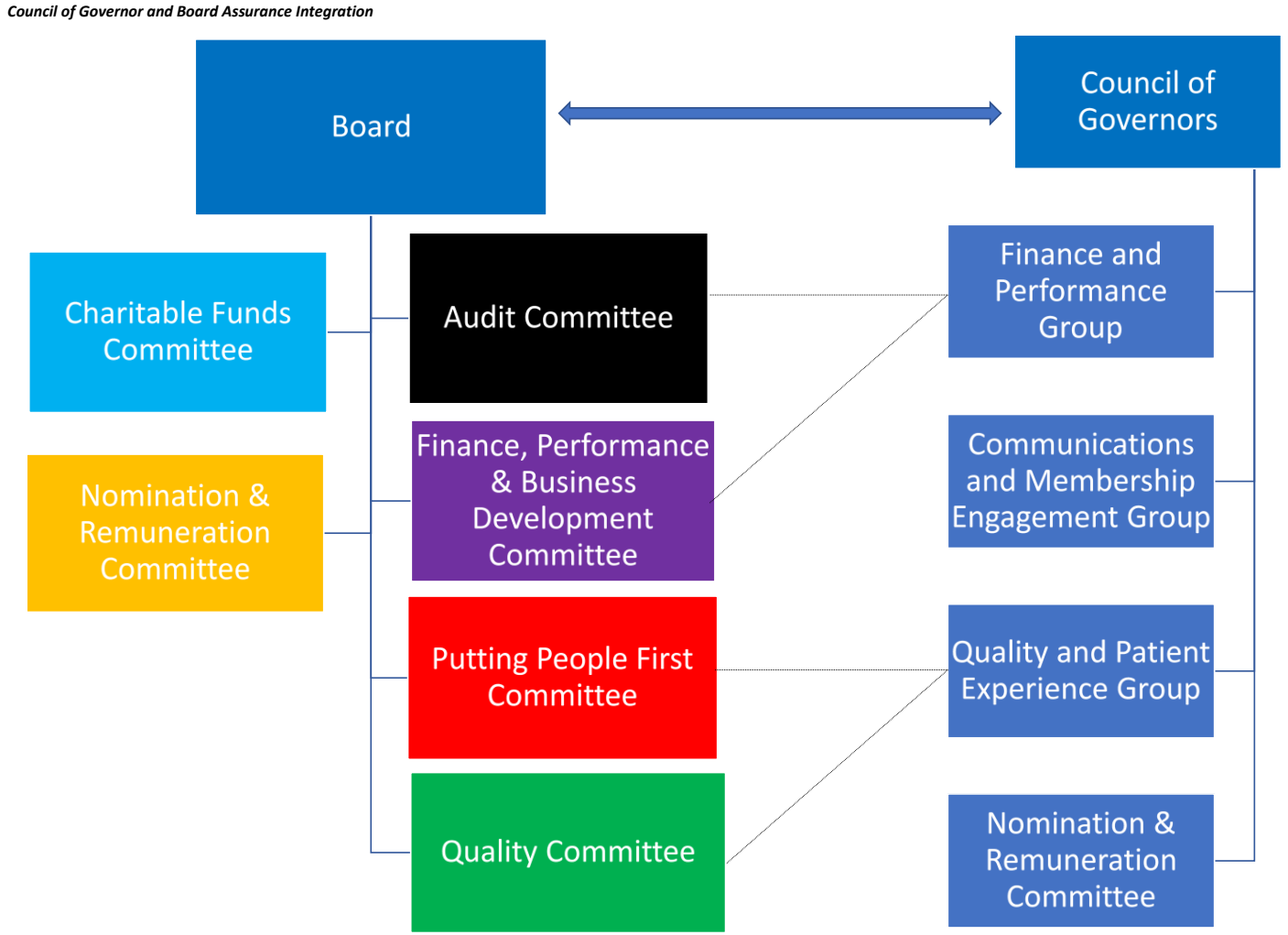
3.3.6. Monitoring performance
Operational and financial performance arrangements at intervals that it shall determine.

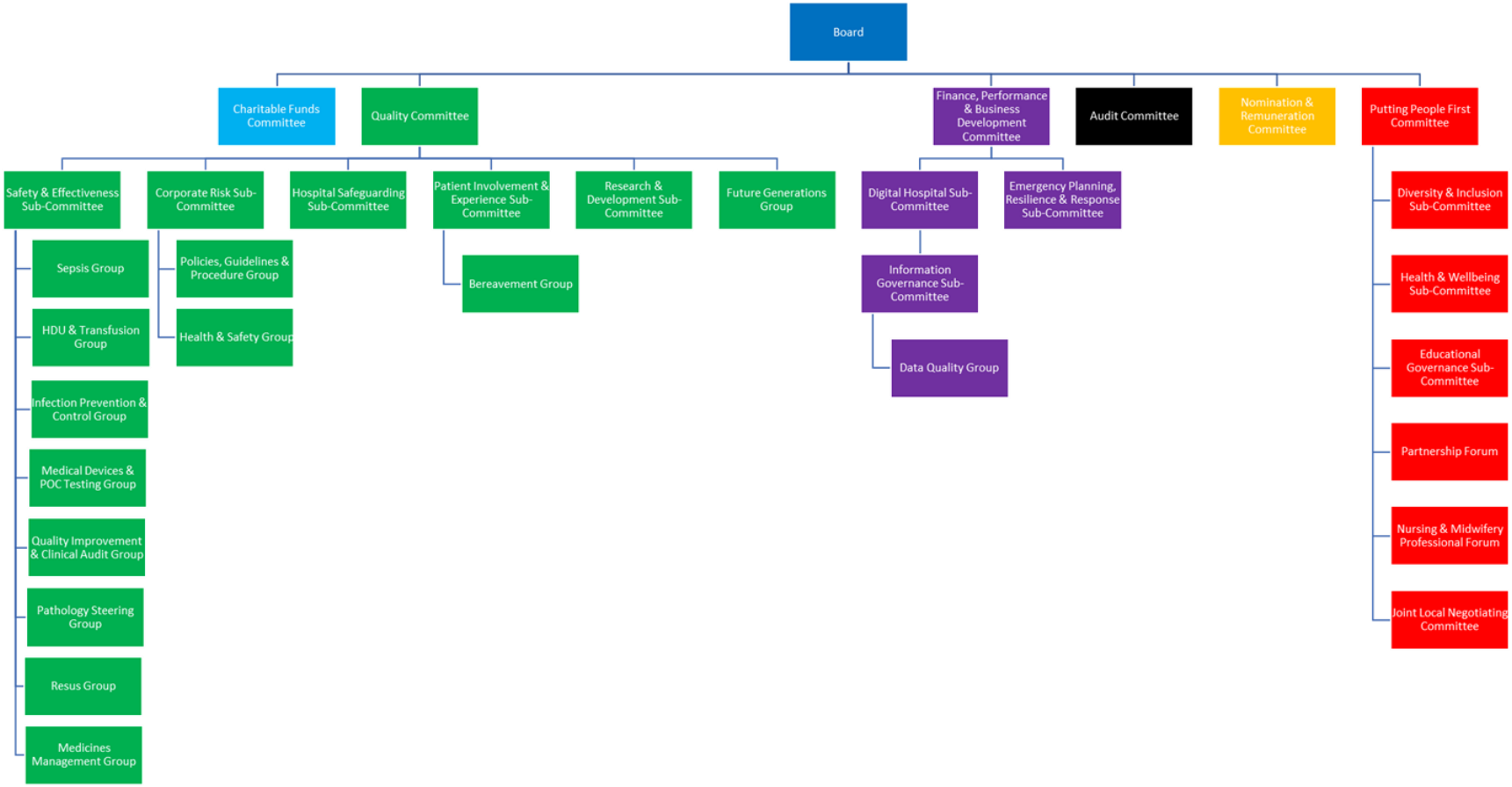
3.3.7. Other matters

- Appointment of bankers
- Approve the opening of bank accounts.
- Approve individual compensation payments.

4. Matters delegated by the Board of Directors to its committees

4.1. Committee Structure




Board
Charitable Funds Committee
Quality Committee
Finance, Performance & Business Development Committee
Audit Committee
Nomination & Remuneration Committee
Putting People First Committee
Safety & Effectiveness Sub-Committee
Corporate Risk Sub-Committee
Hospital Safeguarding Sub-Committee
Patient Involvement & Experience Sub-Committee
Research & Development Sub-Committee
Future Generations Group
Digital Hospital Sub-Committee
Emergency Planning, Resilience & Response Sub-Committee
Diversity & Inclusion Sub-Committee
Sepsis Group
HDU & Transfusion Group
Infection Prevention & Control Group
Medical Devices & POC Testing Group
Quality Improvement & Clinical Audit Group
Pathology Steering Group
Resus Group
Medicines Management Group
Policies, Guidelines & Procedure Group
Health & Safety Group
Bereavement Group
Information Governance Sub-Committee
Data Quality Group
Health & Wellbeing Sub-Committee
Educational Governance Sub-Committee
Partnership Forum
Nursing & Midwifery Professional Forum
Joint Local Negotiating Committee

Board Committee Non-Executive Director membership.

For additional members please refer to TORs.

Board Committee	NED Membership
Audit Committee *Membership requirement is not less than 3 Non-Executive Directors*	Chair: Tracy Ellery NED: Susan Milner NED: Ian Knight Accountable exec: Chief Finance Officer
Finance Performance and Business Development Committee *Membership includes NED Chair and one additional NED* *Additional NED for succession/continuity/ development*	Chair: Tracy Ellery NED: Ian Knight NED: Jo Moore NED: Louise Martin Accountable exec: Chief Finance Officer
Quality Committee *Membership includes NED Chair and one additional NED* *Additional NED for succession/continuity/ development*	Chair: Tony Okotie NED: Susan Milner NED: Ian Knight NED: Louise Kenny Accountable exec: Chief Nurse and Midwife & Medical Director
Putting People First Committee *Membership includes NED Chair and one additional NED* *Additional NED for succession/continuity/ development*	Chair: Jo Moore NED: Tracy Ellery NED: Susan Milner NED: Louise Martin Accountable exec: Chief People Officer
Charitable Funds Committee *Membership includes NED Chair and one additional NED* *Additional NED for succession/continuity/ development*	Chair: Jo Moore NED: Louise Martin NED: Tony Okotie Accountable exec: Chief People Officer
Board Nomination and Remuneration Committee	Chair: Robert Clarke NED: Tony Okotie

Membership includes Chair and all NED's	Ian Knight Tracy Ellery Jo Moore Louise Martin Susan Milner Louise Kenny

4.2. Board of Directors Terms of Reference

BOARD OF DIRECTORS TERMS OF REFERENCE	
Role and Purpose:	The Terms of Reference describe the role and working of the Board of Directors (hereafter referred to as the Board) and are for the guidance of the Board, for the information of the Trust as a whole and serve as the basis of the Terms of Reference for the Board's own Committees. The Trust exists to 'provide goods and services for any purposes related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.' The Trust has a Board which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a Committee of directors or to the Chief Executive. The Board consists of Executive Directors, one of whom is the Chief Executive, and Non-Executive Directors, one of whom is the Trust Chair. The nominated deputy for the Chief Executive and Trust Chair, upon appointment to a substantive or acting up role, must be formally recorded in the minutes.
Duties:	The Board leads the trust by undertaking four key roles: • setting strategy; • supervising the work of the executive in the delivery of the strategy and through seeking assurance that systems of control are robust and reliable; • setting and leading a positive culture for the Board and the organisation; • giving account and answering to key stakeholders, particularly the Council of Governors. The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public. Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust). The practice and procedure of the meetings of the Board, and of its committees, are not set out here but are described in the Board's Standing Orders.

GENERAL RESPONSIBILITIES:

The general responsibilities of the Board are:

- to maintain and improve quality of care;
- to work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, effective, accessible, and well governed services for patients, service users and carers;
- to ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity;
- to ensure relationships are maintained with the Trust's stakeholders, regulators, public, governors, staff and patients, such that the trust can discharge its wider duties;
- to exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner;
- to ensure compliance with all applicable law, regulation and statutory guidance.

In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of non-executive and executive directors.

LEADERSHIP

The Board provides active leadership to the organisation by:

- ensuring there is a clear vision and strategy for the Trust that is well known and understood by stakeholders and is being implemented within a framework of prudent and effective controls which enable risk to be assessed and managed;
- ensuring the Trust is a good employer by the development of a workforce strategy and its appropriate implementation and operation;
- implementing effective Board and Committee structures and clear lines of reporting and accountability throughout the organisation.

STRATEGY

The Board:

- sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;

	• monitors and reviews management performance to ensure the Trust's objectives are met; • oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required; • develops and maintains an annual business plan, with due regard to the views of the council of governors, and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders; • ensures that national policies and strategies are effectively addressed and implemented within the Trust. CULTURE, ETHICS AND INTEGRITY The Board: • is responsible for setting values, ensuring they are widely communicated and adhered to and that the behaviour of the Board is entirely consistent with those values; • promotes a patient-centred culture of openness, transparency and candour; • ensures that high standards of corporate governance and personal integrity are maintained in the conduct of foundation trust business. GOVERNANCE The Board: • ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance and appropriate codes of conduct, accountability and openness applicable to NHS provider organisations; • ensures that all licence conditions relating to the Trust's governance arrangements are complied with; • ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements; • ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective and safe services taking account of patient and carer experiences and maintaining the dignity of those cared for; • ensures that all the required returns and disclosures are made to the regulators;

	• formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation trust business; • agrees the schedule of matters reserved for decision by the Board of Directors; • ensures that the statutory duties of the Trust are effectively discharged; • Acts as corporate trustee for the Trust's charitable funds. RISK The Board: • ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities; • ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement in the development of care plans, the review of quality of services provided and the development of new services; • ensures there are appropriately constituted appointment and evaluation arrangements for senior positions such as consultant medical staff and those reporting to executive directors. COMMUNICATION The Board: • Ensures an effective communication channel exists between the Trust, its governors, members, staff and the local community. • Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback. • Ensures that those Board proceedings and outcomes that are not confidential are communicated publicly through Board meetings in public and also via the Trust's website. FINANCIAL AND QUALITY SUCCESS The Board: • Ensures that an effective system of finance and quality is embedded within the Trust. • Ensures that the Trust operates effectively, efficiently and economically. • Ensures the continuing financial viability of the organisation. • Ensures the proper management of resources and that financial and quality of service responsibilities are achieved. • Ensures that the Trust achieves the quality targets and requirements of stakeholders within the available resources.

- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

RESPONSIBILITIES OF BOARD MEMBERS

All Members of the Board:

- Have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not impact upon the particular responsibilities of the Chief Executive as the Accounting Officer.
- Have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

Role of the Trust Chair:

The Trust Chair is the guardian of the Board's decision-making processes and provides general leadership of the Board and the Council of Governors.

- Responsible for leading the Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.
- Reports to the Board and is responsible for the effective operation of the Board and the Council of Governors.
- Responsible for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives.

Role of the Chief Executive

- The Chief Executive reports to the Trust Chair and to the Board directly. All members of the management structure report either directly or indirectly to the Chief Executive.
- The Chief Executive is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.
- The Chief Executive is responsible for implementing the decisions of the Board and its Committees, providing information and support to the Board and Council of Governors.

Role of Executive Directors (EDs)

- Share collective responsibility with the Non-Executive Directors as part of a unified Board.
- Shape and deliver the strategy and operational performance in line with the Trust's strategic aims.

Role of Non-Executive Directors (NEDs)

	• Bring a range of varied perspectives and experiences to strategy development and decision making. • Ensure that effective management arrangements and an effective management team are in place. • Hold the Executive Directors to account for performance of the operational responsibilities. • Scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. NEDs should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented. • To take an active role in providing advice, support and encouragement to Executive Directors. Role of the Senior Independent Director (SID) • Is a Non-Executive Director appointed by the Board in consultation with the Council of Governors to undertake the role. Normally the SID will not be the Vice Trust Chair although this may be the case if the Board deems it necessary. • Will be available to members of the Foundation Trust and to Governors if they have concerns which, contact through the usual channels of the Trust Chair, Chief Executive, Deputy Chief Executive, Chief Finance Officer and Trust Secretary, has failed to resolve or where it would be inappropriate to use such channels. • Has a key role in supporting the Trust Chair in leading the Board and acting as a sounding board and source of advice for the Trust Chair. The SID has a role in supporting the Trust Chair in his/her role as Trust Chair of the Council of Governors. In addition to the duties described here, the SID has the same duties as the other Non-Executive Directors. Role of the Trust Secretary The Trust Board shall be supported by the Trust Secretary whose duties in this respect will include: • agreement of the agenda, for Board and Board committee meetings, with the relevant Chair, in consultation with the Chief Executive; • collation of reports and papers for Board and committee meetings; • ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward; • ensuring that board procedures are complied with;

	• supporting the Chair in ensuring good information flows within and between the Board, its committees, the Council of Governors and senior management; • advising the Board and Board committees on governance matters; • supporting the chair on matters relating to induction, development and training for directors

Membership:	The composition of the Board shall be:
	• A Non-Executive Chair
	• Not more than seven other non-executive Directors
	• Not more than seven executive Directors including:
	  ○ The Chief Executive (who is the Accounting Officer)
	  ○ The finance director
	  ○ A registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984)
	  ○ A registered nurse or registered midwife.

Quorum:	Six Directors including not less than three executive Directors (one of whom must be the Chief Executive or another Executive Director nominated by the Chief Executive) and not less than three non-executive Directors (one of whom must be the Chair or the Vice Chair of the Board of Directors) shall form a quorum. An officer in attendance for an executive Director but without formal acting up status may not count towards the quorum. If a Director has been disqualified from participating in a discussion on any matter and/or from voting on any resolution by reason of declaration of a conflict of interest, that Director shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minute of the meeting. The meeting must then proceed to the next business.
Voting:	All questions put to the vote shall, at the discretion of the Chair, be decided by a show of hands save that no resolution of the Board of Directors shall be passed if it is opposed by all of the non-executive Directors present or by all of the executive Directors present. A paper ballot may be used if a majority of the Directors present so request. In case of an equality of votes the Chair shall have a second and casting vote.

	If at least one third of the Board members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot). If a Board member so requests, her vote shall be recorded by name. In no circumstances may an absent Director vote by proxy. Subject to Standing Order 59, absence is defined as being absent at the time of the vote. An officer who has been appointed formally by the Board to act up for an executive Director during a period of incapacity or temporarily to fill an executive Director vacancy, shall be entitled to exercise the voting rights of the executive Director. An officer attending the Board to represent an executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive Director. An officer's status when attending the meeting shall be recorded in the minutes. Where an executive Director post is shared by more than one person: • Each person shall be entitled to attend meetings of the Board • Each of those persons shall be eligible to vote in the case of agreement between them • In the case of disagreement between them no vote should be case • The presence of those persons shall count as one person.
Attendance:	The Board of Directors may agree that Directors can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting. Directors who are unable to attend a meeting shall notify the Secretary in writing in advance of the meeting in question so that their apologies may be submitted.
Frequency:	Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Secretary will publish the dates, times and locations of meetings of the Board in advance.
Accountability and reporting arrangements:	The Council of Governors is responsible for holding the Board to account, for example by attending Board meetings in public and meeting with the Trust Chair, Chief Executive and Committee Chairs on the day of Board meetings / Council of Governors' meeting. The agenda and minutes of Board meetings will be shared with the Council of Governors.

	The Trust Chair will be responsible for ensuring the Board of Directors adheres to its Terms of Reference and Annual Work Plan. The Board shall self-assess its performance following each board meeting. A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all directors and others as agreed with the Chair and Chief Executive from time to time.
Monitoring effectiveness:	The Board will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Board.
Reviewed by Board of Directors:	*1 April 2021*
Approved by Board of Directors:	1 April 2021
Review date:	April 2022
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

4.3. Committees of the Board – Terms of Reference

- Audit Committee
- Nomination & Remuneration Committee
- Quality Committee
- Putting People First Committee
- Finance, Performance and Business Development Committee
- Charitable Funds Committee

AUDIT COMMITTEE
TERMS OF REFERENCE

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

- The arrangements by which Trust staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In so doing the Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

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

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

b. Internal audit

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

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

c. External audit

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

- Consideration of the appointment and performance of the external auditor, including making recommendations to the Council of Governors regarding the former

- Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure coordination with internal auditors and with other external auditors

- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

- Reviewing all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any audit work performed outside the annual audit plan, together with the appropriateness of management's response

- Recommending to the Council of Governors the engagement of the external auditor in respect of non-audit work, taking into account relevant ethical guidance regarding the provision of such services

- Annual review of the effectiveness of external audit.

d. Other assurance functions

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

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

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

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

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

	The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be two members.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. **b. Officers** The Chief Finance Officer, Deputy Chief Finance Officer, Financial Controller and Deputy Chief Nurse and Midwife shall normally attend meetings. At least once a year the Committee will meet privately with external and internal auditors. The Chief Executive and other executive directors will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are within the responsibility of that director. The Chief Executive will also be required to attend when the Audit Committee discusses the process for assurance that supports the Annual Governance Statement. The Trust Secretary will attend to provide appropriate support to the Chair and Committee members.
Frequency:	Meetings shall be held at least four times per year. The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

Accountability and reporting arrangements:	The Audit Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year and, as part of this report, will provide commentary in support of the Annual Governance Statement (AGS), specifically dealing with the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts. In providing this commentary in support of the AGS the Committee will seek relevant assurance from the Chair of the Board's Quality Committee. Trust standing orders and standing financial instructions apply to the operation of the Audit Committee.
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Audit Committee:	23 March 2021
Approved by Board of Directors:	01 April 2021
Review date:	March 2022
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

NOMINATION & REMUNERATION COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Nomination and Remuneration Committee (the Committee).
Duties:	The Committee is responsible for: a. Overseeing the recruitment and selection process for the posts of [1]Chief Executive and Executive Directors b. Preparing a description of the role and capabilities required for the Chief Executive and Executive Director posts to reflect the balance of skills, knowledge and experience required c. Succession planning Executive appointments taking into account the challenges and opportunities facing the Trust and the skills and expertise required on the Board d. Reviewing the structure, size and composition of the Executive Director composition of the Board of Directors e. Reviewing Executive Directors' performance. f. Determining the remuneration and terms of service of the Chief Executive and the Executive Management Team g. Determining the annual cost of living award for senior managers (excluding those paid under Agenda for Change arrangements) h. Succession planning for Executive Director appointments i. Overseeing agreement of appropriate contractual arrangements relating to the Chief Executive and Executive Management Team j. Scrutinising any termination payments relating to the Chief Executive or the Executive Management Team, ensuring that they have been properly calculated and take account of any relevant guidance k. To be responsible for any disciplinary issue relating to the Chief Executive or member of the Executive Management Team which may result in their dismissal? The Committee will not be responsible for any disciplinary issue which is short of dismissal l. Such other duties as the Board of Directors may delegate.

Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Trust Chair • All Non-Executive Directors

[1] Note that Chief Executive appointments are subject to approval by the Council of Governors

	Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Chair of the Board of Directors will be the Chair of the Committee. The Vice Chair of the Board will be the Vice Chair of the Committee from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent.
Quorum:	A quorum shall be three members including the Chair or Vice Chair and at least two Non-Executive Directors.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. **b. Officers** The Chief Executive and Chief People Officer (or equivalent executive lead for the Trust with responsibility for the human resources functions of the Trust) will be in attendance at its meetings, as and when appropriate and necessary. The Trust Secretary will act as Secretary to the Committee.
Frequency:	Meetings shall be held at least once per year or as required to fill Executive Director vacancies. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Nomination and Remuneration Committee will be accountable to the Board of Directors. The minutes of the Nomination & Remuneration Committee will be

	formally recorded and submitted to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it or require executive action. Summary minutes will also be circulated to members of the Audit Committee. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Remuneration and Nomination Committee.
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Nominations Committee:	1 July 2021
Approved by Board of Directors:	TBC
Review date:	April 2022
Document owner:	Mark Grimshaw, Trust Secretary 0151 702 4033

QUALITY COMMITTEE
TERMS OF REFERENCE

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

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

Strategy and Performance

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

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

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

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

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

Governance

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

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

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

i) Obtain assurance that the Trust is compliant with guidance from NICE (through receipt of an Annual Report) and other related bodies.

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

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

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

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

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

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

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

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

Overall

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

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

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

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

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

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

- Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- *Medical Director
- *Chief Nurse and Midwife
- *Chief Finance Officer
- *Chief People Officer
- *Chief Operating Officer
- Deputy Chief Nurse and Midwife
- Head of Governance

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

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

The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
A quorum shall be three members including two Non-Executive Directors and one Executive Director (one of whom must be either the Medical Director or Chief Nurse and Midwife or their deputy). The Chair of the Trust may be included in the quorum if present.
Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
a) Members Members will be required to attend a minimum of 75% of all meetings. b) Officers The Trust Secretary shall normally attend meetings. Other executive directors (including the Chief Executive) and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Meetings shall be held monthly. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.
The Quality Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Committee.
The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) Annual Report setting out the progress they have made and future developments.

The following sub committees/groups will report directly to the Committee: • Effectiveness and Safety Sub-Committee • Patient Involvement & Experience Sub-Committee • Corporate Risk Sub-Committee • Trust Safeguarding Sub-Committee • Research and Development Sub-Committee
The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
These terms of reference will be reviewed at least annually by the Committee.
22 March 2021
01 April 2021
March 2022
Mark Grimshaw, Trust Secretary, Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

FINANCE, PERFORMANCE AND BUSINESS DEVELOPMENT COMMITTEE TERMS OF REFERENCE

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

	k. Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management l. Advise the Board and maintain an oversight on all major investments, disposals and business developments. m. Advise the Board on all proposals for major capital expenditure over £500,000 n. Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors • Chief Executive • Chief Finance Officer • Director of Operations • Chief Nurse and Midwife Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	The quorum for the transaction of business shall be three members including at least two Non-Executive Directors (one of whom must be the Chair or Vice Chair of the Committee), and one Executive Director. The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**c. Members** Members will be required to attend a minimum of 50% of all meetings. **d. Officers**

	Ordinarily the Deputy Chief Finance Officer and Trust Secretary will attend all meetings. Other executive directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.
Frequency:	Meetings shall be held at least 8 times per year. Additional meetings may be arranged if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.
Accountability and reporting arrangements:	The Finance, Performance and Business Development Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Finance, Performance and Business Development Committee.
Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) an Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee (see appendix 1): • Emergency Planning Resilience & Response Committee • Digital Hospital Sub-Committee • Crown Street Enhancement Programme Board • Future Generations Project Group

Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by: Finance, Performance & Business Development Committee	23 March 2021
Approved by: Board of Directors	01 April 2021
Review date:	March 2022
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

PUTTING PEOPLE FIRST COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Putting People First Committee (the Committee).
Duties:	The Committee is responsible for: h. Developing and overseeing implementation of the Trust's People Strategy (integrated workforce, wellbeing and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process i. Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee) j. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce k. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors l. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues m. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys n. Reviewing and approving partnership agreements with staff side o. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues p. Monitor and evaluate compliance with the public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics q. Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings r. Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required. s. Receiving and considering issues from other Committees when appropriate and taking any necessary action.

Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • 2 other Non-Executive Director • *Chief People Officer • *Chief Nurse and Midwife • *Chief Operating Officer • Staff Side Chair • Medical Staff Committee representative • Senior Finance Manager *or their nominated representative who will be sufficiently senior and have the authority to make decisions. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be four members including: • The Chair or at least one other Non-Executive Director • At least one from either Director of Workforce and Marketing or Chief Nurse and Midwife • Director of Operations or their Deputy • Either Staff Side Chair or Medical Staff Committee representative
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**e. Members** Members will be required to attend a minimum of 75% of all meetings. **f. Officers** HR & OD Senior Team, Education Governance Chair, and a representative from the Nursing & Midwifery Board shall normally attend meetings. Members may send a nominated representative to attend meetings on their behalf when they are not available, provided they are sufficiently senior and have the authority to make decisions.

	Other executive directors, officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held at least 6 times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Putting People First Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the subsequent Board of Directors for assurance. Approved minutes will be made available to all Board members upon request. Approved chairs reports will also be circulated to members of the Audit Committee. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Putting People First Committee.
Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; b) an Annual Report setting out the progress they have made and future developments; c) Terms of reference

	The following sub committees/groups will report directly to the Committee: • Diversity & Inclusion Committee • Health & Wellbeing Committee • Partnership Forum • Nursing & Midwifery Professional Forum • Educational Governance Committee • Joint Local Negotiating Committee
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Putting People First Committee:	22 March 2021
Approved by Board of Directors:	01 April 2021
Review date:	March 2022
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

CHARITABLE FUNDS COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee has been established to exercise the Foundation Trust's functions as sole corporate trustee of the Liverpool Women's Charity (registered charity number 1048294). The Trust Board is regarded as having responsibility for exercising the functions of the Trustee. The Trust Board delegates these functions to the Committee, within any limits set out in these terms of reference and the sections of the standing financial instructions pertaining to charitable funds.
Duties:	The Committee's responsibilities fall broadly into the following areas: **Compliance** a. Manage the affairs of the Liverpool Women's Charity in accordance with appropriate legislation and ensure statutory compliance with the Charity Commission regulations. b. Ensure systems and processes are in place to receive, account for, deploy and invest charitable funds in accordance with charity law. c. Scrutinise requests for use of charitable funds to ensure that any such use is in accordance with the aims and purposes of any charitable fund or donation and are clinically and ethically appropriate. Committee members will bear in mind due diligence to Charity Commission and Trust guidance regarding the ethical use of funds and acceptance of donations. **Budget, Income & Expenditure** d. Review and approve an Annual Business plan and budget e. Receive and approve periodic income and expenditure statements, ensuring that performance is in line with the Charity's budget and plan. f. Receive and consider the Annual Accounts including the Annual Report from the auditors, before submission to the Board of Directors for approval. **Fundraising** g. Ensure a fundraising strategy is prepared and monitored which complies with Charity Commission guidance and legislation and which includes appropriate communication and marketing plans; h. ensure systems and processes are in place to receive, account for, deploy and invest funds raised in accordance with charity law;

	i. ensure systems, processes and communication are in place around fundraising, staff engagement and funding commitments; j. ensure a cohesive policy around external media and communication; k. encourage a culture of fundraising and raise the profile of the Charity within the Trust and with external partner organisations l. ensure effective communication regarding 'whistleblowing' relating to fundraising, donations or subsequent use of funds. **Investment Management** m. Consider and agree an investment strategy for the safe and secure investment of funds not immediately required for use, taking into account any appropriate ethical considerations. n. Appoint and review external investment advisors and operational fund managers. o. Review the performance of investments on a regular basis (utilising comparator information) with the external investment advisors to ensure the optimum return from surplus funds.
Membership:	The Committee membership shall consist of the following: • A Chairman who shall be a Non-executive director • Two other Non-executive Directors • Chief Finance Officer (or nominated deputy) • Director of Workforce and Marketing • Chief Nurse and Midwife • Financial Accountant • Head of Fundraising Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be three members which must include one Executive Director and one Non-Executive Director.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**g. Members** Members will be required to attend a minimum of 75% of all meetings.

	h. Officers The non-executive Chairman shall normally attend meetings. Other Board members shall also have right of attendance subject to invitation by the Chairman of the Committee. The Fundraiser to attend as required at request of the Committee. Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held on a quarterly basis. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. This includes seeking the advice of specialists from within and outside the NHS as appropriate.
Accountability and reporting arrangements:	The minutes of the Charitable Funds Committee shall be formally recorded and a Chair's Report will be submitted to the subsequent Board of Directors for assurance. Approved minutes will be made available to all Board members upon request.
Reporting Committees/Groups	The Charitable Funds Committee has no reporting committees / groups.
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by: Charitable Funds Committee:	15 December 2020 16 March 2021
Approved by: Board of Directors	January 2021 01 April 2021
Review date:	March 2022

Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

5. Scheme of delegation (including the NHS Foundation Trust Accounting Officer Memorandum)

5.1 Introduction

5.1.1 Reservation of powers

The Trust's Standing Orders (for its Board of Directors) provide that "Subject to the scheme of reservation and delegation, and such directions as may be given by statute, the independent regulator or the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Foundation Trust, of any of its functions by a committee or subcommittee, or by a Director or an officer of the Trust in each case subject to such restrictions and conditions as the Board things fit." The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Foundation Trust Board of Directors.

The purpose of this document is to detail how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Foundation Trust policies and procedures. The Board of Directors remains accountable for all of its functions, even those delegated to committees, subcommittees, individual directors or officers. A formal structure is in place for monitoring the functions delegated to committees and subcommittees enabling the Board to receive information and to maintain its monitoring role.

5.1.2 Role of the Chief Executive

All powers of the Foundation Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions they shall perform personally and which functions have been delegated to other directors and officers for operational responsibility.

All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

5.1.3 Caution over the Use of Delegated Powers

Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

5.1.4 Absence of Directors or Officer to whom Powers have been Delegated

In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

Further details about situations where the Accounting Officer is unable to fully discharge their responsibilities are available in the Accounting Officers' Memorandum, sections of which are reproduced below and which is available separately from NHS Improvement.

5.2 Delegation of powers

5.2.1 Delegation to committees

The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors. The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with Standing Order

7.18 committees may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors.

In exercising any delegated power a committee or director must comply with the Foundation Trust's Standing Orders, Standing Financial Instructions and written procedures and with any statutory provisions or requirements. They must not incur expenditure over and above the Foundation Trust's annual budget (excluding the Chief Executive in conjunction with the Chief Finance Officer).

In cases of doubt or difficulty and/or where no policy guidelines exist, decisions should be referred to the Board of Directors.

5.2.2 Delegation to Officers
Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive, the Chief Finance Officer and other directors.

5.2.3 The Accounting Officer Memorandum
The responsibilities of the Accounting Officer are set out in the NHS Foundation Trust Accounting Officer Memorandum[1], relevant sections of which are reproduced below:

Introduction
The National Health Service Act 2006 (the Act) designates the chief executive of an NHS foundation trust as the accounting officer.

The principal purpose of the NHS foundation trust is the provision of goods and services for the purposes of the health service in England. The NHS foundation trust has a general duty to exercise its functions effectively, efficiently and economically.
The Act specifies that the accounting officer has a duty to prepare the accounts in accordance with the Act. An accounting officer has the personal duty of signing the NHS foundation trust's accounts. By virtue of this duty, the accounting officer has the further duty of being a witness before the Public Accounts Committee (PAC) to deal with questions arising from those accounts or, more commonly, from reports made to Parliament by the Comptroller and Auditor General (C&AG) under the National Audit Act 1983.

Associated with these duties are the further responsibilities that are the subject of this memorandum. It is incumbent on the accounting officer to combine these duties with their duties to the board of directors of the NHS foundation trust.
5. It is an important principle that, regardless of the source of the funding, accounting officers are responsible to Parliament for the resources under their control.

General responsibilities
The accounting officer has responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matters. The accounting officer must ensure that:

- there is a high standard of financial management in the NHS foundation trust as a whole
- the NHS foundation trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation
- financial considerations are fully taken into account in decisions by the NHS foundation trust.

Specific responsibilities
The essence of the accounting officer's role is a personal responsibility for:

[1] NHS Foundation Trust Accounting Officer Memorandum, NHS Improvement (2015)

- the propriety and regularity of the public finances for which he or she is answerable
- the keeping of proper accounts
- prudent and economical administration in line with the principles set out in *Managing public money*
- the avoidance of waste and extravagance
- the efficient and effective use of all the resources in their charge.

As accounting officer you must:

- personally sign the accounts and, in doing, so accept personal responsibility for ensuring their proper form and content as prescribed by Monitor (now NHSI/E) in accordance with the Act
- comply with the financial requirements of the NHS provider licence
- ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS foundation trust)
- ensure that the resources for which you are responsible as accounting officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official
- ensure that assets for which you are responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate
- ensure that any protected property (or interest in) is not disposed of without the consent of Monitor
- ensure that conflicts of interest are avoided, whether in the proceedings of the board of directors, or council of governors or in the actions or advice of the NHS foundation trust's staff, including yourself
- ensure that, in the consideration of policy proposals relating to the expenditure for which you are responsible as accounting officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the board of directors.

An accounting officer should ensure that effective management systems appropriate for the achievement of the NHS foundation trust's objectives, including financial monitoring and control systems, have been put in place. An accounting officer should also ensure that managers at all levels:

- have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives
- are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS foundation trust), including a critical scrutiny of output and value for money
- have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

Accounting officers must make sure that their arrangements for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in the *Public Sector Internal Audit Standards*.

5.2.4 Absence of an accounting officer

An accounting officer should ensure that he or she is generally available for consultation, and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, there will be a senior officer in the NHS foundation trust who can act on his or her behalf if required.

If it becomes clear to the board of directors that an accounting officer is so incapacitated that he or she will be unable to discharge these responsibilities over a period of four weeks or more, the board of directors should appoint an acting accounting officer, usually the Chief Finance Officer, pending the accounting officer's return. The same applies if, exceptionally, the accounting officer plans an absence of more than four weeks during which he or she cannot be contacted.

The PAC may be expected to postpone a hearing if the relevant accounting officer is temporarily indisposed. Where the accounting officer is unable by reason of incapacity or absence to sign the accounts in time for submission, the NHS foundation trust may submit unsigned copies pending the accounting officer's return. If the accounting officer is unable to sign the accounts in time for printing, the acting accounting officer should sign instead.

5.3 Schedule of Delegated Authority

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The **'Delegated to'** authority is in accordance with the Standing Orders and Standing Financial Instructions. The **'Operational Responsibility'** shown below is the lowest level to which authority is delegated.

- Table A - Delegated Authority
- Table B - Delegated Financial Limits

Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Managers as appropriate.

Table A – Delegated Authority

Delegated matter	Delegated to[2]	Operational responsibility
1. Standing Orders (SOs) and Standing Financial Instructions (SFIs)		
a. Final authority in interpretation of Standing Orders	Chair	Chair
b. Notifying Directors, employees and governors of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Chief Executive	All Line Managers
c. Responsibility for security of the Foundation Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions and financial procedures	Chief Executive	All Directors and Employees
d. Suspension of Standing Orders	Board of Directors	Board of Directors
e. Review suspension of Standing Orders	Audit Committee	Audit Committee
f. Variation or amendment to Standing Orders	Board of Directors	Audit Committee
g. Emergency powers relating to the authorities retained by the Board of Directors	Chair and Chief Executive with two non-executives	Chair and Chief Executive with two non-executives
h. Disclosure of non-compliance with Standing Orders to the Chief Executive (report to the Board of Directors)	All staff	All staff
i. Disclosure of non-compliance with SFIs to the Chief Finance Officer (report to the Audit Committee)	All staff	All staff
j. Advice on interpretation or application of SFIs and this Scheme of Delegation	Chief Finance Officer	Chief Finance Officer with input from Internal Audit
2. Audit arrangements		
a. Ensure an adequate internal audit service is provided	Audit Committee	Chief Finance Officer
b. To make recommendations to the Council of Governors in respect of the appointment, re-appointment and removal of the external auditor and to approve the remuneration in respect of the external auditor	Audit Committee (for recommendation to the Council of Governors for approval)	Chief Finance Officer
c. Monitor and review the effectiveness of the internal audit function	Audit Committee	Chief Finance Officer
d. Review, appraise and report in accordance with Public Sector Internal Audit Standards (PSIAS) and best practice	Audit Committee	Head of Internal Audit

[2] If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

Delegated matter	Delegated to[2]	Operational responsibility
e. Provide an independent and objective view on internal control and probity	Audit Committee	Internal Audit / External Audit
f. Ensure cost-effective audit service(s)	Audit Committee	Chief Finance Officer
g. Implement agreed recommendations	Chief Executive	Relevant Officers
3. Authorisation of Clinical Trials & Research Projects	Chief Executive	Director of Research and Development through the Research and Development committee
4. Authorisation of New Drugs	Chief Executive	Medical Director through the Medicines Management committee
5. Bank Accounts/Cash (including on Trust (Charitable / Non Charitable))		
a. Operation: Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements)	Chief Finance Officer	Deputy Chief Finance Officer
b. Opening bank accounts as approved by the Board of Directors	Chief Finance Officer	Deputy Chief Finance Officer
c. Authorisation of transfers between bank accounts	Chief Finance Officer	In accordance with bank mandate / internal procedures
d. Approve and apply arrangements for the electronic transfer of funds	Chief Finance Officer	In accordance with bank mandate / internal procedures
e. Authorisation of: • BACS schedules • Automated payment schedules • Manual cheques	Chief Finance Officer	In accordance with bank mandate / internal procedures
f. Investments: • Investment of surplus funds in accordance with Treasury Management Investment Policy • Preparation of investment procedures	Chief Finance Officer Chief Finance Officer	Deputy Chief Finance Officer Deputy Chief Finance Officer
g. Petty Cash	Chief Finance Officer	See Delegated Limits Table B (section 2(a))
6. Capital Investment		
a. Programme: Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on Business Plans	Chief Executive	Chief Finance Officer
b. Preparation of Capital Investment Programme	Chief Executive	Chief Finance Officer / Deputy Chief Finance Officer
c. Preparation of a business case for expenditure over £100,000	Chief Executive	Divisional Manager with advice from Chief Finance Officer or Deputy Chief Finance Officer or Divisional Accountant
d. Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Chief Finance Officer	Deputy Chief Finance Officer / Head of Estates
e. Authorisation of capital requisitions	Chief Executive	See Delegated Limits Table B (Section 5)

Delegated matter	Delegated to[2]	Operational responsibility
f. Construction industry tax scheme	Chief Executive	Chief Finance Officer
g. Assessing the requirements for the operation of the construction industry taxation deduction scheme	Chief Finance Officer	Financial Controller
h. Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost	Chief Executive	Chief Finance Officer and Head of Estates and Facilities
i. Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences	Chief Executive	Chief Finance Officer
j. Issue procedures to support: • Capital investment • Staged payments	Chief Executive	Chief Finance Officer
k. Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes	Chief Finance Officer	Deputy Chief Finance Officer
l. Issuing the capital scheme project manager with specific authority to commit capital, proceed / accept tenders in accordance with the standing orders and SFIs	Chief Executive	Chief Finance Officer
m. Private Finance: • Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector • Proposal to use PFI must be specifically agreed by the Board of Directors.	Chief Executive Board of Directors	Chief Finance Officer
n. Leases (property and equipment) in accordance Delegated Limits Table B (Section 4)	Chief Executive	Chief Executive or Chief Finance Officer
7. Clinical Audit	Chief Executive	Medical Director
8. Commercial Sponsorship		
Agreement to proposal	Chief Executive	Chief Finance Officer
9. Complaints		
a. Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Executive	Chief Nurse and Midwife
b. Responsibility for ensuring complaints relating to a clinical division are investigated thoroughly	Chief Nurse and Midwife	Chief Operating Officer and Head of Governance & Legal
c. Coordination of the management of medico-legal complaints	Chief Executive	Chief Nurse and Midwife and Head of Governance & Legal
10. Confidential Information		
a. Review of the Trust's compliance with the Caldicott report on protecting patients' confidentiality in the NHS	Chief Executive	Caldicott Guardian (Medical Director)
b. Freedom of Information Act compliance code	Chief Executive	Chief People Officer & Trust Secretary
11. Controlled drugs accountable officer	Medical Director	Head of Pharmacy
12. Data Protection Act		

Delegated matter	Delegated to[2]	Operational responsibility
Review of Trust's compliance	Chief Executive	Chief Information Officer
13. Declaration of Interests		
a. Maintaining a register of interests	Chief Executive	Trust Secretary
b. Declaring relevant and material interests	Board of Directors and Council of Governors	Board of Directors, Council of Governors, Senior Managers, Clinical consultants and all decision-making staff as defined in the Trust policy 'Managing Conflicts of interest'
14. Disposals and Condemnations		
a. Items obsolete, redundant, irreparable or cannot be repaired cost effectively	Chief Finance Officer	(Clinical Director or Divisional Manager or Department Heads) – Approved in accordance with Delegated Limits, Table B Section 8 Head of Procurement or Deputy Chief Finance Officer
b. Develop arrangements for the sale of assets	Chief Finance Officer	(Clinical Director/ Divisional Manager / Department Heads) – Approved in accordance with Delegated Limits Table B Section 8 Head of Procurement or Deputy Chief Finance Officer
c. Disposal of Protected Property (as defined in the Licence	Chief Executive (with authorisation of the Independent Regulator)	Chief Executive
15. Environmental Regulations		
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Finance Officer	Head of Estates & Facilities
16. External Borrowing		
a. Advise Board of Directors of the requirements to repay / draw down Public Dividend Capital	Chief Finance Officer	Deputy Chief Finance Officer
b. Approve a list of employees authorised to make short term borrowings for the Trust	Board of Directors	Chief Executive / Chief Finance Officer
c. Application for draw down of Public Dividend Capital, overdrafts and other forms of external borrowing in accordance with approved mandates	Chief Executive	Chief Finance Officer and Deputy Chief Finance Officer
d. Preparation of procedural instructions concerning applications for loans and overdrafts	Chief Finance Officer	Deputy Chief Finance Officer
17. Financial Planning / Budgetary Responsibility		
• **Budget setting**		
a. Submit budgets to the Board of Directors	Chief Finance Officer	Deputy Chief Finance Officer
b. Submit to the Board of Directors financial estimates and forecasts	Chief Finance Officer	Deputy Chief Finance Officer

Delegated matter	Delegated to[2]	Operational responsibility
c. Compile and submit to the Board of Directors an Operational Plan which takes into account financial targets and forecast limits of available resources. The Business Plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan	Chief Executive	Chief Operating Officer and Chief Finance Officer
• **Budget monitoring**		
d. Devise and maintain systems of budgetary control	Chief Finance Officer	Deputy Chief Finance Officer
e. Delegate budgets to budget holders	Chief Executive	Chief Finance Officer
f. Monitor performance against budget	Chief Finance Officer	Deputy Chief Finance Officer and Divisional Accountants
g. Ensuring adequate training is delivered on an ongoing basis to budget holders to facilitate their management of the allocated budget	Chief Finance Officer	Deputy Chief Finance Officer
h. Submit financial monitoring returns in accordance with NHS Improvement's requirements	Chief Executive	Chief Finance Officer
i. Identify and implement cost improvements and income generation activities in line with the Operational Plan	Chief Executive	All budget holders
j. Preparation of annual accounts	Chief Finance Officer	Deputy Chief Finance Officer / Financial Controller
k. Preparation of annual report	Chief Executive	Trust Secretary
• **Budget responsibilities**		
l. Ensure that: • no overspend or reduction of income that cannot be met from virement is incurred; • approved budget is not used for any other than specified purpose subject to rules of virement; • no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment	Chief Finance Officer	Budget Holders All corporate posts are reviewed by the Vacancy Control Panel and all clinical posts by the Executive team
• **Virement**		
m. It is not possible for any officer to vire from non-recurring budgets to recurring, budgets or from capital to revenue / revenue to capital. Virement between different budget holders requires the agreement of both parties	Chief Executive	Refer To Delegated Limits Table B Section 1

Delegated matter	Delegated to[2]	Operational responsibility
• **Financial procedures and systems**		
n. Maintenance and updating of Trust Financial Procedures	Chief Finance Officer	Deputy Chief Finance Officer
o. Accountability for financial control	Chief Executive / Chief Finance Officer	All budget holders
p. Responsibility for: • Implementing the Trust's financial policies and co-ordinate corrective action • Ensuring that adequate records are maintained to explain the Trust's transactions and financial position. • Providing financial advice to members of the Board of Directors and staff • Maintaining such accounts certificates, records, etc to meet statutory requirements • Designing and maintaining compliance with all financial systems	Chief Finance Officer	Deputy Chief Finance Officer
• **Financial systems Information Management & Technology (IM&T)**		
q. Developing financial systems in line with the Trust's IM&T strategy	Chief Finance Officer	Deputy Chief Finance Officer
r. Implementing new systems to ensure they are developed in a controlled manner and thoroughly tested	Chief Finance Officer	Deputy Chief Finance Officer and Chief Information Officer
s. Seeking third party assurances regarding financial systems operated externally	Chief Finance Officer	Deputy Chief Finance Officer
t. Responsibility for the accuracy and security of computerised financial data	Chief Finance Officer	Deputy Chief Finance Officer
u. Ensure that contracts for computer services for financial applications define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage	Chief Finance Officer	Chief Information Officer
v. Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place	Chief Finance Officer	Chief Information Officer
18. Fire precautions		
Ensure that the Fire Precaution and Prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact	Chief Executive	Head of Estates in conjunction with Head of Resilience, Health and Safety
19. Fixed assets		
a. Maintenance of asset register including asset identification and monitoring	Chief Executive	Deputy Chief Finance Officer in conjunction with Financial Controller
b. Approving procedures for reconciling balances on fixed asset accounts in ledgers against balances on fixed asset registers	Chief Finance Officer	Deputy Chief Finance Officer in conjunction with Financial Controller

Delegated matter	Delegated to[2]	Operational responsibility
c. Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with relevant legislation	Chief Finance Officer	Financial Controller in conjunction with Director of Estates
d. Calculate and pay capital charges in accordance with the requirements of the Department of Health / independent regulator	Chief Finance Officer	Deputy Chief Finance Officer
e. Responsibility for security of Trust's assets including notifying discrepancies to the Chief Finance Officer and reporting losses in accordance with Trust procedures	Chief Executive	All staff
20. Fraud (See also 26 & 37)		
a. Monitor and ensure compliance with Secretary of State Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist	Audit Committee	Local Counter Fraud Specialist
b. Notify NHS Protect and External Audit of all suspected Frauds	Chief Finance Officer	Local Counter Fraud Specialist
21. Funds Held on Trust (Charitable and Non Charitable Funds)		
a. Appropriate management of funds held on trust	Charitable Funds Committee	Chief Finance Officer
b. Maintenance of authorised signatory list of nominated fundholders	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
c. Expenditure Limits	Chief Finance Officer	See Delegated Limits Table B Section 7
d. Developing systems for receiving donations	Chief Finance Officer	Deputy Chief Finance Officer
e. Dealing with legacies	Chief Finance Officer	Deputy Chief Finance Officer
f. Fundraising appeals • Preparation and monitoring of budget • Reporting progress and performance against budget	Charitable Funds Committee Chief Finance Officer	Deputy Chief Finance Officer in conjunction with Financial Controller Deputy Chief Finance Officer in conjunction with Financial Controller
g. Operation of Bank Accounts - managing banking arrangements and operation of bank accounts	Chief Finance Officer in conjunction with the Charitable Funds Committee	Deputy Chief Finance Officer
h. Opening bank accounts	Chief Finance Officer in conjunction with Charitable Funds Committee	Deputy Chief Finance Officer
i. Appointing Investment Manager	Charitable Funds Committee	Deputy Chief Finance Officer through Charitable Funds Committee

Delegated matter	Delegated to[2]	Operational responsibility
j. Nominated deposit taker	Charitable Funds Committee	Chief Finance Officer
k. Placing investment transactions.	Chief Finance Officer	Deputy Chief Finance Officer in conjunction with Financial Controller
l. Registration of funds with Charities Commission	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
22. Gifts and hospitality		
a. Keeping of gifts and hospitality register	Chief Executive	Trust Secretary
b. Declaration and registration of all individual and collective items in excess of £50.00 per item	Chief Executive	All staff
23. Health and Safety		
Review of all statutory compliance with legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Chief Executive	Chief Nurse and Midwife with Head of Governance & Legal and Head of Resilience, Health & Safety
24. Infectious Diseases and Notifiable Outbreaks	Chief Nurse and Midwife	Director of Infection Prevention & Control
25. Legal Proceedings		
a. Engagement of Trust's Solicitors / Legal Advisors	Chief Executive	Executive Directors
b. Approve and sign all documents which will be necessary in legal proceedings, i.e. executed as a deed	Chief Executive	Executive Directors
c. Sign on behalf of the Trust any agreement or document not requested to be executed as a deed	Chief Executive	Executive Directors
26. Losses, write-offs and special payments		
a. Prepare procedures for recording and accounting for losses and special payments including preparation of a Fraud Response Plan and informing Local Counter Fraud Specialist of frauds	Chief Executive	Chief Finance Officer
b. Setting financial limits	Chief Executive	See Delegated Limits Table B Section 9
b. Losses of cash due to theft, fraud, overpayment and others	Chief Executive	Chief Finance Officer
c. Fruitless payments (including abandoned Capital Schemes)	Chief Executive	Chief Finance Officer
d. Bad debts and claims abandoned	Chief Executive	Chief Finance Officer
e. Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson)	Chief Executive	Chief Finance Officer
f. Reviewing appropriate requirement for insurance claims	Chief Finance Officer	Deputy Chief Finance Officer
g. Compensation payments by court order	Chief Executive	Chief Executive
h. Clinical negligence, covered by membership of CNST/NHSLA scheme	Chief Executive	Chief Nurse and Midwife

Delegated matter	Delegated to[2]	Operational responsibility
i. Ex-gratia payments • Setting financial limits • Other	Chief Finance Officer Chief Executive	See Delegated Limits Table B Section 9 See Delegated Limits Table B Section 9
j. A register of all losses and special payments should be maintained by the Finance Department and made available for inspection	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
k. A report of all losses and special payments should be presented to the Audit committee	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
27. Medical		
a. Clinical Governance arrangements	Medical Director	Head of Governance
b. Medical Leadership	Medical Director	Medical Director
c. Programmes of medical education	Medical Director	Medical Director
d. Medical staffing plans	Medical Director	Medical Director
e. Medical Research	Medical Director	Director of Research & Development
28. Medicines inspectorate regulations		
• Review regulations	Chief Executive	Medical Director / Head of Pharmacy
29. Meetings		
a. Calling meetings of the Board of Directors	Chair / Trust Secretary	Chair / Trust Secretary
b. Chair all Board of Director meetings and associated responsibilities	Chair	Chair
30. Non pay expenditure		
a. Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Delegated Limits Table B Section 4	Chief Executive	Financial Controller in conjunction with Deputy Chief Finance Officer
b. Obtain the best value for money when requisitioning goods / services	Chief Executive	Chief Operating Officer, Clinical Directors, Department Heads and Head of Procurement
c. Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement (subject to Delegated Limits Table B Section 4)	Chief Executive	Chief Finance Officer
d. Develop systems for the payment of accounts	Chief Finance Officer	Deputy Chief Finance Officer and Financial Controller
e. Prompt payment of accounts in line with national requirements	Chief Finance Officer	Deputy Chief Finance Officer and Financial Controller
f. Financial Limits for budgetary expenditure and ordering / requisitioning goods and services (including invoice authorisation without orders)	Chief Executive	See Delegated Limits Table B Section 4
g. Approve prepayment arrangements	Chief Finance Officer	Chief Finance Officer
31. Nursing		

Delegated matter	Delegated to[2]	Operational responsibility
a. Compliance with statutory and regulatory arrangements relating to professional nursing and midwifery practice	Director of Nursing &Midwifery	Professional nursing and midwifery leads
b. Matters involving individual professional competence of nursing and midwifery staff	Chief Nurse and Midwife	Professional nursing and midwifery leads
c. Compliance with professional training and development of nursing and midwifery staff	Chief Nurse and Midwife	Professional nursing and midwifery leads
d. Quality assurance of nursing and midwifery processes	Chief Nurse and Midwife	Professional nursing and midwifery leads
32. Patient Services Agreements		
a. Negotiation of Foundation Trust Contract and Non Commercial Contracts	Chief Executive	Chief Finance Officer and Chief Operating Officer
b. Quantifying and monitoring out of area treatments	Chief Finance Officer	Director Operations and Deputy Chief Finance Officer
c. Reporting actual and forecast income including payment by results	Chief Finance Officer	Chief Operating Officer and Deputy Chief Finance Officer
d. Costing Foundation Trust Agency Purchase Contracts and Non Commercial Contracts	Chief Finance Officer	Chief Operating Officer and Deputy Chief Finance Officer
e. National Cost Collection Exercise	Chief Finance Officer	Deputy Chief Finance Officer
f. Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Chief Finance Officer	Chief Operating Officer and Deputy Chief Finance Officer
33. Patients' property (in conjunction with financial advice)		
a. Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Chief Executive	Chief Nurse and Midwife
b. Prepare detailed written instructions for the administration of patients' property	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
c. Informing staff of their duties in respect of patients' property	Chief Finance Officer	Divisional Managers, Clinical Managers and Legal Services Manager
d. Issuing property of deceased patients (See SFI 6.25). In accordance with Delegated Limits Table B Section 4	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller in conjunction with nominated Divisional Lead
34. Human Resources		
a. Develop Human resource policies and strategies for approval by the Board of Directors including training, industrial relations	Chief People Officer	Chief People Officer
b. Nomination of officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts	Chief People Officer	Divisional Managers or Heads of Departments
c. Ensure that all employees are issued with a contract of employment in a form approved by the Board of Directors and which complies with employment legislation	Chief People Officer	Chief People Officer

Delegated matter	Delegated to[2]	Operational responsibility
• **Staff establishment (including engagement of staff not on the establishment) and re-gradings**		
d. Authority to fill funded post on the establishment with permanent staff	Chief People Officer	Clinical Directors, Divisional Managers or Heads of Departments
e. Additional staff to the agreed establishment with specifically allocated finance	Chief People Officer	Clinical Directors, Divisional Managers or Heads of Departments
f. Additional staff to the agreed establishment without specifically allocated finance	Chief Executive	Chief Finance Officer
g. Self-financing changes to an establishment	Chief People Officer	Human Resources Business Partner and Divisional Accountant
h. Nominate officers to enter into contracts of employment regarding staff, agency staff or non-medical consultancy service contracts	Chief Executive	Chief People Officer
i. Booking of bank staff • Nursing and midwifery • Other	Chief Nurse and Midwife Divisional Manager	Deputy Chief Nurse and Midwife or Matron. Chief Operating Officer
j. Booking of agency staff • Nursing and midwifery • Other	Chief Nurse and Midwife Divisional Manager	Chief Operating Officer, Matron or Heads of Nursing / Midwifery. Chief Operating Officer or Heads of Departments
k. The granting of additional increments at recruitment stage to staff within budget (other than automatic increments)	Chief People Officer	Clinical Directors, Chief Operating Officer or Heads of Departments
l. Re-grading requests / major skill mix changes (all requests shall be dealt with in accordance with Trust procedure)	Chief People Officer	Clinical Directors, Chief Operating Officer or Heads of Departments
m. Waiting list payments (approval of rates of pay and variations to agreed rates)	Chief Executive	Chief Operating Officer, Chief People Officer or Chief Finance Officer
• **Grievance and disciplinary procedures**		
n. Operation of grievance procedure (all grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Chief Operating Officer must be sought when the grievance reaches the level of Clinical Director / Divisional Managers / Heads of Department)	Chief People Officer	As per Trust procedure
o. Operation of the disciplinary procedure (excluding Executive Directors)	Chief People Officer	To be applied in accordance with the Trust's Disciplinary Procedure
• **Terms and conditions of employment**		
p. Renewal of fixed term contract	Chief People Officer	Chief Operating Officer on advice from Vacancy Control Panel

Delegated matter	Delegated to[2]	Operational responsibility
q. Authorise mobile phone use / issue	Chief People Officer	Executive Directors, Chief Operating Officer or Heads of Departments
r. Authorisation of payment of removal expenses, excess rent and house purchases (all staff in accordance with Trust policy and as agreed at interview)	Chief People Officer	Executive Directors, Chief Operating Officer or Heads of Departments
• **Pay**		
s. Presentation of proposals to the Board of Directors for the setting of remuneration and conditions of service for those staff not covered by the Nominations committee	Chief Executive	Chief People Officer
t. Authority to complete standing data forms affecting pay, new starters, variations and leavers	Chief People Officer	Clinical Directors, Chief Operating Officer, Heads of Departments or line or departmental managers
u. Authority to complete and authorise staff attendance record / positive reporting forms	Chief People Officer	Clinical Directors, Chief Operating Officer, professional Heads of Service, Heads of Departments or ward or departmental managers
v. Authority to authorise overtime	Chief People Officer	Clinical Directors & Chief Operating Officer
w. Authority to authorise travel and subsistence expenses	Chief People Officer	Executive Directors, Clinical Directors, Chief Operating Officer, Heads of Departments or authorised approvers.
• **Annual and special leave (refer to leave policies)**		
x. Approval of annual leave	Chief People Officer	Departmental Manager (as per Trust policy)
z. Approval of annual leave carry forward (up to maximum of 5 days)	Chief People Officer	Departmental Manager (as per Trust policy)
aa. Approval of annual leave carry forward of 6 to 10 days (to occur in exceptional circumstances only)	Chief People Officer	Executive Directors, Chief Operating Officer, or Heads of Department
bb. Approval of annual leave carry forward in excess of 10 days	Chief People Officer	Executive Directors
cc. Special leave arrangements for personal, domestic and family reasons including compassionate / bereavement leave, parental leave, paternity leave, carers leave and adoption leave (to be applied in accordance with Trust Policy)	Chief People Officer	Line or Departmental Managers
dd. Special Leave for non-domestic / personal / family reasons including jury service and armed services (to be applied in accordance with Trust Policy)	Chief People Officer	Chief Operating Officer or Heads of Departments
ee. Leave without pay (including short-term unpaid leave and career break)	Chief People Officer	Chief Operating Officer, Heads of Departments or line or departmental managers
ff. Medical Staff leave of absence – paid and unpaid	Chief People Officer	Clinical Director with advice from Medical Director

Delegated matter	Delegated to[2]	Operational responsibility
gg. Time off in lieu	Chief People Officer	Divisional Managers or Line Managers
hh. Maternity Leave - paid and unpaid	Chief People Officer	Automatic approval with guidance
• **Sick leave**		
ii. Extension of sick leave on pay	Chief People Officer	Divisional Managers or Human Resources staff, as per Trust policy
jj. Return to work part-time on full pay to assist recovery	Chief People Officer	Deputy Director of Workforce or Divisional Managers
• **Study leave**		
kk. Study leave outside the UK	Chief Executive	Relevant Executive Director
ll. Medical staff study leave (UK): • Consultant • Career Grade • Non Career Grade	 Medical Director Medical Director Post Graduate Tutor	 Clinical Director Clinical Director Clinical Director
mm. All other study leave (UK)	Chief People Officer	Executive Directors, Clinical Directors, Divisional Managers or Department Heads
• **Retirement (including ill-health retirement)**		
nn. Authorisation of return to work in part time capacity under the flexible retirement scheme	Chief People Officer	Divisional Manager
oo. Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department	Chief People Officer	Divisional Manager
• **Redundancy (as approved by Board of Directors)**	Chief Executive	Chief People Officer
35. Quotation, tendering and contracting procedures		
a. Entering into contracts on behalf of the Trust, regardless of value	Chief Executive	Executive Directors or nominated Deputy
b. Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Chief Finance Officer, Chief Operating Officer and Head of Procurement
c. Nominate officers to oversee and manage contracts on behalf of the Trust	Chief Executive	Chief Finance Officer, Chief Operating Officer ,Head of Procurement or Divisional Managers
d. Set competitive tender authorisation limits (see Delegated Limits Table B, section 6)	Chief Executive	Chief Finance Officer
e. Maintain a register to show each set of competitive tender invitations despatched	Chief Executive	Financial Controller or Head of Procurement
f. Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote	Chief Executive	Chief Finance Officer or Head of Procurement
g. Receipt and custody of tenders prior to opening	Chief Executive	Chief Finance Officer or Head of Procurement

Delegated matter	Delegated to[2]	Operational responsibility
i. Waiving the requirement to request tenders (subject to SFI 6.26.11.6, reported to the Audit Committee)	Chief Executive	Chief Executive or Chief Finance Officer
j. Waiving the requirement to request quotes (subject to SFI 6.26.11.6)	Chief Executive / Chief Finance Officer	Chief Executive or Chief Finance Officer
36. Records		
a. Review Trust's compliance with the Retention of Records Act	Chief Executive	Executive Directors
b. Review the Trust's compliance with the Records Management Code of Practice	Chief Executive	Chief Nurse and Midwife, Chief Information Officer, Chief Operating Officer and Heads of Departments
c. Ensuring the form and adequacy of the financial records of all departments	Chief Finance Officer	Deputy Chief Finance Officer
37. Reporting of Incidents to the Police		
a. Where a criminal offence is suspected: • Criminal offence of a violent nature • Arson or theft • Other	Chief Operating Officer	Executive Director on call
b. Where a fraud is involved (reporting to NHS Protect and external audit)	Chief Finance Officer	Local Counter Fraud Specialist in conjunction with Chief Finance Officer
c. Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption	Chief Finance Officer	Local Counter Fraud Specialist in conjunction with Chief Finance Officer
38. Risk Management		
a. Ensuring the Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Chief Operating Officer
b. Developing systems for the management of risk	Chief Operating Officer	Head of Governance & Legal
c. Developing incident and accident reporting systems	Chief Operating Officer	Head of Governance & legal
d. Compliance with the reporting of incidents and accidents	Chief Operating Officer	All staff
39. Seal		
a. The keeping of a register of seal and safekeeping of the seal	Chief Executive	Trust Secretary
b. Attestation of seal in accordance with Standing Orders	Chief Executive	Chief Executive and Chief Finance Officer (report to Board of Directors)
c. Property transactions and any other legal requirement for the use of the seal	Chair and Chief Executive	Chair or Non-Executive Director and the Chief Executive or their nominated Executive Director
40. Security Management		
Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management	Chief Executive	Chief Operating Officer and Local Security Management Specialist

Delegated matter	Delegated to[2]	Operational responsibility
including appointment of the Local Security Management Specialist		
41. Setting of Fees and Charges (Income)		
a. Private Patient, Overseas Visitors, Income Generation and other patient related services	Chief Finance Officer	Deputy Chief Finance Officer and budget holders
b. Non patient care income	Chief Finance Officer	Divisional Managers, Heads of Departments or Divisional Accountants
c. Informing the Chief Finance Officer of monies due to the Trust	Chief Finance Officer	All Staff
d. Recovery of debt	Chief Finance Officer	Deputy Chief Finance Officer
e. Security of cash and other negotiable instruments	Chief Finance Officer	Deputy Chief Finance Officer
42. Stores and Receipt of Goods		
a. Responsibility for systems of control over stores and receipt of goods, issues and returns	Chief Finance Officer	Clinical Directors, Divisional Managers, Heads of Departments or Head of Procurement
b. Stocktaking arrangements	Chief Finance Officer	Clinical Directors / Divisional Managers, Heads of Departments or Head of Procurement
c. Responsibility for controls over pharmaceutical stock	Head of Pharmacy	Head of Pharmacy and Ward Managers
d. Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items	Chief Finance Officer	Clinical Directors, Divisional Managers, Heads of Departments or Head of Procurement

Table B – Delegated Financial Limits

Delegated matter	Delegated limit	Delegated to[4]
1. Virement		
Authorisation of virement	£100,000 and above	Chief Executive or Chief Finance Officer and reported to Board of Directors
	£50,001 up to £100,000	Chief Finance Officer or Deputy Chief Finance Officer
	Up to £50,000	Divisional Managers, Hewitt Centre Managing Director,, Head of Management Accounts and relevant budget holder, subject to virement signed off by Divisional Accountant
2. Cash and banking		
a. Petty cash disbursements	Up to £50	Petty cash imprest holder
b. Sundry exchequer items	£100 up to £5,000	Deputy Chief Finance Officer or Financial Controller
c. Patient monies	£5,000 and above	Chief Finance Officer or another Executive Director
d. Acceptance of cash transactions	Up to £10,000	Chief Finance Officer, Deputy Chief Finance Officer or Financial Controller
3.Non-establishment pay expenditure		
Nominated officer entering into contracts or agreements with staff not on the establishment:		
a. Where aggregate commitment in any one year (or total commitment) is less than £20,000	Chief Executive	Executive Directors or Divisional Managers
b. Where aggregate commitment in any one year is more than £20,000	Chief Executive	Chief Finance Officer
4. Non-pay expenditure (including invoice authorisation without orders)		
Approving requisitions, authorising invoices and recommending contract awards.	£500,000 and above	Board Approval
	£250,000 up to £500,000	Two Executive Directors – one of which must be the Chief Executive or Chief Finance Officer
	£189,330 (excluding VAT) up to £250,000	Chief Executive or Chief Finance Officer
	£40,000 up to £189,330 (excluding VAT)	Executive Director with advice from Deputy Chief Finance Officer and/or Head of Procurement
	£5,000 up to £40,000	Divisional Manager or Head of Department

[4] If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

Delegated matter	Delegated limit	Delegated to[4]
	Up to £5,000	Budget holder
5. Capital expenditure		
Requisitioning items / services against capital budget	Over £500,000	Board of Directors (minute approval)
	£250,000 up to £500,000	Chief Executive and Chief Finance Officer
	£25,000 up to £250,000	Chief Finance Officer or Director of Operations
	Up to £25,000	Chief Finance Officer or project sponsor or delegated nominee
6. Quotation, tendering and contract procedures		
a. Quotations: *Obtaining* a minimum of 3 written quotations for goods / services	£5,000 up to £40,000 including VAT	Head of Procurement
b. Competitive tenders: *Obtaining* a minimum of 3 written competitive tenders for goods / services (in compliance with EC directives as appropriate)	Over £40,000 including VAT	Head of Procurement
c. Waiving requirements for tenders, subject to full compliance with standing orders: Tenders	£40,000 up to £189,330 (excluding VAT)	The Chief Finance Officer in the first instance. Should the Chief Finance Officer be absent for an extended period of time; or absent when an urgent requirement occurs relating to either service continuity or patient care; any Executive Director will have delegated authority to authorise the use of a waiver
d. Waiving requirements for quotes, subject to full compliance with standing orders: Quotations	£5,000 up to £40,000 including VAT	The Chief Finance Officer in the first instance. Should the Chief Finance Officer be absent for an extended period of time; or absent when an urgent requirement occurs relating to either service continuity or patient care; any Executive Director will have delegated authority to authorise the use of a waiver
7. Funds held on trust		
a. Expenditure authorisation (per request) – General Purpose Fund	£40,001 and above	Chief Nurse and Midwife or Deputy Chief Finance Officer plus Chief Finance Officer plus Charitable Funds Committee
	£20,001 up to £40,000	Chief Nurse and Midwife or Deputy Chief Finance Officer plus Chief Finance Officer
	Up to £20,000	Chief Nurse and Midwife or Deputy Chief Finance Officer

Delegated matter	Delegated limit	Delegated to[4]
b. Expenditure authorisation (per request) – Funds other than the General Purpose Fund	£30,000 and above	Nominated fund holder(s) plus Deputy Chief Finance Officer plus Chief Finance Officer and NED plus Charitable Funds Committee
	£10,001 up to £29,999	Nominated fund holder(s) plus Deputy Chief Finance Officer plus Chief Finance Officer and NED
	Up to £10,000	Nominated fund holder(s) plus Deputy Chief Finance Officer
8. Disposals and condemnations		
With current / estimated purchase price	£5,000 and above	Divisional Manager or Deputy Chief Finance Officer with advice of relevant professional lead where appropriate
	Up to £5,000	Divisional Manager or Head of Department with advice of relevant professional lead where appropriate
9. Losses and special payments		
Losses a. Fruitless payments (including abandoned capital schemes)	£250,000 and above	Board of Directors
	£5,000 up to £250,000	Chief Executive or Chief Finance Officer and reported to Audit Committee
	Up to £5,000	Chief Executive or Chief Finance Officer
b. Losses of cash due to theft, fraud, overpayment and others	£50,000 and above	Board of Directors
c. Bad debts and claims abandoned	£1,000 up to £50,000	Chief Executive or Chief Finance Officer and reported to Audit Committee
	Up to £1,000	Deputy Chief Finance Officer
d. Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson)	Up to £1,000	Chief Executive or Chief Finance Officer
Special payments	£50,000 and above	Board of Directors
e. Compensation payments by court order	£2,000 up to £50,000	Chief Executive or Chief Finance Officer
	Up to £2,000	Legal Services Manager
f. Ex-gratia payments to patients / staff for loss of personal effects	£50,000 and above	Board of Directors
	£2,000 to £50,000	Chief Executive or Chief Finance Officer
	Up to £2,000	Legal Services Manager
	£50,000 and above	Board of Directors
g. Other ex-gratia payments	Up to £50,000	Chief Executive or Chief Finance Officer
10. Legally binding contracts for clinical service provision or purchase of clinical support services under Foundation Trust contracts		

Delegated matter	Delegated limit	Delegated to[4]
	£1million annual value and above	Chief Executive or Chief Finance Officer or Director Operations
	Up to £1million annual value	Chief Finance Officer or Chief Operating Officer

6 Standing Financial Instructions

6.1 Introduction

6.1.1 The independent regulator sets the Licence for the Foundation Trust that require compliance with the principles of best practice applicable to corporate Governance within the NHS/ Health Sector with any relevant code of proactive ad guidance issued by the independent regulator.

6.1.2 The Code of Conduct and Accountability in the NHS5 requires that each NHS Foundation Trust shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code. They shall have effect as if incorporated in the Standing Orders (SOs) of the Foundation Trust.

6.1.3 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Foundation Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board of Directors and the Scheme of Delegation adopted by the Foundation Trust.

6.1.4 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust and its constituent organisations, including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. The Chief Finance Officer must approve all financial procedures.

6.1.5 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Chief Finance Officer MUST BE SOUGHT BEFORE ACTING. The user of these SFIs should also be familiar with and comply with the provisions of the Foundation Trust's SOs.

FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER, WHICH COULD RESULT IN DISMISSAL.

6.1.6 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.

6.2 Terminology

6.2.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in the constitution and these instructions bear the same meaning as in the National Health Service Act 2006. References in the Constitution to legislation include all amendments, replacements, or re-enactments made.

[5] Code of Conduct, Code of Accountability, Department of Health (1994 & 2004)

6.2.2 Wherever the title Chief Executive, Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other directors or employees who have been duly authorised to represent them. Wherever the term "employee" is used, and where the context permits, it shall be deemed to include employees of third parties contracted to the Foundation Trust when acting on behalf of the Foundation Trust, including nursing and medical staff and consultants practising on the Foundation Trust premises and members of staff of private contractors or trust staff working for private contractors under retention of employment model.

6.3 Responsibilities and Delegation

6.3.1 The Foundation Trust shall at all times remain a going concern as defined by the relevant accounting standards in force. The Board of Directors exercises financial supervision and control by:

(a) Formulating the financial strategy;
(b) Requiring the submission and approval of budgets within overall income;
(c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money) and by ensuring appropriate audit provision; and
(d) Defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

6.3.2 The constitution dictates that the Council of Governors may not delegate any of its powers to a committee or sub-committee. The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the “Reservation of Powers to the Board of Directors” document, published within the Scheme of Delegation. The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Foundation Trust.

6.3.3 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors and as the Accounting Officer for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Foundation Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Foundation Trust’s system of internal control.

6.3.4 The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

6.3.5 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions. All staff shall be responsible for ensuring conformity with the Standing Orders, Standing Financial Instructions and financial procedures of the Foundation Trust.

6.3.6 The Chief Finance Officer is responsible for:

(a) Implementing the Foundation Trust’s financial policies and for co-ordinating any corrective action necessary to further these policies (the SFIs themselves do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes);
(b) Maintaining an effective system of internal financial control, including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) Ensuring that sufficient records are maintained to show and explain the Foundation Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Foundation Trust at any time and, without prejudice to any other functions of directors and employees to the Foundation Trust, the duties of the Chief Finance Officer include:
(d) The provision of financial advice to other members of the Board of Directors, Council of Governors and employees;
(e) The design, implementation and supervision of systems of internal financial control; and
(f) The preparation and maintenance of such accounts, certificates, estimates, records and financial reports as the Foundation Trust may require for the purpose of carrying out its statutory duties.

6.3.7 All directors and employees, severally and collectively, are responsible for:
(a) The security of the property of the Foundation Trust;
(b) Avoiding loss;
(c) Exercising economy and efficiency in the use of resources; and
(d) Conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

6.3.8 Any contractor or employee of a contractor who is empowered by the Foundation Trust to commit the Foundation Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

6.3.9 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

6.4 Audit

6.4.1 Audit Committee

6.4.1.1 In accordance with Standing Orders, the Board of Directors shall formally establish an Audit Committee with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

(a) Overseeing internal and external audit services;
- Internal audit
  - to monitor and review the effectiveness of the internal audit function
- External audit
  - to assess the external auditor's work and fees on an annual basis to ensure that the work is of sufficiently high standard and that the fees are reasonable
  - to ensure a market testing exercise for the appointment of the external auditor is undertaken at least once every five years
  - to make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the external auditor and to approve the remuneration and terms of engagement of the external auditor
  - to review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements.

(b) Reviewing financial and information systems and monitoring the integrity of the financial statements and any formal announcements relating to the Trust's financial performance and reviewing of significant financial reporting judgements;

(c) Reviewing the effective implementation of corporate governance measures to enable the Foundation Trust to implement best practice as set out in appropriate guidance. This will include the Assurance Framework and control related disclosure statements, for example the Statement on Internal Control and supporting assurance processes, together with any accompanying audit statement, prior to endorsement by the Board of Directors
(d) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical, operational, compliance controls and risk management systems) that support the achievement of the organisation's objectives
(e) Monitoring compliance with Standing Orders and Standing Financial Instructions;
(f) Reviewing schedules of losses and compensations and making recommendations to the Board of Directors.

6.4.1.2 The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

6.4.1.3 Where the Audit Committee feels there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chair of the Audit Committee should raise the matter at a full meeting of the Board of Directors (to the Chief Finance Officer in the first instance).

6.4.1.4 It is the responsibility of the Chief Finance Officer to ensure an adequate internal audit service is provided, and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

6.5 Chief Finance Officer

6.5.1 The Chief Finance Officer is responsible for:
(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control, including the establishment of an effective internal audit function and the coordination of other assurance arrangements;
(b) Ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;
(c) Deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities not involving fraud or corruption;
(d) Ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:
  (i) An opinion to support the statement on the effectiveness of internal controls in accordance with current guidance issued by the Department of Health;
  (ii) Major internal financial control weaknesses discovered;
  (iii) Progress on the implementation of internal audit recommendations;
  (iv) Progress against plan over the previous year;
  (v) Strategic audit plan covering the coming three years;
  (vi) A detailed plan for the coming year.

6.5.2 The Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:
(a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
(b) Access at all reasonable times to any land, premises, members of the Board of Directors and Council of Governors or employee of the Foundation Trust;
(c) The production of any cash, stores or other property of the Foundation Trust under a member of the Board of Directors or employee's control; and
(d) Explanations concerning any matter under investigation.

6.6 Role of Internal Audit

6.6.1 The NHS Foundation Trust Accounting Officer Memorandum requires the Foundation Trust to have an internal audit function.

6.6.2 The role of internal audit embraces two key areas:

- The provision of an independent and objective opinion to the Accounting Officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives
- The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

6.6.3 Internal Audit will review, appraise and report upon:

(a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
(b) The adequacy and application of financial and other related management controls;
(c) The suitability of financial and other related management data;
(d) The extent to which the Foundation Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
    i) fraud and other offences
    ii) waste, extravagance, inefficient administration
    iii) poor value for money or other causes.
(e) Internal Audit shall also independently verify the assurance statements in accordance with guidance from NHS Improvement and the Department of Health.

6.6.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

6.6.5 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Foundation Trust.

6.6.6 The Head of Internal Audit shall be accountable to the Audit Committee. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Auditing Standards (PSIAS). The reporting system shall be reviewed at least every three years. Where, in exceptional circumstances, the use of normal reporting channels is thought to limit the objectivity of the audit, the Head of Internal Audit shall have access to report direct to the Chair or a non-executive member of the Foundation Trust's Audit Committee.

6.6.7 Managers in receipt of audit reports referred to them have a duty to take appropriate remedial action within the agreed timescales specified within the report. The Chief Finance Officer shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate remedial action has failed to take place within a reasonable period, the matter shall be reported to the Chief Finance Officer.

6.7 External Audit

6.7.1 Duties

6.7.1.1 The Foundation Trust is to have an external auditor and is to provide the external auditor with every facility and all information which they may reasonably require.

6.7.1.2 The external auditor is to carry out their duties in accordance with Schedule 10 of the 2006 Act and in accordance with any directions given by the Independent Regulator on standards, procedures and techniques to be adopted.

6.7.1.3 In auditing the accounts the financial auditor must, by examination of the accounts and otherwise, satisfy themselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

6.7.1.4 The external auditor will also audit the quality report of the Foundation Trust.

6.7.1.5 The Foundation Trust is required to include an annual governance statement within its annual report and financial accounts which include the quality report. The external auditors have a responsibility to:

- consider the completeness of the disclosures in meeting the relevant requirements; and
- identify any inconsistencies between the disclosures and the information that they are aware of from their work on the financial statements, quality report and other work.

6.7.2 Appointment of External Auditor

6.7.2.1 The external auditor is appointed by the Council of Governors following recommendation from the Audit Committee. 6The Audit Code for NHS Foundation Trusts ("the Audit Code") contains the directions of NHS Improvement with respect of those eligible to be appointed under the National Health Service Act 2006, and with respect to the standards, procedures and techniques to be adopted by the external auditor.

6.7.2.2 A person may only be appointed as the external auditor if they (or in the case of a firm of each of its members) are a member of one or more of the bodies referred to in Schedule 10 of the 2006 Act.

6.7.2.3 The Council of Governors at a general meeting shall appoint or remove the Foundation Trust's external auditor.

6.7.2.4 The Board of Directors may, upon taking the advice of the Audit Committee, resolve that external auditors be appointed to review and publish a report on any other aspect of the Foundation Trust's performance. Approval of the engagement of external auditors on non-audit work will take into account relevant ethical guidance regarding the provision of such services. Any such auditors are to be appointed by the Council of Governors.

6.7.3 Undertaking Work

6.7.3.1 NHS Improvement may require auditors to undertake work on its behalf at the Foundation Trust. In this situation, a tripartite agreement between the Independent Regulator, the auditor and the Foundation Trust will be agreed. This agreement, which will include details of the subsequent work and reporting arrangements, will be in accordance with the principles established in the guidance issued by the Institute if

[6] Audit Code for NHS Foundation Trust, NHS Improvement (2011)

Chartered Accountants in England and Wales in audit 05/03: Reporting to Regulators or Regulated Entities.

6.7.3.2 The auditor may, with the approval of the Council of Governors, provide the Foundation Trust with services which are outside of the scope as defined in the code (additional services). The Foundation Trust shall adopt and implement a policy for considering and approving any additional services to be provided by the auditor.

6.7.4 Liaison with Internal Audit

6.7.4.1 It is expected that the external auditors will liaise with the internal audit function in order to obtain a sufficient understanding of internal audit activities to assist in planning the audit and developing an effective audit approach. The auditors may also wish to place reliance upon certain aspects of the work of internal audit in satisfying their statutory responsibilities as set out in the 2006 Act and the Audit Code. In particular the financial auditor may wish to consider the work of internal audit when undertaking their procedures in relation to the statement on internal control.

6.7.5 Access To Documents

6.7.5.1 The Auditors of the Foundation Trust have a right of access at all reasonable times to every document relating to the Foundation Trust which appears to them necessary for the purpose of their functions under Schedule 10 of the 2006 Act.

6.7.6 Public Interest Report

6.7.6.1 In the event of the External Auditor issuing a Public Interest report the Foundation Trust shall:

- Send the public interest report to the Council of Governors, the Board of Directors and NHS Improvement:
  - At once if it is an immediate report; or
  - Not later than 14 days after conclusion of the audit.
- Forward a report to NHS Improvement within 30 days (or such shorter period as the Independent Regulator may specify) of the report being issued. The report shall include details of the Foundation Trust's response to the issues raised within the Public Interest report.

References in 6.6.5 and 6.6.7 relate equally to internal and external audit.

6.8 Fraud and Bribery

6.8.1 Fraud applies to any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006. Bribery applies in the giving (or offering) or receiving (or requesting) a financial or other advantage in connection with the improper performance of a position of trust, or a function that is expected to be performed impartially or in good faith.

6.8.2 The Foundation Trust shall take all necessary steps to counter fraud and bribery affecting NHS funded services in accordance with Clause 47 of the "Foundation Trust Agency Purchase Contract" (FTAPC) including Schedule 11 and in accordance with:

(a) The NHS Fraud and Corruption Manual published by NHS Protect;
(b) The policy statement "Applying Appropriate Sanctions Consistently" published by NHS Protect;
(c) Any other reasonable guidance or advice issued by CFSMS that affects efficiency, systemic and/or procedural matters
(d) The Fraud Act 2006;
(e) The Bribery Act 2010.

The Chief Executive and Chief Finance Officer shall monitor and ensure compliance with the above.

6.8.3 The Foundation Trust shall nominate a suitable, independent person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

6.8.4 The Local Counter Fraud Specialist shall report to the Foundation Trust Chief Finance Officer and shall work with the staff of NHS Protect in accordance with the Department of Health Fraud and Corruption Manual.

6.8.5 All allegations of fraud and bribery will be reported and if necessary investigated by the Local Counter Fraud Specialist. All accountable officers should also be aware of their obligation to pass any referrals onto the Local Counter Fraud Specialist at their earliest convenience.

6.8.6 The Local Counter Fraud Specialist will provide a written plan and report, at least annually, on counter fraud work within the Foundation Trust.

6.9 Security Management

6.9.1 The Foundation Trust shall promote and protect the security of people engaged in activities for the purposes of the health service functions of that body, its property and its information in accordance with the requirements of the 'Foundation Trust Contract', having regard to any other reasonable guidance or advice issued by NHS Protect.

6.9.2 The Foundation Trust shall nominate and appoint a local security management specialist as per the Foundation Trust contract.

6.9.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

6.10 Allocations/Payment by Results, Business Planning, Budgets, Budgetary Control, and Monitoring

6.10.1 Preparation and approval of Business Plans and Budget

6.10.1.1 The Chief Executive will compile and submit to the Board of Directors an annual plan that takes into account financial targets and forecast limits of available resources. The annual plan will contain:

(a) A statement of the significant assumptions on which the plan is based;
(b) Details of major changes in workload, delivery of services or resources required to achieve the plan.

6.10.1.2 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets relating to income and expenditure for approval by the Board of Directors. Such budgets will:

(a) Be in accordance with the aims and objectives set out in the annual plan, and the commissioners' local delivery plans;
(b) Accord with workload and workforce plans;
(c) Be produced following discussion with appropriate budget holders;
(d) Be prepared within the limits of available funds;
(e) Identify potential risks;
(f) Be based on reasonable and realistic assumptions; and

6.10.1.3 The Chief Finance Officer shall monitor financial performance against budgets, periodically review it and report to the Board of Directors. Any significant variances should be reported by the Chief Finance Officer to the Board of Directors as soon as they come to light, and the Board of Directors shall be advised of action to be taken in respect of such variances.

6.10.1.4 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled.

6.10.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

6.10.1.6 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders and budget managers to help them manage successfully.

6.10.2 Budgetary Delegation

6.10.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Section 31 of the Health Act 1999. This delegation must be in writing and be accompanied by a clear definition of:

(a) The amount of the budget;
(b) The purpose(s) of each budget heading;
(c) Individual and group responsibilities;
(d) Authority to exercise virement (which cannot be from a non-pay heading into a pay heading) (see also sections 6.10.2.2 and 6.10.2.3 below);
(e) Achievement of planned levels of service; and
(f) The provision of regular reports.

6.10.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

6.10.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

6.10.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive as advised by the Chief Finance Officer.

6.10.3 Budgetary Control and Reporting

6.10.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

(a) Regular financial reports to the Board of Directors in a form approved by the Board of Directors containing:
    i) Income and expenditure to date showing trends and forecast year-end position;
    ii) Balance sheet, including movements in working capital;
    iii) Capital project spend and projected outturn against plan;
    iv) Explanations of any material variances from plan/budget;
    v) Details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation;
(b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder and budget manager, covering the areas for which they are responsible;
(c) Investigation and reporting of variances from financial, and workload budgets;

(d) Monitoring of management action to correct variances;
(e) Arrangements for the authorisation of budget transfers;
(f) Advising the Chief Executive and Board of Directors of the consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the economic and financial impact of future plans and projects; and
(g) Review of the bases and assumptions used to prepare the budgets.

In the performance of these duties the Chief Finance Officer will have access to all budget holders and budget managers on budgetary matters and shall be provided with such financial and statistical information as is necessary.

6.10.3.2 Each budget holder is responsible for ensuring that:
(a) Any planned or known overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors;
(b) Officers shall not exceed the budget limit set;
(c) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and
(d) No permanent employees are appointed without the approval of the Chief Executive or Chief Finance Officer other than those provided for in the budgeted establishment as approved by the Board of Directors.

6.10.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

6.10.4 Capital Expenditure

6.10.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure (the particular applications relating to capital are contained in Section 6.18). A project sponsor will be identified who will assume responsibility for the budget relating to the scheme.

6.10.5 Monitoring Returns

6.10.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation within specified timescales.

6.11 Annual Accounts and Reports

6.11.1 Accounts

6.11.1.1 The Foundation Trust shall keep accounts in such form as NHS Improvement may with the approval of HM Treasury direct. The accounts are to be audited by the Foundation Trust's external auditor. The following documents will be made available to the Comptroller and Auditor General for examination at their request:

- the accounts;
- any records relating to them; and
- any report of the financial auditor on them.

6.11.1.2 The functions of the Foundation Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

6.11.1.3 In preparing its annual accounts, the accounting officer shall cause the Foundation Trust to comply with any directions given by the Independent Regulator with the approval of the Treasury as to:

- the methods and principles according to which the accounts are to be prepared;
- the information to be given in the accounts;

and shall be responsible for the functions of the Foundation Trust as set out in Schedule 10 to the 2006 Act.

6.11.1.4 The annual accounts, any report of the external auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting. The Accounting Officer shall cause the Foundation Trust to:

- lay a copy of the annual accounts, and any report of the financial auditor on them, before Parliament; and
- once it has done so, send copies of those documents to NHS Improvement.

6.11.1.5 Responsibility for complying with the requirements relating to the form, preparation and presentation of the accounts shall be delegated to the Accounting Officer.

6.11.2 Annual Reports

6.11.2.1 The Foundation Trust is to prepare annual reports and send them to the independent regulator, NHS Improvement. The reports are to give:

- information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual membership of its public constituencies and of the classes of the staff constituency is representative of those eligible for such membership; and
- any other information NHS Improvement requires.

6.11.2.2 The Foundation Trust is to comply with any decision NHS Improvement makes as to:

- the form of the reports;
- when the reports are to be sent to them;
- the periods to which the reports are to relate.

6.11.2.3 The external auditors of the Foundation Trust have a responsibility to read the information contained within the Annual Report and consider the implications for the audit opinion and/or certificate if there are apparent misstatements or material inconsistencies with the financial statements.

6.11.2.4 Annual Plans

6.11.2.5 The Foundation Trust is to give information as to its forward planning in respect of each financial year to be submitted in accordance with requirements and timescales set by NHS Improvement. The document containing this information is to be prepared by the Directors, and in preparing the document, the Board of Directors must have regard to the views of the Council of Governors. The Annual Plan must be approved by the Board of Directors.

6.11.3 Other Reports

6.11.3.1 The Foundation Trust is required to publish a separate Quality Account each year as required by the NHS Act 2009 and in the terms set out in the NHS (Quality Accounts) Regulations 2010 and any guidance issued by NHS Improvement.

6.11.3.2 The Foundation Trust is also required to provide the following three types of in-year reports:

- regular reports, (quarterly monitoring reports), subject to review;
- Exception reports, which may relate to any in-year issue affecting compliance with the Authorisation, such as performance against core national healthcare targets and standards; and
- Ad hoc reports, following up specific issues identified either in the Annual Plan or in-year.

6.12 Bank and OPG Accounts

6.12.1 General

6.12.1.1 The Chief Finance Officer is responsible for managing the Foundation Trust banking arrangements and for advising the Foundation Trust on the provision of banking services and operation of accounts.

6.12.1.2 The Board of Directors shall approve the banking arrangements.

6.12.2 Bank and OPG Accounts

6.12.2.1 The Chief Finance Officer is responsible for:

(a) Bank accounts including those provided by the Government Banking Service (GBS), and other forms of working capital financing;
(b) Establishing separate bank accounts for the Foundation Trust's non-exchequer funds;
(c) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;
(d) Reporting to the Board of Directors all arrangements made with the Foundation Trust's bankers for accounts to be overdrawn (together with the remedial action taken).

6.12.2.2 All accounts should be held in the name of the Foundation Trust. No officer other than the Chief Finance Officer shall open any account in the name of the Foundation Trust or for the purpose of furthering Foundation Trust activities.

6.12.3 Banking Procedures

6.12.3.1 The Chief Finance Officer will prepare detailed instructions on the operation of bank accounts which must include:

(a) The conditions under which each bank is to be operated;
(b) The limit to be applied to any overdraft; and
(c) Those authorised to sign cheques or other orders drawn on the Foundation Trust's accounts.

6.12.3.2 The Chief Finance Officer must advise the Foundation Trust's bankers in writing of the conditions under which each account will be operated.

6.12.3.3 The Chief Finance Officer shall approve security procedures for any cheques issued without a handwritten signature e.g. lithographed. Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate. All

cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

6.12.3.4 Acceptance of cash will be limited to a maximum of £10,000.

6.12.4 Tendering and Review

6.12.4.1 The Chief Finance Officer will review the banking arrangements of the Foundation Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Foundation Trust's business banking.

6.12.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board of Directors. This review is not applicable to GBS accounts.

6.13 Income, Fees and Charges and Security of Cash, Cheques and other Negotiable Instruments

6.13.1 Income Systems

6.13.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.13.1.2 All such systems shall incorporate, where practicable, in full the principles of internal check and separation of duties.

6.13.1.3 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

6.13.2 Fees and Charges other than Foundation Trust Agency Purchase Contract

6.13.2.1 The Foundation Trust shall follow the Department of Health advice in the NHS Costing Manual in setting prices for non-commercial contracts with NHS organisations other than those covered by the Foundation Trust Agency Purchase Contract and non-NHS organisations.

6.13.2.2 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the guidance in the Department of Health's [7]'Commercial sponsorship: Ethical standards in the NHS' shall be followed.

6.13.2.3 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.13.3 Non-NHS Income

6.13.3.1 In accordance with Part 4 of the Health and Social Care Act 2012 the Foundation Trust shall ensure that the income it receives from providing goods and services for the NHS is greater that its income from other sources.

6.13.3.2 Where the Foundation Trust proposed to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of

[7] Commercial sponsorship: Ethical standards for the NHS, Department of Health (2000)

goods and services for the health service, it will seek approval from the Council of Governors.

6.13.4 Debt Recovery

6.13.4.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts, including a formal follow up procedure for all debtor accounts.

6.13.4.2 Income not received should be dealt with in accordance with losses procedures (see paragraph 6.21 below).

6.13.4.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.13.5 Security of Cash, Cheques and Other Negotiable Instruments

6.13.5.1 The Chief Finance Officer is responsible for:

(a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable (no form of receipt which has not been specifically authorised by the Chief Finance Officer should be issued);
(b) Ordering and securely controlling any such stationery;
(c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and
(d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Foundation Trust.

6.13.5.2 Official money shall not under any circumstances be used for the encashment of private cheques, nor IOUs.

6.13.5.3 Staff shall be informed in writing on appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques etc.

6.13.5.4 All cheques, postal orders, cash or other negotiable instruments shall be banked promptly intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

6.13.5.5 The Foundation Trust will not accept a cash payment for a single transaction which is in excess of the current limit (€15,000 as at October 2010 or sterling equivalent or £10,000, whichever is lower.) This exempts the Trust from the requirement to register under the 2007 Money Laundering Regulations that came into effect on 15 December 2007.

6.13.5.6 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Foundation Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Foundation Trust from responsibility for any loss.

6.13.5.7 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be monitored and recorded within the Finance Department. Any significant trends should be reported to the Chief Finance Officer and internal audit via the incident reporting system. Where there is prima facie evidence of fraud or corruption, this should follow the form of the Foundation Trust's Fraud and Corruption Response Plan and the guidance provided by NHS Protect .

6.13.5.8 Where there is no evidence of fraud or corruption, the loss should be dealt with in line with the Foundation Trust's Losses and Compensations Procedures (see section 6.20 below).

6.14 Foundation Trust Contracts

6.14.1 Provision of Services

6.14.1.1 The Board of Directors shall regularly review and shall at all times maintain and ensure the capacity and capability of the Foundation Trust to provide Commissioner Requested Services in accordance with the Trust's Licence.

6.14.2 Foundation Trust Contract

6.14.2.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Foundation Trust enters into suitable Foundation Trust Contracts (FTCs) with CCGs and other commissioners for the provision of NHS services. The Foundation Trust will follow the priorities contained within the schedules of the contract, and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- The standards of service quality expected;
- The relevant national service framework (if any);
- The provision of reliable information on cost and volume of services;
- The Performance Assessment Framework contained within the FT;
- That FTC builds where appropriate on existing partnership arrangements.

6.14.3 A good FTC will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Foundation Trust works with all partner agencies involved in both the delivery and the commissioning of the service required.

6.14.4 The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from FTCs. This will include appropriate payment by results performance information.

6.14.5 Non Commissioner Contracts

6.14.5.1 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services – clinical or non-clinical, the responsible executive director should ensure that an appropriate non-commercial contract is present and signed by both parties. This should incorporate:

- A description of the service and indicative activity levels
- The term of the agreement
- The value of the agreement
- The lead officer
- Performance and dispute resolution procedures
- Risk management and clinical governance agreements.

6.14.5.2 Non-commissioner contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement so as to ensure value for money and to minimise the potential loss of income.

6.15 Terms of Service, Allowances and Payment of Members of the Board of Directors and Employees

6.15.1 Nominations and Remuneration Committee (Executive Directors)

6.15.1.1 In accordance with Standing Orders, the Board of Directors has established a Nominations and Remuneration Committee which is responsible for the appointment of Executive Directors and for agreeing the terms of service of Executive Directors. It has clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

6.15.1.2 The terms of reference for the Nominations and Remuneration Committee (Executive Directors) can be found in this Corporate Governance Manual.

6.15.1.3 The Remuneration and Nomination Committee will be accountable to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it or require executive action.

6.15.1.4 The Board of Directors will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

6.15.1.5 **Nominations and Remuneration Committee (Non-Executive Directors)**

6.15.1.6 In accordance with Standing Orders, the Council of Governors have established a Nominations and Remuneration Committee which is responsible for the appointment and setting the terms of appointment of Non-Executive Directors. It will make recommendations to a general meeting of the Council of Governors on the appointment of Non-Executive Directors. It has clearly defined terms of reference, specifying its area of responsibility, its composition and the arrangements for reporting.

6.15.1.7 The terms of reference of the Nominations and Remuneration Committee (Non-Executive Directors) can be found in this Corporate Governance Manual.

6.15.2 **Funded Establishment**

6.15.2.1 The workforce plans incorporated within the annual budget will form the funded establishment. The establishment of the Foundation Trust will be identified and monitored by the Chief People Officer under delegation from the Chief Executive.

6.15.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or individual nominated within the relevant section of the Scheme of Reservation and Delegation. The Chief Finance Officer is responsible for verifying that funding is available.

6.15.3 **Staff Appointments**

6.15.3.1 No Executive Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

i. Unless authorised to do so by the Chief Executive; and
ii. Within the limit of his approved budget and funded establishment as defined in the Scheme of Reservation and Delegation.

6.15.3.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

6.15.3.3 **Processing of the Payroll**

6.15.3.4 The Chief People Officer in conjunction with the Chief Finance Officer is responsible for:

(a) Specifying timetables for submission of properly authorised time records and other notifications;

(b) The final determination of pay and allowances; including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;
(c) Making payment on agreed dates; and
(d) Agreeing method of payment.

6.15.3.5 The Chief People Officer will issue instructions, taking into account the advice of the Chief Finance Officer and provider of payroll services regarding:

a) Verification and documentation of data;
b) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;
c) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
d) Security and confidentiality of payroll information;
e) Checks to be applied to completed payroll before and after payment;
f) Authority to release payroll data under the provisions of the Data Protection Act;
g) Methods of payment available to various categories of employee;
h) Procedures for payment by cheque, bank credit, or cash to employees;
i) Procedures for the recall of cheques and bank credits;
j) Pay advances and their recovery;
k) Maintenance of regular and independent reconciliation of pay control accounts;
l) Separation of duties of preparing records and handling cash; and
m) A system to ensure the recovery from leavers of sums of money and property due by them to the Foundation Trust.

6.15.3.6 Appropriately nominated managers have delegated responsibility for:

(a) Processing a signed copy of the contract/appointment form and such other documentation as may be required immediately upon an employee commencing duty;
(b) Submitting time records, and other notifications in accordance with agreed timetables;
(c) Completing time records and other notifications in accordance with the Chief People Officer's instructions and in the form prescribed by the Chief People Officer; and
(d) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Chief People Officer must be informed immediately. In circumstances where fraud might be expected this must be reported to the Chief Finance Officer.

6.15.3.7 Regardless of the arrangements for providing the payroll service, the Chief People Officer, in conjunction with the Chief Finance Officer, shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

6.15.4 Contracts of Employment

6.15.4.1 The Board of Directors shall delegate responsibility to a manager for:

(a) Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment and Health and Safety legislation; and
(b) Dealing with variations to, or termination of, contracts of employment.

6.16 Non Pay Expenditure

6.16.1 Delegation of Authority

6.16.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

6.16.1.2 The Chief Executive will set out:

(a) The list of managers who are authorised to place requisitions for the supply of goods and services (see Table B Delegated Financial Limits Section 4) which should be updated and reviewed on an ongoing basis and annually by the Finance Department in conjunction with departmental officers;

(b) Where the authorisation system is computerised, the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system; and

(c) The maximum level of each requisition and the system for authorisation above that level.

6.16.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

6.16.2 **Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services**

6.16.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Foundation Trust with particular reference to the requirements for quotations and tenders detailed in Table B delegated limits of the Scheme of Reservation and Delegation. In so doing, the advice of the Foundation Trust's Procurement Department and advisor on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Executive) shall be consulted.

6.16.2.2 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall only commit expenditure within delegated approval limits with the raising of an official Trust Purchase Order (PO). Invoices received by the Trust without an official PO number quoted will be returned unpaid to the supplier.

6.16.2.3 The Chief Finance Officer shall be responsible for the prompt payment of properly authorised accounts and claims in accordance with the Better Payment Practice Code (BPPC). Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

6.16.2.4 The Chief Finance Officer will:

(a) Advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained and, once approved, the thresholds should be incorporated in the Scheme of Reservation and Delegation and regularly reviewed;

(b) Prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;

(c) Be responsible for the prompt payment of all properly authorised accounts and claims;

(d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) A list of directors/employees (including specimens of their signatures) authorised to approve or incur expenditure. Where the authorisation system is computerised, the list will be maintained within the

computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system.

ii) Certification that:
- Goods have been duly received, examined and are in accordance with specification and the prices are correct;
- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- The account is arithmetically correct;
- The account is in order for payment.

iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment. Provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department

v) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as below).

6.16.2.5 Prepayments outside of normal commercial arrangements, for example fully comprehensive maintenance contracts and rental insurance, are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate);

(b) The appropriate officer in conjunction with the Procurement Department must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Foundation Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

6.16.2.6 Official Orders must, where not generated by the Trust's computerised procurement system:

(a) Be consecutively numbered;

(b) Be in a form approved by the Chief Finance Officer;

(c) State the Foundation Trust terms and conditions of trade; and

(d) Only be issued to, and used by, those duly authorised by the Chief Executive.

6.16.2.7 Managers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

(a) All contracts other than for a simple purchase permitted within the Scheme of Delegation or delegated budget, leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

(b) Contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement;

(c) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health. Where an officer certifying accounts relies upon other officers to do preliminary checking, he/she shall wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms;

(d) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

- Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars
- Conventional hospitality, such as lunches in the course of working visits

(e) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(f) All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or on purchasing cards;

(g) Verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order, and clearly marked "Confirmation Order";

(h) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) Goods are not taken on trial or loan in circumstances that could commit the Foundation Trust to a future uncompetitive purchase;

(j) Changes to the list of directors/employees authorised to certify invoices are notified to the Chief Finance Officer;

(k) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

(l) Petty cash records are maintained in a form as determined by the Chief Finance Officer; and

(m) Orders are not required to be raised for utility bills, NHS recharges and ad hoc services such as private hospital fees. Payments must be authorised in accordance with the delegated limits set for non pay.

6.16.2.8 The Chief Executive and Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the Capital Investment Manual and any other relevant guidance issued by NHS Improvement. The technical audit of these contracts shall be the responsibility of the relevant Director.

6.16.2.9 Under no circumstances should goods be ordered through the Foundation Trust for personal or private use.

6.16.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

6.16.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with these Acts.

6.17 External Borrowing and Investments

6.17.1 Public Dividend Capital

6.17.1.1 On authorisation as a Foundation Trust, the Public Dividend Capital held immediately prior to authorisation continues to be held on the same conditions.

6.17.1.2 Additional Public Dividend Capital may be made available on such terms the Secretary of State (with the consent of the Treasury) decides.

6.17.1.3 Draw down of Public Dividend Capital should be authorised in accordance with the mandate held by the Department of Health Cash Funding Team, and is subject to approval by the Secretary of State.

6.17.1.4 The Foundation Trust shall be required to pay annually to the Department of Health a dividend on its Public Dividend Capital at a rate to be determined from time to time, by the Secretary of State.

6.17.2 Working Capital Loan Facility

6.17.2.1 The Foundation Trust may be required by NHS Improvement to have a working capital facility. This will be provided by the Trust's banker or other commercial provider if available and cost effective. Such a facility may be of variable term.

6.17.2.2 The Foundation Trust must only draw down against this facility in respect of true working capital needs, and in accordance with the terms and conditions of the facility.

6.17.3 Commercial Borrowing and Investment

6.17.3.1 The Foundation Trust may borrow money from any commercial source for the purposes of or in connection with its functions.

6.17.3.2 The Foundation Trust may invest money (other than money held by it as charitable trustee) for the purposes of or in connection with its functions. Such investment may include forming, or participating in forming, or otherwise acquiring membership of bodies corporate.

6.17.3.3 The Foundation Trust may also give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.

6.17.4 Investment of Temporary Cash Surpluses

6.17.4.1 Temporary cash surpluses must be held only in such public and private sector investments as authorised by the Board of Directors.

6.17.4.2 The Finance, Performance and Business Development committee is responsible for establishing and monitoring an appropriate investment strategy.

6.17.4.3 The Chief Finance Officer is responsible for advising the Board of Directors on investments and shall report periodically to the Board of Directors concerning the performance of investments held.

6.17.4.4 The Chief Finance Officer will prepare detailed procedural instructions on investment operations and on the records to be maintained. The Foundation Trust's Treasury

Management Policy will include instructions on funding and investing, safe harbour investments, risk management, borrowing, controls, reporting and performance management. It will also incorporate guidance from NHS Improvement as appropriate.

6.18 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

6.18.1 Capital Investment

6.18.1.1 The Chief Executive:

(a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
(b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and
(c) Shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

6.18.1.2 For capital expenditure proposals, the Chief Executive shall ensure (in accordance with the limits outlined in the Scheme of Delegation):

(a) That a business case is produced, setting out:
    i) An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and
    ii) Appropriate project management and control arrangements; and
    iii) The involvement of appropriate Foundation Trust personnel and external agencies; and
(b) That the Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case.

6.18.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the capital investment manual and any other relevant guidance issued by NHS Improvement.

6.18.1.4 The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme, in accordance with Inland Revenue guidance.

6.18.1.5 The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised budgets.

6.18.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:

(a) Specific authority to commit expenditure
(b) Authority to proceed to tender
(c) Approval to accept a successful tender.

6.18.1.7 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the capital investment manual guidance and any other relevant guidance issued by NHS Improvement, and the Foundation Trust's Standing Orders.

6.18.1.8 The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

6.18.2 Private Finance

6.18.2.1 The Foundation Trust should normally test for PFI when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector, the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;
(b) A business case must be referred to NHS Improvement for approval or treated as per current guidelines;
(c) The proposal must be specifically agreed by the Foundation Trust, in the light of such professional advice as should reasonably be sought, in particular with regard to vires;
(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

6.18.3 Asset Registers

6.18.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

6.18.3.2 The Foundation Trust shall maintain an asset register recording fixed assets. As a minimum, the minimum data set to be held within these registers shall be as specified in the NHS Foundation Trust Annual Reporting Manual as issued by NHS Improvement.

6.18.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder, and be validated by reference to:

(a) Properly authorised and approved agreements, architects' certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;
(b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and
(c) Lease agreements in respect of assets held under a finance lease and capitalised.

6.18.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

6.18.3.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on the Asset Register.

6.18.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

6.18.3.7 The value of each asset shall be depreciated using methods and rates as specified in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

6.18.3.8 The Chief Finance Officer shall calculate and pay capital charges as specified by the Department of Health.

6.18.4 Protected Property

6.18.4.1 A register of protected property is required to be maintained in accordance with requirements issued by NHS Improvement. The property referred to in Condition 9(1)

of the Licence, which is to be protected, is limited to land and buildings owned or leased by the Foundation Trust (assets such as equipment, financial assets, cash or intellectual property will not be regarded as protected assets).

6.18.4.2 No protected property may be disposed of (including disposing of part of it or granting an interest in it) without the approval of NHS Improvement.

6.18.4.3 This will be achieved through the annual planning process. The annual plan will include proposed changes in the treatment of assets that are protected and proposed disposals and acquisitions.

6.18.4.4 The Foundation Trust is required to notify relevant bodies of the publication date of their plans to allow them to lodge any objections. Twenty-one days is allowed before the plans are then approved.

6.18.4.5 During the year when the proposed changes are made the Asset Register must be updated accordingly. The relevant bodies should then be notified that an updated Asset Register is available.

6.18.4.6 As required by its Licence the Foundation Trust must make the Asset Register available for inspection by the public. The Foundation Trust may charge a reasonable fee for access to this information.

6.18.5 Security of Assets

6.18.5.1 The overall control of fixed assets is the responsibility of the Chief Executive advised by the Chief Finance Officer. Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) Recording managerial responsibility for each asset;
(b) Identification of additions and disposals;
(c) Identification of all repairs and maintenance expenses;
(d) Physical security of assets;
(e) Periodic verification of the existence of, condition of, and title to, assets recorded;
(f) Identification and reporting of all costs associated with the retention of an asset; and
(g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

6.18.5.2 All significant discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

6.18.5.3 Whilst each employee has a responsibility for the security of property of the Foundation Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

6.18.5.4 Any damage to the Foundation Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

6.18.5.5 Where practical, assets should be marked as Foundation Trust property.

6.19 Stock, Stores and Receipt of Goods

6.19.1 Stocks are defined as those goods normally utilised in day to day activity, but which at a given point in time have not been used or consumed. There are three broad types of store:

(a) Controlled stores – specific areas designated for the holding and control of goods;
(b) Wards and departments – goods required for immediate usage to support operational services;
(c) Manufactured Items – where goods and consumables are being made or processes are being applied which add to the raw material cost of the goods.

6.19.2 Such stocks should be kept to a minimum and for:

(a) Controlled stores and other significant stores (as determined by the Chief Finance Officer) should be subjected to an annual stock take or perpetual inventory procedures; and
(b) Valued at the lower of cost and net realisable value.

6.19.3 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any pharmaceutical stocks shall be the responsibility of the Head of Pharmacy. The control of any fuel oil shall be the responsibility of the Head of Estates and Facilities.

6.19.4 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager.

6.19.5 Wherever practicable, stocks should be marked as NHS property.

6.19.6 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

6.19.7 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

6.19.8 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

6.19.9 The designated manager shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also 6.20, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

6.19.10 Receipt of Goods

6.19.10.1 All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification. A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available.

6.19.10.2 All goods received shall be entered onto an appropriate goods received/stock record (whether a computer or manual system) on the day of receipt. If goods received are unsatisfactory, the records shall be marked accordingly. Further, where the goods

received are found to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately.

6.19.10.3 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note to satisfy themselves that the goods have been received. The Finance Department will make payment on receipt of an invoice. This may also apply for high-level low volume items such as stationery.

6.19.11 Issue of Stocks

6.19.11.1 The issue of stocks shall be supplied by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer. Where a 'topping up' system is used, a record shall be maintained as approved by the Chief Finance Officer. Regular comparisons shall be made of the quantities issued to wards/departments etc, and explanations recorded of significant variations.

6.19.11.2 All transfers and returns shall be recorded on forms/systems provided for the purpose and approved by the Chief Finance Officer.

6.20 Disposals and Condemnations, Insurance, Losses and Special Payments

6.20.1 Disposals and Condemnations

6.20.1.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

6.20.1.2 When it is decided to dispose of a Foundation Trust asset, the head of department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

6.20.1.3 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;

(b) Recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

6.20.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

6.21 Losses and Special Payments

6.21.1 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Chief Finance Officer must also prepare a fraud response plan that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

6.21.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their directorate manager or head of department, who must immediately inform the Chief Finance Officer who will liaise with the Chief Executive or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Chief Finance Officer who will liaise with the Chief Executive.

6.21.3 Where a criminal offence such as theft or arson is suspected, the Divisional Manager or departmental head must immediately inform the police and obtain a crime number, which should be forwarded to the Chief Finance Officer. In cases of fraud, bribery or corruption, or of anomalies which may indicate fraud, bribery or corruption, the Chief Finance Officer must inform their Local Counter Fraud Officer, who will inform NHS Protect before any action is taken and reach agreement on how the case is to be handled.

6.21.4 The Chief Finance Officer must notify NHS Protect and the external auditor of all frauds.

6.21.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:
(a) The Board of Directors, and
(b) The external auditor, and
(c) NHS Protect (through LSMS).

6.21.6 The Board of Directors shall approve the writing-off of all losses and special payments in accordance with the Scheme of Delegation.

6.21.7 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Foundation Trust's interests in bankruptcies and company liquidations.

6.21.8 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

6.21.9 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

6.22 Insurance

6.22.1 The Chief Finance Officer shall ensure that insurance arrangements exist in accordance with the risk management programme.

6.23 Compensation Claims

6.23.1 The Foundation Trust is committed to effective and timely investigation and response to any claim which includes allegations of clinical negligence, employee and other compensation claims. The Foundation Trust will follow the requirements and note the recommendations of the Department of Health, and the NHS Litigation Authority (NHSLA), in the management of claims. Where appropriate external insurance has been contracted, this will be within the above mentioned requirements and recommendations. Every member of staff is expected to co-operate fully, as required, in assessment and management of each claim.

6.23.2 The Foundation Trust will seek to reduce the incidence and adverse impact of clinical negligence, employee and other litigation by:

- Adopting prudent risk management strategies including continuous review
- Implementing in full the NHS Complaints Procedure, thus providing an alternative remedy for some potential litigants
- Adopting a systematic approach to claims handling in line with the best current and cost effective practice
- Following guidance issued by the NHSLA relating to clinical negligence
- Achieving compliance with the relevant core Care Quality Commission standards
- Implementing an effective system of clinical governance.

6.23.3 The Chief Nurse and Midwife in association with the Medical Director is responsible for clinical negligence, for managing the claims process and informing the Board of Directors of any major developments on claims related issues.

6.24 Information Technology

6.24.1 Responsibilities and duties of the Chief Finance Officer

6.24.1.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Foundation Trust, shall:

(a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Foundation Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (updated 2000) and the Computer Misuse Act 1990;

(b) Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) Ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks;

(e) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

6.24.1.2 The Chief Finance Officer shall satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

6.24.1.3 The Foundation Trust has published and maintains a Freedom of Information (FoI) Publication Scheme as approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

6.24.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

6.24.2.1 In the case of computer systems which are proposed General Applications (i.e. those applications which a number of NHS organisations wish to sponsor jointly), all responsible directors and employees will send to the Chief Finance Officer:

(a) Details of the outline design of the system;

(b) In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

6.24.3 Contracts for Computer Services with other health bodies or outside agencies

6.24.3.1 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation, or any other agency, shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

6.24.3.2 Where another health organisation, or any other agency, provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

6.24.4 Requirement for Computer Systems which have an impact on corporate financial systems

6.24.4.1 Where computer systems have an impact on corporate financial systems, the Chief Finance Officer shall satisfy themselves that:

(a) Systems acquisition, development and maintenance are in line with corporate policies, such as an Information Management and Technology Strategy
(b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
(c) Chief Finance Officer staff have access to such data; and
(d) Such computer audit reviews as are considered necessary are being carried out.

6.24.5 Risk Assessment

6.24.5.1 The Chief Finance Officer shall ensure that risks to the Trust arising from the use of information technology are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

6.24.5.2 The Foundation Trust shall disclose to NHS Improvement and directly to any third parties, as may be specified by the Secretary of State, information, if any, as specified in the Licence. Other information, as requested, shall be provided to NHS Improvement.

6.24.5.3 The Foundation Trust shall participate in the national programme for information technology, in accordance with any guidance issued by NHS Improvement.

6.25 Patients' Property

6.25.1 The Foundation Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

6.25.2 The Chief Executive is responsible for ensuring that patients, or their guardians as appropriate, are informed before or at admission by

- Notices and information booklets
- Hospital admission documentation and property records
- The oral advice of administrative and nursing staff responsible for admissions

that the Foundation Trust will not accept responsibility or liability for patients' property brought into its premises, unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt.

6.25.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. The said instructions shall cover the necessary arrangements for withdrawal of cash or disbursement of money held in accounts of patients who are incapable of handling their own financial affairs. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

6.25.4 A patient's property record, in a form determined by the Chief Finance Officer, shall be completed in respect of the following:
(a) Property handed in for safe custody by any patient (or guardian as appropriate); and
(b) Property taken into safe custody, having been found in the possessions of:

- Mentally disordered patients
- Confused and/or disorientated patients
- Unconscious patients
- Patients dying in hospital
- Patients found dead on arrival at hospital (property removed by police).

A record shall be completed in respect of all persons in category (b), including a nil return if no property is taken into safe custody.

6.25.5 The record shall be completed by a member of the hospital staff, in the presence of a second member of staff and the patient (or representative) where practicable. It shall then be signed by both members of staff and by the patient, except where the latter is restricted by physical or mental incapacity. Any alterations shall be validated by signatures as requested for the original entry on the record.

6.25.6 Where Department of Health instructions require the opening of separate accounts for patients' monies (separate from those containing Foundation Trust monies), these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

6.25.7 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Works and Pensions. For long stay patients, the Chief Executive shall ensure that positive action is taken to use their funds effectively and so reduce balances accruing.

6.25.8 Refunds of cash handed in for safe custody will be dealt with in accordance with current Department of Works and Pensions guidance. Property other than cash, which has been handed in for safe custody, shall be returned to the patient as required by the officer who has been responsible for its security. The return shall be receipted by the patient, or guardian as appropriate, and witnessed.

6.25.9 The disposal of property of deceased patients shall be effected by the officer who has been responsible for its security. Such disposal shall be in accordance with written instructions issued by the Chief Finance Officer. In particular, where cash or valuables have been deposited for safe custody, they shall only be released after written authority has been given by the Chief Finance Officer. Such authority shall include details of the lawful kin or other person entitled to the cash and valuables in question.

6.25.10 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

6.25.11 Property handed over for safe custody shall be placed into the care of the appropriate administrative staff. Where there are no administrative staff present, the property shall be placed into the care of the most senior member of nursing staff on duty.

6.25.12 In respect of deceased patients, if there is no will and no lawful next of kin the property vests in the Crown and particulars shall, therefore, be notified to the Treasury Solicitor.

6.25.13 Any funeral expenses necessarily borne by the Foundation Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any element of the estate held by the Foundation Trust may be appropriated towards funeral expenses, upon the authorisation of the Chief Finance Officer.

6.25.14 Staff should be informed, on appointment, by the appropriate departmental or senior manager, of their responsibilities and duties for the administration of the property of patients.

6.25.15 Where patients' property or income is received for specific purposes and held for safekeeping, the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing**.**

6.26 Funds held on Trust

6.26.1 General

6.26.1.1 The Foundation Trust has a responsibility as a corporate trustee for the management of funds it holds on trust. The management processes may overlap with those of the organisation of the Foundation Trust. The trustee responsibilities must be discharged separately, and full recognition given to its dual accountabilities, to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

6.26.1.2 The reserved powers of the Board of Directors and the Scheme of Delegation make clear where decisions where discretion must be exercised are to be taken and by whom.

6.26.1.3 As management processes overlap, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

6.26.1.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

6.26.1.5 Charitable Funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the Trust and the objectives of which are for the benefit of the NHS in England. They are administered by the Foundation Trust Board of Directors acting as the Charitable Funds Committee (the trustees).

6.26.1.6 The Chief Finance Officer shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Foundation Trust as trustees of non-exchequer funds, including an Investment Register.

6.26.2 Existing Charitable Funds

6.26.2.1 The Chief Finance Officer shall arrange for the administration of all existing funds. A Deed of Establishment must exist for every fund, and detailed codes of procedure shall be produced covering every aspect of the financial management of charitable funds, for the guidance of fund managers. The Deed of Establishment shall identify the restricted nature of certain funds, and it is the responsibility of fund managers, within their delegated authority, and the Charitable Funds Committee, to ensure that funds are utilised in accordance with the terms of the Deed.

6.26.2.2 The Chief Finance Officer shall periodically review the funds in existence, and shall make recommendations to the Charitable Funds Committee regarding the potential for rationalisation of such funds within statutory guidelines.

6.26.2.3 The Chief Finance Officer shall ensure that all funds are currently registered with the Charities Commission in accordance with the Charities Act 1993 or subsequent legislation.

6.26.3 New Charitable Funds

6.26.3.1 The Chief Finance Officer shall recommend the creation of a new fund where funds and/or other assets received for charitable purposes cannot adequately be managed as part of an existing fund. All new funds must be covered by a Deed of Establishment, and must be formally approved by the Charitable Funds Committee.

6.26.3.2 The Deed of Establishment for any new fund shall clearly identify, inter alia, the objects of the new fund, the nominated fund manager, the estimated annual income and, where applicable, the Charitable Funds Committee's power to assign the residue of the fund to another fund contingent upon certain conditions e.g. discharge of original objects.

6.26.4 Sources of New Funds

6.26.4.1 All gifts accepted shall be received and held in the name of the Charity and administered in accordance with the Charity's policy, subject to the terms of specific funds. As the Charity can accept gifts only for all or any purposes relating to the NHS, officers shall, in cases of doubt, consult the Chief Finance Officer before accepting any gift. Advice to the Board of Directors on the financial implications of fund raising activities by outside bodies or organisations shall be given by the Chief Finance Officer.

6.26.4.2 All gifts, donations and proceeds of fund-raising activities which are intended for the Charity's use must be handed immediately to the Chief Finance Officer via the Finance Department to be banked directly to the Charitable Funds Bank Account.

6.26.4.3 In respect of donations, the Chief Finance Officer shall:

(a) Provide guidelines to Officers of the Foundation Trust as to how to proceed when offered funds. These will include:
- The identification of the donors intentions;
- Where possible, the avoidance of creating excessive numbers of funds;
- The avoidance of impossible, undesirable or administratively difficult objects;
- Sources of immediate further advice; and
- Treatment of offers for personal gifts.

(b) Provide secure and appropriate receipting arrangements, which will indicate that donations have been accepted directly into the appropriate fund and that the donor's intentions have been noted and accepted.

6.26.4.4 In respect of Legacies and Bequests, the Chief Finance Officer shall be kept informed of and record all enquiries regarding legacies and bequests. Where required, the Chief Finance Officer shall:

(a) Provide advice covering any approach regarding:
- The wording of wills;
- The receipt of funds/other assets from executors.

(b) After the death of a testator, all correspondence concerning a legacy shall be dealt with on behalf of the Charity by the Chief Finance Officer who alone shall be empowered to give an executor a good discharge;

(c) Where necessary, obtain grant of probate, or make application for grant of letters of administration;

(d) Be empowered to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and

(e) Be directly responsible, in conjunction with the Charitable Funds Committee, for the appropriate treatment of all legacies and bequests.

6.26.4.5 In respect of fund-raising, the final approval for major appeals will be given by the Board of Directors. Final approval for smaller appeals will be given by the Charitable Funds Committee. The Chief Finance Officer shall:

(a) Advise on the financial implications of any proposal for fund-raising activities;
(b) Deal with all arrangements for fund-raising by and/or on behalf of the Charity, and ensure compliance with all statutes and regulations;
(c) Be empowered to liaise with other organisations/persons raising funds for the Charity, and provide them with an adequate discharge;
(d) Be responsible for alerting the Charitable Funds Committee and the Board of Directors to any irregularities regarding the use of the Charity's name or its registration numbers; and
(e) Be responsible for the appropriate treatment of all funds received from this source.

6.26.4.6 In respect of Trading Income (see also NHS Charitable Funds Guidance Chapter 6), the Chief Finance Officer shall:

(a) Be primarily responsible, along with designated fund managers, for any trading undertaken by the Charity; and
(b) Be primarily responsible for the appropriate treatment of all funds received from this source.

6.26.4.7 In respect of Investment Income, the Chief Finance Officer shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

6.26.5 Investment Management

6.26.5.1 The Charitable Funds Committee shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the approved investment policy. The issues on which the Chief Finance Officer shall be required to provide advice to the Charitable Funds Committee shall include:

(a) The formulation of investment policy which meets statutory requirements (Trustee Investment Act 1961) with regard to income generation and the enhancement of capital value;
(b) The appointment of advisers, brokers and, where appropriate, investment fund managers and:
- The Chief Finance Officer shall recommend the terms of such appointments, and for which
- Written agreements shall be signed by the Chief Executive

(c) Pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;
(d) The participation by the Charity in common investment funds and the agreement of terms of entry and withdrawal from such funds;
(e) That the use of assets shall be appropriately authorised in writing and charges raised within policy guidelines;
(f) The review of the performance of brokers and fund managers;
(g) The reporting of investment performance.

6.26.5.2 The Chief Finance Officer shall prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for Charitable Funds.

6.26.6 Expenditure from Charitable Funds

6.26.6.1 Expenditure from Charitable Funds shall be managed on a day to day basis by the Financial Accountant and by the Charitable Funds Committee in accordance with delegated limits on behalf of the Corporate Trustee. In so doing, the committee shall be aware of the following:

(a) The objects of various funds and the designated objectives;
(b) The availability of liquid funds within each trust;
(c) The powers of delegation available to commit resources;

(d) The avoidance of the use of exchequer funds to discharge endowment fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;
(e) That funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Foundation Trust; and
(f) The definitions of "charitable purposes" as agreed by the Department of Health with the Charity Commission.

6.26.6.2 Delegated authority to incur expenditure which meets the purpose of the funds is set out in the Scheme of Delegations. Exceptions are as follows:
(a) Any staff salaries/wages costs require Charitable Funds Committee approval;
(b) No funds are to be "overdrawn" except in the exceptional circumstance that Charitable Funds Committee approval is granted.

6.26.7 Banking Services

6.26.7.1 The Chief Finance Officer shall advise the Charitable Funds Committee and, with its approval, shall ensure that appropriate banking services are available in respect of administering the Charitable Funds. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

6.26.7.2 Asset Management

6.26.7.2.1 Assets in the ownership of or used by the Charitable Fund shall be maintained along with the general estate and inventory of assets of the Foundation Trust. The Chief Finance Officer shall ensure:
(a) That appropriate records of all donated assets owned by the Charitable Fund are maintained, and that all assets, at agreed valuations are brought to account;
(b) That appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;
(c) That donated assets received on trust shall be accounted for appropriately;
(d) That all assets acquired from Charitable Funds which are intended to be retained within the funds are appropriately accounted for.

6.26.8 Reporting

6.26.8.1 The Chief Finance Officer shall ensure that regular reports are made to the Charitable Funds Committee and Board of Directors with regard to, inter alia, the receipt of funds, investments and expenditure.

6.26.8.2 The Chief Finance Officer shall prepare annual accounts in the required manner, which shall be submitted to the Board of Directors within agreed timescales.

6.26.8.3 The Chief Finance Officer shall prepare an annual trustees' report and the required returns to the Charity Commission for adoption by Charitable Funds Committee and subsequently the Board of Directors as Corporate Trustee.

6.26.9 Accounting and Audit

6.26.9.1 The Chief Finance Officer shall maintain all financial records to enable the production of reports as above, and to the satisfaction of internal and external audit.

6.26.9.2 Distribution of investment income to the charitable funds and the recovery of administration costs shall performed on a basis determined by the Chief Finance Officer.

6.26.9.3 The Chief Finance Officer shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He/she will liaise with external audit, and provide them with all necessary information.

6.26.9.4 The Charitable Funds Committee and subsequently the Board of Directors shall be advised by the Chief Finance Officer on the outcome of the annual audit.

6.26.10 Taxation and Excise Duty

6.26.10.1 The Chief Finance Officer shall ensure that the Charity's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

6.27 Tendering, Quotation and Contracting Procedures

6.27.1.1 Duty to comply with Standing Orders and Standing Financial Instructions

6.27.1.1.1 The procedure for making all contracts by or on behalf of the Foundation Trust shall comply with the Trust's Standing Orders and Standing Financial Instructions (except where Suspension of Standing Orders is applied). In particular reference should be made to the Trust Delegated Authorities Table A Section 35 and Table B Section 6 Delegated Financial Limits of this Corporate Governance Manual.

6.27.1.2 EU Directives Governing Public Procurement

6.27.1.2.1 Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions. Details of EU thresholds and the differing procedures to be adopted can be obtained from the Supplies Departments (see paragraph 6.27.1.4.1).

6.27.1.2.2 NHS ProCure22 was launched in 2016 as a standardised approach to the procurement of healthcare facilities. It is based upon long term relationships with selected supply chains that have the ability to work with NHS bodies across the whole life cycle of a capital scheme. For further details see the ProCure22 website at www.procure22.nhs.uk

6.27.1.3 Formal Competitive Tendering

6.27.1.3.1 The Foundation Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

6.27.1.3.2 Where the Foundation Trust elects to invite tenders for the supply of healthcare these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

6.27.1.3.3 Formal tendering procedures are not required where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the limit set in the Scheme of Reservation and Delegation; or
(b) the supply is proposed under special arrangements negotiated by the Department of Health in which event the said special arrangements must be complied with; or
(c) regarding disposals as set out in Standing Financial Instruction 'Disposals and Condemnations'.

6.27.1.4 Fair and Adequate Competition

6.27.1.4.1 No company must be given any advantage over its competitors, which might hinder fair competition between prospective contractors or suppliers. In this context see also the section on awarding contracts in the section below containing Standards of Business Conduct for NHS Staff.

6.27.1.4.2 The Foundation Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

6.27.1.5 Items which subsequently breach thresholds after original approval

6.27.1.5.1 Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Foundation Trust record.

6.27.1.6 Waiving of Formal Tendering / Quotation Procedures

6.27.1.6.1 There is no exemption from formal procedures if the total financial value exceeds the threshold. In this instance, and in accordance with the Public Contract Regulations 2015, tendering/quotation procedures cannot be waived.

6.27.1.6.2 Formal tendering procedures may be waived in the following circumstances:

(a) In very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures;
(b) Where the requirement is covered by an existing contract;
(c) Where national or other framework agreements are in place and have been approved by the Board of Directors;
(d) Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
(e) Where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;
(f) Where specialist expertise is required and is available from only one source;
(g) When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
(h) Where there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
(i) For the provision of legal advice and services providing that any legal firm or partnership commissioned by the Foundation Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Chief Finance Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

6.27.1.6.3 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

6.27.1.6.4 Competitive tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with CONCODE) without Departmental of Health approval.

6.27.1.6.5 Where it is decided that competitive tendering or quotation is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded on the Trust's standard Waiver Request Form. The originating department should submit the completed Waiver Request Form for approval in advance of any requisitioning activity to the Chief Finance Officer / Chief Executive.

6.27.1.6.6 All requests to waive tenders should be reported to the Audit Committee on a quarterly basis.

6.27.1.6.7 Exceptionally a single tender action may be permitted. However it should not be used retrospectively i.e. after a contract has been awarded nor should it be used for administrative convenience or to avoid competition. In all cases the reasons should be documented and reported by the Chief Finance Officer to Audit Committee and through to the Board via the Chair's Report.

6.27.1.7 Competitive Tenders and Quotations

6.27.1.7.1 Wherever practicable, at least three competitive tenders or quotations shall be obtained for the supply of goods or services in accordance with the Trust Delegated Financial Limits Table B Section 6.

6.27.1.7.2 In respect of any formal procurement exercises to be undertaken over the £5,000 threshold, the Head of Procurement's advice must be sought prior to commencement of the exercise. The Head of Procurement will lead any procurement exercises which exceed the EU procurement threshold.

6.27.1.8 Contracting / Tendering Procedure

6.27.1.8.1 Invitation to Tender

6.27.1.8.1.1 All invitations to tender on a formal competitive basis shall state the date and time as being the latest time for the receipt of tenders and no tender will be considered for acceptance unless submitted via the Trust's accepted method of receiving completed tender responses. All tenders must be received in this way and no exceptions will be made.

6.27.1.8.1.2 Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

6.27.1.8.1.3 Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with CONCODE; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

6.27.1.8.1.4 Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Contract conditions as are applicable.

Every tenderer must give a written undertaking not to engage in collusive tendering or other restrictive practice.

6.27.1.8.1.5 Selection and award criterion must always be established in advance of tender selection taking place. Subsequent decisions to vary these criteria will be closely scrutinised before final approval is given.

6.27.1.8.1.6 Before the due date of the tender, the electronic tendering portal will issue an automatic notification to the directors responsible for receiving and the releasing of electronic tenders.

6.27.1.8.2 Receipt and safe custody of tenders

6.27.1.8.2.1 Formal competitive tender documents will be received electronically via the Trust's electronic tendering portal.

6.27.1.8.2.2 The Chief Executive or their nominated representative will be responsible for ensuring a secure system is in place for the safe custody of tenders. Electronic tenders received will be kept 'locked' in a secure electronic tender box within the electronic portal until the tender deadline for receipt of completed tender responses.

6.27.1.8.2.3 The electronic tenders will remained sealed until the electronic seal is removed by the Chief Executive's designated receiving officer. The date and time of receipt of each tender will be recorded on the electronic tender portal along with any tenders that have been received after the tender deadline, which will include details of the date and time the late tender(s) was/were received.

6.27.1.8.2.4 The Chief Executive shall designate a Releasing Officer, not from the originating Department, to release the electronic tenders which have had the seal removed by the receiving officer. Appropriate records will be provided by the electronic portal, as below.

6.27.1.8.2.5 Tenders will be held by the electronic tender portal under electronic seal until the closing date and time have been reached.

6.27.1.8.3 Opening tenders and Register of tenders

6.27.1.8.3.1 The rules relating to the opening of tenders should be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

6.27.1.8.3.2 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened (i.e. the electronic seal will be removed) at one time in the presence of the Chief Executive or his/her nominated Executive Director together with one other Executive Director who is not from the originating Department (i.e. the department sponsoring or commissioning the tender).

6.27.1.8.3.3 The involvement of Finance Department staff in the preparation of a tender proposal will not preclude the Chief Finance Officer from serving as one of the two Executives to open and release tenders. All Executive Directors are authorised to open and release tenders and for this purpose the Foundation Trust Secretary will count as a Director for the purposes of opening tenders.

6.27.1.8.3.4 Should a tender be procured directly by an Executive Director, that officer should not be present at the opening or releasing of tenders.

6.27.1.8.3.5 The electronic tender portal will provide an extensive audit trail of the time of the tenders being opened and the time they are released to the evaluation team.

6.27.1.8.3.6 No tender shall be amended after it has been received except to correct bona fide errors endorsed as such by the Chief Executive or his nominated Executive Director. Any corrections shall be recorded.

6.27.1.8.3.7 On completion of the opening and releasing arrangements, all accepted tenders will be made available to the issuing department via the electronic tender portal.

6.27.1.8.3.8 Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e. those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (See 6.27.1.8.4.2 below).

6.27.1.8.4 Admissibility

6.27.1.8.4.1 In considering which tender to accept, the designated Officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Executive.

6.27.1.8.4.2 Tenders received after the due time and date may be considered only if the Chief Executive or nominated Executive Director decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Executive or nominated Executive Director shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted, the late arrival of the tender should be reported to the Board of Directors at its next meeting.

6.27.1.8.4.3 Incomplete tenders i.e. those from which information necessary for the adjudication of the tender is missing and amended tenders i.e. those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt should be dealt with in the same way as late tenders under Section 6.26.11.9.4.2 above.

6.27.1.8.4.4 Where examination of tenders reveals errors that would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their offer.

6.27.1.8.4.5 Necessary discussions with a tenderer of the contents of their tender, in order to elucidate technical points etc, before the award of a contract, need not disqualify the tender.

6.27.1.8.4.6 Formal pre-contract discussions must have the written consent of the Chief Executive and at least two Officers must be present and all details must be confirmed in writing.

6.27.1.8.4.7 If for any reason the designated officers are of the opinion that the tender received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

6.27.1.8.4.8 Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

6.27.1.8.4.9 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or if the process of evaluation and adjudication has not started.

6.27.1.8.4.10 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or their nominated officer.

6.27.1.8.5 Acceptance of formal tenders

6.27.1.8.5.1 Where only one tender is sought and/or received, the Chief Executive and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Foundation Trust, obtaining an independent assessment if required.

6.27.1.8.5.2 A tender other than the lowest (if payment is to be made by the Trust), or other than the highest (if payment is to be received by the Trust) shall not be accepted unless there are good reasons to the contrary. Such reasons shall be set out in a permanent record and be reported to the Board.

6.27.1.8.5.3 A financial appraisal should be undertaken by the Chief Finance Officer of successful tenderers who bid for contracts in excess of £50,000 and for all contractors bidding for financial services.

6.27.1.8.5.4 All tender documentation should be treated as confidential and should be retained for inspection / audit.

6.27.1.8.5.5 Note, unsuccessful bidders will be debriefed by the Head of Procurement involved, as required.

6.27.1.8.5.6 A contract cannot be concluded until the expiry of a period of at least 10 calendar days with effect from the day following the date on which the contract award decision is sent to the tenderers concerned if fax or electronic means are used; or, if other means of communication are used, before the expiry of a period of either at least 15 calendar days with effect from the day following the date on which the contract award decision is sent to the tenderers and candidates concerned.

6.27.1.8.5.7 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender (see also 6.27.1.8.4.6 above).

6.27.1.8.5.8 The lowest tender, if payment is to be made by the Foundation Trust, or the highest, if payment is to be received by the Foundation Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

6.27.1.8.5.9 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

6.27.1.8.5.10 The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

6.27.11.9.5.11 All tenders must be treated as confidential and will be retained within the secure electronic tender portal for inspection.

6.27.11.9.6 Tender reports to the Board of Directors

6.27.11.9.6.1 Reports to the Board of Directors will be made for spend above £500,000 to be approved in line with delegated limits.

6.27.11.9.7.1 **Responsibility for maintaining list**

6.27.11.9.7.1.1A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Foundation Trust is satisfied. All suppliers must be made aware of the Foundation Trust's terms and conditions of contract.

6.27.11.9.7.1.2 **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

6.27.11.9.7.1.3 **Financial Standing and Technical Competence of Contractors**

The Chief Finance Officer may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

6.27.11.9.7.1.4 **Exceptions to using approved contractors**

6.27.11.9.7.1.4.1 If in the opinion of the Chief Executive and the Chief Finance Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

6.27.11.9.7.1.4.2 An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

6.27.11.10 **Quotations: Competitive and non-competitive**

6.27.11.10.7 **Quotation Procedures**

6.27.11.10.7.1 Quotations must be obtained in writing as specified in the Delegated Financial Limits Table B Section 6 of this Corporate Governance Manual.

6.27.11.10.7.2 Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Foundation Trust.

6.27.11.10.7.3 Quotations should be in writing unless the Chief Finance Officer or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

6.27.11.10.7.4 Wherever practicable, requests for quotations and quotation responses should be provided via the electronic tendering portal. This electronic tendering portal will allow for all quotations to be received electronically and will record the time and date of receipt.

6.27.11.10.7.5 If quotations are to be received outside of the electronic tendering portal they should be opened by the nominated Receiving Officer.

6.27.11.10.7.6 Where only one quotation is received the Foundation Trust shall, as far as practicable, ensure that the price to be paid is fair and reasonable, obtaining an independent assessment if required.

6.27.11.10.7.7 A quotation other than the lowest (if payment is to be made by the Foundation Trust), or other than the highest (if payment is to be received by the Foundation Trust) shall not be accepted unless there are good reasons to the contrary. Such reasons shall be set out in a permanent record and be reported to the Board.

6.27.11.10.7.8 All quotation documentation should be treated as confidential and should be retained either via the electronic tendering portal of in hard copy format for inspection / audit.

6.27.11.10.8 **Non-Competitive Quotations**

6.27.11.10.8.1 Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.(i) and (ii) of this SFI) apply.

6.27.11.10.8.2 **Quotations to be within Financial Limits**

6.27.11.10.8.

2.1 No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Finance Officer.

6.27.11.10.9 Instances where formal competitive tendering or competitive quotation is not required

6.27.11.10.9.1 Where competitive tendering or a competitive quotation is not required the Foundation Trust should adopt one of the following alternatives:

(a) The Foundation Trust shall use the NHS Supply Chain or nominated procurement partner for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Foundation Trust does not use the NHS Supply Chain - where tenders or quotations are not required, because expenditure is below the levels defined in the Scheme of Reservation and Delegation, the Foundation Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer, where a suitable framework agreement exists which does not require further mini competitions

6.27.11.11 Private Finance for capital procurement

6.27.11.11.1 The Foundation Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the independent regulator, NHS Improvement, for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Foundation Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

6.27.11.12 Compliance requirements for all contracts

6.27.11.12.1 The Board may only enter into contracts on behalf of the Foundation Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Foundation Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) Any relevant directions including the NHS FREM, Estate code and guidance on the Procurement and Management of Consultants;

(d) Such of the NHS Standard Contract Conditions as are applicable.

(e) Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Foundation Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Foundation Trust.

6.27.11.13 Foundation Trust Contracts / Healthcare Services Agreements

6.27.11.13.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the requirements of the law. A contract with a Foundation Trust, being a Public Benefits Corporation, is a legal document and is enforceable in law.

6.27.11.13.2 The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board of Directors (refer to Scheme of Reservation and Delegation).

6.27.11.14 Disposals (See also Section 6.20 Condemnations and Disposals)

6.27.11.14.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;

(b) Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Foundation Trust;

(c) items to be disposed of with an estimated sale value of less than that defined on the Scheme of Delegation, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

6.27.11.15 In-house Services

6.27.11.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Foundation Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

6.27.11.15.2 In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Finance Officer representative.

6.27.11.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

6.27.11.15.4 The evaluation team shall make recommendations to the Board of Directors.

6.27.11.15.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Foundation Trust.

6.27.11.16 Applicability of SFIs on Tendering and Contracting to funds held in trust

6.27.11.16.1 These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Foundation Trust's trust funds and private resources.

6.27.12 Acceptance of Gifts and Hospitality by Staff

6.27.12.1 The Chief Finance Officer shall ensure that all staff are made aware of the Foundation Trust policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the [8]Department of Health Standards of Business Conduct for NHS Staff.

6.27.13 Retention of documents

6.27.13.1 **Context**

6.27.13.1.1 All NHS records are public records under the terms of the Public Records Act 1958 section 3 (1) – (2). The Secretary of State for Health and all NHS organisations have a duty under this Act to make arrangements for the safe keeping and eventual disposal of all types of records. In addition, the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 must be achieved.

6.27.13.1.2 Accountability

6.27.13.1.2.1 The Chief Executive and senior managers are personally accountable for records management within the organisation. Additionally, the organisation is required to take positive ownership of, and responsibility for, the records legacy of predecessor organisations and /or obsolete services. Under the Public Records Act 1958 all NHS employees are responsibility for any records that they create or use in the course of their duties. Thus any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations.

6.27.13.1.2.2 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in the [9]Department of Health guidance, Records Management: NHS Code of Practice.

6.27.13.1.3 **Types of Record Covered by The Code of Practice**

6.27.13.1.3.2 The guidelines apply to NHS records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the media on which they are held:

- Patient health records (electronic or paper based)
- Records of private patients seen on NHS premises;
- Accident and emergency, birth and all other registers;
- Theatre registers and minor operations (and other related) registers;

[8]Standards of business conduct for NHS staff (HSG(93)5), NHS Management Executive, 1993
[9]Records Management: NHS Code of Practice, Department of Health 2006 & 2009

- Administrative records (including e.g. personnel, estates, financial and accounting records, notes associated with complaint handling);
- X-ray and imaging reports, output and other images;
- Photographs, slides and other images;
- Microform (i.e. fiche / film)
- Audio and video tapes, cassettes, CD-ROM etc.
- Emails;
- Computerised records;
- Scanned records;
- Text messages (both outgoing from the NHS and incoming responses from the patient).

6.27.13.1.3.3 The documents held in archives shall be capable of retrieval by authorised persons.

6.27.13.1.3.4 Documents held in accordance with the Records Management Code of Practice shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

6.27.14 Risk Management

6.27.14.1 The Chief Executive shall ensure that the Foundation Trust has a programme of risk management which must be approved Board of Directors and monitored by the Quality committee.

6.27.14.2 The programme of risk management shall include:

(a) A process for identifying and quantifying risks and potential liabilities;
(b) Engendering among all levels of staff a positive attitude towards the control of risk;
(c) Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
(d) Contingency plans to offset the impact of adverse events;
(e) Audit arrangements, including internal audit, clinical audit, health and safety review;
(f) Decisions on which risks shall be insured;
(g) Arrangements to review the risk management programme.

6.27.14.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of internal control within the Annual Report and Accounts, as required by current guidance.

6.27.15 Insurance arrangements

6.27.15.1 The Board shall decide if the Foundation Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

6.27.15.2 Arrangements to be followed by the Board of Directors in agreeing Insurance cover:

(a) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

(b) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.
(c) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

6.27.15.3 **Standard Areas for Commercial Insurance Cover**

(a) Foundation Trust's may enter commercial arrangements for insuring motor vehicles owned by the Foundation Trust including insuring third party liability arising from their use;
(b) Where the Foundation Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and
(c) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Foundation Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Foundation Trust's powers to enter into commercial insurance arrangements the Finance Director should consult NHS Improvement or the Department of Health as appropriate.

6.27.15.4 Consideration for Other Areas of Insurance Cover

6.27.15.4.1 As a Foundation Trust the Board need to consider the adequacy of insurance cover recognising the Public Benefit Corporation status. Key areas to consider include:

(a) Directors and Officers Liability – Recognising the cover available through the NHSLA, consideration is required to the adequacy of the cover in respect of selling assets, entering into contracts and insolvency indemnity cover
(b) Property Damage – consider the provision for underwriting claims.
(c) Business interruption resulting from property damage-consider the provision to cover for loss of income.

7 Standing Orders for the Board of Directors

These are contained in the Trust Constitution

8. Code of Conduct for the Board of Directors

8.1 Introduction

8.1.1 High standards of corporate and personal conduct are an essential component of public services. As an NHS foundation trust, Liverpool Women's NHS Foundation Trust is required to comply with the principles of best practice applicable to corporate governance in the NHS/health sector and with any relevant code of practice. The purpose of this code is to provide clear guidance on the standards of conduct and behaviour expected of all directors.

8.1.2 This code, with the Trust's Constitution, Corporate Governance Framework and Code of Conduct for Governors forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the foundation trust. The code is intended to operate in conjunction with the principles of the NHS Foundation Trust Code of Governance, the NHS Constitution, requirements set out within the 2006 Health and Social Care Act, and all subsequent amendments, and Regulation 5 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Fit and Proper Persons: Directors. The code applies at all times when directors are carrying out the business of the foundation trust or representing the foundation trust.

8.2 Principles of public life

8.2.1 All directors are expected to abide by the Nolan principles of: selflessness, integrity, objectivity, accountability, honesty, transparency and leadership:

Selflessness
Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

8.3 General principles

8.3.1 Foundation Trust Boards of Directors have a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public. The Board of Directors therefore undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct. The Board of Directors will lead in ensuring that the provisions of the Constitution, the Standing Orders, Standing Financial Instructions and accompanying Scheme of Delegation conform to best practice and serve to enhance standards of conduct. The Board of Directors expects that this Code will inform and govern the decisions and conduct of all directors.

8.4 Confidentiality & access to information

8.4.1 Directors must comply with the Foundation Trust's confidentiality policies and procedures. Directors must not disclose any confidential information, except in specified lawful circumstances.

8.4.2 Information on decisions made by the Board of Directors and information supporting those decisions should be made available in a way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation and directors must not seek to prevent a person from gaining access to information to which they are legally entitled.

8.4.3 The Foundation Trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation which will be followed at all times by directors.

8.5 Register of interests

8.5.1 Directors are required to register all relevant interests on the Board of Directors' Register of Interests in accordance with the provisions of the Trust's Constitution. It is the responsibility of each director to update their register entry if their interests change. The register is held by the Trust Secretary. Directors must send notification of any updates to the Trust Secretary and request confirmation that the register has been updated. Failure to register a relevant interest in a timely manner may constitute a breach of this Code.

8.6 Conflicts of interest

8.6.1 Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Foundation Trust. Directors have a further statutory duty not to accept a benefit from a third party by reason of being a director or for doing (or not doing) anything in that capacity.

8.6.2 If a director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the Chairman or Trust Secretary. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before the Trust enters into the transaction or arrangement.

8.6.3 The Chairman will advise directors in respect of any conflicts of interest that arise during Board of Directors meetings, including whether the interest is such that the director should withdraw from the meeting for the period of the discussion. In the event of disagreement, it is for the Board of Directors to decide whether a director must withdraw from the meeting. The Trust Secretary will provide advice on any conflicts that arise between meetings.

8.7 Bribery

8.7.1 The Bribery Act 2010 introduces a new, clearer regime for tackling bribery that applies to all businesses (including NHS organisations) based or operating in the UK. It covers all sorts of bribery, the offering and receiving of a bribe, directly or indirectly, whether or not it involves a public official, in the UK or abroad.

8.7.2 The Board of Directors has a responsibility to protect both the Trust and the wider NHS from bribery or corruption. Directors shall at all times comply with the Bribery Act 2010 and with the Trust's policy. Directors will not request or receive a bribe from anybody, nor imply that such an act might be considered. This means not agreeing to receive or accept a financial or other advantage from any source as an incentive or reward to perform improperly the function or activities of the Liverpool Women's NHS Foundation Trust.

8.8 Gifts & hospitality

8.8.1 The Board of Directors will set an example in the use of public funds and the need for good value in incurring public expenditure. The use of the Foundation Trust for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Board of Directors is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Foundation Trust in the eyes of the community.

8.8.2 The Board of Directors has adopted a policy on gifts and hospitality, within its Standards of Business Conduct, which will be followed at all times by directors. Directors must not accept gifts or hospitality other than in compliance with this policy.

8.9 Whistle-blowing

8.9.1 The Board of Directors acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this Code and other concerns of an ethical nature. The Trust has adopted a whistle-blowing policy (concerns reporting procedure) that is available for staff.

8.9.2 This policy reflects the provisions of the Public Interest Disclosure Act 1998, which gives protection from dismissal, harassment, fear of reprisal or other detrimental treatment to "workers" (this term means Trust employees, agency or bank staff, the staff of one of our contractors, or volunteers) who wish to report information, which they reasonably believe, is in the patient or public interest. This enables staff to express concerns safely, so that issues are raised at an early stage and in the right way. Directors will understand and fulfil their responsibilities in respect of the Trust's Whistleblowing Policy and the Public Interest Disclosure Act 1998.

8.10 Personal conduct

8.10.1 Directors are expected to conduct themselves in a manner that reflects positively on the Foundation Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Foundation Trust into disrepute.

8.10.2 Specifically directors must:

- Act in the best interests of the Foundation Trust and adhere to its Values, expected Behaviours and this Code of Conduct.
- Respect others and treat them with dignity and fairness.
- Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion.
- Be honest and act with integrity and probity.
- Contribute to the workings of the Board of Directors as a Board of Directors member in order for it to fulfil its role and functions.
- Recognise that the Board of Directors is collectively responsible for the exercise of its powers and the performance of the foundation trust
- Raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate.
- Recognise the differing roles of the Chairman, Vice-Chairman, Senior Independent Director, Chief Executive, Executive Directors and Non-Executive Directors.
- Make every effort to attend statutory meetings.
- Adhere to good practice in respect of the conduct of meetings and respect the views of others.
- Take and consider advice on issues where appropriate.
- Acknowledge the responsibility of the Council of Governors to represent the interests of the Foundation Trust's members and partner organisations in the governance and performance of the Foundation Trust and to hold Non-Executive Directors to account for the performance of the Board of Directors, and to have regard to the views of the Council of Governors.
- Not use their position for personal advantage or seek to gain preferential treatment; nor seek improperly to confer an advantage or disadvantage on any other person.
- Accept responsibility for their performance, learning and development.

8.11 Eligibility Criteria

8.11.1 The Trust's Provider Licence requires that the Trust will not appoint as a director any person who is an unfit person, and shall ensure termination is enforced promptly on discovering any director to be an unfit person, except with the approval in writing of Monitor.

8.11.2 The Trust's Constitution also sets the approved criteria, which deem a person to be an unfit person to become or continue as a Director of the Foundation Trust, as follows:

- s/he is a member of the Council of Governors, or a Governor of an NHS body or another NHS Foundation Trust;
- s/he is a member of a Local Involvement Network, its successor organisation, Local Healthwatch, or any of its successor organisations;
- s/he is the spouse, partner, parent or child of a member of the Board of Directors of the Trust;
- s/he is a member of a Local Authority's committee which scrutinises health matters.;
- s/he is a Director or member of a Clinical Commissioning Group with whom the Trust contracts;
- s/he been adjudged bankrupt or her estate has been sequestrated and in either case s/he has not been discharged;

- s/he has made a composition or arrangement with, or granted a Trust deed for, her creditors and has not been discharged in respect of it;
- s/he is the subject to a sex offender order;
- s/he has within the preceding five years been convicted in the British Islands of any offence:
- against a woman or child; or
- any other offence for which a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed
- s/he is the subject of a disqualification order made under the Company Directors Disqualification Act 1986;
- in the case of a non-executive Director, s/he is no longer a member of one of the public constituencies or an individual exercising functions for a University providing a medical or dental school to a hospital of the Trust;
- s/he is a person whose tenure of office as a Chair or as a member or Director of a health service body has been terminated on the grounds that her appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
- s/he has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;
- in the case of a non-executive Director s/he has refused without reasonable cause to fulfil any training requirement established by the Board of Directors; or
- s/he has refused to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors.

8.11.3 In addition, Regulation 5 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Fit and Proper Persons Directors states that Directors should be of good character, have the required skills, experience and knowledge and as such that their health enables them to fulfil the management function.

8.11.4Furthermore, Directors would be excluded from office if they have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying out a regulated activity, or discharging any functions relation to any office or employment with a service provider.

8.11.4 Directors will notify the Trust Secretary immediately if any of the above criteria apply to their personal or professional circumstances.

8.12 Removal of a Director under the Fit and Proper Person Test

8.12.1 In addition to the Trust Disciplinary Rules which apply to all staff there is a requirement for Directors to be Fit and Proper Persons and to meet the Care Quality Commission Fit and Proper Person Test (FPPT) on an ongoing basis under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

8.12.2 Where a Director fails to meet the FPPT then consideration will be given to removing that person from their role of Director.

8.12.3 Directors should be of good character, have the required skills, experience and knowledge and as such that their health enables them to fulfil the management function. To pass the FPPT none of the criteria of unfitness should apply, which include bankruptcy, sequestration and insolvency, appearing on a barred list and being prohibited from holding Directorships under other laws. Directors should not have been involved or complicit in any serious misconduct, mismanagement of failure of care in carrying on a regulated activity.

8.12.4 An individual can be appointed as a Director with the expectation that they develop specific competence to undertake the role within specified timescales. Failure to do so may result in the FFPT not being met.

8.12.5 Where information is discovered that suggests an individual is not of good character after appointment to a role (e.g. through annual checks or through information provided to, or discovered by, the Trust) then appropriate and timely action will be taken to investigate and rectify the matter. Immediate action will be taken to protect people receiving services from risk or potential risk.

8.12.6 In such cases the Chair or Deputy Chairman may suspend a Non-Executive Director or the Chief Executive where this is deemed appropriate. The Chief Executive may suspend an Executive Director and he/she, will notify the Chair of the reasons for this decision and the Chair shall forthwith call a meeting of the Board Nominations and Remuneration Committee to consider what actions should be taken. All concerns will be investigated quickly and due diligence in all such investigations demonstrated.

8.12.7 For concerns regarding a Non-Executive Director the Council of Governors Nominations and Remuneration Committee, supported by the Chief People Officer or other nominated person, will investigate the concerns and make a recommendation to the Chair and to the Council of Governors on the continued fitness of the Director where concerns are substantiated. Where the Director is deemed not to be a fit and proper person then action, as is proportionate, up to and including the termination of their engagement with immediate effect will be considered.

8.12.8 For concerns regarding an Executive Director or other Director level appointment, then an investigating officer will be appointed by the Chief Executive or Chief People Officer. The Investigating Officer may be an employee or Director of the Trust or may be a person or organisation engaged to undertake this role. They will investigate and present a case to a Director or Chief Executive of the Trust who will determine an outcome to be recommended in the first instance to the Board Nominations and Remuneration Committee and thereafter to the Board of Directors. Proportionate action up to summary dismissal will be taken as appropriate.

8.12.9 Where concerns are substantiated but an individual is retained as a Director, the rationale for this will be recorded and made available to those that need to be aware of this.

8.12.10 Where an individual appointment is terminated because they no longer meet the FPPT then this will be reported to the Regulator and to any appropriate professional body.

8.13 Compliance

8.13.1 All Directors will be required to:

- prior to appointment, and annually thereafter, give an undertaking to abide by the provisions of this Code of Conduct by signing the declaration below.

9. Code of Conduct for the Council of Governors

9.1 Introduction

This Code seeks to outline appropriate conduct for the Council of Governors and addresses both the requirements of office and the personal behaviour of individual Governors. Ideally any sanctions for non-compliance would never need to be applied, however a Code is considered an essential guide for Foundation Trust (FT) Governors. The Code seeks to expand on and complement our NHS Foundation Trust Constitution.

As a member of the Council of Governors sometimes dealing with difficult and confidential issues, Governors are required to act with discretion and care in the performance of their role. They will be required to maintain confidentiality with regard to information gained via their involvement with the Trust.

9.2 Qualifications for Office

Governors must continue to comply with the qualifications required to hold elected office throughout their period of tenure. The Trust Secretary should be advised of any changes in circumstances which disqualify the Governor from continuing in office. An example of this would be joining the Trust as an employee, given that the number of employees sitting on the Trust's elected body is limited.

All Governors will be expected to understand, agree and promote the Trust's Equal Opportunities Policy in every area of their work.

One of the key objectives of the governing body is to promote social inclusion through its activities and as such the development and delivery of initiatives should not prejudice any part of the community on the grounds of age, race, disability, marital status, sexual orientation or religious belief.

9.3 Role of Governors and the Council of Governors

- To hold the Non-Executive Directors (NEDs) individually and collectively to account for the performance of the Board of Directors
- To represent the interests of the members of the Foundation Trust as a whole and the interests of the public, bringing a fair and open-minded view on all issues
- To appoint and, if appropriate, remove the Chair
- To appoint and, if appropriate, remove the other Non-Executive Directors
- To decide the remuneration and allowances and other terms and conditions of office of the Chair and the other NEDs
- To approve the appointment of the Chief Executive
- To appoint and, if appropriate, remove the NHS Foundation Trust's auditor
- To receive the NHS Foundation Trust's annual accounts, any report of the auditor on them, and the annual report
- Put forward views on the Foundation Trust's forward plan and communicate the Trust's plans to members
- To adhere to the seven principles of public life, as defined by the Nolan Committee (further information at www.public-standards.org.uk). The seven principles are:
    - Selflessness
    - Integrity
    - Objectivity
    - Accountability
    - Openness
    - Honesty
    - Leadership
    - To actively support and promote the principle of FT and contribute to its success
    - To adhere to the Trust's policies and procedures and support its objectives

- To lead the Trust's membership development strategy, including membership recruitment
- To engage and consult with the membership of the Trust
- To encourage members to become future Governors.
- To recognise that their role is a collective one whereby they exercise collective decision making in the meeting room which is recorded in the minutes. Outside the meeting room a Governor has no more rights and privileges than any other member
- To undertake an advisory role to the Board of Directors.

In addition, individual Governors are required to:

- To attend Council of Governor meetings
- To contribute to the workings of the Council, ensuring that it fulfils its role and functions.

It should be noted that the functions allotted to the Council of Governors are not of a managerial nature.

9.4 Confidentiality

In the course of their duties Governors may receive information which is confidential. All Governors are required to respect the sensitivity of the information they are made privy to as a result of their position and to adhere to the Trust's policy in this regard. Information made available to Governors in confidence must remain confidential. Failure to maintain confidentiality may result in removal from the Council of Governors.

9.5 Conflict of Interest

Governors should act with the utmost integrity and objectivity and in the best interests of the Trust in performing their duties. They should not use their position for personal advantage or seek to gain preferential treatment. They should declare any conflicts of interest which may arise and should not vote on any such matters. If in any doubt they should seek advice from the Trust Secretary. It is important that conflicts of interest are addressed and are seen to be actioned in the interests of the trust and all individuals concerned.

Governors must declare any involvement they may have in any organization with which the hospital may be considering entering into a contract.

There is a Register of Interests in which Governors must enter any pecuniary and non-pecuniary interests that might create a conflict of interest. It also records 'nil' returns. Failure to declare interests may result in removal from the Council of Governors.

Please see separate declaration of interests documentation included in the induction pack.

9.6 Council of Governors meetings

Governors have a responsibility to attend meetings of the Council. When this is not possible they should submit an apology to the Trust Secretary in advance of the meeting.

Absence from the Council of Governors meetings without good reason established to the satisfaction of the Council is grounds for disqualification. Absence from three consecutive meetings will result in the member being deemed to have resigned their position unless the grounds for absence are deemed to be satisfactory by the Council of Governors.

Governors are expected to attend for the duration of the meeting.

9.7 Personal Conduct

Governors are required to adhere to the highest standards of conduct in the performance of their duties. In respect of their interaction with others they are required to:

- Adhere to good practice in respect of the conduct of the meetings and respect the views of their fellow members, both elected and appointed.
- Be mindful of conduct which could be deemed to be unfair or discriminatory.
- Treat the Trust's employees and fellow members with respect and in accordance with the trust's policies.
- Recognise that the Council of Governors and the Board of Directors and its management team have a common purpose, ie the success of the trust, and to work together as a team to this end.
- Governors should conduct themselves in such a manner as to reflect positively on the trust. When attending external meetings or any other events at which they are present, it is important for Governors to be ambassadors for the trust.

9.8 Accountability

Governors are accountable to the membership and should demonstrate this by attending members' meetings and other key events which provide opportunities to interface with their electorate in order to best understand their views.

9.9 Training and Development

Training and development are essential for the Council of Governors in respect of the effective performance of their role and Governors will be expected to both contribute to the formulation of a Training Programme for the Council and to actively participate in training events which are arranged for them. Governors may be removed from the Council of Governors if they have refused without reasonable cause to undertake any training which the Council of Governors requires all Governors to undertake.

9.10 Visits to Trust premises

Where the Governors wish to visit the premises of the Trust in a formal capacity as opposed to individuals in a personal capacity, the Council should liaise with the Trust Secretary to make the necessary arrangements. When attending Trust premises in the formal capacity of Governor, Governors must wear their identity badge which clearly indicates that they are a Governor of Liverpool Women's NHS Foundation Trust.

9.11 Non-compliance with the Code of Conduct

Non-compliance with the Code may result in action being taken as follows:

- Where misconduct takes place, the Chair shall be authorized to take such action as may be immediately required, including the exclusion of the person concerned from a meeting.
- Where such misconduct is alleged, it shall be open to the Council of Governors to decide by simple majority of those in attendance, to lay a formal charge of misconduct.
- The individual will be notified in writing of the charge/s, detailing the specific behaviour which is considered to be detrimental to the trust and inviting their response for consideration by the Council within a defined timescale.
- The Governor will be invited to address the Council in person if the matter cannot be resolved satisfactorily through correspondence.
- The Council of Governors will decide by simple majority of those present and voting whether to uphold the charge of conduct detrimental to the trust.
- The Council of Governors may impose such sanctions as shall be deemed appropriate, ranging from the issuing of a written warning as to the member's future conduct, to the removal of the individual from office.
- In order to aid participation by all parties it is imperative that all Governors observe the points of view of others and conduct likely to give offence will not be permitted. The Chair will reserve the right to ask any member of the Council who, in his or her opinion, fails to observe the Code to leave the meeting.

This Code of Conduct does not limit or invalidate the right of the Council of Governors or the trust to act under the constitution.

10. Code of Conduct for NHS Managers[10]

10.1 Introduction

The Code of Conduct for NHS Managers sets out the standards of conduct expected of NHS Managers. It serves two purposes:

- to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make
- to reassure the public that these important decisions are being made against a background of professional standards and accountability.

10.2 The Code

10.2.1 As an NHS manager, I will observe the following principles:

- make the care and safety of patients my first concern and act to protect them from risk;
- respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- be honest and act with integrity;
- accept responsibility for my own work and the proper performance of the people I manage;
- show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community;
- take responsibility for my own learning and development.

10.2.2 This means in particular that I will:

- respect patient confidentiality;
- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of the public and patients;
- be guided by the interests of the patients while ensuring a safe working environment;
- act to protect patients from risk by putting into practice appropriate support and disciplinary procedures for staff; and
- seek to ensure that anyone with a genuine concern is treated reasonably and fairly.

10.2.3 I will respect and treat with dignity and fairness, the public, patients, relatives, carers, NHS staff and partners in other agencies. In my capacity as a senior manager within the NHS I will seek to ensure that no one is unlawfully discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin. I will also seek to ensure that:

- the public are properly informed and are able to influence services;
- patients are involved in and informed about their own care, their experience is valued, and they are involved in decisions;
- relatives and carers are, with the informed consent of patients, involved in the care of patients;
- partners in other agencies are invited to make their contribution to improving health and health services; and
- NHS staff are:
  - valued as colleagues;
  - properly informed about the management of the NHS;
  - given appropriate opportunities to take part in decision making.

[10] Based on Code of Conduct for NHS Managers published by the Department of Health, 2002 time to time amended.

- given all reasonable protection from harassment and bullying;
- provided with a safe working environment;
- helped to maintain and improve their knowledge and skills and achieve their potential; and
- helped to achieve a reasonable balance between their working and personal lives.

10.2.4 I will be honest and will act with integrity and probity at all times. I will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to my own duties or the functions of my employer.

10.2.5 I will seek to ensure that:

- the best interests of the public and patients/clients are upheld in decision-making and that decisions are not improperly influenced by gifts or inducements;
- NHS resources are protected from fraud, bribery and corruption and that any incident of this kind is reported to the NHS Protect;
- judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and are properly founded; and
- open and learning organisations are created in which concerns about people breaking the Code can be raised without fear.

10.2.6 I will accept responsibility for my own work and the proper performance of the people I manage. I will seek to ensure that those I manage accept that they are responsible for their actions to:

- the public and their representatives by providing a reasonable and reasoned explanation of the use of resources and performance;
- patients, relatives and carers by answering questions and complaints in an open, honest and well researched way and in a manner which provides a full explanation of what has happened, and of what will be done to deal with any poor performance and, where appropriate giving an apology; and
- NHS staff and partners in other agencies by explaining and justifying decisions on the use of resources and give due and proper consideration to suggestions for improving performance, the use of resources and service delivery.

10.2.7 I will support and assist the Accountable Officer of my organisation in his or her responsibility to answer to Parliament, Ministers, the Department of Health and the Independent Regulator of Foundation Trusts in terms of fully and faithfully declaring and explaining the use of resources and the performance of the local NHS in putting national policy into practice and delivering targets.

10.2.8 For the avoidance of doubt, nothing in paragraphs 10.2.3 to 10.2.7 of this Code requires or authorises an NHS manager to whom this Code applies to:

- make, commit or knowingly allow to be made any unlawful disclosure;
- make, permit or knowingly allow to be made any disclosure in breach of his or her duties and obligations to his or her employer, save as permitted by law.

10.2.9 If there is any conflict between the above duties and obligations and this Code, the former shall prevail.

10.2.10 I will show my commitment to working as a team by working to create an environment in which:

- teams of frontline staff are able to work together in the best interests of patients;
- leadership is encouraged and developed at all levels and in all staff groups; and
- the NHS plays its full part in community development.

10.2.11 I will take responsibility for my own learning and development. I will seek to:

- take full advantage of the opportunities provided;
- keep up to date with best practice; and
- share my learning and development with others.

10.2.12 I will also uphold the seven principles of public life as outlined by the Nolan Committee:

- Selflessness – holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family or their friends
- Integrity – holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties
- Objectivity – in carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit
- Accountability – holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office
- Openness – holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands
- Honesty – holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest
- Leadership – holders of public office should promote and support these principles by leadership and example

10.3 Implementing the Code

10.3.1 The Code should be seen in a wider context that NHS managers must follow the 'Nolan Principles on Conduct in Public Life' (see paragraph 8.2.11 above), the 'Corporate Governance Codes of Conduct and Accountability', the 'Standards of Business Conduct', the 'Code of Practice on Openness in the NHS' and standards of good employment practice.

10.3.2 In addition many NHS managers come from professional backgrounds and must follow the code of conduct of their own professions as well as this Code.

10.3.3 In order to maintain consistent standards, the Trust will consider suitable measures to ensure that managers who are not their employees but who:

- manage their staff or services; or
- manage units which are primarily providing services to their patients also observe the Code.

10.3.4 It is important to respect both the rights and responsibilities of managers. To help managers to carry out the requirements of the Code, the Trust will provide reasonable learning and development opportunities and seek to establish and maintain an organisational culture that values the role of managers. NHS managers have the right to be:

- treated with respect and not be unlawfully discriminated against for any reason;
- given clear, achievable targets;
- judged consistently and fairly through appraisal;

- given reasonable assistance to maintain and improve their knowledge and skills and achieve their potential through learning and development; and
- reasonably protected from harassment and bullying and helped to achieve a reasonable balance between their working and personal lives.

10.4 Breaching the Code

10.4.1 Alleged breaches of the Code of Conduct will be promptly considered and fairly and reasonably investigated. Individuals must be held to account for their own performance, responsibilities and conduct where employers form a reasonable and genuinely held judgement that the allegations have foundation. Investigators should consider whether there are wider system failures and organisational issues that have contributed to the problems. In order to learn from and prevent future breaches of the Code, it is necessary to look at the wider causes of alleged breaches.

10.4.2 Local employers should decide whether to investigate alleged breaches informally or under the terms of local disciplinary procedures. It is essential however that both forms of investigation should be, and be seen to be, reasonable, fair and impartial. If Chief Executives or Directors are to be investigated, the employing authority should use individuals who are employed elsewhere to conduct the investigation. The NHS Confederation, the Institute of Healthcare Management and the Healthcare Financial Management Association are among the organisations who maintain lists of people who are willing to undertake such a role.

10.5 Application of the Code

10.5.1 The Code codifies and articulates certain important contractual obligations that apply to everyone holding management positions. These include Chief Executives and Directors who as part of their duties are personally accountable for achieving high quality patient care.

10.5.2 The Trust will:

- incorporate the Code into the employment contracts of Chief Executives and Directors and include the Code in the employment contracts of new appointments to that group
- identify any other senior managerial posts, i.e. with levels of responsibility and accountability similar to those of Director-level posts, to which they consider the Code should apply
- include the Code in new employment contracts as appropriate
- incorporate the Code into the employment contracts of existing postholders as appropriate.
- investigate alleged breaches of the Code by those to whom the Code applies promptly and reasonably as at paragraphs four to five
- provide a supportive environment to managers (see paragraph 10.2.5 above).

See also Standards of Business Conduct for NHS Staff, included in this manual

11. Standards of Business Conduct for NHS Staff

11.1 Introduction

11.1.1 These guidelines are based on recommendations by the NHS Management Executive to assist NHS employers and staff in maintaining strict ethical standards in the conduct of NHS business. They cover:

- the standards of conduct expected of all NHS staff where their private interests may conflict with their public duties; and
- the steps which NHS employers should take to safeguard themselves and the NHS against conflict of interest
- Action checklist for NHS Managers -*Part C* (omitted from this extract)
- Short guide for staff - *Part D*
- Ethical Code of the Chartered Institute of Purchasing and Supply (CIPS) (reproduced courtesy of IPS) - *Part E.*

11.1.2 The guidance is in four parts:

- Part A - brief summary of the main provisions of the Bribery Act 2010
- Part B - general policy guidelines
- Part C – Short guide for staff
- Part D - Ethical Code of the Chartered Institute of Purchasing and Supply (CIPS).

Part A

Bribery Act 2010

Bribery is generally defined as an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage, on behalf of oneself or another.

The Act repeals the UK's existing anti-corruption legislation – the Public Bodies Corrupt Practices Act 1889, the Prevention of Corruption Acts of 1906 and 1916 and the common law offence of bribery – and provides an updated and extended framework of offences to cover bribery both in the UK and abroad.

Zero Tolerance

Bribery is a criminal offence. Liverpool Women's NHS Foundation Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor do we or will we, accept bribes or improper inducements. This approach applies to everyone who works for us, or with us. To use a third party as a conduit to channel bribes to others is a criminal offence. We do not, and will not, engage indirectly in, or otherwise encourage, bribery.

Proactively combatting bribery has clear benefits for this Trust and the wider NHS. It helps prevent:

- adverse damage to or criticism of the organisation's reputation and funding;
- the potential diversion and/or loss of resources from NHS care;
- unforeseen and unbudgeted costs of investigations and/or defence of any legal action; and,
- a negative impact on patient/stakeholder perceptions.

Part B

General policy guidelines

Responsibility of the Trust
The Trust is responsible for ensuring that these guidelines are brought to the attention of all employees; also that machinery is put in place for ensuring that they are effectively implemented.

Responsibility of NHS staff
It is the responsibility of staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. This primary responsibility applies to all NHS staff, i.e. those who commit NHS resources directly (e.g. by the ordering of goods) or those who do so indirectly (e.g. by the prescribing of medicines). A further example would be staff who may have an interest in a private nursing home and who are involved with the discharge of patients to residential facilities.

Guiding principle in conduct of public business
It is a long established principle that public sector bodies, which include the NHS, must be impartial and honest in the conduct of their business, and that their employees should remain beyond suspicion. It is also an offence under the Bribery Act 2010 for an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage, on behalf of oneself or another (see Part A).

A breach of the provisions of the Act renders employees liable to prosecution and may also lead to loss of their employment and superannuation rights in the NHS.

NHS staff are expected to:
- ensure that the interest of patients remains paramount at all times;
- be impartial and honest in the conduct of their official business;
- use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.

It is also the responsibility of staff to ensure that they do not:
- abuse their official position for personal gain or to benefit their family or friends;
- seek to advantage or further private business or other interests, in the course of their official duties.

Implementing the guiding principles
Casual gifts
Casual gifts offered by contractors or others, e.g. at Christmas time should be politely but firmly declined.

Any gifts received from or offer of gifts by a contractor or potential contractor must be reported immediately to the Chief Executive. In the context of these instructions contractor means any supplier of goods and/or services to the Trust. Exception may be made only for items of a trivial nature, otherwise staff should decline all offers of gifts.

Articles of low intrinsic value such as diaries or calendars, or small tokens of gratitude from patients or their relatives, need not necessarily be refused. In cases of doubt staff should either consult their line manager or politely decline acceptance.

Hospitality
Modest hospitality provided it is normal and reasonable in the circumstances, e.g. lunches in the course of working visits, may be acceptable, though it should be similar to the scale of hospitality which the NHS as an employer would be likely to offer.

Visits to contractors or potential contractors or to another site to inspect their installations must be made at the Trust's expense and not the contractor's. Exception to this rule may be granted by the Chief Executive where reasonable. Otherwise only minimal hospitality should be accepted from a contractor or potential contractor and an immediate explanation must be given to the Chief Executive if a breach of the rules occurs. As with gifts, unless of a minor nature hospitality and entertainment should be declined.

Staff should decline all other offers of gifts, hospitality or entertainment. If in doubt they should seek advice from their line manager.

Any item/s of gifts and hospitality accepted, which are over the value of £25.00, should be entered into the gifts and hospitality register held in the Chief Executive's office.

Declaration of interests
For conflict of interests please refer to the Trust policy 'Managing Conflicts of interest' which sets out the requirement for staff to disclose any conflict or perceived conflict with the Trust's activities.

All NHS staff should therefore declare such interests to their employer, either on starting employment or on acquisition of the interest, in order that it may be known to and in no way promoted to the detriment of either the employing authority or the patients whom it serves.
One particular area of potential conflict of interest, which may directly affect patients, is when NHS staff hold a self-beneficial interest in private care homes or hostels. While it is for staff to declare such interests to their employing authority, the employing authority has a responsibility to introduce whatever measures it considers necessary to ensure that its interests and those of patients are adequately safeguarded. This may for example take the form of a contractual obligation on staff to declare any such interests. Advice on professional conduct issued by the General Medical Council recommends that when a doctor refers a patient to a private care home or hostel in which he or she has an interest, the patient must be informed of that interest before referral is made.
In determining what needs to be declared, employers and employees will wish to be guided by the policy referred to above and to the following documents that can be found on NHS England's website at https://www.england.nhs.uk/ourwork/coi/.
The Trust will:

- ensure that staff are aware of their responsibility to declare relevant interests
- keep a register of all such interests and make them available for inspection by the public
- develop a local policy, in consultation with staff and local staff interests, for implementing this guidance. This may include the disciplinary action to be taken if an employee fails to declare a relevant interest or is found to have abused his or her official position, or knowledge, for the purpose of self-benefit, or that of family or friends.

Preferential treatment in private transactions
Individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of their NHS employer. (This does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interest, on behalf of all staff - for example, NHS staff benefits schemes.)

Contracts
All staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign purchase orders, or place contracts for goods, materials or services, are expected to adhere to professional standards of the kind set out in the Ethical Code of the CIPS, reproduced at Part D.

Favouritism in awarding contracts

Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of NHS Standing Orders and of EC Directives on Public Purchasing for Works and Supplies. This means that:

- no private, public or voluntary organisation or company which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the NHS employer, such as a long-running series of previous contracts
- each new contract should be awarded solely on merit, taking into account the requirements of the NHS and the ability of the contractors to fulfil them.

The Trust will ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

Warnings to potential contractors- Trust bribery statement
NHS employers will wish to ensure that all invitations to potential contractors to tender for NHS business include a notice warning tenderers of the consequences of engaging in any corrupt practices involving employees of public bodies.

Liverpool Women's NHS Foundation Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor do we or will we, accept bribes or improper inducements. This approach applies to everyone who works for us, or with us. To use a third party as a conduit to channel bribes to others is a criminal offence. We do not, and will not, engage indirectly in, or otherwise encourage, bribery.

Outside employment
NHS employees are advised not to engage in outside employment which may conflict with their NHS work, or be detrimental to it. They are advised to tell the Trust if they think they may be risking a conflict of interest in this area: the Trust will be responsible for judging whether the interests of patients could be harmed, in line with the principles in 'Implementing the guiding principles' above.

Second employments must also be considered carefully. These activities should neither take precedence over an officer's main employment with the Trust nor should engagement in these activities in any way affect an officer's efficient discharge of duties under his or her main employment. Where an officer has reason to believe that this or her second employer has any business dealings whatsoever with the Trust the fact must be reported to the Chief Executive.

For full time staff, the main employment of officers necessarily takes precedence over any other paid or voluntary activities undertaken. Employees should not engage in any second or spare time job which affects in any way their performance or discharge of their duties with this Trust.

Second or spare time jobs are permissible without the need for registration or authorisation where the activity is not with a supplier or contractor to the Trust or not with any other NHS organisation.

Extra jobs, whether regular or occasional, should not be with a supplier to the Trust unless specifically approved by the Chief Executive who will keep a register detailing the personnel, the activity, the employer, and any other such details as deemed desirable.

Details of such situations must be submitted as and when these arise and confirmed on an annual basis.

Particular care must be taken to disclose any employment, even if only on a temporary or supply basis, with another NHS or private health care body.

Private practice
Consultants (and associate specialists) employed under the Consultant Contract are permitted to carry out private practice in NHS hospitals subject to the conditions outlined in the handbook and in accordance with the Code of Conduct for Private Practice

Other grades may undertake private practice or work for outside agencies, providing they do not do so within the time they are contracted to the NHS, and they observe the conditions in the paragraph above. All hospital doctors are entitled to fees for other work outside their NHS contractual duties (paragraph 41 of the TCS of Hospital Medical and Dental staff) e.g. examinations and reports for life insurance purposes. Hospital doctors and dentists in training should not undertake locum work outside their contracts where such work would be in breach of their contracted hours. Career grade medical and dental staff employed by NHS Trusts may agree terms and conditions different from the National Terms and Conditions of Service.

Rewards for Initiative
The Trust will identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that it receives any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by their employees in the course of their NHS duties. Most IPR are protected by statute e.g. patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. To achieve this, the Trust will build appropriate specifications and provisions into the contractual arrangements which they enter into *before* the work is commissioned, or begins. They should always seek legal advice if in any doubt in specific cases.

With regard to patents and inventions, in certain defined circumstances the Patents Act gives *employees a right* to obtain some reward for their efforts, and employers should see that this is effected. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

In the case of collaborative research and evaluative exercises with manufacturers, NHS employers should see that they obtain a fair reward for the input they provide. If such an exercise involves additional work for an NHS employee outside that paid for by the NHS employer under his or her contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should however be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

Commercial sponsorship for attendance at courses and conferences
Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where the employee seeks permission in advance and the employer is satisfied that acceptance will not compromise purchasing decisions in any way.
On occasions when NHS employers consider it necessary for staff advising on the purchase of equipment to inspect such equipment in operation in other parts of the country (or exceptionally, overseas), employing authorities will themselves want to consider meeting the cost, so as to avoid putting in jeopardy the integrity of subsequent purchasing decisions.

Commercial sponsorship of posts - “linked deals”
Pharmaceutical companies, for example, may offer to sponsor, wholly or partially, a post for the Trust. The Trust will not enter into such arrangements, unless it has been made abundantly clear to the company concerned that the sponsorship will have no effect on purchasing decisions by the Trust.

Where such sponsorship is accepted, monitoring arrangements will be established to ensure that purchasing decisions are not, in fact, being influenced by the sponsorship agreement.

Under no circumstances should employers agree to "linked deals" whereby sponsorship is linked to the purchase of particular products, or to supply from particular sources.

"Commercial in-confidence"
Staff should be particularly careful of using, or making public, internal information of a "commercial in-confidence" nature, *particularly if its disclosure would prejudice the principle of a purchasing system based on fair competition. This principle applies whether private competitors or other NHS providers are concerned,* and whether or not disclosure is prompted by the expectation of personal gain (see the paragraphs above and Part D).

However, NHS employers should be careful about adopting a too restrictive view on this matter. It should certainly not be a cause of excessive secrecy on matters which are not strictly commercial per se. For example, the term "commercial in confidence" should not be taken to include information about service delivery and activity levels, which should be publicly available. Nor should it inhibit the free exchange of data for medical audit purposes, for example, subject to the normal rules governing patient confidentiality and data protection. In all circumstances the overriding consideration must be the best interests of patients.

Disciplinary action
Failure to follow the principles and the guidance in this Code may result in disciplinary action and possibly prosecution under the Bribery Act 2010.

Officers should take action to report as soon as possible any instance where they feel the guidelines have been broken, accidentally or otherwise, by themselves or others. It should be emphasised that the crime occurs when any money, gift or consideration has been offered, requested or received and the recipient then shows favour or partiality to the donor. The recipient should be prepared to, and be able to demonstrate that any gift or hospitality was not received corruptly. Money should never be accepted. Prompt disclosure and registration are important acts to refute the charge of corruption.

Part C

Short guide for staff
Do:

- make sure you understand the guidelines on standards of business conduct, and consult your line managers if you are not sure
- make sure you are not in a position where your private interests and NHS duties may conflict (3)
- declare to your employer any relevant interests. If in doubt, ask yourself:
  - am I, or might I be, in a position where I (or my family/friends) could gain from the connection between my private interests and my employment?
  - do I have access to information which could influence purchasing decisions?
  - could my outside interest be in any way detrimental to the NHS or to patients' interests?
  - do I have any other reasons to think I may be risking a conflict of interest?
  - if still unsure - declare it!
- adhere to the ethical code of the Chartered Institute of Purchasing and Supply if you are involved in any way with the acquisition of goods and services
- seek your employer's permission before taking on outside work, if there is any question of it adversely affecting your NHS duties (special guidance applies to doctors)
- obtain your employer's permission before accepting any commercial sponsorship.

Do not:

- accept any gifts, inducements or inappropriate hospitality
- abuse your past or present official position to obtain preferential rates for private deals
- unfairly advantage one competitor over another or show favouritism in awarding contracts
- misuse or make available official “commercial in confidence” information.

If in doubt seek advice from the Trust Secretary on 0151 702 4033 or if you wish to report any concerns in relation to fraud or corruption contact the Trust’s LCFS on 07800 617 012 , the Fraud and Corruption Reporting Line 0800 028 4060 or www.reportnhsfraud.nhs.uk.

Part D

Chartered Institute of Purchasing and Supply - Ethical Code (Reproduced by kind permission of CIPS)

Introduction
The code set out below was approved by the CIPS Council on 11 March 2009 and is building on CIPS members.

- maintain the highest standard of integrity in all my business relationships
- reject any business practice which might reasonably be deemed improper
- never use my authority or position for my own personal gain
- enhance the proficiency and stature of the profession by acquiring and applying knowledge in the most appropriate way
- foster the highest standards of professional competence amongst those for whom I am responsible
- optimise the use of resources which I have influence over for the benefit of my organisation
- comply with both the letter and the intent of:
  - the law of countries in which I practise
  - agreed contractual obligations
  - CIPS guidance on professional practice
- declare any personal interest that might affect, or be seen by others to affect, my impartiality or decision making
- ensure that the information I give in the course of my work is accurate
- respect the confidentiality of information I receive and never use it for personal gain
- strive for genuine, fair and transparent competition
- not accept inducements or gifts, other than items of small value such as business diaries or calendars
- always declare the offer or acceptance of hospitality and never allow hospitality to influence a business decision
- remain impartial in all business dealing and not be influenced by those with vested interests.

See also Code of Conduct for NHS Managers, included in this manual.

12. Standing Orders of the Council of Governors –

These can be found in the Trust Constitution

13. Procedure for amending the Corporate Governance Manual

13.1 Procedure for Reviewing and Updating

13.1.1 Background

This manual sets out how the Trust operates and regulates itself. This is of vital importance in the public sector where the use of public funds and the performance and conduct of the organisation is under constant scrutiny.

13.1.2 Annual Review

The manual will be reviewed annually. It will be reviewed by the Trust Audit Committee in July. Thereafter it will be presented to the Board of Directors for formal approval and adoption at the next available meeting.

All changes[11] to the manual will be reviewed by the Audit Committee. These changes will be clearly highlighted in the updated Manual which is presented for subsequent adoption to the Board of Directors.

Following adoption, the Chief Executive and the Trust Secretary are responsible for ensuring that all directors, governors and trust staff are made aware of the manual and their responsibilities in respect of it. An up-to-date version of the manual will at all times be available on the Trust's intranet and website.

Where there are proposed changes to the manual that require initial review and approval by the Council of Governors, this will be done prior to consideration by the Audit Committee and the Board of Directors.

Care should be taken to ensure that all changes are consistent with the Trust's Constitution. Any proposed changes to the Constitution must first be approved by the Trust's members and NHS Improvement as per paragraph 23 of the Constitution.

Changes to Standing Financial Instructions, Scheme of Delegation of Board powers and associated section or which have financial implications or impact must always be routed through the Trust's Finance Department, where the Deputy Chief Finance Officer will ensure all financial aspects of the change are given due consideration and approval. These changes must be subsequently approved by the Finance, Performance and Business Development Committee ahead of consideration by the Audit Committee and Board of Directors.

The Trust Secretary will co-ordinate the submission of Corporate Governance Manual changes for approval to the Audit Committee, the Board of Directors and the Council of Governors as required.

13.1.3 Periodic Updating

The manual will be reviewed annually when necessary changes will be made. However it is recognised that changes may need to be made in-year to reflect legislative, constitutional, operational or other requirements i.e. periodic updating.

In such circumstances the same procedures must be followed, in due order, as specified above in respect of the annual review.

[11] With the exception of minor changes such as an organisational name change which will be reported for noting to the next available Audit Committee

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/75f*		Date: 02/09/2021	
Report Title	Updated LHP Members Agreement following formal dissolution of LHP Ltd.			
Prepared by	*Liverpool Health partners*			
Presented by	*Kathryn Thomson, Chief Executive*			
Key Issues / Messages	*LHP transferred to LHCH in February 2020 and in doing so stated in its Members Agreement that it was transferring from a Ltd. company hosted by UoL to a hosted business as part of LHCH.* *• It was subsequently agreed to dissolve LHP Ltd in 2021.* *• LHP Ltd. was formally dissolved on 4th June 2021. This now therefore requires a variation to the 2020 LHP members agreement which will need to be signed by all parties*			
Action required	Approve ☒	Receive ☐	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to review the documents and approve the CEO to sign the updated LHP members agreement and variation agreement.			
Supporting Executive:	*Kathryn Thomson, Chief Executive*			

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* 5.1 Failure to progress our research strategy and foster innovation within the Trust		Comment: This report is a key source of assurance against this BAF risk area.					
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

LHP transferred to LHCH in February 2020 and in doing so stated in its Members Agreement that it was transferring from a Ltd. company hosted by UoL to a hosted business as part of LHCH.

• It was subsequently agreed to dissolve LHP Ltd in 2021.

• LHP Ltd. was formally dissolved on 4th June 2021. This now therefore requires a variation to the 2020 LHP members agreement which will need to be signed by all parties.

REPORT

INTRODUCTION

1. LHP transferred from UoL to LHCH in February 2020 and in doing so transferred from a Ltd. Company hosted by UoL to a “hosted business” as part of LHCH.

2. The original members agreement for LHP Ltd. was amended to allow for this transfer and was circulated at the March 2020 LHP Board meeting as a consent item. The transfer also had an associated Business Transfer Agreement and Service Level Agreement drawn up between LHP and LHCH. At the effective date of the adjusted Members Agreement in March 2020, it had been proposed that LHP Ltd. would continue to exist as a company in parallel to LHP being hosted as a business under LHCH.

3. It was since agreed by LHP Board that LHP Ltd. would be formally dissolved. Dissolution took place on 4th June 2021. This however requires a variation to the Members Agreement of March 2020.

4. Hill Dickinson have worked with LHP to produce a variation to the agreement which each partner will be required to sign up to. In the meantime, the signing of any new contracts have been halted until the process has been finalised. The Board is asked to review and approve the variation agreement (Appendix 1) and the next steps.

KEY POINTS/PROPOSALS

5. Previously, when contracting with other organisations, LHP has been listed as LHP Ltd. and has signed on behalf of the company and not the partnership. By dissolving LHP Ltd, LHP has invested the right to sign legally binding contracts to LHCH under the hosted business arrangement.

6. LHP sought follow up advice from Hill Dickinson to ensure that the existing members agreement was edited to reflect the dissolution of LHP Ltd and the new hosted business relationship.

7. Hill Dickinson have since drafted a variation to the members agreement which is attached.

8. The membership agreement is the same one as signed historically, with the exception that the changes to membership tenure agreed at the LHP Board in September 2019 have been reflected in the revision (namely a five-year signup with a sliding period of notice up to the next renewal period).

CONCLUSION

9. LHP has formally dissolved LHP Ltd as agreed by the LHP Board.

10. LHP has sought advice from Hill Dickinson regarding the development of a variation to the current LHP members agreement to reflect this. This agreement will need to be signed by all parties. Until signed, working in the spirit of partnership is cordially requested.

RECOMMENDATION

11. To approve the CEO to sign the revised membership agreement and variation agreement

LIVERPOOL HEALTH PARTNERS
COLLABORATE • DISCOVER • IMPROVE

DATED

5th June 2021

VARIATION AGREEMENT

between

(1) University of Liverpool

and

(2) Liverpool John Moores University

and

(3) Edge Hill University

and

(4) Liverpool School of Tropical Medicine

and

(5) Liverpool University Hospitals NHS Foundation Trust

and

(6) The Walton Centre NHS Foundation Trust

and

(7) Mersey Care NHS Foundation Trust

and

(8) The Clatterbridge Cancer Centre NHS Foundation Trust

and

(9) Liverpool Women's NHS Foundation Trust

and

(10) Liverpool Heart and Chest Hospital NHS Foundation Trust

and

(11) Alder Hey Children's NHS Foundation Trust

and

(12) NHS Liverpool Clinical Commissioning Group

Relating to the Members Agreement
for the Academic Health Science Partnership known as Liverpool Health Partners

LIVERPOOLHEALTHPARTNERS.ORG.UK
1st Floor, Liverpool Science Park
131 Mount Pleasant
Liverpool, L3 5TF
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LIVERPOOLHEALTHPARTNERS.ORG.UK
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This agreement is dated 5th June 2021

PARTIES

(1) **UNIVERSITY OF LIVERPOOL** of Liverpool L69 3BX (**Liverpool University**);

(2) **LIVERPOOL JOHN MOORES UNIVERSITY** of Brownlow Hill, Liverpool L3 5UG (**LJM**);

(3) **EDGE HILL UNIVERSITY** of St Helens Rd, Ormskirk L39 4QP (**EHU**);

(4) **LIVERPOOL SCHOOL OF TROPICAL MEDICINE** of Pembroke Pl, Liverpool L3 5QA (**LST**);

(5) **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST** of Prescot Street, Liverpool, L7 8XP (**LUH**);

(6) **THE WALTON CENTRE NHS FOUNDATION TRUST** of Lower Ln, Liverpool L9 7LJ (**TWC**);

(7) **MERSEY CARE NHS FOUNDATION TRUST** of V7 Building, Kings Business Park, Prescot, L34 1PJ (**MCT**);

(8) **THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST** of Clatterbridge Rd, Birkenhead, Wirral CH63 4JY (**CCC**);

(9) **LIVERPOOL WOMEN'S NHS FOUNDATION TRUST** of Crown St, Liverpool L8 7SS (**LWT**);

(10) **LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST** of Thomas Drive Liverpool L14 3PE (**LHCH**);

(11) **ALDER HEY CHILDREN'S NHS FOUNDATION TRUST** of Eaton Road Liverpool, L12 2AP (**AHC**); and

(12) **LIVERPOOL CLINICAL COMMISSIONING GROUP** of 2 Renshaw St, Liverpool L1 2SA (**LCCG**).

(collectively known as the "**Parties**" and individually known as a "**Party**")

BACKGROUND

(A) The Parties are the members of the Academic Health Science Partnership known as Liverpool Health Partners and have entered into an agreement dated 5th June 2021 for the purpose of governing Liverpool Health Partners (the **Members Agreement**).

(B) A party to the Members Agreement is Liverpool Health Partners Limited (**the Company**). The Company is hosted by LHCH which has decided to wind up the Company. As a consequence, the Parties have agreed to amend the Members Agreement to address the fact that the Company will no longer be a party to the Members Agreement. The Parties wish to make the following amendments to the Members Agreement as set out below with effect from the date of this variation agreement (**Variation Date**).

AGREED TERMS

1 **TERMS DEFINED IN THE AGREEMENT**

In this variation agreement, expressions defined in the Members Agreement and used in this variation agreement have the meaning set out in the Members Agreement.

2 **CONSIDERATION**

In consideration of the mutual promises set out in this agreement, the parties agree to amend the Members Agreement as set out below.

3 **VARIATION**

3.1 With effect from the Variation Date the parties agree to amend the Members Agreement as shown in the copy of the Agreement attached as a Schedule to this Agreement, where deletions to the original contract are shown in struck through text and additions are shown in underlined text.

3.2 Except as set out in clause 3.1, the Members Agreement shall continue in full force and effect.

4 **GOVERNING LAW AND JURISDICTION**

4.1 This variation agreement and any dispute or claim (including non-contractual disputes or claims) arising out of or in connection with it or its subject matter or formation shall be governed by and interpreted in accordance with the law of England and Wales.

4.2 The parties irrevocably agree that the courts of England and Wales have [non-]exclusive jurisdiction to settle any dispute or claim (including non-contractual disputes or claims) that arises out of, or in connection with, this variation agreement or its subject matter or formation.

This agreement has been entered into on the date stated at the beginning of it.

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131 Mount Pleasant
Liverpool, L3 5TF
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SCHEDULE 1 - VARIED AGREEMENT

Signed by [NAME OF DIRECTOR] for and on behalf of **UNIVERSITY OF LIVERPOOL**	…….. Director
Signed by [NAME OF DIRECTOR] for and on behalf of **LIVERPOOL JOHN MOORES UNIVERSITY**	…….. Director
Signed by [NAME OF DIRECTOR] for and on behalf of **EDGE HILL UNIVERSITY**	…….. Director
Signed by [NAME OF DIRECTOR] for and on behalf of **LIVERPOOL SCHOOL OF TROPICAL MEDICINE**	…….. Director
Signed by [NAME OF DIRECTOR] for and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**	…….. Director

Signed by [NAME OF DIRECTOR] for and on behalf of **THE WALTON CENTRE NHS FOUNDATION TRUST**	…….. Director
Signed by [NAME OF DIRECTOR] for and on behalf of **MERSEY CARE NHS FOUNDATION TRUST**	…….. Director
Signed by [NAME OF DIRECTOR] for and on behalf of **THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST**	…….. Director
Signed by [NAME OF DIRECTOR] for and on behalf of **LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**	…….. Director
Signed by [NAME OF DIRECTOR] for and on behalf of **LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST**	…….. Director

Signed by [NAME OF DIRECTOR] for and on behalf of **ALDER HEY CHILDREN'S NHS FOUNDATION TRUST**	…….. Director
Signed by [NAME OF DIRECTOR] for and on behalf of **LIVERPOOL CLINICAL COMMISSIONING GROUP**	…….. Director

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