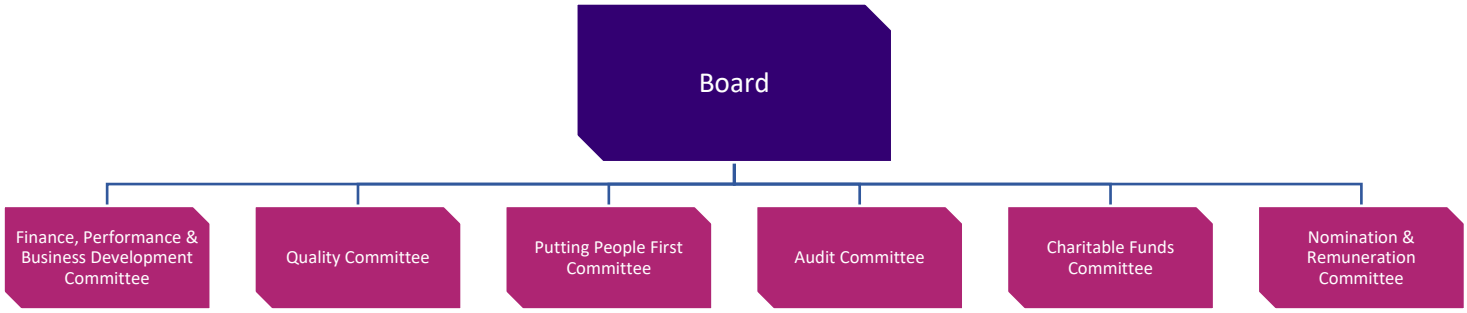
Liverpool Women's NHS Foundation Trust

Trust Board

7 April 2022, 09.30am

Blair Bell Lecture Theatre & Virtual, via Teams



Liverpool Women's
NHS Foundation Trust

Trust Board

Location	Blair Bell Lecture Theatre & Virtual via Teams
Date	7 April 2022
Time	9.30am

Item no. 22/23/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
001	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	0930 (5 mins)
002	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
003	Minutes of the previous meeting held on 3 March 2022	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
004	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
005	Service Outline	To receive service outline	Verbal	Chief Operating Officer	0935 (10 mins)
006	Patient Story	To receive a patient story	Verbal	Chief Nurse & Midwife	0950 (15 mins)
007	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	1000 (5 mins)
008	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	1005 (20 mins)
QUALITY & OPERATIONAL PERFORMANCE					
009a	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	1025 (70 mins)
009b	Major Incident Update	For assurance	Written	Chief Operating Officer	
009c	Learning from Deaths – Quarter 3 2021/22	For assurance	Written	Medical Director	
009d	Integrated Governance Report – Quarter 3 2021/22	For assurance	Written	Chief Nurse & Midwife	

009e	Bi-annual staffing paper, July-December 2021 (Q2 & Q3)	For assurance	Written	Chief Nurse & Midwife	
009f	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	For assurance	Written	Chief Nurse & Midwife	
009g	Chair's Reports from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
BREAK – 10 mins					
Board Thank You – 5 mins					
PEOPLE					
010a	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	1150 (20 mins)
010b	Equality, Diversity & Inclusion Annual Report	To receive	Written	Chief People Officer	
010c	Chair's Report from the Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
FINANCE & FINANCIAL PERFORMANCE					
011a	Finance Performance Review Month 11 2021/22	For assurance - To note the current status of the Trust's financial position	Written	Chief Finance Officer	1210 (40 mins)
011b	Revenue and Capital Budgets 2022/23	For approval	Written	Chief Finance Officer	
011c	Chair's Reports from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
011d	Chair's Report from the Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
011e	Chair's Report from the Charitable Funds Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
BOARD GOVERNANCE					
012a	Corporate Objectives 2021/22: Final Outturn Review	For approval	Written	Chief Executive	1250 (20 mins)
012b	Proposed Risk Appetite Statement 2022-23	For approval	Written	Chief Nurse & Midwife	
012c	A new approach to non-executive director champion roles	For approval	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.*					

013	Board Assurance Framework	For assurance	Written	Trust Secretary	Consent
014	Trust Board Terms of Reference	For approval	Written	Trust Secretary	
015	Board Committee Annual Reports, 2022/23 cycles of business and Terms of Reference	For approval	Written	Trust Secretary	
016	Revised Risk Management Strategy for 2022-23	For approval	Written	Chief Nurse & Midwife	
CONCLUDING BUSINESS					
015	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1310 (5 mins)
016	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
017	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
018	Jargon Buster	For reference	Written	Chair	

Date of Next Meeting: 5 May 2022

1315 - 1325	*Questions raised by members of the public*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

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

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

Liverpool Women's
NHS Foundation Trust

Meeting 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 via Teams at 09.30am on 3 March 2022

PRESENT

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

IN ATTENDANCE

Jackie Bird	Non-Executive Director (Designate)
Dianne Brown	Interim Associate Director
Matt Connor	Chief Information Officer
Peter Norris	Public Governor
Pat Denny	Public Governor
Iris Cooper	Public Governor
Jackie Sudworth	Public Governor
Rebecca Lunt	Staff Governor
Rev. Dr Miranda Threlfall-Holmes	Appointed Governor
Jane Rooney	Appointed Governor
Lesley Mahmood	Member of the public
Felicity Dowling	Member of the public
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Prof. Louise Kenny CBE	Non-Executive Director
Dr Lynn Greenhalgh	Medical 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	✓	✓	✓	✓		A	Non-member					
Tracy Ellery - Non-Executive Director / Vice-Chair	✓	✓	✓	A		✓		A	✓	✓	✓	✓

Louise Martin - Non-Executive Director	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓
Ian Knight - Non-Executive Director	✓	✓	✓	✓		✓	Non-member					
Tony Okotie - Non-Executive Director	A	✓	✓	✓		✓		✓	A	✓	✓	✓
Prof Louise Kenny - Non-Executive Director	✓		✓	✓		A		✓	A	✓	A	A
Jenny Hannon – Chief Finance Officer	✓	✓	✓	✓		✓	Non-member					
Eva Horgan – Chief Finance Officer	Non-member							✓	✓	✓	✓	✓
Marie Forshaw – Chief Nurse & Midwife	✓	A	✓	✓	✓	✓		✓	✓	✓	✓	✓
Gary Price - Chief Operating Officer	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓
Michelle Turner - Chief People Officer	✓	A	✓	✓		✓		✓	✓	A	✓	✓
Dr Lynn Greenhalgh - Medical Director	✓	✓	✓	✓		✓		✓	✓	✓	✓	A
Zia Chaudhry – Non-Executive Director	Non-member								✓	✓	✓	✓
Gloria Hyatt – Non-Executive Director	Non-member								✓	✓	✓	✓
Sarah Walker – Non-Executive Director	Non-member								✓	✓	✓	✓
Present (✓) Apologies (A) Representative (R) Non attendance (NA)												

21/22/	
168	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. No declarations of interest were made, and apologies were noted as above.
169	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
170	**Minutes of the previous meetings held on 3 February 2022** The minutes of the Board of Directors meetings held on 3 February 2022 were agreed as a true and accurate record.
171	**Action Log and matters arising** The Action Log was noted.
172	**Chair's and CEO announcements** The Chair welcomed Dianne Brown and Jackie Bird to the meeting. Reference was made to the recent requirement in the current Maternity incentive scheme CNST timetable for the Board to provide sign off for an Avoiding Term Admissions into Neonatal units (ATAIN) action plan by the 28 February 2022. As this deadline passed outside of the standard reporting cycle, it was explained that the underpinning assurance went to the Quality Committee on Monday 21 February 2022 and a recommendation was made to the Board to provide this sign off. This was confirmed via email ahead of the deadline and the Board was asked to ratify this agreement. The Board noted the Chair's and CEO update and ratified the approval of the Avoiding Term Admissions into Neonatal units (ATAIN) action plan.
173	**Ockenden One Year On** The Chief Nurse & Midwife introduced the report noting that it outlined the current actions and work being undertaken to date, to enable the Trust to provide assurance that the full implementation of the Ockenden Immediate and Essential recommendations (IEAs) was underway. The report was in response to a request from the Chief Nursing Officer to ensure that several issues had been discussed

with the Board in public before the end of March 2022. Progress against the seven IEAs was outlined with the actions to close out any outstanding areas highlighted.

It was acknowledged that a key fundamental of Maternity Safety was ensuring an effective system of clinical workforce planning for both the Obstetric and Midwifery Workforce. A detailed report on the midwifery staffing had been received by the Board in February 2022 and it was noted that a developing Medical Workforce Plan had bene shared with the Board as a draft.

The Chief Nurse & Midwife continued to state that the report also provided an opportunity to reflect on the wider issues raised by the Ockenden Report (in addition to the points of compliance) that were identified by the Board in January 2021 and to consider the progress made against these and what future actions may be necessary. These wider issues included ensuring that once lessons were learned, improved practice was embedded and could be evidenced, ensuring that the patient 'voice' was heard and was used to drive service improvements and finally how the lessons identified in the Ockenden report could be applied across the whole organisation. The Chief Nurse & Midwife gave a position statement against each of these noting both the progress had been made and the further work that was required.

There was agreement that the issues and themes raised in the initial Ockenden Report were fundamental to the core business of the Trust and a focus on maternity safety should remain a top priority for 2022/23 and ahead of the imminent publication of the second Ockenden report. It was also asserted that whilst the Trust had made progress in being a system and national leader for maternity safety, further improvements in this area were required. Attention was drawn to the fact that the Trust had created a new Director of Midwifery post and would also be recruiting a new Head of Midwifery. It was stated that this reflected true investment and capacity building for the midwifery service, and it was also expected that the candidates for the two roles would provide a fresh approach.

The Chief People Officer added that it would also be important to develop the capacity of existing staff and to ensure that the culture in the maternity service improved. An important aspect of the Board receiving assurance on progress with the themes within the Ockenden Report would be the ability to ensure that it retained a strong understanding of the experience of front-line staff. Non-Executive Director Tony Okotie noted that there had recently been disappointing results from a maternity patient experience survey reported to the Quality Committee and it had been asserted that this was indicative of a staff culture that had room for improvement.

The Chief Operating Officer acknowledged that whilst there had been issues requiring improvement in the maternity service, there had been significant challenges during the Covid-19 pandemic which had broadly been well responded to. This had supported the development of several key members of maternity staff and this resilience had recently been demonstrated during the response to the Omicron variant.

Non-Executive Director Louise Martin asserted that a key lesson from the Ockenden Report was the need to listen to women, particularly from underrepresented groups. It was queried how the Trust was pro-actively responding to this issue. The Chief Nurse & Midwife noted that a cultural diversity midwife had recently been appointed and this individual was energised about engaging with underrepresented groups. Following the recent maternity patient experience survey, the patient experience team were proactively contacting women about their experiences and the clinical audit team would be analysing the results. The Chief People Officer added that whilst the Trust had a positive relationship with the Maternity Voices Partnership, it was recognised that, for the most part, it was 'motivated voices' that made contact through this route. There was therefore more work to be done to hear from hard-to-reach groups. The Chief Executive noted that work was progressing to present Key performance Indicators from an Equality, Diversity, and Inclusion (ED&I) perspective which would provide additional clarity to the Board on the direction of travel.

	Action: For a Board Development Session to be held on how best to utilise available ED&I data to identify areas of focus for improvement. The Board noted the progress made by the Trust in response to the Ockenden Report.
174	Standalone Site - Update on Quality and Safety Risks The Chief Nurse & Midwife stated that despite investment in mitigations at the Crown Street site, there remained significant structural risks in place meaning that even after all planned mitigations were in place, Liverpool Women's Hospital on the current Crown Street site would remain as no longer clinically viable, as formally declared in 2014. It was asserted that it was important for the Board to be clearly sighted on these risks, and what management was doing to mitigate them where this was possible. In particular, a Partnership Board was now in place with Liverpool University Hospitals NHS FT, as recommended by the Single-Issue Quality Surveillance Group (SIQSG) as part of the 2020 action plan. The Chief Nurse & Midwife continued to set out the key risks and mitigations, the residual risk, and the changes to reporting that was planned going forward to ensure that Quality Committee and the Board were clearly sighted on the ongoing impacts of this position. The Chief Executive noted that it was encouraging to see the assurance on the mitigations that the Trust had put into place to reduce the risk, particularly noting the recent development of securing a CT scanner on site. It was reported that a Northeast Clinical Senate would be reviewing the updated counterfactual case to provide an independent level of challenge and scrutiny on the conclusions reached by the Trust. This was a repeat of a process first undertaken in 2017. Non-Executive Director Zia Chaudhry sought additional evidence regarding the impact of the stated clinical risk on the recruitment and retention of staff. The Chief Executive explained that there had been discussions to remove the Trust's oncology service towards the end of the previous decade due to the Trust's challenges in recruiting consultants. The consultants that had subsequently joined the Trust had done so with an understanding that they would remain at the Trust if there was a trajectory towards co-location. The Chief Executive explained that due to the move towards more specialist medical training, newer consultants did not have the quantity of general medical training and experience that had once been provided, given the earlier specialisation in training programmes and the expectation within the training of easy access to colleagues from different specialisms. As more experienced consultants retired, this risk increased and would start to fully manifest as the decade progressed. There was a particular risk in relation to the availability of obstetric anaesthetists due to their requirement to be attached to an acute hospital to maintain their competency training. The Board of Directors: • noted the actions taken to mitigate quality and safety risks and the residual level of risk which remains • Noted the proposed reporting of the issue going forward to ensure there was clear sight on remaining risks and their impacts
175	Review of risk impacts of items discussed The Chair identified the following risk items and positive assurances: Risks: • Despite investment in mitigations at the Crown Street site, there remained significant structural risks in place meaning that Liverpool Women's on the current Crown Street site would remain as no longer clinically viable, as formally declared in 2014. Positive Assurance:

	• Demonstrable progress against the IEAs in the Ockenden Report and some of the wider themes identified by the Board. Further work and progress required, however.
176	Chair's Log None noted.
177	Any other business & Review of meeting Noted that the Trust was providing support to Ukrainian colleagues. Review of meeting No comments noted.

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
April 2022

Key	Complete	On track	Risks identified but on track	Off Track

Meeting Date	Ref	Agenda Item	Action Point	Owner	Action Deadline	RAG Open/Closed	Comments / Update
3 March 2022	21/22/173	Ockenden – One Year On	For a Board Development Session to be held on how best to utilise available ED&I data to identify areas of focus for improvement.	Chief People Officer & Chief Operating Officer	June 22	On track	
3 February 2022	21/22/163c	Board Assurance Framework	For Executives to review and update the actions contained within their aligned BAF risks.	All Execs	May 22	On track	
3 February 2022	21/22/160d	Learning from Deaths Quarter 2, 2021/22	To include national or statistical neighbour benchmarking in future learning from deaths quarterly reports.	Medical Director	April 22	Complete	Benchmarking data included within the report – please see item 009c
3 February 2022	21/22/160a	Quality & Operational Performance Report	For the next iteration of the Integrated Governance Report to include a detailed analysis of complaints to inform the reasons behind a reduced patient satisfaction position.	Chief Nurse & Midwife	April 22	Complete	Included within the report – please see item 009d
2 December 2021	21/22/121f	Integrated Governance Assurance Report 2021/22 – Quarter 2	For the Board to receive a report on the work to mitigate the blood sampling errors issue.	Medical Director	April 22	Complete	Detailed report received by the Quality Committee – please see Chair's Report in item 009g
2 December 2021	21/22/118	Patient Story	For the Board to receive an overview of the work being undertaken by the Patient Experience Matron in April 2022.	Chief Nurse & Midwife	July 22	On track	

4 November 2021	21/22/86c	Cheshire & Merseyside Women's Health & Maternity Services Programme Update	For the April 2022 Board to receive an update on the work undertaken by the Women's Health & Maternity Services Programme to reduce health inequalities.	Chief Operating Officer	~~Apr 22~~ May 22	On track	Owing to length of April's agenda, this item has been deferred to May 2022.
2 September 2021	21/22/72a	Workforce Performance Report	For consideration to be given to how senior leaders provide accountability to the Board regarding flexible working arrangements for staff.	Chief People Officer	Apr 22	Complete	'Flex for the future' update provided to the March 2022 PPF Committee. Noted that the Committee would continue to receive updates on progress.

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Received	24.03.22	To receive a proposed method of assessing the maturity of Divisional Governance arrangements to support the Audit Committee in undertaking reviews. Lead Officer: TS	Audit	May 2022	On track	
Delegated	03.02.22	To undertake a reflective exercise on the regional joint procurement for the Linen and Laundry and Clinical Waste contracts.	FPBD	March 2022	Complete	Verbal Update provided at the March 2022 FPBD meeting.
Delegated	03.02.22	To receive regular assurance updates on CNST compliance	Quality	March 2022	Complete	Monthly updates being received.
Delegated	03.02.22	To receive a detailed explanation behind the Trust's ITU transfers of care performance Lead Officer: MD	Quality	March 2022	Complete	Information shared with Louise Martin, NED. Verbal update to provided to QC March 2022.
Delegated	03.02.22	To review the development of a business case for an expanded endometriosis service.	FPBD	October 2022	On track	To be progressed through the Divisional Operational Planning

		Lead Officer: CFO				process with an update provided to the FPBD Committee as part of the six month review of progress.
Delegated	06.01.22	To explore the potential staffing barriers to implementing obstetric twilight shifts and 24/7 consultant cover. Lead Officer: CPO	PPF	March 2022	Complete	Update provided to the March 22 PPF Committee
Delegated	06.01.22	To receive an update on the progress with wellbeing actions, particularly those that provide guidance for line managers to support their direct reports. Lead Officer: CPO	PPF	May 2022	On track	
Received	20.12.21	Remitted a combined report to note quality impacts, commissioning needs and the wider system which support the Trusts key strategic items to the Trust Board. Executive Lead: Medical Director	Quality	April 2022	On track	Divisional Transformation Plans will be communicated to the Board.
Delegated	02.12.21	To receive a review of the learning from the Major Incident and its implications for the Trust's EPRR arrangements. Lead Officer: Chief Operating Officer	FPBD	April 2022	On track	

Liverpool Women's
NHS Foundation Trust

CEO Report

Trust Board
April 2022

Executive Summary:

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

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

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

Section A - *Internal*

Final Report of the Ockenden Review

On 30 March 2022, Donna Ockenden, chair of the independent review into maternity services at the Shrewsbury and Telford Hospital NHS Trust (the Trust), published the final report detailing the findings, conclusions and essential actions.

Everyone connected with maternity care will know what a difficult task it has been to read the final Ockenden Report – none more so than the women and families who have received maternity care in the past or will do so in the future.

As a specialist Trust for women and babies, we have carefully taken some time to reflect on the contents of the report before providing our initial response.

Please see the briefing in appendix 1 to this report which contains our initial response to the report and what we are already doing to deliver against the 15 essential actions which all maternity providers must prioritise immediately.

You can also access a similar briefing on our Trust website which has been shared with the public here: https://www.liverpoolwomens.nhs.uk/news/our-initial-response-to-the-ockenden-report/

Board members will recall that a paper was received at the March 2022 Board that provided a reflection against the Interim Ockenden Report, a year on from its publication. The February 2022 Board meeting also provided an opportunity for the Board to review its maternity staffing arrangements in detail.

Section A - *Internal*

Armed Forces Covenant - Update

On 12 August 2021 the Trust signed the Armed Forces Covenant. On the 16 December 2021, the Trust was awarded the bronze certificate in national recognition of our commitment to the Armed Forces.The Trust is now developing an action plan to apply for the silver certificate.

The Trust is LSO working closely with Lynsey Nicholson, the Veterans Covenant Healthcare Alliance (VCHA) lead for the Northwest. The VCHA is a group of NHS providers that have volunteered to be exemplars of the best care for / and support to the armed forces community. It is funded by NHS England. To gain this accreditation there are a series of standards to be achieved, some of which overlap with the silver certification requirements noted above but also includes the recruitment of staff.

Liverpool Women's Hospital BSGE Accredited Centre 2022

On behalf of the endometriosis team we are delighted to share the news, of achieving the goal, of becoming a British Society of Gynaecological Endoscopy Accredited Centre 2022.

We would really like to thank the team involved in achieving this success. We also acknowledge the continuing ambition in developing and expanding the service to make it one of the best in the country.

Trust Seal
In line with paragraph 118 of the Trust's Standing Orders, there is a requirement to report all sealings to the Board of Directors on an annual basis. The report should contain details of the seal number, the description of the document and date of sealing. The seal was utilised once during 2021/22:

172 – Lease relating to Car Park in the NW Corner of Mulgrave St and Selbourne St, Liverpool *between* Liverpool City Council and the Trust – 3 June 2021.

Section A - *Internal*

WOMEN OF THE YEAR PRESENTS SPECIAL ACCOLADE TO THE WOMEN OF THE NHS AT 40TH ANNIVERSARY AWARDS

The Women of the Year Luncheon & Awards has presented a special accolade to the Women of the NHS at this year's ceremony, which took place on Friday 1 April 2022 in Birmingham.

The prestigious Women of Achievement award celebrates women who have shown extraordinary courage in extraordinary circumstances, as well as making a contribution to society.

This year, the award has been presented to the Women of the NHS in recognition of their unwavering dedication, commitment and compassion.

An inspiring team of NHS workers collected the award at the ceremony - including nurses, midwives, consultants and surgeons from the Neonatal Ward at Liverpool Women's Hospital and Alder Hey Children's Hospital, as well as twelve other NHS workers chosen by Chief Nursing Officer for England, Ruth May and her team from specialist areas including specialists in cancer treatment, physiotherapy, mental health support services, children's services and many more.

The annual awards ceremony marked its 40th anniversary this year, as it returned to the Hilton Metropole Birmingham after two years of absence due to the Covid-19 pandemic.

Zalena Vandrewala, Chair of the Awards, said: "We are delighted to welcome such an inspiring group of women to accept this award on behalf of the Women of the NHS. 2020 marked the Year of the Nurse and the Year of the Midwife, which we were unable to celebrate at the time due to the Covid-19 pandemic. It is therefore incredibly fitting to welcome NHS nurses and midwives to today's ceremony and give them the recognition and thanks they deserve.

"The Covid-19 pandemic placed unfathomable pressure on the NHS and we are in awe of the unfaltering commitment and dedication of the women here with us today. They represent thousands more female workers across every sector of the NHS, who work relentlessly, day in and day out, to provide life-saving care, treatment and support to those in need. It is a real honour to welcome them to today's ceremony and this award represents our immense gratitude and respect for all that they do."

Jen Deeney, Head of Neonates at the Liverpool Women's/ Liverpool Neonatal Partnership said, "The past two years have been incredibly difficult for so many people and I am extremely humbled and excited to be part of these amazing awards and it's an absolutely privilege for our team to be asked to represent the Women of the NHS"

Women of the Year Luncheon & Awards was established in 1982 as a ladies' luncheon to raise vital funds for charitable causes and to highlight and celebrate the many and varied achievements of women.

Since then, the annual awards have gone from strength to strength both as an event and as a movement to promote women's achievements. Over the last four decades, winners have included Baroness Karren Brady CBE, Katie Piper, Dame Asha Khemka DBE (Principal and CEO of West Nottinghamshire College) and British Paralympian, Martine Wright MBE.

This year's ceremony welcomed keynote speaker Team GB Paralympian, Lucy Shuker as well as nearly 600 professionals from the private and public sectors.

Zalena Vandrewala added: "As we mark our 40th anniversary, this year's awards ceremony was a real celebration. It was a wonderful opportunity to highlight the incredible achievements of women, give thanks for their ongoing contribution and to hopefully inspire others to achieve great things."

All proceeds from this year's Women of the Year Luncheon & Awards will go directly to charity, with just under £600,000 raised to date. For 2022, the event will support The Prince's Trust: Women Supporting Women Initiative, a passionate group of supporters who are committed to changing the lives of young women, and NHS Charities Together which continues to support our NHS in the life saving work that they do.

For more information, please visit www.womenoftheyear.org.uk.

Chief Executive Report

Section A - *Internal*

Bereavement Support Officer Sarah Martin wins GOLD for the 'Exceptional Support Worker of the Year' at the National 'Our Health Heroes awards'

Our very own Sarah Martin Bereavement Support Officer has won GOLD for the 'Exceptional Support Worker of the Year' at the National 'Our Health Heroes awards'

In recognition of her work supporting parents and their families whose baby has died as a result of molar or ectopic pregnancy, miscarriage, stillbirth or just after birth. Sarah is part of our Honeysuckle Bereavement Team, a service that cares for bereaved families following the loss of a baby from very early in pregnancy to just after birth. The Honeysuckle Team is a small team with Sarah and two bereavement midwives who provide support across the Trust.

Sarah won the public vote due to her tireless work to meet and exceed the team's ethos to ensure that positive memories are created by showing due diligence in all processes that ensure the last part of a baby's journey, however small, is carried out with compassion and dignity.

The death of a baby is a taboo subject; Sarah strives to break down this taboo subject by engaging with staff across the Trust. She supports all grades of staff with her expert knowledge of the legalities involved around bereavement services. Sarah actively listens, provides reassurance, guidance and comfort. Sarah co-ordinates the annual Trust memorial service that takes place during Baby Loss Awareness Week and goes above and beyond to ensure everything is seamless and cohesive across to ensure that all Honeysuckle families are remembered.

Liverpool Women's Patient Experience Matron Gillian Walker had this to say:
"Sarah is a unique, special person who is remembered by the people whose lives she touches. Sarah is honest, warm, open and more than anything: caring. Her energy and focus is second to none and an asset to our Trust. Sarah is humble and does not see how absolutely amazing she is."

Speaking at a glittering Awards ceremony held at the Science Museum in London Sarah said: "I can't quite believe they read my name out! I was quite shocked that I was even nominated and shortlisted. It's a lovely thing to get recognised for what you do. People here today don't do what we do to get recognised, but it's just a lovely thing to learn that people do really care about what we do."

We would like to wish Sarah a huge congratulations on winning such a brilliant award.

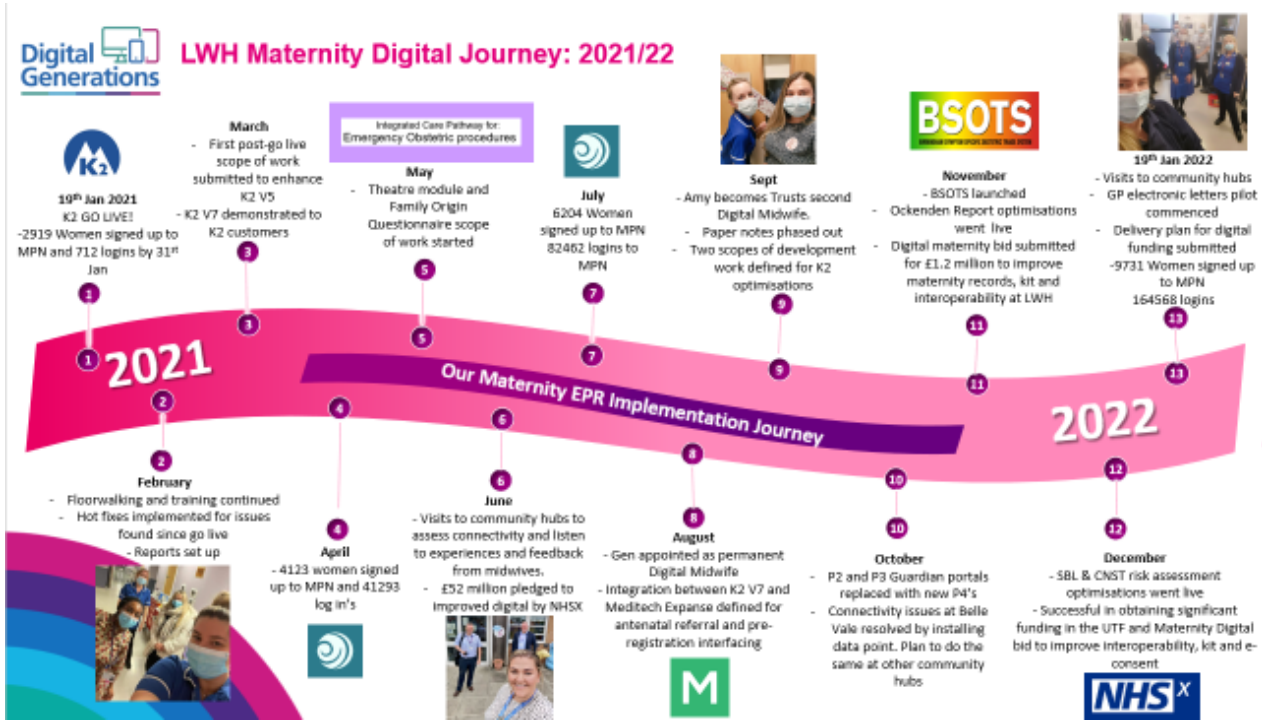
Employee & Team of the Month – Congratulations to our February winners

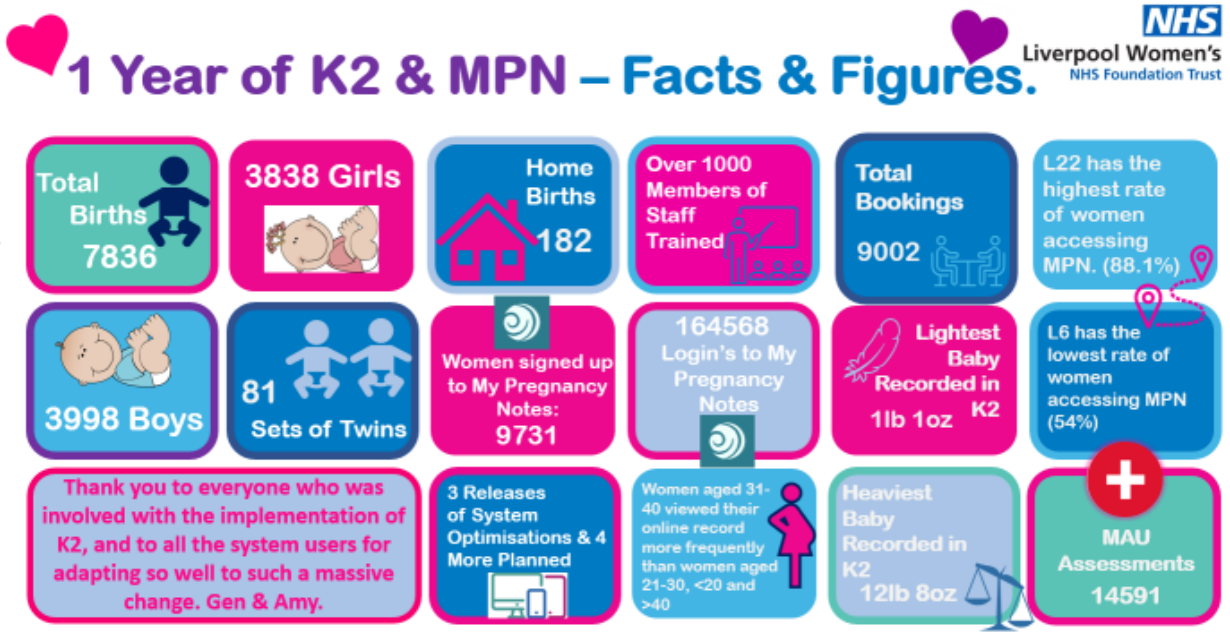
Congratulations to Senior Neonatal Nurse Nicola Leicester for winning Employee of the Month for going above and beyond in the interest of our babies and families every day and to the Maintenance Team Ged and Terry who are always cheerful, positive and hard winning and won Team of the Month.

Section A - *Internal*

LWH Maternity Digital Journey 2021/22

This infographic has been developed to show the work of the first year of K2





Section A - *Internal*

LWH Joins in Planting Trees for the Queens Jubilee

Liverpool Women's Hospital has joined thousands of other organisations in planting three new trees in the hospital grounds which will form part of the Queens Green Canopy.

Three trees have been planted in the Liverpool Women's Hospital grounds near to the main entrance as part of the Queens Green Canopy, a unique tree planting initiative to create a legacy in honour of the Queens Jubilee, which will help to benefit our future generations.

The Lord Lieutenant of Merseyside Mark Blundell attended the hospital with John and Mary Roberts to plant the trees.

Gary Price, Chief Operating Officer said, "Liverpool Women's are delighted to be marking Her Majesty's Platinum Jubilee year by supporting this initiative, a big thanks to our staff who supported the Lord Lieutenant in the planting."

The trees that have been planted include one Acer Plat Princeton Gold, which will take 20-50 years to reach its ultimate height of higher than 12 meters and two Morus Nigra which will produce beautiful dark fruits in the summer months for patients, visitors, and staff to enjoy.

Members of the hospitals clinical and corporate teams also attended to support the planting of the trees.

Section B - *Local*

Chair appointed to lead the NHS in Cheshire and Merseyside

The Cheshire and Merseyside Health and Care Partnership has confirmed that following a robust and competitive, national recruitment process, NHS England and NHS Improvement have recommended, and the Secretary of State has agreed, that Raj Jain will be the new Chair-designate of the NHS Cheshire and Merseyside Integrated Care Board (ICB), ready to take up the post from July 2022 should Parliament confirm the current plans.

Raj has extensive experience in leadership roles spanning a 26-year career in the NHS which began when he joined in 1995. Raj's career has been marked by a committed to innovation and improvement at every NHS organisation he has worked in, and he was instrumental during his time at Salford Royal NHS FT in the successes and achievements of that organisation. He also led improvement work across Pennine Acute Hospitals NHS Trust, when the trust joined with Salford Royal NHS FT playing a pivotal role bringing both organisations together, firstly as the Northern Care Alliance group, but following formal merger of those trusts, leading the newly formed Northern Care Alliance NHS FT as its chief executive.

In addition, Raj has chaired several partnership boards, including some outside of health, with recent examples including Greater Manchester's Diagnostic Board, Salford's Digital Board (for the local authority) and the Working Group of the NW Black Asian Minority Ethnic Assembly.

The confirmation of Raj in this role is a significant step in the development of integrated care in Cheshire and Merseyside and the establishment of an NHS Integrated Care Board which, subject to legislation, will hold a substantial budget for commissioning high quality patient care and have the authority to establish performance arrangements to ensure this is delivered. Prior to the Government confirming its plans for the formal establishment of ICBs, Raj will join the ICS so he can help with both the establishment of the ICB and ensure the smooth transition from the current system.

Section B - *Local*

Walton Centre – Appointment of Chair

The Walton Centre has announced the appointment of Max Steinberg CBE as the Chairman of The Walton Centre NHS Foundation Trust following a comprehensive recruitment and interview process.

Born and bred in Liverpool, Max was awarded the OBE in 1997 for services to Housing and Regeneration on Merseyside and the CBE for services to Business and the Community in 2013. He was awarded a Doctorate at Liverpool University in 2019 and commissioned as a Deputy Lieutenant in 2020.

Max has extensive experience across business, innovation and industry, most recently eight years as Chief Executive of Liverpool Vision where he oversaw award-winning participation in the World EXPO Shanghai and was instrumental in securing the first UK International Festival for Business, in Liverpool in 2014.

He has served on a number of other boards, including Liverpool John Moores University European Institute of Urban Affairs. In August 2015, Max was appointed Chairman of the Roy Castle Lung Cancer Foundation, and in December 2018 Chair of the Board of The ACC Liverpool Group.

Section B - *Local*

Place directors for NHS Cheshire and Merseyside Integrated Care Board confirmed

Following a thorough recruitment process, the C&M HCP has announced the appointment of nine place directors.Working closely with local partners, place directors will play a central role in the future integration of health and care, taking a lead on tackling the health inequalities within our communities. The successful candidates will take up their posts on 1 July 2022, when NHS Cheshire and Merseyside Integrated Care Board (ICB) is established; but will become involved from early April so they can contribute to the further design of the integration agenda.

The successful candidates are detailed below, together with information about their current roles.

Place	Appointed place director	Current role	Current employer
Cheshire East	Mark Wilkinson	Director of Strategic Asset Management	Betsi Cadwaladr University Health Board
Cheshire West	Delyth Curtis*	Deputy Chief Executive Officer (Health and Wellbeing)	Cheshire West and Chester Council
Halton	Anthony Leo	Regional Director of Primary Care and Public Health Commissioning	NHS England and Improvement
Knowsley	Alison Lee	Managing Director	Cheshire West Integrated Care Partnership
Liverpool	Jan Ledward	Accountable Officer	NHS Liverpool Clinical Commissioning Group
Sefton	Deborah Butcher*	Executive Director, Adult Social Care and Health	Sefton Council
St Helens	Mark Palethorpe*	Executive Director of Integrated Health and Social Care / Accountable Officer	St Helens Council and NHS St Helens Clinical Commissioning Group
Warrington	Carl Marsh	Chief Commissioner	NHS Warrington Clinical Commissioning Group
Wirral	Simon Banks	Accountable Officer	NHS Wirral Clinical Commissioning Group

* These place directors will have statutory responsibilities in both the ICB and the relative local authority.

Section B - *Local*

Independent Non-Executive Members appointed for new NHS organisation

NHS Cheshire and Merseyside ICB is set to be established in July 2022. On 18 February 2022, David Flory CBE, Interim Chair of Cheshire and Merseyside Health and Care Partnership, named three critical designate appointments to the new board.

David said: “We had tremendous interest in the non-executive roles and a very strong field of applicants from diverse backgrounds, with valuable experience to consider. I’m very pleased to be able to announce the designate appointment of three excellent individuals and am looking forward to them all joining us over the coming months as the new organisation is established. Each of our new designate non-executives bring important individual skills and experience to the table. Collectively, their backgrounds cover a range of organisations and sectors.”

Recruitment of a fourth non-executive director is ongoing and an appointment will be made in due course. All appointees will take up their roles on 1 July.

The appointments are:

Neil Large MBE (Chair of Audit Committee)
Neil has enjoyed a long and proud career in the NHS and was awarded an MBE for his services to healthcare in both the NHS and third sector. Following a series of executive positions in Cheshire and Merseyside, he is currently Chair of Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH), rated by the CQC as ‘outstanding’. He will retire from LHCH at the end of March. Neil is an accountant by background and has always felt part of a care team, supporting patient-facing staff to do their jobs well – an ethos he continues to support and actively demonstrate. Neil says his motivation for this position is simple: “I have loved my professional and voluntary roles and if I can continue to help the people of Cheshire and Merseyside, I’d be delighted to do so.”

Tony Foy (Chair of Quality Committee)
Tony has an extensive background in the public sector, having worked in both the NHS and local government in executive, non-executive and lay member positions in social care, primary care, acute trusts and mental health. He is currently Chair of the Audit Committee for St Helens CCG, having retired from Knowsley Borough Council in 2011. His professional and personal experience make him an ideal choice for this important role. Tony is a values-driven leader, committed to collaborative approaches, partnership building and common purpose. The role of public servant is important to Tony, who works only for the public interest, with integrity, commitment and professionalism.

Erica Morris
Erica had a long career in the commercial sector with the NatWest Group before joining Healthwatch Cheshire as a Board Member, Citizens Advice Cheshire West as a Trustee and other non-executive roles in the community. As well as a solid understanding of quality, risk and finance, Erica has a keen interest in service to communities, stakeholder engagement and relationships, and enabling the voice of the community to be served. Erica is passionate about reducing inequalities and giving the health and care workforce the priority support they deserve to achieve engagement, motivation and positive buy-in to our mission. She brings insight, knowledge and experience.

Section C – *National*

Integrated care partnership (ICP): engagement summary
In September 2021, the Department of Health and Social Care (DHSC) published the ICP engagement document which set out the role that ICPs will play within statutory ICSs. Between September and December 2021, DHSC, NHS England and NHS Improvement (NHSE/I), and the Local Government Association (LGA) engaged with a range of stakeholders to understand how systems are developing their ICP arrangements. This briefing summarises the key findings from their latest paper, published 23 March 2022, which includes the themes from that engagement process and key actions for systems.

https://nhsproviders.org/media/693310/241022-dhsc-icp-engagement-next-day-briefing-final.pdf

Workforce planning survey 2022
This briefing summarises the findings from NHS Providers' March 2022 workforce planning survey.

This survey was sent out to a range of executive directors including chairs, chief executives, medical directors, nursing directors, directors of operations, HR directors and directors of strategy. The online survey was open from 14 – 23 March 2022.

They received 236 responses from trust leaders to the survey from 142 unique trusts accounting for 67% of the provider sector (212 trusts in England). All trust types and regions were represented in the survey.

https://nhsproviders.org/media/693314/workforce-planning-survey-march-2022-external-media-briefing.pdf

Summary of statutory board meetings: CQC, February 2022
February's summary includes updates on the Care Quality Commission's (CQC) partnership working, operational priorities and vaccination as a condition of deployment.

https://nhsproviders.org/media/693162/summary-of-statutory-board-meetings-cqc-february-2022.pdf

Staff Briefing

NHS
Liverpool Women's
NHS Foundation Trust

Our initial response to the Ockenden Report – 1st April 2022

Dear colleagues,

Everyone connected with maternity care will know what a difficult task it has been to read the final Ockenden Report on the findings, conclusions, and essential actions from the independent review of maternity services at The Shrewsbury and Telford NHS Trust – none more so than the women and families who have received maternity care in the past or will do so in the future.

As a specialist Trust for women and babies, we have carefully taken some time to reflect on the contents of the report before providing our initial response.

We know that anyone who is receiving or providing maternity care – at Liverpool Women's and elsewhere – will have found reading this report particularly difficult. We would like to assure colleagues that members of the Trust's leadership team will be regularly visiting areas across the Trust to check in on you, as they have over the last couple of days. In addition, if you require any support, please speak to your line manager in the first instance.

Firstly, we would like to extend our thanks to everyone involved in enabling this final report to be published. We thank Donna Ockenden for leading the review but most importantly we thank the families who showed extreme bravery in sharing their experiences and whose contribution will help improve the safety of maternity services in the future.

At Liverpool Women's we pride ourselves on being an open and transparent Trust which prioritises the safety of the people we care for. We always try to do the right thing and every decision we make is in the interests of our women, babies and their families.

We also acknowledge that we don't always get things right and we are taking the time to reflect on the report in full to understand what we can do to provide even better, safer and more excellent maternity services in the future.

Therefore, we welcome the 15 essential actions for maternity providers that are included in the report. As part of this initial response we would like to briefly explain what we are already doing against the essential actions and what we will focus on as immediate priorities to deliver against the actions in full over the coming weeks and months:

1st April 2022

- We encourage women to be involved in decisions about their care during their pregnancy, labour and birth and support them to make these decisions

- We have launched an electronic notes system that can be accessed using a mobile phone; we are using feedback to shape the development of this

- We continue to work closely with the Liverpool Maternity Voices Partnership (MVP) and other community groups to ensure we act on feedback from families who use our maternity services

- We are committed to ensuring that we hear the voices of those who are often less heard, so that we can adapt our services to meet their needs

- We continue to expand our staff group – including midwives, support staff, obstetricians, anaesthetists and the neonatal team

- We provide twice daily consultant-led multidisciplinary ward rounds on Delivery Suite and are working towards 24/7 consultant presence

- We have practice educator facilitators and a preceptorship programme to ensure that our students and newly qualified midwives are supported in their roles

- We have a Maternity Education Team who provide high quality multidisciplinary team training; we recognise that staff who work together should train together

- We have a Fetal Monitoring Lead Midwife and Lead Obstetrician, who ensure that we follow best practice when monitoring your baby's heartbeat during pregnancy and labour

- We will shortly launch as one of three Maternal Medicine Centres within the North West, ensuring that women with complex medical conditions in pregnancy have access to specialist care when needed

- We have a research-active Preterm Birth Clinic, which aims to reduce the risk of your baby being born too soon

- We have a Level 3 Neonatal Intensive Care Unit, which looks after babies who require the highest level of care within the region

- We have a Bereavement Team who provide compassionate, individualised, high quality bereavement care to families that sadly experience a miscarriage, stillbirth or neonatal death

- We have robust processes in place to investigate incidents and we encourage the involvement of independent experts when required

- We are working with other hospitals across the region to ensure that lessons are learnt and shared

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

1st April 2022

We will be providing regular updates to show progress against the essential actions in full and this will be shared internally with staff and publicly in due course.

Over the coming weeks you will see opportunities to get involved in our response to the Ockenden Report, including attendance at workshops. The Ockenden Report will also feature as a key agenda item on meetings and events such as Safety Check-Ins, Monthly Safety Champions Feedback and inclusion within regular Trust wide communication updates.

Liverpool Women's NHS Foundation Trust commits to being open and transparent about how we are responding to the Ockenden Report and we will keep all staff engaged and informed along this journey.

Please follow this link to read the Ockenden Report in full (the Executive Summary can be found on pages 11-14):

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf

1st April 2022

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report
April 2022

Trust Board Performance Report

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

Report Layout:

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

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

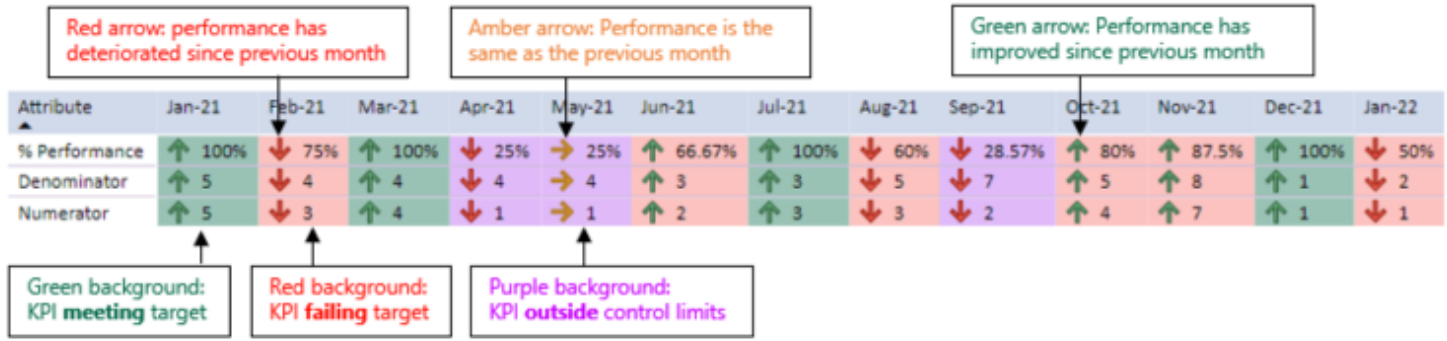
- Outside of a control limit, having previously been within control limits
- A consecutive deterioration of performance over a quarter, which is not insignificant
- A significant drop in performance over the space of a month
- A consecutive improvement in performance over a quarter, which is not insignificant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

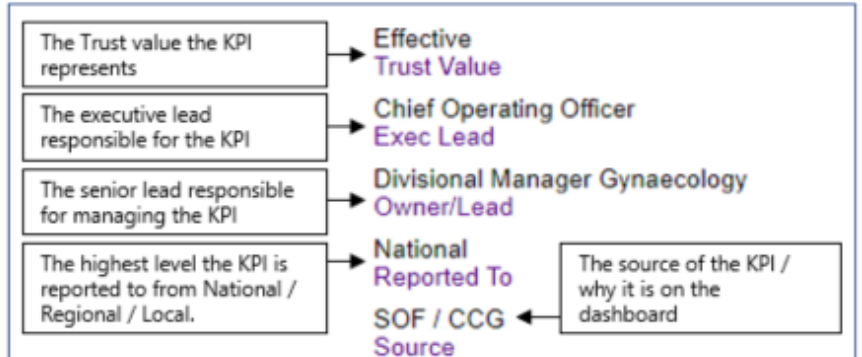
Data Sheets - these provide detailed information for each specific KPI measured. This includes data values for the previous 13 months, a sparkline included performance dating back to April 2018 where available. The sparkline graph includes the performance, target and control limits for the specific KPI.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

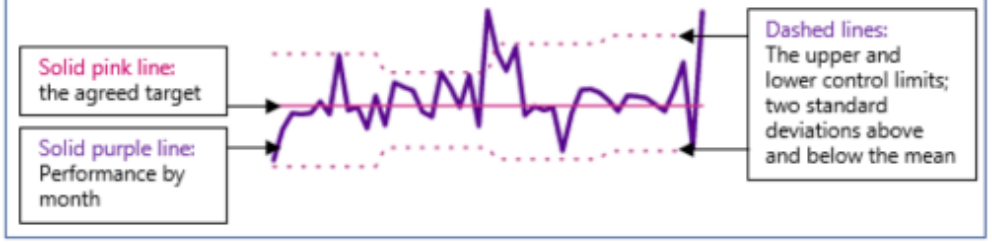
Data Health Check - highlights where KPIs have denominators outside of control limits along with a summary of the data quality kite mark scores for each KPI.

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

How to interpret the report:



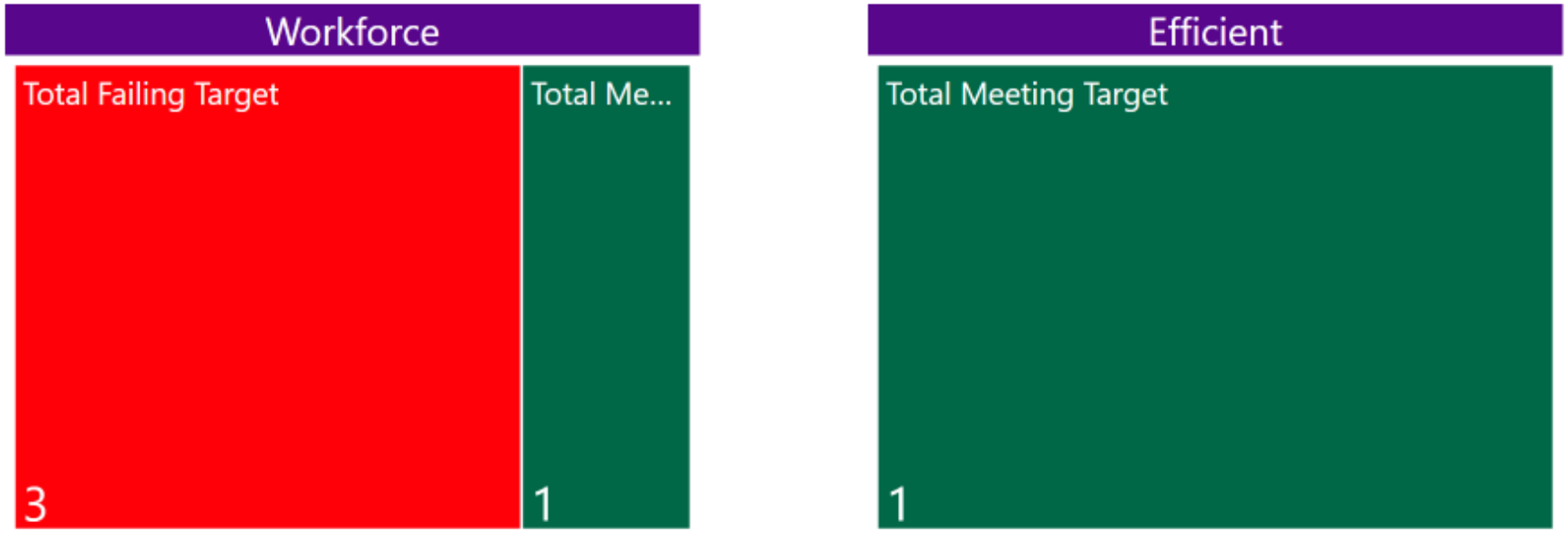




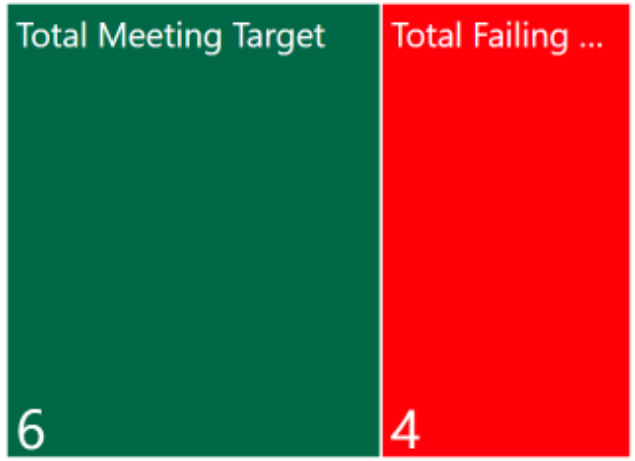
Control limits are set using statistical process control. The standard deviation for each indicator is calculated based on the previous two financial years data unless recalculation is required due to service changes. the upper and lower control limits are two standard deviations above and below the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

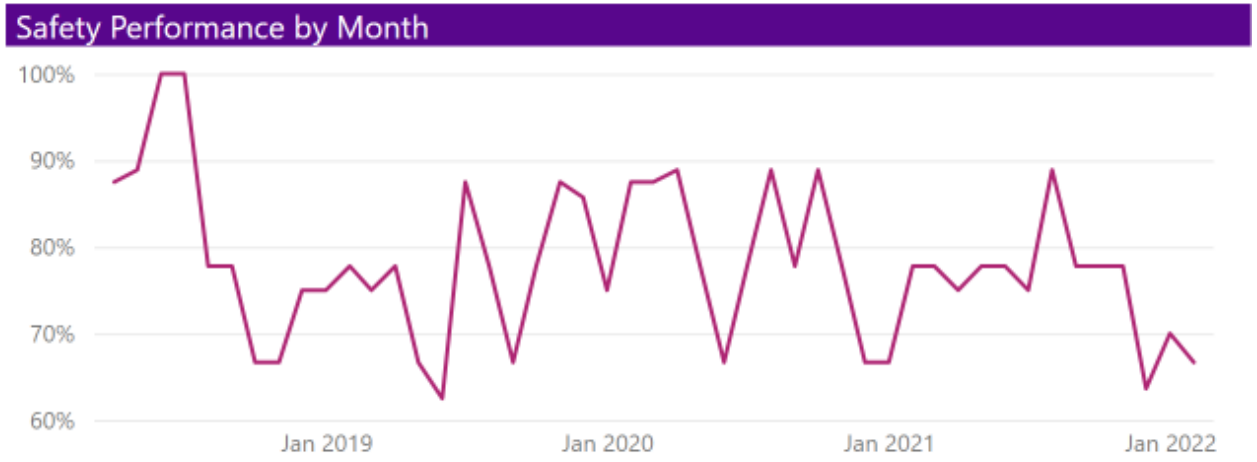
Performance is reported one or two months in arrears depending on submission deadlines. The reporting month is highlighted against each specific KPI.

WE SEE Summary



To deliver **Safe** services





Positive Developments

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

Areas of Challenge

The Trust has seen an increase in open serious incidents and a never event was declared in February. These have been discussed in detail at Quality Committee within governance papers.

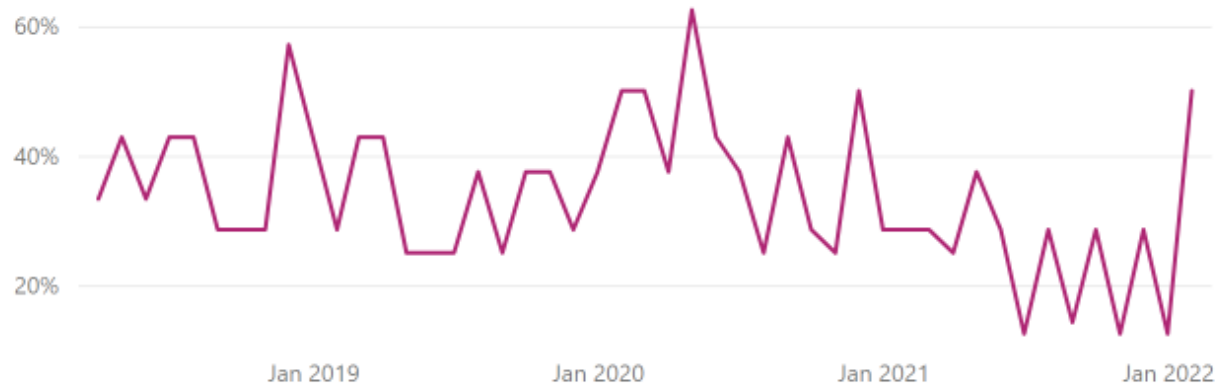
KPI	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	1
Serious Untoward Incindents: Open	8	8	7	8	8	8	5	9	9	13	16	19	19

KPIs Selected for Review

Multiple selections

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

To deliver the most **E**ffective outcomes



Positive Developments

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

Areas of Challenge

In relation to 2 week wait performance, the Trust experienced significant sickness in January in line with the Omicron wave, in addition there were significant cancellations by patients due to Omicron in January affecting performance. This was a national picture. Performance has improved for this metric in February.

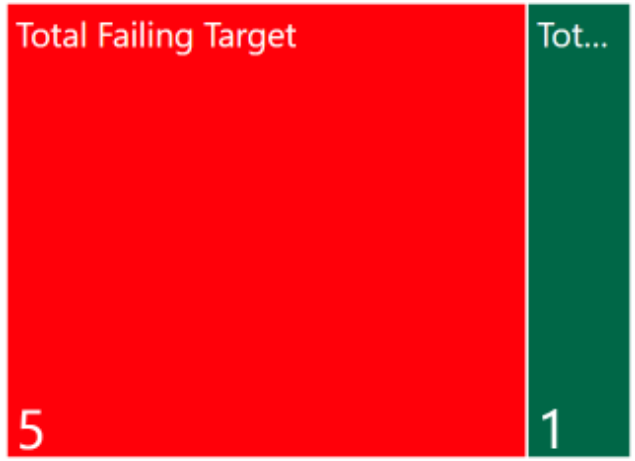
KPI	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022
18 Week RTT: Incomplete Pathway > 52 Weeks	190	290	214	170	194	209	244	256	288	294	354	406	479
Cancer: 2 Week Wait	96.4% ↑	97.48% ↑	95.71% ↓	97.92% ↑	96.2% ↓	95.32% ↓	96.42% ↑	96.06% ↓	95.33% ↓	97.04% ↑	95.31% ↓	76.65% ↓	

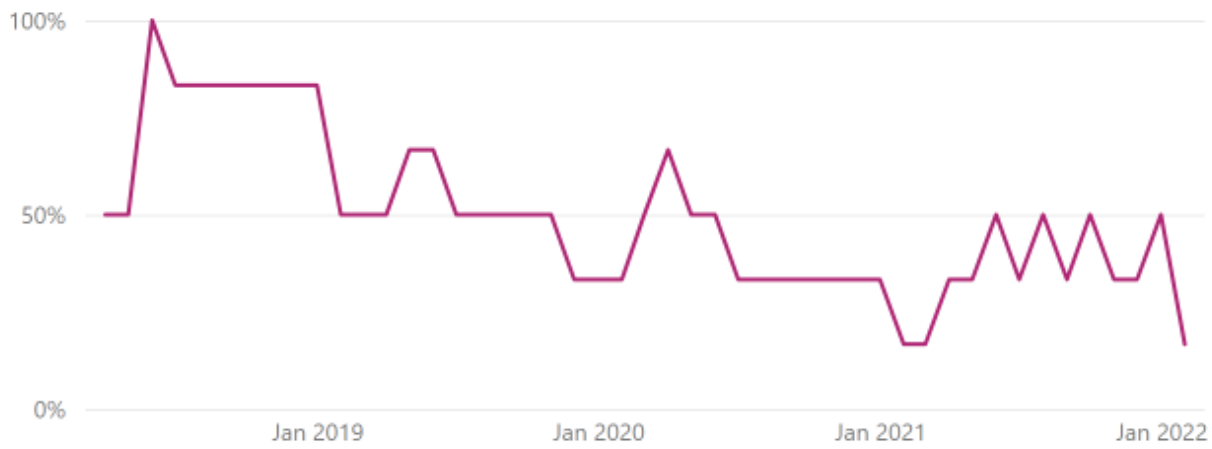
KPIs Selected for Review

Multiple selections

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

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





Positive Developments

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

Areas of Challenge

Within the GED performance reduced in month due to sickness in our ENP cohort. This has improved in March.

KPI	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	88.6% ↓	94.83% ↑	97.57% ↑	96.67% ↓	96.37% ↓	95.95% ↓	96.06% ↑	97.43% ↑	96.58% ↓	98.64% ↑	95.36% ↓	97.02% ↑	94.11% ↓
Diagnostic Tests: 6 Week Wait	89.67% ↑	87.13% ↓	89.29% ↑	93.16% ↑	89.3% ↓	90.95% ↑	82.73% ↓	69.65% ↓	85.81% ↑	87.25% ↑	90.13% ↑	83.08% ↓	94.39% ↑

KPIs Selected for Review

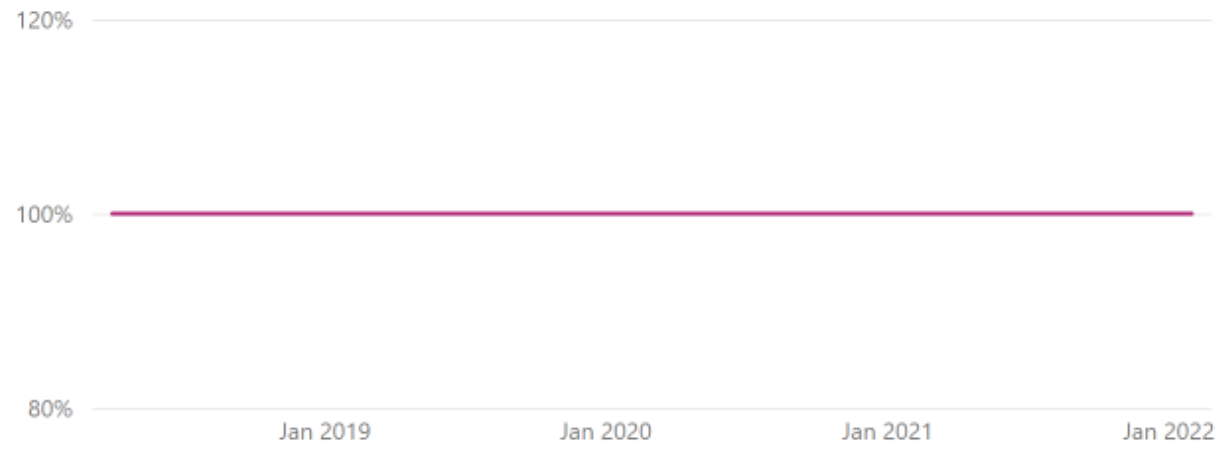
Multiple selections

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

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

Total Meeting Target

1



Positive Developments

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

Areas of Challenge

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

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

KPIs Selected for Review

Financial Sustainabilit...

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

February 2022 – Maternity Facts.

NHS
Liverpool Women's
NHS Foundation Trust

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

569 Total Births

10 Vaginal Birth After CS

14 Home Births

Girls 268

301 Boys

986 Visits to Maternity Assessment Unit

2 Breech Births

Spontaneous Vaginal Births 283

6 Sets of Twins

Women Booked For Care 793

125 Elective C - Sections

89 Emergency C - Sections

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

Births on MLU 78

Instrumental Births 70

Discharges from NICU 69

28 Pool Births

Heaviest Baby 10lb 10oz
Lightest Baby 1lb 5oz

St Valentines Day 14th February: 24 Births. Our busiest day: 21st February - 28 Births.

To deliver Safe Services – Serious Incidents

Overview

There were four SI's reported in January 2022 and three in February 2022 making a total of 25 SI's reported for the year to date for 2021/22. Comparations to previous years are shown below.

Year Comparison

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

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

January 2022 Serious Incidents

Service	StEIS Ref.	Reported in Line with Policy	Summary
Neonatal	2022 - 863	Yes	Decision made by a consultant to place a urinary catheter into a baby who was in urinary retention due to sedation medication. The bladder was expressed, and a large blood clot drained, and the bladder felt full but no urine was produced. Blood was seen in the catheter. The urinary catheter was removed, and fresh blood and clots drained from the penis. Surgeons unable to pass a catheter urethrally, large bladder was noted so a suprapubic catheter was inserted and secured - blood-stained urine was seen to be draining. The baby was transferred to Alder Hey intensive care unit for further management of the persistent pulmonary hypertension with the suprapubic catheter still in situ. **Immediate Action Taken:** A consultant must attend all urinary catheterizations **Immediate Lesson Learnt:** Equipment has changed which was unfamiliar to staff Policy for insertion of urinary catheter must be followed Consultant presence at the time if the urinary catheter insertion would have prevented this error
Maternity	2022 - 875	Yes	Category 1 caesarean section at 34 weeks (pre-eclampsia). Accumulated risks os pre-eclampsia, CTG abnormalities and repeated episodes of reduced fetal movements. Baby required resuscitation and had poor cord gas readings. Therapeutic cooling was commenced within 6 hours of birth. Mother had repeated episodes of tachycardia, these were not escalated for senior obstetric review. When seen by Consultant transfer to HDU and then transferred to Trust 2 for Echo for investigation and management plan for ongoing maternal tachycardia. This case does not meet HSIB criteria as less than 37 weeks gestation **Immediate Action Taken:** Ongoing investigations with Trust 2 re maternal tachycardia **Immediate Lesson Learnt:** Ongoing RFM with Dawes Redman criteria not met on 2 CTG was an opportunity for admission for close fetal monitoring.
Maternity	2022 - 881	Yes	Primigravida with low-risk pregnancy English second language admitted in early labour with abnormal CTG and signs of sepsis. Delivered by cat 2 caesarean section 4 hours after admission. Baby required resuscitation and transfer to neonatal unit. Meconium aspiration diagnosed - transferred to Trust 2 for ECMO. Potential for earlier identification of pathological CTG prior to deterioration with earlier delivery. Sepsis treatment indicated on admission, delay in sepsis screen and treatment of sepsis. **Immediate Action Taken:** Lesson of the week regarding sepsis recognition and escalation **Immediate Lesson Learnt:** Recognition and escalation of abnormal and deteriorating CTG Recognition and treatment if sepsis importance of golden hour to commence treatment Documentation surrounding treatment decision regarding therapeutic cooling
Maternity	2022-1320	Yes	Disparity between operative summary and postnatal documentation on whether a tubal ligation and been performed during a planned caesarean section **Immediate Action Taken:** K2 to be reviewed to identify if the TL section of the operative summary can be pulled through to the discharge summary. Review of the operative summary on transfer to the ward to be highlighted to the midwifery team – requires incorporation in to the SBAR **Immediate Lesson Learnt:** Potential failure in confirming the procedure undertaken in theatre at the 'sign out' Operative summary not reviewed to complete the SBAR or handover to the ward. Medical notes not used to confirm the procedure completed Discharge summary and delivery summary produced independently to the operative delivery and the medical notes

To deliver Safe Services – Serious Incidents

February 2022 Serious Incidents

Service	StEIS Ref.	Reported in Line with Policy	Summary
Maternity	2022 - 2587	Yes	NEVER EVENT – two retained swabs **Immediate Action Taken:** Reiteration to staff at each hand over to document swab counts pre and post procedure for all swabs within the pack (10) – This has been sent to all Obs cons and midwifery managers, also appears on the DS Teams channel K2 to be contacted to request swab count to be added to perineal repair, delivery and operative delivery and to be made mandatory Small white boards in delivery rooms to record swabs Consideration of QI project LOTW screen reminder to all staff logging onto K2 maternity IT system: The swab count Wizard must be completed after each delivery; this includes operative vaginal delivery and perineal repair. **Immediate Lesson Learnt:** Mandatory documentation of swab counts pre and post procedure for all swabs within the pack (10) The K2 swab count Wizard must be completed after each delivery; this includes operative vaginal delivery and perineal repair.
Maternity	2022 - 2594	Yes	36 weeks admission. Missed opportunities for decision to deliver. **Immediate Action Taken:** Duty of Candour planned verbally and in writing. Additional enquiry- acuity from DS and Theatres. **Immediate Lesson Learnt:** CTG interpretation when abnormal AN CTG and DR criteria not met with accumulated risks
Gynae	2022 - 2722	Yes	A sub total hysterectomy had been carried out and not a total hysterectomy. **Immediate Action Taken:** Statement to be requested from the Consultant Gynaecological Surgeon and Oncologist. Duty of Candour letter to be sent to the patient **Immediate Lesson Learnt:** No images on PACs from operation Cervix missed intra-operatively

To deliver Safe Services – Serious Incidents

HSIB Cases Reported and NHSR Early Notification Scheme

During January 2021 there were 2 cases and 1 in February 2022 which met the HSIB criteria and has been reported to HSIB

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

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

Duty of Candour

Duty of Candour was completed for the Serious Incidents and HSIB cases.

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: February Fill Rate

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

Attendance/ Absence – sickness absence for the ward 3.45%, any sickness in the month has been short term, there are 4.23 WTE on Maternity leave

Vacancies – 0 vacancies, ward manager to commence 11th April 22

Red Flags – There were no red flags reported in February

Bed Occupancy – during the month of February the occupancy was 59%

CHPPD – the care hours provided to each bed combined Registered/Non-Registered staff overall is 9.1hrs

Neonates: February Fill Rate

Fill-rate –February has continued to be a quiet month on NICU with occupancy dropping for the second month. Safe staffing has been maintained throughout and fill rates are reflective of occupancy and acuity. The reduced activity has seen a decrease in bank usage and has allowed flexibly for staff to use leave before year end and complete mandatory training.

Attendance/Absence – February sickness is 6.21%, this is down from January by just under 6%. Short term sickness sits at 39% with long term sickness making up 61%. Covid sickness and covid special leave made up approximately 3.6%, this is down by nearly 2% on the previous month. Maternity leave has reduced to 10.99 FTE and turnover sits at 8% well below the Trust target.

Vacancies – We have recruited into all our vacant Band 5 posts with a reserve list to fill partnership posts. The standard of applicants exceeded our expectations. Band 7 seconded posts have been filled by internal candidates. Band 7 education post is being interviewed mid-March.

Red Flags – No red Flags

Bed Occupancy – Unit occupancy has run at 58.9% this continues to run below the expected 80%. IC ran at 46.1%, HD 55.5%, LD 63%, and TC at 75.6%. There have been some challenges around accepting in-utero transfers of extreme preterm due to capacity and acuity issues within maternity services, however an escalation plan in now in place to manage effectively. Transitional care has been busy and there have been occasional term admissions to NICU due to lack of capacity within TC.

To deliver Safe services - Safer Staffing

Maternity: February Fill Rate

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

Attendance/Absence – Maternity sickness is reported at 11.45% which is a combination of clinical, non-clinical and administration staff, this monthly rate has decreased from previous month (11.83%), and maternity is demonstrating a downward trend for sickness absence. Maternity has seen a decrease in sickness rates with staff resuming back to duty. Maternity have requested that reports should be reviewed, and clinical staff reported separately to the overall division's sickness absence rate to support a focus of improvement. Maternity sickness has a higher rate of LT sickness than ST sickness (64%STS versus 36%LTS). Ward managers/matrons have individual sickness reviews, and maternity are planning return to work programmes with all LT employees to facilitate appropriate returns to work. A comprehensive sickness review programme overseen by the HRBP and HOM is undertaken on a weekly basis and the oversight has supported the reduction in active LTS cases.

Vacancies – Current vacancy rate of 12.51wte for midwifery staff. The division continues to note a rise in staff requesting retirement and requests for contractual hours to be reduced. Maternity maintains an active recruitment plan with a rolling NHS jobs advert and open days to showcase Midwifery Careers at LWH. 9.8wte midwives are currently undergoing recruitment checks and will commence in the coming weeks to narrow this gap. Maternity is currently implementing an International Recruitment programme as part of the Northwest Collaboration with 8 overseas trained midwives expected to arrive in summer pending issues with any covid travel restrictions.

Red flags – Maternity have a positive reporting culture for red flags, with monthly oversight reports at the Maternity Risk and Clinical Meeting. Induction of Labour delays due to high acuity and availability of midwifery staffing has been the main theme highlighted in month

Bed Occupancy – Maternity continues to experience high levels of clinical activity. Maternity awaits a refreshed power BI occupancy report which will demonstrate both modality of birth, expected date of transfer to community services, length of stay, as well as bed occupancy. There has been no requirement to divert maternity services during this reporting period. The urgent requirement of this work has been escalated to the Interim Divisional Manager.

To deliver Safe services - Safer Staffing

February 2022					
WARD	Fill Rate Day % RN/RM *	Fill Rate Day % Care staff **	Fill Rate Night % RN/RM *	Fill Rate Night % Care staff **	Supporting narrative (RN/RM = *; Care staff = **)
Gynae Ward	93.8%	70.2%	137.5%	100.0%	* The fill rate for RN in February reflects the change in the establishment template. The overfill of RN on nights are due to a trial of Senior Nurse Band 6 cover rostered onto night duty to support the junior staff and the Gynaecology Emergency Department. Safe staffing was maintained throughout February, HDU staff have also supported the ward due to the low occupancy and demand for HDU beds.
Induction & Delivery Suites	88.5%	75.0%	93.1%	94.6%	*Delivery Suite reported high sickness in month for registered staff, which required the Maternity Bleep holder to redeploy staff to maintain clinical safety and prioritise 1:1 care in labour, which included the intermittent closure of MLU. Vacant shifts are filled with bank and agency as required.
Maternity & Jeffcoate	78.6%	83.7%	73.5%	83.0%	Jeffcoate remains permanently closed due to maternity staffing and the lack of women wishing extended stay who are suitable for the low risk offer of inpatient rooms *Maternity Base continues to experience high levels of sickness for Registered Midwives, although this has been a decrease from previous month. This shortfall is covered with use of agency staff or the redeployment of non-direct care providers who are clinical staff within Business continuity plans, to ensure that safe staffing has been maintained.
MLU	74.1%	42.9%	82.1%	78.6%	MLU is reviewed on a daily basis to agree if MLU is to open or close based on the current Covid-19 situation to ensure safe staffing. **The staffing fill rate affecting care staff is reduced, however this is reflective of MLU closure for significant periods. The area was staffed safely when opened.
Neonates (ExTC)	89.5%	89.3%	86.8%	98.2%	* and ** Fill rates are reflective of occupancy and acuity on the NICU during February. Safer staffing was always maintained.
Transitional Care	53.6%	114.3%	100.0%	60.7%	* and ** February saw a busier TC and fill rates are reflective of this. Safer staffing was always maintained.

Neonatal Deaths per 1000 live Births

Target: **(Blank)**

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

DQKM

Safety
Trust Value

Medical Director
Exec Lead

Clinical Director Family Health
Owner/Lead

Local
Reported To

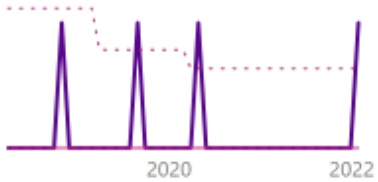
Trust
Source

Never Events

Target: **0**

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

DQKM



Safety
Trust Value

Medical Director
Exec Lead

Head of Governance
Owner/Lead

National
Reported To

Trust
Source

NHSE / NHSI Safety Alerts Outstanding

Target: **0**

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

DQKM

Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

TBC
Source

Venous Thromboembolism (VTE)

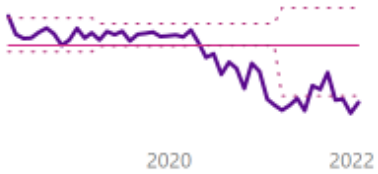
Target: **>= 95%**

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% Performance	↓ 86.39%	↓ 85.48%	↓ 84.62%	↑ 85.39%	↑ 86.51%	↓ 84.58%	↑ 88.55%	↓ 87.96%	↑ 90.64%	↓ 86.25%	↑ 86.39%	↓ 84.16%	↑ 85.86%
Denominator	↓ 999	↓ 1143	↓ 1053	↑ 1157	↑ 1156	↓ 1167	↑ 1127	↓ 1138	↑ 1111	↓ 1098	↑ 1029	↓ 1111	↑ 1011
Numerator	↓ 863	↓ 977	↓ 891	↑ 988	↑ 1000	↓ 987	↑ 998	↓ 1001	↑ 1007	↓ 947	↑ 889	↓ 935	↑ 868

DQKM

December 2021

New VTE policy now ratified. Gynae & Maternity risk leads emailed to table a discussion on their relevant governance meetings as this KPI is regularly breached.



Safety
Trust Value

Medical Director
Exec Lead

Deputy Medical Director
Owner/Lead

National
Reported To

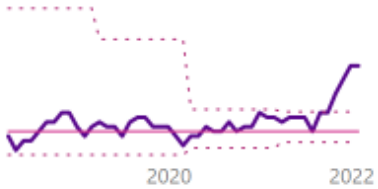
SOF / CCG
Source

Serious Untoward Incidents: Open

Target: <5

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

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

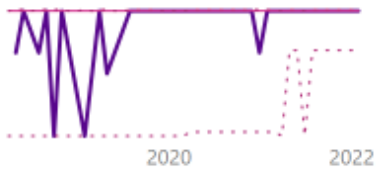
TBC
Source

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

Target: 1

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

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

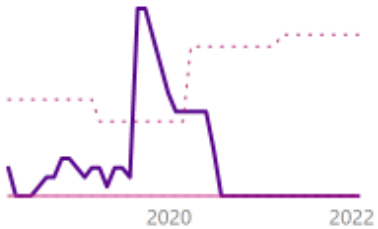
TBC
Source

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

Target: 0

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

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

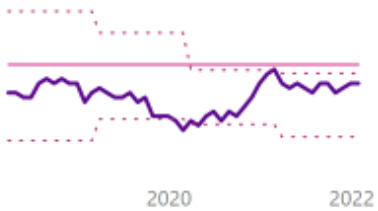
TBC
Source

Serious Untoward Incidents: New (Rolling per year)

Target: 24 /year

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

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

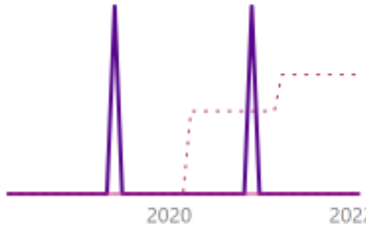
TBC
Source

Infection Control: MRSA

Target: **0**

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

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Infection Control Lead
Owner/Lead

National
Reported To

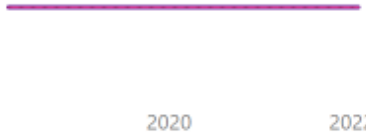
SOF / CCG
Source

Infection Control: Clostridium Difficile

Target: **1**

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

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Infection Control Lead
Owner/Lead

National
Reported To

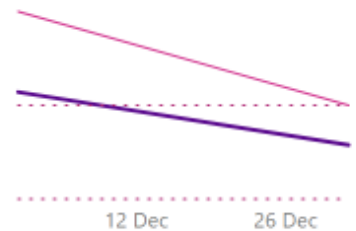
SOF / CCG
Source

Flu Vaccine Uptake Trustwide

Target: **>=100%**

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

DQKM



Safety
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

National
Reported To

External
Source

18 Week RTT: Incomplete Pathway > 52 Weeks

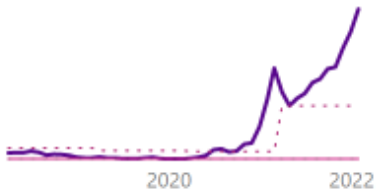
Target: **0**

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Performance Value	190	290	214	170	194	209	244	256	288	294	354	406	479

DQKM

January 2022

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



Effective
Trust Value

Chief Operating Officer
Exec Lead

Deputy Chief Operating Officer
Owner/Lead

National
Reported To

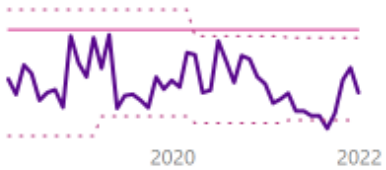
SOF / CCG
Source

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

Target: **>=85%**

Attribute	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
% Performance	↓ 41.67%	↓ 26.32%	↑ 29.41%	↑ 34.21%	↓ 20%	→ 20%	↓ 16.13%	↑ 16.22%	↓ 6.06%	↑ 18.18%	↑ 44.83%	↑ 54.55%	↓ 34.78%
Denominator	↓ 12	↓ 9.5	↑ 17	↑ 19	↓ 10	→ 10	↓ 15.5	↑ 18.5	↓ 16.5	↑ 16.5	↑ 14.5	↑ 11	↓ 11.5
Numerator	↓ 5	↓ 2.5	↑ 5	↑ 6.5	↓ 2	→ 2	↓ 2.5	↑ 3	↓ 1	↑ 3	↑ 6.5	↑ 6	↓ 4

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

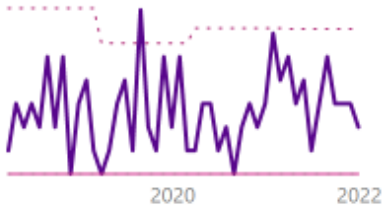
CCG
Source

Cancer: 104 Day Breaches

Target: **0**

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

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

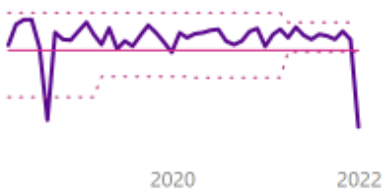
External
Source

Cancer: 2 Week Wait

Target: **>= 75%**

Attribute	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
% Performance	↓ 93.85%	↑ 96.4%	↑ 97.48%	↓ 95.71%	↑ 97.92%	↓ 96.2%	↓ 95.32%	↑ 96.42%	↓ 96.06%	↓ 95.33%	↑ 97.04%	↓ 95.31%	↓ 76.65%
Denominator	↓ 244	↑ 278	↑ 317	↓ 280	↑ 289	↓ 342	↓ 299	↑ 279	↓ 279	↓ 300	↑ 338	↓ 277	↓ 257
Numerator	↓ 229	↑ 268	↑ 309	↓ 268	↑ 283	↓ 329	↓ 285	↑ 269	↓ 268	↓ 286	↑ 328	↓ 264	↓ 197

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

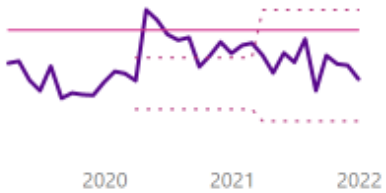
CCG
Source

Cancer: 28 Day Faster Diagnosis

Target: >= 75%

Attribute	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
% Performance	65.04%	68.46%	69.4%	64.12%	56.72%	65.18%	61.24%	71.12%	49.12%	64.14%	60.5%	59.93%	54.1%
Denominator	266	298	366	262	305	336	307	232	397	290	362	287	305
Numerator	173	204	254	168	173	219	188	165	195	186	219	172	165

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

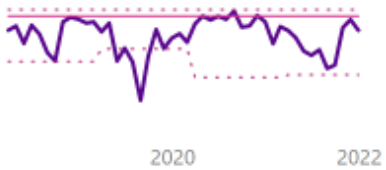
SOF / CCG
Source

Cancer: 31 Days from Diagnosis to 1st Definitive Treatment

Target: >=96%

Attribute	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
% Performance	91.3%	73.91%	87.5%	84.380%	78.57%	68%	64.52%	68.97%	54.05%	56.76%	86.67%	93.1%	84.62%
Denominator	23	23	24	32	28	25	31	29	37	37	30	29	26
Numerator	21	17	21	27	22	17	20	20	20	21	26	27	22

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

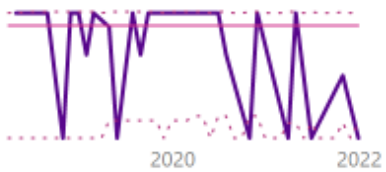
CCG
Source

Cancer: 62 Day Screening Referrals (Percentage)

Target: >=90%

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

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

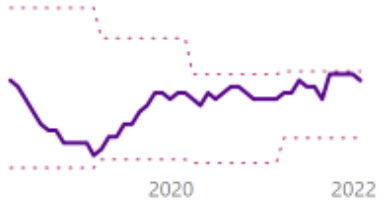
CCG
Source

Intensive Care Transfers Out (Rolling 12 Months)

Target: **(Blank)**

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

DQKM



Effective
Trust Value

Medical Director
Exec Lead

Deputy Medical Director
Owner/Lead

Local
Reported To

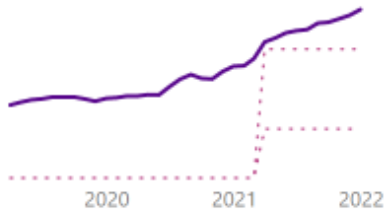
Trust
Source

Overall size of Elective Waiting List

Target: **(Blank)**

Attribute	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Performance Value	8934	8981	9551	10884	11198	11609	11782	11877	12389	12458	12736	13017	13481

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Clinical Sup…
Owner/Lead

National
Reported To

SOF
Source

Proportion of patient activity with an ethnicity code

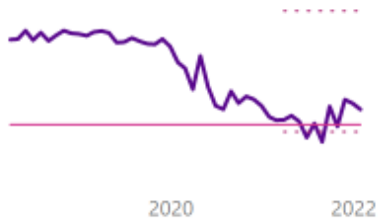
Target: **>=96%**

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% Performance	↓ 96.24%	↓ 96.14%	↑ 96.15%	↑ 96.28%	↓ 96.1%	↓ 95.59%	↑ 96.03%	↓ 95.45%	↑ 96.58%	↓ 95.94%	↑ 96.8%	↓ 96.68%	↓ 96.49%
Denominator	↓ 14805	↓ 16971	↑ 15646	↑ 15151	↓ 16178	↓ 15200	↑ 14120	↓ 15339	↑ 14525	↓ 15273	↑ 13116	↓ 14184	↓ 13606
Numerator	↓ 14249	↓ 16316	↑ 15044	↑ 14588	↓ 15547	↓ 14529	↑ 13560	↓ 14641	↑ 14028	↓ 14653	↑ 12696	↓ 13713	↓ 13128

DQKM

February 2022

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



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

SOF
Source

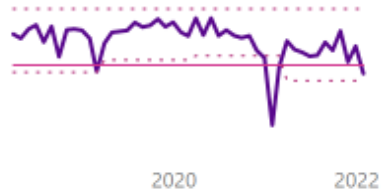
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge

Target: >= 95%

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% Performance	88.6%	94.83%	97.57%	96.67%	96.37%	95.95%	96.06%	97.43%	96.58%	98.64%	95.36%	97.02%	94.11%
Denominator	921	1064	947	1021	1073	1036	989	971	1052	883	969	1039	1086
Numerator	816	1009	924	987	1034	994	950	946	1016	871	924	1008	1022

DQKM

February 2022: A&E performance fell below 95% during February. This was primarily due to high levels of sickness within the department due to Covid. Performance is expected to improve from April onwards.



Experience
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

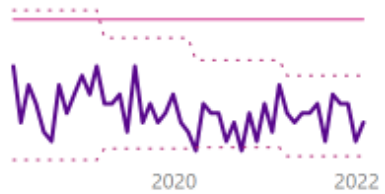
CCG
Source

Complaints: Number Received

Target: <= 15

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Performance Value	3	8	5	4	5	5	6	2	7	6	6	2	4

DQKM



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

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

Local
Reported To

Trust
Source

Diagnostic Tests: 6 Week Wait

Target: >= 99%

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

DQKM

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

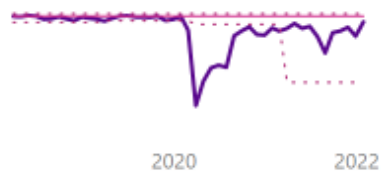
Dexa: Numerator 35, Denominator 36, Achievement 97.22%

Non-Obstetric Ultrasound: Numerator 559, Denominator 573, Achievement 97.56%

Cystoscopy: Numerator 3, Denominator 5, Achievement 60.00%

Cystometry: Numerator 76, Denominator 99, Achievement 76.77%

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



Experience
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Clinical Sup...
Owner/Lead

National
Reported To

CCG
Source

Friends & Family Test: A&E % positive

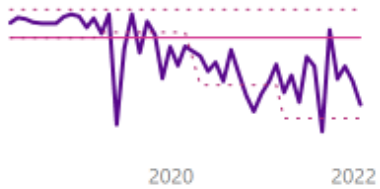
Target: **95%**

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% Performance	85.71%	89.29%	83.33%	86.96%	81.25%	90.91%	88.89%	75%	96.67%	86.21%	88.89%	85.71%	80.77%
Denominator	56	28	30	46	32	33	27	36	30	29	36	35	26
Numerator	48	25	25	40	26	30	24	27	29	25	32	30	21

DQKM

February 2022

The positive response rate has shown a downward trend since October 21, in Febuary 26 patients eligible to respond and 21 positive responses received, themes for displeased comments have been reviewed by the team and the theme appears to be not allowing partners into the department, and communication with the patient, the themes will be shared with the team for learning and will be displayed on the " you said we did" board



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Nursing Gynaecology
Owner/Lead

National
Reported To

External
Source

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

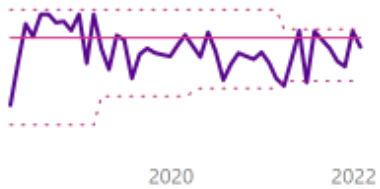
Target: **0.95**

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% Performance	89.58%	86.32%	84.76%	90.35%	96.52%	85.45%	96.4%	94.53%	92.79%	90%	88.89%	96.4%	93.07%
Denominator	96	117	105	114	115	110	111	128	111	130	108	111	101
Numerator	86	101	89	103	111	94	107	121	103	117	96	107	94

DQKM

February 2022

93% response rate
101 eligible to respond positively, 94 responded, the division is monitoring displeased comments for this area , review for themes, discharge process and time waiting for surgery main cause of displeased, discuss at theatre operational group review the times for patients arriving



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Nursing Gynaecology
Owner/Lead

National
Reported To

External
Source

Friends & Family Test: Maternity % positive

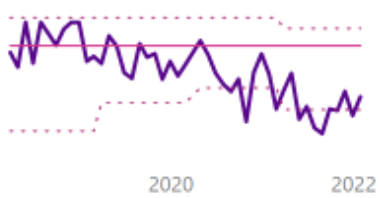
Target: **95%**

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% Performance	88.89%	81.52%	85.6%	89.12%	79.35%	82.03%	77.5%	76.28%	81.52%	81.2%	85.27%	80.14%	84.09%
Denominator	18	184	125	147	155	128	160	156	184	133	129	146	132
Numerator	16	150	107	131	123	105	124	119	150	108	110	117	111

DQKM

February 2022

Friends and family response Maternity. Target is 90%. Achieved 84.09% responses were positive in February. The service is still being impacted with COVID 19 restrictions affecting women's experience . Visiting restriction's are being reviewed this week by the Head of Midwifery . Work is ongoing with the Maternity Voices partnership in co-production to improve the women's experience especially in post natal care.



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Midwifery
Owner/Lead

National
Reported To

External
Source

Digital.Information Data Health Check

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

Exec Lead	KPI	Current Month Reported	Target	KPI Meeting Target	Denominator Check
Chief Operating Officer	18 Week RTT: Incomplete Pathway > 52 Weeks	February 2022	0	Control Limit Breached	N/A
Chief Operating Officer	A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	February 2022	>= 95%	No	As Expected
Chief Operating Officer	All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	January 2022	>=85%	No	As Expected
Chief Operating Officer	Cancer: 104 Day Breaches	January 2022	0	No	N/A
Chief Operating Officer	Cancer: 2 Week Wait	January 2022	>= 93%	Control Limit Breached	As Expected
Chief Operating Officer	Cancer: 28 Day Faster Diagnosis	January 2022	>= 75%	No	As Expected
Chief Operating Officer	Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	January 2022	>=96%	No	As Expected
Chief Operating Officer	Cancer: 62 Day Screening Referrals (Percentage)	January 2022	>=90%	Control Limit Breached	As Expected
Chief People Officer	Clinical Mandatory Training Compliance	February 2022	>= 95%	No	LCL Breached
Director of Nursing & Midwifery	Complaints: Number Received	February 2022	<= 15	Yes	N/A

Digital.Information Data Health Check

Exec Lead	KPI	Current Month Reported	Target	KPI Meeting Target	Denominator Check
Chief Operating Officer	Diagnostic Tests: 6 Week Wait	February 2022	>= 99%	No	As Expected
Director of Finance	Financial Sustainability Risk Rating: Overall Score	February 2022	3	Yes	N/A
Chief People Officer	Flu Vaccine Uptake Trustwide	January 2022	>=100%	Control Limit Breached	N/A
Director of Nursing & Midwifery	Friends & Family Test: A&E % positive	February 2022	95%	No	As Expected
Director of Nursing & Midwifery	Friends & Family Test: In-patient/Daycase % positive	February 2022	0.95	No	As Expected
Director of Nursing & Midwifery	Friends & Family Test: Maternity % positive	February 2022	95%	No	As Expected
Director of Nursing & Midwifery	Infection Control: Clostridium Difficile	February 2022	1	Yes	N/A
Director of Nursing & Midwifery	Infection Control: MRSA	February 2022	0	Yes	N/A
Medical Director	Intensive Care Transfers Out (Rolling 12 Months)	February 2022			N/A
Chief People Officer	Mandatory Training Compliance	February 2022	>= 95%	No	N/A
Medical Director	Neonatal Deaths per 1000 live Births	February 2022			N/A
Medical Director	Never Events	February 2022	0	Control Limit Breached	N/A
Director of Nursing & Midwifery	NHSE / NHSI Safety Alerts Outstanding	February 2022	0	Yes	N/A
Chief Operating Officer	Overall size of Elective Waiting List	January 2022		Control Limit Breached	N/A
Chief Operating Officer	Proportion of patient activity with an ethnicity code	February 2022	>=96%	Yes	As Expected
Director of Nursing & Midwifery	Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	February 2022	1	Yes	As Expected
Director of Nursing & Midwifery	Serious Untoward Incidents: Number of SUI's with actions outstanding	February 2022	0	Yes	N/A
Director of Nursing & Midwifery	Serious Untoward Incindents: New (Rolling per year)	February 2022	24 /year	Yes	N/A
Director of Nursing & Midwifery	Serious Untoward Incindents: Open	February 2022	<5	Control Limit Breached	N/A
Chief People Officer	Sickness Absence Rate	February 2022	<= 4.5%	No	As Expected
Chief People Officer	Turnover Rate	February 2022	<= 13%	Yes	N/A
Medical Director	Venous Thromboembolism (VTE)	February 2022	>= 95%	Control Limit Breached	As Expected

KPI Lineage

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

KPI Lineage

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/009b***		**Date: 07/04/2022**	
Report Title	**Major Incident Update**			
Prepared by	***Diane Brown Interim Associate Director***			
Presented by	***Diane Brown Interim Associate Director***			
Key Issues / Messages	Following the Major Incident in November 2021 the Trust has completed the local and regional debrief process. The paper outlines governance proposals in order to ensure the learning from the incident is embedded within 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.***			
	To note the assurances provided in the report.			
Supporting Executive:	**Gary Price: Chief Operating Officer**			

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

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

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

EXECUTIVE SUMMARY

The purpose of this paper is to provide an update to the Trust Board in relation to the response to the major incident (MI) declared on the 14th of November 2021. Formal reports and updates have previously been received by Committees and the Board of Directors in November and December 2021 respectively.

Following the de-escalation of the MI on the 24.11.2021 a Restoration and Recovery Oversight Group was commissioned by the Trust's Chief Operating Officer to oversee the ongoing actions required relating to learning, debrief and reporting. A full debrief report has been produced and shared with external stakeholders. This identified a range of actions for the Trust to complete. Ongoing monitoring of these actions will be overseen by the Emergency Planning, Response and Resilience (EPRR) Group which reports into FPBD.

As part of the learning formal security reports have been commissioned and influenced the Trust response and are included in a Security Management Workplan (SMW). The delivery of the SMW will be overseen by an Environmental Safety Group which will ensure robust oversight and engagement with other Trust functions and departments. The Environmental Safety Group will report to the Finance, Performance and Business Development (FPBD) Committee by the Chief Operating Officer on a quarterly basis.

MAIN REPORT

1. Introduction

On 14th November 2021, at approximately 10:59 am, an explosion occurred inside a taxi as it arrived in front of the main entrance of the hospital on the Crown Street site. This was later declared a terrorist incident. A Major Incident was declared under the Trust Emergency Planning policies and associated oversight remained in situ until Wednesday 24.11.2021, whereby a Trust decision to deescalate took place.

Support mechanisms were immediately provided and continue for all staff in the Trust. Patients and families have been supported in accordance with best practice and communications have worked to support the key messages needed through both internal and external stakeholders.

A full debrief and After-Action Review (AAR) has been completed with stakeholders and staff and a debrief report completed by the Trust. The findings of this report have been shared though the Merseyside Resilience Forum who have led on the system wide debrief and learning. Feedback from this process for the Trust was extremely positive with recognition for the approach to the response being commended. The Trust debrief process has identified several longer-term actions to be completed. Operational and executive leads and have been assigned and appropriate operation groups will oversee and monitor the actions identified through this process

Early feedback from specialist security colleagues throughout the debrief process indicated that there were recommendations relating to the delivery of security services. It is important to note that these findings did not impact on the Trust ability to respond to the Major Incident at the time, however, should be considered as incidental findings of the debrief and learning process and as such good practice.

To enable the Trust to fully understand the current position relating to security management a full Trust Security review has been commissioned and received. Red Octopus Solutions was identified with the requisite skills and knowledge to complete a comprehensive review of all Security systems and arrangements within the Trust, this included the current Governance and reporting arrangements.

Additionally, the Trust has been fortunate to have insight and expertise from the Northwest Counter Terrorism Unit who have provided initial high-level findings from a vulnerability survey completed. A formal written report is due before the end of March 2022.

Therefore, the Trust will be in receipt of two elements of formal feedback relating the provision of a safe environment and security provision.

- Red Octopus Solutions – Security Review and Recommendations (received)
- NW CTU Trust Environment Feedback (due end March 22)

Both reports will be aligned into a single series of recommendations and one overarching Security Management Action Plan, which will continue to evolve and develop as we work through solutions

2. Issues for consideration

2.1 Incident Debrief Learning and Actions

As described above through the debrief process the Trust is making good progress in terms of completion. They will continue to be delivered through operational teams, overseen by the Emergency Planning, Response and Resilience Group. It is anticipated that these actions will be completed and closed by the end of Quarter 4 and taken through FPBD in April.

2.2 Security Review

The report identified key issues that have been divided in to four sections: The report completed by Red Octopus Solutions review found that the Trusts approach to security and associated risks was both passive and reactive.

Environment

The Trust external estate has changed since the original build in 1992, however despite growth, there remains one main entrance/exit on to Trust premises

People

The Trust commissions Outsourced Client Solutions Group (OCS) to provide Security staff to increase asset and people safety. Upon review, their client procedures (Assignment Instructions) are not designed from a specific Trust assessment and appear generic.

Training

The Trust has significant improvements to be made relating to training and education to support staff understanding of security.

Governance and Effectiveness

The report identified complex governance arrangements as well as a lack of accountability. This is further complicated by the gaps in contractual agreements and outdated policies and procedures which hinders operational deliverables. The report also identified a lack of consistent reports from a security perspective making it difficult for the Executive Team/Board to receive assurances. An overarching strategy and implementation plan is required to ensure that security is embedded at all levels across the organisation.

To respond to some initial findings the following actions have been taken.

- Continue to work with experts and leads in the development of the response to findings and key recommendations
- Commissioned Counter Terrorism Safety Advisors (CTSAs) to conduct a vulnerability survey
- Requested CTSAs to complete a feedback communications piece for Trust staff which will be shared as part of the learning and ongoing assurance and confidence building for staff.
- Reviewed all current security systems to assess suitability and upgrade capability (e.g., CCTV, Car Park)
- Reviewed the Soft FM contract (OCS), increasing the Security Services section including performance monitoring and additional security touchpoints
- Reviewed the Trust Major Incident Plan and Lockdown Policies
- Liaised with NHSE/I EPRR Lead to arrange MI testing and response
- Commissioned Gilling Dod Architects to submit a scoping document in consideration of the Trusts external estate considering report findings
- Commissioned Clarion to complete full assessment and update into the Trust internal lock down systems and
- Working with local schools, faith leaders and Merseyside Fire and Rescue Services on developing garden designs for near the completed main entrance once final safety and security designs are completed

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3. Next Steps

The steps identified below have been embedded within one overarching implementation plan. The plan will be implemented by the development of a new Environmental safety Group, chaired by the LSMS and reporting into FPBD. This will commence in March 2022 and will have appropriate representation from corporate and operational colleagues to deliver the plan at pace.

1. Environment
   - Commission a review of the Trust Estate with a security strategy embedded to assess the way staff/service users access the Trust premises
   - Review the Security measures in place to physical assets (e.g., vehicle mitigation) and establish improvement actions
   - Review the Security systems/contracts (Access Control, CCTV, ANPR) with particular focus on enhancing their current operational deliverables.

2. People
   - Complete a Security Strategy that incorporates people safety
   - Assess the suitability of the OCS Security contract
   - Increase the current operational deliverables from OCS security
   - Ensure OCS Security are included in any EPRR testing regime

3. Training
   - Develop a Trust training framework to increase security awareness which includes advanced awareness training for Board and Executive colleagues.
   - Assess associated costs with the above framework
   - Develop a full Trust EPRR testing programme
   - Increase training for OCS Security following the review recommended above

4. Governance and Effectiveness
   - Review the identified Trust security risks and create any new risks identified within the report following assessment
   - Review and redevelop the Security governance framework and streamline the structure
   - Implementation progress reports to be delivered to the Executive Team/Board at least quarterly

4. Conclusion/Recommendations

The initial findings and recommendations identified from the formal debrief of the Major Incident have been responded to at pace.

Incidental findings relating to security management have been identified and further expertise and information have been sought which has supported the development of the Security Implementation Workplan. This will be overseen by a newly formed Environmental Safety Group, reporting into FPBD. The Terms of reference for this group will ensure alignment with EPRR, Estates, Education, Finance and Operational colleagues to ensure appropriate engagement and sustainability of response.

The Board is asked to note the assurances provided in the report.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/009c*		Date: 07/04/2022	
Report Title	**Learning from Deaths Quarter 3, 21/22**			
Prepared by	Lidia Kwasnicka, gynaecology risk lead; Ai-Wei Tang, Consultant Obstetrician; Rebecca Kettle, Consultant Neonatologist and Chris Dewhurst, Deputy Medical Director.			
Presented by	Lynn Greenhalgh, Medical Director			
Key Issues / Messages	**The Board is asked to review the contents of the paper and take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board**			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	It is it is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths. In addition, as per The Learning from Deaths framework requirements the Board is requested to note: ***• number of deaths in our care*** ***• number of deaths subject to case record review*** ***• number of deaths investigated under the Serious Incident framework*** ***• number of deaths that were reviewed/investigated and as a result considered due to problems in care*** ***• themes and issues identified from review and investigation*** ***• actions taken in response, actions planned and an assessment of the impact of actions taken.*** ***• Specific recommendations*** ***- the monitoring and review of the stillbirth rate continues by the Family Health board, with a thematic review to be conducted with Q4 data. Issues identified at the reviews and recommendations made will now be tracked through the Maternity Clinical Meeting*** ***- the monitoring and review of the neonatal mortality rate continues with an external review of mortality for extremely preterm infants to be available in Q1 2022-23***			
Supporting Executive:	Lynn Greenhalgh Medical Director			

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

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks*	Comment: N/A
Link to the Corporate Risk Register (CRR) – CR Number:	Comment: No

EXECUTIVE SUMMARY

This "Learning from Deaths" paper presents the mortality data for quarter 3 with the learning from the reviews of deaths from quarter 2. The learning from deaths does not usually occur in the quarter in which the death occurred due to the formal processes and MDT reviews that take place. For this reason, the "learning" is from deaths occurring in the previous quarter. The review of stillbirths and neonatal deaths are subject to a multidisciplinary review panel meeting with external professionals utilising the Perinatal Mortality Review Tool (PMRT). All cases invited parents to be involved in the review by submitting comments and questions for discussion.

In quarter 3 there were the following deaths:

Adult deaths	**0**
Stillbirths	**10 (rate 5.1/1000 total births)**
Neonatal deaths	**11 inborn (rate 5.7/1000 inborn births) + 5 deaths from postnatal transfers**

The stillbirth rate has increased at LWH since 2019/20. It is unknown if this is a pattern replicated in the UK with ONS data for 2021 awaited. There has been no increase in care issues identified from reviews of stillbirths. A thematic review of stillbirths will be conducted with full year data for 2021/22.

Lessons learnt from quarter 2 and actions taken are presented in this paper. Common themes from recent learning from deaths reviews include:

1. Importance of integrating the electronic growth chart into the maternity electronic patient record
2. Importance of sending placentas for analysis.

Changes in clinical care due to the covid pandemic may have played a role in the outcome of 3 cases of stillbirth in Q1 and Q2.

The data and narrative within this paper has previously been presented at the Quality Committee on 21st February 2022. The discussion included the following:

1. The successful narrative of learning provided within the report
2. The need for the national data on stillbirths in 2021 to be published in order to benchmark LWH data against
3. A thematic review of stillbirths in multiple pregnancy to be presented in the Q4 report
4. The external review of mortality for extremely preterm infants to be available in Q1 2022-23

The Committee was assured that adequate processes and progress against the requirements laid out by the National Quality Board.

Recommendation: It is it is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths. In addition, as per The Learning from Deaths framework requirements the Board is requested to note:

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.
- Specific recommendations
    - the monitoring and review of the stillbirth rate continues by the Family Health board, with a thematic review to be conducted with Q4 data. Issues identified at the reviews and recommendations made will now be tracked through the Maternity Clinical Meeting
    - the monitoring and review of the neonatal mortality rate continues with an external review of mortality for extremely preterm infants to be available in Q1 2022-23

MAIN REPORT

This is the quarter 3 mortality report for adults, perinatal and neonates. This report updates the Trust Board regarding the Trust systems and processes to review and learn from deaths of patients under their care. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust. This is in accordance with recommendations by the National Quality Board and the Care Quality Commission. It outlines the work taking place operationally and being overseen by the Safety and Effectiveness Sub - Committee and Quality Committee.

The data presented in this report relates to quarter 3 2021-22. The learning relates to deaths in Q2. This is due to the MDT review of deaths not occurring in the quarter when the death occurred. Previously, the learning from reviews of adult deaths was often presented in the same quarter as the death occurred. This report will now present the learning from adult deaths in the same time frame as stillbirths and neonatal deaths, i.e. the data from quarter 3 and learning from quarter 2. However, as the learning from deaths for quarter 2 relating to gynaecology deaths has already been presented to the committee in the Q2 it will not be included in this report.

Learning from deaths may take longer than 1 quarter to be demonstrated. This is particularly for cases that undergo an SUI or Coronial review. The learning from these deaths will be included and the dates the death occurred will be highlighted.

Additional data relating to mortality is available to the Board via the supporting documents folder.

1 Adult Mortality

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

1.1 Obstetric Mortality Data Q3

There were no obstetric deaths in quarter 3.

Out of hospital deaths in Maternity are considered as community deaths and not allocated to the Trust. The Trust does however, review care provided in all these cases to determine any thematic points for learning. In Q3, there was one death of a woman who died approximately 8 weeks after delivery. This case is subject to a Coronial investigation and at the time of writing the cause of death has not yet been determined. This case has been subject to a 72- hour review and a more detailed review may be initiated following further information from the coroner. Learning from this

1.2 Gynaecology Mortality data Q3

There were no deaths within Gynaecology Oncology nor out of hospital deaths in Q3.

1.2.1 Learning from Gynaecology Mortality Q2

This information was presented in the Q2 "learning from Deaths "paper. The SI from Q2 has not yet concluded with learning form this will be presented in the Q4 paper.

2 Stillbirths

2.1 Stillbirth data

There were 10 stillbirths, excluding terminations of pregnancy (TOP), in the third Quartile of 2021/2022. This has resulted in an **adjusted stillbirth rate of 5.1/1000.**

Table 1 Stillbirth rates for 2021-22

STILLBIRTHS	Apr -21	May-21	Jun -21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	TOTAL 2021/22
Total Stillbirths	3	6	4	7	4	2	4	6	3	39
Stillbirths (excluding TOP)	**3**	**3**	**2**	**7**	**3**	**1**	**3**	**5**	**2**	**29**
Births	639	672	696	692	695	684	655	665	622	6020
Overall Rate /1000 births	4.7	8.9	5.7	10.1	5.8	2.9	6.1	9.0	4.8	6.5
Rate (excluding TOP)/1000	**4.7**	**4.5**	**2.9**	**10.1**	**4.3**	**1.5**	**4.6**	**7.5**	**3.2**	**4.8**
Quarterly rate/1000 births (excl TOP)	**4.0**			**5.3**			**5.1**			**4.8**

The annual stillbirth rate for 2021-22 is on trajectory to be higher than for previous years. (see fig 2 below). The NHS Long Term plan has set a target of reducing stillbirths by 50% by 2025. That would require England to reduce its stillbirth rate to 2.6 stillbirths per 1,000 births. The most recent ONS data from 2020 records the still birth rate for England and Wales to be 3.8/1000 births. There has been a slow decline in the national stillbirth rate in the years prior to this.

Quarter	Rate 2019/2020	Rate 2020/2021	Rate 2021/2022
Q1	4.0	5.5	4.0
Q2	4.1	2.5	5.3
Q3	1.5	2.7	5.1
Q4	1.7	3.2	TBC
ANNUAL	**2.9**	**3.4**	**4.8**

Table 2: LWH Stillbirth rates by quarter in and year since 2019. NB The difference between 2020/21 and 2021/22 is not statistically significant, though it is statistically significantly increased when 2021/22 is compared with 2019/20

It is not clear if the increasing still birth rate in the LWH data is replicated throughout the UK. There have been worldwide reports of an increased stillbirth rate during the covid pandemic. UK data from a single centre in London demonstrated a fourfold increase in the still birth rate during the first lockdown of 2020. The ONS data for the full year of 2020 however showed a still birth rate of 3.8/1000 births, a decrease from 3.9/1000 in the previous year. The ONS data relating to stillbirth rates for 2021 are not yet available. We are not therefore unable to determine if the rise in stillbirth rate at LWH since 2020 is also seen on a national scale and await the ONS national data to benchmark against.

National data is available from the NHS trusts that submit data to the CHKS group for benchmarking. CHKS data for Jan – Dec 2021 are below demonstrating that LWH stillbirth rates are within the expected range when compared with peers.

Fig 1. LWH within the interquartile range for stillbirths amongst CHKS data.

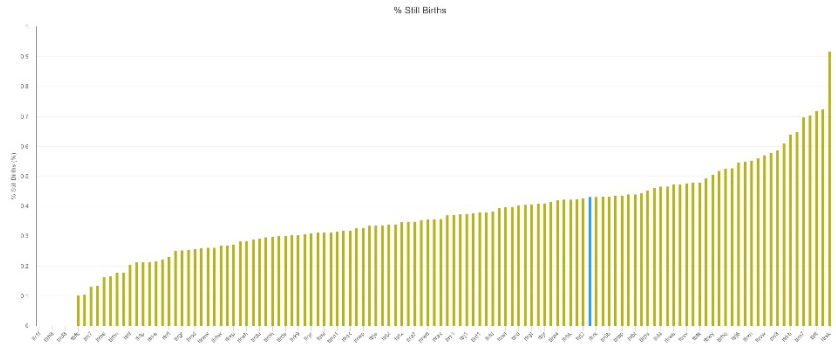


Chart 1 Stillbirths for Jan – Dec 21, LWH in blue.

2.1 Learning from Stillbirth reviews Q3

2.1.1 Impact of covid

In the review of Stillbirths in Q1 and Q2, changes in the service and operational provision of clinical care due to the Covid 19 pandemic (either directly or indirectly) were identified as a contributory factor in 3/26 cases.

- Two cases relate to the change from face-to-face booking appointment to telephone booking appointments. We are expecting this to no longer be identified as an issue as all antenatal bookings have now reverted to face to face as per the pre covid pandemic provision of care.
- The remaining case relates to the rescheduling of USS appointment due to unexpected medical sickness related to COVID 19. This led to a delay in the ultrasound provision scan in FMU and the delayed potential to identify fetal growth restriction, which may have led to a differing care pathway. This case has been escalated as a SUI.

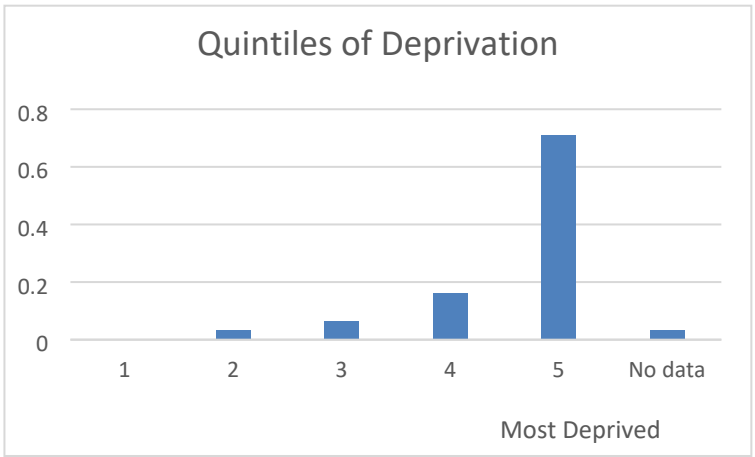
2.1.2 Multiple pregnancy

In Q1-3 2021-2022, there were seven twin pregnancies reported in the stillbirths cohort compared with 1 twin pregnancy on 2020-21. In Q4, data and learning from a thematic review of these twin pregnancies will be presented.

2.1.3 Social deprivation

From the National Embrace data for 2014-19, social and financial disadvantage was associated with a higher stillbirth rate: 4.80/1000 births for the most deprived areas compared with 2.70 for the least deprived.

The quintile of deprivation for Women who suffered a stillbirth are presented below. This demonstrates that of the stillbirths so far in 2021-22, 71% live in the most deprived quintile. This distribution is similar to the population deprivation distribution for Liverpool. There is a need to have a multi-agency targeted approach to support women in these areas to reduce perinatal mortality. The proposed Continuity of Carer model is part of this approach.



2.1.4 Still birth case reviews

All eligible cases undergo a full PMRT review, with care from across the antenatal and intrapartum period being subject to clinical and managerial scrutiny. The care that the mother receives is subject to a grade which aligns with the MBRRACE-UK grading system. Postnatal care is reviewed, typically with a focus on the bereavement care the family receive. Any complications of labour and within the postnatal period are subject to the same grading system. (Table 4 in additional information shows the current MBRRACE criteria for grading)

All 14 cases (including pregnancy losses at 22-24 weeks) in Q2, have been reviewed and subject to grading of care provided as below. In the antenatal period, the proportion of cases with no care issues identified has remained similar to those percentages reported in Q1.

Grade	Care in antenatal period	Percentage (%)	Care in postnatal period	Percentage (%)
A	9	64.3	9	64.3
B	2	14.3	4	28.6
C	2	14.3	1	7.1
D	1	7.1	0	0
Total cases reviewed	14		14	

Table 3: Grading of care for babies in Q2 of 2021-22 (14 cases including 22-24 week loss)

Given the increasing stillbirth rate it is reassuring to note that when comparing 2021-22 with 2020-21 there has not been an increase in the proportion of cases where antenatal care issues have been identified which may have impacted on the pregnancy outcome. (See additional data table 6 and 7).

2.1.4 Learning from Stillbirths

Review of cases in Q2 identified the following learning:

- Improvement in the process for follow up by Community Midwife teams after the booking appointment. The Continuity of Care model being implemented is aimed to address this issue.
- Need to integrate the fetal growth charts with the electronic patient records. The transition to the electronic patient records from January 2021 has led to the difficulty in collating evidence for monitoring of fetal growth in some cases. The GROW chart and K2 systems will be integrated to allow this function Q4 2021-22.
- To adhere to the growth screening pathway for small for gestational age fetuses. The SGA guideline has been updated to be aligned with Saving Babies Lives initiative
- To learn the importance of accurate antenatal risk assessments when reviewing patients who access care. In a case, smoking was not identified as a risk factor for stillbirth. A lesson of the week has been circulated related to this.
- To accurately risk assess when rescheduling appointments in the fetal medicine unit. The FM team are reviewing the process for rescheduling of appointment.

There has been an increase in care issues identified in the provision of Postnatal care, 2 of which were identified through parental feedback. Learning from these issues include:

- Continue to provide support and training to MW in providing bereavement care.
- Review the Honeysuckle service provision.
- Reminder of the importance postnatal investigations in the investigation of stillbirth. A LOTW has been disseminated to all staff with discussion with the team members involved and maternity team are reviewing the process for storing and sending placentas for analysis.

In order to maintain a close monitoring of any identified themes, trends, rising data and issues resulting from stillbirth reviews, the stillbirth data and a summary of cases discussed at the PMRT MDT reviews will be an agenda item at the monthly Maternity Clinical Meeting. A review of the annual stillbirth data

3. Neonatal Mortality

3.1 Neonatal mortality Data

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

Table 4 details the mortality for babies born at LWH only and admitted to the neonatal unit. These data exclude post-natal transfers.

NICU (LWH INBORN)	Apr 21	May 21	Jun 21		Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	21/22 Total
Discharges	100	97	106	93	119	113	129	129	114	628
Total Mortality	2	0	0	3	2	2	4	4	3	20
Births	622	654	673	692	695	684	655	665	622	5962
Mortality Rate per 1000 births	3.2	0	0	4.3	2.9	2.9	6.1	6.0	4.8	3.3

Table 4: NICU Mortality (inborn LWH). These data are the numbers of deaths of babies born in LWH and admitted to NICU.

In addition to babies who are born at LWH, some babies are transferred into LWH following birth in another centre. This is because they require level 3 neonatal care and their local unit is unbale to provide this, or they require specialist surgical or cardiac care that can only be provided in large tertiary neonatal units. Examples would include extremely preterm infants, those with congenital anomalies or acquired surgical conditions such as necrotising enterocolitis in preterm infants. Data relating to babies transferred into LWH and mortality is presented below.

NICU PNT into LWH	Apr-21	May-21	Jun-21	Ju 21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	21/22 total
Number of PNTs (babies)	12	10	10	11	13	12	20	8	8	104
Mortality following transfer into LWH	1	1	2	2	1	1	4	1	0	13

Table 5: Mortality from babies transferred into LWH.

Babies also die in the delivery room or after transfer to another care setting for ongoing management, or to hospice for end of life care. If a baby dies after transfer to AH (Alder Hey) the case is reviewed through the AH mortality review process by the hospital mortality review group (HMRG) with neonatal input from the Liverpool Neonatal Partnership. These mothers and babies' are reviewed through the LWH PMRT process which will then feed into the AH HMRG for a complete review of the mother and babies' care.

If a baby is transferred from LWH to hospice or home for end of life care the case is reviewed through the LWH PMRT process. In Q3, 2 babies died after transfer to other care settings for palliation, there was 1 delivery room death this quarter of an

extremely preterm baby with multiple congenital abnormalities and 2 babies died at AHCH with complications of complex congenital heart disease.

Table 6: Mortality ***before or after*** NICU admission

	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
Delivery room deaths	1			1	1	1		1	
Alder Hey Children's Hospital	2								2
Hospice	1			1					
Repatriation to booking hospital									
Home		1						**1**	
Other									**1**

3.2 Benchmarking data

We benchmark our mortality through MBRRACE nationally and the international VON network. MBRRACE has reported most recently on 2019 data, figure 1 demonstrates mortality rates over time, the grey lines demonstrate UK average for the LWH comparator group i.e. other NICUs with neonatal surgery. As the graph demonstrates for 2019 LWH has moved back towards the UK average in comparison to 2018. MBRRACE data includes only babies born >24 weeks gestational age and deaths within 28 days of birth. The VON data will be presented when 2021 data is complete and benchmarking can be made.

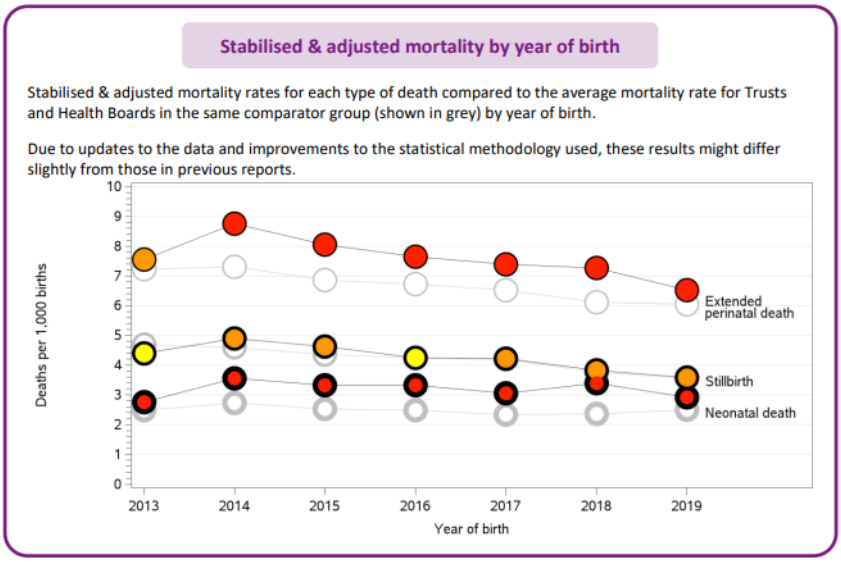


Figure 2. Embrace data 2013 - 2019

An ongoing external review by the North West Neonatal ODN of LWH mortality for extremely preterm infants is continuing. This was initiated following benchmarking data relating to a higher mortality in infants of 24 weeks gestation age when compared with other level 3 neonatal units in the North West and a spike in mortality rates in 2020. This report is now due to be available in Q1-Q2 2022.

3.3. Learning from neonatal mortality reviews for Q2

All neonatal deaths on NICU are reviewed using the standardised national perinatal mortality review tool (PMRT) (see additional information for further details). All Q2 reviews have been completed (11/11).

Of 11 reviews 5 were found to have care issues which would not have affected the outcome, 1 case identified care issues which may have made a difference to the outcome, the care issue in that case was in respect of care at the referring hospital prior to transfer to LWH.

LWH Learning identified included the following (see additional information)

- Incomplete investigations completed for a baby with hydrops fetalis. An electronic investigation form is now created on the Badger EPR.
- There was a delay in a radiograph being performed out of hours. This has been escalated to CSS for review of out of hours radiology provision.
- There was a delay in management in the first hour for an extreme preterm infant. A new extreme preterm pathway has been developed and is now in use to act as a prompt for intervention.

5. Revised 2021/2022 Maternity Incentive Scheme requirements

The Trust was in receipt of the revised maternity incentive scheme guidance which has included updated timescales and deadlines for the reporting and reviewing of stillbirths and neonatal deaths. The detail below, demonstrates our current position against the newly revised timescales.

A. i) 100% all deaths have been reported to MBRRACE within the seven working day timeframe with 100% of deaths having surveillance completed within one month to date.
B. ii) 87% - 27 of 31 cases have had their review started within two months of the death, standard is 95%. By way of assurance processes to ensure that compliance is achieved, the FHD have implemented actions to ensure timely commencement of case reviews.
C. All reports are either in draft format or are planned to be in draft status by the timeline for CNST.
D. 100% of families have been informed and offered involvement in the review of their care and that of their baby.
E. All quarterly Learning from Deaths Reports have been submitted to Trust Board in a timely manner

This quarterly report (and pervious quarterly reports) will continue to be discussed with the maternity, neonatal and Board level safety champions. Dissemination of learning will continue through associated clinical meetings and feedback to staff.

4. Recommendations

It is it is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths. In addition, as per The Learning from Deaths framework requirements the Board is requested to note:

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.
- Specific recommendations
    - the monitoring and review of the stillbirth rate continues by the Family Health board, with a thematic review to be conducted with Q4 data. Issues identified at the reviews and recommendations made will now be tracked through the Maternity Clinical Meeting
    - the monitoring and review of the neonatal mortality rate continues with an external review of mortality for extremely preterm infants to be available in Q1 2022-23

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/009d*		Date: 07/04/2022	
Report Title	**Integrated Governance Assurance Report Quarter 3 2021/22**			
Prepared by	*Phil Bartley, Associate Director of Quality and Governance*			
Presented by	*Marie Forshaw, Chief Nurse & Midwife*			
Key Issues / Messages	This 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 members of the 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, Director of Nursing and Midwifery*			

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:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	March 22	DoN&M	The Committee noted the continued progress with the formatting and content of the report.

EXECUTIVE SUMMARY

The following Integrated Governance Assurance report covers Quarter 3 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.

At the request of the Quality Committee, this report has been revised to ensure it captures the key risks and achievements for the Trust, clearly identifying areas for improvement documenting plans in place to address such issues.

MAIN REPORT

1. INTRODUCTION

This integrated governance report is a quarterly integrated review of quality governance and the standard of care at Liverpool Women's Hospital. The intention of the report is to complement the monthly quality governance dashboards and performance reports by providing a longer term, thematic analysis of key issues and providing an opportunity for wider dissemination of learning.

2. ANALYSIS AND TRIANGULATION OF KEY RISKS ACROSS THE TRUST

The report has clearly identified themes (both positive and negative) within incidents and complaints and the triangulation of these across the divisions. These are outlined as follows.

2.1 Positive Findings

- There is confidence that incidents are being reported as they should be. The number of incidents for 52-week breaches, clinical management, communication and staffing levels have reduced for Q3. PALS data for the quarter demonstrated contact in relation to communications remained static, only 1 complaint was received in relation to staffing numbers. This will be measured and reported on in the next version of this report for Q4 triangulating with data from complaints, claims & Incidents.
- The Trust has now secured the services of an approved, qualified, and accredited Face Fit Mask Tester in early January 2022. They have been assigned to us for a period of up to six months. Progress on this will reported in the Q4 IGR.
- As new telephony software (Netcall) has been introduced, there are greater reporting capabilities available. The Patient Experience Department has requested continued to request 4 weekly reports detailing the call performance statistics from the operational leads of the Divisions. Progress on this will reported in the Q4 IGR.
- Patient Experience Matron has been in post since November 2021. This is a trust wide post with an emphasis on being able to demonstrate and evidence the patient experience journey, with consideration given to our new QI methodology to enable improvements where required. The Patient Experience Matron

provides feedback and learning trust wide via the Patient Experience Meeting where evidence of actions taken is clearly documented.

- Our Quality Improvement Framework has now been approved and shared Trust wide. Work is on-going to make this work a reality and showcasing improvements and outstanding pieces of work trust wide. Progress on this will reported in the Q4 IGR.

2.2 Triangulation of key risks for the Trust as outlined in this report

Division	Key risks noted for improvement	What are we doing to improve the position both short and long term	Committee/division/person responsible
Trust Wide	A key area of risk continued to be within the investigations cause group relating to blood sampling errors for Q3. There was a significant level of rejected samples from the laboratory.	Clinical Support Services have undertaken a significant piece of work in relation to this area which this committee is already sighted on. Their report was presented to the February 2022 Quality Committee and can be read in conjunction with this paper. This piece of work is now under the oversight of the pathology steering group, the committee will be updated as to progress in this area as agreed at the previous Quality Committee.	CSS Pathology Steering Group
Trust wide	A gap has been identified in managers, supervisors, team leaders' health and safety legal duties and responsibilities knowledge	A set of health and safety related questions for all staff grades are being created to ascertain interview candidates' knowledge of H&S law and duty, this will assist in identifying any additional health and safety training needs H&S Manager is to design suitable and sufficient training media for all new managers, supervisors, team leaders in additional to corporate induction health and safety training The Governance team are currently reviewing their approach to Health & Safety with new roles in the process of being recruited	HR Interview Panels Health and Safety Manager Governance

		to and created to support this agenda. Further progress will be reported in the Q4 IGR.	
Trust wide	A new requirement from CNST requires the Trust to review its scorecard at least twice in the MIS reporting period at either a Board or Directorate Level Meeting. The Trusts is reviewing its approach to CNST and the use of the Trust Scorecard and will update its practice accordingly being able to evidence the triangulation of data in relation to incidents, claims and complaints.	The Associate Director of Quality & Governance is currently working with the Trusts legal team to ensure that a programme of training is delievered to its staff so they have the skills and knowlegde in realtion in the Scorecard. Furhermore, with the support of Divisional SLT's within the trust, work is also on-going between governance and the finance team to establish a robust process between teams in relation this. The scorecard will be presented to the April Safety & Effectiveness Meeting to increase awareness of it whilst this piece of work is on-going.	Associate Director of Quality & Governance Director of Finance CNST leads

The detailed underpinning information for the identification of these key themes and risks can be found in the appendices (key headlines identified underneath for each area):

The appendices have been made available to the Board via the Supporting Documents folder.

Appendix 1 – Incidents

Key Headline(s): A key area of risk for Q3 was within the investigations cause group relating to blood sampling errors. There continues to be a significant level of rejected samples from the laboratory.

Appendix 2 - Medicines Management & Incidents

Key headline(s): Medication incident reporting is decreasing across the Trust.

Appendix 3 – Health and Safety

Key headline(s): The Trust has now secured the services of an approved, qualified and accredited Face Fit Mask Tester who has been assigned to us for a period of up to six months.

Appendix 4 - Complaints, PAL's & PALS +

Key headline(s): As new telephony software (Netcall) has been introduced, there are greater reporting capabilities available. The Patient Experience Department has requested continued to request 4 weekly reports detailing the call performance statistics from the operational leads of the Divisions.

There was a specific request from the Board to undertake a lookback exercise on complaints received during 2021/22 to explore if Covid-19 was the main driver of issues raised. This has ben extracted for ease of reference:

Complaint and feedback overview for 2021/22

We have received 53 complaints this year, with approximately 30 being assigned as the gynaecology division as the main complaint lead. This compares to 48 last year when many services were paused.

Below are the overall received complaints in 21/22 by category (*1 complaint may have many different heads of complaint which are recorded individually to give a more detailed picture of the concerns raised*)

Category Type	Total
Clinical Treatment	125
Communications	81
Patient Care	40
Trust Admin/Policies/Procedures Including Patient	19
Admission And Discharges	17
Values and Behaviours (Staff)	17
Access To Treatment or Drugs	13
Appointments	9
Privacy, Dignity & Wellbeing (PDW)	5
Consent	4
Facilities	3
Waiting Times	3
Staff Numbers	2

To review if COVID is still influencing complaints there are questions that come from this that we do not have the detail to address. You can look at the clinical treatment complaints investigations that we have upheld (below) and see that there is an element of individual error, but there is nothing in the individual investigation that links this directly to COVID related issues.

But digging under the surface and looking across a broad range of cases there are further questions that can be considered with looking through the lens of the pandemic. Are the errors because staff are too busy as we are /have been low on numbers? Or unconscious actions of a dispirited and burnt-out workforce?

The patient care and values and behaviour cases are difficult to investigate as they rely a lot on perception during the investigation. We know that potential increased workload due to lack of numbers should not prevent people showing basic care and compassion, but if staff feel under so much strain and stress then is it foreseeable that we see cases around these issues.

Communications is the next category and these relate to lack of, or quality of contact to the patient. Some of these relate to difficulties contacting services for updates or appointments.

Upheld – resolved cases 21/22

Category Type	Total
Clinical Treatment	37
Communications	36
Values and Behaviours (Staff)	20
Patient Care	19
Trust Admin/Policies/Procedures Including Patient	9
Admission And Discharges	7
Appointments	6
Access To Treatment Or Drugs	4
Facilities	4
Consent	2
Privacy, Dignity & Wellbeing (PDW)	2
Other	1
Prescribing	1

Appointments and difficulties in contacting the trust are also major themes in the PALS cases received by the Trust. During the initial COVID period, patients were more accepting of any delays that were caused by reduced clinics/appointment availability. As the general perception that COVID is "over" and society getting back to normal the tolerance for any wait for appointments has greatly reduced. Patients are all aware nationally of the waiting lists across the NHS and that fear of not getting their own appointment is leading to an increase in more forceful queries being raised to try and expedite their own case.

A fluctuating satisfaction rate is evident in the Friends and Family Test (FFT) data during different times of the year. The FFT tends to identify "Low Level" niggles were as complaints mainly contain more impactful experiences. The FFT data regularly cites the difficulties in contacting the Trust or the perceived lack of staff available upon attendance. Other points raised in FFT include the continuing COVID restrictions, waiting times and discharge that are influencing their opinions.

Appendix 5 - Clinical Effectiveness and Audit

Key headline(s): The prenatal 'Situation, Background, Assessment, Recommendation' (SBAR) database has been successfully integrated into clinical practice within the Liverpool Centre for Genomic Medicine (LCGM)

Appendix 6 - Claims cases and Inquests

Key headline(s): The Trust is reviewing its approach in relation to CNST and the use of the Trust Scorecard and will update its practice accordingly.

Appendix 7 – Patient Experience

Key headline(s): A new Patient Experience Matron commenced in post in November 2021.

Appendix 8 - Freedom to speak up

Key headline(s): There are currently no issues raised with our Freedom to Speak Up Guardians that have a direct impact on patient safety.

Appendix 9 – Quality Improvement

Key headline(s): Our Quality Improvement Framework was approved at February Quality Committee

3. RECOMMENDATION

It is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place 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)	***22/23/009e***		**Date: 07/04/2022**	
Report Title	Bi-annual staffing paper, July-December 2021 (Q2 & Q3)			
Prepared by	***Nashaba Ellahi, Deputy Director of Nursing and Midwifery***			
Presented by	***Marie Forshaw, Chief Nurse and Midwife***			
Key Issues / Messages	***The Board is asked to note the contents of the paper and take assurance of the actions undertaken to effectively manage and provide safe staffing within Nursing, Midwifery and AHP to support the delivery of safe care.***			
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): NA			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is asked to note the contents of the paper and take assurance of the actions undertaken to effectively manage and provide safe staffing within Nursing, Midwifery and AHP to support the delivery of safe care.			
Supporting Executive:	Marie Forshaw, Chief Nurse and Midwife			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1.2 Failure to recruit and retain key clinical staff	Comment: Scored at 20
Link to the Corporate Risk Register (CRR) – CR Number: The below are service level risks, however for context are highlighted. **FH (Maternity)** Risk number: 1705 – midwifery staffing "insufficient midwifery staffing levels as recognised by birth rate plus. Risk score of 20; target 6 **Gynaecology** Risk number: 2256 – Risk to staff the Telephone Triage Line (GED). Risk score of 8; target 3 Risk number: 2395 - OPD ambulatory staffing Risk score of 8; target 6 Risk number: 2416 - in-patient ward for staffing, risk review due as recently achieved full establishment. Risk score of 8; target 4	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Putting People First Committee	21.03.22	Marie Forshaw	Approved with recommendations agreed and supported

EXECUTIVE SUMMARY

The bi-annual Nursing, Midwifery and Allied Health Professional (AHP) staffing report is provided to the Board of Directors through the Putting People First (PPF) Committee. The report sets out the Liverpool Women's NHS Foundation Trust (LWH) position in the context of the National Nursing, Midwifery and AHP workforce challenges. This report covers the period from July 2021 to December 2021 (Quarter 2 and Quarter 3). The report provides assurance that there are robust systems and processes in place throughout the year to monitor and manage Nursing, Midwifery and AHP staffing requirements. The report will demonstrate the adoption of a triangulated approach to the bi-annual staffing report and therefore includes discussion of evidence-based tools, professional judgement, and outcomes (e.g., complaints, incidents) to support understanding.

The report was previously presented at Putting People First Committee (PPF) on 21st March 2022. The PPF Committee were assured with the triangulation of information presented that provided a Trustwide overview. The committee commented on the available detail at a divisional level, noted in several appendices, which were discussed, supported, and demonstrated divisional actions being taken to address and improve safe staffing. The summary report provided to Trust Board highlights the following areas for discussion and noting (July 2021-December 2022).

Adoption of principles within National Quality Board (2016), NICE Guidance (2014;2015) and Delivering Workforce Safeguards (2018) to support workforce planning, care hours per patient per day (CHPPD) requirements and the operational oversight of staffing and acuity-based care is embedded in the Trust.

Communication regarding use of Safer Nursing Care Tool (SNCT) in Gynaecology continues with NHS/I, with plans for training previously halted due to Covid-19.

During the reporting period:

- Vacancy position (December 2021) is 6.76%, with Gynaecology division reflecting the greatest vacancies
- Maternity leave fluctuates between 53 and 60 staff on maternity leave per month
- Sickness has been above target of 4.5% with December 2021 reflecting 13.48% (8.90% non-covid related sickness)
- Long-term sickness remains the greatest challenge with December 2021 highlighting 60% (NMC/HCA) and 80% in AHP
- Turnover has remained under the threshold (13%) in NMC/HCA, however, is high in small teams as reflected in AHP workforce
- Age profile remains a relatively static position except for an increase seen in NMC (21-25 years) and likely due to newly qualified staff commencing
- Staff training and Personal Development Review targets were not achieved, except for Local Mandatory Training (LMT) for AHPs in Quarter 3
- Clinical Incidents (245) related to staffing or staff sickness were noted highest in Maternity Services with 191. Red Flag events (163) were highest in Maternity services with 138. There were 12 Serious Incidents: 8 in Maternity and 4 in Gynaecology
- Patient experience – 28 comments (from 4878) comments received in Friends and Family Test (FFT) mentioned staffing numbers or staffing shortages in the patients' experience. 80 comments (from 2235) relating to the Trust question "please tell us anything we could have done better" also related to staffing numbers or staff shortages
- Complaints – 28 formal complaints received with 3 relating to staffing levels, none were upheld. No PALS+ recorded in relation to staffing as main concern. 2 PALS cases (from 1263) noted staff shortages in concerns raised
- Compliments – 68 compliments received. Gynaecology Adult In-Patient Survey received reflecting positive results. Maternity Survey – awaiting unembargoed report
- Staff experience – 20 reported violence and aggression incidents, with 5 incidents relating to challenging adherence to Covid-19 practices. Trust Staff Survey December 2021 shows an improvement in positive responses related to areas such as Violence and Aggression and Health and Wellbeing
- Recruitment and Retention – Successful recruitment of newly qualified midwives in September-October 2021. All divisions have rolling adverts for key roles. International recruitment plans in Maternity and Theatres commenced. Successful NHSI funding to support retention with Midwives and Health Care Support Workers (HCSW) with the aim of locally supporting return to practice, recruiting HCSWs without prior experience and support career

pathways. Recruitment intention to key roles that will evolve and embed an infrastructure that supports attraction, recruitment, and retention.

MAIN REPORT

1. Introduction

To provide the Board with a six-monthly update of the 2021/2022 staffing establishment reviews in relation to the Nursing, Midwifery and Allied Health Professional (AHP) workforce requirements. To report against the workforce requirements identified in 2021/2022 to achieve safe staffing across services within the Trust.

2. Background

NHS organisations have a responsibility to undertake an annual comprehensive Nursing and Midwifery skill mix review to ensure that there are safe care staffing levels to provide assurance to the Board and stakeholders that the organisation is safe to provide high quality care.

The annual Nursing and Midwifery staffing establishment review considers relevant guidance and resources available to support NHS providers to deliver the right staff, with the right skills, in the right place at the right time (National Quality Board (NQB), 2016) through effective staffing (NICE, 2014; NICE, 2015; NHSI, 2018).

The annual comprehensive Nursing and Midwifery workforce planning skill mix review will be underway in February-March 2022 ahead of budget setting to effectively inform any changes before staffing establishments are reviewed and signed off by the Chief Nurse and Midwife and Trust Board.

The bi-annual Nursing and Midwifery staffing report details the Trusts 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).

The Board receives twice-yearly staffing review papers; one which reflects a complete Nursing and Midwifery establishment review and a further comprehensive staffing report to ensure workforce plans are still appropriate across the clinical workforce, allowing for seasonal variance to be captured and reviewed appropriately.

Additionally, separate twice-yearly Midwifery staffing oversight reports are presented to Trust Board that updates on staffing/safety issues, as a requirement for the maternity incentive scheme, year four reporting period. Neonatal services report staffing to Trust Board yearly in line with Clinical Negligence Scheme for Trusts (CNST) requirements.

Each month the Board receive an overview of the Nursing and Midwifery staffing including fill rates, attendance/absence, vacancies, red flags, and bed occupancy. The information is presented within the Integrated Performance Report.

Developing Workforce Safeguards (NHSI, 2018) additionally recommends:

- Adoption of the principles of safe staffing utilising a 'triangulated' approach to staffing, utilising evidence-based tools, and data, where available, professional judgement and outcomes (e.g., nurse sensitive indicators, complaints, incidents)
- implementation of care hours per patient day (CHPPD) as a metric as recommended by Lord Carter's review of NHS productivity, however with the caution that it should not be used in isolation

Safe, Effective, Caring, Responsive and Well Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Table 1: National Quality Board (2016)

3. Workforce planning - Setting evidenced based establishments

Evidence based workforce planning is supported using available tools such as Safer Nursing Care Tool (SNCT, 2014) developed to assist NHS hospitals measure patient acuity and dependency on adult inpatient areas and Emergency Departments to inform decision making on staffing and workforce as part of a triangulated approach. SNCT is not suitable for day-case patients.

The licence for SNCT has been acquired by the Trust in July 2021 to use within Gynaecology in-patient ward ahead of the annual workforce planning review in February 2022-March 2022. Ahead of use there is a requirement to be trained by externally recognised experts to ensure consistent and standard approach. Due to the impact of Covid-19, Omicron variant, and the challenges this has posed with training this may not happen prior to budget setting.

National guidance (Intensive Care Society, 2019) supports staffing recommendations in Level 2 care facilities (High Dependency Units) as a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.

Maternity Services are assessed using Birthrate Plus®. The Birthrate Plus® methodology is based on an assessment of clinical risk and the needs of women and their babies during labour, delivery, and the immediate post-delivery period. Birthrate Plus® utilises the accepted standards of one midwife to one woman to determine the total midwife hours and therefore the staffing required to deliver midwifery care to women across the whole maternity pathway using NICE guidance (2015) and acknowledged best practice (RCM, 2018)

British Association of Perinatal Medicine (BAPM) standards have been utilised to provide the benchmark for staffing within the Neonatal Unit.

Theatre staffing is based on the Association for Perioperative Practice (AfPP) guidance. This methodology adopted supports efficient management of elective and scheduled operating sessions by effective use of resources and clinical efficiency in operating departments.

3.1 Care Hours Per Patient Per Day (CHPPD) and Actual versus Planned Care

From April 2016, following the Carter Review all Trusts were required to publish staffing fill rates of RN/RM and Care Staff by hours and percentages (Actual versus Planned) and CHPPD via the Strategic Data Collection Service (SDCS), run by NHS Digital. A summary of the submission is uploaded onto the Trust website each month. Appendix 1 highlights data submitted from July 2021-December 2021.

CHPPD relates only to hospital wards where patients stay overnight and is calculated by taking all the shift hours worked over the 24-hour period by Registered 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 mothers and babies are included in the census.

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

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

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

4. Operational oversight of staffing and acuity-based care

A series of actions are taken on a monthly, weekly, and daily basis to manage safe and effective staffing and optimise care for women, babies across services and divisions. This is captured as:

- Monthly rosters sign off meetings undertaken by Deputy Director of Nursing and Midwifery across all divisions where roster effectiveness is challenged against roster compliance KPIs. Final roster approvals are signed off by Heads of NMAHPs.
- Weekly forward view of staffing overseen by Heads of NMAHP and Matrons.
- Maternity and Neonatal services provide information for staffing on a weekly basis to NHS Gold command.
- Staffing reported to Bronze (staffing meetings) twice daily (Mon-Fri) and recorded on Power BI (RAG rated). Any identification of risk is addressed and where not resolved escalated to Silver (daily huddle) for resolution. First on call manage staffing at weekends and bank holidays.
- RAG rated staffing matrix in place for Neonatal and Maternity. Acuity and activity review is undertaken at 10am/10pm and 12am/12pm each day with MDT jointly in NNU and Maternity; focusing on staffing, activity, dependency, and ability to take women and babies recorded.
- Maternity helicopter role (104 bleep) completes 4 hourly oversight reviews of acuity, dependency and staffing to determine appropriate midwifery care across all areas. Helicopter role oversees and supports staff moves, staff breaks and care ratios
- Neonatal services adhere to national reporting to Cot Bureau three times daily

- Silver (daily huddle) informed of staffing forecasts position as they arise, into the following shift and ahead of a weekend.

4.1 Temporary Staffing

Since 22nd November 2021, NHS Professionals (NHSP) service has commenced in the Trust. It remains early days, however operational oversight on a weekly basis allows early resolution to issues arising. Early commencement of actions to reduce agency expenditure are in place, however with Covid 19 and the more easily transmissible variant (Omicron) the Trust saw a rise in sickness and isolation with predictions of further sickness anticipated. This resulted in a need to block book staffing to mitigate and support safe staffing. This in turn saw a rise in spend due to challenges in Midwife availability on Bank (as own staff were affected) and the few agencies that can supply Midwives were high cost.

The ongoing focus on recruitment and retention further aims to reduce the reliance on agency usage alongside the following actions:

- NHSP onsite team supporting workers with onboarding and NHSP systems
- NHSP onsite team to promote NHSP sign up and Agency migration
- NHSP attendance at twice daily staffing meetings to support priority shift allocation
- NHSP team proactively manage agencies and cancellations
- Review and agree competitive incentives through NHSP Operational Group to support increase in fill rate
- Ongoing training and support of Managers and Matrons in use of NHSP
- NHSP Recruitment Team who will support with Bank Only recruitment
- Maternity roster management/forward view meeting to support decision making on shifts escalating to agency

5. Trustwide Nursing, Midwifery and AHP Workforce Measures (July 2021-December 2021 data; Q2 & Q3 position))

5.1 Vacancy position

The data highlights the vacancy position in December 2021 (Table 2) for Nursing, Midwifery and AHP of 61.88wte. This demonstrates a vacancy rate of 6.76%. However, the higher vacancy position relates to new posts added to vacancy figures, yet to be recruited to, to support recovery work. Additionally, and assuring positive recruitment from Maternity services has seen actual reduction in vacancies.

The vacancy position of 61.88 wte is largest in the Gynaecology Division (25.86wte), then Family Health Division (FHD) with a total of 21.87 wte (Maternity, 8.75wte; Neonatal, 13.12wte). CSS have a vacancy position of 14.15wte.

Sum of Wte Budget	Sum of Wte Contracted	Sum of Wte Actual	Sum of Wte Vacancy
915.29	**853.41**	**801.3**	**61.88**

Table 2: December 2021 Trustwide vacancy position

5.2 Maternity Leave

Table 3 highlights the rolling and fluctuating position of staff on maternity leave. The Trustwide position highlights that November 2021 had the highest maternity leave across Nursing, Midwifery and AHP (NMAHP) with 60 staff on maternity leave. The group of staff with the largest maternity leave are those who are registered midwifes or nurses.

Maternity Leave	Jul			Aug			Sep			Oct			Nov			Dec		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Total	2	49	2	2	52	2	4	48	2	4	51	2	4	54	2	4	48	1

Table 3: Maternity leave

5.3 Sickness absence

The sickness absence over the reported six-month period (table 4) has remained high and above the Trust threshold of 4.50%, with the largest combined peak across all staff groups in December 2021. The lowest combined overall sickness rate was seen in November 2021 which was largely down to the AHP workforce having a sickness rate of 0.77% which was the lowest seen in the last six months and the only time any of the staff groups were below the Trust target.

The sickness seen in the reported six-month period was largely due to the impact of Covid-19, specifically the more easily transmissible omicron variant.

The overall % of sickness across the 3 staff groups in December 2021 is 13.48% and further breakdown of this illustrates the following:

- 8.90 % was all non-covid related sickness
- 4.58 % was covid-19 related sickness
- 0.55 % was covid -19 special leave (this is not calculated in the sickness recorded)

Sickness	Jul-21			Aug-21			Sep-21			Oct-21			Nov-21			Dec-21		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Total	**10.50%**	**9.46%**	**6.22%**	**10.25%**	**10.14%**	**11.35%**	**11.54%**	**9.41%**	**11.08%**	**11.96%**	**9.46%**	**5.54%**	**12.35%**	**9.49%**	**0.77%**	**13.19%**	**13.36%**	**5.79%**

Table 4: Sickness absence

5.4 Long-term and short-term sickness

Sickness over the six-month period reflects that long-term sickness continues to remain the greatest challenge across NMC/HCA staff groups. AHPs saw a reduction in long-term sickness for three months (September-November 2021) which reflected short term sickness percentage was greater.

December 2021 shows all staff groups long-term sickness accounts for 60% (NMC/HCA) or 80% (AHP) of the total sickness.

NMC	Jul-21		Aug-21		Sep-21		Oct-21		Nov-21		Dec-21	
	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
Total	**22%**	**78%**	**23%**	**77%**	**28%**	**72%**	**28%**	**72%**	**30%**	**70%**	**40%**	**60%**
HCA	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
Total	**22%**	**78%**	**18%**	**82%**	**23%**	**77%**	**21%**	**79%**	**23%**	**77%**	**40%**	**60%**
AHP	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
Total	**11%**	**89%**	**48%**	**52%**	**65%**	**35%**	**60%**	**40%**	**100%**	**0%**	**20%**	**80%**

Table 5: Long-term and short-term sickness proportions

5.5 Turnover

The Trust Turnover threshold is 13%. The position has fluctuated over the last six months with the AHP workforce reflecting higher turnover than target due to AHPs being a relatively small cohort of staff in small teams which artificially raises the percentage of turnover when the numbers of leavers may be only 1-2 staff. NMC and HCA staff groups have remained under target for the complete six-month period.

Turnover	Jul-21			Aug-21			Sep-21			Oct-21			Nov-21			Dec-21		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Total	**9%**	**12%**	**10%**	**9%**	**12%**	**23%**	**8%**	**11%**	**30%**	**9%**	**12%**	**37%**	**9%**	**12%**	**29%**	**11%**	**12%**	**29%**

Table 6: Turnover

5.6 Age profile

The age profile in the staff groups overall have not shifted greatly in the past six months and remain a relatively static position across all age groups. The exception to this has been noted in Nursing and Midwifery (Table 7) where we see an increase in 21–25-year-olds working in the Trust. The is likely attributed to newly qualified midwifes, who are often a younger workforce (but not exclusively so) commencing posts from September onwards. There remains a risk in Nursing and Midwifery to those who may retire now or in the next five years, however the numbers have positively marginally reduced since July 2021.

Staff Group	Age Band	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Nursing and Midwifery Registered	21-25	32	33	44	57	58	59
Nursing and Midwifery Registered	26-30	99	96	93	92	90	88
Nursing and Midwifery Registered	31-35	109	113	117	112	113	113
Nursing and Midwifery Registered	36-40	84	80	85	96	95	94
Nursing and Midwifery Registered	41-45	87	90	90	87	88	91
Nursing and Midwifery Registered	46-50	76	76	76	77	77	75
Nursing and Midwifery Registered	51-55	96	92	93	93	93	92
Nursing and Midwifery Registered	56-60	93	93	89	92	89	88
Nursing and Midwifery Registered	61-65	38	37	36	37	36	36
Nursing and Midwifery Registered	66-70	4	4	3	4	4	3
Nursing and Midwifery Registered	>=71 Years	1	1	1	1	1	1
Nursing and Midwifery Registered Total		**719**	**715**	**727**	**748**	**744**	**740**

Table 7 N&M age profile data

6. Trustwide Nursing, Midwifery and AHP Training and Personal Development Review (July 2021-December 2021 data; Q2 & Q3 position)

Across all staff groups it can be seen (table 8) that the achievement and performance of training (MT, CMT, LMT) and Personal Development Reviews (PDRs) has been a fluctuating position across the six-months. Trust targets for indicators are as follows:

- Core Mandatory Training (CMT) – 95%
- Local Mandatory Training (LMT) – 95%
- Mandatory Training (MT) – 95%
- PDR – 90%

None of the indicators were achieved over the six-month reporting period except for AHP as a staff group during October -December 2021 where LMT was achieved for three months. All Divisions continue to work to improve this position with oversight within Divisions.

NMC	Jul-21				Aug-21				Sep-21				Oct-21				Nov-21				Dec-21			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
Staff Group Total	77.07%	58.89%	81.18%	75.85%	80.88%	62.60%	83.11%	76.43%	79.09%	61.47%	81.65%	78.60%	78.70%	63.55%	82.00%	78.33%	77.48%	64.42%	82.68%	82.51%	75.94%	63.44%	82.56%	77.44%
HCA	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
Staff Group Total	79.54%	61.29%	79.33%	70.50%	77.23%	58.42%	84.21%	79.51%	77.55%	58.49%	86.08%	80.37%	76.39%	65.65%	87.38%	85.45%	76.91%	68.74%	87.06%	86.27%	75.75%	68.83%	86.64%	78.33%
AHP	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
Staff Group Total	82.65%	87.50%	83.76%	50.00%	84.00%	83.33%	88.89%	43.75%	86.00%	83.33%	89.63%	37.50%	86.54%	100.00%	91.99%	47.06%	76.74%	100.00%	93.79%	75.00%	79.45%	100.00%	92.68%	82.35%

Table 8: Training and PDR data

7. Measurement of Quality of Care

7.1 Clinical Incident Reporting

The Trust has a local incident reporting system (Ulysses) that staff access to report any patient safety incident that is unintended or unexpected which could have (near miss) or did lead to harm, allowing the organisation to investigate, learn and take action to prevent re-occurrence. Incidents related to staffing levels are an example of incidents reported.

The number of Trustwide clinical incidents reported within the last six months (July 2021-Dec 2021) can be seen in Table 9. The data further highlights the incidents related to staffing levels and/or staff sickness affecting staffing levels and is drawn from the overall incidents reported within the timeframe.

Of the total clinical incidents related to staffing Family Health Division had the largest volume of 195; (Maternity, 191; Neonatal, 4), Clinical Support Services (CSS) Division reported 20 and Gynaecology Division reported 29.

Reporting Period July 2021-Dec 2021 (Q2 and Q3)
Total incidents reported = 3701
Total clinical incidents reported = 3326
Total staffing levels / staff sickness incidents reported related to clinical incidents = 245 (1 incident relates to Corporate Services)

Table 9**:** Trustwide overview of incidents

Future reports aim to provide comparisons of incident reporting related to staffing and staff sickness impact over time.

7.2 Red flag events

NICE guidance (2014, 2015) recommends that the trust have a mechanism to capture "red flag" events (Appendix 2). The trust has incorporated the reporting of red flag events into the Trust incident reporting system. Incidents can be triangulated against acuity and dependency and planned versus actual staffing levels for the day. Triangulation of data assists with informed decision making related to staffing.

There were 163 red flags reported between July 2021-December 2021 with the majority reported in Maternity services. The breakdown of red flags is as follows: Maternity services,138; Neonatal Unit, 7; CSS, 7 and Gynaecology, 11.

Divisional oversight of Red Flags is reported into the Trust Integrated Performance Report each month.

7.3 Serious Incidents

As highlighted by the Serious Incident Framework (NHSE, 2015) serious incidents in health care are events where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant that they warrant attention to ensure these incidents are identified correctly, investigated thoroughly and trigger actions that will prevent them from happening again.

During July 2021-December 2021 there were a total of twelve serious incidents in the Trust. None occurred in either Neonatal services or CSS division. Eight occurred in Maternity (5 Treatment delays, 1 Divert, 2 Unexpected deaths). Four occurred in Gynaecology division (1 Unexpected death, 1 Treatment delay, 1 surgical/invasive procedure, 1 diagnostic incident).

7.4 Patient Experience - Friends and Family Test (FFT)

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. Guidance sets out the requirement of FFT under the NHS Standard Contract for organisations (NHSE/I, 2019).

A total of **4874** "Overall Experience" comments were received during the period July 2021 – December 2021.

Of these **331** (6.7%) comments were received by patients noting themselves as "displeased". Of these displeased comments **28** (8.5%) mentioned staffing numbers/shortages in their description of their experience. These mainly

related to Maternity services but did cover other areas also. The common theme identified related to a lack of support on the ward which the patients attributed to being understaffed.

Following changes in National FFT requirements commencing (2020) the Trust introduced an additional question and started to ask patients "please tell us anything we could have done better". In the period from July 2021 to December 2021, **2235,** comments were left in this section covering both Pleased and Displeased results. Of these, **80** (3.6%) identified staffing numbers/shortages as an area that needed to be improved. The majority of these related to Maternity services with common themes such as: waiting for pain relief; delayed discharge; need for extra support due to lack of partners being allowed due to COVID restrictions.

Other themes were seen in Gynaecology relating to delayed discharge and staff not answering the telephones in Gynaecology Emergency Department.

7.5 Complaints, Concerns and Compliments

There were **28** formal complaints received in the Trust during July 2021-December 2021. Of these complaints three complaint categories relate to staffing levels and of these two complaints were not upheld and one remains under investigation.

There were **13** PALS+ recorded during the reporting timeframe with **none** of these cases noting staffing as the main issue raised.

There were **1263** PALS cases noted within timeframe and of these **2** noted staff shortages as the issue raised.

There was a total of **68** compliments Trustwide received (via PALS) within the timeframe which broadly covered general satisfaction of the service provided, which includes staff groups and individuals. Of the **68** compliments the clinical divisions breakdown is: Gynaecology, 21; Maternity, 31; CSS, 4 and Neonatal 1. The remainder were in more than one area or in corporate services.

The NHS Adult Inpatient Survey 2020 (undertaken in Gynaecology) has been received by the Trust during this reporting period. Of the 9 categories where an overall rating was published for the Trust, Liverpool Women's overall scores were 'much better' compared to other hospitals in 2 categories and 'better' in a further 4 categories. Across all categories the Trust was rated either better or in line with other NHS hospitals across the country. The results highlight 5 areas that require improvement which have been supported by a divisional action and improvement plan.

The Maternity Survey which runs every other year is a requirement for all eligible organisations in England to conduct the survey. The survey aimed to look at experiences of women that had a live birth in February 2021 to take part in the survey. The results are anticipated in February 2022.

7.6 Staff Experience

Whilst operational controls are in place to support safe and effective use of staff to maintain safe patient case it is recognised that deploying staff can impact upon staff morale. Future reports will examine the extent of any impact on staff to improve how we continue to manage.

The reported incidents related to verbal or physical acts of violence or aggression against staff is during July 2021-December 2021 is recorded as twenty (16 in clinical areas; 4 in non-clinical areas). Five of these incidents relating to patients or visitors challenging covid rules and one of the incidents was a physical assault with remainder verbal assault.

The Trust staff survey results for December 2021 show an improvement in statistically positive responses in the areas of health and wellbeing and reporting of violence at work. Areas of understanding and improvement relate to the Trust as a Great Place to Work and as a place to receive treatment. There is continued emphasis on hearing staff views to make improvements on their experience.

8. Attraction, Recruitment and Retention

LWH continues to engage and support plans within the North-West Maternity Region on International Recruitment (IR) as part of a collaborative bid hosted by Wrightington, Wigan and Leigh NHS FT. We are expecting 8 international recruits in Midwifery to commence in the Trust following successful completion of OSCE and entry onto the NMC register in Summer 2022. Timescales of the IR staff arriving are dependent on ongoing challenges around the Covid-19 pandemic with current progress reports highlighting perspective recruits being interviewed in February 2022. Initial conversation to engage and progress IR in Theatres with plans to have 10 WTE to progress further during 2022.

The Trust recruited 27.64wte Newly Qualified Midwives in September-October 2021. Additionally, 2.0wte registered midwives were commenced on a bespoke programme after qualifying for a year.
Continuous recruitment of newly qualified nurses and midwives continues as students qualify and in line with vacancy position across all divisions.

The Trust attraction strategy includes a rolling advert for posts in Maternity as the service with the largest challenge with all divisions adopting a similar approach until they reduce or resolve their vacancy position.

LWH has been successful in bidding for two sources of NHSI funding to be used to support Midwifery and Health Care Support Workers (HCSW) retention and ongoing support. The funding will be used to support midwifery experience of work, promote retention, and locally support return to practice learners. HCSW monies will support the recruitment of HCSWs without prior experience, support career conversations with HCSWs and provide pastoral care and support to reduce attrition.

To support ambitions a Staff Engagement and Retention Midwife has been appointed for twelve months with plans to recruit a HCSW Development and Support Lead and a HCSW Peer Support Lead, both for six months to create and embed an infrastructure that supports attraction, recruitment, and retention.

9. Actions and recommendations:

The following actions are proposed during next six months (January 2022 - June 2022):

- Staffing establishment reviews incorporating refreshed headroom calculations
- Future training requirements be considered with a calculation of headroom annually

- Any agreement to new training be planned to commence at start of each financial year (unless regulatory requirement to commence sooner)
- Gynaecology to review establishment further utilising the Safer Nursing Care Tool (SNCT) following a Trust sign off process from the National Team
- Future bi-annual staffing reports to continue in current format and will provide comparisons of current alongside previous positions to demonstrate improved or deteriorated positions
- Include bank and agency fill rates from NHSP in future reporting
- Deputy Director of Nursing and Midwifery to work closely with Workforce Information Manager to pull data relevant and specific to the reported staff groups by month with sign off by HR Business Partners and Heads of Nursing, Midwifery and AHP
- Develop corporate teams Business Continuity Plans (BCPs) to support Divisional BCPS and Winter Preparedness aimed for completion by August 2022 overseen by relevant Deputy Directors.

10.0 Conclusions

The Trust Board are asked to recognise that managing Nursing, Midwifery and AHP staffing is not without risk (as noted on the Corporate Risk Register), however this is effectively managed by utilising a triangulated approach and through a series of actions, escalations, and mitigations to support the delivery of safe patient care.

The Trust Board are asked to note the actions and recommendations highlighted in Section 9.0 of the report that have been agreed and supported by the Putting People First Committee.

Furthermore, the Trust Board are requested to take assurance that divisional level oversight and actions to address areas of challenge is in place. Specifically noting that Maternity services report staffing twice yearly directly to Putting People First Committee and Trust Board to fulfil requirements as outlined by The Maternity Incentive Scheme (MIS) Year 4. Neonatal services provide Trust Board with a yearly Clinical Negligence Scheme for Trusts (CNST) compliance report.

Appendix 1 – CHPPD and Actual versus Planned Fill Rates

The Unify Return- Safe Staffing Fill Rate each month are noted as per below from July 2021-December 2021. The data is presented monthly to Trust Board via the Integrated Performance Report, supported by a detailed narrative and triangulation of information from the Heads of Nursing and Midwifery.

July 2021

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % 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%

August 2021

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	66.5%	112.9%	87.1%	187.1%
Induction & Delivery Suites	89.6%	108.1%	96.0%	93.5%
Maternity & Jeffcoate	66.8%	88.7%	66.8%	99.1%
MLU	66.9%	74.2%	71.8%	90.3%
Neonates (ExTC)	98.1%	56.5%	95.1%	91.9%
Transitional Care	90.3%	109.7%	129.0%	51.6%

September 2021

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	65.33%	110.00%	90.00%	206.67%
Induction & Delivery Suites	98.46%	95.00%	94.10%	90.00%
Maternity & Jeffcoate	76.19%	85.71%	63.81%	85.19%
MLU	35.83%	43.33%	55.00%	70.00%
Neonates (ExTC)	95.61%	65.00%	93.51%	83.33%
Transitional Care	96.67%	90.00%	156.67%	76.67%

October 2021

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	67.7%	111.3%	89.2%	183.9%
Induction & Delivery Suites	96.3%	101.6%	95.0%	92.5%
Maternity & Jeffcoate	67.7%	92.1%	53.5%	91.7%
MLU	39.5%	48.4%	56.5%	54.8%
Neonates (ExTC)	96.1%	69.4%	93.9%	77.4%
Transitional Care	90.3%	87.1%	83.9%	41.9%

November 2021

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	70.0%	98.3%	84.4%	193.3%
Induction & Delivery Suites	96.2%	80.0%	103.3%	85.6%
Maternity Base & Jeffcoate	78.6%	76.8%	65.7%	87.0%
MLU	87.5%	46.7%	74.2%	83.3%
Neonates (ExTC)	96.1%	73.3%	95.4%	80.0%
Transitional Care	80.0%	63.3%	96.7%	46.7%

December 2021

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	66.45%	80.65%	79.57%	167.74%
Induction & Delivery Suites	87.10%	100.00%	86.10%	80.65%
Maternity Base & Jeffcoate	64.06%	71.55%	56.22%	88.29%
MLU	72.58%	41.94%	68.55%	58.06%
Neonates (ExTC)	94.91%	98.39%	94.57%	88.71%
Transitional Care	70.97%	106.45%	83.87%	74.19%

CHPPD

CHPPD	July-21	Aug -21	Sept-21	Oct-21	Nov-21	Dec-21
Trust wide	6.2	7.3	7.2	7.8	8.0	8.1

Appendix 2: NICE Guidance on Red Flag Events

Midwifery Red Flag Events (NICE NG54-Safe midwifery staffing for maternity settings, 2015)

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Other midwifery red flags may be agreed locally.

Nursing Red Flag Events (Nice SG1 – Safe staffing for nursing in adult inpatient wards in acute hospitals, 2014)

A nursing red flag event is a warning sign that something may be wrong with nurse staffing. If a red flag event occurs, the nurse in charge of the service should be notified. The nurse in charge should determine whether nurse staffing is the cause, and the action that is needed.

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
    - Pain: asking patients to describe their level of pain level using the local pain assessment tool.
    - Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
    - Placement: making sure that the items a patient needs are within easy reach.

- Positioning: making sure that the patient is comfortable, and the risk of pressure ulcers is assessed and minimised.

- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).
- Less than 2 registered nurses present on a ward during any shift.

Other nursing red flag events may be agreed locally.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/009f*	Date: 07/04/2022
Report Title	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	
Prepared by	*Angela Winstanley – Maternity Quality & Safety Matron* *Marie Forshaw – Chief Nurse and Midwife*	
Presented by	*Marie Forshaw – Chief Nurse and Midwife*	
Key Issues / Messages	This report outlines the scheme requirements for compliance required to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year 4 and the Trust's current status against this. Specific information is required to be noted by the Board. This relates to the following: • Safety Action 4 - Neonatal Nursing Workforce (Appendix A) • Safety Action 4 – Neonatal Medical Workforce (Appendix B) • Safety Action 9 - Perinatal Surveillance Dashboard Update (Appendix C)	

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

	The Board is asked to:
	• ***Receive the current position in relation to CNST Year 4***
	• ***Note the specific updates in relation to:***
	  ○ ***Neonatal Nursing Workforce***
	  ○ ***Neonatal Medical Workforce***
	  ○ ***Perinatal Surveillance Dashboard Update***			

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

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☐

Strategic Objective(s)

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

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

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

- Neonatal Nursing Workforce (Appendix A)
- Neonatal Medical Workforce (Appendix B)
- Perinatal Surveillance Dashboard Update (Appendix C)

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

Introduction

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

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

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

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

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

Trusts must meet the following compliance conditions:

- Trusts must achieve all ten maternity safety actions.

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

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

- Trust submissions will be subject to a range of external validation points, these include cross checking with: ---
  - MBRRACE-UK data (safety action 1 standard a, b and c),
  - NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, standard 2 and 3),
  - National Neonatal Research Database (NNRD)

- HSIB for the number of qualifying incidents reportable (safety action 10, standard a)).
- Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

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

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

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

Scheme Safety Actions.

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

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

Scheme Management

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

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

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

Current Position for Year 4

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

Safety Action Point	Description	Issue / Update for consideration	Status RAG
SA.1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Leads: Ae Wei Tang – Obstetrics Rebecca Kettle – Neonates Angela Winstanley – Midwifery	A. i) 100% all deaths have been reported to MBRRACE within the seven working day timeframe with 100% of deaths having surveillance completed within one month to date. ii) 93% - 41 of 44 cases have had their review started within two months of the death, standard is 95%. The inherent risk with this safety action is that if there is failure to review and report in the recognised timeframe this would become failure to achieve this criterion compliance and would therefore preclude LWH from achieving CNST Year 4. By way of assurance processes, to ensure that compliance is achieved the FHD have implemented actions to ensure timely commencement of case reviews. This will be managed and owned by the safety action leads reporting to clinical leads via FHDB and the governance process for CNST (Appendix 1). Since the pause in the reporting period against the scheme was introduced, we have continued to surveillance report and commence reviews of all applicable deaths in line with the scheme guidance. This data is complicated by the scheme pause, as the MBRRACE-UK reporting system has started to record the deaths of babies, in this pause period as not applicable. If we are to disregard the data of perinatal mortality cases reported in the pause, our current compliance rate would sit at 84%. B. All reports are either in draft format or are planned to be in draft status by the timeline for CNST. C. 100% of families have been informed and offered involvement in the review of their care and that of their baby. D. Q1 21/22 Learning from Deaths Report. - Submitted to QC Sept 21 - Submitted to Trust Board - Nov 21. Q2 21/22 Learning from Deaths Report. - Submitted to QC Nov 21. - Submitted to Board Dec 21. Q3 21/22 Learning from Deaths Report. - Submitted to QC Feb 21	
SA.2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? Leads:	Head of Information has received the following update from NHSD in relation to the scheme guidance and pause period. Safety Action leads do not anticipate any difficulties with the data provision within this safety action unless there was an unanticipated request for data.	

	Richard Strover & Hayley McCabe	**CNST Safety Action 2 – submitting data to the maternity services dataset (MSDS)** A letter was circulated to trusts from NHS Resolution in December notifying of a minimum three month pause in the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, due to the impact of the Omicron variant on frontline services. This is being kept under review by NHS Resolution. In relation to Safety Action 2, this means that trusts will no longer be assessed on their MSDS data in January. However, trusts should continue to make every reasonable effort to make a submission to MSDS and to apply the principles of the 10 Safety Actions. Revised guidance on the scheme will be published later in the year, once the situation has been reviewed. Following feedback received, the decision has been taken to revise the CNST Maternity Incentive Scheme Safety Action 2 criteria relating to personalised care and support plans (PCSP). Due to this revision the existing metrics relating to PCSP have been removed from the Maternity Services Monthly Statistics publication series. Guidance on the new criteria and timescales for assessment will be released in the next update to the Maternity Incentive Scheme year 4 guidance and reflected in this publication series once available.	
SA.3	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? Leads: Anna Paweletz– Neonates Sarah Kildare – Neonates Paula Nelson – Neonates Kate Alldred – Obstetrics	All workstreams on track. ATAIN Action Plan has been shared with the LMS. All Transitional Care and ATAIN audits are on track, no delays anticipated with Quarter 4 audits. All requirements for Safety Champion reviews have been complete and will be minuted formally through the Safety Champions meetings.	
SA.4	Can demonstrate an effective system of clinical workforce planning to the required standard? Leads: Alice Bird – Obstetrics	Obstetric Workforce – Paper submitted to Trust Board in December 2020, outlining the current obstetric position as outlined in the RCOG Workforce document. Requirement for action plan to be formulated by Clinical Lead for Obstetrics and monitored by Clinical Lead for Maternity Neonatal Nursing Workforce – Please see **Appendix A** Neonatal Medical Workforce – Medical workforce paper – Please see **Appendix B**	

	Christopher Dewhurst – Neonates Neonatal Nursing – Jen Deeney Anaesthetic Workforce – Rakesh Parikh	Anaesthetic Workforce – Rakesh Parikh – This paper will be made available for the April 2022 Board.	
SA.5	Can demonstrate an effective system of midwifery workforce planning to the required standard? Leads: Alison Murray – Interim Head of Midwifery	Full Birth-rate Plus and Maternity Staffing paper received at Trust Board in February 2022. Trust Board paper covered all aspects of the evidential requirements. A further detailed midwifery staffing analysis should be expected to Quality Committee and Trust Board by June 2022.	
SA.6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version 2? Leads: Alice Bird – Obstetrics Angela Winstanley – Midwifery	All Safety Actions within this element are on track for compliance, with action plans and audit standards monitored through the CNST Assurance meeting. An identified risk of the lack of compliance to the CO screening in pregnancy programme at 36 weeks has been rectified. An anomaly with the K2 System since the optimisation update in November has been corrected, with cross divisional input and screening rates are now reported to be >85% for February at the 36wk appointment. This data compliance is being monitored closely the Head of Information, COO, Chief Nurse and Midwife and CNST Assurance meeting. A further identified risk that has been identified with this safety action is the implementation of a formal risk assessment of fetal growth restriction at the 20 week anomaly USS. The MIS requires compliance of 80% of completed risk assessments, however these risk assessments are not yet embedded into standardised midwifery care provision as per NICE guidance. In order to meet this requirement additional midwifery workforce within the antenatal clinic has been identified at 2.0 WTE. This will be an additional cost and will need to be resourced with midwifery staffing capacity.	
SA.7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services? Leads: Gill Diskin – Midwifery Alison Murray – Midwifery Hannah Sloan – MVP Chair.	Safety Action Lead working with MVP Chair to collate required evidence to demonstrate compliance with safety standards. The Chief Nurse and Midwife has contacted the LMS Lead to request assurance in relation to the MVP work plan and strategy. Assurance has been provided to the Chief Nurse and Midwife that the continue collaborative work between LWH and the MVOP will support this strategy. No issues reported.	

SA.8	Can you evidence that at least 90% of each maternity unit staff group attendance an 'in-house' multi-professional maternity emergencies training session within the last year. Leads: Alison Murray – Midwifery Jonathon Hurst – Neonatal	There is a formal maternity training plan which incorporates all the requirements of the Core Competency Framework in accordance with this safety action. This has been tabled and approved by the FHDB and acknowledgment given to recognise the staffing shortages during COVID have disrupted progress. However, we are endeavouring to meet full compliance prior to submission with the acknowledgment that staffing, and sickness absence are risk to the 90% compliance target. The LWH Maternity TNA has been shared with the Cheshire & Merseyside LMS and it has been confirmed that we are compliant with training requirements and have a validated training programme. Owing to the quality of the maternity TNA provided by LWH the LMS have asked for this to be used as a template for the maternity providers within the Cheshire & Merseyside region.	
SA.9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on Maternity and neonatal safety and quality issues? Leads: Rachel McFarland – Obs Safety Champion Angela Winstanley – Midwifery Safety Champion Fauzia Paize – Neonatal Safety Champion.	There are robust processes in place feeding into the Trust Board monthly via the Perinatal Clinical Quality Dashboard – please see updated version in Appendix C The Trust are now in receipt of the Cheshire and Merseyside LMS Provider Trust Board information pack and will review the governance processes described in the document that support how the Safety Champions will provide the LMS of assurance of perinatal safety.	
SA.10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme? Leads: Laura Thorpe Governance.	All cases required have been reported to HSIB. All families have had information on HSIB and Early Notification/NHSR Scheme All DOC duties undertaken. Information pertaining to HSIB reporting is included in the Perinatal Quality Surveillance Paper aswell as the Trust Board Performance Report. A full breakdown of all activity pertaining to HSIB, Duty of Candour will be presented to QC and Trust Board when the MIS scheme is re-released after the scheme pause.	

Conclusion.

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

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

Neonatal Staffing Review

January 2022

J. Deeney /S.Oneil /J. Kearney/R. Reeves

Appendix A

Brief overview of Service/ Ward/ Department

1. This paper is to provide assurance to the Committee that the Neonatal Services workforce is safe and sustainable and is capable of delivering services now and in to the future.

2. **Background**

Overview of the Neonatal Workforce Makeup

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).

The majority ANNP's have studied to Master's level qualification over a two-year period to complete and gain required competencies. The ANNP's will have also completed a non-medical prescribing course. The level of training received by ANNP's allows them to work on the Tier 1 and Tier 2 of the medical rotas. This is fully supported by BAPM standards and in line with expectations set out in the new national framework for Advanced Clinical practice.

Currently, we have a small number of un-registered staff who work within the low dependency (LD) nursery and the transitional care unit (TC). They are responsible for most of the delivery of care to the babies within these areas with the only limitation being the inability to give certain medications. This is an area of nursing that needs further development, and this is recognised nationally. Currently, there are no bespoke neonatal trainee associate (NTA) courses. However, we are working with local universities to create an appropriate training model for future NTA's and hope to have our first NTA later this year.

TC can be defined as "care at the mother's bedside". In the delivery of this model of care, midwives care for the mothers and neonatal staff support mothers in caring for their babies to prevent un-necessary separation, which an admission to the Neonatal Unit would cause. These babies include babies requiring an intervention or support with feeding and weight gain. LWH has a standalone TC with its own budget and staffing.

Neonatal Community Outreach is also supported by the TC team. This is provided 5-6 days a week for babies from both the Neonatal Unit and Transitional Care, this allows a smooth and confident transition home.

It is accepted nationally the NICU is a difficult to recruit to area and this is reflected in the national shortage of neonatal nurses. BLISS (2015) reported in their "hanging in the balance report" that only 14% of units in England had enough staff to manage the current demand. The national critical care review (2020) acknowledged this by making £50 million available to address the shortage of both cot side nurses and nurses within quality roles in neonatal units.

This is further compounded by the fact that we have an aging workforce and because of the shortage of junior Doctors we now need more ANNP's to help cover the service, however, we must be mindful that this may create senior nursing gap which may impact service in later years.

At LWH we continue to be very successful in the recruitment of staff there is a current vacancy rate of approximately 8%, there is an expectation that these vacancies will be filled before end of quarter 4. We have also had great success with internal recruitment and our talent pool is now embedded within our internal recruitment process at all grades of registered staff. Turnover remains well below the trust average at 9%.

Appendix A

For newly qualified staff or those appointed without previous neonatal experience they are enrolled on the Neonatal Induction Programme, this is run jointly with Northwest Neonatal Operational Delivery Network. This programme provides these nurses with the theoretic knowledge and clinical skills required to look after the sick preterm or newborn infant with complex needs. The course runs over 6 months., this year the team are looking at how this course can be condensed to meet the needs of those who already have experience. All staff have an induction period of 6-8weeks, more or less dependent on the individual, and during and after this time they will work closely with their mentor and the education team.

Following a 12-month consolidation period, staff are then progressed on to the Neonatal Qualification in Speciality course (QIS) to enhance their knowledge and skills. LWH run the QIS course and it is validated by Liverpool John Moore's University at Level 6, and it is a requirement that at least 70% of our staff hold this qualification. (DoH, 2009, Toolkit for High Quality Neonatal Services).

Nurses on NICU are also responsible for the delivery of the IV antibiotics **and** BCG immunisations for all eligible babies born at Liverpool Women's.

3. Activity

Activity has remained consistent over the last 12 months. Unit occupancy has run at an average of 81.4%, this is just over the expectation of 80% set by BAPM standards. All clinical areas, IC, HD, LD have had peaks and troughs throughout the year. With IC running at 96.9% in the last quarter of the year.

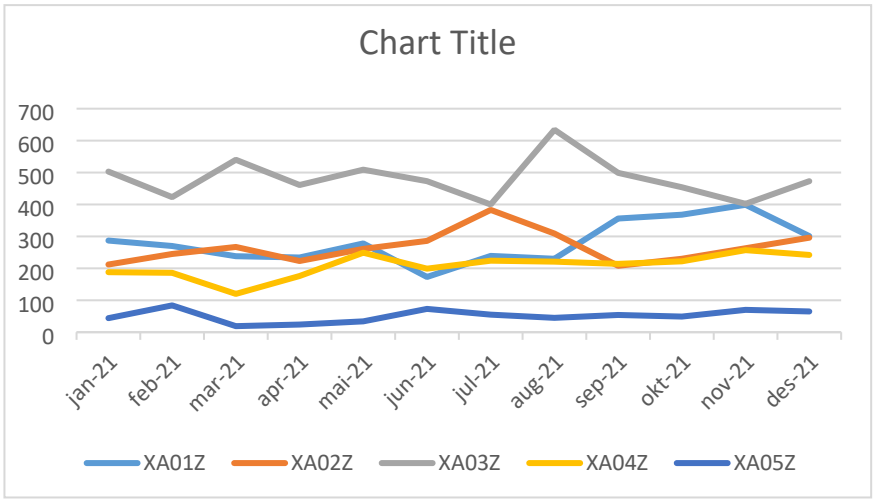


Fig. 1 Unit Activity

HRG Code	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Total
XA01Z	287	270	238	234	278	173	239	230	356	368	399	301	**3373**
XA02Z	212	245	267	223	261	286	383	309	208	230	263	296	**3183**
XA03Z	503	423	540	461	509	473	400	634	499	454	402	473	**5771**
XA04Z	188	186	120	176	249	199	224	221	214	222	257	242	**2498**
XA05Z	44	84	19	24	34	73	55	45	54	49	70	65	**616**
	1234	**1208**	**1184**	**1118**	**1331**	**1204**	**1301**	**1439**	**1331**	**1323**	**1391**	**1377**	**15441**

4. 0 Staffing

Appendix A

4.1 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. BAPM standards can be reviewed in the link below.

http://www.bapm.org/publications/documents/guidelines/BAPM_Standards_Final_Aug2010.pdf

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 we maintain safe and appropriate levels of staffing.

https://improvement.nhs.uk/resources/safe-staffing-neonatal-care-and-children-and-young-peoples-services/

Some of the standards set are listed below.

1. Nursing ratio's IC 1:1, HD 2:1, LD 4:1
2. Supernumerary Shift Leader 24/7. The shift leaders work clinically for the majority of their shifts (90%) with administration time for managing their teams, PDR's etc.
3. 70% QIS

There is also a requirement to have quality roles extra to the establishment; these include education, breast-feeding, infection control, development care.

The above requirements have been included in the Neonatal staffing budgets for 2021/2022. These budgets are rota based and were reviewed and agreed by the Head of Neonates and the Deputy Director of Nursing & Midwifery. The 2022/2023 rota will be completed in the last quarter

Please refer to Appendix 1: Neonates Agreed Rota 2021 (including 21% headroom)

4.2 CRG Workforce Tool – Nursing

The Maternity incentive scheme stipulates the use of the CRG Workforce Tool to achieve compliance and this be clearly stated in the technical guidance, See below

Technical guidance Neonatal nursing workforce where can we find more information about the requirements for neonatal nursing workforce?

The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, the Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies

The CRG Workforce calculator looks at staffing in relation to activity. It considers a multiplier of 6.07 wte for 1 nurse per shift, supernumerary shift leader and only gives the requirement for cot side nursing.

This tool gives assurance of the following.

Appendix A

- The establishment in place meets the current needs of activity within the unit ensuring that safer staffing is maintained.
- While there appear to be a small difference in the requirements of staff needing QIS to match activity, it can be noted that minimum standards of 70% of staff QIS is met and exceeded. There are currently 12 staff undertaking the QIS and they will complete their course in Summer 22.
- 93.5% are registered staff

Please see the tool below;

Neonatal Nursing Workforce Tool (2020): Neonatal

Input unit details			
Trust	LWH		
Unit	Neonatal		
Designation	NICU		
Completed by	J. Deeney/J.Kearney		
Date completed	24/02/21		
Activity period	2018/19	Days in period	365

Input activity (HRG 2016)		
	Activity	Declared cots
HRG 1 (IC)	3,393	12
HRG 2 (HD)	3,150	12
HRG 3 (SC)	5,812	20
Total	**12,355**	**44**

Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	106.40	106.50
Total Non QIS	28.07	24.32
Total Non Reg	11.97	8.50
Total	**146.44**	**139.32**

Activity (HRG 2016)							
	Activity	*For calculations*		Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	3,393	*11.6*	*6.07*	12	77.47%	12	0
HRG 2	3,150	*10.8*	*3.04*	12	71.92%	11	1
HRG 3	5,812	*19.9*	*1.52*	20	79.62%	20	0
Total	**12,355**			**44**	**76.93%**	**43**	**1**

Appendix A

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 145.68, of which 101.98 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	146.44	139.32	139.55	6.89	-0.23
Total reg nurses	134.47	130.82	130.49	3.98	0.33
Total QIS	106.40	106.50	109.34	-2.94	-2.84
Total non-QIS	28.07	24.32	21.14	6.93	3.18
Total non-reg	11.97	8.50	9.06	2.91	-0.56
Reg nurses as % nursing staff	91.8%	93.9%	93.5%		
QIS as % reg nurses	79.1%	81.4%	83.8%		

Assumptions For further detail please refer to the narrative sheet.

- Calculations are valid for neonatal unit only - transitional care staffing and activity should be excluded.
- 6.07 WTE is required for 1 nurse per shift. The detail of how this multiplier was calculated is on a separate sheet.
- Staffing requirements are based on activity, and BAPM nurse to baby ratios are used, ie IC 1:1; HD 1:2; SC 1:4.
- Numbers are for nurses **providing direct patient care only**. Exclude additional roles e.g. management, outreach, education.
- A supernumerary nurse in charge is included for all units on all shifts.
- At least 70% of registered nurses should be Qualified In Specialty (QIS).
- All intensive and high dependancy care should be undertaken by registered nurses with QIS training.
- For special care, registered to non-registered staff ratios are calculated at 70:30.
- Cot calculations assume that cots can be flexed up but not down, so round up to the higher level cots. See narrative for more detail.

If we look at these figures, we know that the majority of BAPM standards are met, but it must be highlighted that this is only in relation to cot side nursing and does not take in account the other roles required within a tertiary service. While we have had a reduction in activity, what this has enabled us to do is to move towards being BAPM compliant.

The CRG tool focuses on the cot side nurses however there are many quality roles that all need to be included with the delivery of neonatal care to ensure that standards are met and maintained. Some of these are listed below.

- Education team
- Breast feeding team
- Palliative/ Bereavement care
- Discharge Co- Ordinator
- FiCare/ Care Co-Ordinator
- Developmental Care
- ROP team
- Surgical specialist Nurse
- Tissue Viability Nurse
- IPC Team

Appendix A

- Risk Lead/Safety Champion
- Outreach Team

Currently there is some provision within LWH for these roles however, most are supported from cot side nurse establishment.

A gap analysis (Appendix 3) was carried out by the NWNODN, and it was shown that there is a gap of approximately 12 wte within these roles. While as a unit we meet the BAPM standard for cot side nursing the service falls short of those quality roles.

The review of neonatal critical care services has seen an additional funding been made available this year with unit receiving funding for cot side nursing. LWH did not receive any finding which was expected in line with the results of the CRG workforce tool, however, we are anticipating that we will receiving funding to help support quality roles. This will be recurrent monies.

Below is a synopsis of where we are in relation to standards set by BAPM.

Standard	Achieved/ not achieved	Rationale/Action
Ability to meet care ratio's set by BAPM	Achieved	This in the whole is achieved by the NICU. Depending on activity and acuity, this at times can be challenged but staffing is always within the limits of safety. However, it must be also noted within these bedside figures staff are also responsible for quality roles, FiCare, Developmental care, breastfeeding and extended roles such as ROP, cannulation, discharge planning.
70% staff qualified in speciality (QIS)	Achieved	77% staff are qualified in speciality
Supernumerary shift leader	Achieved	There is always a senior band 6/band 7 as supernumerary shift leader 24/7. Where we are challenged on this is the expectation that in a tertiary level unit this should be at band 7 level. However, the new CRG tool does not stipulate the number of bands 7's on the unit so we move from partially achieved to fully achieved

New staff complete the neonatal Induction Programme		All staff are put forward for NIP

4.3 ANNP

The role of the ANNP is widely acknowledged as being essential to the provision of continuity of safe and effective care to sick and vulnerable new-born infants. The ANNP role is to assume total management of the neonate, that is, to make medical diagnoses, to order medication, and to plan management under the supervision of a neonatologist. The ANNP can instigate investigations, prescribe medications, and perform procedures previously undertaken by a doctor and at LWH neonatal care provision is integrated between the ANNP and medical teams to provide a balanced skill mix of care.

ANNPS work across 4 pillars of advanced practice, providing.

- Expert clinical care
- Education to neonatal nurses, junior ANNPS, all grades of medical staff
- Leadership – Clinical leadership to junior medical staff and neonatal nurses, involvement in clinical incident reviews/ mortality reviews/ addressing complaints/
- Research – involvement in multiple neonatal research trials / audit / quality improvement

There have been ANNPs working in NICU at LWH since 1995, with a sharp increase in recruitment to the ANNP team since 2016, with annual recruitment of trainee and trained ANNPS. The successful recruitment has been as a result of active succession planning and careful workforce planning to be in a position to provide a skilled ANNP workforce to staff the new 22 bed surgical neonatal Intensive care unit, in addition to accounting for changes to neonatal training for paediatricians which will lead to a reduction in experienced medical staff working on neonatal units in the next five years.

This recruitment reflects the ambition of the HEE national framework for ACP in line with the NHS 5 year forward view and LWH 5 year forward strategy. ANNPs at LWH all meet the e portfolio requirements of the Academy for Advancing practice, and are in the process applying for their personal e portfolio credentials

There is a skill mix structure to the ANNP team which can be compared to BAPM tier 1 and 2 medical staffing. With a senior tier working at above BAPM tier 2 level.

In May 2021 5 new lead ANNPS were appointed – uplifted from their 8a senior ANNP roles. Each lead ANNP line manages a small group of 6 ANNPs with responsibility for managing sickness and absence, mandatory training, and annual appraisals

This is illustrated in the table below.

Tier 2+	Number	Comments
Nurse Consultant 8b	1	
Lead ANNP 8b	5 (4.36 WTE)	+1 vacancy be appointed Feb 22 internal from existing senior group
Senior ANNP Band 8a	8 (7.56 WTE)	
Tier 2		

Appendix A

ANNP Band 8a	12 (11.72 WTE)	+1 new applicant to start Apr 22 (external recruitment)
Tier 1		
ANNP Band 7	4	In training qualify Sep 2022
Total	30 (27.64 WTE)	

Fig. 2 ANNP Team

ANNPS currently provide 24/7 cover to NICU at LWH, 12 hours at Alder Hey Surgical Neonatal unit and 4 x 12 hour shifts to Connect NW neonatal transport team.

Tier 2 ANNPs wishing to work at tier 2+ level complete local competency assessment, assessed by neonatologist and nurse consultant, they also have bespoke neonatal transport training provided by Connect NW

Tier 1 ANNPS wishing to work at tier 2 level complete a 1-year post qualification consolidation period before competency is assessed to work as 8a.

In future all competencies will be available as e portfolio which is standardised for all ACPs to provide assurance of up-to-date competent advanced level practice.

5.0 Workforce KPIs

5.1 Sickness Absence

Sickness absence in the service has seen fluctuations since March 2021 with the service reporting a sickness rate of 11.19% as at December 2021. It can be seen from the graph below that this increase in month is mainly attributable to increasing COVID-19 cases of the Omicron wave given absence for this reason accounted for 4.5% of unavailability.

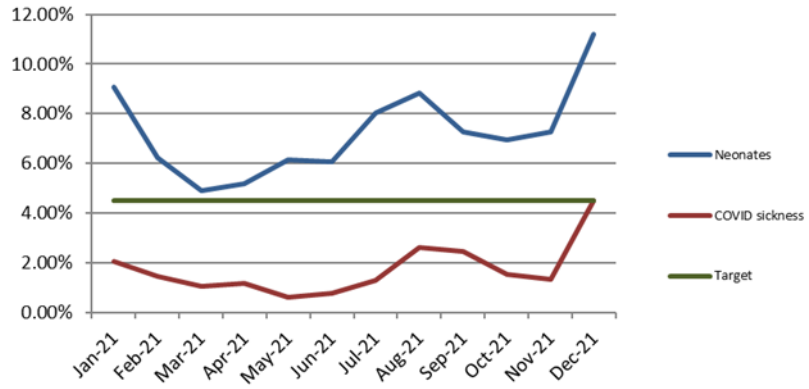


Fig. 3 Sickness Absence

In terms of the reason for absences, across a 12-month period, the main reason given is anxiety/stress/depression/other psychiatric illness which accounts for 32.7% / 36 absence occurrences, followed by cough/cold/flu at 27.3 % / 159 absence occurrences and gynaecological disorders at 9.9% / 21 absence occurrences. Stress/anxiety typically leads to longer absence periods hence the smaller total figure reported above in terms of occurrences in comparison to the other top reasons detailed.

When reviewing sickness absence further, the highest levels are within the unregistered positions of Healthcare Assistants and Healthcare Support Workers, followed by registered staff then Admin and Clerical.

Appendix A

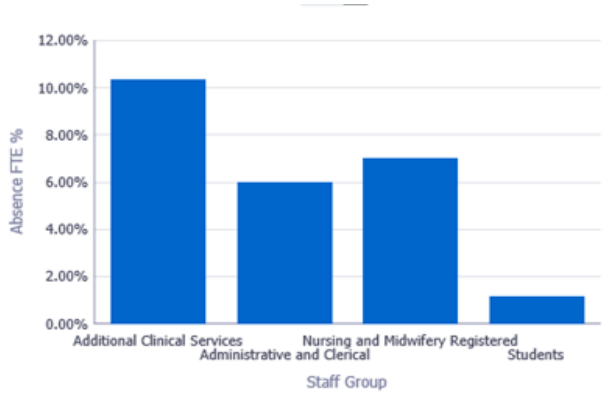


Fig 4: Sickness by group

Active management continues within the service and the work ongoing evidenced a positive improvement in both long terms sickness and short-term sickness moving into July 2021 and August 2021 respectively as shown in graph 3.0 below. It can be seen that the reduction in short term sickness was a trend across 3 months', then impacted by COVID-19 in the current month as referenced above; it is anticipated that this increase is short term in nature given COVID-19 infection rates locally and nationally are decreasing.

The long-term data in December 2021 represents 7 cases of which 2 cases have been resolved in January 2022 with 2 further planned phased/supported returns scheduled in February 2022. The remaining cases are complex linking to mental health matters, bereavement and COVID-19. All are actively management appropriately and in accordance with current policy.

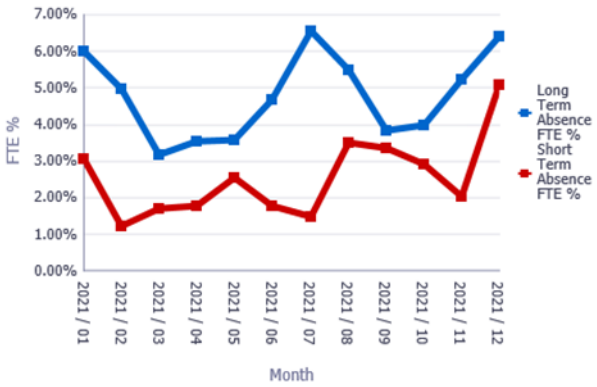
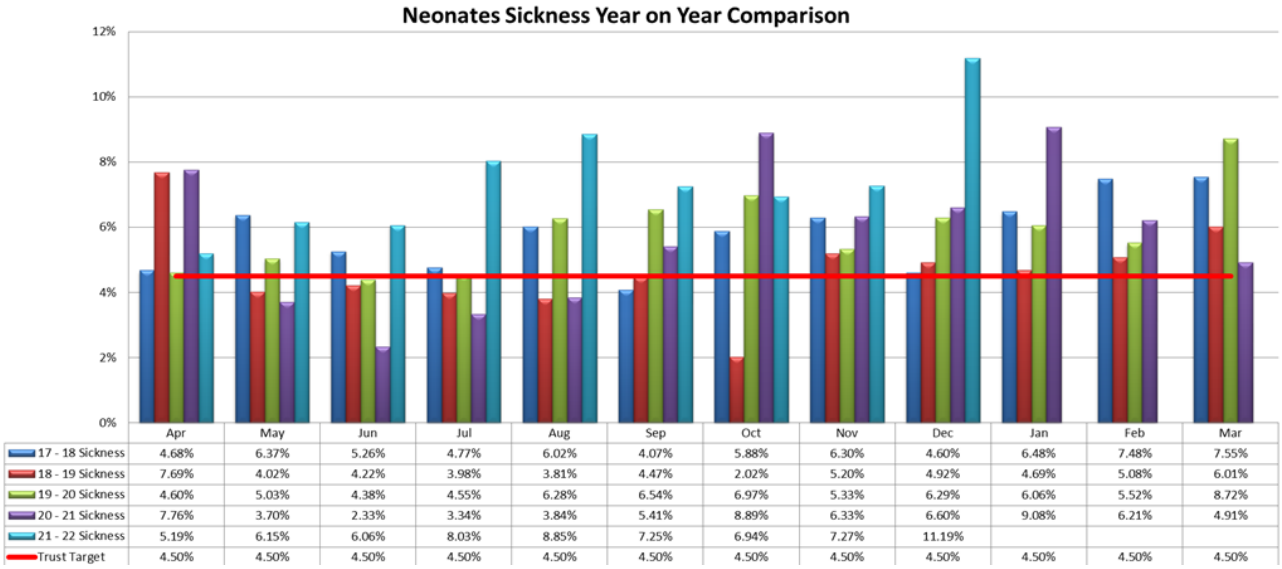


Fig.5: Long term Sickness

The 12-month rolling sickness absence rate for the service stands at 7.55%, with the overall 12-month trend shown in the graph below, along with a further look back across the last five years.

Appendix A



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17 - 18 Sickness	4.68%	6.37%	5.26%	4.77%	6.02%	4.07%	5.88%	6.30%	4.60%	6.48%	7.48%	7.55%
18 - 19 Sickness	7.69%	4.02%	4.22%	3.98%	3.81%	4.47%	2.02%	5.20%	4.92%	4.69%	5.08%	6.01%
19 - 20 Sickness	4.60%	5.03%	4.38%	4.55%	6.28%	6.54%	6.97%	5.33%	6.29%	6.06%	5.52%	8.72%
20 - 21 Sickness	7.76%	3.70%	2.33%	3.34%	3.84%	5.41%	8.89%	6.33%	6.60%	9.08%	6.21%	4.91%
21 - 22 Sickness	5.19%	6.15%	6.06%	8.03%	8.85%	7.25%	6.94%	7.27%	11.19%			
Trust Target	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%

Fig.6: Rolling absence

There are current mechanisms in place across the service to ensure sickness absence is actively managed, these interventions include

- Use of a local sickness absence tracker to monitor short term triggers, long term absence meetings and trends in sickness absence reporting reasons; this also ensures appropriate stages are in place and timeliness of meetings can be tracked as early intervention is vital
- Weekly oversight between Head of Nursing/Matron
- Weekly COVID-19 reporting
- Weekly oversight with Executive Team
- Monthly HR catch ups with the line managers
- Monthly reporting to Divisional Board

5.2 PDR Compliance & Mandatory Training

PDR performance has been largely on an upwards/sustained pathway from April 2021 until December 2021 at which time compliance stood at 85%. The impact of short-term sickness on availability to hold such discussions not planned and could not be predicted. It should also be noted that the Trust moved into business continuity from mid-December 2021 until mid-January 2022, during which time, all non-essential activity was stood down to ensure staff staffing and maintained patient care.

Assurance is provided that outstanding PDRs are booked in and so it is expected that compliance will increase across coming months to reach compliance.

Appendix A

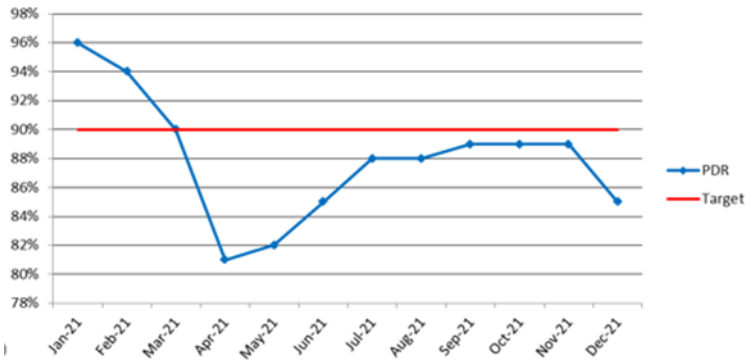


Fig. 7 PDR compliance

It is acknowledged that clinical training has seen a downwards trajectory during 2021 with compliance currently at 78%; a trajectory to improvement is currently in development as part of the weekly oversight process and in addition to this, the service is taking proactive action by arranging blockbuster days to ensure volumes of training can be supported. The importance of completing such training is acknowledged however, it is also important to triangulate this information with unavailability of staff due to sickness.

As above, blockbuster days have been planned to improve compliance and this is showing a positive impact with compliance increasing by 4% to stand at 88.5% in December 2021. Work continues to ensure all staff complete this training and where self-directed training is needed, that time is provided to enable such completion.

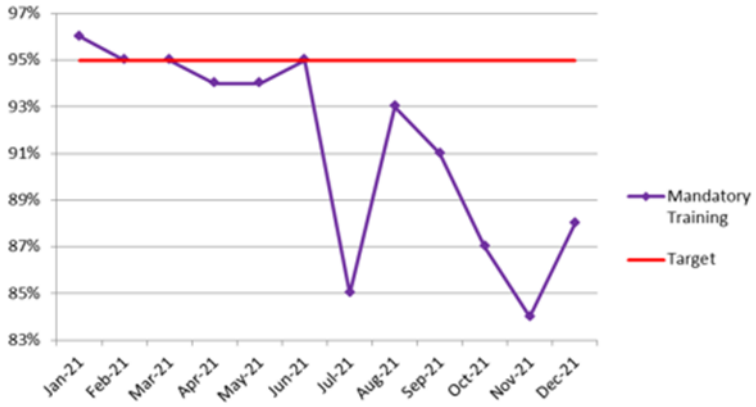


Fig.8 Impact **blockbuster days**

5.3 Turnover

Turnover has seen a steady increase since September 2019 and currently stands at 9% as displayed in the graph below. Whilst there are no concerns to highlight, the data below represents 29 leavers in year, of which the majority (27) were registered members of staff. In terms of reasons for leaving, 79% reported leaving to move to another NHS organisation; exit interviews are held as requested.

The service is currently involved in a Trust-wide programme named 'Flex for the Future' which is a centrally led programme and involves other Trusts and looks at ways of working and how to ensure flexibility is offered to the workforce to aid retention in the NHS. This work is ongoing.

Appendix A

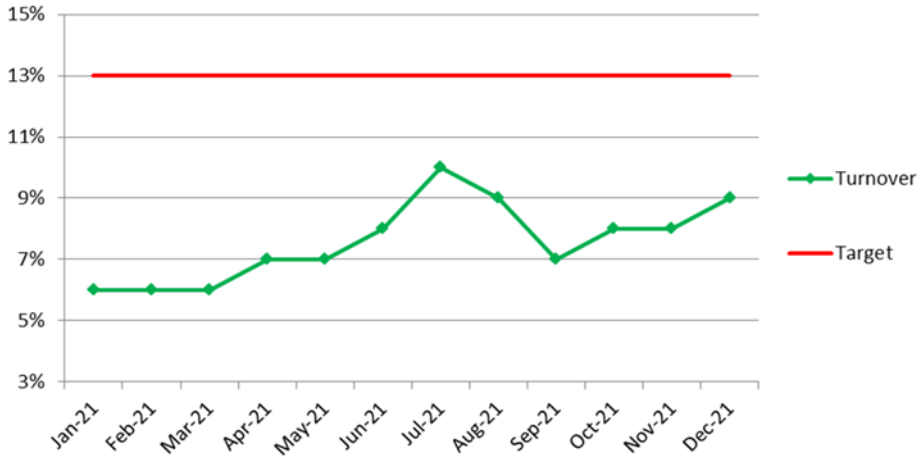


Fig.9 Turnover

5.4 Equality, Diversity & Inclusion

Of our workforce in the service, we have 3% declaring a disability or noting an unspecified disability; undeclared rates stand at 12.3% with 84.7% of the workforce noting that they do not have a disability.

As a service we are committed to supporting the wider Trust Equality objectives with regards to positively improving BAME representation within the workforce and ensuring that our BAME colleagues are treated equally and supported to fulfil their potential at the Trust. As reported in the Equality & Diversity annual report (2020), the Trust workforce remained largely static with a marginal increase to 8.5% of BAME employees. In terms of the service, there is a 9.6% representation of colleagues from BAME backgrounds.

We support our BAME colleagues via involvement in the staff supporter network, engagement in Great Place to Work and recognising the importance of the skills in our current workforce when recruiting; this all-in addition to completing fair and transparent recruitment practices i.e., adverts accessible on several platforms, interview panel including HR and/or staff side representatives, reasonable adjustments made to process as required etc.

In the 2020 NHS Staff Survey, the service achieved a higher marking that the overall Trust for the topic equality, diversity and inclusion at a rating of 9.7; the overall Trust rating was 9.5.

We recognise that ongoing work needs to take place to ensure we continue our positive recruitment practice and will work jointly with HR colleagues to support this.

5.5 Age Profile

The age profile of NHS workers is largely reported nationally, as is the aging workforce from a Trust-wide perspective. As such, the age profile of the workforce within service (as per the data held in ESR) has been reviewed and is displayed in the below graph.

Appendix A

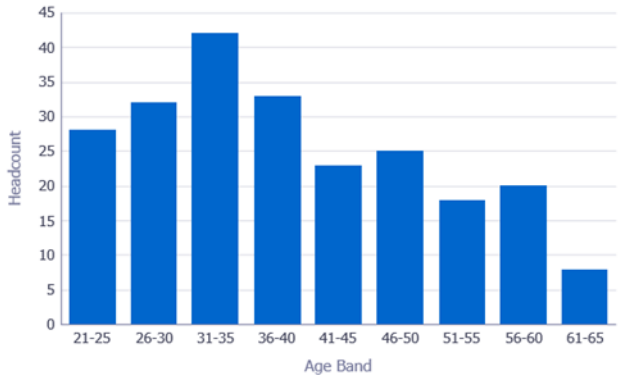


Fig.10: Age profile

As shown, there is a distribution of ages within the workforce, with the largest grouping in the age band 31-45 followed by the ranges 36 – 40 and 26 – 30. In previous years, the age range 36 – 40 has been most prominent. Whilst there is a highest % age group, there is a wide distribution of other ages within the service, and this therefore provides evidence that the service encourages new entrants whilst also valuing skills of employees with longer service; this in turn supp0orts succession planning.

5.6 Flexible working review to support work-life balance and staff well-being.

All staff had the opportunity to submit flexible working requests in December for consideration. The review was required to not only provide staff with an opportunity to improve their work-life balance, but to ensure appropriate skill mix on each shift and ensure fairness and equity for all staff regardless of personal circumstances.

All requests were submitted to the Matron and reviewed with the roster managers. All requests considered in line with the flexible working policy and with consideration to ensuring required numbers of staff and skill mix could be maintained on each shift. The only staff group that could not be approved initially was the band 6 group due to the high number of staff returning from maternity leave and requests to work the same set night shifts per week. Further consultations held with the band 6 group and alternatives considered and granted. There have been no appeals following the review and staff advised the flexible working review would be repeated 6-12 monthly.

Two band 5 nurses have applied and been granted short term career breaks for this year.

5.7 Vacancy

Vacancy rate at December 21 sits at 8.1% for clinical staff. Posts have been advertised and shortlisted and it is expected tat this will be filled before the end of quarter 4.

Maternity leave continues to run on average at 11-14 wte.

5.8 Bank Usage

Due to pressures of the pandemic, sickness and maternity leave bank spend has been on average £40,000/month. This spend has ensured that fill rates have been maintained in line with occupancy and acuity this has allowed safe staffing to be maintained. However, with Covid, short term and long term sickness reducing this will see a reduction in bank spend also.

Appendix A

6.0 Governance:

6.1 Parent Feedback/Complaints

There is a lack of formal data regarding patient/parent satisfaction and with the need to encourage Family Integrated (FI) care on the unit in preparation for the FI Care accreditation assessment in March, the team have designed a parent survey to improve services. The survey has now been approved by the patient experience team and has been introduced since 31st January. Results from the survey will be presented at the next Patient Experience and Involvement Sub- Committee.

6.2 Complaints:

Complaints are in the main escalated on the unit to the Matron and HoN have been resolved at local level, however, there have been some complaints received through PALs. Complaint themes are mainly with regards to communication and visiting restrictions due to changing national guidance and restrictions on visiting opportunities for extended family members, including siblings. Exceptions have been granted due to extenuating circumstances on a case-by-case basis.

As communication is a key theme in the majority of cases and involve both medical and nursing staff, there are plans for joint awareness sessions for all staff facilitated by the Lead Neonatologist and Matron. Key themes of complaints are presented at risk meeting, integrated governance meeting, staff meetings, weekly consultant meetings and monthly senior nursing ops meetings.

6.3 Fill Rates:

Throughout the year occupancy and acuity in the NICU has continued to run at commissioned rates, with some peaks especially in the last quarter, however, safe staffing has been maintained and fill rates have been reflective of acuity and occupancy. To ensure fill rates are maintained to achieve safer staffing this has required increased use of Bank and the flexibility of staff swapping and changing shifts and on occasions the use of incentives. There also have been points in the last quarter where the escalation policy has been used. This was undertaken in a collaborative way with our maternity colleagues, ensuring that occupancy, acuity, and staffing were considered and that all services within the family health division remained safe.

6.4 Risk:

Incident and risk register management are reviewed monthly on the NICU. There are no staffing risks on the risk register currently. What has been seen is a drop in the reporting of near misses and incidents. However, themes over the last 12 months remain the same, medication errors, communication and clinical incidents. We have carried out several tabletop reviews and have had no SI's over the last 12 months. Lesson learned have been shared with the team through LOTW, implementation of QI projects, changes in guidelines to inform changes in practice and sharing at our service clinical governance day.

7.0 Liverpool Neonatal Partnership (LNP)

The LNP is a partnership which will join two services across two site and across two Trusts, the aim of this partnership is to ensure that all babies receive the appropriate care in the appropriate environment by the appropriately qualified team. The LNP will ensure that surgical babies will receive their care in a timely, safe and effective manner to achieve

this it will mean that nursing teams on both sites will need to be competent in both neonatal surgical and medical nursing. The following are the priorities of the LNP Nursing team over the next 12 months.

1. Development of staff in relation to QIS and neonatal Surgical Module.
2. Recruitment of 50 wte
3. Robust training plans to include NIP and QIS delivery
4. Rotation of staff to gain experience in speciality
5. Development of band 7 team
6. Recruitment of Matron

This list is by no means exhaustive but gives overview of the year ahead.

8.0 Conclusion:

The NICU has had a year where sickness has been high and where there have been extreme peaks in activity; however, when we triangulate sickness, acuity, occupancy, and themes within governance we can see at pressured points family experience and staff experience has not been optimum. However, the service has continuously managed to safely staff the NICU and at times of extremes has correctly used the processes available to ensure that patient safety was not compromised and correctly escalated both within in the Trust and to the wider NWNODN to gain support and provide assurance of safe practice.

Sickness has been actively managed with positive result for those who have been actively supported back to work after extended absences.

Staff development has continued at all levels and our talent pool continues to be a success and the team have put focus on staff wellbeing by offering flexible working opportunities, career breaks, supporting changes in clinical role to support wellbeing, encouraging access to support services and putting staff forward for the PNA roles.

The team continues to experience great student feedback with positive recruitment of students. The ANNP team continue to attract high calibre qualified ANNP's.

9.0 Recommendations

This review would recommend the following.

1. That a formal bid is put forward to the NWNODN (once open) to help support and develop the quality roles within the unit.
2. The senior nurse leadership team requires reviewing to ensure there is always appropriate support and cover.
3. That recruitment of new staff continues, and these staff complete the NIP and are fast tracked where competent to complete the QIS, as there is an expectation that staff will rotate across the LNP. This will help ensure that we maintain the standard above 70% of staff QIS.
4. Work with the LNP to develop a staffing model that ensures fill rates and that safer staffing in line with BAPM standards are maintained.
5. Further reviews of activity capacity and demand both locally and within the network to ensure the unit at LWH has correct cot basis.
6. The unit will go through further change as the LNP develops further over the next 24 months, this is a huge process of change, including new environment and new way of working, this must be approached using organisational change to ensure establishments are not destabilised having implications for patient safety

and performance. This should be reviewed again in January 2022 to enable more accurate budget setting in the new environment and to encompass changes within the network

Head of Nursing Commentary:

The last 12 months have been an extraordinary time within healthcare, but the neonatal team have maintained their professionalism and passion for some of the sickness and smallest babies within this Trust. The team have shown resilience, compassion, and kindness not only to the families and babies they look after but also to each other. They are a credit to their profession, to themselves and to our Trust. I am very proud of what we have achieved over these months and of each and every member of my team.

Appendix 1 – Neonates Agreed Rota 2021

Neonates Rota Final 2021.xlsx

Appendix A

Nurse Staffing Action Plan Jan 22

Issue	Action	TRI Lead	Operational Lead	RAG	Completion date	Update
Insufficient number of substantive quality roles	1. Prepare bid for NCCR monies to address role gaps. 2. Continue to support roles within current establishment as occupancy and acuity allows.	J.Deeney J.Deeney	J.Deeney J. Kearney		Spring 23 Review 6 monthly	Mar 22: Awaiting invitation to bid Mar 22: roles continued to be supported where possible
Retirements within the senior nurse leadership team	1. Review of roles and responsibilities. 2. Redesign organisational structure	J.Deeney J.Deeney	J.Deeney J.Deeney		May 2022	Mar 22: Formal resignation received.
Development of the LNP staffing model	1. Recruitment of nursing staff 2. Training programme development 3. New ways of working	J.Deeney J.Deeney J.Deeney	J. Balmer/ J.Kearney Educator/J.Kearney /J Balmer			Mar 22: Awaiting finance from Commissioners. Agreed to add to LNP risk register
Increased numbers of ANNP's required to staff LNP	1. Recruitment of qualified ANNP's 2. Development of ANNP trainee programme	J.Deeney J.Deeney	S. ONeil S.ONeil			Mar 22: 2 place secured for ANNP training in Jan 23. Further recruitment for trained ANNP will commence in summer 22

Appendix B

Neonatal Medical Workforce.

Executive Summary

This report is to provide assurance and information that Liverpool Women's NHS Foundation Trust meets Safety Action 4 of the Maternity Incentive Scheme 2021-2 (aka CNST) with regards to Neonatal Medical Workforce.

Safety Action 4 – ''The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met an action plan to address deficiencies is in place and agreed at Board Level'.

The content of report details the standards required and its supporting evidence to meet the BAPM framework or neonatal medical staffing

It concludes that the BAPM standards required to meet the optimal arrangements for neonatal intensive care medical staffing are in place at LWH and that there is no requirement for a Trust Board approved action plan.

The Trust is required to formally record in Trust Board Minutes whether it meets the recommendations of the neonatal medical workforce training action and should take assurance from this report that this is met.

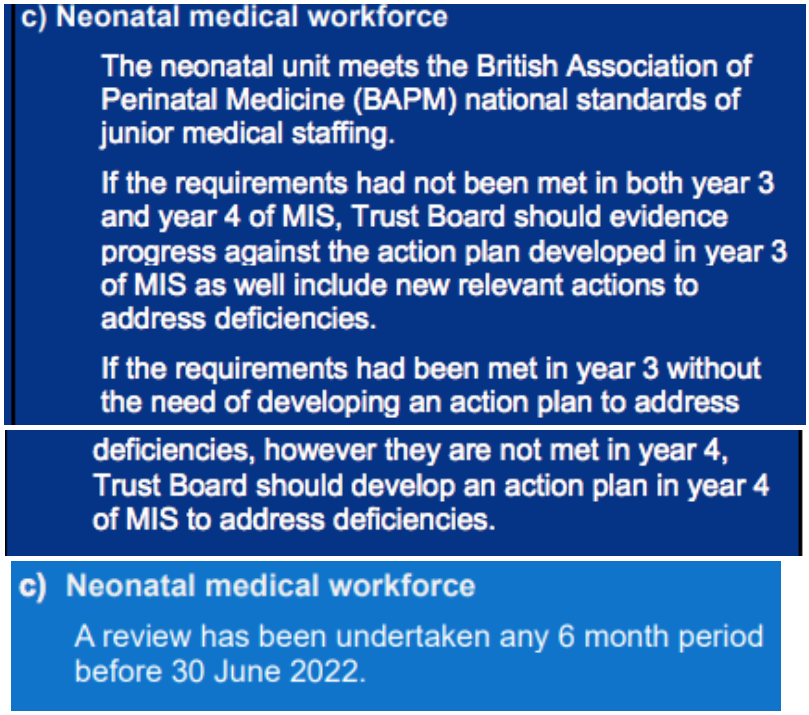
Report

Introduction.

The Maternity Incentive Scheme supports the delivery of safer maternity care through an incentive element to trusts contributions to the CNST. The scheme, rewards trusts that meet ten safety actions designed to improve the delivery of best practice in maternity and neonatal services.

Safety Action 4 is that Trusts can demonstrate an effective system of clinical workforce planning to the required standards across Obstetrics, Anaesthesia, Midwifery, Neonatal Nursing and Neonatal Medical Workforces

Below, are the requirements, as referenced within the Maternity Incentive Scheme specifically for Neonatal Medical Workforces:



The following information and narrative provides assurance that LWH meet the recommendations for both the BAPM standards and the requirements for the Maternity Incentive Scheme.

Compliance with BAPM Medical Staffing Standards for Maternity Incentive Scheme (CNST).

Reference is made to the current BAPM Framework for Practice:

"Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing" (2014) https://www.bapm.org/resources/31-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2014

Adherence to the following criteria is made by reference to and evidenced by staffing rotas for the six-month period Sept 2021 – March 2022.

Criterion 3.2.1: Minimum NICU resident out-of-hours care should comprise one tier 1 clinician (ANNP/ST1-3 junior doctor), *and* a tier 2 clinician (appropriately-trained specialty doctor/ANNP/ST4-8 junior doctor.

*LWH Response - At Liverpool Women's Hospital NICU, out-of-hours staffing (*i.e. *beyond 1700, and overnight), there will be a minimum of two tier 2 clinicians (comprised of ST4-5 paediatric trainees, and Band 8 ANNPs/neonatal grid trainees) and two tier 1 clinicians (comprised of ST1-3 paediatric trainees/Band 7/8 ANNPs).*

No actions required to meet this standard: Fully Compliant

Criterion 3.2.3: NICUs with more than 2500 intensive care days *per annum* should double tier 2 cover at night by adding a second experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP.

LWH Response: In view of intensive care days at Liverpool Women's Hospital NICU exceeding >2500 per annum *(~3500), the tier 2 cover has been accordingly doubled from the minimum outlined in criterion 3.2.1. (one tier 2 clinician out-of-hours) to that described above (two tier 2 clinicians).*

No actions required to meet this standard: Fully Compliant.

Criterion 3.2.4: NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice.

In view of deliveries at Liverpool Women's Hospital exceeding ~8000 per annum*, the tier 1 cover has been accordingly doubled from the minimum outlined in criterion 3.2.1. (one tier 1 clinician out-of-hours) to that described above (two tier 1 clinicians).*

No actions required to meet this standard: Fully Compliant

Criterion 3.2.5: It is recommended that all NICUs seek to extend consultant presence on the unit to at least 12 hours per day.

LWH Response: At Liverpool Women's Hospital NICU, on-unit Consultant Neonatalogist presence is 24 hours per day.

No actions required to meet this standard: Fully Compliant.

Criterion 3.2.6: NICUs undertaking more than 4000 intensive care days *per annum* with onerous on call duties should consider having a Consultant present and immediately available 24 hours per day.

LWH Response: *Not currently applicable on the NICU at Liverpool Women's Hospital as NICU Intensive care days equal to 3,500 but there is already consultant presence 24 hours per day.*

No actions required to meet this standard: Not applicable to LWH.

Criterion 3.2.7: NICUs undertaking more than 2500 intensive care days *per annum* should consider the presence of at least 2 consultant-led teams during normal daytime hours.

LWH Response: At Liverpool Women's Hospital NICU, care is delivered on a mixed acuity basis, where babies receiving intensive-level care are cared for in the same clinical area as those receiving high-

dependency-level care. After progressing to special-level care, babies will be transferred to the adjacent Low Dependency Unit. In the mixed acuity area (capacity 24 cots), care is delivered by two consultant-led teams, with a third consultant leading on the Low Dependency Unit.

No actions required to meet this standard: Fully Compliant.

Criterion 3.2.8: NICUs undertaking more than 4000 intensive care days *per annum* should consider the presence of three consultant-led teams during normal daytime hours.

LWH Response: Not currently applicable on the NICU at Liverpool Women's Hospital.

No actions required to meet this standard: Not applicable to LWH.

Additional Evidence to Support Neonatal Medical Workforce Requirements.

In addition, reference is made to the 2010 document detailing: Service Standards for Hospitals Providing Neonatal Care, which provides additional guidance on medical staffing levels.

https://www.nna.org.uk/assets/bapm_standards_final_aug2010.pdf

Criterion 5.4.1: All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics.

It is anticipated that teams at each tier will be made up from the following groups:
• Tier 1: Staffing can be from paediatric ST1-3, ENNPs or ANNPs, specialty doctors.
• Tier 2: Staffing from paediatric ST4-8, specialty doctors, other non-training grade doctors, ANNPs (with appropriate additional skills and training), resident neonatal consultants.
• Tier 3: Consultant neonatologists. There will be 24/7 availability of a consultant neonatologist for Tier 3.
LWH Response: At Liverpool Women's Hospital NICU, all staff work solely on the neonatal unit, with no general paediatric service located on site.
Roles on the tier 1 rota are fulfilled by ST1-3 paediatric trainees, and Band 7/8a ANNPs.
Roles on the tier 2 rota are fulfilled by ST4-8 paediatric trainees, and Band 8a/b ANNPs.
Tier 3 requirements : Consultant neonatologists are available on site 24 hours per day.
No actions required to meet this standard: Fully Compliant.

Criterion 5.4.2: Recommended numbers of staff for a Neonatal Intensive Care Unit:

• Tier 1: Separate neonatal rotas with a minimum of 8 staff.
• Tier 2: Separate neonatal rota with a minimum of 8 staff.
• Tier 3: A minimum of 7 consultants on the on call rota with resident consultants on the tier 2 rota additional to this number. All tier 3 consultants should be identified neonatal specialists.

LWH Response: The tier 1 rota in the specified period is a 9 person ST1-3 doctors rota, with 8 ST1-3 doctors working 7.2 working time equivalents (WTE). The 1.8 WTE gaps within this period are fully covered by either the complementary tier 1 ANNP workforce, or locum cover to ensure the 9 person rota is run as intended. Additionally, roles within the tier 1 rota are supplemented by a group of 15 tier 1 ANNPs (14.9 WTE) who undertake the same roles across the neonatal unit, on a separate but complementary rota. The tier 2 rota in the specified period is comprised of 10 ST4-8 doctors, working 9.2 WTE on a separate rota and 17 senior tier 2 ANNPs (15.6 WTE) who work on a complementary rota to the tier 2 doctors.
No actions required to meet this standard: Fully Compliant.

Criterion 5.4.3: For larger NICUs, special consideration should be given to the number of staff required at each tier throughout the 24 hours and giving due consideration to the time required at each handover. With increasing size, at some point, essentially the whole of the staffing structure described in 5.4.2 should be doubled.

LWH Response: In recognition of the number of cots and deliveries at Liverpool, as recommended by BAPM, the staffing levels have been essentially doubled from baseline, with 22.1 WTE tier 1 clinicians (ST1-3 doctors and Band 7/8a ANNPs); 24.8 WTE tier 2 clinicians (ST4-5 doctors, neonatal grid trainees and Band 8a/b ANNPs), and 18 consultants (WTE 15).

No actions required to meet this standard: Fully Compliant.

Conclusion.

The neonatal medical workforce and the staffing of the neonatal unit complies with the BAPM standards. The requirements for CNST 2021-22 are fully met and can be evidenced with rota spreadsheets. There is no requirement for an action plan to be formulated and signed off by the Trust Board.

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Liverpool Women's NHS Foundation Trust

Maternity Perinatal Quality Surveillance Model: January 2022.

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

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

Midwifery Red Flag Closed in January	There were 13 incidents closed as midwifery red flags in January 2022. This is a significant reduction from previous months reporting (December 39 and November 20). There were no red flag incidents reported in relation to 1:1 care in labour or inability to provide epidural anesthesia.
Most reported Red Flag in January	**Delay or cancellation of activity:** This relates to the ongoing delays we are reporting with continuation of IOL.
Actions Taken:	In order to enable the maternity management team to monitor this more closely, we have added a customized Midwifery red flag incident that directly relates to delays in IOL process. Midwifery Red Flags are monitored by the Deputy HOM and Q & Safety Matron, they are also subject to review at the Family Health Divisional Board and though the Maternity Risk and Clinical Committee

Quality Feedback.	Comments	Actions

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MVP/Service User Feedback	MVP Strategy shared with all Family Health Division for comments and feedback. Requested made to MVP for further co-production work around maternity base improvements Named Consultant Lead for Maternity Base developing relationship with MVP to strengthen lines of communication Weekly 'MVP' Touch meeting with HOM, Dep HOM and Q&S MW to continue	Requests escalated to Estates – part of ongoing upgrades to front entrance. K2 issue will be resolved with next phase implementation. Community engagement planned by MVP chair
Safety Champions Feedback	Issues escalated to Safety Champions and noted at QC: Safety Champions walkabouts continue MF, LG, RMcF, AW and FP regularly walk the Maternity and Neonatal Unit. The January (11th) walkaround and meeting: – Concerns raised around some breakdown in communication between TH and maternity staff, impacts on team working. -Previously theatre staff attended the twice daily huddle/handover - Attendance at IWG has also reduced resulting in TH issues not being raised and addressed - The maternity TH manager highlight issues with the flow of patients in maternity TH during the elective list which is related to the lack of consistent provision of a 3rd MW to the list. Current staffing pressures are on-going, and this will be feedback to the dept HOM and discussed further through the IWG - NICU - Cards used to show babies milestones. Graduation board all positive stories in NICU – to be highlighted to board. - Learning shared with staff through a monthly 'What you need to know board' seen as really positive and to be shared with maternity	Actions: Intrapartum lead to review at IWG, re-establish attendance at daily huddles, TH/maternity meetings to be restarted to address issues arising Action: Q&S Mw developing a Staff Quality & Safety feedback Board – Highlighting areas of lessons, good practice, you said we did.

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Excellence Reports and/or Employee/Team of Month	Maternity Shining Star awarded to Nicki Dunlop, Maternity Assessment Unit Ward Clerk, nominated by Kim Farrell MAU Manager and will be nominated for employee of the month. *"Congratulations to Nicki for receiving Decembers Shining Star ⭐nominated by Kim Farrell and agreed by all Maternity Managers at the Maternity Managers Quality Meeting.* Nicki is a shining star with a friendly, warm, welcoming face always with a smile when people attend the MAU. This is important as often women are attending with worries or concerns about themselves or their baby. Nicki is professional, resilient and nothing is ever too much trouble. Nicki has played an integral part in the implementation of the new BSOTS maternity triage system. The admission process is paramount to the smooth running of a triage for the midwives and Nicki always completes with accuracy. Our department would not function without our support staff and their contribution to safe care with a good experience should not be underestimated."	Employee of the Month nomination

Number of HSIB Referrals in January 2022.	**PMRT Reviews.**	**Safety Incidents Reported in January 2022.**

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<table>
<tr>
<td>Number of Therapeutic Cooled in January: One.

Details of Case:
- Missed SGA static growth on SFH chart appropriately referred to scan
- 50th centile on scan at 36+2, 3rd centile at birth 38+1
- Slight delay in cat 2 delivery interval due to secondary spinal, CTG monitoring throughout (6 mins without)
-The use of Life-start could have enabled delayed cord clamping
-Appropriate Neonatal clinical pathway allocation for Low pH, Small for Gestational Age and Prevention of Hypoglycemia as per Trust guidance
- Therapeutic cooling commenced at 5 hours within the recommended timeframe

Actions Taken
Duty of Candour planned verbally and in writing
Staff support and statements
Referral to HSIB under term admission to NICU for therapeutic cooling criteria
To be reported in STEISS as non-SI, HSIB case as per Trust agreement</td>
<td rowspan="2">Number of NND Perinatal Deaths in January 2022:

Number of Stillbirth Perinatal Deaths in January 2022: 5

All perinatal deaths In January 2022 Have been reported to MBRRACE and will be subject to a full MDT Review. Details and action plans of every death are detailed in the Quarterly Mortality Report presented by Deputy Medical Director.</td>
<td>Number of STEISS Incidents (Non HSIB) : 2</td>
<td>Case 1: Postnatal retention of Vaginal Swab
- Escalation to harm meeting for consideration
- Reiteration to staff at each hand over to document swab counts pre and post procedure for all swabs within the pack (10) – This has been sent to all Obs cons and midwifery managers, also appears on the DS Teams channel
- K2 to be contacted to request swab count to be added to perineal repair, delivery and operative delivery and to be made mandatory
- Small white boards in delivery rooms to record swabs
- QI Project.
- LOTW screen reminder to all staff logging onto K2 maternity IT system: The swab count Wizard must be completed after each delivery; this includes operative vaginal delivery and perineal repair.
Case 2: Inpatient Intrauterine Death.
- Missed opportunities for decision to deliver,
- Complex cases and prioritisation.
- Confirmation bias regarding plans to induce
- Repeated CTG’s in the presence of an abnormal trace.
- Non recognition of abnormal antenatal CTG
Accumulated risks, known SGA, treatment for hypertension, intensively monitored, CTG changes and reduced fetal movements.</td>
</tr>
<tr>
<td>Any safety recommendations that are shared with the Trust via completed HSIB Investigations are subject to a detailed action plan, with evidence of completion and monitoring through the Divisional Maternity and Neonatal Risk Meetings.</td>
<td>Moderate Harm Incidents: Two cl In January.</td>
<td>Case 1: Patient attended GED; 7 weeks pregnant Told had TL at CS in 2020 - on review of notes this was not carried out. Patient undergoing TOP on emergency list 26/11/21 – DOC and Formal Review completed. Has been reported to STEISS in November.

Case 2: Patient with deteriorating COVID illness: Required transfer to RLUH. DOC and Formal review completed.</td>
</tr>
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Ockenden Update	On 25 January 2022, the NHS Improvement / England (NHSI/E) Chief Operating Officer and Chief Nursing Officer wrote to trusts requesting that discussions regarding Ockenden progress take place at a public Board before the end of March 2022. The discussion is expected to cover: • Progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance, • Maternity services workforce plans The letter noted that ensuring local system oversight of maternity services was a key element in the Ockenden review and therefore trusts have been requested to ensure progress is shared and discussed with the Local Maternity System (LMS) and ICS. Progress must also be reported to the regional maternity team by 15 April 2022. In April 2022 – the Family Health Division will welcome a visit from the Regional Chief Midwife and her Team where any up-to-date progress can be reported against the remaining outstanding actions. In March 2022 Public Board, the Chief Nurse and Midwife presented the 'Ockenden – One Year On' Paper that detailed Liverpool Women's progress and detailed actions to be taken to progress the Trust to full compliance. IEA 1, 2, 3 and 6 - Completed. All evidence submitted to Portal. CSU and Office of Regional Chief Midwife Validated. IEA 4 – On track to launch as a Maternal Medicine Centre (MMC) in April 2022. Pathways are being agreed across the North West Maternal Medicine Network with the two other MMCs (St Mary's Hospital (Manchester University NHS Foundation Trust) and Royal Preston Hospital (Lancashire Teaching Hospitals NHS Foundation Trust). An electronic referral system has been built and is undergoing testing. The governance process around the regional maternal medicine MDTs and provision of advice is being developed. All women with complex pregnancies will have a named consultant lead. The Cheshire & Merseyside Maternal Mental Health Service is planning to launch at the end of February 2022. IEA 5 – Audit of Personalized care and Support Plans outstanding – will be completed as per action plan with Digital Midwifery Team. IEA 7 - Ongoing work to enable women to participate equally in all decision-making processes, use of BRAIN tool and associated audit requirements.
Maternity Risk Register	Extreme Risks: 20 High Risks:10 Moderate Risks: 4 Low Risk: 1

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Progress Against CNST Year 4 Safety Standards	**Progress against the Year 4 Maternity Incentive Scheme (CNST):** 1. PMRT – Full details of the Trusts progress against the standards in this element are detailed in the quarterly learning from deaths report prepared by the Deputy Medical Director. 2. MSDS – No reported problems. 3. ATAIN – Trust Board have received the ATAIN Action Plan, and this has been shared with the LMNS. Divisional Leads have been updated, named Cons Obstetrician and Midwife planned to take ownership of obstetric and midwifery requirements. 4. Clinical Workforce – Obs workforce paper submitted in January 2022. Neo Nursing and Medical workforce paper to be submitted to Board in April. 5. Midwifery Workforce – Detailed staffing paper against Birth Rate Plus Report of 2021 has been sighted at Trust Board. 6. SBLCBv2 –- PTL Risk assessment to be updated. 20 Weeks FGR Risk assessment to be embedded into pregnancy journey. Audits of compliance ongoing. Difficulties with UAD USS in Main US Department - 7. MVP – Continued close working relationship with MVP and MVP/LWH Strategy under development. 8. Mandatory MPMET and Neonatal Resus Training – MPMET Training session reinstated in face-to-face capacity. Target of 90% of all staff groups to attend by scheme end. See further details below. 9. Safety Champions – Safety Issues continue to be escalated. BLSC sighted on Perinatal Clinical dashboard and submitted monthly. 10. HSIB and NHSR Notifications – No issues identified. All HSIB and D.O.C duties completed to date. Details to Trust Board in May 2022.

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Training Compliance Update	January 2022		
	MPMET:	Fetal Surveillance:	Newborn Resuscitation:
Midwifery Staff	70%	3%	66%*
Consultant Obstetricians	73%	11%	73%
Obstetric Trainees	53%	0%	53%
Maternity HCA	68%		
Anaesthetic Consultants	52%		
ODPs	65%		
Consultant Neonates			94%
Neonatal Trainees			95%
ANNP's			85%
Neonatal Nurses			84%*

Training Compliance Narrative:	Maternity Training Needs Analysis: Liverpool Women's NHS trust (LWHT) is committed to the vision of the National Maternity Review Better Births Report to become safer, more personalised care with women and families receiving high quality care. Robust education and training are key components of providing safe care and contribute to creating a supportive learning environment where all staff are able to learns from incidents and concerns to continuously improve the care we are providing to women, families and babies. The Maternity training needs analysis (TNA) has been developed and identifies the training required to underpin our commitment. It includes the training required to meet the Core Competency Framework for maternity staff. To support this, LWHT maternity has successfully bid for Health Education England funding for safety training. Following publication of the CNST MIS Year 4 in August 2021, the TNA was reviewed and revised further to ensure compliance to CNST Safety Action 8. Updates in relation to the Midwifery Preceptorship programme and have also been included in v1.1 of this document to reflect current practices. The LWH Maternity TNA has been shared with the Local Maternity System Lead Midwife for Quality & Safety, ratified, and agreed and is currently being utilised as a template for other maternity providers within the region as a benchmarking tool. All managers, clinical leads and rota co-ordinators have been contacted and have ensured that staff are booked onto applicable course sessions that are planned and diarised. To note, Anaesthetic trainees are a small cohort of staff (average number 12) who complete a short three-month rotation to Obstetric Anaesthesia at LWH and therefore the compliance figure fluctuates dramatically for this group at the rotation times through the year. The Maternity Education Team have developed an excellent relationship with the rota coordinators who ensures that all obstetric consultant and trainees attend a MPMET session during their placement to achieve compliance.

	** Midwifery and neonatal nurse compliance data is based on the one year in house update and does not include and reflect those clinicians who have at reg course and therefore this would supersede annual update. This will require manual verification later. This data has been sighted at the Trust Resuscitation Committee. Fetal Surveillance Training days commenced this month (January 2022) to include all elements of the Saving Babies Lives Care Bundle, in addition to the fetal monitoring training requirements. An increased number of courses have been arranged from March 2022, with an increased capacity for attendance. A trajectory is in place to ensure that we meet this requirement. Fetal Surveillance Training prior to January had been completed to a compliance rate of 90%. However, the requirements now include SBLCBV2 training and this differs from previous training agendas and this would explain the 0% starting position in January 2022.

	Metric	Standard	Running Total/	Jun-21	Jul-21	Aug-21	Sep-21	Oct 21	Nov-21	Dec 21	Jan 21
		National standard/Average where available.	average								
Perinatal	1:1 Care in Labour	100% (CNST)		99.6%	99.3%	99.2%	98.6%	99.6%	99.4%	98.1%	98.3%
	Stillbirth Number >24wk (Adjusted)	Actual Number		2	7	3	1	2	5	2	5
	Apgar <7 @ 5 Min (>37weeks)	<1.2%		0.8%	0.6%	1.3%	0.8%	05.%	1.15%	1.28%	0.51%
	Term Admission to NICU	<6%		3.54%	4.01%	4.91%	5.1%	4.52%	7.69%	5.46%	5.90%
	Women in receipt of Continuity of Care	100%		15.35%	14.49%	16.67%	19.91%	17.85%	20.52%	20.52%	18.7%
	BAME in receipt of Continuity of Care	100%		29.41%	31.63%	39.81%	47.96%	39.60%	41.58%	37.89%	37.2%
	Social Depravation Continuity of Care			18.18%	19.89%	24.21%	26.40%	22.26%	24.78%	23.62%	21.7%
	Provision of Epidural in Labour.	Actual Number		15.1%	20.3%	19.4%	20.3%	22.82%	17.78%	16.78%	18.97%
	Obstetric Haemorrhage >1.5L			4.28%	3.96%	3.77%	4.14%	3.37%	4.26%	2.96%	3.2%
	Coroner Reg 28 Made to Trust			0	0	0	0	0	0	0	0

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	HSIB Report Returned			1	0	0	1	1	1	0	1
Workforce	**Super Numerary DS Shift Leader.**	100% (CNST)	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Midwifery Sickness	% of workforce		10.13%	12.28%	12.17%	14.11%	13.31%	12.63%	15.26%	16.37%
	Midwifery Sickness	WTE		36.6	44.6	43.7	50.7	50.1	47.7	57.0	60.7
	Midwife to Birth Ratio (in Post)	>1:30		30	31	31	32	30	29	30	30
	Midwifery Vacancy	% of workforce		2.40%	1.40%	4.40%	3.30%	5.32%	8.72%	7.84%	2.46%
	Rostered Cons on DS (Hrs per Wk)	>60 hrs		91	91	91	91	91	91	91	91
	Number of Formal Complaints	Actual Number		2	2	1	2	3	2	2	2
Feedback	**Number of Maternity Incidents over 30 Days**	Actual Number		188	261	89	161	376	97	119	121
	FFT Response Rate	>50%		<10%	<10%	<10%	<10%	<10%	<10%	<10%	<10%
	Number of PALS/PALS+	Actual Number		74	66	67	46	52	44	32	TBC

Conclusion

The Family Health Division are currently awaiting formal confirmation of the Cheshire and Merseyside regional assurance and governance pathway led by the Local Maternity System, to work collaboratively with regional leaders including the Regional Chief Midwife and her Team. The Head of Midwifery has escalated the requirements of this framework and a response in January 2021, has outlined a proposed governance and assurance structure from the LMS. This process will formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern and the Trust should expect to hear feedback from this in April 2022. The information within this report will be feedback to frontline clinicians via the Safety Champions Check In. The Trust Board are asked to accept the information within this report and dashboard as information and assurance of sight of perinatal quality safety issues in the Family Health Division.

Quality Committee Chair's Highlight Report to Trust Board
21 February 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Issues with Trust's performance in the safe administration of Anti D had been raised. The reason for the missed dose was understood in all cases with the dominant root causes being communication issues. The Sub-Committee had commissioned a review and action plan from the Senior Leadership Teams of all three Divisions. The Committee considered the significance of the matter and requested to receive a position update within the next sub-committee chair report. • Performance against the EDS2 toolkit had declined, with a contributing factor being the vacancy of one of the two EDI Leads within the Trust. This had impacted on the pace of key workstreams. The vacancy to recruit to the workforce EDI Lead was open. • The Committee received a report which detailed the blood sample error incidents, quality improvement work undertaken and recommendations for additional actions to reduce the number of blood sample errors. Implementation of actions had begun with benefits to be realised by Summer 2022. The aim to provide an onsite Phlebotomy Service would be a significant improvement to current provision and a business case would be developed. Blood sampling errors had also been escalated within the Corporate Risk Committee Chairs Report and had been added to the Corporate Risk Register. It was agreed that cross checking across other sample collection could be undertaken following this review. It was noted that regular oversight would be remitted to the Safety and Effectiveness Sub-Committee to escalate any issues as necessary. Due to the significance of the matter the Committee requested a 6-month progress report. • The Learning from Deaths report had highlighted an increasing rate of stillbirths since 2019/20, and that multiple pregnancy had been identified as an area of concern within the stillbirth cohort during quarter 3. A thematic review of stillbirths would be conducted with full year internal and national data. The review on multiple pregnancy stillbirths would not be delayed and a thematic review of the multiple pregnancy stillbirths would be underway and presented within the quarter 4 report. • The Committee noted disappointing results from the national Maternity Survey 2021. Discussion had been challenging and the Committee had required more detail in relation to the negative responses and assurances as to how the position would be improved to allow an informed debate. It was agreed that only limited assurance could be taken from the report and the Committee commissioned a revised report with additional interrogation of findings and a thorough action plan.	• The Committee noted the high number of transformation projects underway within the Trust, alongside other business as usual responsibilities, leading to capacity issues. A mapping exercise was being undertaken overseen by the Maternity Transformation Board. It was anticipated that improved stability in the leadership team alongside additional project management support would improve capacity issues. The Committee suggested an update on transformation projects for further assurance. • Received the Month 10 performance report. The Committee noted that the omicron variant had continued to impact on both staff absence rate and patient availability during January 2022. In relation to cancer performance, it was proposed to set up a cancer forum including internal and external representation to gain traction to take forward key projects and pathway developments. It was noted that an assessment against the quality principles of the long wait harm review process would be undertaken. The Committee requested additional narrative detail to be added to the performance report to explain any incidents of negative fluctuations. • The Committee noted the changes to the reporting requirements of the Quality Account 2021/22. The Committee agreed with the recommendation to incorporate the Quality Account within the Annual Report as a section for ease of reference for the public. The draft Quality Account would be presented to the Committee in May 2022 ahead of Board sign off in June 2022. • It was noted that the Trust had received a letter from NHS Resolution outlining concerns in relation to induction of labour for women. The divisional leadership team were formulating a response. It was noted that Trust practice was deemed safe if not fully compliant with NICE guidance.

Positive Assurances to Provide	Decisions Made
• The Committee received an overview in respect of the progress that services have made against their priorities set within the Clinical Quality Strategy. Key priorities had been agreed by each of the Clinical Services towards achieving the targets of the Clinical Quality Strategy. • Received positive assurance from the Safeguarding Quarterly report and noted the reassurance that staff were appropriately utilising safeguarding tools to identify risk. • An informative case study detailing a recent Quality Improvement project was presented to the Committee. The Committee was assured by the progress reported and approved the Quality Improvement Framework. The benefits of introducing a consistent methodology across the Trust was noted. • The Committee received and noted positive assurance from the monthly Serious Incidents & Learning Report covering the period January 2022. • The Committee received and noted positive assurance from the LocSSIPs Quarterly Assurance Report Quarter 3, 2021/22. • It was noted that the Trust had achieved CNST Level 3 and been awarded committed funding.	• Committee reviewed the Quality related BAF risks. No changes to risks scores or narrative was recommended. • The Committee was assured that the Safety Action 3 was on target and approved the ATAIN action plan. The Committee recommended Trust Board sign off.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- A positive meeting
- Level of discussion had been operationally focussed and required more focus on assurance.
- Report authors should be reminded to provide an effective executive summary (not simply an introduction) as per the template.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
214.	Board Assurance Framework	Assurance	220.	Progress Safety Action 3 for Maternity Incentive Scheme year 4	Assurance
215.	Sub-committee Chair Reports	Assurance	221.	Quality Improvement Framework	Assurance
216.	Quality Performance Report Month 10, 2021/22	Assurance	222.	Blood Sample Errors Report	Information
217.	Clinical Quality Strategy Update (including Quality Account Update)	Information	223.	Maternity Picker Survey	Information
218.	Mortality and Perinatal Report (Learning from Deaths) Quarter 3	Assurance	224.	Serious Incidents & Learning Report (Monthly Update)	Assurance
219.	Safeguarding Quarterly Report Quarter 2	Information	225.	LocSSIPs Quarterly Assurance Report Quarter 3	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	✓	A	✓	✓	✓	✓	
Susan Milner	✓	✓	A	✓	✓	✓	A	✓	✓	✓	✓	✓	
Ian Knight	✓	✓	✓	✓	✓	✓	NON MEMBER						
Louise Kenny	✓	✓	✓	✓	✓	✓	A	✓	✓	A	A	A	
Marie Forshaw	✓	✓	✓	✓	✓	A	A	✓	✓	✓	✓	A	
Gary Price	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	A	
Lynn Greenhalgh	✓	✓	A	✓	A	✓	✓	✓	✓	✓	✓	✓	
Jenny Hannon	✓	✓	A	✓	✓	✓	✓	Non-Member					
Eva Horgan	Non-Member							✓	✓	✓	✓	✓	
Michelle Turner	✓	✓	✓	✓	✓	✓	A	✓	✓	A	✓	✓	
Nashaba Ellahi	NON MEMBER			✓	✓	✓	✓	A	A	✓	A	✓	
Christopher Lube	✓	✓	✓	✓	NON MEMBER								
Philip Bartley	NON MEMBER						✓	A	✓	A	✓	✓	

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

Quality Committee Chair's Highlight Report to Trust Board
28 March 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Staffing pressures in the Senior Leadership Team in the Family Health Division were having a demonstrable impact on the overview of safety actions. The Committee considered that the pressures would be having a similar impact on all areas of work in addition to the safety actions. The Chief Executive advised that the corporate teams, i.e. Operational, Governance, Human Resources, should be offering additional support during the interim recruitment stage. The Maternity Oversight Group with Executives would continue. • The performance report indicated the following key risks: an increase in gynaecology unplanned return to theatres, an increase in Serious Incidents within Maternity and a never event reported in Maternity. It was requested that a considered narrative against the identified risks should be provided alongside the performance report to better inform and assure the Committee.	• Risk that the Nursing, Midwifery and AHP research talent pipeline might not be funded was noted. This would be picked up through financial planning and a proposal presented to the Executive Team. The Chief Finance Officer confirmed that this had been identified as a cost pressure and had been included in the budget planning 2022/23 to be considered by the FPBD Committee that afternoon and by the Trust Board on 07 April 2022. • Further interrogation into the responses received on the Committee effectiveness survey to be undertaken with members of the Committee to inform the Committee Annual Report ahead of discussion at the Trust Board 07 April 2022.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**

• The Committee received a newly formatted performance dashboard. Although some data was yet to be populated the Committee agreed that the data had evolved and provided more clarity.
• The Committee received a newly formatted Integrated Governance Report and noted new additions to the report including Health and Safety, Freedom to Speak Up, and Quality Improvement. The Committee advised that the report should include reference to the Future Generations as a key organisational risk.
• Received assurance of progress and compliance against the ten safety actions and their associated standards for the Maternity Incentive Scheme Year 4. A weekly oversight meeting had been introduced to ensure evidence was in place. The Committee noted the specific updates in relation to:
  ○ Neonatal Nursing Workforce
  ○ Neonatal Medical Workforce
  ○ Anaesthetic Workforce
  ○ Perinatal Surveillance Dashboard Update
• The Committee had a robust discussion on the proposed risk appetite and tolerance levels, particularly in relation to the risk appetite for experience as low and risk appetite for effective as high. The Committee agreed with the proposed statement.
	• The Committee noted the review undertaken against the Corporate Objectives 2021/22 and approved the update to be presented to the Trust Board in April 2022.
	• Approved the Statement of Purpose subject to the addition of reference to the Community Diagnostic Centre and its alignment with Trust services. The Statement of Purpose would be submitted to the Care Quality Commission (see Appendix 1).
	• Recommend to the Board the appetite and risk tolerance levels for 2022/23 against the strategic aims for which the Committee is responsible.
	• Recommend approval of the Committee Terms of Reference and Workplan 2022/23.
	• Submission of the Committee Annual Report to the Board to provide assurances of Committee effectiveness.
	• Recommend Board approval of the Risk Management Strategy 2022/23.

• The Committee noted the Serious Incident and Learning monthly report. • The Committee received positive assurance from the Safeguarding Quarterly Report, Q3 2022/23.	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the Quality related BAF risks. No changes to risks scores or narrative was recommended. It was noted that a formal review of BAF risks to be taken forward into 2022/23 would be undertaken at the next meeting.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- A positive meeting
- Satisfactory reports and sighted on the most appropriate issues
- Committee functionality had improved during the past 12 months

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
234.	Board Assurance Framework	Assurance	240.	CNST Year 4 Assurance	Information
235.	Sub-committee Chair Reports	Assurance	241.	Risk Appetite Statement – Quality Committee	Approval
236.	Corporate Objectives 2021/22: Designated Quality Objectives Year-end Outturn	Information	242.	QC Committee Effectiveness Review, Terms of Reference & Workplan	Approval
237.	Quality & Regulatory Update	Assurance	243.	Serious Incidents & Learning Report (Monthly Update)	Assurance
238.	Quality Performance Report Month 11, 2021/22	Assurance	244.	Safeguarding Quarterly Report Quarter 3	Assurance
239.	Integrated Governance Assurance Report Quarter 3	Assurance	245.	Annual Review of Risk Management Strategy	Approval

3. 2021 / 22 Attendance Matrix

Core members	Apr		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie, Chair	✓	✓	A	✓	✓	A	✓	A	✓	✓	✓	✓	✓
Susan Milner	✓	✓	A	✓	✓	✓	A	✓	✓	✓	✓	✓	✓
Ian Knight	✓	✓	✓	✓	✓	✓	NON MEMBER						
Louise Kenny	✓	✓	✓	✓	✓	✓	A	✓	✓	A	A	A	A
Marie Forshaw	✓	✓	✓	✓	✓	A	A	✓	✓	✓	✓	A	✓
Gary Price	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	A	✓

Lynn Greenhalgh	✓	✓	A	✓	A	✓	✓	✓	✓	✓	✓	✓	✓
Jenny Hannon	✓	✓	A	✓	✓	✓	✓	Non-Member					
Eva Horgan	Non-Member							✓	✓	✓	✓	✓	✓
Michelle Turner	✓	✓	✓	✓	✓	✓	A	✓	✓	A	✓	✓	✓
Nashaba Ellahi	NON MEMBER			✓	✓	✓	✓	A	A	✓	A	✓	A
Christopher Lube	✓	✓	✓	✓	NON MEMBER								
Philip Bartley	NON MEMBER						✓	A	✓	A	✓	✓	✓
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) *Non-quorate meetings highlighted in greyscale*													

Statement of Purpose

1.Aims and Objectives

Our vision is 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.

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 strategic aims are:

- 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 in order to deliver the most effective outcomes
- To deliver the best possible experience for patients and staff.

Our ambitions are:

- 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 Strategy for 2021-2025 was written in collaboration with our staff, our patients, our governors, our members and our wider community. It sets out our ambitions for Liverpool Women's Hospital for the next five years, and will be our guide to the decisions we make on our journey to becoming outstanding in everything we do and

achieving our vision of being the recognised leader in healthcare for women, babies and their families

Listening to the views of our staff, patients and community was central to the development of this strategy. We asked what was most important to
Them, what they valued most about Liverpool Women's and where they thought our main focus for the future should be. All the groups we engaged with were clear and consistent in what they told us:

- 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 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

This strategy is underpinned by a series of supporting strategies and plans. Our Clinical and Quality Strategy, our Future Generations long term strategy and our Research and Innovation strategy have all been key influences in developing our overall plan for the future. They, along with our supporting corporate strategies, set out some of the detail in how we intend to deliver our objectives. Our strategies are cohesive, are tied together by our common aims and work in harmony to achieve our vision. Some of our supporting strategies are still under development, and some will be refreshed to ensure all of our plans are consistent.

2. Services/Regulated Activities

2.1 Surgical procedures

Gynaecology

The Trust carries out the full range of Gynaecological surgical procedures commensurate with the Trust's status as a tertiary centre and Gynaecological Cancer Centre for Cheshire and Merseyside.

Reproductive Medicine

There are a number of related surgical procedures carried out by the Hewitt Centre for Reproductive Medicine:

- Male – testicular biopsy, surgical sperm retrieval (SSR);
- Female – diagnostic laparoscopy, diagnostic hysteroscopy, ovarian diathermy, salpingectomy, ovarian cystectomy.

Maternity

Emergency and planned Caesarean sections are carried out at Liverpool Women's Hospital only, as are emergency hysterectomies.

Surgical Support Services

Anaesthetic input for surgical procedures includes the following:

- Traditional theatre list sessions, with associated pre- and post-operative input and care
- High dependency level II cares and procedures in both Obstetrics and Gynaecology
- Obstetric analgesia and anaesthesia
- Pre-operative Surgery Clinics
- Obstetric Medical Disorder Clinics

Neonatal

The Neonatal Unit at Liverpool Women's Hospital works in partnership with Alder Hey Children's Hospital to provide a surgical service for neonates. The majority of surgery is undertaken at Alder Hey Children's Hospital. The following surgical procedures are performed at LWH:

- Retinopathy of Prematurity (ROP) treatment
- Removal of surgically placed central venous catheters
- Emergency paracentesis

Screening

- Retinopathy of Prematurity Screening
- NIPE
- Audiology screening

2.2 Diagnostic and screening procedures

- Genetics laboratories – cyto and molecular
- Dexa scanning
- Hystosalpingogram
- Ultrasound scanning
- Amniocentesis
- Chorionic villus sampling
- Fetal Blood Sampling
- Newborn hearing screening
- Ovarian cancer screening

- Urodynamics:

1. Bladder instillation
2. Electrical Stimulation
3. Pad testing
4. Anorectal tests
5. Cystometry

- Reproductive Medicine:
- Pre-treatment laboratory tests

1. Andrology laboratory tests
2. Hormone tests
3. Rubella
4. Semen analysis

5. Post-vasectomy semen analysis
6. Virology screening tests
7. Chromosome studies
8. Cystic fibrosis screening

- Ante natal screening:

1. Down's Syndrome
2. Hepatitis B
3. HIV
4. Rubella
5. Sickle Cell and Thalassemia
6. Infectious diseases

- Examination of the newborn.

2.3 Maternity and midwifery services

Liverpool Women's NHS Foundation Trust remains one of only two NHS trusts in the country specialising in maternity care. This has enabled us to continue to provide a comprehensive range of services to the women, babies and families of Liverpool and beyond.

- Antenatal care – hospital and community based
- Fetal medicine including laser fetoscopy
- Home birth
- Midwifery led birth
- Consultant led birth
- Postnatal care
- Infant feeding
- Smoking cessation
- Specialist clinics including:
- Perinatal mental health
- Endocrinology
- Obstetric haematology
- Neurology
- Substance misuse
- Multiple pregnancy
- Teenage pregnancy
- Non-English speaking
- Rheumatology
- Medical disorders
- Bariatric care
- Intra uterine growth retardation clinic
- Vaginal Birth After Caesarean section clinic
- External Cephalic Version clinic

2.4 Termination of pregnancies

Bedford Clinic is a nurse led day case termination of pregnancy unit offering a full range of counseling and support for women accessing the service. This includes both medical and surgical options for patients depending on gestation. The service if offered seven days a week. Further developments have resulted in an increased

nurse-led capacity with ultrasound support from within the unit as all women undergo a gestation ultrasound prior to any procedure. Working in partnership with Abacus clinics, the unit offers Chlamydia screening to all women who attend.

Medical terminations of pregnancy are carried out at both Liverpool Women's Hospital and at the Trust's Aintree site. Surgical terminations are carried out at Liverpool Women's Hospital only.

2.5 Treatment of disease, disorder or injury

Gynaecology

Liverpool Women's NHS Foundation Trust provides a wide range of gynaecology care in both acute and elective settings. In addition to general gynaecological clinics the Trust offers many specialised services. These include urogynaecology, oncology, and infertility sub-specialty clinics which cater for the local population as well as providing tertiary level care for the Mersey Region. In addition there are many specialised clinics including:

- one-stop menstrual disorders
- hysteroscopy
- colposcopy
- endocrinology
- miscarriage
- vulva clinic
- menopause
- ambulatory gynaecology
- rapid access clinics for potential gynaecological cancers

Emergency Room

The Emergency Room is based at the Crown Street site and is open 7 days a week, 24 hours a day for women who have emergency gynaecological problems and pregnant women under 16 weeks with pregnancy related complications. Over the years there has been an exponential increase in the number of early pregnancy complications seen and treated in the emergency room. Patients are offered treatment and support from the co-located Early Pregnancy Assessment Unit.

Oncology

The Trust is now well-established as the Gynaecological Oncology Centre within the Mersey Gynaecological Cancer Network. The service is provided by four sub-specialist gynaecological oncology consultants, one consultant in palliative medicine, four Macmillan Clinical Nurse Specialists and a team of specialist Macmillan dieticians.

Reproductive Medicine

The Trust's Hewitt Centre for Reproductive Medicine is a national and international centre of excellence in the field of assisted conception. The Hewitt Centre remains proud of its high-quality service to patients and has maintained its prestigious International Standards Organisation, ISO 9001:2000 Quality Standard award. Most of the work of the Hewitt Centre continues to fall under the statutory regulation of the Human Fertilisation and Embryology Authority (HFEA) and holds an unconditional

treatment and storage licence. The Unit is the largest provider of NHS-funded fertility services in the UK, treating over 1500 couples as well as providing private treatment to nearly 500 couples per annum. Both activity and success rates within the Hewitt Centre have continued to rise year on year with around 30% of patients achieving a pregnancy per cycle.

The Hewitt Centre offers the following services:

Consultation services - Initial and review consultations carried within dedicated consulting facilities within the Hewitt Centre by medical, nursing and scientific staff.

Gamete and embryo storage - pre-vasectomy semen storage, semen storage for treatment 'back-up', sperm storage following SSR, pre-chemo/radio therapy semen storage, egg storage, embryo storage. The Hewitt Centre contains a very large gamete storage facility holding semen, surgically-retrieved sperm and eggs. All material is held under liquid nitrogen in vessels that are constantly monitored and alarmed.

'Non-invasive' treatment modalities - Induction of ovulation, intrauterine insemination (IUI) using partner or donor sperm. The Hewitt Centre is able to provide the 'simpler' forms of assisted conception treatment. These treatments are provided on an out-patient basis within dedicated facilities.

'Invasive' treatment modalities - In vitro fertilisation (IVF), intracytoplasmic sperm injection (ICSI), embryo freezing and storage, frozen embryo transfer (FET), transport IVF, ICSI and FET with the Countess of Chester Hospital and Leighton Hospital in Crewe, egg donation, embryo donation, egg sharing. The Hewitt Centre is able to provide the full range of 'high-tech' assisted conception services (listed above) on an out-patient basis within dedicated facilities. Similarly, dedicated facilities at the Countess of Chester Hospital and Leighton Hospital in Crewe allow the successful performance of 'transport' assisted conception services whereby patients are managed up to and including the egg recovery procedure at the transport centre.

Counselling – covering treatment implications, support and therapeutic counselling. The Hewitt Centre is able to provide a full range of independent fertility counselling and has a discreet counselling room.

Regulation

In accordance with regulatory requirements the Hewitt Centre is inspected and licensed by the Human Fertilisation and Embryology Authority (HFEA) The following services are listed on the Hewitt Centre's HFEA 'Treatment with storage' licence (L0007-14-a):

- Storage of eggs
- Storage of sperm
- Storage of embryos
- Insemination
- Processing of gametes and embryos
- Gamete intra-fallopian transfer (GIFT)
- Treatment with donor gametes and donor embryos
- ICSI
- Zygote intra-fallopian transfer (ZIFT)
- Chemical assisted hatching

Neonatal Services

Neonatal Services at the Liverpool Women's NHS Foundation Trust is one of the two level three unit in the Cheshire and Mersey Region. The unit works in a partnership with Alder Hey Children's Hospital as the Liverpool Neonatal Partnership, providing neonatal medical, surgical, and cardiac services for Liverpool and the surrounding area. On the LWH site there are 52 cots, 12 of which are designated for intensive care of the new-born, 12 for high dependency, 20 low dependency care, 8 transitional care. There is also a community outreach service.

The service provides care for up to 1000 babies and their families per year. The Neonatal service ensures the whole family is included in the care and decision making of their baby in order to provide family centred care of the highest quality and in accordance with the Neonatal Unit's Philosophy of Care. The Trust also has provision to accommodate 14 families from outside the Liverpool area who have a baby requiring care and treatment on the site of Liverpool Women’s Hospital at Crown Street.

At the heart of our philosophy of care, is the commitment to put the babies requiring our specialist care first, ensuring they and their families have a positive experience, irrespective of the final outcome of their care. Our aim is to realise the Trust’s vision to be the recognised leader in healthcare for women, babies and their families.

Genomic medicine

Clinical genetics/genomics is a clinical specialty that advises on the diagnosis and clinical management of patients and families with genomic conditions, including inherited cancer, application and interpretation of increasingly complex genomic and other diagnostic testing and the screening and management of at risk and affected family members.

The Genomic medicine service for Cheshire and Merseyside is provided by the Liverpool Centre for Genomic Medicine, sited at Liverpool Women’s Hospital. The Genomic Laboratory Hub (GLH) provides cytogenetic and molecular genetics services and is on two sites: Liverpool Women’s Hospital and St Mary’s Hospital in Manchester.

Fetal Medicine Unit

The Fetal Medicine Unit provides a specialist commissioned tertiary level service to Cheshire and Merseyside, Isle of Man, and North Wales. In addition, we offer Fetal therapy service for complex singleton and twin/multiple pregnancies. We provide a multidisciplinary team approach to care, with joint clinics with paediatric surgeons, neurosurgeons, radiologists, neonatologists, geneticists, and palliative care specialists.

The following procedures take place at the Fetal medicine Unit

- Amniocentesis
- Chorionic Villus Sampling (CVS)
- Fetal blood sampling
- Amniodrainage
- Intrauterine Fetal Blood Transfusion

- Intrauterine fetal platelet transfusion
- Fetal Vesico-amniotic shunt insertion
- Fetal Pleuro- amniotic shunt insertion
- Fetoscopic Laser photocoagulation of placental communicating blood vessels
- Cord Occlusion
- Intrafetal Laser ablation
- Ex utero intrapartum treatment (EXIT) procedures
- Transplacental treatment for Fetal supraventricular tachycardia (SVT)
- Feticide
- Selective termination in complex twin/multiple pregnancies
- Selective reduction of multiple pregnancy
- Ultrasound-guided Laser photocoagulation of fetal or placental tumours

The following specialist clinics are based in the Fetal medicine Unit:

- Fetal echocardiography service linked to Alder Hey Children's Hospital which hosts a regional paediatric cardiac, Extracorporeal membrane oxygenation (ECMO), and surgery service
- Combined Neurology Clinic where patients are seen jointly by the Fetal Medicine Consultant and Paediatric Neurosurgeon from Alder Hey Children's Hospital
- Combined Surgical Clinic where patients are seen jointly by the Fetal Medicine Consultant and Paediatric Surgeon from Alder Hey Children's Hospital
- The Liverpool Multiple Pregnancy clinic is one of only a handful of dedicated integrated multiple pregnancy clinics in the UK
- The Harris Preterm Birth clinic, a dedicated research-active high-risk clinic
- Fetal Growth Restriction clinic is a dedicated clinic where pregnancies complicated by fetal growth restriction or at high risk of placental insufficiency are monitored
- North-West Coast Placenta Accreta Service (PAS) was recently established to provide diagnostic and MDT services for abnormally invasive placenta cases across the Liverpool, Cheshire, and Merseyside region

All these clinics are supported by a team of experienced specialist Fetal medicine midwives. In addition, a representative from the Claire House team attends these weekly MDT meetings in order to provide hospice services and undertake parallel planning with families of babies with life-limiting disorders when needed.

The Fetal Medicine Unit holds a weekly MDT meeting where all the complex cases, imaging findings, prenatal laboratory and genetic investigations, and management plans are discussed with input from all relevant members of the team. In addition, peripartum and neonatal management plans are agreed upon by the MDT. These meetings have been organised virtually since the beginning of the COVID pandemic.

This provides an opportunity for many team members to join the meeting, which is a learning opportunity for trainees and facilitates closer working relationships with Fetal medicine clinicians across the Cheshire and Mersey Neonatal Network.

2.6 Family planning services

The Trust provides a comprehensive family planning service including the fitting of intra uterine devices and sterilisation.

2.7 Transport, triage and medical advice provided remotely

The Trust is a Level III provider of neonatal care services and hosts the regional Neonatal Transport Service. This service transports critically ill neonates across Cheshire and Merseyside in order to receive medical and surgical care in the most appropriate clinical setting. Part of this service includes providing medical advice remotely to other health care professionals.

2.8 Assessment or medical treatment for persons detained under the 1983 Act (The Mental Health Act 1983)

Although not a provider of mental health services, very rarely an inpatient at the Trust may be subject to section under the Mental Health Act. In such circumstance the mental health Trust where the woman is being detained would accompany the woman to Liverpool Women's Hospital and provide staff 24/7 to supervise them.

3.Service provider details

For all regulated activities, the contact details are as follows:

Name of Provider: Liverpool Women's NHS Foundation Trust

Name of CQC Nominated Individual: Kathryn Thomson, Chief Executive

Name of Chief Nurse & Midwife: Marie Forshaw

Business address: Liverpool Women's NHS Foundation Trust, Crown Street, Liverpool L8 7SS

Telephone: 0151 702 4040

Email addresses: kathyrn.thomson@lwh.nhs.uk Marie.Forshaw@lwh.nhs.uk

4.**Legal Status**

Liverpool Women's NHS Foundation Trust was authorised on 1st April 2005 and operates in accordance with its Terms of Authorisation and in accordance with the National Health Service Act 2006.

5.Locations

The Trust is registered to carry out regulated activities at two main locations:

- Liverpool Women’s Hospital, Crown Street, Liverpool L8 7SS
- Liverpool Women’s at Aintree, Longmoor Lane, Liverpool, L9 7AL

Liverpool Women's
NHS Foundation Trust

Trust Board

Workforce Performance Report
April 2022

Trust Board Performance Report

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

Report Layout:

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

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

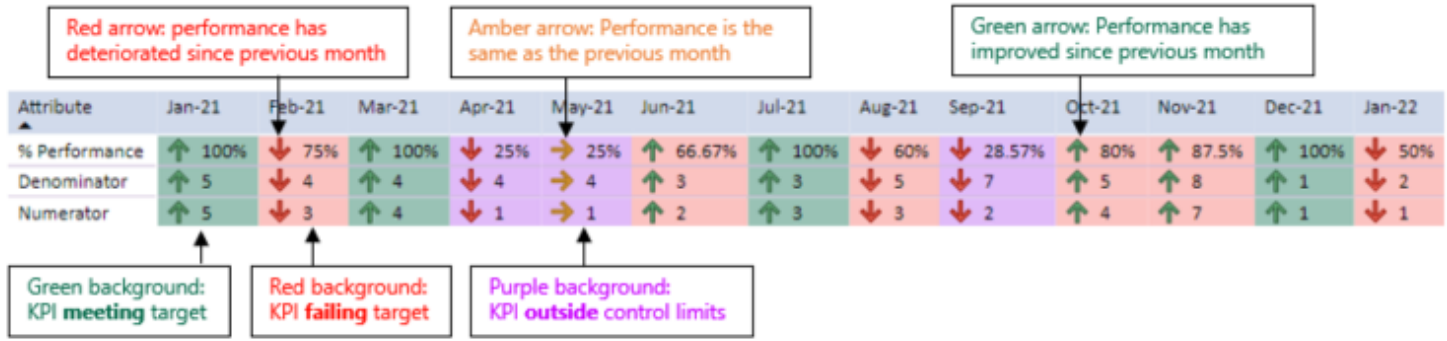
- Outside of a control limit, having previously been within control limits
- A consecutive deterioration of performance over a quarter, which is not insignificant
- A significant drop in performance over the space of a month
- A consecutive improvement in performance over a quarter, which is not insignificant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

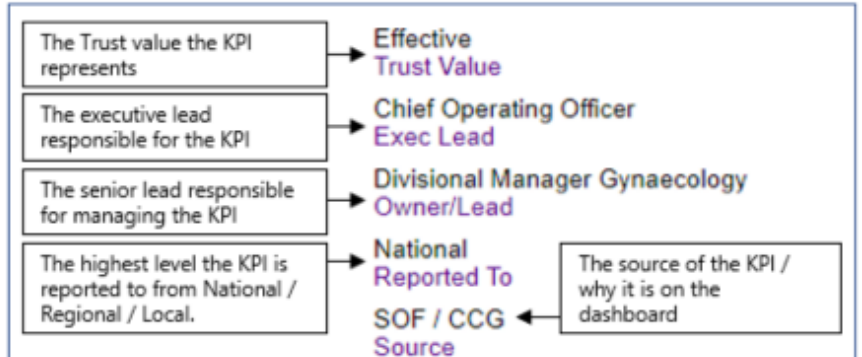
Data Sheets - these provide detailed information for each specific KPI measured. This includes data values for the previous 13 months, a sparkline included performance dating back to April 2018 where available. The sparkline graph includes the performance, target and control limits for the specific KPI.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

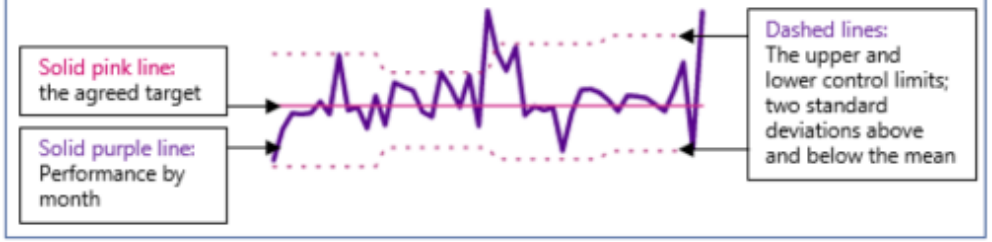
Data Health Check - highlights where KPIs have denominators outside of control limits along with a summary of the data quality kite mark scores for each KPI.

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

How to interpret the report:



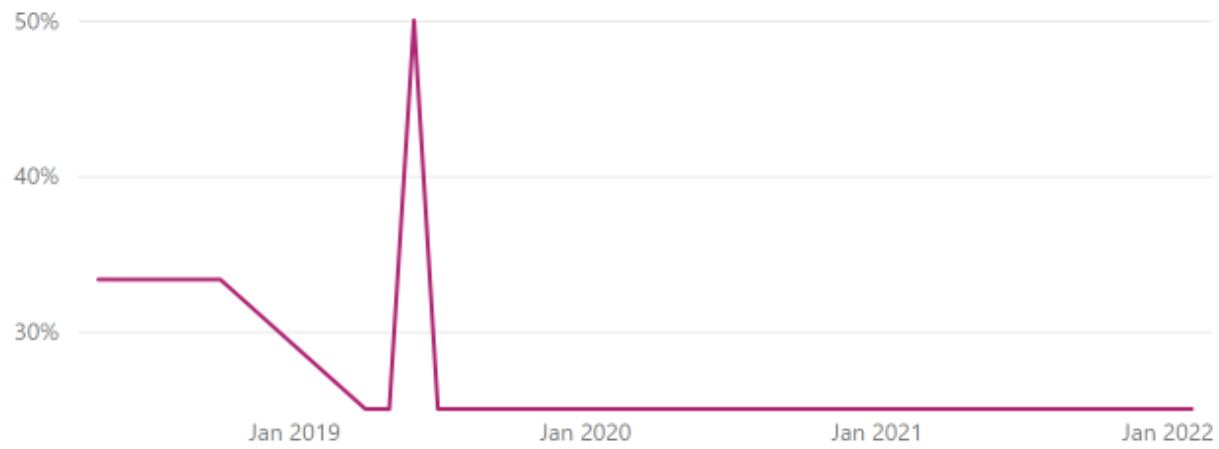




Control limits are set using statistical process control. The standard deviation for each indicator is calculated based on the previous two financial years data unless recalculation is required due to service changes. the upper and lower control limits are two standard deviations above and below the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

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

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



Positive Developments

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

Areas of Challenge

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

KPI	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022
Clinical Mandatory Training Compliance	85.57% ↓	85.23% ↓	83.42% ↓	79.16% ↓	80% ↑	81.88% ↑	81.17% ↓	81.91% ↑	80.35% ↓	79.21% ↓	78.26% ↓	68.06% ↓	79.22% ↑
Mandatory Training Compliance	86.64% ↓	86% ↓	89% ↑	86% ↓	87% ↑	80% ↓	88% ↑	89% ↑	85% ↓	86% ↑	86.23% ↑	88.17% ↑	87.82% ↓
Sickness Absence Rate	7.08% ↓	5.63% ↓	5.41% ↓	5.72% ↑	6.21% ↑	7.67% ↑	7.99% ↑	8.35% ↑	8.03% ↓	7.93% ↓	10.26% ↑	10.99% ↑	7.64% ↓
Turnover Rate	9% →	9% →	9% →	9% →	10% ↑	11% ↑	11% →	11% →	13% ↑	12% ↓	12% →	13% ↑	13% →

KPIs Selected for Review

Multiple selections

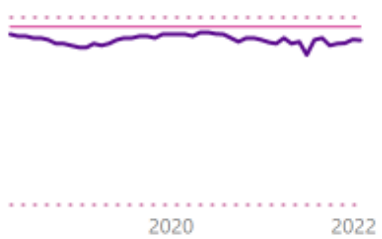
These KPIs have been highlighted for the current reporting month. In depth detail and narrative is included in the reporting pack

Mandatory Training Compliance

Target: >= 95%

KPI095T

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% Performance	86.64%	86%	89%	86%	87%	80%	88%	89%	85%	86%	86.23%	88.17%	87.82%
Numerator	0.87	0.86	0.89	0.86	0.87	0.8	0.88	0.89	0.85	0.86	0.86	0.88	0.88



Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

Local
Reported To

Trust
Source

DQKM

The overall Trust mandatory training compliance for month ten and eleven maintained at 80%, this is still 7% below Trust target of 95% and rated as amber. In the largest clinical areas, compliance increases where seen in Maternity by 0.92% and 1.44% in Gynaecology, while Neonatal maintained at 95.12%. At the divisional level, compliance increased by 0.52% in Family Health, by 1.12% in Clinical Support Services, and 0.60% in Gynaecology while Corporate Division saw a decrease by 0.91%.

The HR and L&D teams continue to provide support, information, and training to managers across the Trust. Positive work is on-going with the OLM task and finish group, which has seen improvements with the accessibility of training with automatic enrolments to e-learning packages, which has already seen a marked reduction in monthly queries being highlighted to the L&D team while efforts are now being reflected in training percentage increases.

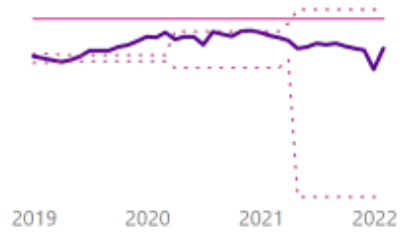
While every effort is being made to improve and maintain compliance rates, it is expected due to a reduction in COVID absence by 2.59%, this will impact on future mandatory training compliance. Nevertheless, every endeavour continues to be made to bring the figure within Trust target through effective collaboration between line managers, Human Resources and Learning & Development.

Clinical Mandatory Training Compliance

Target: >= 95%

KPI378T

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% Performance	85.57%	85.23%	83.42%	79.16%	80%	81.88%	81.17%	81.91%	80.35%	79.21%	78.26%	68.06%	79.22%



Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

Local
Reported To

Trust
Source

DQKM

February 2022

The overall Trust clinical mandatory training compliance increased by 0.05% from 79% in month ten to 79.22% in month eleven. This is now 15.78% under the Trust's target rate of 95%. In the largest clinical areas, compliance decreased by 0.73% in Maternity, while increases where seen in Gynaecology by 1.55% and 3.10% in Neonates. At the divisional level, compliance decreased by 0.66% in Clinical Support Services, and by 10.42% in Corporate Division, while compliance increased in Family Health by 0.43% and Gynaecology by 0.82%.

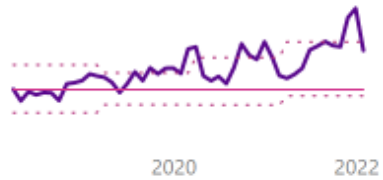
The HR and L&D teams continue to provide support, information, and training to managers across the Trust. L&D Teams are working closely with practice educators to ensure classes are being scheduled and registers are updated accordingly on class completion. In addition, positive work is on-going with the OLM task and finish group, which has seen improvements with the accessibility of training with automatic enrolments to e-learning packages, which has already seen a marked reduction in monthly queries being highlighted to the L&D team. Training validations are scheduled for April, which gives managers and educators the opportunity to audit training requirements for the positions within their areas.

While every effort is being made to improve and maintain compliance rates, it is expected due to a reduction in COVID absence by 2.59%, this will impact on future mandatory training compliance. Nevertheless, every endeavour continues to be made to bring the figure within Trust target through effective collaboration between line managers, Human Resources and Learning & Development.

Sickness Absence Rate

Target: **<= 4.5%**

Attribute	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
% Performance	7.08%	5.63%	5.41%	5.72%	6.21%	7.67%	7.99%	8.35%	8.03%	7.93%	10.26%	10.99%	7.64%



Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

National TBC
Reported To

SOF / CCG / Trust
Source

DQKM

February 2022

The single month sickness absence figure decreased by 3.35%, from 10.99% in month ten to 7.64% in month eleven. This is now 3.14% above the Trust's target figure of 4.50% and is therefore rated as red. In the largest clinical areas, sickness absence decreased in all areas by 4.92% in Maternity, 6.24% in Gynaecology and 3.72% in Neonates. At divisional level, sickness decreased in all areas by 4.50% in Family Health, 4.92% in Gynaecology, 0.88% in the Corporate Division, and 1.25% in Clinical Support Services.

Overall, the proportion of sickness that was short term decreased by 8% from 46% in month ten to 38% in month eleven, which in turn increased long-term sickness by 8% from 54% in month ten to 62% in month eleven. In terms of diagnosis, the top three most common again remained unchanged: cold/cough/flu is the most prevalent diagnoses, followed by anxiety/stress/depression, and then gastrointestinal problems. The figure for sickness specifically resulting from COVID 19 decreased by 2.59% from 4.88% in month ten to 2.29% in month eleven as the OMICRON variant subsides.

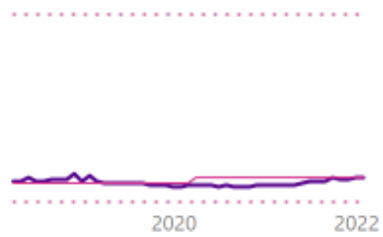
The HR Department are continuing to provide support for managers in managing sickness absence and in supporting staff through this difficult time. A range of measures are in place specifically to address the situation with regards to COVID 19. These are available to all staff and include risk assessments, on-site testing for staff (and family members) with suspected symptoms, and asymptomatic testing which is now mandatory for all staff. A new Return to Work form has been launched with a focus on health and wellbeing rather than short term policy stages, together with a new recording process that will allow the completion of return-to-work meetings to be accurately monitored. A fundamental revision of the Trust's Attendance Management Policy whereby the short term stages for managing attendance will be removed, will be launched shortly.

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

Turnover Rate

Target: **<= 13%**

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



Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

National TBC
Reported To

SOF
Source

DQKM

January 2020

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/010b***		**Date: 07/04/2022**	
Report Title	**Equality, Diversity and Inclusion Annual Report**			
Prepared by	**Rachel London, Deputy Director of Workforce** **Rachel Cowley, Head of Culture and Employee Experience**			
Presented by	**Rachel Cowley, Head of Culture and Employee Experience**			
Key Issues / Messages	This paper presents the Equality, Diversity and Inclusion Annual Report for 2021/2022. The report provides the required information as stipulated in our Quality Contract with the CCG, whilst also providing a summary and overview of some of the key developments and successes in the area of ED&I over the last 12 months. The report will be uploaded onto the public-facing section of the Trust website.			
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.***			
	To receive the report and note the ongoing progress in moving towards our corporate objective.			
Supporting Executive:	***Michelle Turner, Chief People Officer***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1.1 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)	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
PPF	**March 22**	**CPO**	**Committee requested that a bespoke ED&I Strategy be developed.**

EXECUTIVE SUMMARY

This paper presents the Equality, Diversity and Inclusion Annual Report for 2021/2022. The report provides the required information as stipulated in our Quality Contract with the CCG, whilst also providing a summary and overview of some of the key developments and successes in the area of ED&I over the last 12 months. The report will be uploaded onto the public-facing section of the Trust website.

The report should be read with reference to our current BAF risk, regarding the likelihood of LWH reaching our aim of becoming one of the UK's most inclusive employers. The report shows that through investment in additional posts, both the staff and patient ED&I agenda has moved forward, but there remains further work to do to fundamentally change culture. Achievement of place in the Inclusive Companies Top 50 was a positive starting point and the planned Culture Review will provide objective, external benchmarking data of our current position in respect of inclusion and further actions to be taken.

The Putting People First Committee received this report in March 2022. There was recognition of the progress made by the Trust but there was a request that a bespoke ED&I Strategy be developed by the Trust to support further improvements in this area.

The Board is asked to receive the report and note the ongoing progress in moving towards our corporate objective.

Equality & Diversity Annual Report 2022

Contents

1.0 Our Vision, Aims & Values

At Liverpool Women's Hospital we have a common goal - to provide excellent healthcare for women, babies and their families in a safe, friendly and caring environment.

We are proud to push the boundaries of healthcare for our patients and their families and we continue to influence national and international research and development in these fields.

Our Vision

The **vision** for Liverpool Women's Hospital is to be the recognised leader in healthcare for women, babies and their families.

Our Aims – We See

To achieve our vision we aim to do the best in everything that we do whether that is making sure our patients are as safe as possible and have the best experience possible or whether it is the development of our staff and the effective management of our resources. Specifically, we aim to;

- Develop a well led, capable, motivated and entrepreneurial **W**orkforce
- Be ambitious and **E**fficient and make best use of available resources
- Deliver **S**afe services
- Participate in high quality research in order to deliver the most **E**ffective outcomes
- Deliver the best possible **E**xperience for patients and staff.

Our Values – Care and Learn

The values that are important to us at Liverpool Women's Hospital are based around the needs of our patients and our staff. The behaviours we encourage in all our staff are to make sure that our values are delivered every day in the same way;

- **C**are – we show we care about people
- **A**mbition – we want the best for people
- **R**espect – we value the differences and talents of people
- **E**ngage – we involve people in how we do things
- **Learn** - we learn from people past, present and future

2.0 Context

The Trust has five over-arching Equality Objectives in our action plan for the period 2019 - 2023;

- Create a workforce representative of the community we serve
- Ensure that we meet the communication needs of our patients
- Ensure that staff training & development promotes the values of inclusion and tolerance for all, whilst meeting the needs of all staff groups

- Develop the EDI agenda into the culture of existing meetings and committees
- Continue to engage with our patient and staff groups to understand further the needs of individuals with protected characteristics and respond proactively to identified needs

The Trust Equality Objectives action plan (2019/23) can be found on the Trusts website (https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/).

To support the Trust in progressing and achieving the above objectives they have been mapped to the EDS2 framework. EDS2 is a tool designed to help NHS organisations, in partnership with local stakeholders, to review and improve their performance for people with protected characteristics (as defined by the Equality Act 2010), and to support organisations in meeting the Public Sector Equality Duties.

3.0 Activity in 2021/22

3.1 Our EDI Ambition and Achievements in 2021/22

There has been lots of great work at Liverpool Women's Hospital (LWH) over the past 12 months in relation to inclusion for both staff and patients and it is important that this is captured and celebrated, along with reporting our aspirations and plans to continually improve.

LWH has clear Strategic ambitions in relation to Equality Diversity and Inclusion (EDI). These are clearly outlined in the Strategies and regularly reported and monitored at Putting People First Committee and Trust Board.

As outlined within the trust Strategy 2021-25 LWH is

> ***'Committed to being recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)'***

With ambitions to achieve this including:

- ***Trebling the 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.***

LWH have made some positive progress in the past 12 months in relation to the equality Diversity and Inclusion agenda, these include:

- Membership of Inclusive Companies for professional support on EDI and to share and learn from other organisations (public and private) who have positive initiatives and experiences for staff from protected characteristics.
- Entered the Inclusive companies IT50 (inclusive top 50) and placed 41st with positive feedback and recommendations on how we can improve on this position moving forward.
- Recruited to four new roles in 2021/22 within the Trust with key focus on EDI and patient, these include:
  - Equality, Diversity and Inclusion lead
  - Head of Culture and Staff Experience
  - Patient Experience Matron
  - Culture Liaison Midwife
- Supporting Patients with Additional Needs strategy has recently been developed with clear actions on how we learn from our patients and improve moving forward.
- EDI is a standard agenda item at all Senior and Executive Leadership meetings, with more formal reporting into Trust Board and sub-board Putting

People First Committee. Agenda items include listening to and learning from staff and patient EDI stories and experiences.

- In June 2021 LWH devoted a full day to the theme of ED&I at the 'Great Day' an education day for medical and clinical staff. We welcomed an external medical consultant to provide training on topics such as microaggressions, improving patient experience for diverse groups. Lived experiences were shared from our staff networks, and John Barnes MBE was a popular speaker sharing his own lived experiences.
- Accredited as a "Disability Confident Employer" and 'Mindful Employer' we are committed to supporting staff to gain access to and maintain employment. Recruitment policy supports all staff in relation to promotion opportunities and career development.
- With long standing values of 'we care and we learn' we recently refreshed communications encapsulating them into a 'Be Kind' message which has been displayed in a high visibility poster campaign. Plans to develop this into a LWH People Promise maintaining a focus on the 'Be Kind' messaging which includes our values, behaviours and Just Culture.
- Diverse interview panel member at Senior leadership roles (Band 8A and above) interview, asking EDI questions as part of the interview process and acting as a check and challenge to appointing manager decision making.
- Strengthened community partnerships in L8 with ethnically diverse groups, promoting LWH as a great place to work and options available such as volunteering, widening participation programmes and current vacancies. e.g. Fair at Pakistani centre (unfortunately covid restrictions have meant future Health and Careers fairs have had to be cancelled or postponed).
- Performance Development Review (PDR) policy ensures staff from diverse backgrounds are not discriminated against and Talent Management Strategy includes colleagues from diverse backgrounds ensuring additional bespoke support and career conversations to enable them to overcome any barriers.
- Implemented diverse interview panels for senior roles and plans in place to develop staff with disability and BAME staff in recruitment processes so we can extend this offer.
- New Leadership development programme implemented in 2021/22 with a dedicated session on inclusive and compassionate leadership.
- The Trust has worked in partnership with the local constabulary to promote awareness of domestic violence and hate crime. This was aimed at staff, patients and the public and generated a positive response.
- Established links with Merseyside Deaf Society and monthly coffee mornings are dedicated the Patient Experience Matron to listen to any concerns raised and actions needed to improve accessibility.
- Established links with the Al-Ghazali Centre working in partnership with our local community and the local Mosque.

- A schedule of patient stories covering a range of protected characteristics, one example was Jenny and Nutmeg, this was a lady who is registered blind who had experienced Gynaecology services. As a result of Jenny's story, Jenny will be a patient representative and will be part of the group looking at how digital technology can improve the patient experience.

3.2 Delivering Inclusion throughout COVID-19

The impact of COVID-19 throughout 2020 and in to 2022 has had an unprecedented impact on our personal and working lives. Following the announcement of national lockdown measures in March 2019, we had to re-prioritise some of our planned actions and focus for the year ahead.

We applied the ethos of the Putting People First strategy and put our people at the forefront of the decisions made with focus firmly on the health and well-being of our colleagues by providing on-going well-being support and guidance.

We understand that all colleagues have different circumstances so we aimed to take forward the ethos of our Trust values in showing that we **C**are, **R**espect and **E**ngage whilst promoting kindness amongst all colleagues. Below provides some examples of the support we continue to provide to colleagues;

- Dedicated support to enable workplace adjustments from home
- Full access to mental wellbeing resources and tools
- Continuation of Schwartz rounds to enable discussions amongst colleagues to provide a platform for discussions on emotional well-being
- Staff networks for colleagues from protected characteristic groups
- Materials on how to manage and work in inclusive teams remotely

Staff from diverse backgrounds were supported during Covid, a staff survey and listening event were conducted, BAME staff representation at the Covid Oversight Committee ensured the voice of diverse colleagues was heard at Board level, plus our BAME staff were also offered Vitamin D testing.

3.3 Mental Health First Aiders (MHFA) and REACTMH

Work has continued throughout 2021/22 with staff who have been trained to become Mental Health First Aiders. MHFA training provides the skills to enable the 'First Aiders' to provide immediate support to other colleagues who feel they are developing a mental health issue, experiencing a worsening existing issue and/or experiencing a mental health crisis.

The training is available to all staff at all levels throughout the Trust and once trained, they are identified via a green badge displayed on their lanyard.

There are 105 trained MHFAs at LWH, this includes an additional 15 that were trained during 2021/22. There are 2 MHFA trainers at LWH and in 2022/23 we plan to expand this through securing charitable funds for additional MHSFA trainers.

The Trust has also invested in 2 trainers in REACTMH (active listening skills training). REACTMH is a tool that you can use to support your colleagues by having open and honest conversations about their mental health and wellbeing. REACTMH can be used to start a conversation with colleague (family member, patient or friend) who perhaps needs to talk but does not want to seek help or does not recognise that they need further support.

3.4 Widening Participation

The Trust supports pre-employment programmes with the purpose of providing an opportunity to those within the community to experience what it is like to work both at the Trust and within the NHS. The programme also aims to enable those on the programme to be employment ready.

In 2021/22, successful programmes include;

- The **Kickstart Scheme** makes up part of the Government's plan for jobs skills and employment programmes. The Kickstart Scheme offers six-month additional jobs for young people aged 16 to 24 years old who are currently claiming Universal Credit and are at risk of long-term unemployment.

- The Trust is working with the Assistant Head Teacher of **LEEP (Liverpool Education Employment Partnership)** about providing careers advice for her pupils, to showcase career and job opportunities within the NHS. These students have been removed from mainstream schools for various reasons.

- Working in partnership with NHS organisations, Southport College recruits 16 to 19 year old students onto the **ACORN programme** and supports them throughout the duration of their training. ACORN's will undertake a 2 year BTEC Level 3 in Healthcare. The programme combines academic study and valuable work placements to ensure that when the ACORNs complete their programme they are equipped with the necessary qualifications, skills and experience to apply for employment or university, hopefully in healthcare such as nursing or midwifery.

- **Functional skills** teaches post-16 and adult learners in England how to apply practical Maths and English skills to real-life and vocational contexts. These qualifications will support our staff development and potentially enable progression internally within their chosen career path and onto other widening participation programmes such as apprenticeships.

- **Apprenticeship programmes** can help upskill and retain existing employees enabling them to gain formal qualifications in specialist areas. In addition, apprenticeship opportunities can help an organisation to recruit people into

development roles that suit the learning and development needs of the organisation.

3.5 Colleague Inclusion Networks

The Trust has an established BAME staff network and a Disability staff network, both networks meet quarterly.

Networks have supported the work for Black History Month and raising awareness of support available to colleagues with hidden disabilities such as neurodiverse and mental health conditions.

3.6 Supporting patients with additional needs

A key component of Liverpool Women's NHS Foundation Trust overall clinical service strategy is to become an exemplar site for the care of patients with additional needs, including those with dementia, learning and or physical disabilities and autism.

Building on the work already completed, the Trust have approved a three-year strategic plan detailing how we will continue to respond to the profile of our local population and work with our patients, carers, staff and partners to further enhance the delivery of high quality, person-centred care for people with additional needs and their carers/families.

This strategy sets out our plans to ensure equality of access to patient centred health care, provided by a workforce skilled to deliver our expectations built on ‘Our Values’.

To provide assurance, the Trust developed a bespoke audit tool to demonstrate compliance against national standards that support the NHS Long Term Plan (2018); which aims to develop a clearer and more widespread focus on the needs of people with a learning disability, autism and dementia.

The findings demonstrated:

- The arrangements in place to identify and flag patients with learning disabilities, autism and or dementia from the point of admission through to discharge are effective.
- Where relevant, reasonable adjustments to care pathways were made to ensure people with learning disabilities, autism and or dementia are able to access highly personalised care and achieve equality of outcomes.

- Those providing care have the specialist knowledge and skills to meet the unique needs of people with learning disabilities, autism and or dementia.
- The experiences of those included in the audit against the Trust Friends and Family Test (FFT) scores for patients without a learning disability, autism or dementia were equal.

In addition, the Trust have also relaunched a service that is designed to provide volunteers to support patients with additional needs. This service was introduced to provide respite for relatives/carers as well as provide support for those patients who attend without any support.

4.0 Measures & Objectives

4.1 Gender Pay Gap Report (2021)

Gender pay gap reporting regulations require UK employers in the public sector with 250+ employees to disclose workforce details in relation to their gender pay gap based on a single date each year, namely 31 March. As such, the gender pay gap report gives a snapshot of the gender balance within an organisation. It measures the difference between the average earnings of all male and female employees, irrespective of their role and/or seniority.

The full 2021 Gender Pay Gap report for the Trust can be found on the Trust website (https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/).

4.2 Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) was most recently submitted on 30th August 2021, in line with the national deadline.

In summary from the latest 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.

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.

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.

A WRES action plan for the coming year is available to view which takes into account the above noted key findings from the latest WRES submission and this can be found at on the Trust website (https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/).

4.3 Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) was introduced in 2019 and entails a set of specific measures/metrics that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. The deadline for this data submission was successfully met on 31st August 2021.

The data shows that the overall number of disabled staff in the Trust 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 not wishing to disclose a disability when they commence in post on ESR, though the position has improved slightly since 2019. This remains the topic of on-going communication and assurance with regards to support available.

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%).

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.

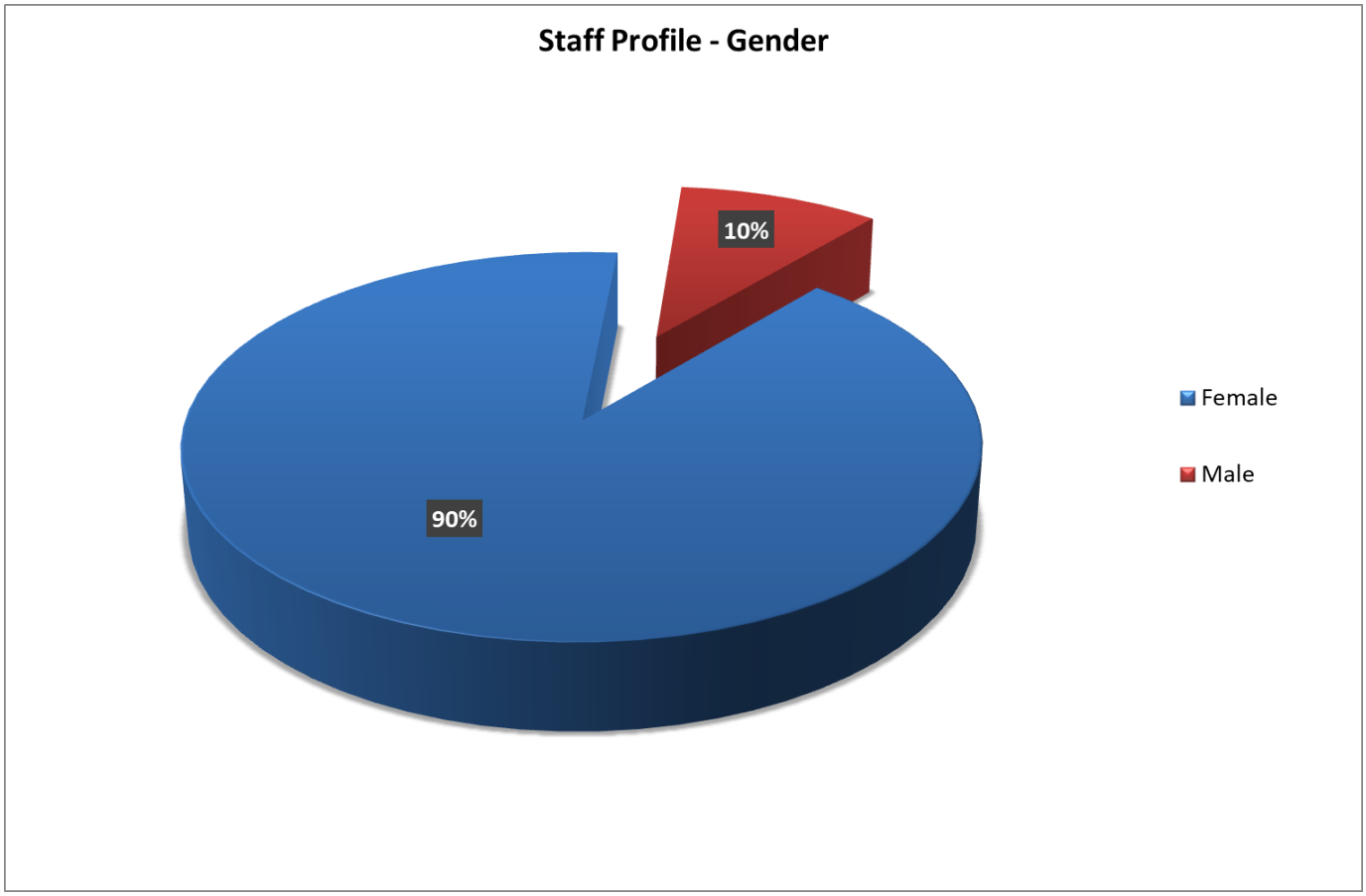
The Trust WDES action plan can be found on the Trust website (https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/).

4.4 Staff Profiles

Headcount for the workforce as of December 2021 stood at 1571 which is an increase of 55 staff from 2020.

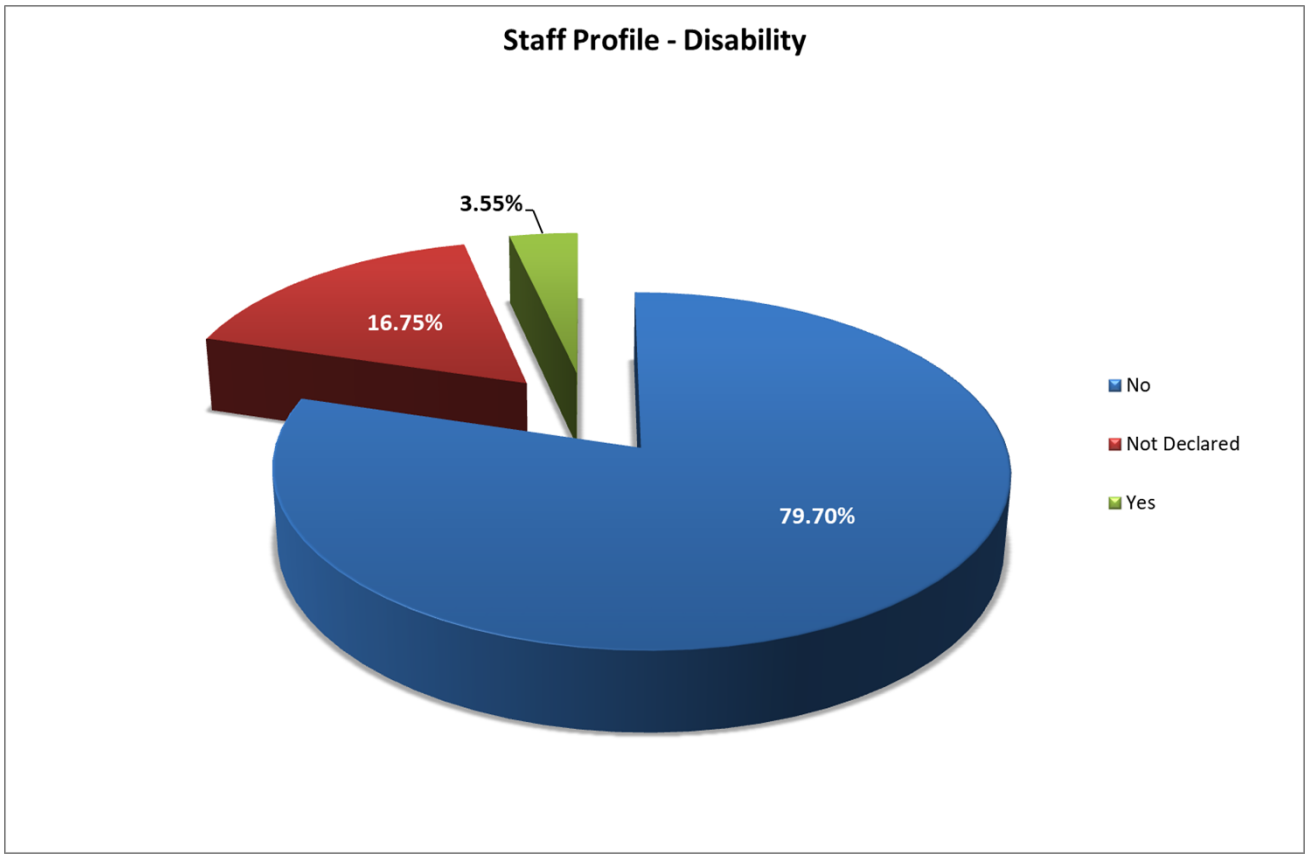
Staff Profile - Gender

Liverpool Women's NHS Foundation Trust has an 90% female workforce which equates to 1413 colleagues.



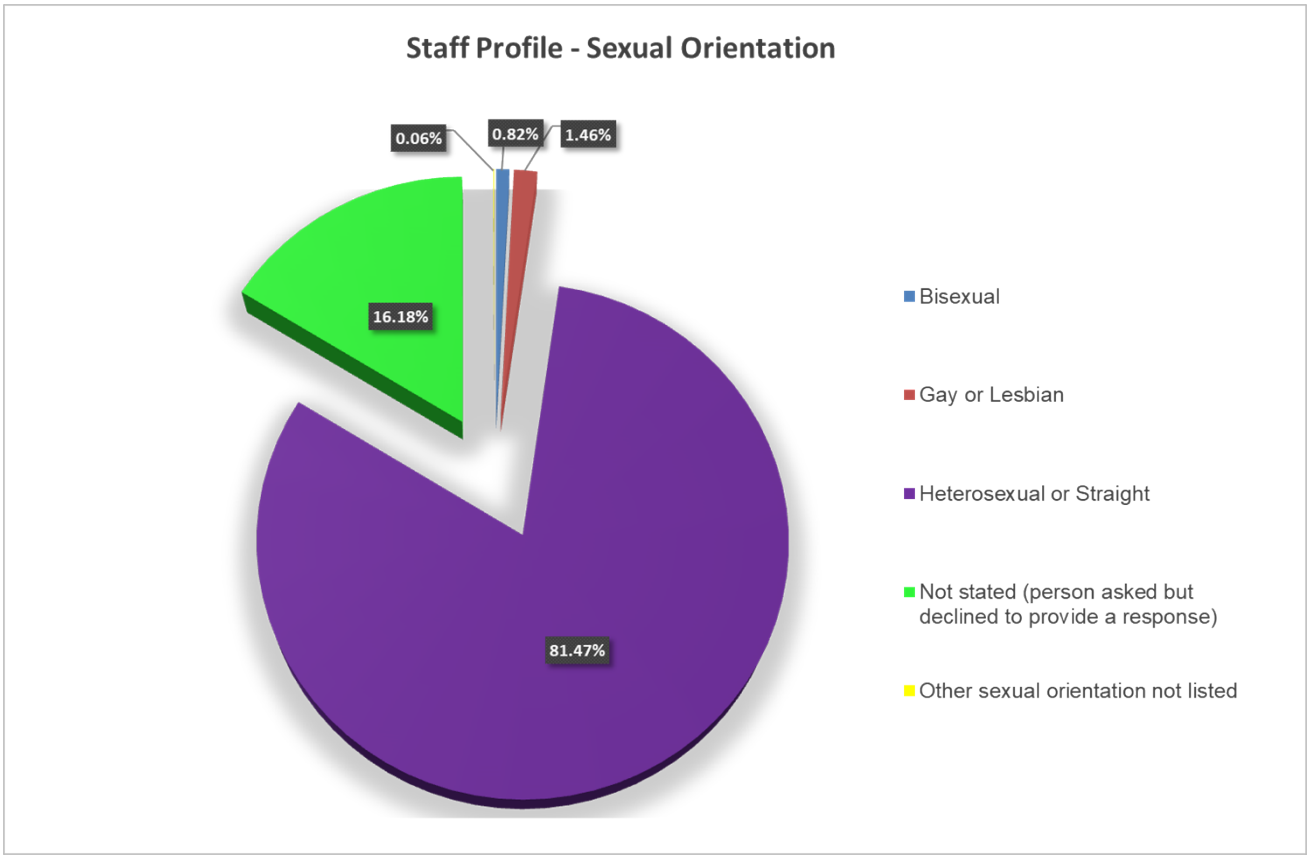
739 staff are in the Nursing and Midwifery staff group; 99.19% of this group are female.

Staff profile - Disability



The figures relating to disability declarations 79.70% of colleagues state they do not have a disability and 3.55% state that they do. 16.75% of colleagues declined to provide an answer to the question and therefore not providing a full representation of disability within our colleague base. Further information can be found in the Trust WDES report which can be found via https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/

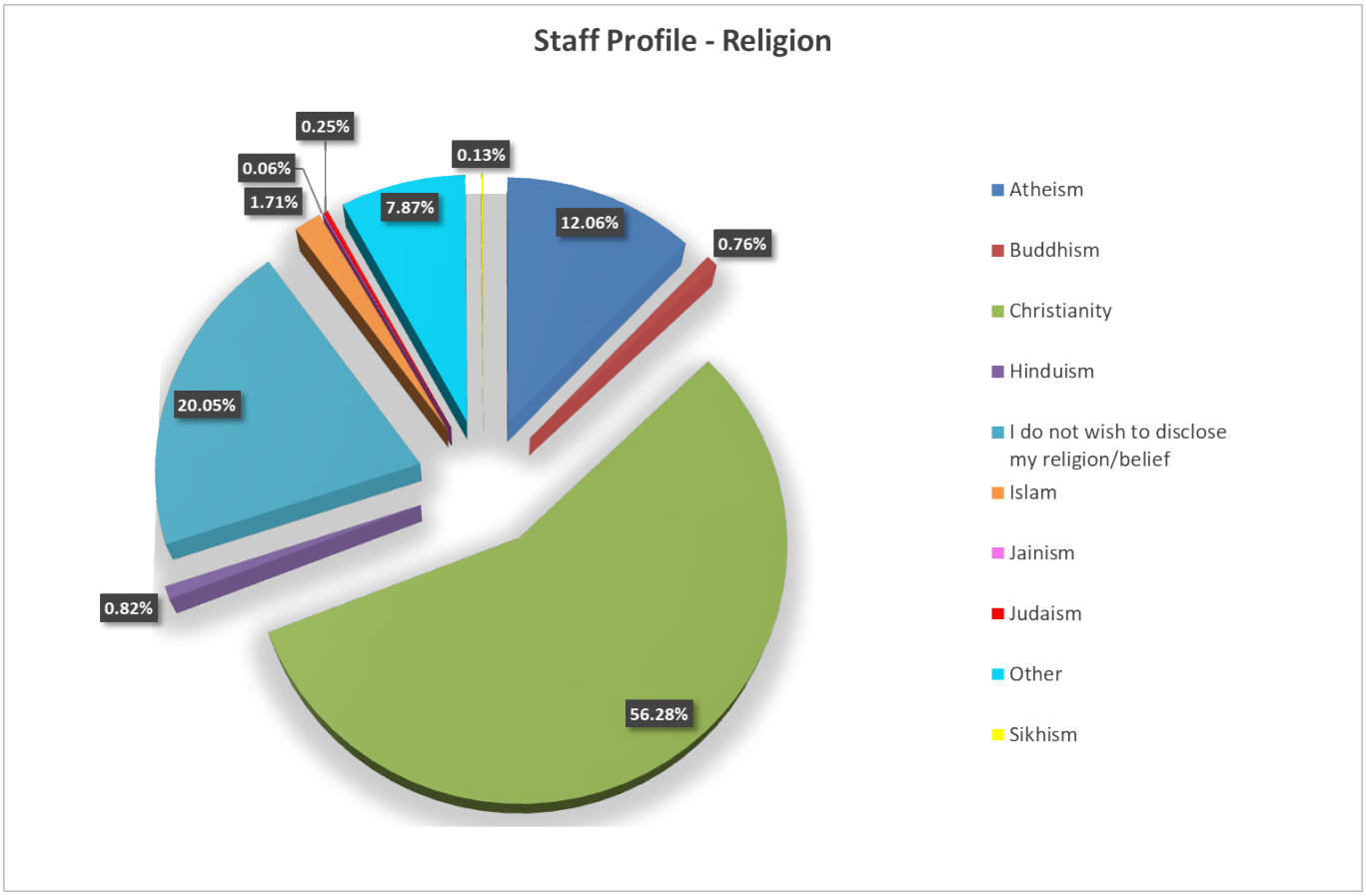
Staff profile – Sexual Orientation



81.47% of colleagues define their sexual orientation as Heterosexual; this remains comparative to last year in which 78% of colleagues reported the same. Those identifying as Gay or Lesbian account for 1.46% of the staff group.

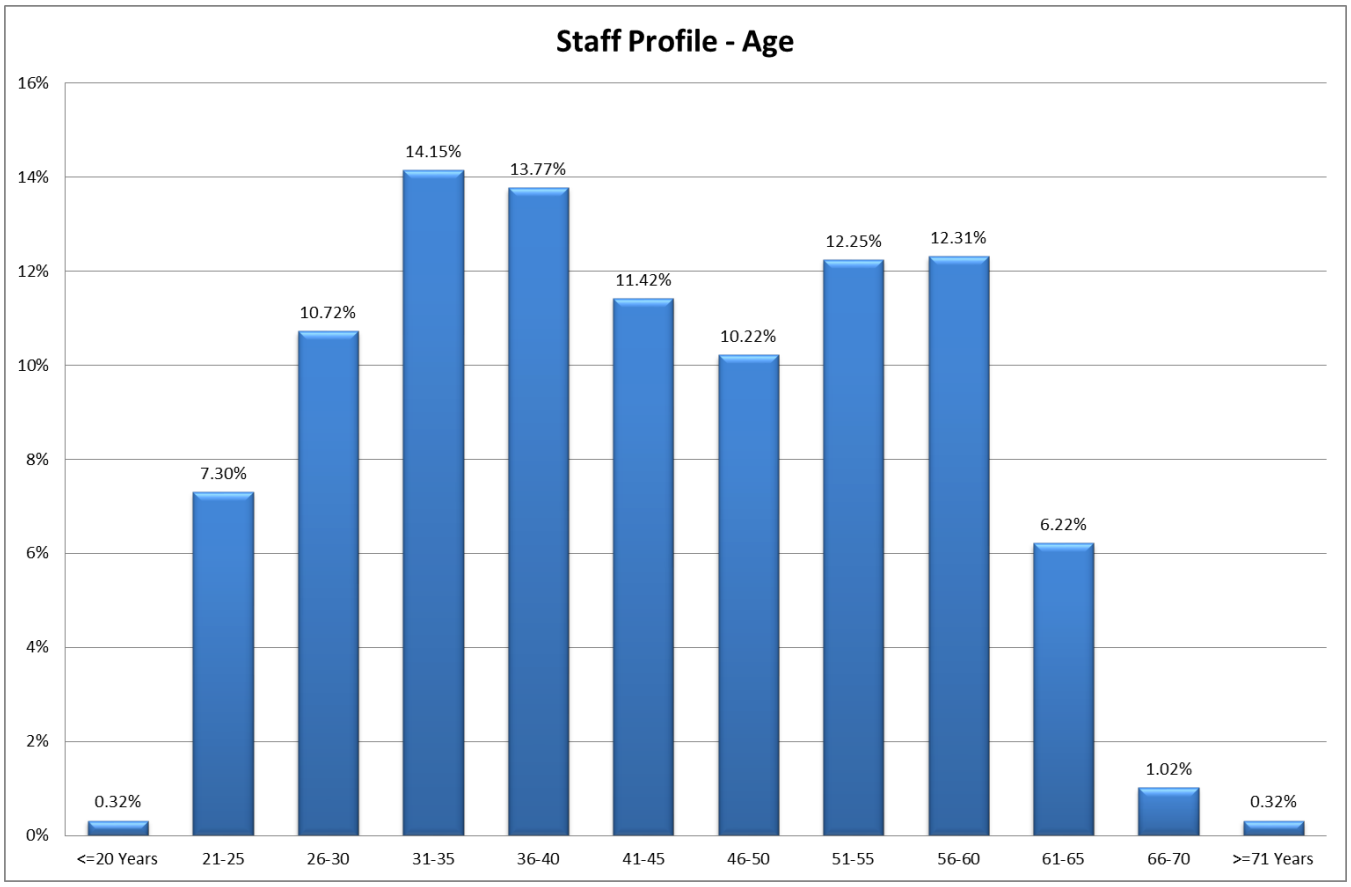
As with disability declarations, the above does not provide a full representation of colleagues' orientation as 16.18% declined to provide an answer.

Staff profile – Religion



887 or 56.28% of colleagues define their Religious beliefs as Christian, followed by Atheisim equating for 12.06%. As with previous declarations this does not provide a full representation of colleagues' orientation as 20.05% declined to provide an answer.

Staff profile – Age

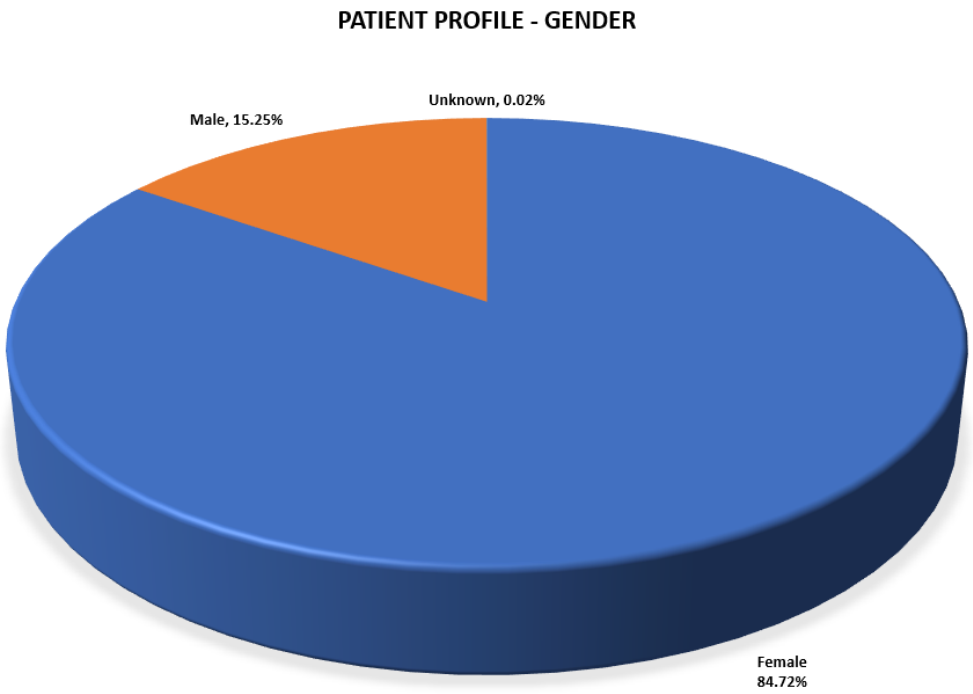


The main body of the staff profile is made up between age groups 31 – 40 and between 51 – 60 which shows although we have a high level of younger staff we have a high levels of staff who are nearing retirement age. Work is on-going to develop those staff so we do not loose valuable experience and knowledge when staff retire.

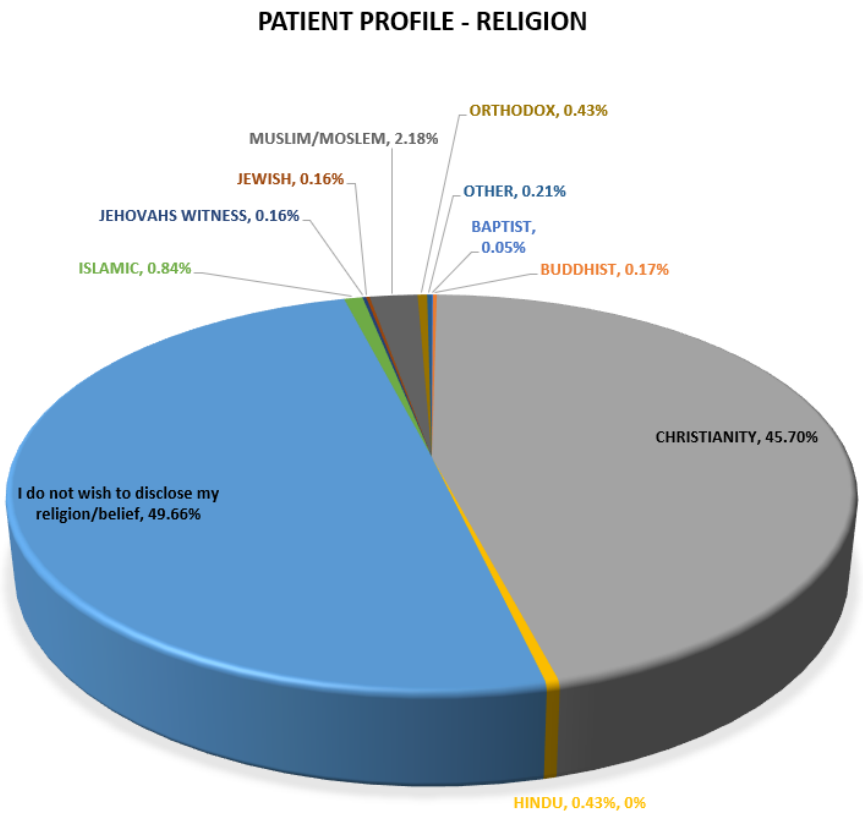
4.5 Patient Profile

Between April 2021 and March 2022 Liverpool Women's NHS Foundation Trust treated 60,158 patients, of which 50,968 were female equating for 84.72% of all patients, to be expected due to the nature of Liverpool Women's services.

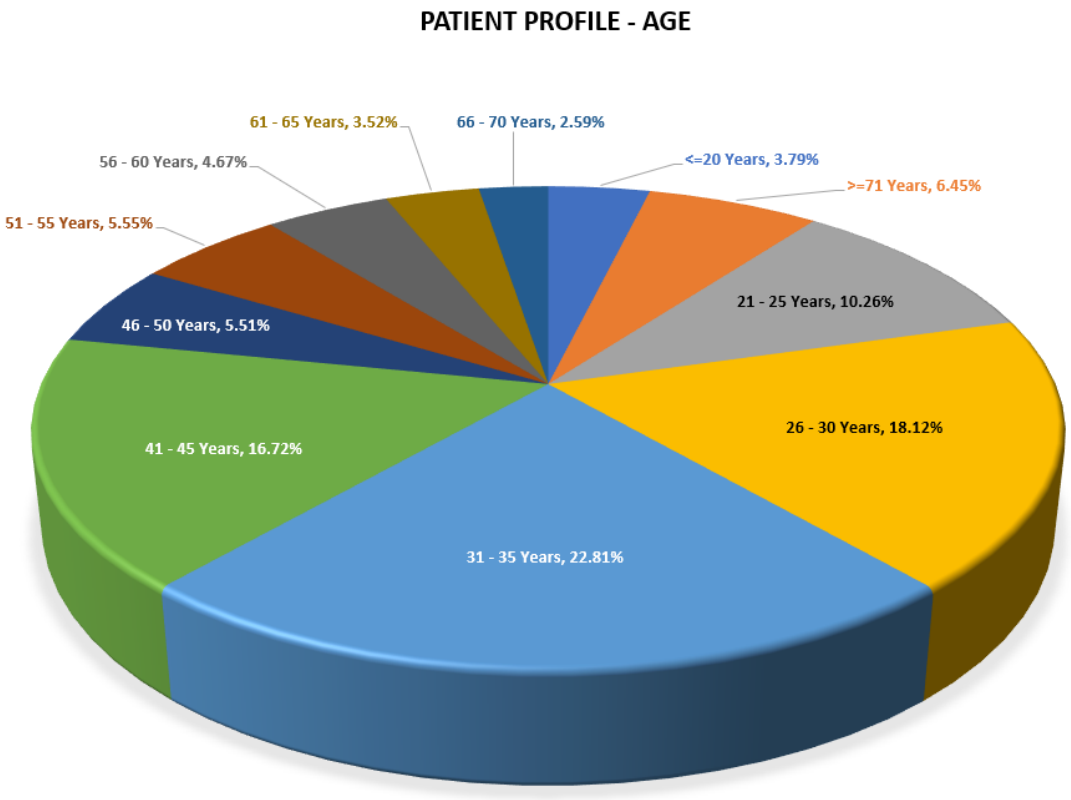
The Trust treated 9,177 men who equated for 15.25% of patients; this was mainly within our fertility departments. 13 patients refused to identify themselves as male or female so were categorised as unknown.



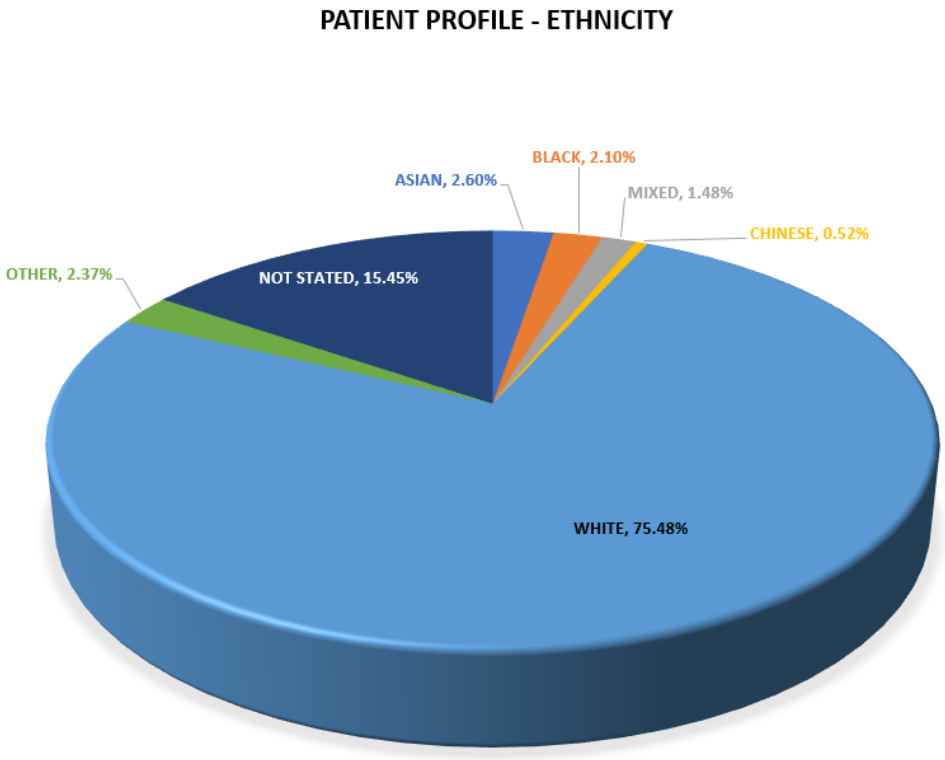
Figures relating to religion show that just under half of patients are Christian with 45.70%, while 49.66% did not wish to disclose their religions belief.



Figures show the main ages of patients are between the ages of 21 – 45 which accounts for 67.92% of all patients, with 31-35 equating for the largest group at 22.81% which is 10,728 of patients



The main Ethnicity of patients is White with 75.48% which equates to 45,410 patients. 15.45% do not wish to disclose their ethnicity which is 9,295 patients.



The table below shows the wide range of cultural backgrounds of our patients

Language	Percentage
AKAN - GHANA (ASHANTI)	0.0066%
ALBANIAN	0.1047%
AMHARIC - ETHIOPIA	0.0648%
ARAB/EGYP - EGYPT	0.0166%
ARABIC	1.0838%
ARABIC SUDANESE - SUDAN	0.0166%
ARABIC, MOROCCAN	0.0100%
ARABIC,SANAANI - YEMEN	0.0216%
ARABIC/NAJDI - SAUDI ARABIA	0.0066%
ARABIC/SAIDI - EGYPT	0.0066%
AZERBAIJANI - IRAN	0.0033%
AZERBAIJANI,NORTH	0.0033%
BELARUS	0.0017%
BENGALI	0.1430%
BULGARIA	0.1313%
BURMESE - MYANMAR	0.0066%
CANTONESE	0.1064%
CEBUANO - PHILIPPINES	0.0017%
CHATTISGARHI - INDIA	0.0066%
CHINESE	0.1064%
CHITTAGONIAN - BANGLADESH	0.0033%
CZECHOSLAVAKIAN	0.2277%
DUTCH - NETHERLANDS	0.0150%
ENGLISH	82.4382%
FARSI - AFGHANISTAN	0.1213%
FARSI - IRAN	0.0781%
FRENCH	0.1114%
GERMAN	0.0499%
GREEK - GREECE	0.1031%
GUJRATI - INDIA	0.0017%
HAITIAN CREOLE FRENCH - HAITI	0.0017%
HARYANVI - INDIA	0.0017%
HAUSA - NIGERIA	0.0033%
HINDI - INDIA	0.0549%
HUNGARIAN - HUNGARY	0.1629%
IGBO - NIGERIA	0.0116%
INDONESIAN	0.0083%
ITALIAN	0.1612%
JAPANESE	0.0150%
KANNADA - INDIA	0.0033%
KOREAN	0.0050%
KURDISH	0.4039%
KURMANJI - TURKEY	0.0033%
LINGALA (AFRICA/ZAIRE)	0.0033%
LITHUANIA	0.1496%
MAGAHI - INDIA	0.0017%

Language	Percentage
MAITHILI - INDIA	0.0017%
MALAYALAM - INDIA	0.0283%
MALAYSIA,PENINSULAR	0.0083%
MANDARIN	0.1164%
MONGOLIAN	0.0100%
NEPAL	0.0233%
NOT KNOWN	2.3953%
NULL	7.4486%
OROMO - ETHIOPIA	0.0066%
OTHER	0.2527%
PANJABI - INDIA	0.0233%
PASHTO - AFGHANISTAN	0.0465%
PERSIAN	0.0565%
POLISH - POLAND	0.8245%
PORTUGUESE	0.4372%
PT. DOES NOT WISH TO ANSWER	0.0183%
PUNJABI	0.0249%
ROMANIAN - ROMANIA	0.8245%
RUSSIAN	0.1114%
SARAIKI - PAKISTAN	0.0083%
SERBO-CROATIAN - YUGOLSLAVIA	0.0017%
SHONA - ZIMBABWE	0.0100%
SINDHI - PAKISTAN	0.0017%
SINHALA - SRI LANKA	0.0332%
SOMALI	0.1130%
SPANISH	0.2493%
SUNDA - INDONESIA(JAVA&BALI)	0.0017%
SWAHILI	0.0216%
SWEDISH	0.0116%
SYLHET/BANGLADESH	0.0017%
TAGALOG - PHILIPPINES	0.0066%
TAMIL - INDIA	0.1363%
TAMIL - SRI LANKA	0.0864%
TELUGU - INDIA	0.0183%
THAI	0.0349%
TIERINYA (AFRICAN)	0.0266%
TIGRINYA (AFRICAN)	0.1263%
TURKISH	0.1280%
URDU	0.2377%
URKRAINIAN	0.0133%
UZBEKISTAN	0.0017%
VIETNAMESE	0.0715%
YEMINI	0.0017%
YORUBA - NIGERIA	0.0050%
ZULU - SOUTH AFRICA	0.0050%
Grand Total	**100.00%**

5.0 Plans for 2022/23

This report has provided an update on many of the activities and actions that have taken place in 2021/22 across the Trust.

There is board level commitment to review the Trust approach to Equality, Diversity and Inclusion in its entirity following events of the past 12 months; the Trust has an ambition to be amongst the best Trusts in the UK in creating an inclusive culture that harnesses and encourages diverse leadership at all levels in the organisation.

Specific plans are outlined below and will form part of the revised set Equality Objectives (currently in place until 2023):

- Reciprocal mentoring programme launching in February 2022 commencing the process with BAME staff and plan to extend to other protected characteristics throughout 2022/23.
- Consideration of Digital inclusion for both staff and patients, working jointly with our Chief Information Officer at LWH and Microsoft on how we can ensure we lead the way in this for NHS Trusts.
- Review of turnover for staff from protected characteristics and exit interview information to establish learning to retain staff from these groups.
- Data cleanse campaign in February 2022 to improve disclosure on ESR staff personnel system for all protected characteristics highlighting the reason it's important to disclose and educating our staff by sharing examples conditions that fall within the category of a disability.
- 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 Health and Wellbeing conversations for all staff ensuring all staff from protected characteristics or with long term health conditions have either completed a refreshed Covid Risk Assessments or had opportunity to discuss what will support them to sustain positive health and wellbeing.
- Sharing of staff experience stories of staff from protected characteristics, listening and learning how the Trust can improve and embed an inclusive culture. These are shared at EDI Committee, Putting People First Committee and Trust Board.
- 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, Cost Improvement Programmes, policies, 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 EDI 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 LWH, utilising widening participation programmes and alternative ways to advertise and promote our job opportunities.
- Exploring potential to report on Disability and Race pay gaps on Trust website in addition to the Nationally required reports; Gender Pay Gap, Workforce Race Equality Standard, Workforce Disability Equality Standard and EDS2.
- Ringfence places on Liverpool Women's new Leadership Development Programme for staff from an ethnic minority background
- BAME network in place, considering terminology our staff wish to use, ensuring we are inclusive and considering all staff views.

6.0 Summary

This annual report collates some of the activities that have taken place in the last 12 months at the Trust. There is clear direction with regards to the Equality, Diversity and Inclusion strategy, with the Trust seeking to further develop the overall approach in 2022/23.

Whilst it is important to note the positive work that continues to take place for both patient/service-user and colleague groups, it is equally important to recognise that this journey for the Trust is ever moving and changing to ensure the best possible experience for all. To support this development, it is vital to work in partnership with stakeholders including our local community in a collaborative approach to address the areas for improvement as highlighted in this report.

As a final word, the Trust is confident that the Equality Objectives (2019/23) as set out are achievable in order to reach the overall ambition of being a great place to work.

Putting People First (PPF) Committee Chair's Highlight Report to Trust Board
21 March 2022

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 Workforce Assurance report from Clinical Support Services. The position in relation to permanent staffing pressures particularly in theatres was noted and partial assurance received. The Committee noted the efforts within the division to improve sickness absence, mandatory training compliance and turnover rate during 2021/22. It was noted that a governance process in relation to the Theatres Workforce was underway and overseen by the Senior Management Team (SMT). • The Committee noted risks and cost pressures from the medical workforce plans which would need to be more robustly understood. • A revised performance report was submitted. It was noted that the underperforming KPIs are under Executive Scrutiny. A review of the workforce KPI targets would be undertaken to ensure appropriate reach targets are set. • Committee received a trust wide deep dive into mandatory training compliance. The Committee supported the recommendations although noted that whilst the report provided an overview of issues it did not provide a substantial level of detail as to provide assurances. A further deep dive of areas with significant difficulties as a targeted report was commissioned. It was noted that a training update on the trajectory for training compliance for Maternity / Family Health would be presented to Committee in May 2022. • Received feedback from the Freedom to Speak Up (FTSU) temperature check surveys undertaken in December 2021, noting negative perception of FTSU process by the junior doctor workforce. Remitted to the Medical Staff Committee to discuss preventative factors with the medical workforce and noted work to be undertaken by the newly appointed FTSU Guardian Srinivasarao Babarao, Neonatal Consultant.	• Received the Equality, Diversity and Inclusion (EDI) Annual Report 2021/22 noting that the content had been workforce focussed. The gap between workforce and patient EDI processes was acknowledged. It was noted that significant work had been undertaken within patient EDI provision which would be incorporated into the Annual report ahead of submission to the Trust Board in April 2022. Consideration of a bespoke EDI Strategy to structure the process more robustly and improve Board ownership was given. A proposal would be included within the EDI cover report to the Trust Board. • Noted disappointing results of the currently embargoed Staff Survey 2021. Trend data was being collated and a formal report would be presented at the next meeting. • Received the Corporate Objectives year-end review. Further evidence of achieving metrics would be added to the report prior to Trust Board sign-off in April 2022. • Putting People First Strategy 2019-2024 Annual Review received and positive progress against the aims noted. Due to significant changes to the working environment during recent years the Committee agreed to the proposal to refresh the Strategy ahead of 2024. This work would be taken forward by the CPO.
Positive Assurances to Provide	**Decisions Made**
• The Trust has been successful in securing funding from Health Education England which must be used in 2021/22 for delivery on additional workforce upskilling. Departments across the Trust have made requests for specific pieces of equipment or resources to aid clinical training and development. • Noted that the initial workforce planning return had been submitted as part of the 2022/23 Priorities and Operational Planning Guidance: April 2022 to March 2023. • Confirmed that the Trust had offered staff the opportunity to sell annual leave, in recognition that workloads have prevented some individuals accessing their full leave entitlement. Caps were put in place to ensure that employees could access their statutory entitlements and maintain health and wellbeing. • The Committee received the Bi-Annual Safer Staffing Review and had been positively assured by the update provided. The Committee approved the newly formatted report and level of detail provided within the appendix pack. A discussion in relation to retire and returns was held, and initiatives being taken within Maternity to improve rates noted. A formal report on retire and returns would be presented to the Committee at a later date.	• Reviewed the PPF aligned BAF risks. The Committee approved the proposed rearticulation of risk 2.1: Failure to recruit and retain key clinical staff to recognise the lower than optimal levels of engagement across the workforce, the impact of covid on staff wellbeing and retirement intentions and likely impact of the challenging elective recovery programme. Work will be undertaken to review and refresh the controls/mitigation and gaps in controls prior to bringing back for review at the next meeting. • Amendments to the EDI Annual Report ahead of submission to the Trust Board. • Considered the Risk Appetite Statement aligned to the Committee (to deliver the best possible experience for patients and staff) and agreed with the recommendation to maintain the risk appetite level as low. Recommend that the Trust Board accepts the recommendation. • Approved the Annual Effectiveness Review and the Terms of Reference of the PPF Committee and would submit for ratification by the Trust Board.

• Received an update against the Medical Workforce Strategy which included workforce plans and 5-year transformation plans from each division. Substantial work had been delivered to provide the plans yet further work to finalise the plans was noted. It was recommended that subsequent impact of the plans on the wider medical workforce should also be considered. • Noted a focus on encouraging staff to become staff side representatives from the Partnership Forum Sub-Committee Chair Report. • Received the Professional Forum of Nurses, Midwives and AHP's Chair Report and noted a continued effort and focus on the vacant Children and Young People Nurse post, whereby neonatal and gynaecology services regularly review risks to progress actions in the workplan and work across the teams to mitigate any potential risk due to the vacancy. Interview date for the position had been arranged. • The Committee received the Communications, Marketing and Engagement Strategy Annual Review 2021/22.	• Considered the proposal to increase the frequency of PPF Committee meetings. An additional 4 meetings would be added to the workplan 2022/23 for focussed meetings, and not for standard agenda reports, to allow sufficient time to discuss identified risks during an increasingly challenging period within the Trust. The Trust Board would be asked to support the recommendation.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Timely
- Robust discussion

2. Summary Agenda

No.	Agenda Item	Purpose	Rating	No.	Agenda Item	Purpose	Rating
97.	Board Assurance Framework (BAF): Workforce related risks	Approval		105.	Staff Survey 2021 Update	Assurance	
98.	CSS Service Workforce Assurance	Assurance		106.	Medical Workforce Strategy	Information	
99.	Chief People Officer Report	Information		107.	Review of Risk Appetite Statement	Approval	
100.	Workforce KPI Dashboard Report	Assurance		108.	Corporate Objectives Year End Review	Information	
101.	Mandatory Training Deep dive	Assurance		109.	Committee effectiveness review: Annual report; Terms of reference; Workplan 2022/23	Approval	
102.	Freedom to Speak Up Guardian Update	Information		110.	Sub Committee Chair Reports	Assurance	
103.	Bi-Annual Safer Staffing Review Q2 and Q3	Assurance		111.	Putting People First Strategy 2019-2024 Annual Review	Assurance	
104.	Equality, Diversity and Inclusion Annual Report 2021/22	Information		112.	Communications, Marketing and Engagement Strategy Annual Review	Assurance	

3. 2021 / 22 Attendance Matrix

Core members	May	Jun	Sep	Nov	Jan	Mar
Jo Moore	✓	A	NM	MEETING CANCELLED	NM	
Dr Susan Milner	A	✓	✓		✓	✓
Tracy Ellery	A	✓	✓		✓	✓
Louise Martin	Non member	✓	✓		✓	✓
Michelle Turner	✓	✓	✓		✓	✓
Marie Forshaw	✓	✓	✓		✓	✓

Gary Price	✓	✓	✓		✓	✓
Claire Scott	A	✓	A		A	NM
Liz Collins	✓	✓	✓		✓	✓
Dyan Dickins	Vacant	Vacant	✓		✓	

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/11a**		**Date: 07/04/2022**	
Report Title	**Finance Performance Review Month 11 2021/22**			
Prepared by	***Claire Deegan, Deputy Chief Finance Officer***			
Presented by	***Eva Horgan, Chief Finance Officer***			
Key Issues / Messages	***To take assurance from the Month 11 financial position.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – If no – please outline the reasons for deviation.			
	The Board is asked to note the Month 11 Financial Position.			
Supporting Executive:	***Eva Horgan, Chief Finance Officer***			

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Finance, Performance and Business Development Committee	28/03/2022	Eva Horgan, Chief Finance Officer	The Committee noted the report.

EXECUTIVE SUMMARY

At Month 11, the Trust is reporting a £1.5m deficit Year to Date (YTD) against a £0.1m deficit plan, and a breakeven forecast in line with the revised Board approved plan. The YTD trust wide position has improved in month due to non-recurrent benefits, such as the maternity incentive scheme additional funding distribution, offsetting ongoing pressures in agency staffing and gas and electricity prices. Work continues through the Financial Recovery Board and other forums to ensure that all pressures are being managed effectively.

Whilst the Cost Improvement Programme (CIP) continues to deliver, Elective Recovery Fund (ERF) income is significantly behind plan, with the year-to-date position reflecting the risk relating to Cheshire & Merseyside (C&M) delivery as well as ongoing uncertainty regarding the Termination of Pregnancy baseline adjustment. However, subsequently to the position being finalised and following escalation to the national team, the baseline adjustment has now been agreed. The impact of this will be assessed and amended as necessary in Month 12.

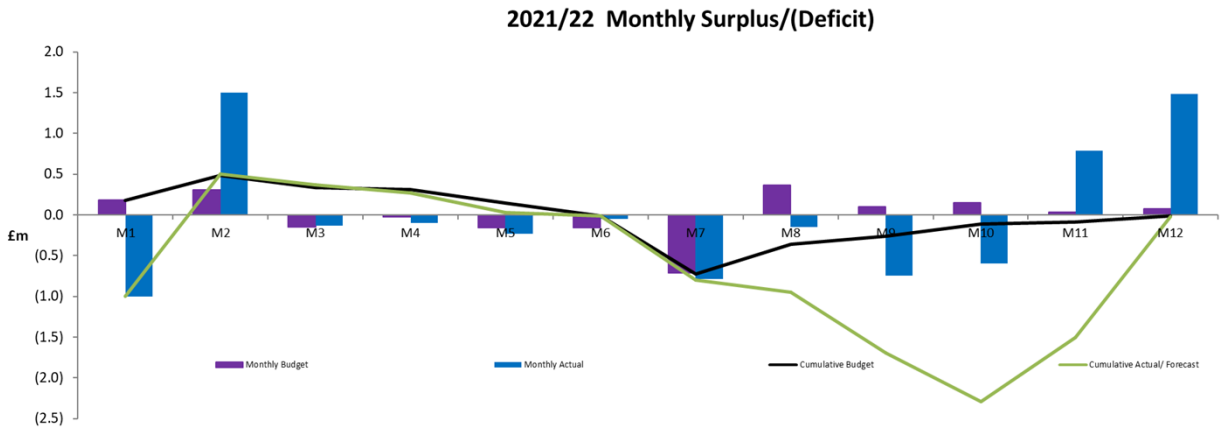
	Plan (Revised)	Actual	Variance	RAG	*R*	*A*	*G*
Surplus/(Deficit) YTD	-£0.1m	-£1.5m	-£1.4m	↑	*>10% off plan*	*Plan*	*Plan or better*
I&E Foreccast	£0.0m	£0.0m	£0.0m	↔	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	↔	*4*	*3*	*2+*
Cash	£4.5m	£9.3m	£4.8m	↑	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement	£1.6m	£1.9m	£0.3m	↑	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement	£1.6m	£1.4m	-£0.2m	↓	*>10% off plan*	*Plan*	*Plan or better*
Elective Recovery Fund (net)	£2.4m	£1.5m	-£0.8m	↓	*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£0.0m	£3.7m	£3.7m	↔	*>£0*		*<£0*
Capital Spend YTD	£6.6m	£5.1m	-£1.5m				

MAIN REPORT

1. Summary Financial Position

At Month 11 the Trust is reporting a Year to Date (YTD) deficit of £1.5m, against a £0.1m deficit plan per the revised budget. The graph below shows the forecast against the revised plan. Additional income of £1.5m in relation to system funding has been agreed and is forecast into Month 12. This will offset the underachievement of ERF income

in H2. Additional pressures in year have been managed through non-recurrent mitigations and additional contribution from the Community Diagnostic Centre (CDC).



2. Divisional Summary Overview

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

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

Gynaecology: The division is overspent YTD, with a full year forecast outturn overspend of £4.3m. The overspend is primarily related to activity and income being behind plan.

Clinical Support Services: The division are expected to deliver an underspend of £0.96m by year end driven by higher than plan income and lower than plan pay costs.

Agency: Agency spend across the Trust is now £3.0m YTD, and the forecast increased to £3.2m full year. Work is ongoing to reduce this, particularly in maternity.

Fuel costs: Year to date cost pressures relating to fuel price are £0.6m. These pressures are forecast to increase to £0.8m by year end and will continue in 2022/23.

3. Community Diagnostic Centre

Expenditure and income in relation to the Community Diagnostic Centre is included in the forecast. As this was not budgeted it shows as a variance against budget. In totality, the Trust is expecting to spend the full revenue allocation.

This is kept under close review and is managed via the CDC Oversight Group.

4. Elective Recovery Fund

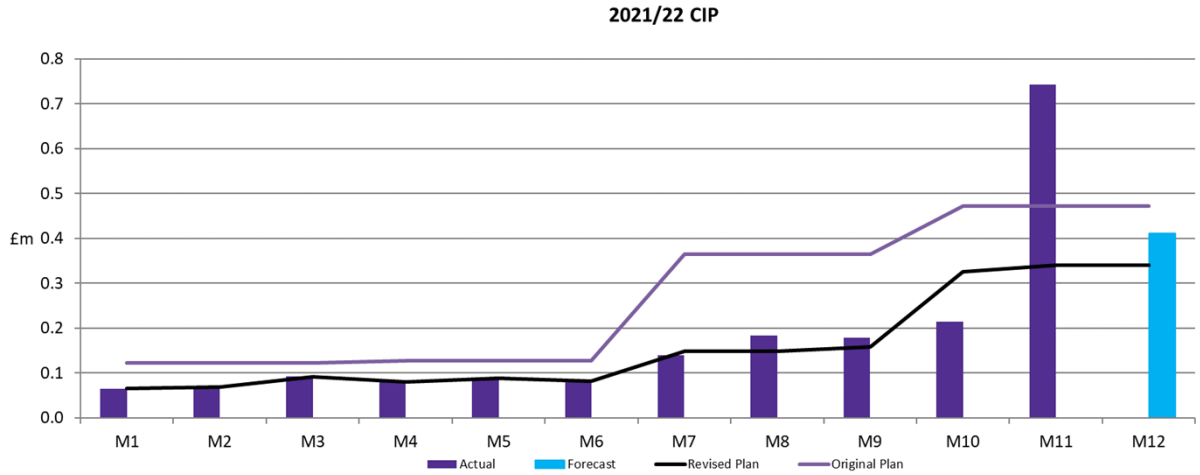
The Elective Recovery Fund was put in place during H1 to incentivise providers to undertake more elective activity and to pay for the additional costs associated with this. The mechanism for ERF has changed in H2 and is based on completed referral to treatment (RTT) pathway activity rather than total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

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

Quarter 3 outturn has now been validated with a 90% confirmed outturn for December 2021 across Cheshire & Merseyside. This is an improvement from previous estimates and has led to a distribution of £18.5m, of which LWH received just £20k due to the ongoing baseline issue. The national team have now agreed to adjust the LWH baseline.

5. CIP

The CIP plan was revised as part of the H2 planning process and approval. Monitoring against the original agreed CIP plans continue as well as against the revised target. Divisional budgets have not been adjusted where CIP has not been achieved and they are still monitored against their original agreed targets. The graph below shows both the original and revised plans and the forecast.



At month 11 the CIP programme is forecasting to exceed the plan by £0.34m, but with £0.68m reliance on non-recurrent savings.

6. CNST Maternity Incentive Year Three

The Trust has now officially been informed that it has been successful in achieving the CNST Maternity Incentive (MIS) Year Three. This has led to not only the receipt of the £1.6m contribution, but also additional funding of which was confirmed during February 2022.

7. COVID-19

The Trust has spent £1.3m on direct Covid-19 related costs YTD to Month 11. Costs identified as Covid-19 related were reallocated to the Covid-19 budget in Month 11 and remain under review. A budget is in place for the full year.

8. Cash and Borrowings

The closing cash balance in Month 11 is £9.3m. This is a significant increase as the Trust has now received the CNST MIS Year Three payment and also does not need to pay regular CNST payments in later months. The position also reflects the receipt of PDC funding for digital investment schemes. However, the medium and long-term position still remains a risk. The Trust's finance team continue to run a number of scenarios and closely monitor the situation.

9. Capital Expenditure

The overall capital plan has increased from the original £7m to £13.2m (due to an additional £3.8m for the Community Diagnostic Centre and £2.1m for digital diagnostics). The Trust remains forecast to underspend by £1.4m.

Spend to Month 11 is £5.1m so there remains a significant amount to spend in March. Significant medical equipment investment has been made with deliveries confirmed in month 12.

A capital working group meets weekly to ensure expenditure is monitored and progressed.

10. Balance Sheet

Debtors remain consistent with last month. Following further correspondence with the liquidators of One to One (North West) Ltd the remaining balance will be written off in M12 as it is highly unlikely there will be any funds remaining to reduce the overall residual debt. This was approved at Audit Committee in March.

Performance against the Better Payment Practice Code for non-NHS suppliers has reduced slightly from M10 to 88% by value. This is a slight improvement compared to 87% at year-end 2020/21. This excludes non-NHS disputed invoices.

Note also that the Trust is in a position of holding negative retained earnings at Month 11 but this is forecast to reverse by year end.

11. BAF Risk

There are no proposed changes to the BAF score.

12. Conclusion & Recommendation

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M11

YEAR ENDING 31 MARCH 2022

Liverpool Women's NHS Foundation Trust

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Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M11
YEAR ENDING 31 MARCH 2022

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	5,773
(b) PDC + Interest Payable + Loans Repaid	1,882
CSC Ratio = (a) / (b)	**3.07**
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	(15,426)
(b) Expenditure	118,059
(c) Daily Expenditure	353
Liquidity Ratio = (a) / (c)	**(43.6)**
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)	1,502
Total Income	(123,829)
I&E Margin	**-1.21%**
NHSI I&E MARGIN SCORE	**4**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)	
I&E MARGIN VARIANCE FROM PLAN	
I&E Margin (Actual)	-1.20%
I&E Margin (Plan)	-0.10%
I&E Variance Margin	**-1.1%**
NHSI I&E MARGIN VARIANCE SCORE	**3**
Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%	
AGENCY SPEND	
YTD Providers Cap	1,639
YTD Agency Expenditure	3,028
	85%
NHSI AGENCY SPEND SCORE	**4**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%	
Overall Use of Resources Risk Rating	**3**

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

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M11
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE	Month 11			YTD			YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income									
Clinical Income	(10,158)	(11,853)	1,695	(115,265)	(117,567)	2,301	(126,035)	(131,654)	5,619
Non-Clinical Income	(598)	(734)	136	(6,366)	(6,263)	(103)	(6,943)	(6,831)	(112)
Total Income	**(10,755)**	**(12,587)**	**1,832**	**(121,631)**	**(123,829)**	**2,198**	**(132,978)**	**(138,485)**	**5,508**
Expenditure									
Pay Costs	6,685	6,981	(296)	71,285	74,260	(2,975)	77,976	81,286	(3,309)
Non-Pay Costs	1,798	2,875	(1,077)	25,582	26,693	(1,111)	27,917	30,573	(2,656)
CNST	1,581	1,297	284	17,387	17,106	281	18,968	18,687	281
Total Expenditure	**10,063**	**11,153**	**(1,090)**	**114,254**	**118,059**	**(3,805)**	**124,861**	**130,545**	**(5,684)**
EBITDA	**(692)**	**(1,434)**	**742**	**(7,377)**	**(5,771)**	**(1,607)**	**(8,117)**	**(7,940)**	**(177)**
Technical Items									
Depreciation	478	458	20	5,339	5,107	232	5,821	5,591	231
Interest Payable	3	3	0	35	36	(2)	38	39	(2)
Interest Receivable	0	(1)	1	0	(2)	2	0	(2)	2
PDC Dividend	183	185	(2)	2,092	2,152	(59)	2,275	2,349	(74)
(Profit) / Loss on Disposal of assets	0	0	0	0	(20)	20	0	(20)	20
Total Technical Items	**663**	**645**	**19**	**7,465**	**7,273**	**192**	**8,134**	**7,957**	**177**
(Surplus) / Deficit	**(29)**	**(789)**	**761**	**88**	**1,503**	**(1,414)**	**17**	**17**	**0**

NHS
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NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **2a**
INCOME & EXPENDITURE HOSTED SERVICES: M11
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE £'000	Month 11 Budget	Month 11 Actual	Month 11 Variance	YTD Budget	YTD Actual	YTD Variance
Income						
Clinical Income	(454)	(185)	(270)	(3,079)	(2,988)	(92)
Non-Clinical Income	0	20	(20)	0	0	0
Total Income	**(454)**	**(165)**	**(289)**	**(3,079)**	**(2,988)**	**(92)**
Expenditure						
Pay Costs	127	84	43	1,097	577	520
Non-Pay Costs	327	81	247	1,982	2,410	(428)
Total Expenditure	**454**	**165**	**289**	**3,079**	**2,988**	**92**
(Surplus) / Deficit	**0**	**(0)**	**0**	**0**	**(0)**	**0**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
ELECTIVE RECOVERY FUND ESTIMATE: M11
YEAR ENDING 31 MARCH 2022

	19/20		21/22		21/22 v 19/20				
	Activity	Costed Activity £000	Activity	Costed Activity £000	Activity Variance	Costed Activity Variance	ERF £000	ERF Plan £000	Variance £000
Month 1		**1,715**		**1,597**		**-118**	**520**	**543**	**-23**
DC	530	396	250	199	-280	-197	-71		
EL	100	332	113	417	13	85	230		
OP	6,292	697	5,816	656	-476	-41	210		
OPPROC	1,441	290	1,856	325	415	34	151		
Month 2		**1,625**		**1,631**		**5**	**540**	**646**	**-106**
DC	452	327	303	232	-149	-96	-5		
EL	118	372	127	449	9	77	216		
OP	5,784	616	5,543	623	-241	7	208		
OPPROC	1,440	310	1,869	327	429	17	122		
Month 3		**1,915**		**1,915**		**1,915**	**259**	**205**	**54**
DC	570	406	312	246	-258	-160	-70		
EL	151	413	115	378	-36	-35	69		
OP	6,603	729	6,449	722	-154	-7	190		
OPPROC	1,694	368	1,943	343	249	-25	69		
Month 4		**1,900**		**1,727**		**-173**	**0**	**393**	**-393**
DC	578	434	309	239	-269	-196			
EL	100	294	129	491	29	197			
OP	6,941	756	6,275	692	-666	-64			
OPPROC	1,810	417	1,698	306	-112	-111			
Month 5		**1,793**		**1,527**		**-266**	**0**	**265**	**-265**
DC	598	414	267	223	-331	-191			
EL	102	355	118	383	16	28			
OP	6,037	650	5,512	622	-525	-28			
OPPROC	1,663	374	1,705	298	42	-76			
Month 6		**1,989**		**1,584**		**-405**	**0**	**257**	**-257**
DC	572	394	287	231	-285	-163			
EL	130	450	114	427	-16	-23			
OP	6,834	744	5,584	628	-1,250	-116			
OPPROC	1,951	401	1,509	298	-442	-103			
Month 7		**2,611**		**2,164**		**-447**	**0**	**0**	**0**
Admitted Clock	469	1,340	268	765	-201	-574			
Non Admitted C	1,888	1,271	2,185	1,399	297	127			
Month 8		**2,574**		**2,399**		**-175**	**88**	**778**	**-690**
Admitted Clock	453	1,294	332	948	-121	-346			
Non Admitted C	1,958	1,280	2,270	1,451	312	171			
Month 9		**1,931**		**1,810**		**-121**	**4**	**421**	**-417**
Admitted Clock	283	808	236	674	-47	-134			
Non Admitted C	1,774	1,123	1,771	1,136	-3	13			
Month 10		**2,322**		**2,137**		**-184**	**235**	**194**	**41**
Admitted Clock	290	828	309	883	19	54			
Non Admitted C	2,230	1,493	1,926	1,255	-304	-239			
Month 11		**2,158**		**2,178**		**20**	**223**	**114**	**109**
Admitted Clock	278	794	293	837	15	43			
Non Admitted C	2,073	1,364	2,054	1,341	-19	-23			
Total Income		**22,535**		**20,670**		**51**	**1,869**	**3,816**	**-1,947**
Removal of Months 7-11 due to baseline issue (£135k C&M estimate M7-10)							-415	0	-415
ERF+ Bid							559	0	559
Welsh ERF							114	0	114
Baseline Variance H1							-42	0	-42
Expenditure							0	-777	777
Total Variance							**2,085**	**3,039**	**-954**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
EXPENDITURE: M11
YEAR ENDING 31 MARCH 2022

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR Actual	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	357	374	(17)	3,885	3,834	51	4,252	4,221	31
Medical	1,801	1,421	380	18,814	18,770	44	20,615	20,546	69
Nursing & Midwifery	2,955	3,166	(211)	30,954	32,059	(1,105)	33,906	35,161	(1,255)
Healthcare Assistants	479	524	(45)	5,295	4,888	407	5,774	5,387	387
Other Clinical	412	410	2	4,415	4,387	28	4,827	4,793	35
Admin Support	611	659	(48)	6,745	7,292	(547)	7,356	7,966	(610)
Agency & Locum	70	428	(358)	1,175	3,029	(1,854)	1,245	3,212	(1,967)
Total Pay Costs	**6,685**	**6,981**	**(296)**	**71,285**	**74,260**	**(2,975)**	**77,976**	**81,286**	**(3,309)**
Non Pay Costs									
Clinical Suppplies	753	993	(240)	8,345	8,637	(292)	9,099	10,206	(1,107)
Non-Clinical Supplies	150	755	(605)	4,899	5,371	(472)	5,527	6,099	(572)
CNST	1,581	1,297	284	17,387	17,106	281	18,968	18,687	281
Premises & IT Costs	708	937	(229)	7,834	8,247	(412)	8,543	9,230	(687)
Service Contracts	186	190	(4)	4,504	4,438	65	4,749	5,038	(289)
Total Non-Pay Costs	**3,378**	**4,172**	**(793)**	**42,969**	**43,799**	**(830)**	**46,885**	**49,260**	**(2,375)**
Total Expenditure	**10,063**	**11,153**	**(1,090)**	**114,254**	**118,059**	**(3,805)**	**124,861**	**130,545**	**(5,684)**

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

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
COVID EXPENDITURE: M11
YEAR ENDING 31 MARCH 2022

EXPENDITURE	MONTH			YEAR TO DATE		
£'000	Budget	Actual	Variance	Budget	Actual	Variance
Pay Costs						
Board, Execs & Senior Managers	0	0	0	0	1	(1)
Medical	0	6	(6)	0	27	(27)
Nursing & Midwifery	43	61	(18)	543	407	136
Healthcare Assistants	11	29	(17)	223	164	59
Other Clinical	0	0	(0)	1	4	(3)
Admin Support	32	18	14	295	268	28
Agency & Locum	0	0	0	90	70	20
Total Pay Costs	**86**	**114**	**(28)**	**1,153**	**941**	**212**
Non Pay Costs						
Clinical Suppplies	8	6	2	116	70	46
Non-Clinical Supplies	0	1	(1)	6	(3)	9
CNST	0	0	0	0	0	0
Premises & IT Costs	14	25	(11)	280	250	30
Service Contracts	0	0	0	0	36	(36)
Total Non-Pay Costs	**22**	**32**	**(10)**	**403**	**354**	**49**
Total Expenditure	**109**	**146**	**(38)**	**1,556**	**1,295**	**261**

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

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
BUDGET ANALYSIS: M11
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE	MONTH			YEAR TO DATE			YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Maternity									
Income	(4,000)	(3,979)	(22)	(44,003)	(44,212)	209	(48,003)	(48,259)	256
Expenditure	1,998	2,234	(236)	22,051	24,525	(2,474)	24,049	26,787	(2,738)
Total Maternity	**(2,003)**	**(1,745)**	**(258)**	**(21,952)**	**(19,687)**	**(2,265)**	**(23,954)**	**(21,472)**	**(2,482)**
Neonatal									
Income	(1,743)	(1,801)	58	(19,177)	(19,059)	(117)	(20,920)	(20,801)	(120)
Expenditure	1,261	1,273	(13)	13,957	14,008	(51)	15,217	15,278	(61)
Total Neonatal	**(483)**	**(528)**	**45**	**(5,220)**	**(5,052)**	**(168)**	**(5,703)**	**(5,522)**	**(181)**
Division of Family Health - Total	**(2,485)**	**(2,272)**	**(213)**	**(27,172)**	**(24,739)**	**(2,433)**	**(29,657)**	**(26,995)**	**(2,662)**
Gynaecology									
Income	(2,058)	(1,485)	(573)	(22,489)	(20,207)	(2,281)	(24,547)	(21,858)	(2,689)
Expenditure	1,149	1,262	(114)	12,514	13,392	(878)	13,663	14,572	(910)
Total Gynaecology	**(909)**	**(223)**	**(686)**	**(9,975)**	**(6,815)**	**(3,160)**	**(10,884)**	**(7,286)**	**(3,598)**
Hewitt Centre									
Income	(785)	(957)	172	(8,513)	(8,391)	(123)	(9,449)	(9,234)	(215)
Expenditure	671	738	(67)	7,634	8,069	(436)	8,305	8,779	(474)
Total Hewitt Centre	**(114)**	**(218)**	**104**	**(880)**	**(321)**	**(559)**	**(1,145)**	**(455)**	**(689)**
Division of Gynaecology - Total	**(1,023)**	**(441)**	**(582)**	**(10,854)**	**(7,136)**	**(3,718)**	**(12,029)**	**(7,741)**	**(4,287)**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	830	1,121	(291)	9,210	9,866	(656)	10,041	10,833	(792)
Total Theatres	**830**	**1,121**	**(291)**	**9,210**	**9,866**	**(656)**	**10,041**	**10,833**	**(792)**
Genetics									
Income	(13)	(131)	118	(138)	(186)	49	(150)	(186)	36
Expenditure	147	124	24	1,622	1,393	228	1,769	1,518	251
Total Genetics	**135**	**(7)**	**142**	**1,484**	**1,207**	**277**	**1,619**	**1,332**	**287**
Other Clinical Support									
Income	(382)	(581)	199	(4,069)	(4,353)	284	(4,451)	(4,739)	288
Expenditure	645	373	271	7,028	6,723	305	7,673	7,360	313
Total Clinical Support	**263**	**(208)**	**470**	**2,959**	**2,370**	**589**	**3,222**	**2,620**	**601**
Division of Clinical Support - Total	**1,228**	**906**	**322**	**13,653**	**13,444**	**210**	**14,881**	**14,785**	**96**
Corporate & Trust Technical Items									
Income	(2,228)	(3,818)	1,590	(26,322)	(30,408)	4,087	(28,990)	(36,985)	7,994
Expenditure	4,480	4,836	(356)	50,783	50,342	441	55,812	56,953	(1,141)
Total Corporate	**2,252**	**1,018**	**1,234**	**24,461**	**19,934**	**4,527**	**26,821**	**19,968**	**6,853**
(Surplus) / Deficit	**(29)**	**(789)**	**761**	**88**	**1,503**	**(1,414)**	**17**	**17**	**(0)**
Of which is hosted;									
Income	(454)	(165)	(289)	(3,079)	(2,988)	(92)	(3,533)	(3,577)	44
Expenditure	454	165	289	3,079	2,988	92	3,533	3,578	(44)
Total Corporate	**0**	**(0)**	**0**	**0**	**(0)**	**0**	**0**	**0**	**(0)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
CIP: M11
YEAR ENDING 31 MARCH 2022

	Month 11			YTD			Full Year		
Scheme	**Target**	**Actual**	**Variance**	**Target**	**Actual**	**Variance**	**Target**	**FOT**	**Variance**
Procurement and Non Pay	109	230	120	733	819	86	843	909	67
Estates Utilisation	0	0	0	0	0	0	0	0	0
Staffing and Skill Mix	33	314	281	268	549	281	301	582	281
Outpatients Utilisation	0	0	0	0	0	0	0	0	0
Medicines Management	5	5	0	25	25	0	30	93	63
Service Developments	19	41	23	188	211	23	207	227	20
Strategic Review	17	(8)	(25)	83	93	9	100	136	36
Theatre Efficiency	0	0	0	0	0	0	0	0	0
Technology Driven Efficiences	0	0	0	0	0	0	0	0	0
Other Savings Plans	0	159	159	0	179	179	0	339	339
	183	**742**	**559**	**1,298**	**1,876**	**579**	**1,481**	**2,287**	**806**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
BALANCE SHEET: M11
YEAR ENDING 31 MARCH 2022

BALANCE SHEET £'000	YEAR TO DATE Opening	M11 Actual	Movement
Non Current Assets	90,086	90,138	52
Current Assets			
Cash	4,235	9,308	5,073
Debtors	4,976	5,201	225
Inventories	410	459	49
Total Current Assets	**9,621**	**14,968**	**5,347**
Liabilities			
Creditors due < 1 year - Capital Payables	(3,447)	(2,228)	1,219
Creditors due < 1 year - Trade Payables	(13,728)	(17,944)	(4,216)
Creditors due < 1 year - Deferred Income	(3,136)	(7,050)	(3,914)
Creditors due > 1 year - Deferred Income	(1,592)	(1,561)	31
Loans	(2,136)	(1,830)	306
Provisions	(4,090)	(2,818)	1,272
Total Liabilities	**(28,129)**	**(33,431)**	**(5,302)**
TOTAL ASSETS EMPLOYED	**71,578**	**71,675**	**97**
Taxpayers Equity			
PDC	62,927	64,527	1,600
Revaluation Reserve	7,522	7,522	0
Retained Earnings	1,129	(374)	(1,503)
TOTAL TAXPAYERS EQUITY	**71,578**	**71,675**	**97**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST CASHFLOW STATEMENT: M11 YEAR ENDING 31 MARCH 2022	9

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	663
Depreciation and amortisation	5,108
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	(34)
Movement in working capital	5,421
Net cash generated from / (used in) operations	**11,158**
Interest received	1
Purchase of property, plant and equipment and intangible assets	(6,354)
Proceeds from sales of property, plant and equipment and intangible assets	20
Net cash generated from/(used in) investing activities	**(6,333)**
PDC Capital Programme Funding - received	1,600
PDC COVID-19 Capital Funding - received	0
Loans from Department of Health Capital - repaid	(306)
Loans from Department of Health Revenue - received	0
Loans from Department of Health Revenue - repaid	0
Interest paid	(22)
PDC dividend (paid)/refunded	(1,024)
Net cash generated from/(used in) financing activities	**248**
Increase/(decrease) in cash and cash equivalents	**5,073**
Cash and cash equivalents at start of period	4,235
Cash and cash equivalents at end of period	**9,308**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding
Loans from Department of Health - Capital (ITFF) - 2.0% Interest Rate	5,500	(3,670)	1,830
Loans from Department of Health - Capital (Neonatal) - 2.54% Interest Rate	14,572	(14,572)	0
Loans from Department of Health - Revenue - 1.50% Interest Rate	14,612	(14,612)	0
Total	**34,684**	**(32,854)**	**1,830**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 10
CAPITAL EXPENDITURE: M11
YEAR ENDING 31 MARCH 2022

CAPITAL EXPENDITURE	Year to Date			FOT		
£'000	Plan	Actual	Variance	Plan	Actual	Variance
Estates	**638**	**462**	**176**	**700**	**599**	**101**
Capital Projects	**4,273**	**3,054**	**1,219**	**7,374**	**6,188**	**1,186**
Digital	**1,276**	**1,283**	**(7)**	**2,653**	**1,966**	**687**
Medical Equipment	**303**	**233**	**70**	**302**	**1,617**	**(1,315)**
Other	**99**	**27**	**72**	**101**	**-637**	**738**
Additional PDC - Digital Maternity	0	35	(35)	632	632	0
Additional PDC - Frontline Digitisation	0	13	(13)	1,145	1,145	0
Additional PDC - Digital Diagnostics Capability (DDCP)	0	28	(28)	80	80	0
Additional PDC - Cyber Security	0	0	0	210	210	0
Grand Total	**6,589**	**5,135**	**1,454**	**13,197**	**11,800**	**1,397**

The Capital Expenditure is shown on an "Accruals" basis based on the date of receipt of the capital item by the Trust. This figure differs to the capital expenditure figure shown in the cashflow statement which is on a "Cash" basis.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/011b**		**Date: 07/04/2022**	
Report Title	**Revenue and Capital Budgets 2022/23**			
Prepared by	***Claire Deegan, Deputy Chief Finance Officer*** ***Eva Horgan, Chief Finance Officer***			
Presented by	***Eva Horgan, Chief Finance Officer***			
Key Issues / Messages	*The Board is asked to approve the interim Capital and Revenue Budgets 2022/23 and the Charity Budget 2022/23. The Trust Capital and Revenue Budgets will be finalised in line with national timescales on 28th April 2022. The Board is asked to delegate final approval of these budgets to the Chief Finance Officer and Chief Executive should this be an improved position, following scrutiny at the Finance, Performance and Business Development Committee. An additional Board meeting will be convened if required.*			
Action required	**Approve ☒**	**Receive ☐**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – ***If no – please outline the reasons for deviation.***			
	The Board is asked to approve the Capital and Revenue interim budget for 2022/23 and the Charity Budget 2022/23.			
Supporting Executive:	***Eva Horgan, Chief Finance Officer***			

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

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 4.1 Failure to ensure our services are financially sustainable in the long term	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Finance, Performance and Business Development Committee (for Trust Capital and Revenue budgets)	28/03/2022	Eva Horgan, Chief Finance Officer	The Committee recommended that the Board approve the interim budgets as set out, noting the risks and challenges.
Charitable Funds Committee (for Charity budgets)	21/03/2022	Eva Horgan, Chief Finance Officer	The Committee recommended that the Board approve the budgets, noting the work to be undertaken on a three-year plan for the Charity.

EXECUTIVE SUMMARY

In 2022/23 a revised financial framework and planning process is in place after two years of extraordinary arrangements during the pandemic. It is expected to be a challenging year financially for the NHS.

The Trust is in underlying deficit, and faces additional pressures to maintain levels of workforce recommended by the (first) Ockenden report. There is a significant increase in clinical negligence costs which have not yet been funded. Financial impacts of the second Ockenden review, and any funding available to support this, are being assessed.

There are other significant cost pressures which will be managed through an ambitious and challenging 3% cost improvement plan plus additional non recurrent mitigations. Operational teams have also set an ambitious activity plan aimed at reducing waiting times and increasing overall patient flow.

Similarly, capital allocations are constrained for the next three years. Capital allocations have been devolved to the Integrated Care System and individual providers have been allocated budgets below the level of their internally generated funding.

The proposed budgets are:

- An **I&E deficit plan of £10.57m** after a **CIP programme of £4.2m** and funding **cost pressures of £7.7m** against the original 2021/22 budget, less a vacancy factor of £1.4m. This includes Elective Recovery Fund (ERF) target income of £2.7m (which could have upside or downside), and system funding of £13.6m.
- A **capital programme of £8.5m**- £5m business as usual and £3.5m for the Community Diagnostic Centre.
- Cash support is assumed although this will only be drawn down if ultimately required after a final plan is agreed. Interim cash arrangements are in place in the meantime.

The Board is asked to approve this plan, noting the scrutiny and recommendation for approval from the Finance, Performance and Business Development Committee, and recognising that they reflect a draft position in line with national deadlines. The deadline for final submission is 28th April 2022.

Charity budgets have been reviewed by the Charitable Funds Committee who have recommended Board approval. These represent expected incoming and outgoing resources of £425k, an increase on 2021/22.

MAIN REPORT

1. Introduction

For 2022/23 the proposed Trust plan is a deficit position of £10.6m. For 2021/22 the Trust initially agreed a plan with a £9.5m deficit, but with additional system funding and non-recurrent support, is forecast to end 2021/22 at a breakeven position. The Trust has a significant underlying deficit (c£25m) which has been supported in recent years through additional income including the Provider Sustainability Fund and top-ups. The Trust has been declaring itself financially unsustainable since 2014, with a structural deficit in place due to being a small, standalone organisation.

There remains uncertainty about income levels for 2022/23 and these are under review and negotiation with the Integrated Care System (ICS) and Commissioners. Commissioner contracts have not yet been signed and will not be until these issues are resolved.

In 2021/22 the Trust received £19.7m of growth, top-up and covid funding from the ICS. This funding has reduced to £13.6m in 2022/23. This excludes additional funding for Ockenden and CNST pressures, which together represent £4.7m of additional cost in 2022/23. These gaps in income are the drivers for the Trust's £10.6m interim deficit.

2. National and Regional Position

Nationally, there is additional pressure on NHS budgets moving into 2022/23 as the frameworks in place through the pandemic are changed. There is an implied efficiency requirement which is more that the NHS has historically been able to deliver, as well as an increased requirement in relation to recovery.

Cheshire and Merseyside is also one of the systems which is deemed to be over-funded. For that reason, a "convergence factor" of -0.9% has been applied to allocations for 2022/23. The efficiency requirement for Cheshire & Merseyside is 4.5%, comprising reduction in covid funding, an efficiency requirement and the convergence factor. LWH FPBD Committee has agreed that the maximum level of CIP that can be safely delivered in a financial year is 3%.

3. Revenue Budgets

The Trust has maintained robust budget setting processes throughout the pandemic, including setting full year internal budgets. However in 2021/22, national planning and funding agreements were on the basis of two half-year plans, so this annual plan was overlayed with the two half year plans which ultimately enabled the Trust to agree a breakeven plan for 2021/22. The budget setting process for 2022/23 has proceeded on a full year basis, both internally and with the system. There are no plans for an in-year revision of plans at system level once the final plan is submitted (planned for 28th April).

a. Process

Budget setting is undertaken as part of an overall planning process incorporating budgets, capital, activity planning, workforce planning, QI and other aspects in an integrated way as show in the diagram below. Divisions have produced transformation plans which have been the starting point for plans and the operational plans have all been presented by divisions to the executive team prior to approval.

Trust Clinical & Quality Strategy									
Divisional Clinical Priorities									
Divisional Five-Year Transformation Plan									
Divisional Operational Plan 2022/23									
Clinical Objectives	Business Plan - Including Plan on a Page	Operational KPIs	Workforce Plan	QI Priorities	Activity Plan	Contracts	CIP Programme	Budgets	Capital Plan

b. Income Position

Draft system funding is a reduction of over £6m from 2021/22. In addition, funding has not been released in relation to Ockenden One pressures (£2.2m) or Clinical Negligence Scheme for Trust contributions (£2.5m). There are a number of technical adjustments in relation to the value of block contracts and a proposed reduction by Specialised Commissioning that the Trust is working through. The income position is the driver for the draft deficit plan.

Note that, in a change to 2021/22, contract sign off will be required. LWH will not be able to sign off either Specialised Commissioning or CCG contracts until these issues are resolved.

c. Trustwide and Divisional Budgets

The high-level budget bridge is given below with further detail in Appendix One. These budgets have been built on a bottom-up basis from rotas, consultant job plans, establishments for non-clinical areas, and contracts or projected spend for non-pay. These have been developed in partnership between finance and each of the divisions. Divisions will be approving budgets at Divisional Board meetings, in addition to the individual budget holder sign off.

Specific investment in areas of clinical risk are included within the cost pressures below. The most significant are Ockenden, theatre investment, energy price inflation and clinical safety and quality pressures including staying safe on site initiatives.

All expenditure and non-clinical/NHS income budgets will be approved by the Head of Nursing/Midwifery/Allied Health Professionals, Clinical Director and Operational Manager, or corporate Head of Department, for all divisions and corporate departments. In addition, all nursing rotas will be separately agreed by the Head of Nursing/Midwifery for the area and then presented to and agreed by the Director of Nursing and Midwifery. Note that the bridge below is against out-turn rather than budget.

	Forecast outturn 2021/22	N/R and FYE 21/22	System Income Adjustments	Cost Pressures	CIP	Service Developments	CNST	Non recurrent savings/other	Inflation	Budget 22-23	Movement
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Patient income	131,638	(592)	(7,525)		599	2,032		78	2,426	128,656	(2,982)
Other income	6,847				357					7,204	357
Pay	(81,147)	(254)		(2,396)	584	(1,462)		1,400	(2,407)	(85,682)	(4,535)
Non-pay	(54,989)	(2,771)		(855)	2,660	(570)	(2,472)	750	(165)	(58,412)	(3,423)
Non operating expenditure	(2,366)			26				0		(2,340)	26
Deficit	**(17)**	**(3,617)**	**(7,525)**	**(3,225)**	**4,200**	**0**	**(2,472)**	**2,228**	**(146)**	**(10,574)**	**(10,557)**

Table One: High Level Budget Bridge 2022/23

The pressures identified below total £7.7m. However, a significant proportion of these were incurred in part during 2021/22 and therefore are already reflected in the forecast outturn for 2021/22.

Scenario modelling around risks and opportunities has been undertaken and considered by the Finance, Performance and Business Development Committee. These range from a small surplus to a much more significant deficit.

c. CIP

A full CIP programme has been developed in line with the Trust's procedures. This reflects a 3.4% target for recurrent savings, which will be challenging. This is lower than the Cheshire & Merseyside requirement but vacancy factor and reduction in Covid spend have been classified as additional non-recurrent CIP for externally reporting purposes bringing the revised CIP above the 4.5% target.

Prior to commencement, a Project Initiation Document including a Quality Impact Assessment, Equality Impact Assessment and Data Protection Impact Assessment (if required) will be produced and signed off by the Medical Director and Chief Nurse and Midwife.

The total schemes by division and as a percentage of expenditure budgets is given in the table below.

Division	CIP £000	% of Expenditure Budget
FAMILY HEALTH	51	0.13%
GYNAECOLOGY	633	2.88%
CLINICAL SUPPORT SERVICES	472	2.42%
ESTATES	65	0.86%
IM&T	150	2.69%
FINANCE	274	14.23%
HR & MARKETING	130	4.70%
GOVERNANCE	-	0.00%
Other Corporate	2,425	71.32%
Total	**4,200**	**3.42%**

Table Two: CIP Programme 2022/23 by Division

There is a significant variation in proportion of CIP compared to budget by area. Note also that some areas have high CIP but also high cost pressures. An active decision has been made that Family Health division will not be asked to undertake significant CIP until there is further stability in the management team and also that operational issues are resolved. Also note that a number of trustwide schemes and targets are within the "other corporate" area, these will be devolved to relevant divisions as schemes are agreed and worked up.

The schemes have been RAG rated. A total of £1.9m are considered green rated at this stage with plans in place, £1.1m are amber and £1.2m are red rated. The Board should note that QIAs will not be in place for all schemes by April, but no scheme will be allowed to commence until a QIA is signed off.

d. Cost Pressures

In 2022/23 the Trust faces significant challenges. In addition to the core challenges of Ockenden and staying safe on site, contract and energy price pressures above inflation are significant.

Many other identified pressures are also unavoidable or have already been committed to. As a result, the total value of cost pressures requested (excluding CNST increase) initially exceeded £10m although some of these have now been mitigated. The plan assumes that £7.7m of cost pressures can be funded. Note that this will be offset by a vacancy factor of £1.4m and that it is phased to take account of expected implementation timing. These pressures are against budget so note that in many cases expenditure above budget is already in place and the pressures formalise this, particularly in Maternity.

The table below shows a summary of these pressures.

Summary 2022/23 cost pressures	Themes £000
Activity Related	531
CNST	6
Contract Pressures	235
Energy	993
Estates Pressures	545
Investment in workforce	314
Ockenden	2,208
Other	754
Other Clinical Pressures	1,290
Other Corporate Pressures	318
Price Increase	10
Quality Improvement	77
Staying Safe on Site	446
Cost pressures total	**7,725**

Table Three: Summary Cost Pressures 2022/23

All pressures which are not unavoidable require a business case. Some of these have already been approved. In addition to being subject to business cases, all pressures have been supported by the division and subject to cross-divisional challenge by Senior Management and review by the Executive Team.

e. CNST

The total CNST cost to the Trust is increasing by £2.5m in 2022/23, assuming the CNST Maternity Incentive Scheme Year Four is achieved. The funding for this cost pressure is ultimately held at the ICS (as part of the tariff uplift to CCG allocations) but this has not yet been allocated to the Trust. Negotiations are ongoing with C&M on this matter (and others) and contracts will not be signed off without this being funded. The total cost of CNST for 2022/23 is now over £23m, with the possibility to earn back £1.8m if successful in the CNST Maternity Incentive Scheme.

f. Community Diagnostic Centre

In 2021/22 the Trust was awarded funding to build a community diagnostic centre on the Crown Street site. This will provide diagnostic services for both LWH patients and the wider community including MRI and CT scanner facilities. For 2022/23, revenue funding of £4.4m has been approved. A full business case representing the full revised plan will be brought back to the Trust Board for approval.

g. Maternity Staffing

During 2021/22 there were significant changes and pressures within Maternity which resulted in overspends against budget. The have been assessed in detail and reflected in the 2022/23 budget at an additional cost of £2.5m in total representing an investment in front line staff and midwifery management.

This is a significant investment into the maternity budget but is evidenced based.

Headroom has been increased from 21.4% to 23% following a full assessment of the training requirements of Maternity staffing. This has been agreed with the Head of Midwifery. However this assumes sickness of 4.5%; this is a key area for the division to address as current sickness levels are well in excess of this.

h. Covid-19 Costs

In 2021/22 the Trust will have spent over £1.3m on covid specific costs. This budget has reduced to £0.6m in the 2022/23 plan however there is some risk to this given the current position.

4. Movements from Board Approved Draft

The Board approved a position of £11.9m deficit on 3rd March. The movements noted above have led to a proposed deficit budget of £10.6m. The movement from the position approved by the Board is given below.

	£m
Board Approved Plan	**-11.9**
Additional income agreed	1.3
ERF - TOP adjustment	1.2
ERF - Activity	0.5
Additional pressures	-1.7
Revised Draft Plan	**-10.6**

Table Four: Movements from Previous Board Approved Position

There are a number of technical issues impacting on the Trust's income. Two of these have been resolved since the Board approved budget as noted above - £1.3m in relation to commissioned income and a further £1.2m in relation to ERF due to agreement of the Termination of Pregnancy baseline adjustment with the national team. However, there are still a number of unresolved areas driving the deficit position.

5. Capital

An allocation has been made to Cheshire and Merseyside which is significantly lower than in 2021/22. LWH has been allocated £5.0m initially, which is lower than the Trust's planned depreciation of £6.4m, plus £3.5m to complete works on the Community Diagnostic Centre. Initial capital requests were higher than this but these have been prioritised. A number of reserve schemes are being worked up should further funding become available in year.

	2022/23 plan
	£000
Crown Street Enhancements/CDC investment	**4,145**
Estates	**960**
Medical Equipment	**1,859**
Digital Services	**1,171**
Other	**400**
Grand Total	**8,535**
Funded by	
Baseline depreciation (limited by HCP)	**5,035**
Additional HCP allocation for Crown Street/CDC	3500
Provisional capital allocation	**8,535**

Table Five: Summary Capital Plan 2022/23

5. Cash and Working Capital

If the Trust is not allocated additional funding to allow a breakeven plan, cash support will be required. Both the deficit position and the overall capital plan being above depreciation/internally generated cash means that there is a draw on cash. If a deficit budget is agreed cash support will be sought, via the national team if required.

The Trust has one remaining capital support loan with payments of £612k due in 2022/23. The final payment on this loan will be made in 2023/24.

Significant progress has been made on clearing aged debt so no further assumptions have been made to improve this position. Creditors are expected to remain steady compared to prior years although if cash allows the Trust would look to clear more of these, particularly with LUHFT.

6. Financial Management 2022/23

More stringent financial management will be in place and there will be an expectation that divisions manage within the budgets agreed, managing pressures through prioritisation of resource. Mechanisms such as executive oversight are in place if this does not happen. Conversely, for divisions or departments who are achieving CIP and adhering to budgets, further autonomy will be given e.g. over vacancies and recruitment.

7. Risks for 2022/23

The overall deficit position for 2022/23, and the larger underlying recurrent deficit represent a risk for the Trust in terms of short-term cash management and longer term sustainability.

In addition to the over-arching issue of financial sustainability there are a number of other risks, including

- **Elective recovery income**: There is both upside and downside risk to ERF.
- **CNST Maternity Incentive:** If the scheme requirements are not met, the £1.8m contribution made will not be returned to the Trust.
- **CIP Delivery:** There is significant risk due to the level of schemes within the programme which are red or amber rated. This will be closely monitored and work to develop additional schemes will continue.
- **Agency costs:** Agency costs have been a significant pressure in 2021/22 and the scarcity of some staff groups has an impact on hourly rates.
- **Inflation pressures:** The current economic situation and world events are likely to create ongoing volatility in cost inflation. This is particularly evident in energy prices but is also likely to impact on other supplies.

8. Charity Budget 2022/23

The following budget has been reviewed by the Charitable Funds Committee who recommended Board approval of it. This follows the same principles as 2021/22 around ensuring that income matches expenditure and running costs, and that the Charity continues to repay its creditor with the Trust. Priorities for charitable expenditure have been agreed and are reflected in the budget. There is a plan to increase ambition and both fundraising income and charitable expenditure over the coming year and future years. A three year plan is in the process of being worked up and will be brought back the Charitable Funds Committee for review.

	22/23 Budget £000
Income	
Corporate	40
Community	50
Events/Staff Fundraising	75
NHS Charities Together	70
Individual Giving & Funeral & in Mem	90
Trusts and Foundations	50
Lottery	1
Total Donations	**376**
Trading Activities (e.g. knitting stall)	35
Investment Income	15
Total Income	**426**
Running Costs	
Fundraising Costs	119
Events	20
Governance Costs (Trust Recharge)	21
Total Running Costs	**160**
Charitable Expenditure	
Neonatal Flat Refurbishment	80
Honeysuckle bereavement rooms	40
Honeysuckle	20
Staff Welfare	20
Neonatal	40
General Purpose/Other	15
Mona Lisa Laser	50
Total Charitable Expenditure	**265**
Total Expenditure	**425**
Total Surplus	**1**

Table Six: Charity Budget 2022/23

9. Recommendation

The Board is asked to note the process and detailed work underpinning the budget setting and planning process and the outputs of this outlined above. It is envisaged that there will not be significant further changes to these budgets prior to the final budget agreement, other than in relation to income which is still under discussion with the ICS.

The final plan is due for submission to NHSI/E, having been agreed with the ICS, on 28th April. Should this be an improved position, it is proposed that final agreement of this is devolved to the Chief Finance Officer and Chief Executive to approve, following scrutiny by the Finance, Performance and Business development Committee. Should an improved position not be agreed, or if there are other matters which the Board needs to review, an extraordinary Board meeting will be called following the Finance, Performance and Business Development Committee on 25th April.

Appendix One: Draft Budget 2022/23

Income	2022/23 plan £000
CCG income	78,609
Top up/system income	13,606
ERF income	2,700
NHS England Income	24,234
Private Patients Income	3,837
Income from NHS Trusts/FTs	3,251
Other income from activities	2,419
Operating income	7,204
Total income	**135,860**
Pay expenditure	
Consultants	18,239
Other Medical	15,578
Nursing and Midwives	34,677
HCAs and Support Staff	7,207
Other Clinical	4,651
Non Clinical	5,330
Total pay expenditure	**85,682**
Non-pay expenditure	
Clinical supplies and services	8,577
General supplies and services	3,621
CNST	21440
Other non-pay expenditure	18,365
Depreciation	6,408
Total non-pay expenditure	**58,411**
Non operating expenditure	2,340
Total 2022/23 plan deficit	**(10,574)**

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
21 February 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Month 10, the Trust is reporting a £2.3m deficit Year to Date (YTD) against a £0.1m deficit plan, and a breakeven forecast in line with the revised Board approved plan. The YTD Trust wide position has worsened in month due to the increasing pay cost pressures in relation to rising sickness and staff absence figures predominantly due to Covid-19. An additional pressure relating to fuel costs has also been identified in month. • Committee highlighted the risks in relation to the CIP position for 2021/22 and 2022/23. It was confirmed that there was no unidentified CIP in the forecast outturn and noted that the CIP programme remained under constant review. • The impact of covid-19 on operational performance continued to be noted, the Omicron variant had increased staff sickness absence creating performance challenges through December 2021 and January 2022 however performance had improved during February 2022. Cancer referrals for 2021/22 continue to be above pre-pandemic levels and expected to continue into 2022/23. • Noted a significant amount of Capital Expenditure to spend over the coming months and some risk that this would not be achieved. The Committee noted that a capital working group had been set up internally to ensure expenditure is monitored and progressed.	• Received a comprehensive overview of Planning 2022/23 noting the detailed work undertaken to derive triangulated workforce, activity and finance plans and marrying up top-down assumptions with bottom-up planning and some further specific workstreams underway to support finalising the plan. Planning would be submitted to the Trust Board in April 2022 and to the local system for final approval. It was noted that Cheshire & Merseyside aimed to achieve a breakeven position at system and individual provider level. • Noted the work undertaken in relation to the Soft Facilities Management Contract Extension Update. Committee supportive of approach undertaken and to receive a further report. • Positive update received in relation to the Community Diagnostic Centre, noting a go-live date of 07 March 2022 for the onsite Mobile CT Scanner. These patients would access the service via a portakabin and not within the main building. Other workstreams continued to be progressed. Appropriate and clear signage to CDC services would be provided as diagnostics become incorporated within the building.
Positive Assurances to Provide	**Decisions Made**
• The Trust has been successful in achieving the CNST Maternity Incentive Year Three and the Committee noted the £1.6m contribution and additional funding of £281k awarded to the Trust. • Assured by the Digital Generations Strategy bi-annual review and the Digital Update although the committee challenged the team to include significant problems encountered and actions to address these more robustly within future reports. • The Committee received an update on the Crown Street Enhancements (CSE) Programme noting Phase 2 works (CT and MR imaging and colposcopy) had commenced and progressing well against planned timeframe to complete in December 2022.	• Reviewed and agreed the FPBD related BAF risks. • Agreed that quarterly (vs monthly) reporting of Cancer Wait times should occur going forwards. This will result in improved accuracy of the figures being reported to the committee.
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Good contributions throughout the meeting. • Timely discussions. Well presented reports and presentations.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
189.	Board Assurance Framework Review	Assurance	195.	Digital Generations Strategy 2020-2024 Bi-annual review	Assurance
190.	Finance Performance Report Month 10 2021/22	Assurance	196.	Soft Facilities Management Contract Extension Update	Information
191.	Operational Performance Report Month 10 2021	Assurance	197.	Community Diagnostic Centre Update	Information
192.	Recovery and Restoration	Assurance	198.	Sub-Committee Chairs Reports	Assurance
193.	2022/23 Planning Update	Information	199.	Crown Street Enhancements Programme	Information
194.	Digital Services Update	Assurance			

3. 2021 / 22 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tracy Ellery	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	
Jo Moore	A	✓	✓	A	Non member						
Ian Knight	✓	✓	✓	✓	Non member						
Louise Martin	Non member		✓	✓	✓	✓	✓	✓	✓	✓	
Tony Okotie	Non member				✓	A	✓	✓	A	✓	
Jenny Hannon	✓	✓	✓	✓	✓	Non member					
Eva Horgan	Non member					✓	✓	✓	✓	✓	
Kathryn Thomson	✓	✓	✓	✓	A	✓	✓	✓	✓	A	
Gary Price	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	
Marie Forshaw	✓	✓	✓	✓	A	✓	✓	A	✓	A	

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

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
28 March 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Divisional financial performance remains a concern for Family Health and Gynaecology divisions, with continued use of agency in particular. • Committee received a detailed report on the draft revenue and capital budget 2022/23. The Trust faces increasing pressures to maintain levels of workforce recommended by the Ockenden report and has seen a significant increase in clinical negligence costs which have not yet been funded. There are other significant cost pressures, which will be managed through an ambitious and challenging cost improvement plan, plus additional non recurrent mitigations. Operational teams have also set an ambitious activity plan aimed at reducing long-term waiting and increase overall patient flow. The Committee reviewed the proposed budgets and recommended that the Trust Board approves the interim plan of a £10.5m deficit, whilst recognising that it reflects a draft position to be finalised in April 2022 in line with national deadlines.	• Committee received a presentation detailing the recovery and restoration work programme underway, noting continued hard work from all teams in the Trust to achieve and maintain performance trajectories. The Committee discussed the Trust's offer of support to other NHS trusts to reduce patient backlogs, whilst ensuring no negative impact on Trust patients, and agreed this should be maintained. • It has been agreed to extend the timeframe of the Financial Recovery Board by an additional three months due to successful progress made to consider and resolve matters. • In relation to implementation of the Meditech Expanse System, the Committee highlighted the necessity to ensure that the Digital Team factored headroom of the workforce to receive Meditech Expanse training. • The Committee received an update against the Soft Facilities Management Contract Extension and a recommendation to proceed with Option 4: to extend the OCS contract with certain service specification enhancements for a 2-year extension period, with options to review or remove some or all elements of catering and security after year 1 of extension.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• At Month 11, the Trust is reporting a £1.5m deficit year to date (YTD) against a £0.1m deficit plan, and a breakeven forecast in line with the revised Board approved plan. The Committee received positive assurance that the Trust would achieve the break even plan by year end 2021/22 with additional funding already having been received by the time of the meeting • The Committee noted that the Trust is significantly on track to achieve the CIP programme and utilise capital spending by year-end, and also noted that the financial adjustment to the Termination of Pregnancy baseline has now been agreed by the national team. • Received a newly formatted operational and activity performance report and noted an improved presentation of performance metrics. Improved compliance in relation to statutory estates and facilities KPI's were highlighted. • Received a presentational overview of six key areas required to successfully implement the Meditech Expanse System. Metrics have been assigned to each of the	• Recommend Board approval of the interim Revenue and Capital Budget 2022/23. • Recommend Board approval to proceed with Option 4 in relation to the Soft facilities management (Soft FM) OCS contract extension. • Recommend to the Board the appetite and risk tolerance levels for 2022/23 against the strategic aims for which the Committee is responsible. • Recommend approval of the Committee Terms of Reference and Workplan 2022/23. • Submission of the Committee Annual Report to the Board to provide assurances of Committee effectiveness. • The Committee noted the review undertaken against the Corporate Objectives 2021/22 and approved the update to be presented to the Trust Board in April 2022.

key areas to monitor compliance and will be included within future Digital reports to the Committee. The Committee requested sight of project budget expenditure against targets in future reports. • Received a positive update on the implementation of the Mobile CT Scanner. Effective partnership working had been demonstrated to deliver the service to patients and resolve preliminary setbacks. The other workstreams of the Community Diagnostic Centre continued to be progressed, with a current focus on the Respiratory Service. • The Committee received an update on the Crown Street Enhancements (CSE) Programme noting Phase 2 works (CT and MR imaging and colposcopy) had commenced and progressing well against planned timeframe to complete in December 2022.	
Summary of BAF Review Discussion (Board Committee level only)	
• The Committee reviewed the Quality related BAF risks. No changes to risks scores or narrative was recommended. It was noted that a formal review of BAF risks to be taken forward into 2022/23 would be undertaken at the next meeting.	
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Sufficient time provided to discuss matters thoroughly • Good contributions throughout the meeting.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
208.	Board Assurance Framework Review	Assurance	216.	Community Diagnostic Centre Update	Information
209.	Finance Performance Report Month 11 2021/22	Assurance	217.	Payment Update	Information
210.	Operational Performance Report Month 11 2021/22	Assurance	218.	Review of Risk Appetite Statement 2022/23	Approval
211.	Recovery and Restoration	Assurance	219.	Corporate Objectives Year-end review	Assurance
212.	Revenue and capital budget for 2022/23	Information	220.	FPBD Committee Effectiveness review, Terms of reference and Workplan 2022/23	Approval
213.	Operational Planning (2022/23)	Information	221.	Sub-Committee Chairs Reports	Assurance
214.	Digital Services Update	Assurance	222.	Crown Street Enhancements Programme	Information
215.	Soft Facilities Management Contract Extension Update	Approval			

3. 2021 / 22 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tracy Ellery	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	A
Jo Moore	A	✓	✓	A	Non member						
Ian Knight	✓	✓	✓	✓	Non member						
Louise Martin	Non member		✓	✓	✓	✓	✓	✓	✓	✓	✓
Tony Okotie	Non member				✓	A	✓	✓	A	✓	✓
Jenny Hannon	✓	✓	✓	✓	✓	Non member					
Eva Horgan	Non member					✓	✓	✓	✓	✓	✓
Kathryn Thomson	✓	✓	✓	✓	A	✓	✓	✓	✓	A	✓
Gary Price	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓
Marie Forshaw	✓	✓	✓	✓	A	✓	✓	A	✓	A	✓

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

Audit Committee Chair's Highlight Report to Trust Board
24 March 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Whilst robust assurance was provided on the Trust's data quality processes, the on-going challenge to data quality relating to the multiple clinical systems was highlighted. Noted that the implementation of Meditech expanse would significantly mitigate this risk. • The Committee received an outline of the developing ICS governance landscape and the potential implications on good governance and accountability for the Trust as a sovereign organisation. The challenges of maintaining good governance between organisations was discussed and the Committee agreed to maintain a watching brief on the emerging models of accountability to support the Board in responding effectively.	• It was agreed to undertake a training needs analysis for the Committee (in line with the Terms of Reference). • The Committee remitted a Chair's Log to both the FPBD and Quality Committee with a recommendation that the patients awaiting a follow up appointment metric be included on their respective dashboards (reflecting the different lenses that each Committee provides). • The Committee remitted a Chair's Log to the Board to receive a report on establishing a maturity criterion for Divisional Governance arrangements.
Positive Assurances to Provide	**Decisions Made**
• The Committee noted a continued reduction in the number of outstanding internal audit recommendations. Assurance was provided that those actions identified with an end of March 2022 deadline would be closed by then. • Three internal audit reports were received 1) Assurance Framework (meets requirements) 2) Never Events and Serious Incidents (Substantial Assurance) and 3) Quality Spot Checks (Medicine Management) (Substantial Assurance). Updates were provided on on-going areas of work and the Committee was assured by the progress being made against the 2021/22 internal audit plan. • A draft Head of Internal Audit Opinion was noted. This provided a draft substantial assurance opinion. The outstanding audits still to be completed as part of the 2021/22 programme are unlikely to change this draft opinion. • The Committee noted the MIAA Internal Audit Charter • The Committee received an anti-fraud progress update. Noted that the Trust was on track to receive a 'green rating' in the year-end report. The Deputy CFO would imminently be designated as the Trust's Anti-Fraud Champion. • Noted that the interim external audit had been completed. No significant control issues highlighted although a higher sample would be taken in relation to payroll processes and record keeping, particularly for the approval of vacancies. No substantial risks had been identified for the Trust's Value for Money arrangements • The Committee reviewed the draft Clinical Audit Plan for 2022/23 and was assured that there were processes in place to manage clinical audit programme effectively. Lessons had	• The Committee approved the MIAA Internal Audit Plan for 2022/23. It was recommended that the 2023/24 plan would include a review of CNST year 5 compliance in Q1. The Committee also noted some potential flexibility in the plan and should resource become available, this could be utilised for quality spot checks. • The Committee approved the 2022/23 Anti-Fraud work plan • The Committee approved the areas of judgements in the accounts and agreed that the accounts would be prepared on a 'Going Concern' basis. It was also agreed that there would be a provision in the Accounts to recognise the risk of not achieving the CNST Year 4 rebate. • The Committee recommended the approval of the Risk Management Strategy 2022/23 to the Board. • The Committee agreed to write off £472,515.39 of debt for the 2021/22 financial year. This related to invoices to One to One (North West) Ltd. • The Committee agreed to publish the Trust's Registers of Interest • The Committee reviewed and recommended for approval to the Board the updated Terms of Reference and 2022/23 work programme.

been learned from previous years in terms of the volume of audits and the need to prioritise key areas.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- No comments made

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
21/22/79	**Follow up of Internal Audit and External Audit Recommendations**	To receive assurance of actions implemented on a timely basis.	21/22/86	**Data Quality Assurance**	For assurance
21/22/80	**MIAA Internal Audit Reports** a) Internal Audit Progress Report b) Draft Head of Internal Audit Opinion 2021/22 c) Internal Audit Work Plan 2022/23 d) Internal Audit Charter e) Insight Update	To note the contents and any recommendations from the report.	21/22/87	**Risk Management Strategy Review**	For assurance
21/22/81	**Anti-Fraud** a) Progress Report 2021/22 b) Anti-Fraud Work Plan 2022/23	To note the contents and any recommendations from the report.	21/22/88	**Governance in the context of Integrated Care Systems**	For assurance
21/22/82	**External Audit Plan 2021/22**	To receive update	21/22/89	**Registers of Interests**	For assurance
21/22/83	**Areas of Judgement in the Accounts**	For assurance	21/22/90	**Board Assurance Framework (BAF)**	For assurance
21/22/84	**Debt Write Off Report**	For approval	21/22/91	**Chairs reports of the Board Committees** a) Finance, Performance and Business Development Committee b) Quality Committee c) Putting People First Committee	Review of Chairs' reports for overarching assurance.
21/22/85	**Draft Clinical Audit Forward Plan 2022-23**	To receive	21/22/94	**Review of Committee Terms of Reference & Business Cycle 2022/23**	For approval.

3. 2021 / 22 Attendance Matrix

Core members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tracy Ellery			✓	✓			✓			✓		✓
Ian Knight			✓	A			Non-member					
Susan Milner			✓	✓			A			✓		✓
Tony Okotie	Non-member						✓			A		NM
Zia Chaudhry	Non-member											A
Present (✓) Apologies (A) Representative (R) Non attendance (NA)												

Charitable Funds Committee Chair's Highlight Report to Trust Board
21 March 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Representatives from Investec presented an investment performance report demonstrating a decreased capital value since March 2021. The impact on market performance during geopolitical events was considered and the Charity was advised to maintain their investment position. • The Committee discussed the creditors owing to the Trust, noting an estimate of £100 -110k interdebtedness between the Charity and the Trust at year-end. Reduction of the level of debt had been delayed due to the impact of Covid-19 on fundraising activity. The Committee requested a trajectory to complete payment. It was noted that a plan would be provided to the next meeting and would include repayment of the interdebtedness. • The Committee noted that a number of operational issues had been escalated from the Fundraising Update, including difficulties to deliver projects to completion and digital issues to utilise the onsite fundraising pay terminals. It was recommended that an escalation process should be utilised by the fundraising team to address issues..	• The Committee received an annual review of the Investment Portfolio. A detailed discussion was held to consider whether further exclusions should be applied to align with the Green environmental aims of the Trust whilst not destabilising the investment portfolio of the Charity. The Committee did not support the proposal to maintain the current position and requested proposals for a suggested timescale for the Charity to disinvest in oil, gas and fuel. It was agreed that this would be received at the next formal meeting in June 2022. • It was noted that the current Fundraising Strategy had ended in March 2022. A revised 3-year Strategy was being written by the fundraising team with support from finance to consider future investment and opportunities. The Fundraising Strategy would be submitted to the Committee in June 2022 for approval.
Positive Assurances to Provide	**Decisions Made**
• Noted that the Trust would be receiving an amount of emergency funding from NHS Charities Together following the major incident following approval at the NHS Charities Together Board. • The Committee noted total incoming resources at £219k in comparison with the prior year income comparator figure (excluding NHS Charities Together) of £161k, therefore total incoming resources had increased by £58k during the first 10 months. The closing fund balances are at £560k. • The Committee received the initial revenue and capital budget for 2022/23 noting a conservative approach had been undertaken. The Committee agreed with the budget submitted as an opening position and noted the scope to add to plans during the year. • The Committee received positive assurance of fundraising against the targeted charity appeals including, big Tiny Steps, and Mona Lisa Laser.	• Agreed to submit the Charity revenue and capital budget 2022/23 to the Trust Board • Approved the Annual Committee Effectiveness Review, the Terms of Reference and workplan of the Charitable Funds Committee which would now be submitted for ratification by the Trust Board.

• Noted positive support from the local community towards the Roundabout Replant following the major incident as a joint police and fire & rescue service project to raise funds and support from a local secondary school. • The Committee noted the improved report structure and narrative provided. • The Committee noted the operational charity priorities and income generation action plan and achievements delivered against the Fundraising Strategy.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Positive meeting. Good level of discussion and debate.
- Offered support to the Fundraising Team to escalate matters and encourage further embedding of the Fundraising team within the wider workforce.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
45.	Investment Report	Assurance	**49.**	Fundraising Update	Information
46.	Investment Portfolio Review 2021/22	Information	**50.**	Operational Plan	Information
47.	Monthly Financial Position Report 2021/22 (January 2022)	Information	**51.**	Committee Effectiveness Review: Annual Report; Terms of Reference; Business Cycle 2022/23	Approval
48.	Revenue & Capital Budget for 2022/23	Information			

3. 2021 / 22 Attendance Matrix

Core members	June 2021	Sept 2021	Dec 2021	March 2022
Jo Moore (Chair until end Aug 2021)	✓	NM		
Tracy Ellery (Chair as of Sept 2021)	NM	✓	✓	✓
Tony Okotie	✓	✓	✓	A
Louise Martin	A	✓	✓	✓
Michelle Turner	✓	✓	A	✓
Jenny Hannon*	A	A	NM	
Eva Horgan* (as nominated deputy. CFO as of Oct 2021)	✓	✓	✓	✓
Marie Forshaw	✓	A	✓	✓
Chris Gough	✓	A	✓	✓
Kate Davis	✓	✓	✓	✓

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2022/23/012a*		Date: 07/04/2022	
Report Title	Corporate Objectives 2021/22: Final Outturn Review			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	Executives			
Key Issues / Messages	***The report provides the final outturn position for the 2021/22 Corporate Objectives.***			
Action required	Approve ☐	Receive ☒	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is asked to note the performance / progress to date against the 2021/22 Corporate Objectives.			
Supporting Executive:	Executive Team			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The Board of Directors reviewed the corporate objectives 2020/21 at its meeting on 6 May 2021 and formally approved them.

The cycle of periodic review usually involves the Committees and the Board reviewing progress on the Corporate Objectives on a six-monthly basis. In light of the Covid-19 pandemic, and to ensure that the objectives remained feasible and deliverable, it was agreed that the 2021/22 objectives be reviewed in three months and then again at six months. This report provides the final outturn position.

Consideration of the corporate objectives have been given by each of the Board Committees, and they are now presented to the Board for noting.

It is intended to report the draft Corporate Objectives for 2022/23 at the April 2022 Committees (Putting People First via email) ahead of Board approval in May 2022. In discussing the 2021/22 objectives with the Committees, there was agreement that the 2022/23 objectives would benefit from being more focussed and 'SMART' with clear linkages made to the Corporate Strategy whilst avoiding objectives already in place in other strategies and frameworks. For any 2021/22 objectives that remain outstanding, scrutiny will be provided on the appropriateness of taking these forward as 2022/23 objectives. Any actions not taken forward will be allocated to other fora for continued oversight.

Recommendation

The Board is asked to note the performance / progress to date against the 2022/23 Corporate Objectives.

MAIN REPORT

NHS
Liverpool Women's
NHS Foundation Trust

Corporate Objectives

2021 – 2022

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.

Liverpool Women's NHS Foundation Trust

Key	Complete	On track	Risks identified but on track	Off Track

To develop a Well Led, capable, motivated and entrepreneurial Workforce						
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Year outturn position**	**Progress Rating**
Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	Treble the number of staff from BAME backgrounds in leadership roles (Band 7 and above) by 2022	CPO	PPF Strategy	PPF	In March 2020 there were 14 BAME staff in clinical roles and 2 BAME staff in non-clinical roles at Band 7 and above. In March 2021 there were 17 BAME staff in clinical roles and 3 BAME staff in non-clinical roles at Band 7 and above. In March 2022 there were 18 BAME staff in clinical roles and 5 BAME staff in non-clinical roles at Band 7 and above. The steady trend of increase is being supported by Career conversations Reciprocal mentoring and general mentoring and coaching opportunities Training and support for managers to identify opportunities for development Promotion of LWH as inclusive employer through recruitment branding and attendance at range of careers and community events.	

	Work as an active partner with health, education and the Liverpool Race Equality Task Force, increase the overall % of employees from a BAME background	CPO	PPF Strategy	PPF	LWH continues to work closely with partner organisations including local schools, colleges, community groups and Liverpool City Council. Key outputs in 21/22 include: • Entered the Inclusive companies IT50 (inclusive top 50) and placed 41st with positive feedback and recommendations on how we can improve on this position moving forward including the commencement of a 'Race and Culture Review'. • Accredited as a "Disability Confident Employer" and 'Mindful Employer' we are committed to supporting staff to gain access to and maintain employment. Recruitment policy supports all staff in relation to promotion opportunities and career development. • Reciprocal Mentoring Scheme launched with Executive Directors and BAME Colleagues • Health and careers event at the Pakistani Centre in September 21.	
Recruit and retain key	Demonstrate improvement from the 2020 NHS Staff survey in	CPO	PPF Strategy	PPF	The NHS National Staff Survey shows that there has been a dip in the overall Staff	

clinical staff	relation to staff engagement measures.				Engagement Score from 7.1 to 6.9. This has followed 5 years of steady increase and reflects a Trust wide and national trend of decline, with Covid a contributory factor. The 22/23 PPF Action Plan and strategy refresh will focus on addressing this decline through implementation and sustaining the current workstreams, focusing on - Investing in our leaders through the Leadership Programme - Embedding our Be Kind and Be Brilliant - Getting the basics right with effective rostering, recruitment and establishment management Continued focus on staff engagement and wellbeing including an increase in the number of Listening Events.	
	Make progress to grow the consultant workforce to achieve 24/7 consultant cover by 2023	CPO	PPF Strategy	PPF	The Medical Director presented the Medical Workforce Plan to PPF in March 2022	
	Train 200 managers in Fair & Just processes	CPO	PPF Strategy	PPF	Training is being rolled out in March with completion by June 2022.	
	Develop and launch a Behavioural Framework	CPO	PPF Strategy	PPF	The behavioural framework has been launched and is part of the overall 'Be Kind' employee promise and will be	

					further embedded via the 'Be Kind and Be Brilliant' employee brand. Practically, it is being used as part of behaviours led recruitment for entry level roles such as HCAS.	
	Launch LWH Leadership Programme and talent management process	CPO	PPF Strategy	PPF	There are currently 12 Band 8a and 15 Band 7 managers engaged in the Leadership Programme accessing a mixture of taught learning as well as mentoring/ coaching and other development opportunities. Candidates will be supported to access career development and promotion opportunities.	

To deliver Safe services						
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Year outturn position**	**Progress Rating**
Progress our plans to build a new hospital co-located with an adult acute site	Complete refresh of business case for a new Liverpool Women's Hospital to reflect evolving models of care and system developments.	CFO	Future Generations Strategy	FPBD	Expression of Interest (EOI) for Capital submitted. Future Generations Program relaunched and Clinical Advisory Group underway. Long term financial model being refreshed. LWH not prioritised by C&M but yet national assessment not complete. Meetings undertaken with regional and national colleagues to discuss. On track. CAG underway with options appraisal. SOC refresh underway	

					following Treasury model. Clinical Senate review complete. Support from regional and national colleagues.	
	Contribute to the development and delivery of the Liverpool-wide estates plan during 2021, building on strategic partnerships for optimal outcomes.	CFO	Estates Strategy	FPBD	Membership of C&M Strategic Estates Group. LWH plans (EOI) presented to C&M and Liverpool place strategic estates boards Sept 21. On track in an area that is developing within C&M. Partnerships with other organisations developing.	
	Provide our hospital with the best digital capabilities and embed a digital first culture through delivering the Digital.Generations strategy through to 2025.	CIO	Digital.Generations Strategy	FPBD	The EPR Programme is making steady progress with the EPR build and configuration activities. The programme aims to go-live in Q3 of 22/23, which allows for the system vendor to deliver several localised system requirements. Digital Maternity system is embedding well across the Trust, celebrating a year since go-live. During 22/23 focus continues on optimising the system and delivering improved integration with other Trust systems.	
Implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities	Deliver the Crown Street enhancement work program (including CT and blood bank services) to time and to budget working with system partners to ensure optimal patient benefit	CFO	Estates Strategy	FPBD	Schemes are underway with oversight from the Crown Street Enhancements Board. Guaranteed Maximum Price agreed and Tilbury Douglas engaged to commence building works. FMU now completed.	

for the benefit of our patients as well as those across the system	across the wider Cheshire and Mersey system.				CT scanner delayed to incorporate with the MRI/ CDC building work, due to successful bid for Community Diagnostic Centre (CDC). Mobile CT scanner in place earlier than original permanent CT planned, although overall build programme now put back due to incorporation of the CDC. Blood bank underway although there are operational challenges in delivery. All programmes running to budget.	
	Maximise the clinical workforce to deliver timely, safe and effective care to our patients.	MD	Clinical & Quality Strategy	PPF	The Medical Workforce Plans which include medical workforce plans for 2022-27 were presented at the March 2022 PPF.	
Develop our model of care to keep pace with developments and respond to a changing environment	Review Future Generations model of care for all services, taking account of all post-COVID learning and changes to care delivery models by 2021	MD	Future Generations Strategy	QC	Future Generations Clinical Advisory Group held a workshop on 20th September to review the future models of care. There was good attendance and engagement by senior LWH clinical staff.	
	Deliver the Quality and Clinical strategy year one objectives	MD	Clinical & Quality Strategy	QC	Update to QC on 21st February 2022 on progress. Progress is being made on many of the clinical priorities. These have now been incorporated into the 5 Year Clinical Transformation Plans.	
	Deliver the launch of Trust's EPR programme in line with	MD	Digital Generations Strategy	QC	This work is ongoing with good progress and is monitored through the Meditech Expanse Board meeting. There has been some slippage in the timelines due to	

	established timescales (April 2022)				issues with the pharmacy module it is anticipated that the 'Go Live' will be late summer/early autumn 2022 Subject to formal review and sign off by the EPR programme board.	

To deliver the best possible Experience for patients and staff						
Strategic Aim	**Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 month update**	**Progress Update**
Deliver an excellent patient and family experience to all our service users	Make progress towards achieving Bliss baby charter accreditation by 2023	DONM	Clinical & Quality Strategy	QC	The NNU are not progressing with formal accreditation due to the financial costs.	
	Make progress towards achieving the Unicef Baby Friendly Initiative by 2025	DONM	Clinical & Quality Strategy	QC	Application in process – Accreditation assessment expected in June 2022 Education of staff on-going. Infant feeding team in place	
	Develop and begin to implement the Patient Experience Framework	DONM	Clinical & Quality Strategy	QC	The Women, Babies, and their Families Experience Strategy 2021 – 2026 objectives have been developed after a review of the Patient Experience Framework. Patient Experience Reviews are received from Divisions at the Patient Involvement	

					and Experience Sub Committee which monitor progress against strategy objectives. Key lessons learnt are presented by each area. There has also been a Patient Experience Matron appointed in November 21 who has key objectives linked to the Quality Improvements that are needed to address any shortfalls that was found from undertaking the review of the Patient Experience Framework. The Patient Experience Matron networking externally with groups and listening to what patients want and is also setting up a Co-Design/production group to ensure LWH has robust information before making any changes and has input from patients and partners about what matters to them. Each of the clinical areas has 'You said We did' boards in clinical areas that are visible to patients and	

					visitors to departments and a new Trust template has been developed to give a standardised approach across all areas.	
	Pro-actively seek the views of diverse communities to inform the design of our services for the future, ensuring we champion the voices of our future service users	DONM	Clinical & Quality Strategy	QC	Following the Trust hosted day at the local Pakistan centre on 23rd September a further event was planned for 17th February 2022. This was to be in partnership with the local Al-Ghazi centre. A multi-cultural centre. Unfortunately, due to Covid-19 and associate risk assessments the event had to be postponed. The Trust should be able to reschedule this to take place during quarter1 of the financial year. Going forward events will then be arranged each quarter across different venues in the city. This will include connecting with the homeless and travelling community.	

					Covid -19 pandemic has resulted in community groups not holding regular meetings however as restrictions are beginning to ease meetings are now starting to take place. An example of good practice is that the Trust matron for patient experience is now attending a monthly coffee morning at the Merseyside Centre for the deaf. This is providing an opportunity for the Trust to develop links with the deaf community actively obtaining feedback on their experiences. The British sign language interpreters are also keen to be involved in their experiences supporting their clients in the difficulties they too can encounter.	
	Deliver the Continuity of Care (COC) priorities in 2021/22	DONM	Clinical & Quality Strategy	QC	Evidence from research and the experiences of women in England in the CQC Maternity Service	

					survey has shown that Continuity of Carer is essential to improving the safety, equity and experience of Maternity care. The vision for Liverpool Women`s Hospital is to be an exemplar in delivering national targets for Continuity of Care and address unwanted variation for all women receiving care at LWH.As a Trust we remain committed to ensuring women are in receipt of Continuity of Care as set out in the NHS - long term plan, and have made progress to ensure women of Black, Asian and Minority Ethnic backgrounds and those living in the most deprived LLSOAs are prioritised in our plans to deliver Continuity of Care. Further priorities for the Trust are to review the	

					action plan which describes how the maternity service will work towards Continuity of Care being the default model of care by 2023, ensuring agreed timescales for implementation, prioritising those women from BAME backgrounds and those living in the most deprived LLSOAs, whilst ensuring transitional arrangements and support are in place to uphold the safety of care of all women across the service. A workforce review by Birth rate plus was commissioned across Cheshire and Merseyside LMS which has now been completed and takes into consideration the increase in complexity of women and the requirements to operationally deliver Continuity of Carer. A review of midwifery establishment has been completed which has	

					demonstrated that we are currently not BR + compliant and therefore a business case will be drafted to address the deficit. Whilst this is ongoing further CoC rollout remains in a pause and reflect period, the operational group continues to forward plan to establish that all national mandated building blocks for the effective delivery of CoC are in place.	
	Deliver on the Ockenden recommendations	DONM	Clinical & Quality Strategy	QC	The work continues to deliver on the immediate and essential actions from the Interim Ockenden report. Following formal feedback from the submission of evidence was received in December 2021 which identified that 7 of 122 actions remained outstanding, these related to the establishment of the Maternal Medicine Networks, audits of personalised care and support plans by LMS and	

					the validation of multidisciplinary training plans for Maternity staff. Work is underway to ensure that these actions are complete. The full Ockenden report is anticipated to be published in Spring.	
	Deliver CNST year 3	DONM	Clinical & Quality Strategy	QC	The Trust Board signed off the submission of CNST Year 3. Confirmation received that the Trust had demonstrated compliance.	

To be ambitious and Efficient and make best use of available resources						
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Year-end outturn**	**Progress rating**
Ensure our services are financially sustainable in the long term	Ensure efficient and effective use of all available resources, meeting agreed financial targets and working across the Cheshire and Mersey system for optimum outcomes for the region.	CFO	Finance & Sustainability 2021-2025	FPBD	H1 position delivered and full year breakeven plan agreed. As a Month 11, on track to deliver forecast. On track. Sufficient system funding agreed to support breakeven position.	
	Ensure the Trust has an updated, long term financial plan in place during 2021/22 to reflect recent and	CFO	Finance & Sustainability 2021-2025	FPBD	Work is underway to refresh the long term financial plan however this is still impacted	

	proposed regime changes, with clear views and actions in place in relation to long term sustainability.				by future uncertainty with the financial regime. Deferred to 2022/23 due to uncertainty regarding the 2022/23 plan and financial regime. Supporting work underway.	
	Develop the Trust's commercial strategy during 2021 and pursue appropriate opportunities to maximise Trust income for the benefit of our patients	CFO	Finance & Sustainability 2021-2025	FPBD	Largely paused due to Covid and other operational pressures. Deferred to 2022/23.	
	Appraise options for future organisational form (up to and including merger) by 2022	CEO	Future Generations Strategy	FPBD	This will be reviewed as part of the later Future Generations work and financial modelling. Deferred due to system reconfiguration but discussions and informal options appraisal and supporting work has been undertaken.	
	Look for opportunities to maximise use of the Crown Street estate for the benefit of our patients and the whole of Liverpool and C&M	COO	Estates Strategy	FPBD	Bid has been submitted for Community Diagnostic Hub to increase the clinical offer from LWH for Liverpool and Wider Cheshire and Merseyside.	

					FMU, blood bank and CT scanner development in progress and overseen through Crown Street Enhancements Group. Update November: The bid has been successful and implementation group established to deliver on this through Q4 2021/22 to Q2 2022/23	
	Ensure post Covid-19 recovery including: • Eliminating 52 week waits • Deliver 100% of 2019/20 activity by November 2021 • Restore all cancer services in Q1 and return to pre pandemic performance levels. • Achieve the 75% faster diagnostic target in Q3	COO	Our Strategy	FPBD	The Trust 52-week position has plateaued in Q2 after an initial reduction in Q1. This is due to reduced theatre and clinical capacity and a need to focus on high priority P2 patients and reduction in planned clinical capacity due to sickness absence and challenges in theatre recruitment. H2 planning will address the increased capacity required to deal with the backlog. (New and Inpatient activity is on plan Follow up and Day case activity is behind plan) Cancer services have been fully restored in Q1.	

					The C&M cancer alliance has commissioned a C&M Gynae Optimal pathway cancer review to address the challenges of late referrals and will report in for Q3. November update: The national H2 ask is to "reduce" 52 week waiters. The Trust is reprofiling to eliminate 52 week waits through summer 2022/23 however at present this is subject to H2 planning confirmation and associated bids. A reduction in overdue follow ups has been seen and no further significant increase in the 52 week position In Line with refreshed national standards the Trust will be reporting no 104 week Breeches from March 2022 onwards. The Trust cancer performance has significantly increased.	

To participate in high quality research in order to deliver the most Effective outcomes						
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Year end outturn**	**Progress Rating**
Expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	Maintain and develop the following key partnerships during 2021, ensuring robust governance structures are in place: • The Cheshire and Mersey LMS • Our Local MVP and other user groups • Liverpool Place and Liverpool Provider Alliance • Liverpool University Hospitals • The Liverpool Neonatal Partnership and the NWNODN • The Cheshire and Mersey Cancer Alliance • The North West Genomics Partnership • Liverpool University and LHP	COO	Our Strategy	FPBD	The Trust has taken over the hosting of the LMS for C&M in Q1. The Trust is leading the C&M Maternal Medicine Transformation Programme. Through the Maternal Medicine Transformation Programme, the Trust is actively engaged with LUHFT on ensuring clinical pathways are clear and an SLA with LUHFT of the services deliver in partnership is being developed. The Trust has seen an increase in pregnant ladies in LUHFT due to Covid related challenges and works actively with LUHFT teams to support these ladies in partnership. The trust also holds the C&M Maternity escalation Cell chair to	

					support with the tactical response to Covid. The Trust remains committed to working alongside the MVP for Liverpool and C&M and regularly meets to understand feedback and address challenges. The Trust has the clinical lead post on reviewing the Cheshire and Mersey Gynae Optimal Pathway for C&M which will be complete in Q3. The Trust is represented on the Liverpool Place "Complex Lives" Programme which has been established to address the system challenges of this group	
	Support the developing ICS for C&M and working with the system to improve outcomes for Women's Health including Maternal and Neonatal care.	CEO	Our Strategy	FPBD	The CEO hold the SRO role for the C&M Women's Programme In April 2021 the Trust took over the hosting of the Cheshire and Mersey	

					LMS from Liverpool CCG in order to support enhanced care and outcomes for Women's Health. The LMS has now developed a suite of KPIs and is working across the C&M system supported by the infrastructure Of LWH with several LWH clinicians holding posts in the LMS. The Trust has commenced the Chair of the Maternal Medicine working group for C&M and is working as part of the North West system to develop this.	
Progress our research strategy and foster innovation within the Trust	Make progress to achieve university hospital status by March 2023	MD	Research & Innovation Strategy	QC	The main barrier in achieving this is the number of University employed staff who deliver clinical sessions at LWH. There has been a retirement of one academic member of staff and another has left the Trust. There have been a number of approaches to the UoL by individuals	

					who want to hold an academic post at UoL/LWH and the MD and other senior members of staff have engaged with showing them LWH and encouraging them to apply for an academic post. There is an upcoming interview for an academic post March/April 2022. It is unlikely that this objective will be achieved by March 2023.	
	Provide clear evidence of senior nursing & midwifery research leadership, as per the Trust R&D strategy by March 2021	MD	Research & Innovation Strategy	QC	There are now 2 professors of midwifery who sit on the RD&I sub-committee. They have presented to the Nursing and Midwifery forum regarding opportunities for these staff groups for research. A Nursing Midwifery and Allied Health Professional Research Talent Pipeline has been developed. A business case will now be developed to fund this.	

	Demonstrate full recovery of the RD&I activities by July 2021 following the COVID-19 pandemic	MD	Research & Innovation Strategy	QC	For months 1-4 of this year recruitment to open studies at LWH was above that of 20-21 and 19-20. Due to the COVID-19 pandemic the NIHR Clinical Research Network has set Trysts High Level Objectives (HLOs) to aid recovery. LWH has been set 3 HLOs 1) Efficient Study Delivery – New Commercial Studies 2) Efficient Study Delivery – Commercial Managed Recovery 3) Efficient Study Delivery – Non-Commercial Managed Recovery The Trust is meeting all of its obligations in the 3 HLOs The Trust is now recruiting to NIHR studies at pre pandemic levels and this is increasing above that.	

	Provide clear evidence of the Trust's R&D response to COVID-19 pertaining to the specific needs of the Liverpool population	MD	Research & Innovation Strategy	QC	The LWH RD&I department provided mutual aid to COVID -19 specific research teams across Liverpool. That mutual aid is no longer required but could be mobilised if the situation arises.	
	Commence refresh of R&D strategy by engagement with stakeholders	MD	Research & Innovation Strategy	QC	Engagement with both internal and external stakeholders has taken place and that information collated. The Strategy on a page has been discussed at a Board development session and at a Governors meeting. Wider engagement with LWH staff members will now be undertaken before the Strategy is written.	
	Ensure active engagement with the 'Starting Well' agenda	MD	Research & Innovation Strategy	QC	'Starting Well' is a standard agenda item on the RD&I sub committee agenda. There is to be a 'Starting Well' conference in Spring 2022.	
Fully implement the CQC well-led framework	Achieve a well-led 'good' rating by 2021	DONM	Clinical & Quality Strategy	QC	The CQC Framework for the trust is now in draft. This will present a plan	

throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership					for our CQC preparedness for 2022/23 and will be introduced in conjunction the ward accreditation programme. This process will include the reviews of the current CQC action plans, with new and updated versions produced and presented by the divisions to the executive team at regular intervals. Updates for the clinical quality strategy will continue to be delivered to Quality Committee, this will be on a bi-annual basis for 2022/23. Further work is ongoing with the divisions to develop this paper for each of the key themes of the strategy, in addition to the clinical priorities for each of the services here at LWH	
	Ensure all wards and key areas have ward accreditation in Q1 and 2	DONM	Clinical & Quality Strategy	QC	Work has been underway, led by the Corporate Nurse on streamlining and	

					updating the suite of KPIs and ward/dept accreditation programme. It is anticipated that in December 2021 that the KPIs will be implemented Trust-wide. The accreditation programme will be trialled in December 2021 and thereafter rolled out through the organisation during Q4 and Q1 in 2022. Revised nursing audit programme commenced in Jan 2022. Includes a scheduled timetable of audits linked to Power BI. All teams complete a medication and IPC audit and bespoke key performance Indicators (KPI) are being introduced linked to their area/speciality. The Trust multi-disciplinary 'Be Brilliant Accreditation System' (BBAS) will be trialled in March 22 and results from the above	

					audits will also feed into this process.	

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*21/22/241*	Date: 28/03/2022		
Report Title	**Proposed Risk Appetite Statement for 2022-23**			
Prepared by	*Allan Hawksey – Risk and Patient Safety Manager* *Phil Bartley – Associate Director of Governance and Quality*			
Presented by	*Phil Bartley – Associate Director of Governance and Quality*			
Key Issues / Messages	***The Trust's Risk Management Strategy determines that on an annual basis the Trust will publish its' risk appetite statement as a separate document. This paper asks the Committee to discuss and agree the risk appetite statement setting out the Liverpool Women's NHS Foundation Trust's tolerance levels for risk in relation to the key strategic aims for which this Committee is responsible. The statement will define the Trust's appetite for risk to the achievement of strategic aims for the current financial year.***			
Action required	Approve ☒	Receive ☐	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is requested to receive the recommendations of its sub-committees regarding risk appetite and risk tolerance levels for 2022-23 and approve the Risk Appetite Statement for 2022-23.			
Supporting Executive:	Marie Forshaw, Chief Nurse and Midwife			

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality, PPF and FPBD Committees	March 22	Assoc. Director of Governance	Recommendations made to retain risk appetite levels from 2021/22

EXECUTIVE SUMMARY

The Trust's Risk Management Strategy determines that on an annual basis the Trust will publish its' risk appetite statement as a separate document. This paper asks the Committee to discuss and agree the risk appetite statement setting out the Liverpool Women's NHS Foundation Trust's tolerance levels for risk in relation to the key strategic aims for which this Committee is responsible. The statement will define the Trust's appetite for risk to the achievement of strategic aims for the current financial year.

The following report contains the proposed risk appetite statement for 2022-23 in relation to the Trust's strategic aims. The Board is asked to review the statement and either approve it for the coming year or identify any changes which they feel are required.

MAIN REPORT

1. Introduction and summary

What is Risk Appetite?

Risk appetite can be defined as the amount of risk that an organisation is willing to take on in pursuit of value. It is the total impact of risk an organisation is prepared to accept in the pursuit of its strategic aims. Risk appetite therefore goes to the heart of how an organisation does business and how it wishes to be perceived by key stakeholders including employees, regulators, rating agencies and the public.

The amount of risk an organisation is willing to accept can vary from one organisation to another depending upon circumstances unique to each. Factors such as the external environment, people, business systems and policies will all influence an organisation's risk appetite.

What is the Process?

The Liverpool Women's Risk Management Strategy describes the process as follows:

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

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

Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk. The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk"

Risk Appetite Levels

The following risk appetite levels, developed by the Good Governance Institute form the background to discussion in relation to appetite. Using this model as guidance the Trust should agree an appetite statement that aligns to our strategic aims. The statement should be then be considered when assessing risk target and tolerances in the Board Assurance Framework

Appetite Level	Description:
None	**Avoid** : The avoidance of risk and uncertainty is a Key Organisational objective
Low	**Minimal** : The preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Moderate	**Cautious** : The preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
High	**Open**: Being willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and value for money).
Significant	**Seek**: Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Also described as **Mature**: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

2. Issues for consideration

It is proposed that the Risk Appetite Statement for 2022-23 remains uncharged from 2021-2022 is as follows.

<u>To develop a well-led, capable and motivated workforce</u>

Our risk appetite for workforce is **moderate.**

Liverpool Women's NHS Foundation Trust has a **moderate** appetite for risk to this objective. The Trust operates in a complex environment in which it faces challenging financial conditions and changing demographics alongside intense political and regulatory scrutiny. However, the continued delivery of high-quality healthcare services and service sustainability requires some moderate risk to be accepted where this is likely to result in better healthcare services for patients.

Support for moderate risk in service redesign that requires innovation, creativity, and clinical research to improve patient outcomes are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.

<u>To deliver safe services</u>

Our risk appetite for safety is **low**.

Our fundamental strategic aim describes our commitment to patient and staff safety. When and wherever possible we will apply strict safety protocols for all clinical and non-clinical activity. We will not compromise the safety of our patients, we will report, record, and investigate our incidents and we will ensure that we continue to learn lessons to improve the safety and quality of our services.

<u>To participate in high quality research and to deliver the most effective outcomes</u>

Our risk appetite for effective is **high**.

A level of service redesign to improve patient outcomes that requires innovation, creativity, and clinical research are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.

To deliver the best possible experience for patients and staff

Our risk appetite for experience is **low**.

Liverpool Women's NHS Foundation Trust has a low-risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality and sustainability of the Trust and its patients, may affect the experience of our patients, the reputation of the Trust or the reputation of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Senior Management Team.

Despite retaining this a 'low' risk appetite the Quality Committee agreed that the Trust would need to be more ambitious in its attempts to better understand the views of patients and local communities.

To be ambitious and efficient and make the best use of available resources

Our risk appetite for efficient is **moderate**
This is in respect to meeting our statutory financial duties of maintaining expenditure within the allocated resource limits and adherence to departmental and internal expenditure and financial controls. This includes the demonstration of value for money in our spending decisions, while ensuring quality and safety is maintained.

3. Conclusion

Agreeing a Risk Appetite statement is a requirement of the Board under the Trust Risk Management Strategy. In order to treat, terminate, transfer, or tolerate risks staff undertaking risk assessments and making decisions will need to understand what level of risk is acceptable to the trust.

The Board's sub-committees, QC, PPF and FPBD have met and agreed the parts of the statement for which they are operationally responsible

Recommendations

The Board is requested to receive the recommendations of its sub-committees regarding risk appetite and risk tolerance levels for 2022-23 and approve the Risk Appetite Statement for 2022-23

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/012c***		**Date: 07/04/2022**	
Report Title	**A new approach to non-executive director champion roles**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***The report outlines proposals for the Trust's response to NHS England's guidance document – 'Enhancing Board Oversight – a new approach to non-executive champion roles'***			
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/N ***If no – please outline the reasons for deviation.***			
	To agree the proposed changes to the Trust's NED Champion roles.			
Supporting Executive:	***Name and Job Title***			

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
Board Development	**Feb 22**	**Trust Secretary**	**Recommendations reviewed and reflected in report**

EXECUTIVE SUMMARY

1. Define the issue

Over the last few years within the NHS, there has been an increasing focus on the designation of Board Champions and nominated leads designed to engender board level commitment and focus around key areas of service development or delivery.

2. Key Findings

In response to this issue, NHS England has worked with stakeholders to review the issues the roles were originally established to address, to consider the most effective means of making progress now. There remain a small number that are statutory requirements and some that still require an individual to drive change or fulfil a functional role. Other functions are suggested to be aligned with the responsibilities of Board Committees.

3. Solutions / Actions

The report proposes that the following NED champion roles be retained:

- Freedom to Speak up
- Safeguarding
- Board Maternity Safety Champion
- Wellbeing

The following roles are proposed to be removed with assurances being reported via relevant Committees:

- Termination of Pregnancy
- Mortality
- End of Life Care

4. Recommendations

To agree the proposed changes to the Trust's NED Champion roles.

MAIN REPORT

Introduction

Over the last few years within the NHS, there has been an increasing focus on the designation of Board Champions and nominated leads designed to engender board level commitment and focus around key areas of service development or delivery.

The number of NED champion roles started to make it difficult for trusts to discharge them all effectively, particularly with a limited number of NEDs, and many do not have a role description, making it difficult to measure their impact on delivering change. Some roles have also been in place for over a decade without review.

In response to this issue, NHS England has worked with stakeholders to review the issues the roles were originally established to address, to consider the most effective means of making progress now. There remain a small number that are statutory requirements and some that still require an individual to drive change or fulfil a functional role. Other functions are suggested to be aligned with the responsibilities of Board Committees.

This report proposes how the Trust could respond to the NHS England guidance and asks for approval for the suggested amendments to the Trust's NED Lead allocation.

NHS England Guidance - https://www.england.nhs.uk/wp-content/uploads/2021/12/B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf

Key Points from the NHS England Guidance

NHS England worked with stakeholders during 2021 to review the issues the champion/lead roles were originally established to address and to consider the most effective means of making progress now. They concluded that there are a small number that are statutory requirements and some that still require an individual to drive change or fulfil a functional role. In these instances, the principle of the unitary trust board – with joint responsibility and decision making– remains. However, there are many issues where they consider progress will be best made through existing trust committees rather than through individual NED champion roles.

NHS England state that this new approach will help enhance board oversight for these issues, by ensuring they are embedded in governance arrangements and assurance process, and through providing an audit trail of discussions and actions identified by committees.

Recommended NED Champion roles

The table below sets out the NED champion roles that were in scope for this review and their status under the new approach.

Roles to be retained				
Maternity board safety champion	Wellbeing guardian	Freedom to speak up	Doctors disciplinary	Security management
Roles to transition to new approach				
Hip fracture, falls and dementia	Learning from deaths	Safety and risk	Palliative and end of life care	Health and safety
Children and young people	Resuscitation	Cybersecurity	Emergency preparedness	Safeguarding
Counter fraud	Procurement	Security management- violence and aggression		

Current Trust Position

The Trust does currently have 'Board Champion', or 'Non-Executive Lead' roles assigned – these are as follows:

NED Champion Role	Assigned to:
Whistleblowing (FTSU)	Dr Sue Milner
Safeguarding	Dr Sue Milner
Mortality	Tony Okotie
Termination of Pregnancy	Prof. Louise Kenny
Board Maternity Safety Champion	Prof. Louise Kenny

End of Life Inc. Bereavement Committee	Tracy Ellery
Wellbeing	Louise Martin

There were several NED 'champion' or 'lead' roles (under previous guidance / legislation) that had not been assigned. This was for two reasons – firstly, that there was an awareness that updated guidance was imminent and it was felt germane to await this update prior to making further assignments and, secondly – there has been a general view that the Board retains collective responsibility for discharging its statutory duties and therefore many issues received the requisite attention either through Board or Committee oversight.

The Trust has taken the view that there has only been justification for a NED Champion / Lead role if there has been a requirement for an additional level of oversight and scrutiny either due to national concerns and/or a particularly pertinent issue to the operations of the organisation. A 'tick box' approach to compliance has been attempted to be avoided where it was felt that adequate oversight was being provided at Committee and Board level.

Proposed Way Forward

As noted above, the NHS England guidance, suggests that five NED champion / lead roles be retained. These, together with a Trust position statement, follows in the table below:

NED Champion Role	Trust comment / response.
Whistleblowing (FTSU)	This is an existing role for the Trust, and it is proposed that this is retained. A draft role description is included in Appendix 1.
Board Maternity Safety Champion	This is an existing role for the Trust, and it is proposed that this is retained. A draft role description is included in Appendix 2.
Wellbeing	This is an existing role for the Trust, and it is proposed that this is retained. A draft role description is included in Appendix 3.
Doctors Disciplinary	The Doctors Disciplinary role as described in the guidance has a statutory basis for trusts and *advisory* for Foundation Trusts, which LWH has fulfilled on an adhoc basis as required on occasion. The guidance suggests a named 'designated member', but this need not be the same NED on each occasion. It is proposed that the current arrangements are adequate, and therefore a designated role should not be assigned.
Security Management	The guidance states this role applies to all trusts *excluding* Foundation Trusts. Following consultation with the Board,

	it is proposed that issues relating to Security Management are overseen by the appropriate Board sub-committee.

NED Champion roles beyond the guidance

As noted, the Trust has historically avoided seeking to simply comply with available guidance / statute and has instead sought to implement NED champion roles where it has been felt that there is a need for additional scrutiny and where the input of a Non-Executive Director can add value to the issue in question.

It is important to note that this new approach from NHS England is recommended but not mandatory. If trusts consider NED champion roles an effective tool to provide assurance to their Board on specific issues, then they have the flexibility to retain or implement that approach.

Safeguarding

The Trust's Safeguarding leads have identified that the support of a named Non-Executive Director has been highly appreciated and there is a wish to retain this, particularly considering a likelihood of increased safeguarding activity during the recovery period from the Covid-19 pandemic. For this reason, if there is agreement that the NED adds value, it is proposed that the Trust retains a direct Non-Executive champion role for Safeguarding (see Appendix 4).

Existing NED roles not proposed to continue

Mortality and End of Life

Two existing Trust NED Champion roles (Mortality and End of Life) are currently allocated to two separate NEDs but could be undertaken through the regular and well-established Committee and Board reporting processes and therefore it is felt that there is less of a demand for a separate NED champion for these issues. Quality Committee and the Board's scrutiny of mortality issues has significantly increased since the roles were originally envisaged nationally and are much more embedded into standard governance processes. Consideration will need to be given to NED involvement in the LWH Bereavement Committee which has been part of the End of Life champion role, if this is deemed to add value it could be fulfilled by a Quality Committee NED without a full champion role.

Termination of Pregnancy

This role has not been specifically referenced in the NHSE guidance but is a role that LWH has historically chosen to allocate. It has previously been suggested by the CQC that the Trust have a NED role to cover this issue but with the recent publication of the NHS guidance, it has been confirmed that this is no longer required.

Other roles

The NHSE Guidance recommends that all other roles (beyond the five identified) should be embedded in governance arrangements and aligned to committee structures where possible. The table below provides a list of these roles and identifies the current reporting arrangements. Any proposed amendments are also listed:

Issue / Role	Current reporting	Proposed amendment to reporting (if necessary) – actions in **bold**
Hip fractures, falls and dementia	Trust performance in this area is overseen by the Safety and Effectiveness Sub-Committee with data also reported through to the Quality Committee.	No amendments suggested to reporting but recommendation **to review whether links between dementia and falls is adequately tracked.**
Palliative and end of life care	This is currently reported via the Bereavement Group, through the Patient Involvement and Experience Sub-Committee with any escalations to the Quality Committee.	Suggested that **the Quality Committee receive a bi-annual report detailing how the Trust is performing against Palliative and End of Life Care standards and reviewing any complaints received in this area.** **For a Quality Committee (NED) member to attend at least two meetings of the Bereavement Group a year.**
Resuscitation	The Trust has a designated Resus Group that reports to the Safety and Effectiveness Sub-Committee with matters escalated to the Quality Committee.	No proposed amendments to reporting arrangements.
Learning from deaths	Quarterly reports provided to the Quality Committee and the Board. Named NED for Mortality, which has been aligned to chair of Quality Committee role.	No proposed amendments to reporting arrangements. **Remove the named NED role as the subject area is core QC business.**
Health and safety	There is a Trust Health & Safety Group that reports to the Corporate Risk Committee with matters escalated to the Quality Committee. An annual presentation on the Trust's Health and Safety arrangements is provided to the Board at a Development Session.	No proposed amendments to reporting arrangements.
Safeguarding	There is a Hospital Safeguarding Sub-Committee that reports to the Quality Committee.	No proposed amendments to reporting arrangements.

	Quarterly Safeguarding reports received by the Quality Committee. Annual Report received by the Board. Safeguarding NED champion in place.	Retain a NED Champion Role given the volume and importance of safeguarding activity
Safety and risk	There is a Trust Health & Safety Group that reports to the Corporate Risk Committee with matters escalated to the Quality Committee.	No proposed amendments to reporting arrangements.
Lead for children and young people	Since the CQC inspection, there has been a 16-18 task and finish group in place. Assurances have reported to the Quality Committee.	**Consideration to be given to on-going reporting of the Trust's approach to children and young people (via Quality Committee not a separate NED role).**
Counter fraud	Audit Committee receives quarterly updates and an annual report on Counter Fraud. There is a Counter Fraud Champion (currently CFO but will be Deputy CFO)	No proposed amendments to reporting arrangements.
Emergency preparedness	EPRR arrangements report to the FPBD Committee with an annual statement made to the Board.	There will be additional scrutiny on EPRR arrangements at the FPBD Committee during 2022 following the lessons learned from the Major Incident. (Not a separate NED role)
Procurement	Tender waiver reports received on a quarterly basis at Audit Committee. FPBD Committee scrutinise any major procurement decisions with approval sought by the Board in line with SFIs and the SORD.	Potential **for additional assurance to be provided on procurement processes to the FPBD Committee (not a separate NED role).**
Cyber security	There is a Digital Hospital Sub-Committee that reports directly to the FPBD Committee – matters include cyber security. There is a BAF risk on cyber security reviewed at the FPBD Committee and the Board.	No proposed amendments to reporting arrangements.
Security management – violence and aggression	Currently reported through the PPF Committee.	No changes to reporting suggested.

It should be noted that the table above includes those issues for which an external report or review has historically suggested a NED champion role should be established and does not include all important issues that trusts should have oversight of. The Board and its Committees

have been subject to an annual review during February / March 2022 (see agenda item 015) and this provided an opportunity to consider whether the focus of business had been comprehensive during 2021/22 and whether amends are required for the work programmes of 2022/23. The above noted actions have been factored into these deliberations.

Recommendation

The Board is asked to approve the following changes to the NED champion roles:

To be retained:

- Freedom to Speak up
- Safeguarding
- Board Maternity Safety Champion
- Wellbeing

To be removed with assurances being reported via relevant Committees:

- Termination of Pregnancy
- Mortality
- End of Life Care

See Appendix 5 for change summary

Appendix 1

Non-Executive Director Board-level Freedom to Speak Up Champion

Post Holder: TBC

Date Appointed: TBC

Job Purpose:

The Robert Francis Freedom to Speak Up Report (2015) sought to develop a more supportive and transparent environment where staff are encouraged to speak up about patient care and safety issues. In line with the review, it is recommended that all NHS trusts should have this functional FTSU guardian role so that staff have a clear pathway and an independent and impartial point of contact to raise their concerns in the organisation.

The role of the NED champion is separate from that of the guardian. The NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the board (p.146, Francis FTSU report).

All NEDs should be expected to provide challenge alongside the FTSU guardian to the executive team on areas specific to raising concerns and the culture in the organisation. When an issue is raised that is not being addressed, they should ask why.

The non-executive champion is responsible for:

- role-modelling high standards of conduct around FTSU
- ensuring they are aware of the latest guidance from National Guardian's Office
- challenging the chief executive, executive lead for FTSU and the board to reflect on whether they could do more to create a healthy and effective speaking up culture
- acting as an alternative source of advice and support for the FTSU Guardian
- overseeing speaking up matters regarding board members – see below.

It can be challenging to maintain confidentiality and objectivity when investigating issues raised about board members. This is why the role of the designated non-executive lead is critical. Therefore, in exceptional circumstances, it is expected that the non-executive lead will take the lead in determining whether:

- sufficient attempts have been made to resolve a speaking up concern involving a board member(s) and

Appendix 1

- if so, whether an appropriate fair and impartial investigation can be conducted, is proportionate, and what the terms of reference should be for escalating matters to regulators, as appropriate.

Depending on the circumstances, it may be appropriate for the non-executive lead to oversee the investigation and take on the responsibility of updating the worker. Wherever the non-executive lead does take the lead, they inform the FTSU Guardian, confidentially, of the case; keep them informed of progress; and seek their advice around process and record-keeping.

The non-executive lead informs NHS Improvement and CQC that they are overseeing an investigation into a board member (depending on the circumstances it may be required to provide the name of the board member under investigation). NHS Improvement and CQC can then provide the non-executive with support and advice.

Enablers to achieving these aims:

The non-executive lead can seek assurance from the following sources (not exhaustive):

- Speaking up concerns: numbers and themes
- Incident reporting: numbers, quality of reports, levels of feedback
- Grievances: numbers and themes
- FTSU Guardian user feedback
- Reports from boards doing walk-abouts
- Gap analysis against case reviews produced by the National Guardian
- National staff experience surveys
- FTSU Guardian board report
- Internal audit reports
- Employment tribunal judgements
- National Guardian Office case reviews
- External culture reviews
- CQC inspection reports
- Regular catch ups with Guardians to discuss themes

When necessary, the Trust will enable a non-executive lead to commission an external investigation (which might need an executive director to sign-off the costs) without compromising the confidentiality of the individual worker or revealing allegations before it is appropriate to do so.

Appendix 1

Key reference documents:

https://webarchive.nationalarchives.gov.uk/20150218150953/https:/freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

https://www.england.nhs.uk/wp-content/uploads/2021/05/ftsu-supplementary-information.pdf

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Appendix 2

Non-Executive Director Board-level Maternity Safety Champion

Post Holder: Prof. Louise Kenny

Date Appointed: February 2021

Job Purpose:

In line with recommendations from the Ockenden Review, the Board-level safety champion role (currently held by the Chief Nurse & Midwife) should be supported by a Non-Executive Director. The two should work together to ensure a seamless leadership function.

The role of the Board-level safety champion is to act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, LMS leads, the Regional Chief Midwife and Lead Obstetrician and the Trust Board to understand, communicate and champion learning, challenges and successes.

The Non-Executive Board-level maternity safety champion will act as a support to the Board-level safety champion by:

- bringing a degree of independent, supportive challenge to the oversight of maternity services
- ensuring that they are resourced to carry out their role
- challenging the Board to reflect on the quality and safety of its maternity services
- ensuring that the views and experiences of patients and staff are heard

Together the non-Executive Board-level maternity safety champion and the Board-level safety champion should:

- adopt a curious approach to understanding quality and safety of services
- jointly, with frontline safety champions, draw on a range of intelligence sources to review outcomes, including staff and user feedback to fully understand the services they champion
- Ensure the Board receives regular updates on issues requiring board-level action such as stillbirth rates, progress with implementing the Saving Babies' Lives care

bundle; learning identified from cases meeting the Each Baby Counts criteria and Serious Incident investigations. Ensure that appropriate actions to address the findings are implemented and monitored at Board level to ensure the required improvements are made

- update the Trust Board on a monthly basis, on issues requiring Board-level action.

Enablers to achieving these aims:

- Attending Maternity Safety Champion meetings
- Supporting the Executive Board-level safety champion in reporting outcomes from the Safety Champion meetings to the Quality Committee
- Identifying maternity safety items requiring Board-level action at each Board meeting (verbally through the Quality Committee Chair's Report)
- Drawing attention to maternity related key performance indicators requiring attention during the Quality and Operational Performance item at Board
- Being briefed on outcomes from any locally undertaken culture surveys

Key reference documents:

- https://www.england.nhs.uk/wp-content/uploads/2020/12/annex-role-of-the-non-exec-board-safety-champion.pdf
- https://www.england.nhs.uk/wp-content/uploads/2020/08/Maternity_safety_champions_13feb.pdf

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Appendix 3

Non-Executive Director Board-level Wellbeing Guardian

Post Holder: TBC

Date Appointed: TBC

Job Purpose:

This role originated as an overarching recommendation from the Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) and was adopted in policy through the 'We are the NHS People Plan for 2020-21 – action for us all'.

The NED should challenge the trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision.

The role should help embed a more preventative approach, which tackles inequalities. As this becomes routine practice for the board, the requirement for the wellbeing guardian to fulfil this role is expected to reduce over time.

From an organisational perspective, the Wellbeing Guardian needs to:

- Challenge the organisation to include employee wellbeing in everything they do and actively create a 'culture of wellbeing', to care for people who care for others.
- Act as a 'critical friend' to question the impact of decisions on employee wellbeing – just as financial, performance or care quality impact are questioned.
- Ensure the Board holds senior leaders to account for the way employees are managed, empowered, and supported with their wellbeing.
- Seek data to show what's happening on the ground, evidencing the wellbeing needs of the diverse workforce (inputs) and that wellbeing strategy / policies / initiatives are working and impactful (outputs).
- Champion equality, diversity and inclusion, ensuring that the organisation considers the needs of the diverse groups within its workforce and adapts holistic approaches to wellbeing, appreciating peoples changing needs over time.
- Continually and strategically 'sense-check' the wellbeing agenda for the organisation and prompt improvement / developmental action if needed.
- Demonstrate that the Board (or equivalent senior leadership team) takes their personal wellbeing responsibilities seriously.

From a personal perspective, the Wellbeing Guardian needs to:

Appendix 3

- Strategically influence and shape the wellbeing agenda, speaking to the hearts and minds of the organisation's diverse workforce.
- Hold the values reflected in the role description, role modelling the values of fairness, compassion and inclusivity.
- Actively promote opportunities for the most vulnerable in the workforce to contribute and address wellbeing inequalities and the needs of diverse groups and individuals.
- Although Wellbeing Guardians must be competent and confident in their ability to challenge the executive team on behalf of the board Wellbeing Guardians are not accountable for the entire people agenda. They do not need to be an expert in wellbeing, but they do need to be adept at understanding the breadth of wellbeing in the context of their organisation and holding the organisation to account where improvements are identified.

With this in mind, a Wellbeing Guardian does not need to:

- Be a wellbeing expert.
- Take on executive/management responsibilities for ensuring wellbeing policies are operationally actioned and delivered.
- Get involved in 'the doing', operational management, or individual staff cases.
- Personally collect, analyse or present data on wellbeing.

Enablers to achieving these aims:

The role should be that of assurance and be empowered to act strategically. Therefore, the Trust will enable the Guardian by aligning functions such as HR / OD / Occupational Health and Wellbeing to operationally support them.

Key sources of information include:

- Putting People First Committee meeting papers
- Staff Survey
- Local staff surveys
- Understanding existing wellbeing interventions
- Regular discussions with Trust wellbeing leads

Key reference documents:

https://www.hee.nhs.uk/sites/default/files/documents/NHS%20(HEE)%20-%20Mental%20Wellbeing%20Commission%20Report.pdf

Appendix 3

https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/

https://people.nhs.uk/executivesuite/support-in-difficult-times/wellbeing-guardians/

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Appendix 4

Non-Executive Director Board-level Safeguarding Champion

Post Holder: TBC

Date Appointed: xxx

Job Purpose:

Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff suggests that Boards should consider the appointment of a NED to ensure the organisation discharges its safeguarding responsibilities appropriately and to act as a champion for children and young people. The Trust also extends this remit to scrutinise the Trust's performance for adult safeguarding also.

Enablers to achieving these aims:

- Quarterly meetings to be held with the Trust's Safeguarding Leads to seek assurance on priority areas and actions being undertaken
- Attend at least two meetings of the Hospital Safeguarding Sub-Committee

Key reference documents:

https://www.rcn.org.uk/professional-development/publications/pub-007366

Appendix 5

Change / Decision log/summary

NED Champion Role	Current LWH	NHSE recommended role	Future
Whistleblowing (FTSU)	Yes Allocated to SID	Yes	No Change
Safeguarding	Yes	No	No change (retained)
Mortality	Yes	No Issues to be overseen through Board committees	Remove role as mortality review and learning from deaths is a core agenda item for QC and Board
Termination of Pregnancy	Yes	No Also not referenced in wider roles in scope.	Remove role (assurances to be reported to the Quality Committee)
Board Maternity Safety Champion	Yes	Yes	Retain role
End of Life Inc. Bereavement Committee	Yes	No Issues to be overseen through Board committee	Remove role as EoL is core QC business QC NED presence at bereavement committee
Wellbeing	Yes	Yes	No change
Doctors Disciplinary	No NEDs have been appointed as required	Yes Statutory for Trusts Advisory for Foundation Trusts	No change Guidance allows either a predetermined named NED or a NED to be appointed as required
Security Management	No	Yes But Foundation Trusts are excluded	No change Function is adequately covered by the workplans and NEDs within the Audit and other Board committees
There are 10 other roles referenced in the NHSE guidance	LWH has no NED role allocated	No Issues to be overseen through Board committee	No change Covered by Committee 22/23 workplans

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Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/013***		**Date: 07/04/2022**	
Report Title	**Board Assurance Framework**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***The report outlines any updates relating to the Board Assurance Framework and any key areas for consideration for the Board.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y ***If no – please outline the reasons for deviation.***			
	The Board requested to review the BAF risks and agree their contents and actions.			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

BAF discussed at FPBD, Putting People First and Quality Committees since previous version presented to Board on 3 February 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.

The BAF items are aligned to the Board's assurance committees, and these were reviewed and discussed during March 2022. There will be a detailed review of the BAF during April and this will report through the respective Committees and into the May 2022 Board.

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

Since the report was last circulated and discussed at the Board, there has not been any significant updates made to the BAF.

New Risks or Strategic Threats

Since the report was last circulated and discussed at the Board, there has not any new risks or strategic threats identified.

Closed Risks or Strategic Threats

Since the report was last circulated and discussed at the Board, no risks closed on the BAF.

Conclusions

Board members are asked to comment on the current content and where required make further recommendation for change and agree the current BAF risks.

Recommendation

The Board requested to review the BAF risks and agree their contents and actions.

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BOARD ASSURANCE FRAMEWORK 2021/2022

Trust Board – April 2022

Board Assurance Framework Key

Risk Rating Matrix (Likelihood x Consequence)					
Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Director Lead	
CEO	Chief Executive
CPO	Chief People Officer
COO	Chief Operating Officer
CFO	Chief Finance Officer
CIO	Chief Information Officer
CNM	Chief Nurse & Midwife
MD	Medical Director

Key to lead Committee Assurance Ratings	
	Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity - no gaps in assurance or control AND current exposure risk rating = target OR - gaps in control and assurance are being addressed
	Amber = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy
	Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each BAF Risk and also to identify any further action required to improve the management of those risks.

Board Assurance Framework: Legend	
Strategic Priority	The 2021/25 strategic priority that the BAF risk has been aligned to.
BAF Risk:	The title of the strategic risk that threatens the achievement of the aligned strategic priority
Rationale for Current Risk Score:	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk.
Strategic Threat:	What might cause the BAF risks to materialise
Provider Licence Compliance:	NHS Improvement provider licence conditions that align to the BAF risk providing assurance on compliance.
Controls:	The measures in place to reduce the risk likelihood or risk consequence and assist secure delivery of the strategic priority.
Assurances:	The measures in place to provide confirmation that the controls are working effectively in supporting the mitigation of the risk.
Gaps in Controls / Assurance:	Areas that require attention to ensure that systems and processes are in place to mitigate the BAF risk Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the BAF risk.
Required Action:	Actions required to close the gap in control/ assurance
Lead:	The person responsible for completing the required action.
Implemented By:	Deadline for completing the required action.
Monitoring:	The forum that will monitor completion of the required action.
Progress:	A RAG rated assessment of how much progress has been made on the completion of the required action.

Risk Descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long- term incapacity/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 (I3 x c4)	12 (I3 x c4)	12 (I3 x c4)		⟷	8 (I2 x c4)
	1.2 Failure to recruit and retain key clinical staff	PPF	CPO	20 (I5 x c4)	20 (I5 x c4)	20 (I5 x c4)		⟷	12 (I3 x c4)
SA2 Safe	2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site	FPBD	~~MD~~ CFO	15 (I3 x c5)	15 (I3 x c5)	15 (I3 x c5)		⟷	15 (I3 x c5)
	2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment	FPBD	COO	12 (I3 x c4)	16 (I4 x c4)	16 (I4 x c4)		⟷	8 (I2 x c4)
	2.3 Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	Quality	COO	20 (I4 x c5)	20 (I4 x c5)	20 (I4 x c5)		⟷	15 (I3 x c5)
	2.4 Major and sustained failure of essential IT systems due to a cyber attack	FPBD	CIO	N/A	15 (I3 x c5)	15 (I3 x c5)		⟷	12 (I2 x c5)
SA3 Experience	3.1 Failure to deliver an excellent patient and family experience to all our service users	Quality	CNM	12 (I3 x c4)	12 (I3 x c4)	12 (I3 x c4)		⟷	8 (I2 x c4)
SA4 Efficient	4.1 Failure to ensure our services are financially sustainable in the long term	FPBD	CFO	20 (I5 x c4)	20 (I5 x c4)	20 (I5 x c4)		⟷	16 (I4 x c4)
	4.2 Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	FPBD	~~CFO~~ MD	8 (I2 x c4)	8 (I2 x c4)	8 (I2 x c4)		⟷	8 (I2 x c4)
SA5 Effective	5.1 Failure to progress our research strategy and foster innovation within the Trust	Quality	MD	8 (I2 x c4)	8 (I2 x c4)	8 (I2 x c4)		⟷	4 (I1 x c4)
	5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Quality	CNM	12 (I3 x c4)	12 (I3 x c4)	12 (I3 x c4)		⟷	8 (I2 x c4)

BAF HEAT MAP


Consequence
Likelihood
1
Rare
2 Unlikely
3
Possible
4
Likely
5
Almost certain
5 Catastrophic
4 Major
3 Moderate
2 Minor
1 Negligible
2.1
2.4
2.3
4.2
5.1
1.1
3.1
5.2
2.2
1.2
4.1

Strategic Objective	SA1: To develop a well led, capable, motivated and entrepreneurial WORKFORCE
Committee:	Putting People First Committee
Risk Appetite:	Moderate

Principal risks (BAF)	Risk Score
1.1 Failure to be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	12 (3 x 4)
1.2 Failure to recruit and retain key clinical staff	20 (4 x 5)

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

2087 - No change in risk score since last review. Last reviewed 09/11/2021

2244 - Last reviewed 06/07/21. Recruitment has been completed. Risk has now been removed.

2323 - No change in risk score since last review. Last reviewed 27/08/21

1704 – No change in risk score since last review. Last reviewed 03/11/2021.

Ref	Corporate Risk Register / High Scoring (15+) Risks	Risk Score
2443	Inability to recruit specialised allied health professions in a timely manner	16
1705	Insufficient midwifery staffing levels as recognised by birth rate place plus.	20
2424	Unable to meet safe staffing levels in line with BAPM requirements	15
2087 **(CRR)**	Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	16
~~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
1704 (CCR)	Effective management systems are not in place or sufficient to ensure all employees complete and keep up to date with their mandatory training requirements.	12

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)	12 (3 x 4)	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. The Trust also recently benchmarked within the top 50 inclusive places to work. However, this is an ambitious aim within the Trust's 2021-25 strategy and will require significant cultural change to achieve together with a continued and unrelenting focus. The Trust can also make progress on the mechanisms that it has in place to hear the views and voices from its diverse staffing and patient communities and ensure that these voices have an impact on service improvement and development. Whilst there is evidence that the Trust has responded well to challenge that the pandemic has posed to the Trust in terms of patient and staff inequalities, this will continue to be a challenge over the year.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Unable to create a workforce representative of the community we serve	Monitoring of applications for employment within the Trust throughout the recruitment & selection process over a 12-month period via TRAC reporting	Monitored by the EDI Lead and reported through the ED&I Action Plan	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 and LGBTQ Network to be launched in 2022.	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	December 2021	E&D Sub-Committee	
1.1 / 2	Robust targeting of job adverts – engagement in health and careers fairs with local community groups for example Pakistani Centre, Al Ghazali Centre	Head of Culture, Inclusion, Wellbeing and Engagement	September 2021 (ongoing)	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	February 2022	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 Development of a Supporting Patients with Additional Needs Strategy	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)	20 (4 x 5)	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. In the short term, this issue is being exacerbated by significant absences as a result of the Omicron Covid-19 variant and the in the medium term there is a concern about the potential loss of staff if they do not accept the mandatory Covid-19 vaccine. There are also the following issues to consider: Insufficient numbers of doctors in training; ageing workforce; national shortage of nurses and midwives; isolated site and associated clinical risk impacting on recruitment and retention of specialist consultant staff; pension tax changes impacting on the retention of consultant medical staff (early retirement or reduction in working time). Whilst the severity of this issue is not sufficient to rate this risk at '25', the Board should be cognisant that this risk presents one of the most acute challenges to the organisation.

There are examples of positive assurance in how the Trust has responded to the pandemic in relation to staff wellbeing but there remains some significant challenges during the 'recovery stage' and will require Board oversight and attention.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust.	Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff.	Monthly KPI's for controls.	Quality of appraisal.	
	LWH 'People Promise' to launch in 2022 – bringing together key strands of people strategy including behavioural framework	PPF	None	
	Behavioural framework developed in partnership with staff in 2021	PFF Committee, In the Loop, Great Place to Work Group	None	
	Great Place to Work Group Launched as a cross section of staff committed to improving staff experience and a source of two way communication	Great Place to work minutes to PPF	None	
	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 place.	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 including launch of LWH Staff Support Service, recruitment of LWH Psychologist and Wellbeing Coaches	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	
	Regular Local Staff Surveys	Quarterly internal staff survey (In the Loop)	None	
	Regular Listening Events	Listening events increased to bi-monthly	Nnone	

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 February2022	PPF Committee	

	1.2 / 4	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 in early 2022	Deputy Director of Workforce	March 2022	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	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.	
	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			

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.	
	Work underway to ensure that the number of staff without a Covid-19 vaccine is minimised	PPF Committee	There remains a small number of staff in this cohort – advice is being sought from the centre and the Trust is responding to national guidance and working with the staff in question.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.2/1	E-rostering system for doctors - Allocate is implemented for O&G and work commenced for other specialties	Deputy Director of Workforce	September 2021	PPF Committee	
1.2 / 2	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 / 3	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)
2.4 Major and sustained failure of essential IT systems due to a cyber attack	15 (3 x 5)

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

2084 - No change in risk score since last review. Last reviewed 29/10/21

2085 - No change in risk score since last review. Last reviewed 08/09/2021

2086 - No change in risk score since last review. Last reviewed 12/05/21

2296 - No change in risk score since last review. Last reviewed 08/01/21

2321 - No change in risk score since last review. Last reviewed 06/09/21

2469 – new risk added - Rationale for escalation – This is a statutory compliance issue where the Trust are non-complaint. Resourcing issues within estates and facilities have impacted on compliance. Resourcing is currently under review.

2470 – new risk added - This is a statutory compliance issue where the Trust are non-complaint. There is potentially an engineering project issue regarding pipework

Ref	Corporate Risk Register / High Level (15+) Risks	Risk Score
1961	Risk to patient safety, including risk of misdiagnosis, inaccurate reporting of imaging findings, and lack of evidence that imaging has been performed on PACS.	16
2397	Following a recent serious incident, there is a risk that patients will not be informed of abnormal imaging results from LWH or external organisations when the results are received at the Trust	16
2341	There is a risk that during the Covid-19 pandemic, adult patients who suffer a cardiac arrest will receive suboptimal resuscitation	16
2386	Risk of personal and sensitive information being compromised or being misused	15
2316	Risk of women needing to access emergency care with pregnancy complications and not being able to access advice or care at the point needed. Impact on the safety of patients, (physical/psychological harm)	16
2446	A number of patients who had been waiting for Gynaecology surgery (P4) and had pre-operative scans that were missed / not reviewed in time, subsequently had escalation of diagnosis and further management plan.	16
2084 **(CRR)**	Uncertainty of adequacy of 24/7 access to specialist input to support changing patient profiles and needs, new guidance and the Chief Medical Officer's recommendation of the specialist multidisciplinary team approach to treatment planning and co-ordination, including pre-operative, surgical and up to level 3 post-operative care for improved patient safety and improved outcomes.	6
2085 **(CRR)**	Uncertainty around access to dedicated diagnostic capacity and physiological measurement needed to support needs of a changing patient demographics and an increase in complex multiple comorbidities and meeting the pre-operative assessment standards of the AAGBI and the RCoA, to assess patients' clinical risk and plan for additional requirements for their safety and provide an optimal experience.	12
2086 **(CRR)**	Uncertainty about provision of adequate on-site Blood bank stocking all major blood products necessary to support the needs of the Maternity service.	9
2296 **(CRR)**	The LWH laboratory autoview analyser (the machine used to process Blood Group and Save samples on site) will no longer be supported as of 1st March 2020. This machine cannot continue to be used after this date.	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
2469 **(CRR)**	Allocation of resources to carry out water safety checks and maintenance has failed to achieve required targets despite prioritising this work and reducing resources for other tasks	9
2470 **(CRR)**	Water cold water temperatures in the new NICU build are being recorded as 2% higher than hospital cold water temperatures.	9

BAF Risk 2.1: Failure to progress our plans to build a new hospital co-located with an adult acute site

Lead Director: ~~Medical Director~~ CFO Op Lead: Head of Transformation & Strategy	Review Date: December 2021	Ulysses Ref: TBC

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

Integrated Care Condition

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
15 (3 x 5)	15 (3 x 5)	15 (3 x 5)		⟷	15 (3 x 5)

Rationale for current risk score:

The Trust's services being located on an isolated site away from an acute centre, remains the most significant risk to the organisation. 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 Support for Expression of Interest submitted 9th September 2021 from C&M. Trust has shared EOI with C&M partners, positive support received	Lack of system support outside of Cheshire and Mersey to secure the capital case H&CP submissions for capital bids not successful despite system agreement of clinical case	
	Future Generations Strategy Update	Available on the Trust website Future Generations Strategy has been included within refreshed overall corporate strategy and is a key supporting strategy within Trust strategic framework Future Generations Clinical Advisory Group has been reconstituted	None	
	Business case refresh	Refresh of business case is underway, informed by work of FGCAG. Work includes review of compliance against new clinical standards, counterfactual case refresh, future model of care, updated of clinical case for change (taking account of changes at LWH, in system and health and care landscape over last 5 years)	Business case refresh is led by Trust rather than commissioners as with previous case Public consultation required	
	Active management with all commissioners	Good meetings with CCG via Clinical Quality and Performance Group (CQPG) Relationships with key ICS stakeholders established Escalation of risks of isolated site to system level	None Transfer of commissioning arrangements from CCGs to ICS Potential change in ICS Board in April 2022	
	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)	Lobby systems and MPs for active support External review/testing of counterfactual case External review/testing of refreshed case for change, following completion of FGCAG work/business case refresh	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.1/1	Management of Future Generations Strategy through Project Management Office	Head of Strategy and Transformation	August 2021	Board	On track
2.1/2	Submission of Expression of Interest for new hospital building	Head of Strategy and Transformation	September 2021	Board	Complete
2.1/3	Business case refresh – completion of refreshed case for change, including supporting evidence, clinical standards compliance, refreshed counterfactual case	Head of Strategy and Transformation	November 2021	Board	On track
2.1/4	Business case refresh – completion of options appraisal and refreshed model of care for future of women's and neonatal services	Head of Strategy and Transformation	December 2021	Board	On track
2.1/5	Business case refresh – refreshed estates modelling and schedule of accommodation for new build	Head of Strategy and Transformation	January 2022	Board	On track
2.1/6	Business case refresh – completion of financial modelling and LTFM	Head of Strategic Finance	February 2022	Board	On track
2.1/7	External validation of case for change and counterfactual case	Medical Director	January 2022	Board	On track
2.1/8	Longlisting of EOI (external control of this by NHSE/I)	Chief Finance Officer	December 2021	Board	On track
2.1/9	Approval of EOI (external control of this by NHSE/I)	Chief Finance Officer	April 2022	Board	On track
2.1/10	Commence public consultation (external control of this action by commissioners and NHSE/I)	Head of Communications and Marketing	July 2022	Board	On track

2.1/11	Development and completion of business case (OBC, FBC stages) through New Hospitals Building Programme approach (external control of this by NHSE/I)	Head of Strategy and Transformation	March 2024	Board	On track	
2.1 / 3	Outcomes from the clinical summit to be actioned ***Proposed to move this action to BAF risk 2.3**	Head of Transformation & Strategy	August 2021	Board	On track	
2.2 / 12	Lobby systems and MPs for active support	Head of Communications and Marketing	December 2021	Board		
2.2 / 13	Build relationships with key ICS personnel	Medical Director	December 2021	Board	On track	

BAF Risk 2.2: Failure to develop our model of care to keep pace with developments and respond to a changing environment

Lead Director: COO
Op Lead: Deputy COO

Review Date: Jan 22

Ulysses Ref:

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
12 (3 x 4)	16 (4 x 4)	16 (4 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 because information is spread across disparate systems leading to information being incomplete, hard to find in a timely manner and a potential for inaccuracies due to manual transfer of information. However, there is evidence of pro-active mitigating controls and progress being made in the procurement and subsequent implementation of an integrated Meditech EPR system. The Trust can demonstrate evidence of being open and responsive to change in service development and delivery but further work can be done to strengthen the approach to horizon scanning and longer term, strategic planning at a Divisional level.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Trust's current clinical records system (paper and Electronic) are sub-optimal.	Approved Digital Generations Strategy	Quarterly risk assessments completed	None	
	Approved Meditech Expanse Business Case	FPBD Committee overview and scrutiny	None	
	Maintenance of present system	Digital Hospital Committee oversight	None	
	Development of individual / service solutions e.g. PENs (Gynaecology) and Staff training	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	EPR programme board chaired by MD	None	
	Tactical solutions including the implementation of K2 Athena system	Independent lessons learnt Positive review	Optimisations to K2 system and refinements which are required	
	Exchange/LHCRE enables for patent information sharing	MIAA Critical Application Audit (rolling programme across trust systems) Reporting into Audit Committee and Digital Hospital Group	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		None	
	PACS upgrade removes a separate login for that system, reducing multiple systems issues.		None	
	Task and Finish group established to ensure that clinical investigation undertaken at external trusts have been actioned accordingly.	Safety and Effectiveness Sub-Committee	None	
	Appropriate task and finish groups established as required by Safety and Effectiveness sub-committee	Safety and Effectiveness Sub-Committee	None	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.2 / 1	Develop staff communication plan for new system	CIO	December 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	Complete
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	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	

local population and/or reduce health inequalities	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: Chief Operating Officer
Op Lead: Head of Strategy & Transformation

Review Date: Dec 2021

Ulysses Ref: TBC

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Quality Committee

Provider Licence Compliance link:

N/A

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
20 (4 x 5)	20 (4 x 5)	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	Transfers out monitored by Partnership	None	
	Transfer arrangements for adults	Transfers out monitored at HDU Group	Transfers are often subject to delay due to the Trust being considered a 'place of safety'. Transfer of adults requires accompanying clinical staff, which can lead to staffing pressures on the ward. Action 2.3/4	
	Formal partnership and board established with Liverpool Universities Hospitals with respect to: -Diagnostics -Medical and surgical expertise -Intensive care facilities -Theatre access at Liverpool Universities Hospitals for women with Gynae cancers -Provision of maternity expertise at LUHFT sites -Provision of Gynaecology expertise at LUHFT sites -Placenta accreta service, including specialist imaging and supervision of review from Sheffield Teaching Hospitals NHS FT		Onsite and partnership mitigations cannot fully address the clinical risk - this can only be achieved through co-location. Arrangements not formally agreed and underpinned by detailed SLA. Actions 2.3/5, 2.3/6	
	Blood product provision by motorised vehicle from nearby facility, with protocols in place to prioritise transport of blood products.	Serious incidents, should they occur are tracked and reported through the governance framework,	Lack of 24/7 transfusion laboratory on site leads to delay in patients receiving transfusion. Action 2.3/7, 2.3/8	
	nvestments in additional staffing inc. towards 24/7 cover - Maternity	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 Twilight cover to be in place from April 2022 Action 2.3/9	
	Investments in additional staffing inc. towards 24/7 cover - Anaesthetics	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 24/7 cover required but not yet in place Action 2.3/9	
	Investments in additional staffing inc. towards 24/7 cover – Gynaecology, including additional investment in ANP roles within GED	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 24/7 cover not required Action 2.3/9	
	Investments in additional staffing inc. towards 24/7 cover - Neonates	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 24/7 cover in place from January 2022 Action 2.3/9	
	Enhanced resuscitation training provision - Paediatric	Training compliance rates reported to PPF Committee	Full provision for paediatric resus cover not in place Action 2.3/10	
	Enhanced resuscitation training provision - Adult	Training compliance rates reported to PPF Committee	None	

	Crown Street Enhancements Programme Board established to oversee: -Construction work required to accommodate new FMU, colposcopy suite, CT & MR Imaging suites (ongoing) -Implementation of Robotic Assisted Surgery (complete) -Implementation of 24/7 transfusion laboratory on site (ongoing) -Decant into and new ways of working within FMU (complete) -Decant into and new ways of working within colposcopy (ongoing)	Crown Street Enhancements Programme progress reviewed monthly at FPBD	Financial and workforce constraints for delivery of additional facilities on site. Action 2.3 / 2 Construction works not yet complete – due to complete December 2022 Action 2.3/11 24/7 transfusion laboratory not yet established – aim for completion September 2022 Action 2.3/7 Colposcopy decant not yet complete – aim for completion June 2022 Action 2.3/12	
	Community Diagnostic Centre established at Crown Street, to include the following diagnostics with access for LWH patients: -Imaging – CT, MR, X-ray, ultrasound -Physiological – ECHO, ECG, BP monitoring, Spiro, FeNO, Sleep studies -Pathology	Community Diagnostic Centre Oversight Group reviews progress on a fortnightly basis. Progress also reported to and monitored by regional CDC Programme Board.	Services not yet implemented Action 2.3 / 13	
	Divisional Operational Plans completed	Divisional Boards	5 Year Service Transformation Plans under development – CSS Division plan not yet in place 2022/23 Divisional operational plans not yet developed Action 2.1 / 1	
	Use of telemedicine to facilitate consultations both at Crown Street and other sites	Divisional Boards	Implemented for Neonatal Partnership Expansion to cover other Trusts Expansion to cover maternity services	
	Historic controls still in place include: -Use of cell salvage -Expanded role of anaesthetists to cover HDU patients -Existing informal links with partner organisations -ANP roles -Transfer of patients for urgent imaging and critical care -Theatre slots at LUHFT -ACHD Partnership	Quality Committee	None	
	Progress being made in relation to building relationships with LUFT	Partnership Board meetings and involvement in wider Estates Strategy Mapping of requirements from and interdependencies with LUHFT across all Trust specialties	Establish task and finish groups to address key issues/relationships (to include any outstanding actions from clinical summit) Agreement/engagement from LUHFT Signed SLA	

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 Strategy and Transformation/ Deputy Chief Operating Officer	March 2022	Trust Executive		
2.3 / 2	Agree funding for all mitigations on site are included operational planning	Deputy Chief Finance Officer	March 2022	FPBD Committee		
2.3 / 3	Project to establish robotics surgical service - COMPLETE	Deputy Chief Operating Officer	July 2021	FPBD Committee		
2.3 / 4	Provision of staffed and dedicated ambulance to facilitate transfer of adult patients to be explored.	Deputy Chief Operating Officer	TBC	Quality Committee		
2.3 / 5	Task and finish groups to be established, reporting into the Partnership Board with LUHFT, to formally agree and set out arrangements for partnership working across all four LWH and LUHFT sites	Head of Transformation & Strategy	March 2022	Partnership Board		
2.3 / 6	Detailed agreements to form part of SLA with LUHFT, clearly explaining routes of access and expectations of both organisations.	Deputy Chief Finance Officer	September 2022	Partnership Board, TBDG		
2.3 / 7	Project to establish 24/7 transfusion laboratory on site at Crown Street	Head of AHPs	September 2022	Crown Street Enhancements Programme Board, FPBD		
2.3 / 8	Implement remote issue of blood products to minimise delay in transfusion	Head of AHPs	April 2022	Crown Street Enhancements Programme Board, FPBD		
2.3 / 9	Complete job planning and feed into operational planning process for 2022/23 to facilitate move towards 24/7 consultant cover	Clinical Directors	January 2022	TBDG		
2.3 / 10	Clear SOP to be implemented for paediatric resus provision	Deputy Medical Director	January 2022	Quality Committee		
2.3 / 11	Complete construction of colposcopy, CT & MR imaging suites	Head of Strategy and Transformation	December 2022	Crown Street Enhancements Programme Board, FPBD		

	2.3 / 12	Project to manage decant and new ways of working within colposcopy	Deputy Divisional Manager for Gynaecology	June 2022	Crown Street Enhancements Programme Board, FPBD		
	2.3 / 13	Deliver CDC project plan to establish CDC services: -Imaging – CT, MR, X-ray, ultrasound -Physiological – ECHO, ECG, BP monitoring, Spiro, FeNO, Sleep studies -Pathology	Head of Strategy and Transformation/ Deputy Chief Operating Officer	December 2022	CDC Oversight Group, FPBD		
	2.3 / 14	Project to expand use of telemedicine technology across more providers for neonatal services and implement within maternity	Divisional Manager for Family Health	March 2022	Trust Executive		

BAF Risk 2.4: Major and sustained failure of essential IT systems due to a cyber attack

Lead Director: CIO Op Lead: CIO	Review Date: Oct 2021	Ulysses Ref: TBC

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: FPBD Committee

Provider Licence Compliance link:

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
N/A	15 (3 x 5)	15 (3 x 5)		⟷	12 (2 x 5)

Rationale for current risk score:

The Trust's Digital Services department places cyber security management at the core of operational activities, ensuring it maintains it's Cyber Essentials plus standard. Various controls are implemented that are considered effective and this reduces the likelihood of a cyber-attack impact. However, if a cyber-attack was successful the impact would likely be catastrophic to Trust services, likely rendering digital systems that clinical services are increasingly dependent on, unavailable for a period of time. The Digital Services department continue to strengthen controls through process refinement and the introduction of security technologies. On the basis of this, the impact is considered catastrophic and likelihood is considered as possible resulting in an overall score of 15.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective cyber controls and technology, inadequate investment in systems and infrastructure, failure in skills or capacity of staff or service providers, poor end user culture regarding cyber security and IT systems use, inadequate contract management. **Consequence: Reduced quality or safety of services, financial penalties, reduced patient experience, loss of reputation, loss of market share / commissioner contracts.**	Microsoft Windows security and critical patches applied to all Trust servers on all servers\laptops and desktop devices on a monthly basis. Network switches and firewalls have firmware updates as and when required installed. Wifi network firmware patches applied for Controllers and Access points. Mobile end devices patched as and when released by the vendor. Externally managed network service provider to ensure network is a securely managed with underpinning contract. Robust carecert process to enact advice from NHS Digital regarding imminent threats. Network perimeter controls (Firewall) to protect against unauthorised external intrusion. Robust Information Governance training on information security and cyber security good practice. Regular staff educational communications on types of cyber threats and advice on secure working of Trust IT systems. Additional cybersecurity communications in relation to Covid phishing/ scams, advising diligence. Enhanced VPN solution including increased capacity to secure home working connections into the Trust. Review and updating of information security policies and home working IG guidance to support staff who are remote working. Malware protection identifies and removes known cyber threats and viruses within the Trust's network and at the network boundaries. Cyber Security Monitoring System identifies suspicious network and potential cyber threat behaviour. National CareCert alerts inform of known and imminent cyberthreats and vulnerabilities	Cyber Essentials Plus Standards/KPIs IMT Risk Management Meeting Digital Hospital Sub Committee MIAA Cyber Controls Review Cyber Essentials Plus Accreditation Cyber Penetration Test NHS Care Cert Compliance	Lack of Cyber Security strategy Lack of Network Access Controls within the physical network.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.4 / 1	Implement a Cyber Security strategy	CIO	Dec 2021	FPBD	
2.4 / 2	Procure and implement Network Access Control (NAC) solution	CIO	Mar 2022	DHSC	

Strategic Objective	SA3: To deliver the best possible EXPERIENCE for patients and staff
Committee:	Quality Committee
Risk Appetite:	Low

Principal risks (BAF)	Risk Score
3.1 Failure to deliver an excellent patient and family experience to all our service users	12 (3 x 4)

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

1966 - No change in risk score since last review. Last reviewed 07/09/2021.

2088 - No change in risk score since last review. Last reviewed 09/11/2021

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: Jan 2022

Ulysses Ref: TBC

Strategic Priority: SA3: To deliver the best possible EXPERIENCE for patients and staff

Lead Committee: Quality Committee

Provider Licence Compliance link:

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
12 (3 x 4)	12 (3 x 4)	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 and are sensitive to the inclusion and diversity of the populations that we serve.	Women, babies and their families experience strategy 2021 - 2026	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		
	Patient Experience Matron in place providing clinical view into patient experience team	Reports Patient Involvement and Experience Sub-Committee and attends CoG Comms and Engagement Group		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
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	~~January 2022~~ March 2022	Patient Involvement & Experience Sub-Committee	
3.1 / 4	To appoint a Non-Executive Director with a focus on community engagement	Trust Secretary	November 2021	Board	
3.1 / 5	To ensure that Divisions are adequately utilising patient feedback to drive quality improvement initiatives	Deputy COO	January 2022	Patient Involvement & Experience Sub-Committee	

Strategic Objective	SA4: To be ambitious and EFFICIENT and make the best use of available resources
Committee:	Finance, Performance and Business Development Committee
Risk Appetite:	Moderate

Principal risks (BAF)	Risk Score
4.1 Failure to ensure our services are financially sustainable in the long term	20 (5 x 4)
4.2 Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	8 (2 x 4)

Ref	Corporate Risk Register / High Level (15+) Risks	Risk Score
None identified to date		

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

BAF Risk 4.1: Failure to ensure our services are financially sustainable in the long term

Lead Director: CFO
Op Lead: Deputy CFO
Review Date: Dec 21
Ulysses Ref: TBC

Strategic Priority: SA4: To be ambitious and EFFICIENT and make the best use of available resources

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
20 (5 x 4)	20 (5 x 4)	20 (5 x 4)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. However, a number of cost increases have been approved in relation to quality and safety (including maintaining safety on site and the Clinical Case for Change, investment in maternity services, and service developments such as Robotic Surgery). The Trust has also delivered lower levels of recurrent CIP in 2020/21 and 2021/22 than in previous years. The underlying financial position has therefore deteriorated. This increases the challenge for the Trust; however, this is also coupled with additional funding routes being made available, particularly in relation to Maternity.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Trust is not financially sustainable in the long term	5 Year financial model produced giving early indication of issues	5 Year plan approved (BoD Nov 2014) Long Term Plan Submission Nov 19	Whilst plans are in place, there remains significant on-going uncertainty regarding the financial regime, introduction of Integrated Care Systems and consequent change in commissioning landscape and the impact of changing clinical requirements with resource implications. Model to be refreshed by March 2022.	
	Business case to Trust Board which identifies a solution which minimises 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 Time has now elapsed, and business case is in process of being refreshed. This will be a Strategic Outline Case. There remains uncertainty as to where and by who this will be assessed Additional work being undertaken to quantify financial benefits of co-location.	
	Early and continuing dialogue with NHSE/I and Cheshire and Merseyside ICS	System top up agreed to achieve breakeven for Half One 2021/22 and also Half Two 2021/22, meaning a breakeven plan is in place for 2021/22	Uncertainty re future settlement and regime. Level of current financial system support provided sets a precedent going forward.	
	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. Not actively being pursued at present. However co-location and new build will allow for increased efficiency and reduced cost.	
	Engagement in place with Cheshire and Mersey Partnership to review system solutions	Submission of Cheshire and Mersey STP capital bid Summer 2018 ranked no1 of schemes Active participation in C&M planning processes Trust Expression of Interest as part of New Hospital Programme has not been prioritised by Cheshire and Merseyside in 2021 but was mentioned as (joint) second priority in feedback.	Position potentially superseded by development of ICS Feedback to both ICS and North West region provided.	
	Clinical Engagement and support for proposals	Northern Clinical Senate Report supporting preferred option	Further work programme in place including further Clinical Senate Review of preferred option.	
	Reduction in CNST Premium and achievement of Maternity Incentive Scheme.	Process in place regarding CNST MIS. Prior achievement of MIS. Engagement with NHS Resolution and learning from claims and incidents. Direct engagement with NHS Resolution. Increased resource in Maternity to manage this.	Potential resourcing issues to manage this.	
	Reduction in back office overheads costs.	Oversight on costs at FPBD and Board Focus on benchmarking and efficiencies, including joint working where possible.	Requirement for resource in relation to recovery and covid.	
	Application for emergency capital for mitigations on site	Approved with work now underway	Supports safety on site but will impact on financial position re capital charges, staffing etc.	
	Development of Community Diagnostic Centre.	Upfront capital and revenue funding provided. Letter of comfort from ICS.	Significant revenue implications on an ongoing basis, not directly related to LWH patients. No definitive ongoing revenue funding source in place (although national programme and letter of comfort from ICS provided).	

	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status	
	4.1/1	Agree financial plan for H2 with NHSI/E and C&M	CFO	November 2021	FPBD Committee		
	4.1/2	Agree financial plan for 2022/23 with NHSI/E and C&M	CFO	March 2022	FPBD Committee		
	4.1/3	Work with regional team, commissioners and Local Maternity System to ensure staffing costs and pressures, particularly in relation to maternity, Ockenden and revised clinical standards are funded.	CFO	March 2022	FPBD Committee		
	4.1 /4	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	June 2023	FPBD Committee		
	4.1 /5	Business Case 2 - Public consultation by CCG following development of preferred option (Subject to capital bid)	CFO	June 2022	FPBD Committee		
	4.1 /6	Business Case 3 - Decision making business case produced in partnership with CCG and final decision following outcome of public consultation required	CFO	December 2022	FPBD Committee		
	4.1 / 7	Business case - to support the application for capital to support the relocation required	CFO	December 2021	FPBD Committee		
	4.1 / 8	Merger – Explore options in relation to merger	CFO	December 2022	FPBD Committee		
	4.1 / 9	Explore options for shared executive model with LUHFT.	CFO	December 2022	FPBD Committee		
	4.1/10	Procurement 1 - OJEU - Undertake most appropriate formal procurement process to appoint primary building contractor & architect	CFO	June 2023	FPBD Committee		
	4.1 /11	Procurement 2 - PQQ Stage - Procurement team to complete Pre Qualification Questionnaire stage	CFO	September 2023	FPBD Committee		
	4.1 / 12	Procurement 3 - ITPD Stage - Procurement team to complete Invitation to Participate in Dialogue stage	CFO	April 2024	FPBD Committee		
	4.1/13	Procurement 4 - Financial Close - Procurement team to complete financial close stage	CFO	July 2024	FPBD Committee		
	4.1/14	Procurement 5 - Contract Award - Trust to approve contract award	CFO	September 2024	FPBD Committee		
	4.1/15	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		
	4.1/16	Business Case 5 - Approval for funding from NHSI/E based on refreshed SOC	CFO	April 2023	FPBD Committee		
	4.1/17	Agree ongoing funding model for Community Diagnostic Centre	CFO	March 2022	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- high assurance for all finance related internal audit reports in 2020/21 and 2021/22. External Audit Mitigations being worked up in case of identified risks materialising	Lack of contractual income position due financial framework in place following the Covid-19 pandemic, gap in baseline position and block payment compared to actual activity and cost, risk to CIP and income streams, timing of recovery and uncertainty over future regime. Reliance on Cheshire & Merseyside position and NHS Improvement/England national team to support proposed baseline adjustment for Elective Recovery Funding.		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
4.1/20	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	
4.1/22	Negotiate settlement for Half Two	CFO	November 2021	FPBD Committee	
4.1/23	Agree sufficient cash resource for Half Two	CFO	November 2021	FPBD Committee	
4.1/24	Mitigations to be worked up in case Elective Recovery Fund income note earned.	CFO	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: Medical Director** **Op Lead:** Deputy COO	**Review Date: Jan 22**	**Ulysses Ref: TBC**

Strategic Priority: SA4: To be ambitious and EFFICIENT and make the best use of available resources

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

Integrated Care

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
8 (2 x 4)	8 (2 x 4)	8 (2 x 4)		⟷	8 (2 x 4)

Rationale for current risk score:

The Trust has well defined partnerships and relationships with a number of key stakeholders. These have been strengthened and added to during the Covid-19 pandemic response. The regulatory and system landscape remains uncertain and the Board will be looking for additional clarity on future arrangements (and the Trust's assured role in this) in order to mitigate this risk and work towards the target score and improve the overall assurance rating on the controls.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Conflicting priorities, 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.

2232 - No change in risk score since last review. Last reviewed 12/07/21.

2295 - No change in risk score since last review. Last reviewed 07/09/2021

2329 - No change in risk score since last review. Last reviewed 18/10/2021

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: January 2022

Ulysses Ref: TBC

Strategic Priority: SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes

Lead Committee: Quality Committee

Provider Licence Compliance link:

N/A

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
8 (2 x 4)	8 (2 x 4)	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. Note – Nursing, Midwifery & AHP Research Talent Pipeline report scheduled for R&D Sub-Committee in February 2022.	Medical Director	Feb 2022	Research and Development Sub-Committee	
5.1 / 2	To collaborate with the Professor of Midwifery Update – Three Prof. of Midwifery attend Trust's RD&I Sub-Committee Research midwife now in post (joint appointment).	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 Update – Regular attendance at RD&I sub-committee by LHP theme leads	Medical Director	On-going	Research and Development Sub-Committee	
5.1 / 4	Continue progress towards university hospital status application	Medical Director	October 2022	Research and Development Sub-Committee	
5.1 / 5	Continue Trust engagement with population health and longitudinal studies / workstreams Update – C-Gull programme scheduled to start in Q1 22/23 – Trust is engaged.	Medical Director	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:** Assoc. Director of Governance and Quality	**Review Date: Jan 22**	**Ulysses Ref: TBC**

Strategic Priority: SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes

Lead Committee: Quality Committee

Provider Licence Compliance link:

General Licence Condition 7

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
12 (3 x 4)	12 (3 x 4)	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	
	Realignment of Governance Managers to demonstrate better accountability and ownership of risk	Monthly meetings with the divisions and Assoc. Director of Quality & Governance and Dep. Chief Nurse & Midwife to review the risk profile, ensuring we move at pace being able to evidence the work we are doing, including any learning from incidents/events etc		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 1	To implement updated Ward Accreditation programme	Deputy Director of Nursing & Midwifery	February 2022	Quality Committee	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective understanding and learning following significant events and evidencing improved practice and clinical outcomes.	Regular dialogue with regulators	CQPG Meetings Reporting of incidents and management of action plans through Safety & Effectiveness Sub-Committee Reflection of risks and Corporate Risk Register and Board Assurance Framework CQC Assessment Annual Quality Account Report Monthly meetings with the divisions and Assoc. Director of Quality & Governance and Dep. Chief Nurse & Midwife to review the risk profile, ensuring we move at pace being able to evidence the work we are doing, including any learning from incidents/events etc Discussions with staff on walk arounds conducted by the Director of Nursing & Midwifery and senior clinical staff. Shared learning page now live on the intranet	'Moderate Assurance' from recent MIAA Audit – actions remain in progress but improved processes in place.	
	Incident reporting and investigation policies and procedures.		External criticism from regulators and commissioners – recent position is improving with feedback more positive.	
	MDT involvement in safety		Lack of testing of action plans following audits to ensure they lead embedded change – will be supported by ward accreditation once in place.	
	HR policies in relation to issues relating to professional and personal responsibility		Inconsistent completion and dissemination of actions and improvement plans – signs of improvement but with further work required.	
	Mandatory training in relation to safety and risk		Inconsistent implementation of lessons learnt and lack of evidence - clinical walkarounds by execs and clinical staff capture this now. Further improvements required re blood sampling errors which is now being managed by the pathology steering group	
	Serious Incident Feedback form		Pace of implementing change	
	Serious Incident panels		Lack of consistent between divisional governance meetings (noted in recent well-led report) – now improving	
	Safety is included as part of executive walk rounds.		Well-led external review recommendation regarding walkaround process	
	Risk Management Strategy			

	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	February 2022	Safety & Effectiveness Sub-Committee		
	5.2 / 5	New risk management and patient safety training package to be developed	Head of Governance & Quality	April 2022	Safety & Effectiveness Sub-Committee		
	5.2 / 6	Root Cause Analysis training for staff to be reviewed and updated and to recommence via teams	Head of Risk	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 Update - Significant improvements and updates to CQC action plans are evident. The position is much better compared to July 2021	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	On-going	Safety & Effectiveness Sub-Committee		

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective and / or ill-defined quality improvement methodology will result in the Trust missing opportunities to improve the safety, effectiveness and experience of care.	Quality Improvement training materials available on Trust Intranet	Training levels reported to the Quality & Clinical Audit Group	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	Assoc. Director of Governance & Quality	February 2022	Quality Committee	
5.2 / 12	Increase levels of QI training	Assoc. Director of Governance & Quality	April 2022	Quality Committee	
5.2 / 13	Simplify process to encourage staff to record QI projects within formal framework	Assoc. Director of Governance & Quality	April 2022	Quality Committee	

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/014***		**Date: 07/04/2022**	
Report Title	**Trust Board Terms of Reference**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***The Trust last reviewed the Board Terms of Reference at its meeting held on 1 April 2021. Whilst it is not a requirement to have a Board Terms of Reference, it is considered good practice and had been highlighted as a development point in the Trust's NHS Improvement Well-Led Framework Self-Assessment.*** ***No amendments are proposed but it is good practice to annually review the Terms of Reference.***			
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/N ***If no – please outline the reasons for deviation.***			
	The Board is asked to: ***• Review and if deemed appropriate approve the terms of reference included as appendix 1***			
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:	Comment:

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The Trust last reviewed the Board Terms of Reference at its meeting held on 1 April 2021. Whilst it is not a requirement to have a Board Terms of Reference, it is considered good practice and had been highlighted as a development point in the Trust's NHS Improvement Well-Led Framework Self-Assessment.

No amendments are proposed (apart from a highlighted minor housekeeping item) but it is good practice to annually review the Terms of Reference.

Recommendation

The Board is asked to:

- Review and if deemed appropriate approve the terms of reference included as appendix 1

Appendix 1:

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, Director of Finance 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~~ Chief Finance Officer
	  ○ 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:	*7 April 2021*
Approved by Board of Directors:	*TBC*
Review date:	April 2023
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

MAIN REPORT

N.B. The body of the report should be completed in Arial 11 and should not exceed 2000 words.

INTRODUCTION

Type over these prompts:

Context, background and purpose.

Define the issue / problem and ensure that the report is contextualised:

- *At a macro level with the Trust's Strategic Objectives*
- *At a tactical level with the Terms of Reference of the forum*
- *At a micro level to ensure that the paper addresses its purpose.*

ANALYSIS

Type over these prompts:

What are the key findings and how were they reached?

Use information that is meaningful and relevant – graphs and tables do not require describing. The use of graphs, tables, graphics and RAG ratings focus the reader's attention.

Try to ensure that the report is forward looking / trend based wherever appropriate – not 'snapshot' or two data point reporting. The use of revised trajectories alongside existing can be useful to show the expected impact of actions.

It is better to be exception based in order to direct the reader to the key issues to focus on those areas requiring greater attention.

Your analysis can be enhanced by using benchmarking or comparator information where possible / appropriate.

Solutions:

Try to be action orientated – not just reporting performance. This is where you can provide effective assurance to the Board / Committee / Sub-Committee.

Outline the accountability arrangements for the proposed actions and how they are SMART.

RECOMMENDATION

Type over these prompts:

Be clear on what you are asking the Board / Committee / Sub-Committee. Who will take ownership for delivery?

Liverpool Women's
NHS Foundation Trust

Checklist for report authors

Delete once report is complete

Criteria	
Technical issues	
Alignment with aims and objectives	
Exception based	
Executive Summary capable of standing on own	
Forward looking and trend based	
Succinct with appropriate use of visual aids	
Use of benchmarking / comparators if possible	
Ensure that performance data is valid and accurate.	
Does the report impact on staff, patients or other stakeholders? Is an Equality Impact Assessment required and if so, is this referenced in the report?	
General questions	
Have the issues been clearly articulated?	
Have the solutions been articulated with appropriate timescales and are there any financial implications?	
Have the expected benefits been described with clear measurable outcomes?	

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23015*	**Date: 07/04/2022**		
Report Title	**Board Committee Annual Reports, 2022/23 cycles of business and Terms of Reference**			
Prepared by	*Mark Grimshaw, Trust Secretary*			
Presented by	*Mark Grimshaw, Trust Secretary*			
Key Issues / Messages	*The report presents the following for review.* • *Committee Annual Reports for the Quality, Finance, Performance & Business Development, Putting People First and Charitable Funds Committees* • *Committee Business Cycles for 2022/23 for the Quality, Finance, Performance & Business Development, Putting People First, Audit and Charitable Funds Committees* • *Committee Terms of Reference for the Quality, Finance, Performance & Business Development, Putting People First, Audit and Charitable Funds Committees*			
Action required	**Approve ☒**	**Receive ☐**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is asked to receive and if deemed appropriate approve the following documents: • *Committee Annual Reports for the Quality, Finance, Performance & Business Development, Putting People First and Charitable Funds Committees* • *Committee Business Cycles for 2022/23 for the Quality, Finance, Performance & Business Development, Putting People First, Audit and Charitable Funds Committees* • *Committee Terms of Reference for the Quality, Finance, Performance & Business Development, Putting People First, Audit and Charitable Funds Committees*			
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*	Comment:

5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
PPF, FPBD, Quality, Audit and Charitable Funds Committees	March 2022	Committee Chairs	Documents reviewed and recommended for approval by the Board

EXECUTIVE SUMMARY

In line with best practice in other sectors, the Board's Committees have produced an Annual Report to the Board summarising their activities for the financial year 2021/22, setting out how they met their Terms of Reference. Similarly, to the previous year, this annual effectiveness review has been aligned with the Business Cycle and Terms of Reference review to ensure that the findings translate to improvements in practice.

The exceptions to the review process are the Audit and Nomination & Remuneration Committee – effectiveness reviews for these forums form part of the Annual Report.

The Board is asked to receive and if deemed appropriate approve the following documents:

- Committee Annual Reports for the Quality, Finance, Performance & Business Development, Putting People First and Charitable Funds Committees
- Committee Business Cycles for 2022/23 for the Quality, Finance, Performance & Business Development, Putting People First, Audit and Charitable Funds Committees
- Committee Terms of Reference for the Quality, Finance, Performance & Business Development, Putting People First, Audit and Charitable Funds Committees

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Quality Committee

Annual Report 2021/22

Background

This report covers the period April 2021 to March 2022. There were 13 meetings held during this period. This was in addition to the 10 scheduled meetings for the year. The explanation for this is detailed in the 'Areas for Development' section.

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

Strategy and Performance

- 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).
- 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.
- Review trends in patient safety, experience and outcomes (effectiveness) to provide assurance to the Board on performance and commission 'deep dives' as appropriate.
- 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.
- Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery.

Governance

- 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.

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

- 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.

- Obtain assurance that the Trust is compliant with guidance from NICE (through receipt of an Annual Report) and other related bodies.

- 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.

- 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.

- 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.

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

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

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

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

- Approving the terms of reference and memberships of its subordinate committees.

Overall

- 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.

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

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

- 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.

Constitution

The Quality Committee is accountable to the Board of Directors.

Membership during the year comprised:
- Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- Medical Director
- Chief Nurse & Midwife
- Chief Finance Officer
- Chief People Officer
- Chief Operating Officer
- Deputy Chief Nurse & Midwife
- Assoc. Director of Quality and Governance

Meetings were also attended by other executives and senior management staff as appropriate.

The Committee's constitution allows for members to participate by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference. Due to the on-going Covid-19 pandemic, all meetings during 2021/22 have been held virtually utilising Microsoft Teams.

The Terms of Reference requires that all members of the committee attend a minimum of 75% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2021/22 together with the names of senior management who were invited to attend during the year. The majority of members attended 75% or more of the meetings during 2021/22. This appendix will be updated post meeting so that a full 2021/22 picture can be provided to the Board.

Key achievements / activity

Lesson Learning

The Committee held two meetings in April 2021.The additional meeting was utilised to provide a focus on seeking assurance that the Trust was adequately developing processes to identify lessons and ensure learning was embedded. Items included on this agenda included:

- North West Operational Delivery Network review of Mortality at LWH proposal and Terms of Reference
- Report on Blood Sampling Errors – this issue has been a recurrent area of focus and attention for the Committee during 2021/22.
- Review of actions from Theatres Never Events Assurance
- MIAA Learning from Serious Incidents and Never Events Review Final Assignment Report 2020/21
- Progress of the LocSSIPs Implementation Group Q4 2020/21
- Report on Serious Incidents, Quarter 4 2020/21, including year-end overview of reported SI's

This was followed up by additional meetings (to those scheduled) in August 2021 and December 2021. A specific lesson learning follow up report was received in August 2021 but there were also targeted reports received on the following:

- Patient / Staff Story: Safeguarding Story
- Health and Safety Investigation Branch (HSIB) Referrals
- Concise Investigation Report: ERS waiting lists
- Mersey Internal Audit Agency Care Quality Commission Audit Update
- Family Health Review of actions from Theatre Never Events
- Maternal Medicine Service
- FMU Centre and Service Delivery Plans

Performance Report

The Committee received this report at each scheduled meeting. The opportunity is taken to scrutinise any area of note challenge, particularly from the lens of the impact of the quality and safety of services. During Quarter 2, attention was given to the quality impact of longer waiting times, specifically for cancer patients.

Gynaecology Update through Covid: Responsive Care

Received a deepdive review from Gynaecology which detailed responsive care through Covid-19. The Committee was assured that Gynaecology services had responded safely to support patients during 2020/21 and appropriately followed business continuity plans.

Care Quality Commission (CQC) Action Plan

The Committee received regular reports on the CQC action plan and progress made to close out the key recommendations into embedded practice.

Board Assurance Framework (BAF)

The Committee regularly reviewed the Board Assurance Framework risks assigned in line with the business cycle of activities. The Committee held discussions over the rating of specific risks attributable to the Committee noting that they were being

managed appropriately. The Committee reported all changes to the BAF at the next following Board of Directors meeting for approval.

Clinical Negligence Scheme for Trusts (CNST)

Whilst there have been several amendments to CNST requirements and timescales throughout 2021/22, the Committee has continued to monitor compliance and progress against the 10 safety standards. This was in recognition that working towards the safety standards is an important quality objective and not just a compliance matter.

Ockenden Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust

From the publication of the report in December 2020, the Committee has continued to receive regular reports on the Trust's response to the Ockenden Review. The Committee's fundamental role has been to ensure compliance against the recommendations but to also consider wider issues such as effective lesson learning and patient involvement and engagement.

Integrated Governance Report

The Committee has continued to receive this as a quarterly report and the development of the document, and the information contained therein has been an iterative process. The aim of the report is to enable the Committee to triangulate data from a range of clinical governance areas e.g. incidents, complaints, to identify themes for further exploration and assurance.

Mortality Reporting and Learning from Deaths

The Committee received quarterly reports and improvements were made throughout the year on ensuring that the reports provided the appropriate level of detail and evidence of lesson learning for the purposes and aims of the Committee.

Thematic review of Cerebral Palsy Cases

Received a thematic review of cerebral palsy cases, which reviewed the last ten cases that had been settled through the legal system where intrapartum management resulted in cerebral palsy. It was recommended that the work should be published and shared wider, e.g. to NHS Resolutions, and should be shared internally to improve learning and outcomes.

Ward Accreditation Scheme

The Committee has received regular progress updates on the development of the scheme throughout 2021/22, finally approving an outlined process in January 2022.

CQC Insight Tool

A new addition for 2021/22, the Committee has received this document on a bi-monthly basis. The tool comprises of information about the Trust which is analysed by the CQC to monitor services at provider, location, and core service level. Areas of key focus are identified.

Health and Safety Annual Report 2020/21

The Committee received the annual Health and Safety report and was assured by the overview of compliance and governance assurance regarding the Health and Safety arrangements, activities, performance and improvements illustrated within the annual report.

Medicines Management Quarterly Assurance Reports

This has remained a key concern for the Committee following the CQC Warning Notice issued in 2020. Assurance of the effective management of medicines is received on a quarterly basis.

Maternity Safety Champion Assurance Reports

The Committee receives quarterly reports from the maternity safety champion meetings and escalates any issues of note to the Board.

Research & Development Annual Report

The Committee received the annual Research and Development report and was assured by the overview of compliance and governance assurance related to research activity.

Quality Improvement Engagement and Refresh Project Update

The Committee noted positive progress with the Quality Improvement Engagement and Refresh Project early in 2022. An external assessment of the process had been undertaken and feedback provided to the Committee. The challenge to embed QI within usual practice as opposed to 'in addition' was acknowledged.

Areas for Development

For the second time, an effectiveness survey was circulated to members of the Committee seeking feedback on the activity of the Committee during 2021/22. Overall, the responses received were positive albeit mixed on certain questions – the full results can be seen in Appendix 2. No narrative comments were received but there were mixed results on the following questions:

- Q5 - I believe that the committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management.

- Q6 - I feel that the committee has the right balance of experience, attendance, knowledge and skills to fulfil its role.

- Q7 - The committee has structured its agenda and work plan to cover its key responsibilities.

- Q10 - There is clarity in relation to the work of the committee and its interaction and alignment with other committees.

Throughout the business of the Committee during 2021/22, the following observations have also been made by members of the Committee:

- There remains a significant amount of 'work' for the Committee to progress with. This is evidenced by the fact that there were three additional meeting tabled during the year and the use of the 'consent' agenda has been extensive. Whilst there have been improvements from the previous year and there is evidence of the Committee focusing on emerging priority issues, there remains room to improve in how the Committee ensures that there are robust underpinning assurance structures. This would enable an additional amount of work to be delegated, with the Committee more able to focus on the areas it has identified as issues of risk.
- The 'deep dive' approach utilized in the 'additional' meetings in April, August and December has worked well and enabled robust discussions to take place. The challenge is to create the space for this approach on a regular basis throughout the ten scheduled meetings.
- There have been instances during the year in which the Committee has been challenged in accessing the requested assurances from the Divisional structure in a timely way. There is a need to ensure that Divisions understand how their governance processes map against those of the Quality Committee and are aligned when required.
- Again, whilst improved, the performance reports remains an area that can develop further. It is important that the document does not duplicate the 'performance' discussions held at the Finance, Performance and Business Development Committee, but rather differentiates itself by offering up a view on the 'quality' implications of performance challenges. The Trust can well articulate its current performance against finance or access targets on a day-to-day basis and the challenge is to extend this approach to the wider quality agenda.

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in March 2021 and were approved by the Board in April 2021.

Other than housekeeping amendments e.g. updating of job titles, no other amendments are suggested.

The Terms of Reference is included at Appendix 3.

Proposed Amendments to the Committee Business Cycle

Each of the Committees established by the Board of Directors has an annual business cycle which is subject to review each year. The business cycle forms the 'core' agenda for Committee meetings throughout the year with scheduled business ensuring that the Committee discharges its responsibilities as set out in the Terms of Reference.

The Quality Committee last reviewed its annual business cycle in March 2021 and is therefore scheduled to complete a further review in order to set the business cycle for 2022/23.

All members of the Quality Committee had the opportunity to participate in the annual review and propose any amendments to the business cycle and terms of reference during February 2022 by completing the committee effectiveness survey. The Committee members who responded did not make any suggested amendments to the business cycle or terms of reference.

In addition to the survey, discussions had been held between the Committee Chair, Chief Nurse & Midwife, Medical Director and Trust Secretary to consider means to enhance Committee effectiveness.

During 2021/22, the following amendments to the business cycle were suggested and agreed:

- Review of Quality Strategy Quarterly – September 2021 meeting agreed to change to a bi-annual report and follow corporate objective timetable. Added April and September.
- Serious Incidents & Learning Report – became a monthly report in 2021/22 cycle. Previously a quarterly update.
- Safeguarding Quarterly Report – new addition as of September 2021. Timetabling slightly behind due to meeting dates of the Trust Safeguarding Board. Hoping to resolve into 2022/23.
- CNST Progress report on workplan June and July 2021 but removed from agenda. There is a need to timetable the overview of CNST compliance on new workplan and it is important that this aligns with the respective deadlines within the guidance.
- Ockenden Report Update – was on the 2021/22 workplan as of April 2021 as a monthly update. Received 6 out of 10 months.
- Maternity Transformation Board – added to the subcommittee chair report updates as of June 2021
- CQC Insight Tool – added as of September 2021 bi-monthly

Other suggested additions / amendments:

- Palliative and End of Life Care Report (bi-annual). Due to change in NED Leads document considered by Trust Board.
- Patient Survey/s (to be reported by exception)

Suggested amendments linked to the updated Board Lead guidance from NHS England:

- Suggested that the Quality Committee receive a bi-annual report detailing how the Trust is performing against Palliative and End of Life Care standards and reviewing any complaints received in this area.
- Consideration to be given to on-going reporting of the Trust's approach to children and young people

During 2021/22, over 30 items (above the agreed work programme) were received by the Committee. Whilst ad hoc reports are necessary to ensure that emerging issues are reviewed, this is far in excess than what is seen in the other Board Committees. To achieve some of the desired improvements, it will be important to be vigilant in relation to what is included on the agenda and how the Committee can best utilise the underpinning meeting structure to support this.

It is likely that key areas of attention during 2022/23 will be as follows:

- To continue to oversee progress being made to improve waiting times for Trust services
- To seek robust assurance that the Trust is making progress in its approach to understand the patient experience (from all groups) and actively utilizing this intelligence to improve service delivery
- Continuing to ensure that lesson learning is in place with the effective 'closing of loops'.
- Providing assurance to the Board that the organisation is 'inspection ready' at all times
- Ensuring that Divisional Governance arrangements are maturing and that there is closer alignment with the quality assurance agenda.
- Ensuring that quality data is being utilised to identify and drive through improvement
- That the Trust's QI approach is maturing and embedding.
- That the Trust builds on research successes to be a 'leading voice' in women's health research.

The draft Business Cycle is included at Appendix 4.

Conclusion

In the final analysis, it is concluded that the Quality Committee has achieved its objectives for the Financial Year 2021/22.

Tony Okotie CHAIR
Quality Committee
March 2022

Appendix 1

Quality Committee, Attendance at Committee: April 2021 – March 2022

Core members	19Apr	26Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie Chair	✓	✓	A	✓	✓	A	✓	A	✓	✓	✓	✓	✓
Susan Milner	✓	✓	A	✓	✓	✓	A	✓	✓	✓	✓	✓	✓
Ian Knight	✓	✓	✓	✓	✓	✓	NM						
Louise Kenny	✓	✓	✓	✓	✓	✓	A	✓	✓	A	A	A	A
Marie Forshaw	✓	✓	✓	✓	✓	A	A	✓	✓	✓	✓	A	✓
Gary Price	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	A	✓
Lynn Greenhalgh	✓	✓	A	✓	A	✓	✓	✓	✓	✓	✓	✓	✓
Jenny Hannon	✓	✓	A	✓	✓	✓	✓	NM					
Eva Horgan								✓	✓	✓	✓	✓	✓
Michelle Turner	✓	✓	✓	✓	✓	✓	A	✓	A	A	✓	✓	✓
Nashaba Ellahi	NM			✓	✓	✓	✓	A	A	✓	A	✓	A
Christopher Lube	✓	✓	✓	✓	NM								
Allan Hawksey	NM				✓	✓	NM						
Philip Bartley	NM						✓	A	✓	A	✓	✓	✓

Present (✓) Apologies (A) Representative (R) Non attendance (NA) Non Member (NM)

Invited attendees	**Job Title**	**19**	**26**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**

		April 2021	April 2021	2021	2021	2021	2021	2021	2021	2021	2021	2022	2022	2022
Mark Grimshaw	Trust Secretary	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Drakeley *nominated MD deputy	Interim Deputy Medical Director			✓		✓								
Chris Dewhurst *nominated MD deputy	Deputy Medical Director (as of Jan 2022)										**A**	✓	**A**	✓
Robert Clarke	Chairman	✓		✓					✓	✓	✓	✓		✓
Kathryn Thomson	Chief Executive	✓		✓	✓	✓	A	A	✓	✓	✓	✓	**A**	✓
Matt Connor	Chief Information Officer						A	✓	✓	✓	✓	✓	✓	✓
Louise Martin	Non-Executive Director		✓											
Allan Hawksey	Interim Associate Director of Governance (as of July)				✓	✓	✓	✓						
Clare Fitzpatrick	Head of Maternity												✓	
Dan Nash	Deputy COO / Divisional Manager Gynaecology		✓	✓										
Angela Winstanley	Quality & Safety Midwife		✓	✓								✓		
Rachel McFarland	Consultant Obstetrician		✓	✓										
Louise Hardman	Research & Development Manager				✓									
Amanda McDonough	Associate Director of Safeguarding					✓	✓	✓						
Tim Neal	Director Infection Prevention & Control				✓									
Michelle Rushby	Head of Audit, Effectiveness and Patient Experience					✓								
Matthew Butcher	Divisional Manager, Gynaecology							✓						
Sian Taylor	Clinical Lead, Oncology							✓						
Alice Bird	Clinical Lead, Maternity									✓	✓			
Professor Asma Khalil	Professor Of Fetal Medicine										✓			
Zia Chaudhry	NED, Observer										✓			
Lilian Beasant	Associate Specialist, MIAA											✓		

Gloria Hyatt	NED, Observer											✓		
Lowri Lloyd-Preston	Interim Head of AHP's, CSS											✓		
Ellen Gerrard	Divisional Manager, CSS											✓		
Loraine Turner	Director for Transformation & improvement, Family Health											✓		
Jo Downie	Deputy Chief Operating Officer											✓	✓	
Carl Griffiths	Named Nurse for Safeguarding Adults												✓	
Gill Diskin	Matron Maternity												✓	

Quality Committee Effectiveness Survey 2021/22

6	01:33	Active
Responses	Average time to complete	Status

1. I understand the duties of the committee.

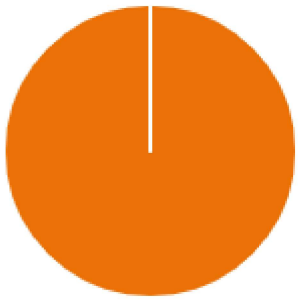
Strongly Agree	3
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

2. I believe the committee receives sufficient assurance to conclude upon its areas of responsibility

Strongly Agree	0
Agree	4
Disagree	2
Strongly disagree	0
Unable to answer	0

3. I am confident that the committee effectively monitors and scrutinises progress against the aligned strategies.

Strongly Agree	0
Agree	6
Disagree	0
Strongly disagree	0
Unable to answer	0

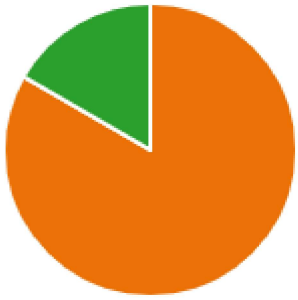


4. I am content that the committee is delivering the right level of assurance to the Board / Committee.

Strongly Agree	1
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0

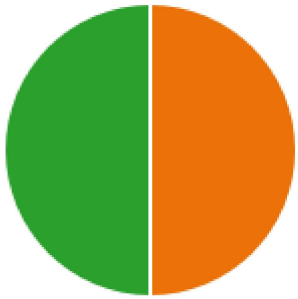
5. I believe that the committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management.

Strongly Agree	0
Agree	5
Disagree	1
Strongly disagree	0
Unable to answer	0



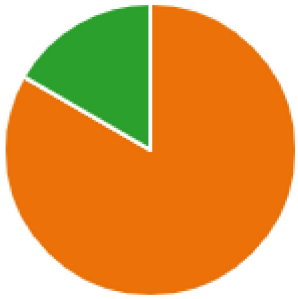
6. I feel that the committee has the right balance of experience, attendance, knowledge and skills to fulfil its role.

Strongly Agree	0
Agree	3
Disagree	3
Strongly disagree	0
Unable to answer	0



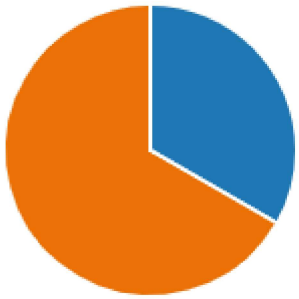
7. The committee has structured its agenda and work plan to cover its key responsibilities.

Strongly Agree	0
Agree	5
Disagree	1
Strongly disagree	0
Unable to answer	0



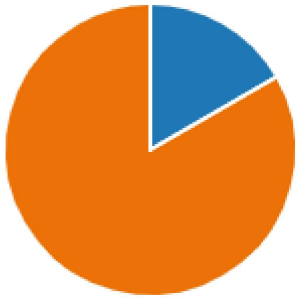
8. The committee is effectively chaired.

Strongly Agree	2
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0



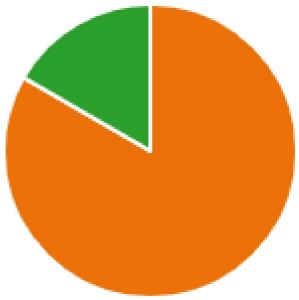
9. All members of the committee are able to participate effectively.

Strongly Agree	1
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0



10. There is clarity in relation to the work of the committee and its interaction and alignment with other committees.

Strongly Agree	0
Agree	5
Disagree	1
Strongly disagree	0
Unable to answer	0



11. Any other comments, suggestions or actions.

1

Responses

Latest Responses

11. Any other comments, suggestions or actions.

1 Responses

ID↑	Name	Responses
1	anonymous	Regular divisional attendance of all members of the SMT should be in attendance to provide clarity on issues, respond directly to queries and encourage the level of healthy exchange required at a sub-Board meeting.

Liverpool Women's
NHS Foundation Trust

Finance, Performance & Business Development Committee

Annual Report 2021/22

Background

This report covers the period April 2021 to March 2022. There were 11 meetings held during this period. This was in addition to the 10 scheduled meetings for the year. The explanation for this is detailed in the 'Areas for Development' section.

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

Finance and performance

- Receive and consider the annual financial and operational plans and make recommendations as appropriate to the Board.
- Review progress against key financial and performance targets
- 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.
- Review the service line reports for the Trust and advise on service improvements
- Provide oversight of the cost improvement programme
- Oversee external financing & distressed financing requirements
- Oversee the development and implementation of the information management and technology strategy
- Examine specific areas of financial and operational risk and highlight these to the Board as appropriate through the Board Assurance Framework
- To undertake an annual review of the NHS Improvement Enforcement Undertaking.
- To review and receive assurance on the appropriateness of the Trust's Emergency Planning Resilience & Response processes and procedures.

Business planning and development

- 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

- Advise the Board and maintain an oversight on all major investments, disposals and business developments.

- Advise the Board on all proposals for major capital expenditure over £500,000

- Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy

Constitution

The Finance, Performance & Business Development Committee is accountable to the Board of Directors.

Membership during the year comprised:
- Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- Chief Executive
- Chief Finance Officer
- Chief Operations Officer
- Chief Nurse and midwife

Meetings were also attended by other executives and senior management staff as appropriate.

The Committee's constitution allows for members to participate by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference. Due to the on-going Covid-19 pandemic, all meetings during 2021/22 have been held virtually utilising Microsoft Teams.

The Terms of Reference requires that all members of the committee attend a minimum of 75% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2021/22 together with the names of senior management who were invited to attend during the year. The majority of members attended 75% or more of the meetings during 2021/22. This appendix will be updated post meeting so that a full 2021/22 picture can be provided to the Board.

Key achievements / activity

Finance Performance Report

The Committee received this report at each scheduled meeting. The opportunity is taken to scrutinise any area of note challenge, particularly from the lens of the impact

of financial performance on the income and cash position, Trust's CIP programme, capital schemes and expenditure.

Whilst national guidance was delayed, the Committee also received updates on the process for financial and operational planning for 2022/23 and updates in relation to the NHS System Oversight Framework 2021/22.

Operational Performance Report

The Committee received this report at each scheduled meeting. During Quarter 2, attention was given to the quality impact of longer waiting times, specifically for cancer patients. The Committee received regular updates on Recovery and Restoration Trajectory for additional assurance that the Trust was working effectively to recover from the impact caused by the Covid-19 pandemic.

Estates and facilities operational performance data was strengthened during the year and an iterative process of improvement continues.

The Committee received a detailed presentation on the Continuity of Carer (CoC) Pathway noting a shift in national timescales to final implementation of CoC as the default model of care for all patients by March 2023. The financial impact to provide sufficient resources to implement the pathway is being monitored.

Board Assurance Framework (BAF)

The Committee regularly reviewed the Board Assurance Framework risks assigned in line with the business cycle of activities. The Committee held discussions over the rating of specific risks attributable to the Committee noting that they were being managed appropriately. The Committee reported all changes to the BAF at the next following Board of Directors meeting for approval.

NHSI Enforcement Undertaking Review

The Committee received was informed that the Enforcement Undertakings with NHSI/E (nee Monitor) had officially been effectively lifted by NHSI/E stating that there were no longer reasonable grounds to suspect that the Trust was in breach of licence.

Treasury Management Quarterly Report

The Committee received quarterly reports which provided assurance on the strength of financial controls.

Post Implementation Review of Cost Improvement Programme (CIP)

The Committee noted that the full year post implementation review exercise had been undertaken in line with the Well-Led Review recommendations and was part of ensuring good governance and ensuring that lessons learnt from both successful and unsuccessful schemes. During 2020/21 there had been no requirement to deliver or

report on CIP, however where it was deemed safe to do so the Trust initiated those schemes that would not negatively impact during the pandemic meaning that there had still been some achievement on a significant number of schemes.

Digital Services Update

The Committee received this report at each scheduled meeting and sought assurance throughout the year on the Trust's progress to move forward with an Electronic Patient Record solution, progress against Global Digital Exemplar (GDE) objectives (and benefits realisation) and cyber-security. The Committee received regular information governance updates and reviewed the Digital Generations Strategy 2020-2024.

Analytical Review – Annual Accounts 2020/21

The Committee received a detailed paper summarising the key financial statements and an analytical review undertaken on the key differences between the 2019/20 and 2020/21 accounts.

Review of Strategic Progress

Throughout the year, the Committee has been involved in the development of the Trust Corporate Strategy and supporting strategies development and progression.

Crown Street Enhancement Programme

In November 2021, the Committee noted Phase 1 (Fetal Medicine Unit (FMU) enabling works) had been completed and that Phase 2 works (CT and MR imaging and colposcopy) had commenced and is due to complete in December 2022. The Committee sought and were provided assurances regarding the project governance in place and the strategic alignment, affordability and deliverability of the preferred option.

Community Diagnostic Hub Business Case and Updates

The Committee has received regular progress updates on the development of the scheme throughout 2021/22 and was supportive of the business case submitted. The Committee oversaw the governance structure and accepted the chair reports from the Community Diagnostic Centre Oversight Group as additional assurance alongside written progress updates.

Neonatal Capital Programme Build benefits realisation

The Committee received a benefits realisation update one year on after implementation of the Neonatal capital build. The Committee noted the benefits realisation as a positive undertaking.

Annual Business Case Post Implementation Reviews

As part of ongoing quality and process improvement, the Committee received the output from a Business Case Post Implementation Review for all cases from the

2020/21 financial year. The Senior Management Team had been asked to ensure that recommendations are actioned going forward.

Review Marketing Strategy

The review of the Marketing Strategy would be presented to the meeting in April 2022.

Emergency Planning Resilience & Response Annual review

The Committee received a summary report detailing the Trust's compliance to the NHSE/I Emergency Preparedness, Resilience and Response (EPRR) Core Standards based on a self-assessment. The Committee was assured by the EPRR annual assurance outcome of 'Substantial Compliance'.

Hewitt Fertility Centre Strategic and Commercial Review Report

The Committee received assurance regarding the approach and actions planned to deliver on the recommendations within the Commercial & Strategic Review of the Hewitt Fertility Centre.

Modern Slavery Act 2015 – Trust Statement

The Committee reviewed the Trust Statement of compliance against the Modern Slavery Act 2015 and authorised the statement to be published on the Trust's website.

Areas for Development

For the second time, an effectiveness survey was circulated to members of the Committee seeking feedback on the activity of the Committee during 2021/22. On the whole, the responses received were positive – the full results can be seen in Appendix 2. One narrative comment received noted that the chair's log could be utilised more effectively by the Committee.

The Committee held one additional meeting in December 2021.The additional meeting was utilised to provide a focus on seeking assurance that the Trust was adequately monitoring the financial position moving towards year end.

As noted above, the Committee has received quarterly updates on progress with the Trust's strategy. There has been a suggestion that this item might be better placed at the Board itself (considering the key role the Board has in strategy development and monitoring. The Committee may wish to consider whether the update should also be received at its meetings.
One area that has been identified as a potential gap in reporting relates to oversight of the Trust's partnership arrangements. These are becoming increasingly important to the operations of the Trust, and it is therefore suggested that a quarterly summary report is provided to the Committee.

The Committee has a strong track record in its approach to providing oversight to the Trust's financial and operational performance and this has been particularly pertinent during the pandemic (and will likely continue to be so). However, the Committee also has a role to seek assurance on the Trust's approach to business planning and

development. Whilst there are examples of items considered that align with this role (e.g. Hewitt Fertility Centre Strategic and Commercial Review Report), there is more scope to develop this aspect, particularly in relation to receiving intelligence on market share.

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in March 2021 and were approved by the Board in April 2021.

Other than housekeeping amendments e.g. updating of job titles, no other amendments are suggested.

The Terms of Reference is included at Appendix 3.

Proposed Amendments to the Committee Business Cycle

Each of the Committees established by the Board of Directors has an annual business cycle which is subject to review each year. The business cycle forms the 'core' agenda for Committee meetings throughout the year with scheduled business ensuring that the Committee discharges its responsibilities as set out in the Terms of Reference.

The Finance, Performance & Business Development Committee last reviewed its annual business cycle in March 2021 and is therefore scheduled to complete a further review in order to set the business cycle for 2022/23.

All members of the Finance, Performance & Business Development Committee had the opportunity to participate in the annual review and propose any amendments to the business cycle and terms of reference during February 2022 by completing the committee effectiveness survey. The Committee members who responded did not make any suggested amendments to the business cycle or terms of reference.

In addition to the survey, discussions had been held between the Committee Chair, Chief Finance Officer and Trust Secretary to consider means to enhance Committee effectiveness.

During 2021/22, the following amendments to the business cycle were suggested and agreed:

- Premises Assurance Group (as of Oct 2021), Financial Recovery Board (as of Nov 2021), and Community Diagnostic Centre Oversight (as of Nov 2021) added to the sub-committee reporting structure
- Annual Estates and Facilities Compliance report - received April 2021 and agreed to add to the workplan
- Analytical Review on Draft 2020/21 Accounts Report - Received May 2021. Committee agreed that FPBD should review the draft accounts if timescales allow ahead of Audit/Board signoff. Added to the workplan.
- Delivering a Net Zero NHS and Trust Green Plans - report received December 2021. Agreed to add to the workplan on a bi-annual basis

- Modern Slavery Act 2015 – review of Trust statement considered in December 2021. Agreed an annual review should be added to the workplan.
- Assurance regarding third party service provider controls - report received January 2022 and added to the workplan on an annual basis

Other suggested additions / amendments:

- Learning from the major incident (quarterly oversight)
- Major procurement decisions (ad-hoc as necessary)
- Removal of NHSI Enforcement Undertaking Review as matter resolved
- Partnership Oversight (quarterly)
- Market share intelligence (bi-annual)
- Skills Development Network Accreditation (annual)

Suggested amendments linked to the updated Board Lead guidance from NHS England:

- Bi-annual update on the Trust's Security arrangements in relation to assets and estates (violence and aggression issues being picked up by the PPF Committee)
- Annual report to provide assurance on the Trust's procurement processes.

It is likely that key areas of attention during 2022/23 will be as follows:

- Monitoring the Trust's approach to managing a structural deficit and potentially a deficit 2022/23 plan
- Seeking assurance on the work being undertaken to recover and restore services against established trajectories
- Ensuring that there is an appropriate balance between the above two points
- Challenging the Trust in its commercial approach and whether opportunities for private income and being fully realized
- Assessing the Trust's approach to partnerships, including those with the third sector
- Seeking assurance that benefits are being realized from the Trust's digital programmes.
- Working to understand and provide assurance on income security and dynamics.

The draft Business Cycle is included at Appendix 4.

Conclusion

In the final analysis, it is concluded that the Finance, Performance & Business Development Committee has achieved its objectives for the Financial Year 2021/22.

Louise Martin CHAIR
Finance, Performance & Business Development Committee
March 2022

Appendix 1

Finance, Performance & Business Development Committee, Attendance at Committee: April 2021 – March 2022

Core members	April 2021	May 2021	June 2021	July 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Tracy Ellery – Chair	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	A
Louise Martin – Chair as of Oct 2022	✓ observer	NM	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jo Moore	AP	✓	✓	A	NM						
Ian Knight	✓	✓	✓	✓	NM						
Tony Okotie	NM				✓	A	✓	✓	A	✓	✓
Jenny Hannon	✓	✓	✓	✓	✓	NM					
Eva Horgan	NM					✓	✓	✓	✓	✓	✓
Kathryn Thomson	✓	✓	✓	✓	A	✓	✓	✓	✓	A	✓
Gary Price	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓
Marie Forshaw	✓	✓	✓	✓	A	✓	✓	A	✓	A	✓
Present (✓) Apologies (A) Representative (R) Non attendance (NA) Non Member (NM)											

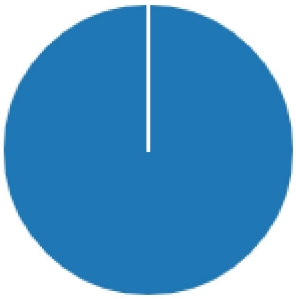
Invited Attendees	Job Title	April 2021	May 2021	June 2021	July 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Robert Clarke	Chair	✓	✓				✓		✓	✓		✓
Eva Horgan	Deputy Director of Finance	✓	✓	✓	✓	✓	See membership above					
Claire Deegan	Deputy Director of Finance	NM									✓	A
Mark Grimshaw	Trust Secretary	AP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matt Connor	Chief Information Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓
Jen Huyton	Head of Strategy & Transformation	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Lynn Greenhalgh	Medical Director	✓		✓	A	✓						✓
Claire Scott	Head of Management Accounts / Acting Deputy Chief Finance Officer (Oct-end Jan)						✓	A	✓	✓		
Susan Roberts	Community Matron				✓							
Matt Butcher	Divisional Manager, Gynaecology					✓		✓				
Joe Downie	Deputy Chief Operating Officer							✓	✓	✓	✓	
Zia Chaudhry	NED, Observer								✓			
Gloria Hyatt	NED, Observer								✓			
Rob Williams	Head of Procurement & Contracts									✓		✓
Philip Moss	Head of Technology										✓	
Nashaba Ellahi	Deputy Director of Nursing & Midwifery										✓	
Philip Bartley	Associate Director of Governance & Quality											✓

2021/22 Finance, Performance & Business Development Committee Effectiveness Survey

6	02:20	Active
Responses	Average time to complete	Status

1. I understand the duties of the committee.

Strongly agree	6
Agree	0
Disagree	0
Strongly disagree	0
Unable to answer	0

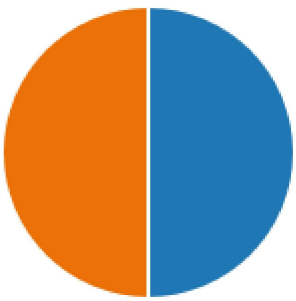


2. I believe the committee receives sufficient assurance to conclude upon its areas of responsibility

Strongly agree	2
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

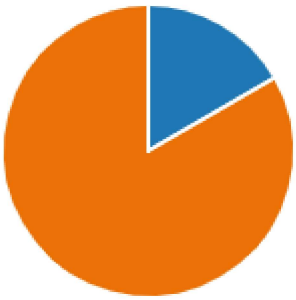
3. I am confident that the committee effectively monitors and scrutinises progress against the aligned strategies.

Strongly agree	3
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0



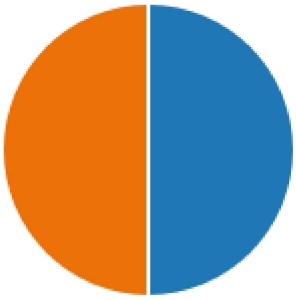
4. I am content that the committee is delivering the right level of assurance to the Board / Committee.

Strongly agree	1
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0



5. I believe that the committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management.

Strongly agree	3
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

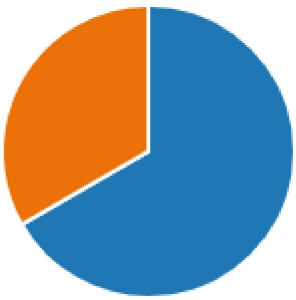


6. I feel that the committee has the right balance of experience, attendance, knowledge and skills to fulfil its role.

Strongly agree	3
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

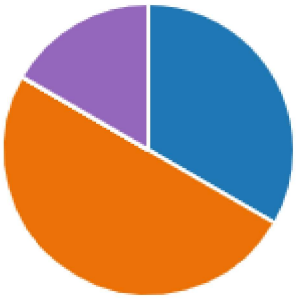
7. The committee has structured its agenda and work plan to cover its key responsibilities.

Strongly agree	4
Agree	2
Disagree	0
Strongly disagree	0
Unable to answer	0



8. The committee is effectively chaired.

Strongly agree	2
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	1

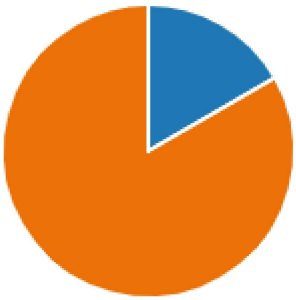


9. All members of the committee are able to participate effectively.

Strongly agree	4
Agree	2
Disagree	0
Strongly disagree	0
Unable to answer	0

10. There is clarity in relation to the work of the committee and its interaction and alignment with other committees.

Strongly agree	1
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0



11. Any other comments, suggestions or actions.

2
Responses

Latest Responses

"Use of the Chair's Log needs to be clarified and utilised more when ne...

11. Any other comments, suggestions or actions.

2 Responses

ID ↑	Name	Responses
1	anonymous	There is a relatively new Chair in situ so difficult to answer at this time. The previous Chair did an excellent job at challenging, supporting and ensuring the views of all committee members were heard.
2	anonymous	Use of the Chair's Log needs to be clarified and utilised more when needed. Allocation of appropriate time on the agenda for each item is being addressed.

Liverpool Women's
NHS Foundation Trust

Putting People First Committee

Annual Report 2021/22

Background

This report covers the period April 2021 to March 2022. There were five meetings held during this period. The November 2021 Committee was cancelled as this was scheduled for the day after the Major Incident experienced by the Trust on 14 November 2021. Two issues were approved outside of the meeting in lieu of an available Committee meeting:

- April 2021: approve draft Corporate Objectives 2021/22
- June 2021: Board Assurance Framework – Update for comment ahead of Board approval
- December 2021: Policy Paper, policies for approval.

The aim of the Putting People First Committee is to develop and oversee the implementation of the Trust's People Strategy, providing assurance to the Board of Directors that this is achieving the outcomes sought and required by the organisation. The terms of reference of the Committee were reviewed in March 2021 and notes the Committee's duties as follows:

a. 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
b. 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)
c. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce
d. 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
e. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues
f. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys
g. Reviewing and approving partnership agreements with staff side

h. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues
i. Monitor and evaluate compliance with the public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics
j. 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
k. 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.
l. Receiving and considering issues from other Committees when appropriate and taking any necessary action

Constitution

The Putting People First Committee is accountable to the Board of Directors.

Membership during the year comprised:
- 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.

Meetings were also attended by other executives and senior management staff as appropriate.

The Committee's constitution allows for members to participate by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference. Due to the on-going Covid-19 pandemic, all meetings during 2021/22 have been held virtually utilising Microsoft Teams.

The Terms of Reference requires that all members of the Committee attend a minimum of 75% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2021/22 together with the names of senior management who were invited to attend during the year. The majority of members attended 75% or more of the meetings during 202/22. This appendix will be updated post meeting so that a full 2021/22 picture can be provided to the Board.

Key achievements / activity

Workforce Key Performance Indicators (KPIs)
The Committee receives a regular report on the Workforce KPIs. Work has progressed throughout the year to improve the report to ensure that it better aligns with the key areas of focus within the workforce domain.

The key areas of attention during 2021/22 related to mandatory training compliance (particularly clinical safety issues) and sickness absence. The Committee oversaw a change to the Trust's approach to managing short term absences within the year and will be continuing to monitor the efficacy of this change into 2022/23.

Continuity of Carer
The Committee received updates throughout the year which detailed the workforce challenges and action taken to deliver the Continuity of Carer model. A staff story from a midwife in a Continuity of Carer team was received.

Guardian of Safe Working Hours (Junior doctors)
The Committee receives quarterly reports on this area and on occasion this has led to issues being escalated to the Committee for further action e.g. missed breaks during the night shift and the impact on the pandemic on junior doctor training.

Leadership and Talent Strategic Framework
The Committees received an update against the Leadership and Talent Strategic Framework noting the introduction of Leadership Forums as an integral part to allow senior leaders to work with executive colleagues in a problem-solving setting.

Ockenden Interim Report
Whilst the Ockenden Report and its recommendations focused predominantly on the quality of midwifery care, the Committee recognised that a significant theme related to staff culture. Updates on staff culture within maternity have therefore been considered during the year. The Trust had also requested that the learning from the report be shared across the whole organisation, and the Committee received assurance of both cross-divisional and corporate reflections.

Freedom to Speak Up
The Committee has received bi-annual updates on the Trust's Freedom to Speak up processes.

Staff Stories
To help support the triangulation of assurance sources, the Committee received a staff story at the majority of meetings. For example, in July 2021, an oversees trainee doctor shared her experience learning at the Trust and embedding into UK culture during the past six years.

Staff Survey
To be completed post March 2022 meeting

Areas for Development

For the second time, an effectiveness survey was circulated to members of the Committee seeking feedback on the activity of the Committee during 2021/22. On the whole, the responses received were positive – the full results can be seen in Appendix 2. One narrative comment received noted that there needs to be enhanced clarity on how the Committee aligns within the Trust's governance structure and interacts with other meetings. There was also a comment that there was uncertainty that the Committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management. To respond to both of these comments, it may be worth holding a committee development session with information on both of these aspects, particularly as the Committee Non-Executive Director membership will be changing moving into 2022/23.

Throughout the business of the Committee during 2022/23, there has also been a couple of instances in which members have noted the importance of continually reviewing the quality of the reports received by the Committee, particularly in relation to the assurance provided. This work will form part of a wider effort across the Trust to strengthen report writing and the quality of assurance provided.

In the recent Assurance Framework review by Mersey Internal Audit Agency there was a recommendation to consider the merits of including a specific section on the BAF in the Chair's Reports from sub-committees to the Trust Board. The Committee is asked to consider, and if deemed appropriate, agreed to this recommendation.

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in March 2021 and were approved by the Board in April 2021. It was proposed last year that the frequency of meetings increase from five to six a year. This enabled a meeting in March to be held which aligns the Committee with other Board level Committees and supports the year-end reporting process.

Reflecting on 2021/22, it is clear that the 'People' agenda is becoming increasingly prominent and ensuring that the Trust has an effective, professional and well-engaged workforce is key to ensuring outstanding patient outcomes and experience. It is therefore suggested that the meeting frequency increased to ten meetings in a calendar year, with the four additional meetings being utilised for 'deep dive' reviews on priority areas.

To align with other Board level Committees (except for the Audit Committee), it is also suggested that the following be added to the 'Quorum' section:

"The Chair of the Trust may be included in the quorum if present"

The draft Terms of Reference is included at Appendix 3.

Proposed Amendments to the Committee Business Cycle

Each of the Committees established by the Board of Directors has an annual business cycle which is subject to review each year. The business cycle forms the 'core' agenda for Committee meetings throughout the year with scheduled business ensuring that the Committee discharges its responsibilities as set out in the Terms of Reference.

The Putting People First Committee last reviewed its annual business cycle in March 2021 and is therefore scheduled to complete a further review in order to set the business cycle for 2022/23.

All members of the Putting People First Committee had the opportunity to participate in the annual review and propose any amendments to the business cycle and terms of reference during February 2022 by completing the committee effectiveness survey. The Committee members who responded did not make any suggested amendments to the business cycle or terms of reference.

In addition to the survey, discussions had been held between the Committee Chair, Chief People Officer, Deputy Director of Workforce and Trust Secretary to consider means to enhance Committee effectiveness.

During 2021/22, the following amendments to the business cycle were suggested and agreed:

- Medical Appraisal & Revalidation Quarterly Report – added as of Sept 2021 based on audit recommendation
- Volunteer Strategy Achievements Annual Report – added to PPF workplan away from the CFC workplan as of 2022/23
- Bi-Annual Safer Staffing Review – changed timetabling 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
- Nursing, Midwifery & AHP Framework Annual Review – removed from the workplan. Agreed to remove Strategy document from organisational structure. (PPF approved the closure and removal of the NMAHP Strategy 2020-2025, acknowledging the likelihood of a National or Regional NMAHP Strategy soon, which will require adoption by the Trust).

It is also suggested to add the following item to support CNST compliance:

- HENW GMC survey feedback report and action plan

As noted in the section above, it is the intention to hold an additional four meetings to the schedule for 2021/22. These meetings will not receive standing items and will enable time for Committee development, staff feedback and deep dives into priority areas.

It is likely that key areas of attention during 2022/23 will be as follows:

- To continue to support the five-year People Strategy and seek progress reports on a regular basis.

- To analyse trend data arising from the monthly KPI data and workforce planning reviews and again identify and mitigate any risks.
- To seek assurance that progress is being made to improve the Trust's sickness absence and mandatory training rates
- To seek assurance that the actions identified from the 2021 Staff Survey are being progressed
- Seek assurance that the Trust is making progress against its Equality, Diversity and Inclusion objectives
- To continue to support the Trust's response to the Ockenden Report by seeking assurance that the Trust can identify any negative cultural issues and take any necessary action in response
- To support the Trust's progress against achieving the Continuity of Carer target through providing assurance on related workforce issues.
- To ensure that robust assurance is available on an improving leadership and organisational culture
- Seeking assurance on robust short, medium and long-term workforce planning and risk mitigation.

The draft Business Cycle is included at Appendix 4.

Conclusion

In the final analysis, it is concluded that the Putting People First Committee has achieved its objectives for the Financial Year 2021/22.

Dr Susan Milner CHAIR
Putting People First Committee
March 2022

Appendix 1

Putting People First Committee, Attendance at Committee: April 2021 – March 2022

Core members	**May**	**July**	**Sept**	**Nov**	**Jan**	**March**
Jo Moore	✓	A	Non member			
Susan Milner	A	✓	✓	Meeting Cancelled	Non Member	
Tracy Ellery	A	✓	✓		✓	✓
Louise Martin	Non member	✓	✓		✓	✓
Michelle Turner	✓	✓	✓		✓	✓
Marie Forshaw	✓	✓	✓		✓	✓
Gary Price	✓	✓	✓		✓	✓
Liz Collins	✓	✓	✓		✓	✓
Dyan Dickins	Non member		✓		✓	A
Claire Scott	A	✓	A		A	Non Member
Claire Deegan	Non member					A
Present (✓) Apologies (A) Representative (R) Non attendance (NA)						

Invited Attendees	Job title	**May**	**July**	**Sept**	**Nov**	**Jan**	**March**
Rachel London	Deputy Director of Workforce	✓	✓	✓		✓	A
Rachel Cowley	Head of Culture and Staff Experience	✓	✓			**A**	✓
Robert Clarke	Chairman		✓			✓	
Nashaba Ellahi	Deputy Director of Nursing & Midwifery		✓	✓			✓
Linda Watkins	Director of Medical Education	✓	✓	✓		✓	✓
Kat Pavlidi	Guardian of Safe Working Hours					✓	
Rochelle Collins	Medical Staffing Advisor / Interim Guardian of Safe working hours May – Sept 2021	✓					
Mark Grimshaw	Trust Secretary	✓	✓	✓		✓	✓
Kathryn Allsopp	HR Business Partner	✓	✓	✓			
Rachel Reeves	HR Business Partner (Family Health)	✓	✓	✓		✓	✓
Angela Hughes	HR Business Partner (Gynae)					✓	✓
Sarah Lucy Thomson	HR Business Partner (CSS)						✓
Kevin Robinson	Freedom to Speak Up Guardian	✓	✓	✓		✓	**A**
Marianne Hamer	Freedom to Speak Up Guardian	✓	✓				
Shri Babarao	Freedom to Speak Up Guardian						✓
Andrew Duggan	Head of Communications & Marketing						✓
Kathryn Thomson	Chief Executive	✓					
Adam Cunliffe	Finance representative	✓					
Kathryn Franey	Head of Learning & Development	✓		✓		✓	✓
Susan Roberts	Matron for Community / Continuity of Carer Lead	✓				✓	
Nicola Murdoch	Divisional Manager	✓					
Kate Walsh	Physiotherapy Manager	✓					
Matt Connor	Chief Information Officer		✓				

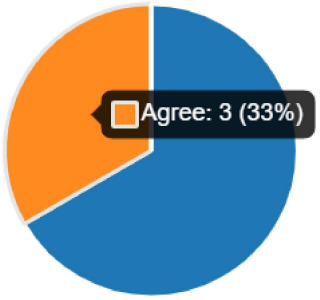
Nuoorul Abidin	Doctor, Obstetrics and Gynaecology		✓				
Alison Murray	Matron, Maternity			✓			
Kathy Smith	Medical & Undergraduate Education & Centre Manager			✓			
Colin Morgan	Consultant Neonatologist			✓			
David Dodgson	Finance Representative			✓			
Emily Anderson	Observer, ST6 Registrar in Clinical Genetics			✓			
Lynn Greenhalgh	Medical Director			✓		**A**	
Laura Doolan	Finance Business Partner					✓	
Loraine Turner	Director of Transformation and Improvement					✓	
Chris Dewhurst	Deputy Medical Director					✓	✓
Zia Chaudhry	Non-Executive Director					✓	
Gloria Hyatt	Non-Executive Director					✓	✓
Jackie Bird	Non-Executive Director						✓
Sarah Walker	Non-Executive Director						✓
Lowri Lloyd-Preston	Head of Nursing & Allied Health Professionals, CSS						✓
Ellen Gerrard	Divisional Manager, CSS						✓
Bheki Thomola	Finance Representative						✓
Rakesh Parikh	Clinical Director, CSS						✓

Putting People First Committee Effectiveness Survey 2021/22

9 Responses 02:03 Average time to complete Active Status

1. I understand the duties of the committee.

Strongly agree	6
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0



2. I believe the committee receives sufficient assurance to conclude upon its areas of responsibility.

Strongly agree	2
Agree	7
Disagree	0
Strongly disagree	0
Unable to answer	0

3. I am confident that the committee effectively monitors and scrutinises progress against the aligned strategies.

Strongly agree	3
Agree	6
Disagree	0
Strongly disagree	0
Unable to answer	0

4. I am content that the committee is delivering the right level of assurance to the Board / Committee.

Strongly agree	2
Agree	7
Disagree	0
Strongly disagree	0
Unable to answer	0

5. I believe that the committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management.

Strongly agree	3
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	1

6. I feel that the committee has the right balance of experience, attendance, knowledge and skills to fulfil its role.

Strongly agree	3
Agree	6
Disagree	0
Strongly disagree	0
Unable to answer	0

7. The committee has structured its agenda and work plan to cover its key responsibilities.

Strongly agree	4
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0

8. The committee is effectively chaired.

Strongly agree	2
Agree	7
Disagree	0
Strongly disagree	0
Unable to answer	0

9. All members of the committee are able to participate effectively.

Strongly agree	2
Agree	7
Disagree	0
Strongly disagree	0
Unable to answer	0

10. There is clarity in relation to the work of the committee and its interaction and alignment with other committees.

Strongly agree	0
Agree	8
Disagree	1
Strongly disagree	0
Unable to answer	0

11. Any other comments, suggestions or actions.

3
Responses

Latest Responses

"*There continues to be changes in the membership of this gr...*

"*I'm not clear on where we report to/how we align with othe...*

11. Any other comments, suggestions or actions.

3 Responses

ID ↑	Name	Responses
1	anonymous	Hefty agendas - but meets less frequently than other Board Committees. Would be interested in view of other members as to frequency change?
2	anonymous	I'm not clear on where we report to/how we align with other committees. I'm not sure I can say we effectively seek assurance we comply with internal and external regulations of governance and risk as I haven't been coming long enough to get a feeling on how we would escalate concerns raised and haven't seen us look at 'all relevant' regulations and standards
3	anonymous	There continues to be changes in the membership of this group and chairing responsibilities due to NeD changes. This needs to be resolved quickly and there needs to be consistency of membership throughout 2022/23.

Liverpool Women's
NHS Foundation Trust

Charitable Funds Committee

Annual Report 2021/22

Background

This report covers the period April 2021 to March 2022. There were four meetings held during this period.

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.

In discharging these duties, the Committee is responsible for:

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.

This remit is achieved through the Committee being appropriately constituted and complying with the duties delegated by the Board of Directors through its terms of reference.

Constitution

The Charitable Funds Committee is accountable to the Board of Directors. Membership during the year comprised:

- Chairman (Non-executive director)
- Two other Non-executive Directors
- Chief Finance Officer
- Deputy Chief Finance Officer
- Chief People Officer
- Chief Nurse & Midwife
- Financial Accountant
- Head of Fundraising

Meetings were also attended by other executives and senior management staff as appropriate.

The Committee's constitution allows for members to participate by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference. Due to the on-going Covid-19 pandemic, all meetings during 2021/22 have been held virtually utilising Microsoft Teams.

The Terms of Reference requires that all members of the committee attend a minimum of 75% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2021/22 together with the names of senior management who were invited to attend during the year. The majority of members attended 75% or more of the meetings during 2020/21. This appendix will be updated post meeting so that a full 2021/22 picture can be provided to the Board.

Key achievements / activity

The key items discussed and reviewed by the Committee during 2021/22 were as follows:

- Regular investment updates have been received from the Charity's Fund Manager. Assurance has been provided on the delivery of fund performance despite the market volatility brought about by the pandemic.
- Regular reports have been received on the financial performance of the charity
- Commissioned a value for money benchmarking exercise to review external provider costs to provide financial services to a charity to ensure best value for money. Assurance was received by the Committee on value for money later in the year.
- Noted the establishment of a Fundraising Group to operationally manage fundraising projects, and a dedicated Fundraising Task and Finish Group to support the 'Give for Gynae' appeal.
- The Committee received an Impact Assessment review against the application of charitable funding across the Trust for staff and patients. The positive benefits demonstrated within the report was acknowledged.
- Review of the Annual Report and Accounts and recommendation for approval by the Board.

Areas for Development

For the second time, an effectiveness survey was circulated to members of the Committee seeking feedback on the activity of the Committee during 2021/22. On the whole, the responses received were positive – the full results can be seen in Appendix 2. The feedback in relation to whether the Committee has the right balance of experience, attendance, knowledge and skills to fulfil its role and on the clarity on the alignment of the Committee within the overall Governance structure will be considered in discussion during 2022/23.

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in March 2021 and were approved by the Board in April 2021. It was proposed last year that the frequency of meetings increase from two to four a year. This has been an effective change and will be retained for 2022/23.

To align with other Board level Committees (except for the Audit Committee), it is also suggested that the following be added to the 'Quorum' section:

"The Chair of the Trust may be included in the quorum if present"

The draft Terms of Reference is included at Appendix 3.

Proposed Amendments to the Committee Business Cycle

Each of the Committees established by the Board of Directors has an annual business cycle which is subject to review each year. The business cycle forms the 'core' agenda for Committee meetings throughout the year with scheduled business ensuring that the Committee discharges its responsibilities as set out in the Terms of Reference.

The Charitable Funds Committee last reviewed its annual business cycle in March 2021 and is therefore scheduled to complete a further review in order to set the business cycle for 2022/23.

All members of the Committee had the opportunity to participate in the annual review and propose any amendments to the business cycle and terms of reference during February 2022 by completing the committee effectiveness survey. The Committee members who responded did not make any suggested amendments to the business cycle or terms of reference.

In addition to the survey, discussions had been held between the Committee Chair, Chief People Officer, Chief Finance Officer and Trust Secretary to consider means to enhance Committee effectiveness.

During 2021/22, the following amendments to the business cycle were suggested and agreed:

- Financial Services Support Costs: Annual Benchmarking Review – new as of September 2021 and added to workplan.
- Review of risks: CFC related risks – new CFC risks created
- Volunteer Strategy Achievements – removed from workplan due to change in reporting lines. Report to go through PPF Committee in the future.

The following additional suggestions for the workplan have been made:

- Review of expenditure - fundraising costs versus other
- Annual review of investments

Suggested changes to the timetabling of the review and approval of the Charitable Funds Annual Report and Accounts were also agreed.

It is likely that key areas of attention during 2022/23 will be as follows:

- To continue to monitor the level of interdebtedness between the Trust and Charity and explore how to reduce this to zero
- To ensure that there is a robust post-implementation process for charitable funds expenditure

- To ensure that there is robust project management in place for the delivery of charitable funded schemes
- To ensure that Charitable Fund activity and spend was aligned with the priorities of the Trust.

The draft Business Cycle is included at Appendix 4.

Conclusion

In the final analysis, it is concluded that the Charitable Funds Committee has achieved its objectives for the Financial Year 2021/22.

Tracy Ellery CHAIR
Charitable Funds Committee
March 2022

Appendix 1

Charitable Funds Committee, Attendance at Committee: April 2021 – March 2022

Core members	**Jun**	**Sep**	**Dec**	**March**
Jo Moore	✓	Non Member		
Tracy Ellery	NM	✓	✓	✓
Tony Okotie	✓	✓	✓	A
Louise Martin	A	✓	✓	✓
Michelle Turner	✓	✓	A	✓
Jenny Hannon* (until end Sept)	A	A	Non Member	
Eva Horgan* (*Nominated Deputy June & Sep. CFO as of Oct*)	✓	✓	✓	✓
Marie Forshaw	✓	A	✓	✓
Chris Gough	✓	A	✓	✓
Kate Davis	✓	✓	✓	✓

Invited attendees	**Job Title**	**Jun**	**Sep**	**Dec**	**March**
David Dodgson	Financial Controller	A	✓	✓	
Mark Grimshaw	Trust Secretary	✓	✓	✓	✓
Andrew Duggan	Communications & Marketing Manager	✓	✓	✓	✓
Nadia Alsafaar	Fundraising Manager	A	✓	✓	✓
Gina Barr	Volunteer Manager	✓			
Nicola Toyer	Investment Director, Investec	✓	✓	✓	

Present (✓) Apologies (A) Representative (R) Non attendance (NA) Non-Member (NM)

Tom Holbrook	Investec Management Services		✓		✓
Rhianna McDermott	Fundraising Admin Assistant	✓	✓		
Jennifer Lloyd	Graduate Intern, LWH		✓		
Zia Chaudhry	Observing, NED			✓	
Gloria Hyatt	Observing, NED			✓	
Claire Deegan	Deputy Chief Finance Officer				✓
Sarah Walker	Observing, NED				✓
Hattie Ella Brignal	Fundraising Assistant				✓
Jackie Bird	Observing, NED				✓

Charitable Funds Committee Effectiveness Review 2021/22

5 Responses 02:29 Average time to complete Active Status

1. I understand the duties of the committee.

Strongly agree	2
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

2. I believe the committee receives sufficient assurance to conclude upon its areas of responsibility.

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0

3. I am confident that the committee effectively monitors and scrutinises progress against the aligned strategies.

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0

4. I am content that the committee is delivering the right level of assurance to the Board / Committee.

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0

5. I believe that the committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management.

Strongly agree	1
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

6. I feel that the committee has the right balance of experience, attendance, knowledge and skills to fulfil its role.

Strongly agree	0
Agree	3
Disagree	1
Strongly disagree	0
Unable to answer	1

7. The committee has structured its agenda and work plan to cover its key responsibilities.

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0

8. The committee is effectively chaired.

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0

9. All members of the committee are able to participate effectively.

Strongly agree	2
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

10. There is clarity in relation to the work of the committee and its interaction and alignment with other committees.

Strongly agree	0
Agree	3
Disagree	1
Strongly disagree	0
Unable to answer	1

11. Any other comments, suggestions or actions.

1
Responses

Latest Responses

"*I have been a member and Chair of the Charitable Funds C...*

11. Any other comments, suggestions or actions.

1 Responses

ID ↑	Name	Responses
1	anonymous	I have been a member and Chair of the Charitable Funds Committee for less than a year so some of the questions were difficult to answer at this stage. The change of membership of the Committee is another factor. Once the membership is established with the new intake of Non Executive Directors some of these aspects can be assessed more accurately.

QUALITY COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Quality Committee (QC) (the Committee).
Duties:	The Committee's responsibilities fall broadly into the following three areas: **Strategy and Performance** a) Oversee the development and implementation of the Quality Strategy with a clear focus on upholding the tenants of quality (Governance, safety, patient experience and clinical effectiveness). b) Ensure that the Quality Strategy and performance are consistent with the Trust's; Vision and strategic objectives and oversee any initiatives undertaken by the Trust that relates to the development and implementation of the Quality Strategy. c) Review trends in patient safety, experience and outcomes (effectiveness) to provide assurance to the Board on performance and commission 'deep dives' as appropriate. d) To receive assurance that action plans arising from in-patient, out-patient and other care related surveys are being undertaken and make recommendations to the Board as appropriate. e) Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery. **Governance** f) Oversee the effectiveness of the clinical systems developed and implemented to ensure they maintain compliance with the Care Quality Commission's Fundamental Standards in relation to Quality, Safety, experience and effectiveness. g) Obtain assurance of the Trust's ongoing compliance with the Care Quality Commission registration. h) Review the controls and assurance against relevant quality risks on the Board Assurance Framework and provide assurance to the Board that risks to the strategic objectives relating to quality and safety are being managed and facilitate the completion of the Annual Governance Statement at year end. i) Obtain assurance that the Trust is compliant with guidance from NICE (through receipt of an Annual Report) and other related bodies. j) Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices from NHSI, the Care Quality Commission, the Health and Safety Executive and other external assessors.

	k) Receive the annual clinical audit programme and provide assurance to the Board that clinical audit supports the Trust to provide safe and clinically effective patient care and obtain assurance that there is delivery against agreed annual clinical audit programme. l) Implement and monitor the process for the production of the Trust's year end Quality Report before it is presented to the Trust Audit Committee and Board for formal approval. m) Undertake an annual review of the Quality and Risk Management Strategies to ensure that they reflect all required priorities. n) To have oversight of the Committees performance measures to ensure they are appropriate and provide assurance of compliance and escalate exceptions to Trust Board. o) To review the proposed internal audit plan for all functions areas within the Committees remit e.g. Clinical Audit, Safety, Experience and Effectiveness. p) Review the Trust's Research and Development Strategy and Innovation Strategy prior to their recommendation it to the Board of Directors. q) Approving the terms of reference and memberships of its subordinate committees. Overall r) To approve any matters that, due to time constraints, could not be approved by the Board within the scope of the Committees areas of responsibility. s) Referring relevant matters for consideration to other Board Committees as appropriate. t) Considering relevant matters delegated or referred to it by the Board of Directors or referred by any of the Board Committees. u) Escalating matters as appropriate to the Board of Directors. Assurances will be provided from internal and external sources and will be included in a work plan approved by the Committee at the commencement of each financial year.
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors • *Medical Director • *Chief Nurse and Midwife • *Chief Finance Officer • *Chief People Officer • *Chief Operating Officer • Deputy Director of Nursing and Midwifery • Associate Director of Quality and Governance *or their nominated representative who will be sufficiently senior and have the authority to make decisions.

	Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be three members including two Non-Executive Directors and one Executive Director (one of whom must be either the Medical Director or Director of Nursing and Midwifery or their deputy). The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	a) Members Members will be required to attend a minimum of 75% of all meetings. b) Officers The Trust Secretary shall normally attend meetings. Other executive directors (including the Chief Executive) and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held monthly. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of 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 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.
Reporting Committees/ Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • Safety and Effectiveness Sub-Committee • Patient Involvement & Experience Sub-Committee • Corporate Risk Sub-Committee • Trust Safeguarding Sub-Committee • Research and Development Sub-Committee • Maternity Transformation Board
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Quality Committee	28 March 2022
Approved by Board of Directors:	[April 2022]
Review date:	March 2023
Document owner:	Mark Grimshaw, Trust Secretary, Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

NHS
Liverpool Women's
NHS Foundation Trust

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

Edited November 2021 to add Premises Assurance Group as a reporting group

	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 • ~~Director of Finance~~ Chief Finance Officer • ~~Director of Operations~~ Chief Operations Officer • ~~Director of Nursing and Midwifery~~ 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:	**a. Members** Members will be required to attend a minimum of 50% of all meetings. **b. Officers** Ordinarily the Deputy Director of Finance and Trust Secretary will attend all meetings. Other executive directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

Edited November 2021 to add Premises Assurance Group as a reporting group

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 • Premises Assurance Group • Financial Recovery Board • Community Diagnostic Centre Oversight

Edited November 2021 to add Premises Assurance Group as a reporting 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	28 March 2022
Approved by: Board of Directors	TBC
Review date:	March 2023
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

Edited November 2021 to add Premises Assurance Group as a reporting group

NHS
Liverpool Women's
NHS Foundation Trust

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: a. 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 b. 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) c. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce d. 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 e. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues f. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys g. Reviewing and approving partnership agreements with staff side h. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues i. Monitor and evaluate compliance with the public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics j. 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 k. 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. l. 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:

Edited November 2021 to amend group names within Reporting Committee's & Groups

	• Non-Executive Director (Chair) • 2 other Non-Executive Director • *Chief People Officer • *~~Director of Nursing & Midwifery~~ Chief Nurse & 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 Director of Nursing and Midwifery • Director of Operations or their Deputy • Either Staff Side Chair or Medical Staff Committee representative • The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. **b. Officers** 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 10 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: • Equality, Diversity & Inclusion Committee • Health & Wellbeing Committee • Partnership Forum • Professional Forum of Nurses, Midwives & AHP's • 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.

Edited November 2021 to amend group names within Reporting Committee's & Groups

Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Putting People First Committee:	21 March 2022
Approved by Board of Directors:	TBC
Review date:	March 2023
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

Edited November 2021 to amend group names within Reporting Committee's & Groups

NHS
Liverpool Women's
NHS Foundation Trust

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 • ~~Director of Finance~~ Chief Finance Officer (or nominated deputy) • ~~Director of Workforce and Marketing~~ Chief People Officer • ~~Director of Nursing and Midwifery~~ Chief Nurse & 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. The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. **b. Officers** The 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:	21 March 2022
Approved by: Board of Directors	TBC
Review date:	March 2023
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

Liverpool Women's NHS Foundation Trust

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 ~~Director of Finance~~ Chief Finance Officer, ~~Deputy Director of Finance~~ Deputy Chief Finance Officer, Financial Controller and Deputy Chief Nurse & Midwife ~~Director of Nursing & Midwifery~~ shall normally attend meetings. At least once a year the Committee will meet privately with external and internal auditors. The Chief Executive and other executive directors will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are within the responsibility of that director. The Chief Executive will also be required to attend when the Audit Committee discusses the process for assurance that supports the Annual Governance Statement. The Trust Secretary will attend to provide appropriate support to the Chair and Committee members.
Frequency:	Meetings shall be held at least four times per year. The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of 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:	24 March 2022
Approved by Board of Directors:	TBC
Review date:	March 2023
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

NHS
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Quality Committee

	BAF Link	Executive Owner	Report up to Board	WORKPLAN 2022 / 23											
				Quarter 1			Quarter 2			Quarter 3			Quarter 4		
				25 April 2022	23 May 2022	27 June 2022	25 July 2022	22 Aug 2022 TBC	26 Sept 2022	24 Oct 2022	21 Nov 2022	19 Dec 2022 TBC	23 Jan 2023	20 Feb 2023	27 Mar 2023
Standing Items															
Minutes of Previous meeting	N/A	TS		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Actions/Matters Arising	N/A	TS		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Chairs Report - Verbal	N/A	Chair		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Monthly Quality Performance Report	All	COO	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of BAF risks	All	CNM	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Quality and Regulatory update – internal reviews (CQC assessments) and External guidelines, statute best practice etc. to be reported by exception	5.2	CNM		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of risk impacts of items discussed	5.2	Chair		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Any other business	N/A	Chair		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of meeting	5.2	Chair		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Annual Reports & Strategies															
Infection Prevention and Control Annual Report	3.1	CNM	✓			✓									
Annual Safeguarding Report	3.1	CNM	✓				✓								
Annual Health & Safety Report	3.1	COO	✓			✓									
Research & Development Annual Report	5.1	MD	✓			✓									
Research and Innovation Strategy and Review	5.1	MD	✓			✓									✓
Complaints Annual Report	3.1	CNM					✓								
Security Management Annual Report	2.2	COO			✓										
Legal Services Annual Report	5.2	CNM								✓					
Review of Annual Quality Report (prior to AC/Board)	5.2	MD	✓		✓										
Review of Quality Strategy (bi-annual)	5.2	MD		✓					✓						
NICE Annual Report	2.2	MD					✓								
Palliative and End of Life Care Report (bi-annual)	3.1	MD													
Patient															
Serious Incidents & Learning Report	5.2	CNM	✓	✓ (Q4)	✓	✓	✓ (Q1)		✓	✓ (Q2)	✓		✓ (Q3)	✓	✓
Mortality and Perinatal Report (Learning from Deaths)	3.1	MD	✓		✓(Q4)				✓(Q1)		✓(Q2)			✓(Q3)	
Integrated Governance Assurance Report	5.2	CNM			✓(Q4)		✓(Q1)				✓(Q2)			x(Q3)	✓(Q3)
Medicines Management Assurance Report	3.1	MD			✓ (Q4)		✓ (Q1)			✓ (Q2)			✓(Q3)		
LocSSIPs Quarterly Assurance Report	3.1	MD			✓ (Q4)		✓(Q1)			✓(Q2)				✓ (Q3)	
Seven Day Working Board Assurance – 6 monthly	2.3	MD		✓						✓					
Ockenden Report Update	3.1	CNM		✓	✓		✓		✓		✓		✓		✓
Safety Champion Update (quarterly)	3.1	CNM		✓			✓			✓			✓		
Safeguarding Quarterly Report	3.1	CNM				✓ (Q4) 2022			✓ (Q1)					✓ (Q2)	✓ (Q3)
Patient Survey/s (to be reported by exception)	3.1	CNM													
Risk															
Annual Review of Risk Management Strategy	5.2	CNM	✓												✓
Risk Appetite Statement – Quality Committee	5.2	CNM	✓												✓
General Governance Arrangements															
Ward Accreditation Scheme - annually	5.2	CNM				✓									
CQC Insight Tool *(bi-monthly)*	5.2	CNM			✓		✓		✓		✓		✓		✓
CNST Progress Report	3.1	CNM		✓	✓								✓	✓	✓
Clinical Audit work plan & annual report	5.2	MD		✓ (WP)					✓ (AR)						
Corporate Objectives: 6 monthly and year-end review & Objective Setting	5.2	TS	✓	✓ (OS)					✓						✓
Terms of reference review and business cycle	5.2	TS													✓
QC Committee Annual Report	5.2	TS													✓

Liverpool Women's
NHS Foundation Trust

Quality Committee				WORKPLAN 2022 / 23											
				Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	BAF Link	Executive Owner	Report up to Board	25 April 2022	23 May 2022	27 June 2022	25 July 2022	22 Aug 2022 TBC	26 Sept 2022	24 Oct 2022	21 Nov 2022	19 Dec 2022 TBC	23 Jan 2023	20 Feb 2023	27 Mar 2023
Subcommittee chairs reports and Terms of Reference • Safety & Effectiveness Sub-Committee • Patient Involvement & Experience Sub-Committee • Corporate Risk Sub-Committee • Trust Safeguarding Sub-Committee • Research and Development Sub-Committee • (Maternity) Transformation Board	N/A														

KEY CODE
Deferred due to COVID-19 implications (Staff remitted to other actions to address COVID-19 within the Trust; National suspension).
Item considered as planned
Item considered following deferral

Q=Quarter WP=Work plan AR=Annual Report AP=Annual Plan OS=Objective Setting

NHS
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NHS Foundation Trust

Finance, Performance and Business Development Committee	BAF Link	Report up to Board	Exec Lead	WORKPLAN 2022/23											
				Quarter 1			Quarter 2			Quarter 3			Quarter 4		
				25 April 2022	23 May 2022	27 June 2022	25 July 2022	22 Aug TBC	26 Sept 2022	24 Oct 2022	21 Nov 2022	19 Dec TBC	23 Jan 2023	20 Feb 2023	27 Mar 2023
Standing Items															
Minutes of Previous meeting	N/A		TS	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Actions/Matters Arising	N/A		TS	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Chairs Report - Verbal	N/A		Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of Board Assurance Framework Risks	**All**	✓	CFO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Subcommittee Chairs reports & Terms of Reference: • Emergency Planning Resilience & Response Committee • Digital Hospital Sub-Committee • Crown Street Enhancement Programme Board • Future Generations Project Group • Premises Assurance Group • Financial Recovery Board • Community Diagnostic Centre Oversight	N/A		COO CIO CFO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of risk impacts of items discussed	N/A		CFO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Any other business	N/A		Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of meeting	5.2		Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
MATTERS FOR DISCUSSION & BOARD ACTION/DECISION															
To be ambitious and efficient and make best use of available resources															
Monthly Finance Performance review (Incl CIP)	**4.1**	✓	CFO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Monthly Operational Performance review	**2.2**	✓	COO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Treasury Management Quarterly Report	4.1		CFO	✓			✓			✓			✓		
Post Implementation Review of Cost Improvement Programme (CIP)	5.2 & 4.1		CFO		✓					✓					
Review of unaudited Annual Accounts (prior Audit)	**4.1**	✓	CFO		✓										
Review of Strategic Progress	2.1, 2.2 & 2.3		CFO	✓			✓			✓			✓		
Crown Street Enhancement Progress Review	2.3		CFO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Neonatal Capital Programme Build benefits realisation	2.3		CFO								✓				
Annual Business Case Post Implementation Reviews	5.2		CFO								✓				
Review Marketing Strategy	2.2		CPO							✓					
Digital Services Update	2.2		CFO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Digital Generations Strategy 2020-2024 Bi-annual review	2.2		CFO				✓						✓		
Information Governance Update	2.2		SIRO	✓			✓			✓			✓		
Revenue and capital budget for 2023/24	**4.1**	✓	CFO												✓
Operational Planning: Six monthly review (2022/23) and Operational Planning (2023/24)	**2.2 & 4.1**	✓	COO						✓ **(BR)**						✓
Corporate Objectives: • Bi-annual (BR) & Year-end review (AR) • Objective Setting for 2022/23 (OS)	**5.2**	✓	TS/Exec	✓**(OS)**					✓ **(BR)**						✓**(AR)**

				WORKPLAN 2022/23											
Emergency Planning Resilience & Response (EPRR) Annual Report	**2.2**	✓	COO	✓											
EPRR NHSE/I Annual Assurance Process Outcome	**2.2**		COO								✓				
Analytical Review on Draft 2021/22 Accounts	**4.1**	✓	CFO		✓										
Annual Estates and Facilities Compliance Report	***2.2***		COO	✓											
Assurance regarding third party service provider controls	***4.1***		CFO										✓		
Delivery a Net Zero NHS and Trust Green Plans	***2.2***		COO				✓						✓		
Learning from the major incident (quarterly oversight)	***2.2***		COO	✓			✓			✓			✓		
Major procurement decisions (ad-hoc as necessary)	***4.1***		CFO												
Modern Slavery Act 2015 Annual review	***5.2***		TS								✓				
Skills Development Network Accreditation	***1.2***		CFO	✓											
Partnership Oversight (quarterly)	***4.2***		CFO		✓		✓				✓			✓	
Market share intelligence (bi-annual)	***2.2***		CFO				✓						✓		
General Governance Arrangements															
Review of Risk Appetite Statement 2023/24	**5.2**	✓	CNM												✓
FPBD Committee Effectiveness Annual Report	**5.2**	✓	CFO												✓
FPBD Terms of Reference	**5.2**	✓	TS												✓
FBPD Business Cycle	5.2		TS												✓

COLOUR KEY

Deferred

Item considered as planned

Item considered following deferral

Q=Quarter WP=Work plan AR=Annual Report AP=Annual Plan OS=Objective Setting

Putting People First Committee				WORKPLAN 2022/23									
				Quarter 1			Quarter 2		Quarter 3		Quarter 4		
	BAF Link	Executive / Senior Owner	⇧ to Board	April	16 May 2022	20 June 2022	18 July 2022	19 Sept 2022	17 Oct 2022	14 Nov 2022	16 January 2023	13 Feb 2023	20 March 2023
Minutes of Previous meeting	N/A	TS			✓		✓	✓		✓	✓		✓
Actions/Matters Arising	N/A	TS			✓		✓	✓		✓	✓		✓
Chairs Report - Verbal	N/A	Chair			✓		✓	✓		✓	✓		✓
Review of risk impacts of items discussed	5,2	Chair			✓		✓	✓		✓	✓		✓
Any other business	N/A	Chair			✓		✓	✓		✓	✓		✓
Review of meeting	5,2	Chair			✓		✓	✓		✓	✓		✓
Review of BAF risks: Workforce related risks	5,2	CPO	✓		✓		✓	✓		✓	✓		✓
Workforce KPI Dashboard Report	5,2	DDoW			✓		✓	✓		✓	✓		✓
Director of Workforce Report	5,2	CPO			✓		✓	✓		✓	✓		✓
Policies for Approval & Policy Audit Update	5,2	DDoW			✓		✓	✓			✓		✓
To develop a well led, capable, and motivated workforce													
Staff Story	1.1 & 1.2	CPO		✓		✓			✓			✓	
Service Workforce Assurance	1,2	CPO / COO / CNM / DDoW			**Medical workforce**		**Corporate**			**Family Health**	**Clinical Support Services**		**Gynaecology & Hewitt**
Talent Management & Leadership Development Review	1,2	DDoW			✓								
HEE Quality Framework Annual Assessment	1,2	DoME								✓			
HENW GMC survey feedback report and action plan	1,2	DoME								✓			
Director of Medical Education Annual Report	1,2	DoME											✓
Medical Appraisal & Revalidation Annual Report	1,2	MD	✓					✓					
Medical Appraisal & Revalidation Quarterly Report	1,2	MD			**Q4**			**Q1**		**Q2**	**Q3**		
Pharmacy Revalidation Annual Report	5,2	MD						✓					
Freedom to Speak Up Guardian Update	1.1 & 1.2	F2SUG						✓					✓
Staff Listening Events Report (to Board)	1,2	DDoW	✓				✓						✓
Flu Campaign	5,2	DDoW	✓					✓					
Volunteer Strategy Achievements Annual Report	2.2 & 4.2	CPO			✓								
To be efficient and make best use of available resources													
Review of External Contracts	5.2 & 4.1	DDoW						✓					
Disciplinary and Grievance processes annual review	1,2	DDoW					✓						
Workforce Planning Return	1,2	DDoW											✓
Freedom to Speak Up Guardian Annual Report including Whistleblowing	1.1 & 1.2	F2SUG	✓										✓
Bi-Annual Safer Staffing Review	1,2	CNM	✓					✓ **Q4 & Q1**					✓ **Q2&Q3**
To deliver the most effective outcomes													
Equality, Diversity and Inclusion Annual Report inlcuding Equality Objectives	1,1	DDoW	✓										✓
Equality, Diversity and Inclusion including WRES/WDES/Gender Pay Gap	1,1	DDoW						✓					✓
Putting People First Strategy 2019-2024 Annual Review (including Volunteer workforce)	1.1, 1.2 & 2.2	DDoW	✓										✓
Communications, Marketing and Engagement Strategy Annual Review	2.2 & 4.2	CPO											✓
To deliver the best possible experience for patients and our staff													
Staff Engagement and NHS Staff Survey Annual Results & Action Plan (Annual and Bi-annual Review)	1.1 & 1.2	Head of Culture and Staff	✓ (annual)					✓ **(bi-annual)**					✓ **(annual)**
Fair and Just Culture Update	1.1 & 1.2	Head of Culture and Staff						✓					✓
Guardian of Safe Working Hours (Junior Doctors) Quarterly Report	1,2	MD / G4SWH	✓ **(AR)**		✓ **(Q4 AR)**			✓ **(Q1)**		✓ **(Q2)**	✓ **(Q3)**		
GOVERNANCE													

Review of Risk Appetite Statement	5,2	DoNM	✓										✓
Annual review of Corporate Objectives aligned to PPF & Objective setting	5,2	CPO	✓					✓ (bi-annual)					✓ (annual & OS)
PPF Terms of reference review	5,2	TS	✓										✓
PPF Committee Annual Report	5,2	CPO / TS	✓					✓ (bi-annual)					✓
PPF Business Cycle	5,2	CPO / TS											✓
Subcommittee chairs reports and Terms of reference: * Equality, Diversity and Inclusion Committee * Education Governance Committee * JLNC * Health & Wellbeing Group * Partnership Forum * Professional Forum of Nurses, Midwives & AHP's													

KEY CODE
Deferred due to COVID-19 implications. Staff remitted to other actions to address COVID-19 within the Trust
Item considered as planned
Item considered following deferral

Q=Quarter WP=Work plan AR=Annual Report AP=Annual Plan OS=Objective Setting

NHS
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Charitable Funds Committee		WORKPLAN 2022/23					
				Quarter 1	Quarter 2	Quarter 3	Quarter 4
Standing Items	**BAF Link**	**Exec / Senior Owner**	**to Board**	**20-jun-22**	**19-sep-22**	**12-des-22**	**20-mar-23**
Minutes of Previous meeting	N/A	Trust Secretary		✓	✓	✓	✓
Actions/Matters Arising	N/A	Trust Secretary		✓	✓	✓	✓
Chairs Report - Verbal	N/A	Chair		✓	✓	✓	✓
Review of risk impacts of items discussed	5,2	Chair		✓	✓	✓	✓
Any other business	N/A	Chair		✓	✓	✓	✓
Review of meeting	5,2	Chair		✓	✓	✓	✓
Review of risks: CFC related risks	5,2	Chief People Officer		✓	✓	✓	✓
MATTERS FOR DISCUSSION & COMMITTEE							
Charitable Funds Strategy Review	4.1 & 4.2	Chief People Officer		x		✓	
Quarterly Financial Position Report	4,1	Chief Finance Officer		✓	✓	✓	✓
Approval of Annual Report and Accounts	4,1	Chief Finance Officer	✓	✓ (Draft)	✓		
Revenue & Capital Budget for 2023/24	4,1	Chief Finance Officer					✓
CF Applications Impact Annual review	4.1 & 2.2	Chief Finance Officer		✓			
Review of expenditure - fundraising costs versus other	4,1	Chief Finance Officer				✓	
Financial Services Support Costs: Annual Benchmarking Review	4,1	Chief Finance Officer			✓		
Investment Report	4,1	Investec			✓	✓	✓
Annual review of investments	.2 & 4.1	Chief People Officer					✓
Fundraising Update	4.1, 2.2 &	Chief People Officer		✓	✓	✓	✓
Authorisation of funding applications expenditure (as required)	4,1	Chief Finance Officer		✓		✓	
Review of Fund Signatories'	5,2	Chief Finance Officer				✓	
MATTERS FOR APPROVAL / DECISION							
CFC Terms of Reference	5,2	Trust Secretary	✓				✓
CFC Effectiveness Review Annual Report	5,2	Trust Secretary	✓				✓
CFC Business Cycle	5,2	Trust Secretary					✓

Liverpool Women's NHS Foundation Trust
Audit Committee Business Cycle 2022/23

Item	BAF Link	Exec lead	16 June 2022	21 July 2022	20 October 2022	19 January 2023	23 March 2023
MATTERS FOR APPROVAL/DECISION							
Standing Items							
Minutes of Previous meeting	N/A	TS		✓	✓	✓	✓
Actions/Matters Arising	N/A	TS		✓	✓	✓	✓
Chairs Report - Verbal	N/A	Chair		✓	✓	✓	✓
Board Assurance Framework	All	TS		✓	✓	✓	✓
Review of risk impacts of items discussed	5,2			✓	✓	✓	✓
Any other business	N/A			✓	✓	✓	✓
Review of meeting	5,2			✓	✓	✓	✓
MATTERS FOR DISCUSSION & COMMITTEE ACTION/DECISION							
Data Assurance Report	5,2	CIO					✓
Follow up of Internal and External Audit Recommendations	5,2	CFO		✓	✓	✓	✓
Register of waivers of standing orders	5,2	CFO		✓	✓	✓	
Areas of Judgement in the Annual Accounts	5,2	CFO					✓
Losses and special payments	5,2	CFO					✓
Raising staff concerns arrangements	5,2	CPO		✓			
Settlement agreements annual report ***for 22/23 programme - to be part of year-end documentation.***	5,2	CN&M	✓				
Bribery Act compliance	5,2	TS			✓		
Review of Board, Governor and Staff register of interests	5,2	TS					✓
Review of Board, Governor and staff register of gifts and hospitality	5,2	TS					✓
Corporate governance manual review	5,2	TS		✓			
Review of assurances processes:	5,2	TS					
• Integrated governance	5,2				✓		
• risk management	5,2						✓
• External Inspections and Accreditations	***5,2***			✓			
Counter fraud							
Counter fraud progress report	5,2	IA		✓	✓	✓	✓
Counter fraud annual report 2021/22	5,2	IA	✓				
Counter fraud work plan 2023/24	5,2	IA					✓
Internal audit							
Head of Internal Audit's opinion and annual report Draft/Final	5,2	IA	✓				✓
Internal Audit Work Plan 2023/24	5,2	IA					✓
Internal audit progress report	5,2	IA		✓	✓	✓	✓
Review of Internal Audit Charter	5,2	IA					✓
Follow up of Internal and External Audit Recommendations	***5,2***	IA		✓		✓	

Liverpool Women's NHS Foundation Trust
Audit Committee Business Cycle 2022/23

Annual Review of effectiveness of Internal audit	5,2	Chair		✓			
External audit							
External audit findings (ISA 260) ***and management letter***	5,2	EA	✓				
External Audit Technical Update (formerly progress report)	5,2	EA		✓	✓	✓	✓
External Audit Plan	5,2	EA				✓	
Review of effectiveness of external audit	5,2	Chair		✓			
Financial Reporting							
Annual Governance Statement	5,2	TS	✓				
Annual report, quality report and financial accounts (to include Code of Governance compliance & Salient Features)	5,2	CFO/MD/TS	✓				
Audit Committee Annual Report	5,2	TS/CFO	✓				
Code of Governance Compliance & NED independance Dec's	5,2	TS	✓				
Other Assurance Functions							
Review of Board Committee Annual Reports	5,2	TS		✓			
Review of Divisional Governance Arrangements (rota) ****March meeting to enable reflection on whole process***	5,2			TBC	TBC	TBC	✓*
Review of Chair reports of Board Committee meetings • Finance, Performance and Business Development Committee	5,2	TS		✓	✓	✓	✓
• Quality Committee				✓	✓	✓	✓
• Putting People First Committee				✓	✓	✓	✓
Clinical Audit Forward plan		MD					✓
Clinical Audit Annual Report & Mid Year Update		MD			✓		
General Governance Arrangements							
Review of Audit Committee effectiveness	5,2	TS/CFO		✓	✓		
Review of Committee terms of reference	5,2	TS					✓
Committee business cycle 2023/24	5,2	TS					✓
Private discussion with auditors (internal and external) when required		Chair		✓	✓	✓	✓

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/16*		Date: 07/04/2022	
Report Title	**Revised Risk Management Strategy for 2022-23**			
Prepared by	*Allan Hawksey, Risk and Patient Safety Manager* *Phil Bartley, Associate Director of Governance and Quality*			
Presented by	*Phil Bartley, Associate Director of Governance and Quality*			
Key Issues / Messages	The Board is requested to review and approve the proposed Risk Management Strategy for 2022/23.			
Action required	Approve ☒	Receive ☐	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is requested to review and approve the proposed Risk Management Strategy for 2022/23.			
Supporting Executive:	*Marie Forshaw, Chief Nurse and Midwife*			

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

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* Choose an item.	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee & Audit Committee	March 22	CN&M	Recommended for approval by the Board

EXECUTIVE SUMMARY

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

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

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

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

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

MAIN REPORT

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

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

Proposed Risk Management Strategy for 2022/23

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

- Reviewed statement of intent from the Chief Executive (subject to finalisation by the Chief Executive)
- Update wording regarding the underpinning of the BAF by Key Strategic Threats
- Risk team profile (and key contacts) including divisional governance management structure

Risk Management Strategy

Liverpool Women's NHS Foundation Trust

Version 15.0
March 2022

Contents (to be re numbered once main body is finalised)

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

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

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

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

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

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

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

Kathryn Thomson
Chief Executive

2 Introduction

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

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

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

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

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

2.1 The Core Elements of the Strategy

Risk Management Process

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

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

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

Governance Structure to Support Risk Management

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

- Board of Directors
- Executive Management Team

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

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

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

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

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

2.2 Aim

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

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

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

in corporate services including business planning, service development, financial planning, project and programme management and education.

2.3 Risk Appetite and Statement

Risk Appetite

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

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

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

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

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

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

Risk Appetite Statement

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

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

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

Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is

exceeded, action taken to reduce the risk.

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

2.4 Responsibility and Accountability

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

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

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

2.5 Individual Responsibilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Support the development of a patient safety culture and safety systems.
- Engage directly with the executive team.
- Lead, oversee or support patient safety improvement and ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes.
- Promote patient safety thinking beyond things going wrong to why things routinely go right healthcare and the systems approach to patient safety.

- Implement the rollout out of the new Patient Safety Incident Response Framework expected from Autumn 2022.

Senior Managers

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

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

Risk and Patient Safety Manager

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

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

All Staff

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

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

2.6 Committee Duties and Responsibilities

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

meetings.

Board of Directors

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

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

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

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

Audit Committee

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

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

Finance, Performance and Business Development Committee

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

Quality Committee

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

Putting People First Committee

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

Trust Executive Team

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

2.7 Clinical Services and Corporate Risk Management Arrangements

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

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

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

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

Corporate Risk Sub Committee

The Sub Committee consists of a quorate of new members and functions to ensure effective oversight and scrutiny of the entire business of the Trust, the relationship between the Corporate Risk Sub Committee, and the other Board Sub- Committees, is based on inclusiveness, clarity of purpose and constructive challenge. The Corporate Risk Sub Committee will oversee the management of all corporate risks, reviewing closed assurance and new risk reports and will provide the Audit Committee with assurance on the effective operation of internal controls. The Trust's divisions (Corporate, Family Health, Clinical Support Services and Gynaecology) report to the Committee bi-annually.

3 Process for Managing Risk

Stage 1 – Clarifying Objectives

Whether a new risk has been identified or staff need to know what to do next; clarifying objectives is a critical stage of the risk management process. To understand whether something constitutes a risk it must first be understood what are the objectives/outcomes to be achieved.

Strategic or corporate objectives; to identify and clarify which Trust strategic or corporate objective is relevant to the division, directorate, or service. Look at the Trust business plan and the latest local business plan. If this step is missed or omitted then the risk register will be neither relevant nor effective.

Local objectives should also be considered. By clarifying the objectives it can be identified whether there is a risk to manage.

Stage 2 – Identifying Risks to Objectives

Once the objectives have been identified then risks can start to be identified. Consider the following questions:

- Do you know what all of the risks to the delivery of your objectives or work are, especially those that impact on delivering high quality, safe services?
- What could happen, and what could go wrong?
- How and why could this happen?
- What is depended upon for continued success?
- Is there anyone else who might provide a different perspective on your risks?
- Is it an operational risk or a risk to a strategic objective?

If possible gather those staff together who are able to assist with the identification of risk for the area. Guidance on how to do this is available from the Governance Team (Section 6).

Stage 3 – Defining and Recording Risks

Once the risk has been identified then:

- Undertake a comprehensive risk assessment
    - Describe the risk, so that others understand what the risk is in relation to the description of condition, cause and consequence, being clear for each one.
    - Complete an initial risk assessment score so that the risk is appropriately escalated to management where required
    - Assign an owner to the risk who will oversee the risk management and review the initial score
    - List the key controls (actions) being taken to reduce the likelihood of the risk happening, or reduce the impact.
    - If it is a severe risk (use risk matrix Appendix A) then consider what the contingency action plan is, i.e. what will you do should the risk happen.
    - Rate the likelihood of the risk materialising.
    - Rate the consequence of the risk happening.

All of these things should be recorded which will allow the risk to be recorded on and appropriate risk register(s) following risk assessment, if the risk assessment process has not enabled the risk to be eliminated or managed. The following sections describe in detail how to complete the risk register.

Stage 4 – Risk Register(s)

All service areas are to maintain a local risk register. This register contains operational and strategic risks that are routinely managed within the service, and for which the service has the required resources, controls and mitigation within the parameters of risk set by the risk appetite.

The Corporate Risk Register is a collection of risks that directly impact on to the delivery of the corporate aims. This register is populated by a variety of sources, i.e. risks that cannot be controlled or mitigated in the service area, external audit reports, and principle risks from the board assurance framework.

Traditionally, completing a risk register can be daunting but the aim is to have a simplified process to allow the monitoring of actions and aid decision-making, electronically.

Headings in the register(s) that need to be completed are:

1. The risk identification (ID) is the unique identifier to distinguish the risk from the other risks in your register. The ID will not change throughout the life of the risk.

The risk owner is the individual who is accountable and has overall responsibility for a risk; it may or may not be the same person as the action owner. High severity corporate risks, for example, will be owned by one Executive Director, but there may be many action owners. The risk owner must know, or be informed that they are the owner, and accept this.

2. Source of, how or where the risk was identified. This could include:
    - Business planning.
    - Clinical audit.
    - Complaints/PALS.
    - External audit.
    - External review.
    - Incident.
    - Internal audit.
    - Legislation.

- Litigation.
- National risks such as financial fraud
- NICE guidance.
- Regulatory standard.
- Risk Assessment.

3. Risk description as the name suggests, allows the risk to be described. It is important that risks are clearly articulated. If not, then it is difficult to put effective controls, or actions, in place to reduce the risk materialising and contingency plans. Using the following subheadings will help to clearly describe risk:
   - Condition
   - Cause
   - I Consequence

For example:
Condition: Inability to release clinical staff for mandatory training due to staffing levels.
Cause: Results in staff not receiving compulsory training in resuscitation or blood safety.
Consequence: Leading to an increased safety risk to patients.

Getting this right is important as the key controls relate directly to the description of the risk. Key controls are the measures put in place as preventative measures to lessen or reduce the likelihood or consequence of the risk happening and/or the severity if it does. You must ensure that each control (or action where a gap in control has been identified) has an owner and target completion date.

These must describe the practical steps that need to be taken to manage and control the risk. Without this stage, risk management is no more than a paper based or bureaucratic process.

Not all risks can be dealt with in the same way. The 5T's provide an easy list of options available to anyone considering how to manage risk:

- **Tolerate** – the likelihood and consequence of a particular risk happening is accepted.
- **Treat** – work carried out to reduce the likelihood or consequence of the risk (this is the most common action).
- **Transfer** – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party.
- **Terminate** – an informed decision not to become involved in a risk situation, e.g. terminate the activity.
- **Take the opportunity** – actively taking advantage, regarding the uncertainty as an opportunity to benefit.

In most cases the chosen option will be to treat the risk. When considering the action to take remember to consider the cost associated with managing the risk, as this may have a bearing on the decision. The key questions in this instance are:

- Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.
- When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.

Stage 5 – Escalation and De-escalation of Risks

The consequence of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example from a service risk to Division and up to the corporate risk register reviewed by the Corporate Risk Committee, Board Sub-Committee, and finally the Board.

Risk will be escalated or de-escalated within the defined tolerances and authority to act for each level.

For example: a service risk scoring high or extreme should only be escalated to the corporate risk register if it is **not** manageable within the service. If the risk **is** manageable within the service then it remains on the service risk register. In a case whereby the risk is to be escalated to the corporate risk register, options for controls or mitigation must be offered. The risk owner should discuss and seek approval from their manager before risk escalation to the next level. Once an escalated risk has reached the Corporate Risk Register, the Corporate Risk Committee will consider the risk control options advised and make recommendations for action, the risk will then be de- escalated and returned to the risk owner for implementation. Where a risk is de-escalated this must be communicated to the management level below, and the risk monitored at the appropriate management level and risk forum.

It is important that risks are reviewed regularly to ensure appropriate action, including closing risks or action plans where necessary.

Stage 6 - Closure of Risk

Risk registers need to be current and up to date. It is therefore essential that risks are continually monitored and fully reviewed at least annually. They should be closed under the following circumstances:

- The Risk has materialised.
- The Risk has reached its target score and has remained stable for an acceptable period of time (following Senior Members authorisation)

All closed risks will be archived and not deleted

3.1 Risk Profile

A summary risk profile is a simple visual mechanism that can be used in reporting to increase the visibility of risks; it is a graphical representation of information normally found on an existing risk register. A risk profile shows all key risks as one picture, so that managers can gain an overall impression of the total exposure to risk.

3.2 Horizon Scanning

Horizon scanning is about identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing formal mechanisms to horizon scanning the Trust will be better able to respond to changes or emerging issues in a planned structured and co-ordinated way. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:

- Legislation.
- Government white papers.
- Government consultations.
- Socio-economic trends.
- Trends in public attitude towards health.
- International developments.
- NHS England publications.

- Local demographics.
- Seeking stakeholders views.
- Risk assessments.

All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.

Board members have the responsibility to horizon scan and formerly communicate matters in the appropriate forum relating to their areas of accountability.

4 Training

Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management.

Training required to fulfil this strategy will be provided in accordance with the Trust's training needs analysis.

All new staff undertake risk management training as part of their Corporate Induction. Training is mandated for all other staff.

Management and monitoring of training will be in accordance with the Trust's statutory and mandatory training policy.

Specific training will be provided for the board, in respect of high level awareness of risk management. Risk awareness sessions are included as part of the board's development programme.

5 Evidence Base

- Home Office Risk Management Policy and Guidance, Home Office (2011).
- A Risk Matrix for Risk Managers, National Patient Safety Agency (2008).
- NHS Audit Committee Handbook, Department of Health (2011).
- UK Corporate Governance Code, Financial Reporting Council (2010).
- 'Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance', Audit Commission (2009).
- The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004).
- Risk Management Assessment Framework, HM Treasury (2009).
- Understanding and Articulating Risk Appetite, KPMG (2008).
- Risk Appetite Frameworks- how to spot the genuine article, Deloitte (2013).
- Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012).
- Good Practice Guide: Managing Risks in Government, National Audit Office (2011).
- Risk Management – principles and guidelines ISO 31000 (2009).
- Patient Safety Strategy (2020)

6 Monitoring Compliance and Audit

The Trust risk team, led by the Associate Director of Governance and Quality oversee all risks recorded on the Ulysses risk management system. The team review all new, closed and outstanding risks and quality assures every risk assessment whether ongoing or completed. The team re-open closed risks if necessary, where it is deemed appropriate action has not been taken and audit risks exceeding timescales, escalating to the appropriate management level where necessary,
This strategy will be reviewed annually.

The Trust Risk Team, which includes the divisional governance managers, are always for available for

operational advice / support when required and are contactable as follows:

Name	Role	Extension
Phil Bartley	Associate Director of Governance and Quality	1383
Allan Hawksey	Risk and patient safety manager	4437
VACANT	Governance support officer	4292
Jenny Lamble	Governance support officer	4489
Laura Thorpe	Divisional Governance Manager (maternity)	4433
VACANT	Divisional Governance Manager (gynaecology / Hewitt Centre)	1048
Kelli Platt	Divisional Governance Manager (Neonatal)	1015
Adam Davies	Divisional Governance Manager (Clinical Support Services)	4421

7 Dissemination, Implementation and Access to the Document

This strategy is available on the Trust intranet. All staff will be notified via email of the strategy and other amendments.

8 Key Performance Indicators

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
All verified BAF strategic threats are reported to the Board of Directors at each formal meeting of the Board.	100%	The following mechanisms will be used to monitor compliance with the requirements of this document:	Corporate Risk Sub Committee & Trust Board (when meetings are scheduled)	Bi-Monthly	Trust Secretary
All significant risks are reported to and reviewed as a standing agenda item at each formal meeting of the Corporate Risk Sub-Committee.	100%	• Evidence of reporting verified significant risk exposures to the Board of Directors at each formal meeting. • Evidence of review of significant risk exposure by the Corporate Risk Sub Committee at each formal meeting. • Periodic internal audit of any or all aspects of the Risk Management process as determined by the Audit Committee (risk identification, assessment, control, monitoring and reviews).	Corporate Risk Committee	Bi-Monthly	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)
The risk profiles (for extreme risks not on the corporate risk register) for all divisions are reviewed by the Corporate Risk Sub Committee at a frequency determined by the Corporate Risk Committee as part of a rolling programme of reviews.	100%		Corporate Risk Committee	Bi-Monthly	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)
Local risk registers are in place, maintained and available for inspection.	100%		Corporate Risk Committee	Bi-Monthly	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)
Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and all risks and risk actions are within review date, and none are overdue for review.	100%		Corporate Risk Committee	Bi-Monthly	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)

Annual review and approval of the Trust's Risk Appetite	100%		Quality Committee	Annual Report	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)
Risk management training mandatory for all staff at corporate induction	100%		Quality Committee	Annual Report	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)
Risk management training mandatory for all staff as part of their mandatory training	100%		Quality Committee	Annual Report	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)
Staff compliance with the risk management standard operating procedure (SOP)	100%		Quality Committee	Annual Report	Associate Director of Governance and Quality (Exec Lead: Chief Nurse & Midwife)

9 Appendices

Appendix A - Risk Descriptors and Grading

Risk Descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Risk scoring = consequence x likelihood (C x L)

	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

The risk matrix above can be used to provide an initial breakdown of the hazards into 4 Categories as follows:

Low Risk	Acceptable risk requiring no immediate action Review annually Place on the appropriate section of the Risk Register
Moderate Risk	Action planned within one month to reduce risk Commenced within 3 months Place on the appropriate section of the Risk Register
High Risk	Actions planned immediately Review Monthly Place on the appropriate section of the Risk Register
Extreme Risk	Immediate Actions required Reviewed weekly by ET Placed on the Corporate Risk Register

Appendix B - Initial Equality Impact Assessment

Name of policy/ business or strategic plans/CIP programme:	**Risk Management Strategy v 15**	
Does the proposal, service or document affect one group more or less favourable than another on the basis of:	**No**	**Justification/evidence and data source**
Age	No	No discrimination / inequality identified, the document sets out the Trust's approach and framework for Risk Management, ensuring this is systematic and objective and applied without prejudice or favour.
Disability: including learning disability, physical, sensory or mental impairment.	No	
Gender reassignment	No	
Marriage or civil partnership	No	
Pregnancy or maternity	No	
Race	No	
Religion or belief	No	
Sex	No	
Sexual orientation	No	
Human Rights – are there any issues which might affect a person's human rights?	**No**	**Justification/evidence and data source**
Right to life	No	No impact on human rights, the document sets out the Trust's approach and framework for Risk Management, ensuring this is systematic and objective and applied without prejudice or favour. The aim being to reduce risks to the organisation, its services and the safety and well-being of patients, visitors, staff and the wider public.
Right to freedom from degrading or humiliating treatment	No	
Right to privacy or family life	No	
Any other of the human rights?	No	

Assessment carried out by:

Date:

Signature and Job Title:

Appendix C – Glossary

Action	A response to control or mitigate risk.
Action Plan	A collection of actions that are specific, measurable, achievable, realistic and targeted.
Assessment	A review of evidence leading to the formulation of an opinion.
Assurance	Confidence based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved (Building the Assurance Framework: A Practical Guide for NHS Boards (2003), Department of Health. Taking it on Trust, Audit Commission (2009), Care Quality Commission, Judgement Framework, (2009).
Board Assurance Framework (BAF)	A matrix setting out the organisation's strategic objectives, the risks to achieving them, the controls in place to manage them and the assurance that is available.
Clinical Audit	'A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria the implementation of change' (Principles of Best Practice in Clinical Audit (2002), National Institute of Clinical Excellence).
Compliance	Acting in accordance with requirements.
Contingency plan	The action(s) to be taken if the risk occurs.
Consequence	The result of a threat or an opportunity.
Corporate Governance	The system by which boards of directors direct and control organisations in order to achieve their objectives.
Control	Action taken to reduce likelihood and or consequence of a risk.
Cumulative Risk	The risk involved in several related activities that may have low impact or be unlikely to happen individually, but which taken together may have significant impact and or be more likely to happen; for example the cumulative impact of cost improvement programmes.
Escalation	Referring an issue to the next appropriate management level for resolution, action, or attention.
External Audit	An organisation appointed to fulfil the statutory functions in relation to providing an opinion on the annual accounts of the Trust.
Gap in Assurance	Failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively.
Gap in Control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risk and achieve objectives.
Hazard	A potential source of damage or harm.
Internal Audit	The team responsible for evaluating and forming an opinion of the robustness of the system of internal control.
Internal Control	A scheme of checks used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation.
Inherent/ Initial Risk	The level of risk involved in an activity before controls are applied.

Integrated Risk Management	A process through which organisations identify, assess, analyse and manage all risk and incidents for every level of the organisation and aggregate the results at a corporate level e.g. patient safety, health and safety, complaints, litigation and other risks.
Key Risk / Key Control	Risks and controls relating to strategic objectives.
Likelihood	The probability of something happening.
Mitigation / treatment of risk	Actions taken to reduce the risk or the negative consequences of the risk.
Negative Assurance	Evidence that shows risks are not being managed and/or controlled effectively e.g. poor external reviews or serious untoward incidents.
Reasonable	Based on sound judgement.
Reassurance	The process of telling others that risks are controlled without providing reliable evidence in support of this assertion.
Residual / Current Risk	The risk that is still present after controls, actions or contingency plans have been put in place.
Risk	The uncertainty of outcome of activity, described as the combination of likelihood and consequence, including perceived importance.
Risk Appetite	The level of risk that the organisation is prepared to accept, tolerate and be exposed to at any point in time.
Risk Capacity	The maximum level of risk to which the organisation should be exposed, having regard to the financial and other resources available.
Risk Management	The processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate and anticipate them, and monitoring and reviewing progress.
Risk Matrix	A grid that cross references consequences against likelihood to assist in assessing risk.
Risk Maturity	The quality of the risk management framework.
Risk Owner	The person/group responsible for the management and control of all aspects of individual risks. This is not necessarily the same as the action owner, as actions may be delegated.
Risk Profile	The overall exposure of the organisation or part of the organisational to risk.
Risk Rating	The total risk score worked out by multiplying the consequences and likelihood scores on the risk matrix.
Risk Register	The tool for recording identified risks and monitoring actions and plans against them.
Risk Tolerance	The boundaries of risk-taking that the organisation is not prepared to go beyond.
Strategy	In the NHS a document that sets out the corporate approach and policy to a particular area or work activity. This is sometimes described as a policy, particularly outside the NHS.
Sufficient	Whatever is adequate

Liverpool Women's NHS Foundation Trust

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Good Governance Institute

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

www.good-governance.org.uk

Liverpool Women's
NHS Foundation Trust

Jargon Buster

We know that the language used in healthcare can sometimes be quite confusing, especially when acronyms are concerned. To make life a little easier, we will try to ensure that we spell out acronyms in full at first mention and then put the abbreviation in brackets, for example, Strategic Clinical Network (SCN) in our reports and minutes.

We've also put together a list of acronyms that you might see throughout our documentation. If you spot a gap, please email our Trust Secretary on mark.grimshaw@lwh.nhs.uk.

The following webpage might also be useful - https://www.england.nhs.uk/participation/nhs/

A		
A&E	Accident & Emergency	hospital department specialising in the acute care of patients who arrive without a prior appointment with urgent or emergency trauma
AC	Audit Committee	a committee of the board – helps the board assure itself on issues of finance, governance and probity
AGM	Annual General Meeting	a meeting to present and agree the trust annual report and accounts
AGS	Annual Governance Statement	a document which identifies the internal controls in place and their effectiveness in delivering effective governance
AHP	Allied Health Professionals	health care professions distinct from dentistry, optometry, nursing, medicine and pharmacy e.g. physiotherapists, radiographers, speech therapists and podiatrists
AHSC	Academic Health Science Centre	a partnership between a healthcare provider and one or more universities
AHSN	Academic Health Science Network	locally owned and run partnership organisations to lead and support innovation and improvement in healthcare
ALOS	Average Length of Stay	the average amount of time patients stay in hospital
AMM	Annual Members Meeting	a meeting that is held every year to give members the opportunity to hear about what the trust has done in the past year; could be part of the AGM
AO	Accountable Officer	senior person responsible and accountable for funds entrusted to their trust; for NHS provider organisations this person will be the chief executive
ALB(s)	Arms Length Bodies	an organisation that delivers a public service but is not a ministerial government department; these include HEE, HSCIC, HRA, HTA, NHSE, NICE, Monitor, NHSBSA, NHSBT, NHSI, NHSLA, MHPRA, CQC, PHE (See individual entries)
	Agenda for Change	the NHS-wide grading and pay system for NHS staff, with the exception of medical and dental staff and some senior managers; each relevant job role in the NHS is matched to a band on the Agenda for Change pay scale

B		
BAF	Board Assurance Framework	the key document used to record and report an organisation's key strategic objectives, risks, controls and assurances to the board
BCF	Better Care Fund	this fund creates a local single pooled budget to incentivise the NHS and local government to work more closely together in local areas
BMA	British Medical Association	trade union and professional body for doctors
BAME	Black Asian Minority Ethnic	terminology normally used in the UK to describe people of non-white descent
BoD	Board of Directors	executive directors and non-executive directors who have collective responsibility for leading and directing the trust
	Benchmarking	method of gauging performance by comparison with other organisations

C		
CAMHS	Child and Adolescent Mental Health Services	specialise in providing help and treatment for children and young people with emotional, behavioural and mental health difficulties
CapEx	Capital Expenditure	an amount spent to acquire or improve a long-term asset such as equipment or buildings. Typically, capital is raised via a loan, but it can come from reserves and is paid back/written off over a number of years from revenue income. This is a contrast with revenue spend which is always from in-year income
CBA	Cost Benefit Analysis	a process for calculating and comparing the costs and benefits of a project
CBT	Cognitive Behavioural Therapy	a form of psychological therapy used mostly in depression but increasingly shown to be a useful part of the treatment for schizophrenia
CCG	Clinical Commissioning Group	groups of GPs, clinicians and managers who are responsible for commissioning local health services in England (all GP practices must belong to a CCG)
CDiff	Clostridium difficile	a bacterial infection that most commonly affects people staying in hospital
CE / CEO	Chief Executive Officer	leads the day-to-day management of a foundation trust, is a board member and the accountable officer for the trust.
CF	Cash Flow	the money moving in and out of an organisation
CFR	Community First Responders	a volunteer who is trained by the ambulance service to attend emergency calls in the area where they live or work
CHC	Continuing Healthcare	Whereby those with long-term or complex healthcare needs qualify for social care arranged for and funded by the NHS
CIP	Cost Improvement Plan	an internal business planning tool outlining the Trust's efficiency strategy
CMHT	Community Mental Health Team	A team of mental health professionals such as psychiatrists,

		psychologists, social workers, community psychiatric nurses and occupational therapists, who work together to help people manage and recover from mental illness.
CoG	Council of Governors	the governing body that holds the non-executive directors on the board to account for the performance of the board in managing the trust, and represents the interests of members and of the public
COO	Chief Operating Officer	a senior manager who is responsible for managing a trust's day-to-day operations and reports to the CEO
CPD	Continuing Professional Development	continued learning to help professionals maintain their skills, knowledge and professional registration
CPN	Community Psychiatric Nurse	a registered nurse with specialist training in mental health working outside a hospital in the community
CQC	Care Quality Commission	The independent regulator of all health and social care services in England
CQUIN	Commissioning for Quality and Innovation	a sum of money that is given to providers by commissioners on the achievement of locally and nationally agreed quality and improvement goals
CSR	Corporate Social Responsibility	A business practice which incorporates sustainable goals, usually positive impacts on environmental, economic and social factors, into a business model
CT	Computed Tomography	A medical imaging technique
CFO	Chief Finance Officer	the executive director leading on finance issues in the trust
	Caldicott Guardian	A board level executive director responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian

D		
DBS	Disclosure and barring service	conducts criminal record and background checks for employers
DBT	Dialectical behavioural therapy	A type of psycho-therapy, or talk therapy, which has been developed from CBT to help those experiencing borderline personality disorder
DGH	District General Hospital	major secondary care facility which provides an array of treatment, diagnostic and therapeutic services, including A&E
DHSC	Department of Health and Social Care	the ministerial department which leads, shapes and funds health and care in England
DN	Director of Nursing	The executive director who has professional responsibility for services provided by nursing personnel in a trust
DNA	Did Not Attend	a patient who missed an appointment
DNAR	Do Not Attempt Resuscitation	A form issued and signed by a doctor, which tells a medical team not to attempt CPR
DPA	Data Protection Act	the law controlling how personal data is collected and used
DPH	Director of Public Health	a senior leadership role responsible for the oversight and care of matters relating to public health
DTOCs	Delayed Transfers of Care	this refers to patients who are medically fit but waiting for care

		arrangements to be put in place so therefore cannot be discharged
	Duty of Candour	a legal duty on hospital, community, ambulance and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm

E		
E&D	Equality and Diversity	The current term used for 'equal opportunities' whereby members of the workforce should not be discriminated against because of their characteristics. This is promoted by valuing diverse characteristics in a workplace.
ED(s)	Executive Directors *or* Emergency Department	senior management employees who sit on the trust board *or* alternative name for Accident & Emergency department
EHR	Electronic Health Record	health information about a patient collected in digital format which can theoretically be shared across different healthcare settings
EOLC	End of Life Care	support for patients reaching the end of their life
EPR	Electronic Patient Record	a collation of patient data stored using computer software
ESR	Electronic staff record	A collation of personal data about staff stored using computer software

F		
FFT	Friends and Family Test	a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care
FOI	Freedom of Information	the right to ask any public sector organisation for the recorded information they have on any subject
FT	Foundation Trust	a public benefit corporation, which is a legal body established to deliver healthcare to patients / service users and has earned a degree of operational and financial independence
FTE	Full Time Equivalent	a measurement of an employees workload against that of someone employed full time e.g. 0.5 FTE would be someone who worked half the full time hours
FTSU	Freedom to speak up	An initiative developed by NHS Improvement to encourage NHS workers to speak up about any issues to patient care, quality or safety
	Francis Report	the final report, published in 2013, of the public inquiry into care provided by Mid Staffordshire NHS FT chaired by Sir Robert Francis QC

G		
GMC	General Medical Council	the independent regulator for doctors in the UK
GDP	Gross Domestic Product	thevalueofacountry'soveralloutputofgoodsand services
GDPR	General Data Protection Regulations	The legal framework which sets the guidelines for collecting and processing personal information from individuals living in the European Union

H		
HCAI	Healthcare Associated Infection	these are infections that are acquired in hospitals or as a result of healthcare interventions; MRSA and Clostridium difficile can be classed as HCAIs if caught whilst in a healthcare setting
HCA	Health Care Assistant	staff working within a hospital or community setting under the guidance of a qualified healthcare professional
HDU	High Dependency Unit	an area in a hospital, usually located close to the ICU, where patients can be cared for more extensively than on a normal ward, but not to the point of intensive care, e.g. patients who have had major surgery
HEE	Health Education England	the body responsible for the education, training and personal development of NHS staff
HR	Human Resources	the department which focusses on the workforce of an organisation including pay, recruitment and conduct
HRA	Health Research Authority	protects and promotes the interests of patients and the public in health research
HSCA 2012	Health & Social Care Act 2012	an Act of Parliament providing the most extensive reorganisation of the NHS since it was established, including extending the roles and responsibilities of governors
HSCIC	Health and Social Care Information Centre	the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care
HTA	Human Tissue Authority	regulates the removal, storage, use and disposal of human bodies, organs and tissue for a number of scheduled purposes such as research, transplantation, and education and training
HWB / HWBB	Health& Wellbeing Board	a local forum to bring together partners from across the NHS, local government, the third sector and the independent sector, led by local authorities
	Health Watch	A body created under the Health and Social Care Act 2012 which aims to understand the needs and experiencesofNHSserviceusersandspeakontheir behalf.

I		
IAPT	Improved Access to Psychological	an NHS programme rolling out services across England

	Therapies	offering interventions approved by the National Institute of Health and Care Excellence for treating people with depression and anxiety disorders
IG	Information Governance	ensures necessary safeguards for, and appropriate use of, patient and personal information. Key areas are information policy for health and social care, IG standards for systems and development of guidance for NHS and partner organisations
ICP	Integrated Care Pathway	a multidisciplinary outline of care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through diagnosis and treatment to positive outcomes
ICS	Integrated Care system	Groups of NHS providers, commissioners and local authorities working together to improve health and care in the local area
ICT	Information Communications Technology	an umbrella term that includes any communication device or application, encompassing: radio, television, cellular phones, computer and network hardware and software, satellite systems, as well as the various services and applications associated with them
ICU *or* ITU	Intensive Care Unit Intensive therapy unit	specialist unit for patients with severe and life threatening illnesses
IP	Inpatient	a patient who is hospitalised for more than 24 hours
IT	Information Technology	systems (especially computers and telecommunications) for storing, retrieving, and sending information
IV	Intravenous	treatment which is administered by injection into a vein

K		
KLOE(s)	Key Line of Enquiries	detailed questions asked by CQC inspectors which help to answer the five key questions to assess services: are they safe, effective, caring, responsive and well-led?
KPIs	Key Performance Indicators	indicators that help an organisation define and measure progress towards a goal
	King's Fund	independent charity working to improve health and health care in England

L		
LD	Learning Disability	a disability which affects the way a person understands information and how they communicate

LGA	Local Government Association	the national voice of local government in England and Wales. It seeks to promote better local government and maintains communication between officers in different local authorities to develop best practice
LOS	Length of Stay	a term commonly used to measure the duration of a single episode of hospitalisation

M

M&A	Mergers & Acquisitions	mergers bring together two or more bodies to form a new legal entity and disband the merging bodies. acquisitions are take-overs of one body by another
MD	Medical Director	a member of the board who has a clinical background and has professional responsibilities for doctors and dentists in the trust
MHPRA	Medicines and Healthcare Products Regulatory Agency	an executive agency of DHSC which is responsible for ensuring that medicines and medical devices work and are acceptably safe
MIU	Minor Injuries Unit	A unit which treats injuries or health conditions which are less serious and do not require the A&E service
MoU	Memorandum of Understanding	describes an agreement between two or more parties
MRI	Magnetic Resonance Imaging	a medical imaging technique
MRSA	Methicillin-Resistant Staphylococcus Aureus	a bacterium responsible for several difficult-to-treat infections in humans
MSA	Mixed Sex Accommodation	wards with beds for both male and female patients

N

NAO	National Audit Office	an independent Parliamentary body in the United Kingdom which is responsible for auditing central government departments, government agencies and non-departmental public bodies. The NAO also carries out Value for Money audits into the administration of public policy
NED	Non Executive Director	directors who are appointed, but not employed by the trust; they have no executive responsibilities and are responsible for vetting strategy, providing challenge in the boardroom and

		holding the executive directors to account
NHSBSA	NHS Business Services Authority	a Special Health Authority of DHSC which provides a range of services to NHS organisations including: NHS Prescription Services, NHS Pensions, Help With Health Costs, Student Services, NHS Dental Services, European Health Insurance Card, Supplier Management (including NHS Supply Chain) and NHS Protect
NHSBT	NHS Blood and Transplant	a Special Health Authority of DHSC responsible for providing a reliable, efficient supply of blood, organs and associated services to the NHS
NHSE	NHS England	an executive non-departmental public body with a mandate from the Secretary of State to improve health outcomes for people within England
NHSI	NHS Improvement	The Independent regulator of NHS Foundation Trusts
NHSLA	NHS Leadership Academy	national body supporting leadership development in health and NHS funded services
NHSP	NHS Professionals	provides bank (locum) healthcare staff to NHS organisations
NHSX		A unit designed to drive the transformation of digital technology in the NHS
NICE	National Institute for Health and Care Excellence	provides national evidence-based guidance and advice to improve health and social care
NIHR	National Institution for Health Research	The largest funder of health and social care research in the UK, primarily funded by the Department of Health and Social Care
NMC	Nursing and Midwifery Council	nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
	Never Event	serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. NHS England defines the list of never events every year
	NHS Digital	The information and technology partner to the NHS which aims to introduce new technology into services
	NHS Providers	NHS Providers is the membership organisation for NHS public provider trusts. We represent every variety of trust, from large acute and specialist hospitals through to community, ambulance and mental health trusts.

	Nolan Principles	key principles of how individuals and organisations in the public sector should conduct themselves comprising of: selflessness, integrity, objectivity, accountability, openness, honesty, leadership. Set by the Committee for Standards in Public Life, an independent advisory non-departmental public body set up to advise the prime minister on ethical standards
	NHS Resolution	not-for-profit part of the NHS which manages negligence and other claims against the NHS in England on behalf of their member organisations. Also, an insurer for NHS bodies
	Nuffield Trust	independent source of evidence-based research and policy analysis for improving health care in the UK, also a charity

O

OD	Organisational Development *or* Outpatients Department	a systematic approach to improving organisational effectiveness *or* a hospital department where healthcare professionals see outpatients (patients which do not occupy a bed)
OOH	Out of Hours	services which operate outside of normal working hours
OP	Outpatients	a patient who is not hospitalized for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment
OPMH	Older People's Mental Health	mental health services for people over 65 years of age
OSCs	Overview and Scrutiny Committees	established in local authorities by the Local Government Act 2000 to review and scrutinise the performance of public services including health services
OT	Occupational Therapy	assessment and treatment of physical and psychiatric conditions using specific activity to prevent disability and promote independent function in all aspects of daily life

P

PALS	Patient Advice & Liaison Service	offers confidential advice, support and information on health-related matters to patients, their families, and their carers within trusts

PAS	Patient Administration System	the automation of administrative paperwork in healthcare organisations, particularly hospitals. It records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient
PbR	Payment by Results or 'tariff'	a way of paying for health services that gives a unit price to a procedure
PCN	Primary care network	A key part of the NHS long term plan, whereby general practices are brought together to work at scale
PDSA	Plan, do, study, act	A model of improvement which develops, tests and implements changes based on the scientific method
PFI	Private Finance Initiative	a scheme where private finance is sought to supply public sector services over a period of up to 60 years
PHE	Public Health England	a body with the mission to protect and improve the nation's health and wellbeing and reduce health inequalities
PHSO	Parliamentary and Health Service Ombudsman	an organisation which investigates complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England
PICU	Psychiatric Intensive Care Unit *or* Paediatric Intensive Care Unit	a type of psychiatric in-patient ward with higher staff to patient ratios than on a normal acute admission ward *or* an inpatient unit specialising in the care of critically ill infants, children, and teenagers
PLACE	Patient-Led	Surveys inviting local people going into hospitals as
	Assessments of the Care Environment	part of a team to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance
PPI	Patient and Public Involvement	mechanisms that ensure that members of the community --- whether they are service users, patients or those who live nearby – are at the centre of the delivery of health and social care services
PTS	Patient Transport Services	free transport to and from hospital for non-emergency patients who have a medical need
	Primary Care	the first point of contact with the NHS for most people and is delivered by a wide range of independent contractors, including GPs, dentists, pharmacists and optometrists, it also includes NHS walk-in centres and the NHS 111 telephone service

Q		
QA	Quality assurance	monitoring and checking outputs to make sure they meet certain standards
QI	Quality improvement	A continuous improvement process focusing on processes and systems
QIA	Quality Impact Assessment	A process within NHS trusts which ensures the quality of service is systematically considered in decision- making on service changes
QUI	Qualities and Outcomes Framework	The system for performance management and payment of GP's in the NHS

R		
R&D	Research & Development	work directed towards the innovation, introduction, and improvement of products and processes
RAG	Red, Amber, Green classifications	a system of performance measurement indicating whether something is on or better than target (green), below target but within an acceptable tolerance level (amber), or below target and below an acceptable tolerance level (red)
RGN	Registered General Nurse	a nurse who is fully qualified and is registered with the Nursing and Midwifery Council as fit to practise
RoI	Return on Investment	the benefit to the investor resulting from an investment of some resource. A high RoI means the investment gains compare favourably to investment cost. As a performance measure, RoI is used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments.
RTT	Referral to Treatment Time	the waiting time between a patient being referred by a GP and receiving treatment

S		
SALT	Speech and Language Therapist	assesses and treats speech, language and communication problems in people of all ages to help them better communicate
SFI	Standing Financial Instructions	Policy used for the regulation of the conduct of an NHS trust in relation to all financial matters
SHMI	Summary Hospital Level Mortality Indicator	reports mortality at trust level across the NHS in England using standard and transparent methodology
SID	Senior independent Director	a non-executive director who sits on the board and plays a key role in supporting the chair; the SID carries out the annual appraisal of the chair, and is available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair
SIRO	Senior Information Risk Officer	a senior manager who will take overall ownership of the organisation's information risk policy
SITREP	Situation Report	a report compiled to describe the details surrounding a situation, event, or incident
SLA	Service Level Agreement	an agreement of services between service providers and users or commissioners
SoS	Secretary of State	the minister who is accountable to Parliament for delivery of health policy within England, and for the performance of the NHS
SRO	Senior Responsible officer	A leadership role which is accountable for the delivery and outcome of a specific project
STP	Sustainability and Transformation Partnership	Partnerships formed between local councils and NHS services to help plan and run services, and agree system-wide priorities
SUI	Series Untoward Incident / Serious Incident	A serious incident which resulted in one or more of the following: unexpected or avoidable death, a never event, a prevention of organisation's ability to continue to deliver healthcare services, abuse, or loss of confidence in a service
SWOT	Strengths, Weaknesses, Opportunities, Threats	a structured planning method used to evaluate the strengths, weaknesses, opportunities and threats involved in a project or in a business venture
	Secondary Care	NHS health service provided through hospitals and in the community

T		
TTO	To Take Out	medicines to be taken away by patients on discharge

	Tertiary Care	healthcare provided in specialist centres, usually on referral from primary or secondary care professionals

V

VTE	Venous Thromboembolism	a condition where a blood clot forms in a vein. This is most common in a leg vein, where it's known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE)
VfM	Value for Money	used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it both acquires and provides, within the resources available to it

W

WLF	Well Led Framework	a set of indicators that seek to identify how well led an organisation is, also used as a framework for board governance reviews
WRES	Workforce Race Equality Standard	a metric to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of black and minority ethnic (BME) board representation
WTE	Whole-time equivalent	See FTE

Y

YTD	Year to Date	a period, starting from the beginning of the current year, and continuing up to the present day. The year usually starts on 1st April for financial performance indicators