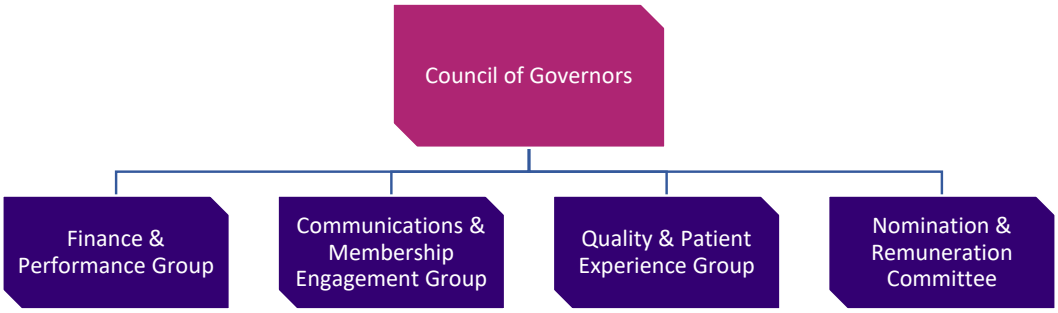
Liverpool Women's
NHS Foundation Trust

Council of Governors

10 February 2022, 5.30pm
Virtual Meeting, via Teams



Liverpool Women's NHS Foundation Trust

Council of Governors - Public

Location	Virtual via Teams
Date	10 February 2022
Time	5.30pm

AGENDA					
Item no. 20/21/	**Title of item**	**Objectives/desired outcome**	**Process**	**Item presenter**	**Time**
PRELIMINARY BUSINESS					
067	**Introduction, Apologies & Declaration of Interest**	Receive apologies & declarations of interest	Verbal	Chair	**17.30 (5 mins)**
068	**Meeting Guidance Notes**	To receive the meeting attendees' guidance notes	Written	Chair	
069	**Minutes of the meeting held on 11 November 2021**	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
070	**Action Log and matters arising**	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
071	**Chair's announcements**	Announce items of significance not found elsewhere on the agenda	Presentation	Chair	**17.35 (10 mins)**
072	**Chief Executive Report**	Report key developments and announce items of significance not found elsewhere on the agenda	Presentation	Chief Executive	**17.45 (5 mins)**
MATTERS FOR RECEIPT / APPROVAL					
073	**Activity Report from the Governor Group Meetings.** • **Finance and Performance Group** • **Quality and Patient Experience Group.** • **Communications and Membership Engagement Group**	Receive minutes for assurance	Written	Group Chairs	**17.50 (10 mins)**

074	**Trust Strategy and 2022/23 Corporate Objectives**	To discuss	Presentation / Group Discussion	Chief Finance Officer	**18.00 (45 mins)**
075	**Research Strategy**	To discuss	Presentation / Group Discussion	Medical Director	**18.45 (20 mins)**
076	**Council of Governor Nomination & Remuneration Committee Terms of Reference**	To approve	Written	Trust Secretary	**19.05 (2 mins)**
CONCLUDING BUSINESS					
077	**Review of risk impacts of items discussed**	Identify any new risk impacts	Verbal	Chair	**19.07 (3 mins)**
078	**Chair's Log**	Identify any Chair's Logs	Verbal	Chair	
079	**Any other business & Review of meeting**	Consider any urgent items of other business	Verbal	Chair	
080	**Jargon Buster**	For information and reference	Written	Chair	
Finish Time: 19.10					

Date of Next Meeting: 12 May 2022

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

Council of Governors

Minutes of the Council of Governors held in the Blair Bell Lecture Theatre and Virtually at 1730hrs on Thursday 11 November 2021

PRESENT

Robert Clarke	Chair
Carol Didlick	Public Governor (South Liverpool)
Patricia Hardy	Appointed Governor (Sefton Council)
Kate Hindle	Staff Governor (Admin & Clerical)
Rebecca Holland	Staff Governor (Nurses)
Rebecca Lunt	Staff Governor (Scientists, Technicians & AHPs)
Sara Miceli-Fagrell	Public Governor (South Liverpool)
Peter Norris	Public Governor (Central Liverpool)
Ruth Parkinson	Public Governor (Central Liverpool)
Olawande Salam	Public Governor (Knowsley)
Niki Sandman	Appointed Governor (University of Liverpool)
Jackie Sudworth	Public Governor (Knowsley)
Yaroslav Zhukovskyy	Public Governor (Sefton)

IN ATTENDANCE

Matt Connor	Chief Information Officer
Marie Forshaw	Chief Nurse and Midwife
Lynn Greenhalgh	Medical Director
Mark Grimshaw	Trust Secretary
Eva Horgan	Chief Finance Officer
Louise Hope	Assistant Trust Secretary (minutes)
Susan Milner	Non-Executive Director
Louise Martin	Non-Executive Director
Tony Okotie	Non-Executive Director
Michelle Turner	Chief People Officer / Deputy Chief Executive
Gary Price	Director of Operations

APOLOGIES:

Iris Cooper	Public Governor (Rest of England and Wales)
Tracy Ellery	Non-Executive Director
Evie Jefferies	Public Governor (Rest of England & Wales)
Kiran Jilani	Staff Governor (Doctors)
Pauline Kennedy	Staff Governor (Midwives)
Louise Kenny	Non-Executive Director
Rhianna Moradi	Appointed Governor (Community & Voluntary Organisations)
Kathryn Thomson	Chief Executive
Miranda Threfall-Holmes	Appointed Governor (Faith Organisations)

Core members	**May**	**July**	**Nov**	**Feb**	**Mar**
Thania Islam	X	x	Non member		
Mary Doddridge	A	A	Non member		
Peter Norris	✓	✓	✓		
Carol Darby-Darton	X	X	x		
Pat Denny	Non member		A		
Ruth Parkinson	Non member		✓		
Si Jones	X	X	Non member		

Sara Miceli-Fagrell	A	✓	✓		
Carol Didlick	Non member		✓		
Carole McBride	A	A	Non member		
Yaroslav Zhukovskyy	✓	✓	✓		
Anne Gorski	Non member		x		
Rev Anne Lawler	A	A	Non member		
Jackie Sudworth	✓	✓	✓		
Olawande Salam	Non member		✓		
Denise Richardson	✓	✓	Non member		
Evie Jefferies	✓	X	x		
Iris Cooper	Non member		x		
Kiran Jilani	✓	✓ (private)	x		
Rebecca Holland	✓	A	✓		
Pauline Kennedy	A	✓	A		
Maria Culligan	A	A	Non member		
Rebecca Lunt	Non member		✓		
Kate Hindle	✓	A	✓		
Cllr Angela Coleman	A	A	Non member		
Cllr Patricia Hardy	A	✓	✓		
Rev. Cynthia Dowdle	✓	✓	Non member		
Mary McDonald	A	✓	Non member		
Valarie Fleming	✓	A	Non member		
Niki Sandman	Non member		✓		
Miranda Threfall-Holmes	Non member		A		
Rhianna Moradi	Non member		A		

21/22/	
45	**Introduction, Apologies & Declaration of Interest** **Apologies**: noted above. **Declaration of Interest:** No new declarations received.
46	**Meeting Guidance Notes** Noted.
47	**Minutes of previous meeting held on 22 July 2021** The minutes of the previous meeting were reviewed by the Committee and agreed as an accurate record.
48	**Action Log and matters arising** The action log was reviewed.
49	**Chair's announcements** The Chair noted the following: • Governor Elections 2021 – newly appointed Governors welcomed to the Council. • Christmas Event with Board – proposed as an opportunity to meet each other and discuss the Trust Strategy to consider key challenges and opportunities. • Council Sub-Groups – noted that new sub-group chairs appointed due to Governor terms of office ending. The Council approved the appointed Sub-Group Chairs. Attendance to the Council Sub-Groups was currently an open invitation. The Council was asked to consider a change to allocated membership to ensure attendance and governor representation. The Council was supportive of an allocated membership approach. • Non-Executive Director (NED) Appointments – NED appointment process undertaken in October 2021. Governors approved the proposal for Tracy Ellery to take on the Vice-Chair role.

	• Integrated Care System (ICS) – The implementation of ICS as of April 2022. A Liverpool wide Governor session on ICS and what it means to a Foundation Trust and Governors would be planned in the New Year. The Council of Governors: • Received and noted the briefing from the Chair.
50	**Chief Executive Report** The Executive Team noted the following: • Finance – Challenging position during the second half of 2021/22 noted. Impact of Covid-19 and backlogs of patient activity causing financial pressures across Cheshire and Merseyside health system. The Trust was working with Cheshire and Merseyside towards a breakeven position. • Recovery – Challenge on Trust to recover clinical services to pre-pandemic levels and reduce the backlog of patients. The Trust faced a challenge in relation to surgical waiting lists due to theatre staffing and anaesthetics. The Trust was actively recruiting to theatre staffing and supported staff to prioritise clinical safety. The number of patients on the 52-week list had plateaued and a reduction of patients waiting for a follow up appointment could also be evidenced. The Trust continued to work with Cheshire and Merseyside within a system approach to reduce the backlog of patients. • Gynaecology Inpatient Survey 2020 - the Trust received an overall rating of 'better' in comparison to other Trusts in 6 of the 9 eligible categories of the survey. This shows Liverpool Women's to have performed among the best trusts in the country across a range of categories. Full details of the Liverpool Women's report was available on the CQC website. • Digital – The Council noted a programme of transformation in terms of clinical systems due to go live during Summer 2022. The importance of clinician support to ensure successful implementation and delivery of digital systems within the clinical setting was noted. Examples of significant roles of the Medical Director as the Senior Clinical Officer and Digital Midwives. The Council of Governors: • Received and noted the briefing from the Chief Executive.
51	**Activity Report from the Governor Group Meetings.** • **Finance and Performance Group held 26 July 2021** Peter Norris, Public Governor reported the following matters to note: ○ Significant risks to financial planning during H2 (second half of 2021/22) ○ Audit Reports received ○ Appointment of the External Auditor process • **Quality and Patient Experience Group (QPEG) held 27 September 2021** Sara Miceli-Fagrell, Public Governor reported the following matters to note: ○ Continued challenges faced within Maternity in relation to communication, staffing and sickness. Positive action taken in relation to recruitment and process changes were noted. ○ Organisational sickness absence • **Communications and Membership Engagement Group held 28 October 2021** Jackie Sudworth, Public Governor reported the following matters to note: ○ Membership Strategy – discussion held on how to engage with external groups and service users. A useful platform would be to invite governors to attend planned engagement events. ○ Awareness Days 2022 – agreed to identify one or two key themes to build membership engagement activity around for the year. The Council of Governors:

	• Received and noted the reports from the Governor Sub-Group meetings.
52	**Sickness Absence and Supporting Staff Wellbeing** The Council received a presentation led by the Chief People Officer which detailed a proposed change in process to manage sickness. Currently the Trust sickness rate was at 8% across the Trust against a Trust benchmark of 4.5%. During 2020/21 the Trust lost the equivalent of 31,000 FTE days to sickness of which 12,000 had been declared as due to stress. 44% of staff in the NHS reported experiencing stress/anxiety or depression during 2020; at the Trust 40% said the same. The Trust has in place a robust 'gold standard' sickness management policy in place (3 stages to dismissal for short term absence) however the Trust rarely dismiss under the short term absence element of the policy. Staff have reported a negative experience when being managed by the policy and managers have reported the process as time consuming. The Chief People Officer suggested that in light of feedback from both staff and managers, and in relation to worsening sickness rate and the high proportion of absence linked to stress that the Trust should try a different method to tackle sickness absence. The Chief People Officer explained that they would remove the formal management arrangements related to short term sickness from the policy and introduce more focus on a positive wellbeing conversation exploring wider impacting factors to enable signposting to support at an earlier stage. She explained that stress was very rarely solely related to work and investment in wellbeing would be sought. The process would be aligned to the Fair and Just Culture programme and Be Kind messaging already commenced within the Trust. Kate Hindle, Lead Governor queried when the integrated psychological support would commence. The Chief People Officer responded that a recruitment advert was due to be released for a role to be based onsite. Jackie Sudworth, Public Governor supported a change in practice due to the evidence presented and asked how the team planned to engage staff to accept the new initiative. The Chief People Officer agreed that the workforce would need to see the policy in action and reported some concern in relation to loss of control had been raised. It had been decided that relatively few members of the workforce would abuse the policy in either form. The Chairman informed the Council that the Trust Board had been supportive of the approach. Peter Norris, Public Governor thought it a good option to reinforce positive behaviours rather than negative and asked what metrics of success had been put in place and potential risks identified. The Chief People Officer responded that key performance indicators would be used as a benchmark of success which included: levels of sickness absence; levels of absence attributable to stress; increased levels of staff engagement demonstrated within surveys and attendance to Trust events etc, and increased levels of staff feeling supported. The Chief People Officer noted no new risks due to the current position of sickness absence. The Chief People Officer informed the Council that costs attributable to the new process should be accounted by savings of less days lost to sickness. A reduction of sickness absence would have tangible benefits to the financial position and to patient safety. Niki Sandman, Appointed Governor asked for evidence from other organisations that had implemented this approach. The Chief People Officer responded that the Trust would be the first to implement this process and that NHSE/I was keen to track the Trust's implementation as a new model. Susan Milner, Non-Executive noted it was an innovative and brave change as the temptation could be to increase control and tighten the existing process.

	Rebecca Holland, Staff Governor informed the Council that the Wellbeing Volunteers had engaged positively with the ward managers and positive feedback had been received from staff and managers that they felt supported by the newly introduced Wellbeing Volunteers. Olawande Salam suggested that the sickness absence position could impact on the retention and recruitment of the workforce. The Chief Nurse and Midwife informed the Council of a refreshed approach to midwifery recruitment which included: a rolling recruitment programme, pre-engagement meetings with new recruits, 2-week intensive induction programme before commencing role, introduction of a yellow pin badge to visibly declare newly qualified midwives, introduction of roster management meetings and engagement with community networks to consider the Trust as a place to work. Kate Hindle, Lead Governor noted the visible enthusiasm and energy from the new cohort of midwives who had recently completed their 2-week induction programme. The Council noted the current Trust position and the actions being taken by the Board in an attempt to drive improvements. The Council of Governors: • noted the update for information.
53	**Trust Strategy Update** The Council received a presentation led by the Chief Finance Officer which detailed Our Strategy 2021 – 2025 which outlines the Trust's plans for the next five years with a focus on workforce, safety of services and experience of service users. The Chief Finance Officer confirmed that a key aim remained to progress plans to build a new hospital co-located with an adult acute site. The Trust would continue to implement all feasible mitigations to ensure services delivered from the Crown Street site would be as safe as possible. The Chief Finance Officer informed the Council that the Crown Street Enhancement programme enabled works to mitigate risks and described key workstreams related to a new Fetal Medicine Unit, a new Colposcopy Suite, and the introduction of CT Imaging to the Crown Street site. In addition to this work, the Chief Finance Officer informed the Council of the national Community Diagnostic Centre (CDC) Programme to reform diagnostic services across the country. The Trust had been nominated as a CDC site to provide access to coordinated diagnostic testing for patients at a single site, closer to home, leading to faster and earlier diagnosis. Diagnostics to be included would be: Physiological testing – including ECHO, ECG, BP monitoring, spirometry, lung function testing, FeNO, sleep studies and oximetry; Imaging – ultrasound, x-ray, CT and MRI; and Phlebotomy and pathology testing. Hosting a CDC would aid the Trust to mitigate some of the clinical risks related to an isolated site. Access to capital funding to introduce an MRI and additional testing and diagnostic services to Crown Street would reduce pre-operative cancellations and the number of transfers of women and babies across the city. Hosting a CDC would also support local health partners to increase diagnostic capacity and ensure that patients in Liverpool and across the whole of Cheshire and Merseyside access services when they need them, eliminating delays. Peter Norris, Governor asked would the introduction of the CDC require additional staffing. The Chief Finance Officer responded that the Trust was working closely with partner organisations to work in tandem with existing providers and increase the number of trained staff. The Chairman noted that the CDC Programme was a tangible example of system wide working as 90% of the service would be provided for the city and 10% for the Trust. The Council of Governors: • noted the update for information.

54	**Review of risk impacts of items discussed** The following risk impacts were noted: • Financial risks moving into the second half of the year 2021/22 • Recovery and restoration of clinical services and risks to achieve • Workforce challenge & sickness absence rates • Strategic short term and long term risks No changes to existing risks were identified as a result of business conducted during the meeting. The following positive impacts were noted: • Positive introduction of new initiatives
55	**Chair's Log** None
56	**Any other business:** In relation to the Governor Sub-Group membership and attendance, the Chairman advised that the groups are designed to be shorter information meetings. The Council agreed that a virtual setting would be preferable for shorter meetings however the option to meet onsite for those that preferred could be arranged. **Review of meeting:** • Good presentations delivered. • Hybrid setting of meeting both onsite and virtual deemed to work well. • New Governors felt that the meeting had been informative and felt more connected being onsite

Liverpool Women's NHS Foundation Trust

Action Log

Council of Governors - Public
February 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
13 February 2020	19/20/74	Chief Executive's Update	Council of Governors to receive a presentation on the C-Gull Research Project	Trust Secretary	February 2022	On Track	Presentation on Research Strategy on the February 2022 agenda. Follow-up video specifically on the C-Gull video to be produced.
13 May 2021	21/22/07	Activity Report from the Governor Group Meetings.	Invite LMS Programme Director to attend a future Council meeting to provide an update on wider maternity issues, incorporate Ockenden review, LMS work with LWH.	Trust Secretary	~~February 2021~~ May 2022	On track	Update being provided to the Trust Board in November 2021. Report to the Council of Governors to be scheduled for May 2022 (insufficient time for item to be considered in February 2022).

Liverpool Women's NHS Foundation Trust

Council of Governors Finance & Operational Performance Group

Minutes of the Council of Governors
Finance and Operational Performance Group
held Microsoft Teams at 5.30pm on Monday, 22nd November 2021

PRESENT

Peter Norris	**(PN)**	Public Governor **(Chair)**
Iris Cooper	**(IC)**	Public Governor
Jackie Sudworth	**(JS)**	Public Governor
Evie Jeffries	***(EJ)***	*Public Governor*

IN ATTENDANCE

Robert Clarke	**(RC)**	LWH Trust Board
Mark Grimshaw	**(MG)**	Trust Secretary
Eva Horgan	**(EH)**	Chief Finance Officer
Louise Martin	**(LM)**	Non-Executive Director
Gary Price	**(GP)**	Chief Operating Officer
Diane Thomson	**(DT)**	Executive PA (minutes)

APOLOGIES

Tracy Ellery	**(TE)**	Non-Executive Director
Kate Hindle	**(KH)**	Lead Governor
Rebecca Holland	**(RH)**	Staff Governor

Item number 21/22/	
020	**Introduction, Apologies & Declaration of Interest** Apologies were received and noted as above. There were no declarations of interest.
021	**Virtual Meeting Guidance Notes** The meeting guidance notes were reviewed for information.
022	**Minutes from the last meeting held on 26 July 2021** Minutes of the previous meeting were reviewed and agreed as an accurate record.
023	**Action Log and Matters arising** The current action log was reviewed and updated accordingly.
MATTERS FOR RECEIPT / APPROVAL	
024	**FPBD Committee and Audit Committee Reports** In addition to the report circulated in the meeting pack, LM gave an update on the Finance, Performance and Business Development (FPBD) meeting held earlier that day.

	Committee was well attended and continued to focus on the financial position of the Trust, and progress against the financial plans for the second half of the financial year. Committee were assured that the Trust was focused on performance and ensuring activity continued to occur to meet targets. A link between meeting particular performance targets and receiving Elective Recovery Funding (ERF) was highlighted. It was noted that all individual organisations across C&M must also meet their targets for the Trust to receive funding. A risk was highlighted that other acute Trusts had winter and COVID pressures to contend with. Committee was informed about several projects; digital, Community Diagnostic Centre (CDC), infrastructure and building work. There were existing pressures on staff from COVID and the committee wouldmonitor the impact on staff of these additional projects. PN questioned whether there was an impact on outpatient performance since the incident on 14 November. GP stated that a decision was made Sunday 14 November to cancel any routine outpatient appointments and 2 theatre sessions as it was unclear how much parking space would be available for staff and patients. All essential appointments went ahead, some services were moved to Aintree and staff and patients both welcomed this and were very understanding. Once the site was returned to the Trust from the police patients would be repatriated from Aintree to LWH. GP noted the tremendous effort from staff to keep the hospital services working in such unprecedented circumstances. <u>Audit Committee</u> Audit Committee have been looking into governance arrangements of divisions; Family Health, Gynaecology and Clinical Support Services (CSS). Audit committee interested in governance arrangements at divisional level, how they govern themselves and monitor their performance and risks. A paper had been commissioned for the March meeting on what the parameters were of an effective divisional governance structure and how this would be assessed. There continued to be progress on the internal audit recommendations, these were closely monitored by the Committee. EH noted there have been positive outcomes for data security and protection. MIAA had been assured on the process LWH go through to monitor recommendations. The committee was seeking assurance on third party controls in our contracts. This would be discussed at a future meeting. PN questioned whether the KPMG deal has successfully concluded. EH stated that the Audit Committee had recommended that a panel was put in place to review options and a recommendation was given to Council of Governors. The recommendation was approved by the Council of Governors and EH was meeting with KPMG to inform them and go through the framework paperwork.
025	**Financial & Operational Planning – H2 2021/22** EH noted that the last 18 months have been unprecedented and financial regime has been completely changed. Previously the more activity the Trust did the more funding it received, and funding would be negotiated with commissioners (e.g., Primary Care Trust or Clinical Commissioning Group). This had now changed to block contracts that had to be agreed across a system with other providers. This system was Cheshire & Merseyside Health and Care Partnership (C&M) which comprised of 26 organisations; a collection of NHS, local authority, voluntary, community, faith, and social enterprise organisations from across the nine local authority areas that make up Cheshire and Merseyside. C&M sat above the 26 organisations and received the funding;

	all 26 organisations then had to agree allocations. C&M was scheduled to become a legally constituted organisation in April 2022 – known as an Integrated Care System (ICS). EH advised the financial plan for 2021/22 was split into two halves: H1 and H2. Trust initially only agreeing a plan for the first half of the year. We had achieved the plan for the first half of the year. A plan for the second half of the year had to be ready for submission 25th November 2021. This had been approved as a breakeven plan by the Finance, Performance and Business Development (FPBD) Committee and was agreed with C&M. Each organisation in Cheshire & Merseyside (C&M) has submitted a breakeven plan. There was a risk to Elective Recovery Fund (ERF) as the whole system needed to deliver on their Cost Improvement Programmes (CIP). There were risks of additional spend from winter pressures, non-elective, and maternity pressures and COVID. All organisations had to work together to ensure targets were met to receive their allocations. The original budget for H2 was a deficit of £4m, however through planning this had become a breakeven position with Board sign off. EH noted that it was based on LWH receiving nearly £8m more income but there also would be an increase in spending. EH advised there were risks to the financial position: ▪ Reliance on receiving the ERF; if other organisations within C&M did not achieve their targets, the Trust would not receive this funding ▪ CIP was more significant than previous savings plans, although it had been identified it must be delivered. ▪ Agency spend on midwives was expected to reduce following the recruitment of permanent contract midwives. ▪ Income received for the Community Diagnostic Centre could be revoked if we did not complete agreed activity (X-Rays, ultrasounds). ▪ Financial impact of the major incident 14 November had not yet been quantified. Despite these risks there were also opportunities to note; we could receive funding from other organisations within C&M if they released funds and delivering activity in the CDC without spending as much money. EH noted that there were mechanisms in place for receiving cash if we were heading to a position where we did not have funds to pay staff or bills. EH stated that it was important for the Trust to be clear on why financial decisions had been made and that decisions had had oversight and input from Governors, Board committees, Exec Teams, and divisions. This would help justify our position externally. JS questioned whether the integrated care system was included in financial planning or whether it was too early for this. EH advised that C&M is a precursor to the integrated care system. PN sought assurance regarding associated costs of the major incident 14 November. EH advised the primary concern was staff and patients and to continue to operate as a hospital. There have been assurances from different bodies as high as Secretary of State for Health offering support however there was accepted no mechanism for funding in place. EH was confident the system would support the funding of any associated costs. PN questioned whether there were any measures to monitor if H2 financial plan was going off plan. EH agreed that there were risks and mitigations against these risks were being worked on.
026	**Cancer Performance**

	In Q2 (summer period) cancer performance in terms of waiting times for operations had been below target. This had been due to a combination of annual leave (predictable) and sickness (unpredictable) and challenges with access to theatre lists at The Royal and Aintree hospital sites for complicated procedures. A clinically led task and finish group was established to review the cancer pathway. The Trust was also working with the Cheshire & Merseyside cancer alliance on system improvements. At FPBD earlier today GP presented position to date figures which showed a significant improvement; 80% for 31-day target and over 60% for 62-day target.
CONCLUDING BUSINESS	
027	**Review of risk impacts of items discussed** A review of risk impacts was discussed, risks identified: ▪ Financial position of Trust during H2 ▪ Cancer wait time performance
028	**Any other business & Review of meeting** The meeting was effective, and actions were progressed. IC explained frustration at the use of acronyms. RC asked if people could explain the acronym they're using. MG agreed to include a jargon buster in future meeting packs and offered to work with all governors regarding the Trust's governance structure. **Action:** *MG to include acronym jargon buster in future meeting packs.*

Date of Next Meeting: 28 March 2022 at 5.30pm on Microsoft Teams

Minutes of the Quality and Patient Experience Governor Sub-Group
held virtually at 17:30hrs on Monday 24th January 2022

PRESENT

Sara Miceli-Fagrell (Chair)	Public Governor
Peter Norris	Public Governor
Evie Jeffers	Public Governor
Jackie Sudworth	Public Governor
Ruth Parkinson	Public Governor
Niki Sandman	Appointed Governor
Jane Rooney	Appointed Governor
Yaroslav Zhukovskyy	Public Governor
Pat Deeney	Public Governor
Kate Hindle	Lead Governor / Staff Governor

IN ATTENDANCE

Gloria Hyatt	Non-Executive Director
Michelle Turner	Chief People Officer
Marie Forshaw	Chief Nurse & Midwife
Lynn Greenhalgh	Medical Director
Mark Grimshaw	Trust Secretary
Tony Okotie	Non-Executive Director
Lisa Gregory	Executive Assistant/Minute Taker

APOLOGIES:

Robert Clarke	Chair of LWH Board

21/22/	Items Covered
028	**Introductions, Apologies & Declarations of Interest** Sara Miceli-Fagrell (Chair) welcomed everyone to the meeting. **Declarations of interest** There were no declarations of interest. **Apologies** Robert Clarke – Chair of LWH Board.
029	**Meeting Guidance notes** Noted.
030	**Minutes of the previous meeting held on 27 September 2021** The minutes of the meeting held on Monday 27 September 2021 were approved.

031	**Action Log and Matters Arising** Fair & Just Culture Training – Mark Grimshaw updated that he had liaised with Kathy Franey; that the Fair & Just Culture sessions would resume in the near-future and that Governors would be invited. Net-call response times – Mark updated that he was working with the Access Manager on the best way to present back; that he would email Governors with further information. Jackie Sudworth asked how many people were on the triage team. Mark Grimshaw updated that there were 5 members of the team. Lynn Greenhalgh updated on a walkabout undertaken by herself and Marie Forshaw. It was noted that triage Midwives were now based in a separate office, with a new designated space which should lead to an improvement in response and quality of service.
032	**Quality Committee and Putting People First Committee Reports** **Quality Committee:** Tony Okotie advised the Committee that a lot of the key points would be covered in the agenda, so opened the floor up to any questions. The Chair questioned whether the Trust was sure that the blood sampling training was sufficiently robust. Lynn Greenhalgh updated that this was multi-pronged and not just about the training; that a paper would be brought through Committees, summarising interventions and looking at next steps. The Chair asked that the outputs be brought to next meeting. *Action – Outputs of Blood sampling assurance to be provided to the next meeting.* **Putting People First Committee:** Michelle Turner updated the Committee on vaccinations being a condition of deployment, stating that there was a lot of focus on staffing pressures. Michelle advised that the PPF Committee had looked at the risk on the BAF re: sufficient numbers of staff to deliver safe care. The Committee noted that the BAF risk was scored at 20, with the highest being 25. Michelle updated that the Family Health Divisional Management Team were in attendance, that there was a very low rate of Mandatory Training compliance as the priority was around safe care and that this had been a real challenge. Michelle updated that the Committee had looked at how Continuity of Carer was implemented into the organisation; at whether this was something the Trust could do better at in the future. It was noted that the Committee had received an update from Freedom to Speak Up Guardian and that discussion had taken place on future Doctors training. Lynn stated that the paper on GPs was very good and outlined areas for improvement. Peter Norris questioned when the Trust would start recruiting for this year, stating that other trusts had already started their recruitment process. Marie advised that a rolling programme of midwife recruitment was in place but undertook to seek clarification on when offers were made by the Trust to student midwives. *Action – To seek clarification on when the Trust opened for applications from student*

	midwives. Peter Norris questioned how resilient teams had been with regards to Continuity of Carer, and whether the Trust has been able to increase numbers in the respective teams. Marie updated that the Trust had taken the opportunity to pause and reflect; that we had been identified as having the right risk profile case. Marie advised that teams had been very resilient; that they were now at the point of reviewing capacity. It was noted that Midwives had reported good job satisfaction. Mark Grimshaw updated the new Governors that Continuity of Carer was a nationally recommended model that meant a patient would have a named Midwife, with the support of a small team, that would work together to provide all the patient care during pregnancy, birth and after the baby was born.
033	Restoration and Recovery – backlog and cancer performance Mark Grimshaw shared a presentation with the Group, explaining the 2 week wait and access targets. Mark updated on the clinically lead task group, stating that the Trust had seen improvements in cancer wait times as a result. Mark updated that the Trust was ahead of trajectory by 15 cases at present – the only Trust to be in this position in the Cheshire and Merseyside system. The Chair questioned why it had started to go in the wrong direction, asking if this was due to the Omicron. It was confirmed that this was primarily due to Omicron and staffing shortages. It was noted that the 52week waits were quite low at the start of the pandemic; that these had risen due to more referrals as people have delayed going to see their GPs, with the Trust now seeing the impact of this, resulting in 320 patients who had now waited over 52 weeks. An update was provided to the Group on the 52 week forecasts and assurance was provided that harm reviews were undertaken on a regular basis. Ruth Parkinson questioned how harm reviews would be done. Lynn advised that these would be carried out by a Senior Nurse or Medic, every three months. That this would either be face-to-face or over the telephone. Lynn Greenhalgh stated that the Theatre and Gynaecology teams had done exceptionally well though the Omicron variant, only having had to cancel one list. Lynn thanked everyone who helped with this. Peter questioned why the Trust was so ahead. Lynn updated that as a smaller Trust, we were able to flex our staff to be more agile and that we had also recruited Theatre staff. Mark updated that diagnostics were also a key cause; that hopefully in 6-9months time, the diagnostic capability would improve was the Community Diagnostic Centre was operational.
034	Quality Improvement Update Marie Forshaw updated the Committee that the 2019 Care Quality inspection noted that improvements were required to the Trust's Quality Improvement processes, particularly in ensuring that it was embedded at all levels in the organisation. In September 2021, the Trust had brought in MIAA to look at processes regarding engaging with staff. The Committee noted that MIAA had presented to the Quality Committee at the meeting of 24 January 2022. Marie advised that MIAA had identified how the Trust effectively use staff time and how it offers training and resource support. Marie stated that she would share any

	updates with Governors. Mark stated he would bring some examples of Quality Improvement to give Governors a better understanding. The Chair stated that something tangible would be good, that this would really bring it to life. *Action – To provide Quality Improvement case studies to the next scheduled meeting*
035	**Vaccine a Condition of Deployment** Michelle updated the Committee on new regulations that came into effect on 6th January 2022. Michelle advised the Governors that the vaccine was a personal choice however, being unvaccinated could mean that staff were not permitted by law to carry out the duties of their role. It was noted that where the Trust were not able to redeploy staff, their contracts would be terminated. The Committee was updated that (to date) 7% of LWH staff had not received the vaccine. It was noted that this number may include pregnant staff and medically exempt staff. The HR team were looking into the reasons for vaccine refusal / hesitancy and connecting staff with different experts for advice, depending on their reasons for not being vaccinated. It was noted that work was taking place with OCS, Educational providers and volunteer staff. Marie stated that lots of opportunities had been created for colleagues to be vaccinated - additional clinics, starting early, finishing late etc. Peter questioned what assurance we had that agency staff have been vaccinated. Marie advised that this process would be robust, that we would build a requirement into contracts. Ruth questioned how redeployment would work. Michelle updated that there was no automatic right of redeployment, that we would identify roles and follow the usual recruitment processes. Mark Grimshaw advised that divisions had had to plan for potentially losing staff; that Non-Executive Directors and Governors were in scope; that he would be emailing to ask individuals if they have been vaccinated and that evidence would be required. Pat Deeney questioned what provisions were in place. Michelle updated that the Trust was looking at worse case scenarios; that the number would reduce but we would still undoubtedly lose staff. It was noted that the Trust should be able to manage risk associated with this; that Divisional Managers were looking at this to ensure it would not de-stable the Trust.
036	**Terms of Reference** The Committee noted that there would be one change with regards to the membership limit, that there would be at least six Governors going forward; that three out of the six Governors would need to be present for each meeting for a quorum. Mark and Marie stated that they would welcome the attendance of Governors at the Patient Involvement and Experience Sub-Committee. Kate Hindle offered to attend going forward. Jacqui Sudworth stated she would also like to be added to the membership.
	CONCLUDING BUSINESS
037	**Review of risk impacts of items discussed** Vaccine a condition of deployment.

	Backlog and waiting lists, these were noted as being closely monitored but remain a risk.
038	**Any other business and review of meeting** Kate stated that she was pleased with assurances from Michelle and Marie. Jackie stated there had been good debates. Mark updated that he was working on a 'jargon buster' with regards to NHS acronyms, that the jargon buster would go into meeting packs going forward.

Date of next meetings:

- The next full Council of Governors – Thursday, 10 February 2022
- The Council of Governors QPEG – 25 April 2022

Liverpool Women's NHS Foundation Trust

Council of Governors 'Communications and Membership Engagement Group'

Minutes of the Council of Governors 'Communications and Membership Engagement Group' held virtually at 5.30pm on 16th December 2021

PRESENT

Jackie Sudworth	Public Governor (Chair)
Susan Milner	Non-Executive Director / SID
Rebecca Lunt	Staff Governor
Gloria Hyatt	Non-Executive Director
Robert Clarke	Trust Chair

IN ATTENDANCE

Mark Grimshaw	Trust Secretary
Lesleyanne Saville	Corporate Affairs Manager (Minutes)

APOLOGIES:

Andrew Duggan	Head of Communications
Peter Norris	Public Governor

21/22/	
031	**Introduction, Apologies & Declaration of Interest** The Chair welcomed all to the meeting and noted apologies as above. No declarations were noted. The Chair noted thanks to the previous Chair of the Group, Cynthia Dowdle, who had left the Trust as her term of office as an appointed governor had ended.
032	**Meeting Guidance Notes** Noted.
033	**Minutes of the Previous Meeting held on 16 December 2021** The minutes of the meeting held on 28 October 2021 were agreed as an accurate record.
034	**Action Log and matters arising** 21/22/16 – The Trust Secretary noted that discussions were taking place with Appointed Governor Nikki Sandman from University of Liverpool. It was also noted that a new governor was due to commence in their role shortly from Edge Hill. Progress on these discussions would be shared at the next meeting. Trust Secretary to also liaise with Tina Atkins, Brownlow Group Practice. Trust Secretary noted the vacancy for Student Governor is available and should this position be filled it would afford further insight into women's services from a young person's perspective. The Chair noted that discussions were on-going with Dez Chow (Diversity and Inclusion Lead) regarding potential engagement events and further information would be shared in

	2022
035	**Identification of key areas of focus – 2022 / Awareness Days 2021** The Group noted and discussed the key areas of focus for awareness days for 2022 in order to gain patient and public feedback to enable service improvement. It was agreed that it would be important to identify key themes to build membership engagement activity around, e.g., such as employment and careers and Women's Health. To be more effective it was agreed that rather than the Committee develop standalone membership events, as from experience they do not necessarily generate strong attendance, but to effectively 'piggyback' on women's health related events in the local community and use this as an opportunity to speak with local people on awareness on women's health. Consultation process to take place early in 2022 to gain which of our services the public want to engage with. In addition to this, it was noted that membership patient leaflets were out of date (albeit not allowed to leave leaflets out currently due to Covid-19 IPC restrictions). Gloria Hyatt, Non-Executive Director, suggested that these could be updated and/or converted into electronic posters for in sit TV monitors. The Chair suggested the Governors should get involved in the planning of the events as this would encourage their areas of interest. The Trust secretary highlighted that he was in conversation with Liverpool trust colleagues who would be sharing their membership events. **Action:** To identify contacts such as Anne Bridson and Equality and Diversity lead Dez Chow and others to gain what events they have planned or know about in the community for 2022. **Action:** Work to be done early in the new year that reaches out to local communities to source what our communities have planned for the coming year and how we can contribute to this. Lesleyanne to compile survey to be circulated in the New Year.
036	**Review of risk impacts of items discussed** None noted.
037	**Any other business & Review of meeting** No comments made. None noted & no comments made.

Date of Next Meeting: TBC – possibly February 2022 once survey results made available.

Liverpool Women's NHS Foundation Trust

Council of Governors

COVER SHEET

Agenda Item (Ref)	***2021/22/76***	**Date: 10/02/2022**		
Report Title	**Council of Governors Nomination & Remuneration Committee Terms of Reference**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***The report presents the Nomination & Remuneration Committee Terms of Reference for approval following a recommendation from the Committee***			
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 Council of Governors is requested to review the Terms of Reference at Annex A of the report, taking into account the Issues for Consideration detailed, and the recommendation for approval from the Committee, ahead of providing approval.			
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**
NARC	Dec 21	Trust Secretary	Recommended for approval.

EXECUTIVE SUMMARY

The report presents the Committee Terms of Reference for review and if deemed appropriate, approval..

MAIN REPORT

INTRODUCTION

The Terms of Reference for the Committee were last reviewed and approved by the Council of Governors on 13 February 2020. Section 11 of the current Terms of Reference states that "***The terms of reference of the committee shall be reviewed by the council of governors at least every two years".*** Consequently, the Terms of Reference are due for review.

ISSUES FOR CONSIDERATION

It is asserted that the Committee has continued to undertake the duties as set out in its Terms of Reference and no issues have been identified to date that would require an amendment.

Other than moving the Terms of Reference onto the agreed Corporate Trust template, no other amendments are proposed.

The updated terms of reference were reviewed by the Council of Governors Nomination & Remuneration Committee on 14 December 2021 and were recommended for approval by the Council of Governors.

RECOMMENDATION

The Council of Governors is requested to review the Terms of Reference at Annex A of the report, taking into account the Issues for Consideration detailed, and the recommendation for approval from the Committee, ahead of providing approval.

Liverpool Women's NHS Foundation Trust

Annex A

COUNCIL OF GOVERNORS
NOMINATION AND REMUNERATION COMMITTEE
TERMS OF REFERENCE

Constitution:	The council of governors' nomination and remuneration committee (the committee) is constituted as a standing committee of the council of governors. Its constitution and terms of reference shall be as set out below, subject to amendment at future meetings of the council of governors. The committee is authorised by the council of governors to act within its terms of reference. All members of staff are requested to co-operate with any request made by the committee. The committee is authorised by the council of governors, subject to funding approval by the board of directors, to request professional advice and request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions. The committee is also authorised to request such internal information as is necessary and expedient to the fulfilment of its functions.
Duties:	**1. NOMINATION ROLE** The committee will: 1.1 Periodically review the balance of skills, knowledge, experience and diversity of the non-executive directors and, having regard to the views of the board of directors and relevant guidance on board composition, make recommendations to the council of governors with regard to the outcome of the review. 1.2 Review the results of the board of directors' performance evaluation process that relate to the composition of the board of directors. 1.3 Review annually the time commitment requirement for non-executive directors. 1.4 Give consideration to succession planning for non-executive directors, taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the board of directors in the future. 1.5 Make recommendations to the council of governors concerning plans for succession, particularly for the key role of chair.

Annex A

	1.6 Keep the leadership needs of the trust under review at non-executive level to ensure the continued ability of the trust to operate effectively in the health economy. 1.7 Keep up-to-date and fully informed about strategic issues and commercial changes affecting the trust and the environment in which it operates. 1.8 Agree with the council of governors a clear process for the nomination of a non-executive director. 1.9 Take into account the views of the board of directors on the qualifications, skills and experience required for each position. 1.10 For each appointment of a non-executive director, prepare a description of the role and capabilities and expected time commitment required. 1.11 Identify and nominate suitable candidates to fill vacant posts within the committee's remit, for appointment by the council of governors. 1.12 Ensure that a proposed non-executive director's other significant commitments are disclosed to the council of governors before appointment and that any changes to their commitments are reported to the council of governors as they arise. 1.13 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported. 1.14 Ensure that on appointment non-executive directors receive a formal letter of appointment setting out clearly what is expected of them in terms of time commitment, committee service and involvement outside board of director meetings. 1.15 Advise the council of governors in respect of the re-appointment of any non-executive director. Any term beyond six years must be subject to a particularly rigorous review. 1.16 Advise the council of governors in regard to any matters relating to the removal of office of a non-executive director. 1.17 Make recommendations to the council of governors on the membership of committees as appropriate, in consultation with the chairs of those committees. **2. REMUNERATION ROLE** The committee will: 2.1 Recommend to the council of governors a remuneration and terms

Annex A

	of service policy for non-executive directors, taking into account the views of the chair (except in respect of his own remuneration and terms of service) and the chief executive and any external advisers. 2.2 In accordance with all relevant laws and regulations, recommend to the council of governors the remuneration and allowances, and the other terms and conditions of office, of the non-executive directors. 2.3 Receive and evaluate reports about the performance of individual non-executive directors and consider this evaluation output when reviewing remuneration levels. 2.4 In adhering to all relevant laws and regulations establish levels of remuneration which: 2.4.1 are sufficient to attract, retain and motivate non-executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the trust; 2.4.2 reflect the time commitment and responsibilities of the roles; 2.4.3 take into account appropriate benchmarking and market-testing, while ensuring that increases are not made where trust or individual performance do not justify them; and 2.4.4 are sensitive to pay and employment conditions elsewhere in the trust. 2.5 Oversee other related arrangements for non-executive directors.
Membership:	The membership of the committee shall consist of: • The chair of the trust and; the following, appointed by the council of governors for a maximum term of three years (subject to individuals maintaining governor status): • two public governors • one staff governor • one appointed governor • the lead governor The committee will be chaired by the chair of the trust. Where the chair has a conflict of interest, for example when the committee is considering the chair's re-appointment, remuneration or performance, the committee will be chaired by the senior independent director (SID) or failing the SID the vice chair. Any non-executive director present at committee meetings, will withdraw from discussions concerning their own re-appointment, remuneration or terms of service.

Liverpool Women's NHS Foundation Trust

Annex A

Quorum:	A quorum shall be three 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:	Only members of the committee have the right to attend committee meetings. At the invitation of the committee, meetings shall normally be attended by the Chief Executive and Chief People Officer. Other persons may be invited by the committee to attend a meeting so as to assist in deliberations.
Frequency:	Meetings shall be held as required, but at least once in each financial year.
Authority:	The Committee is authorised by the Council of Governors 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.
Accountability and reporting arrangements:	The Committee will be accountable to the Council of Governors. Formal minutes shall be taken of all committee meetings and once approved by the committee, circulated to all members of the council of governors unless a conflict of interest or matter of confidentiality exists. The committee will report to the council of governors after each meeting.
Reporting Committees/Groups	N/A
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	The terms of reference of the committee shall be reviewed by the council of governors at least every two years.
Reviewed by Committee	14/12/2021
Approved by Council of Governors	TBC
Review date:	12/23
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

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	the value of a country's overall output of goods and services
GDPR	General Data Protection Regulations	The legal framework which sets the guidelines for collecting and processing personal information from individuals living in the European Union

H		
HCAI	Healthcare Associated Infection	these are infections that are acquired in hospitals or as a result of healthcare interventions; MRSA and Clostridium difficile can be classed as HCAIs if caught whilst in a healthcare setting
HCA	Health Care Assistant	staff working within a hospital or community setting under the guidance of a qualified healthcare professional
HDU	High Dependency Unit	an area in a hospital, usually located close to the ICU, where patients can be cared for more extensively than on a normal ward, but not to the point of intensive care, e.g. patients who have had major surgery
HEE	Health Education England	the body responsible for the education, training and personal development of NHS staff
HR	Human Resources	the department which focusses on the workforce of an organisation including pay, recruitment and conduct
HRA	Health Research Authority	protects and promotes the interests of patients and the public in health research
HSCA 2012	Health & Social Care Act 2012	an Act of Parliament providing the most extensive reorganisation of the NHS since it was established, including extending the roles and responsibilities of governors
HSCIC	Health and Social Care Information Centre	the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care
HTA	Human Tissue Authority	regulates the removal, storage, use and disposal of human bodies, organs and tissue for a number of scheduled purposes such as research, transplantation, and education and training
HWB / HWBB	Health& Wellbeing Board	a local forum to bring together partners from across the NHS, local government, the third sector and the independent sector, led by local authorities
	Health Watch	A body created under the Health and Social Care Act 2012 which aims to understand the needs and experiences of NHS service users and speak on their behalf.

I		
IAPT	Improved Access to Psychological	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 detail 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