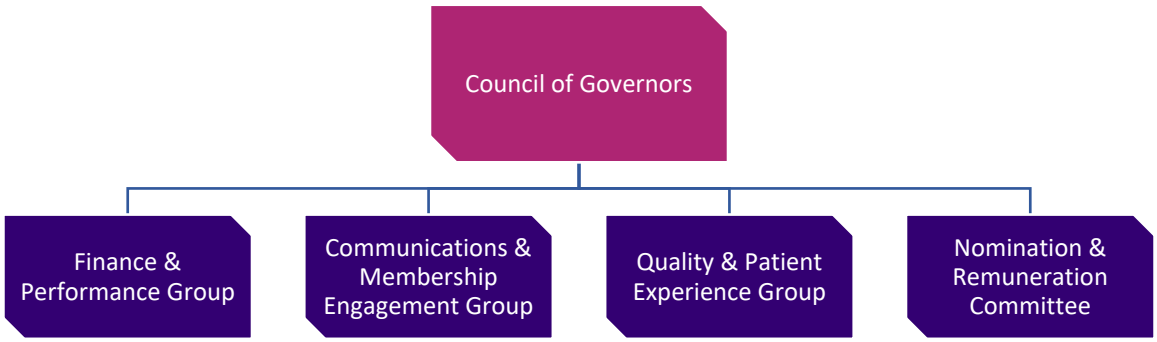
Liverpool Women's
NHS Foundation Trust

Council of Governors

9 February 2023, 5.30pm
Blair Bell Lecture Theatre &
Virtual Meeting, via Teams



Liverpool Women's NHS Foundation Trust

Council of Governors - Public

Location	Blair Bell Lecture Theatre and Virtual via Teams
Date	9 February 2023
Time	5.30pm

AGENDA					
Item no. 22/23/	**Title of item**	**Objectives/desired outcome**	**Process**	**Item presenter**	**Time**
PRELIMINARY BUSINESS					
066	**Introduction, Apologies & Declaration of Interest**	Receive apologies & declarations of interest	Verbal	Chair	**17.30 (5 mins)**
067	**Meeting Guidance Notes**	To receive the meeting attendees' guidance notes	Written	Chair	
068	**Minutes of the meeting held on 17 November 2022**	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
069	**Action Log and matters arising**	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
070	**Chair's announcements**	Announce items of significance not found elsewhere on the agenda	Presentation	Chair	**17.35 (15 mins)**
071	**Chief Executive Report**	Report key developments and announce items of significance not found elsewhere on the agenda	Presentation	Chief Executive	**17.50 (10 mins)**
MATTERS FOR CONSIDERATION					
072	**Draft Minutes from the Governor Group Meetings.** • **Quality and Patient Experience Group held 23.01.23** • **Communications and Membership Engagement Group held 26.01.23**	Receive minutes for assurance	Written	Group Chairs	**18.00 (15 mins)**
073	**Maternity and neonatal services in East Kent: 'Reading the signals' report – LWH Response**	To receive	Presentation	Chief Nurse	**18.15 (30 mins)**

074	**Liverpool Clinical Services Review**	To receive and discuss	Written	Chief Finance Officer	**18.45 (30 mins)**
CONCLUDING BUSINESS					
075	**Review of risk impacts of items discussed**	Identify any new risk impacts	Verbal	Chair	**19.15 (5 mins)**
076	**Chair's Log**	Identify any Chair's Logs	Verbal	Chair	
077	**Any other business & Review of meeting**	Consider any urgent items of other business	Verbal	Chair	
078	**Jargon Buster**	For information and reference	Written	Chair	
Finish Time: 19.20					

Date of Next Meeting: 18 May 2023

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

Minutes of the Council of Governors held in the Blair Bell Lecture Theatre and Virtually at 1730hrs on Thursday 17 November 2022

PRESENT

Robert Clarke	Chair
Iris Cooper	Public Governor (Rest of England and Wales)
Pat Denny	Public Governor (Central Liverpool)
Alison Franklin	Staff Governor (Midwives)
Annie Gorski	Public Governor (Sefton)
Kate Hindle	Staff Governor (Admin & Clerical)
Rebecca Holland	Staff Governor (Nurses)
Rebecca Lunt	Staff Governor (Scientists, Technicians & AHPs)
Peter Norris	Public Governor (Central Liverpool)
Ruth Parkinson	Public Governor (Central Liverpool)
Angela Ranson	Public Governor (South Liverpool)
Jane Rooney	Appointed Governor (Education Institutions)
Niki Sandman	Appointed Governor (University of Liverpool)
Lena Simic	Appointed Governor (Liverpool Council)
Jackie Sudworth	Public Governor (Knowsley)
Yaroslav Zhukovskyy	Public Governor (Sefton)

IN ATTENDANCE

Jackie Bird	Non-Executive Director
Zia Chaudhry	Non-Executive Director
Mark Grimshaw	Trust Secretary
Jenny Hannon	Associate Director of System Partnership
Louise Hope	Assistant Trust Secretary (minutes)
Eva Horgan	Chief Finance Officer
Jen Huyton	Associate Director of Strategy
Gloria Hyatt	Non-Executive Director
Louise Martin	Non-Executive Director
Kathryn Thomson	Chief Executive
Lesley Mahmood	Member of the Public
Sheila Altes	Member of the Public

APOLOGIES:

Carol Didlick	Public Governor (South Liverpool)
Patricia Hardy	Appointed Governor (Sefton Council)
Kiran Jilani	Staff Governor (Doctors)
Olawande Salam	Public Governor (Rest of England and Wales)
Marie Stuart	Appointed Governor (Knowsley Council)
Irene Teare	Public Governor (Central)
Miranda Threfall-Holmes	Appointed Governor (Faith Organisations)

Core members	**May**	**July**	**Nov**	**Feb**
Peter Norris	✓	✓	✓	
Carol Darby-Darton	x	NM		
Pat Denny	✓	✓	✓	
Ruth Parkinson	✓	✓	✓	
Irene Teare	NM		A	

Sara Miceli-Fagrell	✓	A	NM	
Carol Didlick	A	A	A	
Angela Ranson	NM		✓	
Yaroslav Zhukovskyy	A	✓	✓	
Annie Gorski	A	✓	✓	
Jackie Sudworth	✓	✓	✓	
Evie Jefferies	✓	A	NM	
Iris Cooper	✓	✓	✓	
Olawande Salam	NM		A	
Kiran Jilani	A	A	A	
Rebecca Holland	A	A	✓	
Pauline Kennedy	✓	A	NM	
Alison Franklin	NM		✓	
Rebecca Lunt	✓	A	✓	
Kate Hindle	A	✓	✓	
Cllr Lucille Harvey	✓	NM		
Cllr Lena Simic	NM	✓	✓	
Cllr Patricia Hardy	✓	A	A	
Niki Sandman	✓	✓	✓	
Rev Dr Miranda Threfall-Holmes	✓	A	A	
Jane Rooney	✓	✓	✓	
Cllr Marie Stuart	NM	A	A	

22/23/	
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 28 July 2022** The minutes of the previous meetings were reviewed by the Committee and agreed as an accurate record.
48	**Action Log and matters arising** The action log was noted.
49	**Chair's announcements** The Chair noted the following key announcements: • New Governors: welcomed the newly appointed Governors to the Council • A year on from the Major Incident: a remembrance service had been held for staff • Annual Learners celebration had been held celebrating educational achievements of staff • Quality and Patient Experience Sub-Group: announced the new Chair for the group as Ruth Parkinson. • System Update Integrated Care Board (ICB) and Cheshire and Merseyside Acute and Specialist Trust (CMAST): shared the CMAST Governance structure chart and ICS sphere of operation chart for clarity. The Council of Governors: • Received and noted the briefing from the Chair.
50	**Chief Executive Report** The Chief Executive noted the following:

	• Chief Nurse and Midwife: following a competitive interview process, Dianne Brown (currently Interim Chief Nurse) had been appointed to the role of Chief Nurse, subject to the completion of all pre-employment checks. • Chief Midwifery Officer of England, Professor Jacqueline Dunkley-Bent: Prof Jacqueline Dunkley-Bent visited the Trust and officially opened the first Bereavement Room on Delivery Suite, launching our Bereavement Suite Appeal. The appeal aims to raise £100k to transform a number of rooms across Maternity and Gynaecology. During her visit Jacqueline awarded Bereavement Midwives, Maria Kelleher and Pauline McBurnie and Bereavement Support Worker, Sarah Martin with a special Chief Midwife Award for their endless work and compassionate care given to our families at their most difficult time. • The CQC had published its report on the state of health care and adult social care in England 2021/22: The report looks at the trends, shares examples of good and outstanding care, and highlights where care needs to improve. • Independent investigation into East Kent Maternity and Neonatal Services. The Trust had reviewed the findings of the report and had requested that the Family Health division provide a response to the report to the Quality Committee and to the Trust Board to provide the requested assurances. The Council of Governors: • Received and noted the briefing from the Chief Executive.
51	**Activity Report from the Governor Group Meetings** Governors meet and spend time with NEDs and Executives to gain assurance on how the Board and the Non-Executive Directors manage issues and get their assurances. • **Finance and Performance Group held 24.10.22** The Council noted the following key matters: ○ continued challenge to achieve the year-end financial plan. If the Trust could not deliver against plan 2022/23, this would result in additional scrutiny at a system and regional level. The Governors sought assurances that there was sufficient control over spending and had been advised that spending was prioritised appropriately. The Committee would continue to closely monitor the position. ○ continued work to develop a robust annual and long term operational and financial plan. Rebecca Holland, Staff Governor asked whether the financial position had been impacted by the necessary Crown Street Enhancements works. The Chief Executive responded that there had been a small impact as a result of investments made, there had also been additional costs to run as a single site provider, however in-year the majority related to high agency usage. Lena Simic, Appointed Governor referred to staff morale in relation to high sickness absence and its subsequent impact on patient experience, impending industrial strike action, and the negative staff survey results, and queried what was being done to help improve the staff experience. Gloria Hyatt, Non-Executive Director responded that the Putting People First Committee had been regularly monitoring and addressing staff needs at its meetings and noted the following initiatives underway to support staff, e.g. Big Conversation, and Group Huddles. The Chairman noted that the majority of issues expressed related to sufficient staffing, and that a lot of effort had been made to increase staffing which should improve staff experience and retention going forward. The Chief Executive informed the Council that they had appointed a Clinical Psychologist for staff to provide additional support. The Chief Executive noted the positive introduction of the Preceptorship Model to onboard newly qualified midwives and a look towards developing a Postceptorship Model for those already in Band 6/7 positions to improve staff experience and to develop future leaders.

Yaroslav Zhukovskyy, Public Governor asked what percentage of cover staff came from NHS Professionals? The Chief Executive responded that this information could be provided and that the Trust preferred to use NHS Professionals for additional staffing as Trust staff were members of this staff bank.

Jane Rooney, Appointed Governor queried any plans to increase or enhance the role of the Professional Midwifery Advocate and Professional Nurse Advocate (PMA/PNA) as part of staff wellbeing. The Chief Executive responded that this had been included in plans and would ask Dianne Brown to share plans with Jane Rooney.

Action: Share plans in relation to the development of the Professional Midwifery Advocate and Professional Nurse Advocate roles.

- **Quality and Patient Experience Group held 26.09.22**
  Jackie Sudworth, Public Governor reported the following matters to note:
  - Blood sampling errors had been a significant matter monitored by the Quality Committee. In light of limited progress to date the Executive Team are to provide a clear action plan to drive improvements.
  - Patient Experience update in relation to contacting Gynaecology Emergency Department and Maternity Assessment Unit. The group noted that the response time and advice had not always been sufficient and a requirement to relook at the service model. The Group had been assured that that the Quality Committee would continue to monitor the position on a monthly basis.

- **Communications and Membership Engagement Group held 29.09.22**
  Jackie Sudworth, Public Governor reported the following matters to note:
  - Noted limited progress against the Membership Strategy 2021/25 Objectives. The Group agreed to focus on two key aspects of the strategy to support demonstrable progress more timely, which would also support more effective membership engagement
  - The development of a Patient & Public Engagement Group (PPEG), established to undertake the following: targeted Future Generations (FG) engagement in the short term; regular targeted engagement in the longer term more broadly on issues relating to all the Trust's services; and to improve meaningful stakeholder and community engagement across the Trust. It was noted that there would be governor representation on the PPEG.

The Council of Governors:

- Received and noted the reports from the Governor Sub-Group meetings.

Rebecca Lunt left the meeting at this point.

52 **Learning from Governor/NED Development Session**

The Council received a presentation delivered by Ruth Parkinson, Public Governor and Zia Chaudhry, Non-Executive Director (NED) summarising the joint development session facilitated by NHS Providers. The objectives of the session had been to:

- reiterate the roles of Governor and NED and consider key differences
- develop effective questioning and challenge techniques
- develop governor and NED relationships

Ruth Parkinson reflected as a Governor that a key duty of the governors is to hold the Board to account by reviewing Board processes and holding NEDs to account for assurances and less focus should be given on the detail of performance reports. The difference between asked questions for clarification and asking questions to hold to account was noted as important for governors to understand to improve their performance as a Council. The importance of directing holding to account questions to Non-Executive Directors rather than Executive Directors to avoid going into operational detail.

	Zia Chaudhry, reflected as a NED that the session had been useful to reiterate the respective roles of the Governor and the Non-Executive Director. It was important to remember as a Non-Executive Director, to present the 'working out' to governors regarding how assurance has been sought, and where appropriate how triangulation had been utilised by the NEDs to receive sufficient levels of assurance. He reflected the need to avoid 'passing over' questions to Executive Directors to provide the technical detail, and to support the direction of questions to seeking assurance on the process, rather than the outcome. The Trust Secretary suggested that governors email ahead of meetings with technical and clarification questions to help formulate holding to account questions and support effective meetings. The Governors and NEDs that had attended the session agreed that the session had been valuable and meeting other governors and NED's in a face-to-face setting had been beneficial. The Council of Governors: • noted the update for information. *Zia Chaudhry left the meeting at this point.*
53	**Our Strategy – Review of Delivery and looking forward to 2023/24** The Trust's overarching strategy, Our Strategy 2021-2025, was developed during 2020/21 and launched in April 2021. The report provides an update to the Council of Governors in respect of progress made towards delivery of the objectives and achievement of the ambitions set out within the strategy. The Trust Secretary explained that in NHS foundation trusts it is for the board of directors to set and own the organisation's strategy. However, councils of governors have a role in making an input to strategy and, in feeding in the views of foundation trust members and of the public. The Council of Governors also has a role to hold the Board to account for the delivery of the Trust's Strategy. The Associate Director of Strategy provided an update to the Council of what had been achieved by the Trust to date against the objectives within the Strategy, noting sufficient progress despite challenges in relation to workforce and covid recovery during the past year. Peter Norris, Public Governor acknowledged the ambition of the Trust in ensuring its workforce reflected the local community, and queried the specific use of the Riverside ward as a measure. He also added that local government wards were being reviewed which might have an impact on the demographics of this geographical area. Gloria Hyatt, NED accepted the challenge and reiterated the aim of the objective. It was acknowledged that this might need to be reviewed to ensure that it was helping supporting the Trust delivering this aim. A workshop was facilitated which consisted of three groups including Governor and Board members to consider the top three priorities for 2023/24. The report provided to the Council looked ahead to the 2023/24 operational planning process highlighting local, regional and national issues that Governors could consider as part of the breakout discussion. The following key priorities were noted against the question: Group 1 • Staff experience • Equality of health experience and outcomes • Listening and learning effectively Group 2 • Staff people security: work with younger people to encourage clinical careers

	• Safety: securing plans for the future of services in Liverpool • Quality and Experience for patients and staff and not to lose any ambition Group 3 • Gender / Ethnic Inequalities • National Women's Strategy • Workforce – engaged and focussed. In addition, the following priority areas were noted from those attending the meeting virtually: • Patient Experience (reduce unnecessary waiting/improve communications) • Service Resilience (minimise cancellations or postponements of treatment/appointments) • Workforce Engagement (empower staff/maximise support) • Utilising digitalisation increased digital maturity to innovate how we deliver services to our patients It was agreed that the goals must be measurable and achievable. The Council of Governors: • noted the progress towards delivery of Our Strategy and its strategic objectives; • provided options of key priorities for the Trust to contribute to the operational planning for 2023/24 *Jane Rooney left the meeting at this point.*
54	**Review of risk impacts of items discussed** No changes to existing risks were identified as a result of business conducted during the meeting. The following risks were noted: • Engagement with the local community • Health inequalities
55	**Chair's Log** None
56	**Any other business:** Iris Cooper, Public Governor, referred to Alder Hey Children's Hospital NHS Trust recent fundraising campaign for their Neonatal Unit and queried any impact on Trust Neonatal services and fundraising. The Chairman clarified that the Neonatal Unit was a joint venture between this Trust and Alder Hey Children's Foundation Trust as part of the Liverpool Neonatal Partnership to provide a better level of care for neonatal babies requiring surgery. Iris Cooper, Public Governor noted that the publicity had been misleading and that public notice in relation to this joint venture should be more widely publicised. The Chief Executive advised that the Neonatal Partnership Team had attended a Council meeting to inform of the Neonatal plans in Liverpool and suggested that these plans could be shared again with the Council for the benefit of the new governors. **Action: Share Liverpool Neonatal Partnership plans to develop neonatal services across Liverpool.** **Review of meeting:** • Good discussions • Informative

Liverpool Women's
NHS Foundation Trust

Action Log

Council of Governors - Public
February 2023

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
17 November 2022	22/23/56	Any other business	Share Liverpool Neonatal Partnership plans to develop neonatal services across Liverpool.	Chief Nurse	Feb 23	Complete	Plans shared
17 November 2022	22/23/51	Activity Report from the Governor Group Meetings	Share plans in relation to the development of the Professional Midwifery Advocate and Professional Nurse Advocate roles.	Chief Nurse	Feb 23	Complete	Plans shared
28 July 2022	22/23/30	Chair Announcements	A boundary and Trust constitution review for the public Governor constituencies.	Trust Secretary	May 23	On track	Suggest that a task and finish group be established with governor involvement to provide a recommendation to the May 23 CoG meeting
28 July 2022	22/23/33	2021 Staff Survey Results and Response	Invite the Director of Midwifery to discuss development of midwifery workforce.	Trust Secretary	Dec 22	Complete	See item 22/23/072
10 February 2022	21/22/74	Trust Strategy and 2022/23 Corporate Objectives	Patient journey mapping exercise to be undertaken.	Chief Nurse & Midwife	~~July 2022~~ Dec 22	Complete	Maternity Transformation work outlined to CoG Quality & Patient

							Experience Group in January 2023
10 February 2022	21/22/75	Research Strategy	Chief People Officer, Head of Communications and Research & Development Manager to meet to discuss media engagement and promotion of research.	Chief People Officer	~~July 2022~~ February 23	On track	This will be aligned with the launch of the refreshed RD&I Strategy. This is expected in the New Year.

Liverpool Women's NHS Foundation Trust

Quality and Patient Experience Governor Sub-Group

Minutes of the Quality and Patient Experience Governor Sub-Group held virtually at 17:30hrs on Monday 23rd January 2023

PRESENT:

Ruth Parkinson (Chair)	Public Governor
Jane Rooney	Appointed Governor
Jackie Sudworth	Public Governor
Pat Deeney	Public Governor
Iris Cooper	Public Governor

IN ATTENDANCE:

Mark Grimshaw	Trust Secretary
Gloria Hyatt	Non-Executive Director (Chair PPF Committee)
Deborah Keeley	Executive Assistant / Minute Taker
Yana Richens	Director of Midwifery
Jackie Bird	Non- Executive Director (Attendee for Sarah Walker)

APOLOGIES:

Sarah Walker	Non-Executive Director (Chair Quality Committee)
Rebecca Lunt	Staff Governor
Kate Hindle	Lead Governor / Staff Governor
Robert Clarke	Chair of LWH Board
Joe Downie	Deputy Chief Operating Officer
Gill Walker	Patient Experience Matron
Peter Norris	Public Governor
Niki Sandman	Appointed Governor
Michelle Turner	Chief People Officer
Yaroslav Zhukovskyy	Public Governor

22/23	Items Covered
	PRELIMINARY BUSINESS
030	**Introductions, Apologies & Declarations of Interest** Ruth Parkinson (Chair) welcomed everyone to the meeting as the new Chair and formal introductions were made. **Declarations of interest** There were no declarations of interest. **Apologies** Apologies were received and noted.
031	**Meeting Guidance notes** The meeting guidance notes were reviewed for information.
032	**Minutes of the previous meeting held on 26th September 2022**

22/23	Items Covered
	Minutes of the previous meeting held Monday 26th September 2022 were reviewed and were confirmed as an accurate record.
033	**Action Log and Matters Arising** The current action log was reviewed and updated accordingly. <u>Ockenden Report.</u> **MG –** It was proposed and agreed that this report would to be taken to Full Council Meeting scheduled for 9th February 2023 and would include an update on the East Kent Report. <u>Maternity</u> *<u>Action</u>* **MG**- Re-introduce Netcall. Work was being undertaken to assess some of the broader issues involving MAU and Gynaecology Emergency Department access and an update would be provided to the next scheduled meeting. <u>Fair & Just Training for Governors</u> Due to lack of attendance the previous training was rescheduled for the end of February 2023.
MATTERS FOR RECEIPT / APPROVAL	
034	**Quality Committee and Putting People First Committee reports** <u>Quality Committee report</u> JB - Discussed Blood Sampling issues. Reported that the Quality Committee had expressed disappointment that there had not been an adequate handover in the ownership of programme, resulting in a delay to the Committee receiving assurance. The Deputy Director of Nursing had taken robust action to collate information for December 2022. JB- Clarified that at Quality Committee the Chief Operational Officer and Chief Nurse had confirmed a process for handover was in place to prevent recurrence. IC noted concerns regarding potential training issues and asked if staff were being held accountable. JB confirmed LWH did not have a dedicated phlebotomist was an added challenge. MG- Confirmed Actions had been in place over the previous nine months but did not resolve the issues over Blood Sampling. The Chief Nurse had taken the accountability for oversight moving forward. It was noted that there had been no known serious incidents due to Blood Sampling errors but that it was contributing to poor patient experience and financial costs. JB informed the Group; the Medical Director had confirmed that Medical Staff would be assigned to MAU and Gynaecology ED after Ward rounds to help alleviate the pressure. Confirming this was ongoing and awaiting new solutions. JS noted concerns regarding conclusion for Serious Incident in Imaging. YR clarified that the Chief Nurse had commissioned an overview of sonography services, which would cover training, competencies and logging of updates undertaken.

22/23	Items Covered
	PD questioned the poor staff morale and what was being done to support staff. GH concluded that staff shortages were national and poor pay had a knock-on effect in all areas of morale, including ill health. The Trust did however offer a number of health and wellbeing initiatives for staff. IC conceded that the attendance for the Fair & Just Culture training was disappointing. GH acknowledged that uptake on the programmes had started slowly but there was evidence that this was improving. *Action* *GH to share information to IC regarding Fair & Just Culture.* Putting People First Committee report GH referenced ongoing Industrial Action and that management had been fully supporting the staff. Measures were in place to mitigate any challenges and have minimum disruption. Next expected action was reported as 6th February 2023. Staff wellbeing had been raised and a Staff Pantry incorporating food donations that have been funded by Executives and Non- Executives (and other staff) were in place. An audit of sickness had been reported and further wellbeing and staff support with counselling being provided. There had been a removal of the short-term triggers from the wellbeing and management policy to be inclusive for all staff circumstances. It was noted that Mandatory training compliance had shown signs of improvement. Maternity had cancelled mandatory training due to clinical pressure. PD enquired if Mandatory training was incorporated within their working week. YR confirmed mandatory training was in working time and 90% of training must be always up to date as part of CNST requirements.
035	**Maternity Update** YR provided an outline of her role as Director of Midwifery and describes the key maternity transformation projects that she was involved in. Outlining the strategic context, Yana noted that Liverpool had some areas in the highest index of multiple deprivation. This presented multiple challenges to the service and led to greater patient acuity and co-morbidities – placing increasing pressure on the service. Midwifery staffing remained a challenge and the current vacancy rate was 30 whole time equivalent midwives. Nine midwives recruited were due to start in March 2023 and work was in place to address absences with flexible working. Maternity apprenticeship had also started to support local diverse workforce. Other initiatives were noted as follows: • Online Menopause group introduced for staff. • Due to extra funding for the Honeysuckle Bereavement Team a 7 day a week service is available. • LFC are supporting bereaved fathers, providing mental health coach and football tops with their baby's names on the back • All staff are offered bereavement training.

22/23	Items Covered
	CONCLUDING BUSINESS
036	**Review of risk impacts of items discussed** A review of risk impacts was discussed, and no new risks were identified. Industrial Action discussed and was being monitored by the PPF Committee and the Board.
037	**Any other business and review of meeting** The meeting was effective, and all agenda items were covered. No other items were raised. MG noted that the LCS review was scheduled to report to the ICB Board Meeting on Thursday 26th January. There was a recommendation that the Women's Health workstream would be managed by the ICB which would have implications for the Trust. A more detailed update would be provided to the Full Council on 9 February 2023.

Date of next meeting: Tuesday 25th April 2023 at 17:30, Virtual or Boardroom

Liverpool Women's NHS Foundation Trust

Council of Governors Communication and Membership Engagement Group

Minutes of the Council of Governors Communication and Membership Engagement Group held virtually at 1730hrs on Thursday 29 September 2022

PRESENT	
Jackie Sudworth	Public Governor **(Chair)**
Jackie Bird	Non-Executive Director
Iris Cooper	Public Governor
Rebecca Lunt	Staff Governor
Peter Norris	Public Governor
Jane Rooney	Appointed Governor
IN ATTENDANCE	
Andrew Duggan	Head of Communications and Marketing
Mark Grimshaw	Trust Secretary
Gill Walker	Patient Experience Matron
Diane Cushion	Executive Assistant (minutes)
APOLOGIES:	
Zia Chaudhry	Non-Executive Director
Robert Clarke	Chair of LWH Board
Kate Hindle	Lead Governor / Staff Governor
Lena Simic	Appointed Governor

22/23	Items Covered
	PRELIMINARY BUSINESS
029	**Introductions, Apologies & Declarations of Interest** Jackie Sudworth (Chair) welcomed everyone to the meeting. Iris Cooper was recently added to the group membership and attended her first meeting. **Declarations of interest** There were no declarations of interest. **Apologies** Apologies were received and noted.
030	**Meeting Guidance notes** The meeting guidance notes were reviewed for information.
031	**Minutes of the previous meeting held on 29 September 2022** Minutes of the previous meeting held Thursday 29th September 2022 were reviewed and agreed as an accurate record
032	**Action Log and Matters Arising** The current action log was reviewed and updated accordingly.

22/23	Items Covered
	22/23/014: Membership Strategy Update Action was marked as complete; MG, JS and Lesleyanne Saville, Corporate Affairs Manager, continued to meet between meetings.
	MATTERS FOR RECEIPT / APPROVAL
033	**Communications, Marketing & Engagement Group Update** The group provided feedback on the paper, the purpose of which was to help triangulate areas of public, patient, and stakeholder feedback. The Stakeholder feedback would be strengthened once governors began participating in engagement events. It was acknowledged that this was the first iteration of the report and therefore some gaps naturally existed. However, the following themes could be identified, and the Committee was asked to consider how best to utilize this to inform future engagement opportunities. • Appointments (and the communication regarding these) and general issues with contacting and accessing the Trust. • The Trust received strong engagement when it led to a direct outcome (e.g. CDC naming) • Staff internal communications noted as requiring some improvement It was noted that Social Media Engagement favoured direct asks and information on services interesting to patients. Questions asked through social media were primarily regarding patient appointment queries. IC noted that social media engagement was popular on services that affect all women, not just those using maternity services. It was agreed that this was a useful lesson to learn for future engagement activity. GW noted that Dez Chow, Patient Experience & Engagement Facilitator, was assigned to review the community groups listed in the report to ensure geographic coverage. **Action:** *It was agreed that a schedule of engagement opportunities would be circulated to the group and the wider Council.*
034	**Patient & Public Engagement Group (PPEG) Update** AD stated that the Communications Team had linked with the Patient Advice & Liaison Service (PALS) regarding queries received through social media. PALS were granted access to social media queries directly to respond to patients. The Liverpool Clinical Services Review (LCSR) had paused engagement events, with the overall ownership of the Future Generations programme currently under review. The PPEG would continue to have events and recruit new members. The group was open to all members of the public including governors. MG noted that public Trust Board held 2nd February 2023 and Council of Governors held 9th February 2023 would receive further detail on the LCSR and it's potential implications for the Trust, including on engagement activity.

22/23	Items Covered
035	**Pan-Liverpool Membership Forum** MG noted the addendum issued by NHS England regarding governor duties broadening out to consider not just governor constituency but the wider Cheshire & Merseyside footprint. Meeting held 23 February was scheduled and this would look at sharing learning, resources, and intelligence to engage members and hear feedback from other Trusts. Group would continue to meet quarterly and feed back to this group.
	CONCLUDING BUSINESS
036	**Review of risk impacts of items discussed** A review of risk impacts was discussed, and no new risks were identified.
037	**Any other business and review of meeting** The meeting was effective, and all agenda items were covered. PN queried plans to celebrate International Women's Day on 8th March. AD advised engagement events were planned for week commencing 6th March.

Date of next meeting: Thursday 27th April 2023, 17:30, Virtual or Boardroom

Liverpool Women's
NHS Foundation Trust

Maternity and neonatal services in East Kent: 'Reading the signals' report – LWH Response

Dianne Brown

Chief Nurse

*The **best people**, giving the **safest care**, providing **outstanding experiences***

East Kent Report – October 2022

<u>The Panel examined maternity services at 2 hospitals</u>

The Queen Elizabeth The Queen Mother Hospital
William Harvey Hospital These services were part of East Kent University Hospital FT.

Problems with the service were known to managers throughout the period 2009-2020.
Multiple opportunities were missed to tackle problems

***The report has assessed that if the problems in the units had been addressed 45 of the 65 baby deaths assessed by the Panel could have been avoided and 97 of the 202 cases of injury/harm*.**

The Panel also found that there was a repeated lack of kindness and compassion both when care was given and afterwards following injuries or death.

The Panel found that there was a failure to recognise the scale and nature of the problems, because the vast majority of births in the Trusts did not result in damage to either mother or baby.

East Kent Report cont.

There were multiple problems identified

Failures of teamworking

Gross failures were found in teamworking - the different staff teams midwives, obstetricians, neonatal staff, paediatricians did not work together to recognise problems, to escalate and to quickly intervene

Failures of professionalism

Staff were disparaging and disrespectful to other staff in front of women, when something went wrong staff tried to deflect responsibility to others

Failures of compassion

More than technical competence is needed to provide good care. The report contains multiple harrowing examples of lack of compassion and failure to listen.

East Kent Report cont.

Failures after Safety incidents

After an incident there was the same lack of teamworking and uncompassionate behaviour – even for those incidents that resulted in injury or death. Some staff were caring and sympathetic, but many were not and this is what the families remembered. Staff were defensive and did not communicate openly with affected families – safety investigations were often conducted.

Failure in the Trust's response – including at Board level

Where something was found to go wrong the Trust tended to attribute it to individual clinical error (usually junior or locum staff). The Panel found that *"….these are the symptoms of the problems, not the root causes"*

Issues of bullying and divisive behaviour amongst midwifery and obstetric staff were known about but not addressed

East Kent Report cont

The actions of the regulators –

- Multiple regulators were involved with the Trust (the report lists 10 including CQC, NHSE, CCG, GMC etc) but the system as a whole failed to identify shortcomings and ensure improvement
- The report concludes that such a plethora of regulators was a hindrance rather than a help, as the Trust was deflected into managing relationships with the regulators and away from its own responsibilities
- There was denial at board level about the extent of the problem which made the regulators role more difficult – overall the trust view was that the incidents were unlinked and not the result of systemic issues
- The report goes on to list serial missed opportunities incl internal review, CCG report to NHSE, CQC inspection March 2014, Royal College of Obstetricians and Gynaecologists (RCOG) report 2016 etc

East Kent Maternity – Response

Trusts should not wait for the publication of the delivery plan to take actions in response to the East Kent report

- NHSE wrote out to NHS leadership on 20 October following the publication of the report into Maternity services in East Kent

- Every Trust and ICB is to review the report findings at its next public Board meeting and Boards are to be clear about the action they will take and how effective their assurance mechanisms are at “reading the signals”

- NHSE will work with DHSC and partner organisations to review the report recommendations and implications for maternity services and the wider NHS

- In 2023 NHSE will publish a delivery plan for maternity and neonatal care which will incorporate the findings from the East Kent and Shrewsbury and Telford reviews

Monitoring safety performance – finding signals among noise:

East Kent Recommendation	System Response	LWH Benchmarking	Additional steps	By When
Monitoring safety performance – finding signals among noise:	Establishment of a task force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers.	The maternity transformation programmes workstreams have established 5 workstreams (Ockenden, estates and facilities, digital, continuity of carer and staff, culture, R&D). The DOM and HOM have addressed the membership to ensure membership is appropriate and effective. The workstreams have identified KPIs which will be monitored for trends and timely action where necessary.	Review of Trust Quality dashboard and performance framework. This will ensure greater visibility of perinatal dashboard within Board Integrated Performance pack. Deep dives with triangulation at Quality Committee with a focus on clinical outcomes and presentations from the clinical leaders within Family Health and all clinical areas	April 2023

Standards of clinical behaviour – technical care is not enough:

East Kent Recommendation	System Response	LWH Benchmarking	Additional steps	By When
Standards of clinical behaviour – technical care is not enough:	For action by those who train undergraduates , postgraduates and continuous clinical learning and Royal Colleges/Regulators	Staff encouraged to speak up via F2SU Guardian and other routes. Revamped LWH behavioural framework- inappropriate behaviour by senior staff is challenged through processes All clinical staff required to undertake Fair and Just Culture training and human factors training. The first 'Fair and Just' ALS was well attended by medics and we had a Leadership Forum devoted to F&J Civility Saves Lives campaign is integrated into the Fair and Just agenda. Development programme for senior midwifery leadership team underway to ensure cohesive team working	Review approach to Human Factors training and priority plan to be developed for clinical teams Continue to deliver and extend offer of leadership development training Development of Midwifery and Health Care Assistants Forums to promote openness and transparency in communications and to ensure staff have a forum to talk and to be listened to	April 2023

Flawed teamworking – pulling in different directions

East Kent Recommendation	System Response	LWH Benchmarking	Additional steps	By When
Flawed teamworking – pulling in different directions	For action by those who train undergraduates, postgraduates and continuous clinical learning and Royal Colleges/Regulators	All clinical staff now participate in MDT clinical learning. Enhanced access to support with the establishment of Staff Support Service, Wellbeing Coaches and Professional Midwifery Advocates. Processes for learning and de-briefing following incidents has improved and specific programmes around PTSD are being put in place by the Consultant Clinical Psychologist.	Review national Guidance and best practice, consider approach for LWH Share report extensively with staff and engage regarding the findings and outcomes Reflective workshops with staff and clinical teams to develop a framework for effective teamworking We will review the use of the diagnostic tool for team culture, ICE which Creates Culture Map which will be used in maternity.	April 2023

Organisational behaviour – looking good while doing badly

East Kent Recommendation	System Response	LWH Benchmarking	Additional steps	By When
Organisational behaviour – looking good while doing badly	Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.	Board Safety Champions Programme in place with regular reporting . NED Safety Champion Introduction of Ward Accreditation Scheme Trust wide listening events for all areas with feedback to PPF Committee Incidents and complaints reported through the Board including Duty of Candour Regular patient stories identifying problems with care delivery and improvement	The Chief Nurse for LWH represents maternity care at the Trust Board. The Director of Midwifery will attend the meetings of the Board of Directors. The Director and Head of Midwifery are to become members of the Quality Committee. Regular triangulated deep dives into maternity care through Quality Committee	December 2022

East Kent Maternity – Letter

Letter: Report following the independent investigation into East Kent maternity and neonatal services – NHSE 20 October 22
NHS England » Letter: Report following the independent investigation into East Kent maternity and neonatal services

Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation – Dr Bill Kirkup 19 October 2022
https://www.england.nhs.uk/wp-content/uploads/2022/10/B2099-independent-investigation-into-east-kent-maternity-and-neonatal-services-letter.pdf

Ockenden Update

Liverpool Women's
NHS Foundation Trust

*The **best people**, giving the **safest care**, providing **outstanding experiences***

Oversight and Scrutiny - Visit NHSE Purpose

An Insight visit to Liverpool Women's Hospital services took place on the 12th April 2022.

The purpose of the visit was to provide assurance against the 7 immediate and essential actions from the interim Ockenden report. The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the interim Ockenden recommendations were embedded in practice.

Conversations were held with various members of the senior leadership team and various frontline staff ranging in job roles.

Emerging themes from conversations were organised under the immediate and essential actions headings

Enhanced Safety

Listening to Women & Families

Staff Training and Working Together

Managing Complex Pregnancy

Risk Assessment Throughout Pregnancy

Monitoring Fetal Well-Being

Informed Consent

Workforce Planning and Guidelines

Insight Visit Team members: Susan Stansfield, Tom Openshaw, Catherine McClennan, Debbie Edwards, Mandy Platt, Janine Dyson and Danni Gillet.

Key Headlines

Significant investment in the workforce was evident – this included financial investment in the senior leadership team structure and recruitment above establishment of midwifery workforce.

It was evident that the role of the Safety Champions was embedded within the governance structure and is actively promoting a positive leadership and safety culture.

The Governance team had embedded the principles of PMRT and demonstrated robust governance process.

QI work was evident particularly in relation the optimisation care pathway, SBLV2, BSOTS. The Trust should continue to build QI capability across all roles √

Corporate QI role has been appointed to and further investment in Divisional QI leads is underway. Trust QI day planned for January 23 for all staff

The Trust acknowledged a recent increase in their stillbirth rate and confirmed that a thematic review is to be commenced. This offered reassurance to the insights team.

There is currently no MVP chair in post, the LMS are supporting this position until the recruitment is completed. √

The MVP Chair is now in post and the Trust have supported further investment of a Vice Chair role

Consultant audit demonstrated poor compliance whereby only 7 women out of 22 women had a named Consultant recorded on their patient records.

Recommendations / Points for Consideration

The Trust need to ensure that the NED, who has oversight of maternity, has capacity to fulfil the role - √

NED has been identified to provide oversight and possible Deputy identified

Although the Trust demonstrated a passion for QI, there was a lack of evidence in regards the use of QI methodology and continue to ensure that all staff members have an opportunity to partake in QI initiatives to build QI capability. √

Corporate QI role has been appointed to and further investment in Divisional QI leads is underway. Trust QI day planned for January 23 for all staff

The Trust should consider accessibility regarding the PCSP for those who are digitally excluded, who have a cognitive impairment or who English is not their first language. √

Service evaluation has taken place of Essential parent app, which has a number of key features including the ability to provide a wide range of patient information in 36 different languages. Following the successful pilot of IOW we have further invested in additional devices. We have also invested in NEST (Non English Speaking team)

The Trust should consider how to develop and promote the role of the PMA so that it is utilised and valued by all midwives √

Invested in full service evaluation of current PMA service provision at LWH. This is being undertaken by an external PMA peer and following a review an improvement action plan will be developed

The Trust should appoint a new MVP chair who will link directly with the link for maternity to ensure that women's voices in the local area are represented at Board level. √

The MVP Chair is now in post and the Trust have supported further investment of a Vice Chair role

The Trust must actively coproduce and co-design with service users at all levels of service development, furthermore service users must also be involved in the evaluation of service improvements. √

The MVP Chair role is established with regular weekly Divisional/MVP MDT meetings taking place. Initial areas of focus identified as IOL, Mat Base partners staying overnight and a review of Place of Birth survey to commence in December 22

Ockenden Update

- LWH progress with implementation of the Ockenden reports essential actions. Of the total 3… actions progress is monitored integral to Workstream 1 of the Maternity Transformation Program… table shows progress since the 1st workstream meeting.

	September	October	November
Red	3	0	0
Amber	26	24	19
Green	58	61	67
National	5	5	5

Ockenden Update

Red EAs

The prioritisation exercise in September highlighted the need to escalate progression of the red actions.

Following the establishment of the working group we have progressed the three red actions to amber.

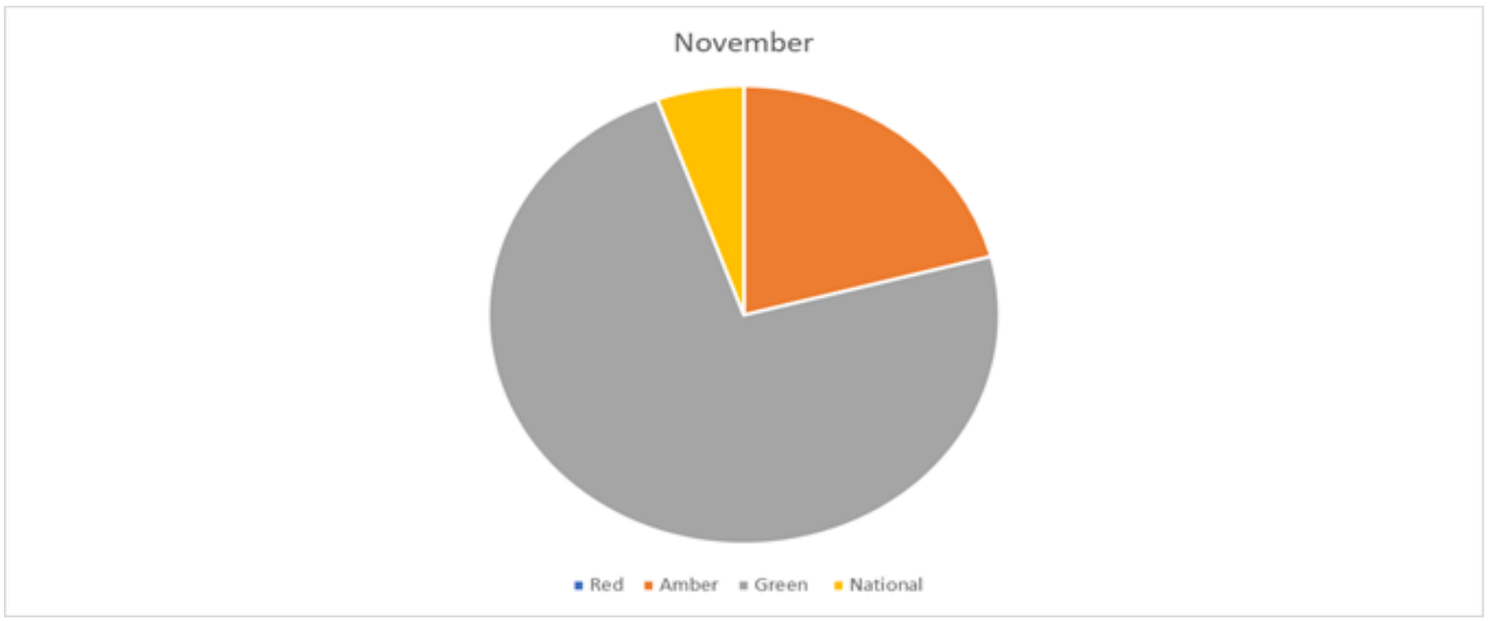
Amber EAs

There has been a continuous downward trend in progressing the amber actions to green.

To date there are 19 amber actions outstanding.

Green EAs

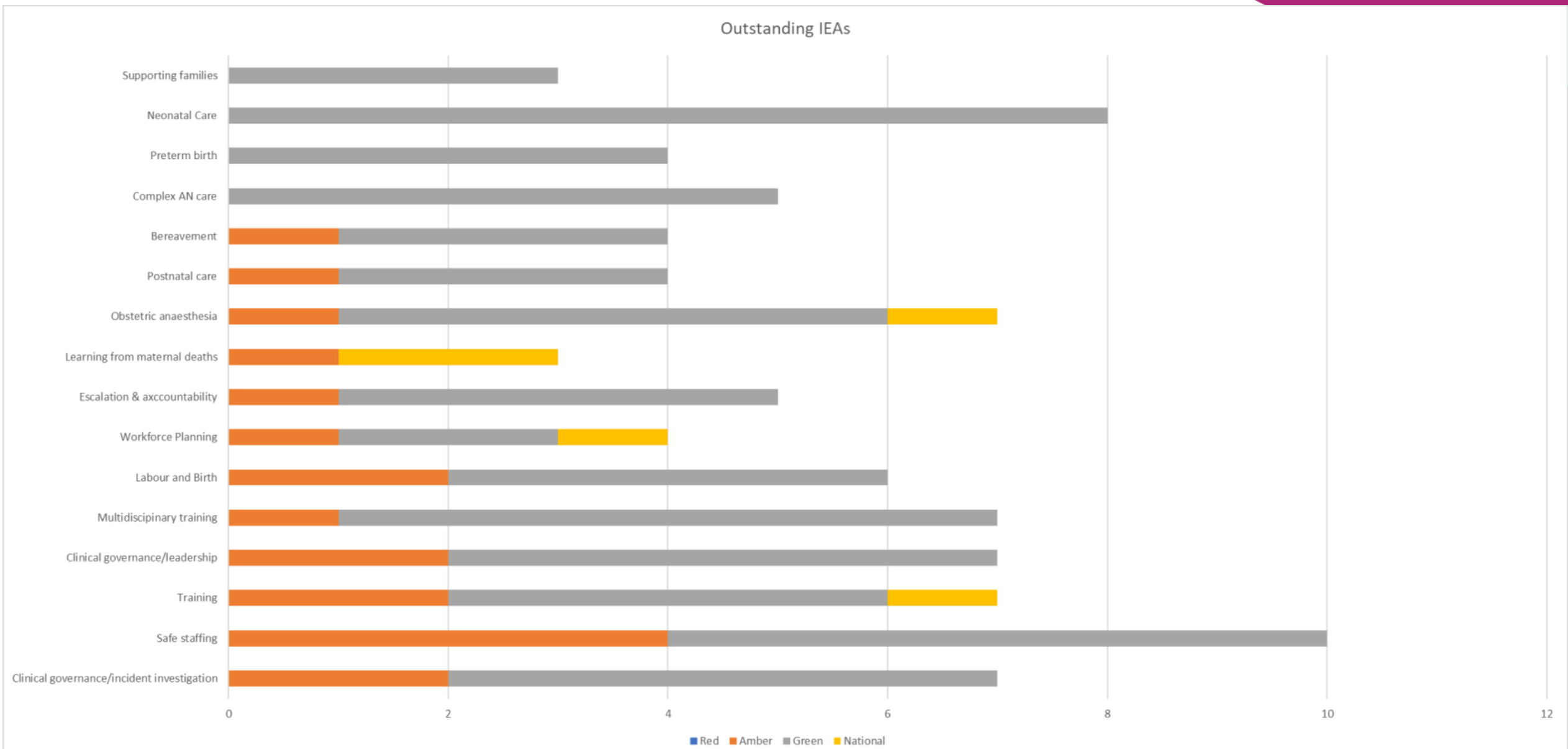
A repository of evidence is being stored and there is a continued upward trend.



Liverpool Women's NHS Foundation Trust

Outstanding Areas with largest volume of EAs to be progressed

The working group have strategically focused on the areas with the largest volume of amber actions.



Ockenden Update

Actions completed

- Bereavement service development – provision of a 7 day service for bereaved families –6 month B6 post out for recruitment.
- Introduction of a 12 month development labour ward coordinator post.
- Identification of a robust leadership and mentorship programme. Mentoring and coaching offered to all newly recruited staff in leadership posts.
- Time for maternity training under review via job plans for Consultants.
- Review of the national maternity self-assessment planned 28.11.22
- Staff members with RCA training identified.
- HOM identified as co-author of guidelines until the Consultant Midwife post is recruited.
- Mechanisms of support in place for staff to support emotional and psychological well-being. Trust have appointed a Psychologist and well-being coaches.
- Development of a patient information leaflet in progress, to inform women opting for home birth of the transfer times to an Obstetric unit.

Ockenden Update

Next steps

Following Novembers meeting 6 amber IEAs were progressed to green.
This now means that safe staffing has the largest volume of amber actions.

Plan for December 22

- To prioritise the Safe staffing EAs during the December meeting.
- To meet outside of the meeting to progress actions at pace where they are complex and require further discussion.

Liverpool Women's NHS Foundation Trust

Council of Governors

COVER SHEET

Agenda Item (Ref)	***22/23/74***		**Date: 09/02/2023**	
Report Title	**Liverpool Clinical Services Review**			
Prepared by	***Jennifer Huyton, Associate Director of Strategy***			
Presented by	***Jenny Hannon, Chief Finance Officer/Executive Director of Strategy & Partnerships***			
Key Issues / Messages	**The Liverpool Clinical Services Review recommends greater collaboration between acute and specialist trusts in Liverpool. It also recommends that the Future Generations Programme is reset as a system priority, managed through a newly established subcommittee of the Integrated Care Board.**			
Action required	**Approve ☐**	**Receive ☒**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	The Council of Governors is asked to • ***receive the report*** • ***note the recommendations within the Liverpool Clinical Services Review*** • ***note the Board's response to the report***			
Supporting Executive:	***Jenny Hannon, Chief Finance Officer/Executive Director of Strategy & Partnerships***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site 4.2 Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT: N/A

EXECUTIVE SUMMARY

An independent consultancy firm, Carnall Farrar, was commissioned by the Cheshire and Merseyside Integrated Care Board (ICB) at the request of NHS England, to undertake the Liverpool Clinical Services Review, an independent review of the acute care model in Liverpool. The review aimed to identify opportunities to improve clinical hospital-based services in terms of clinical quality, efficiency, and effectiveness.

Liverpool Women's Hospital strongly engaged with and fully supported the review process. The review identified 12 opportunities and prioritised three of those opportunities. Solving clinical sustainability challenges affecting women's health in Liverpool was one of those three priorities.

The Liverpool Clinical Services Review concluded in December 2022 and made a series of recommendations primarily concerning the programme and governance arrangements required to deliver the opportunities identified. The report recommends that the Trust's Future Generations Programme, first established in 2014/15, is reset as a system priority. This recommendation is in keeping with the Trust's work within the Programme over several years to demonstrate the system impacts of those risks which arise as a result of the Trust's location, isolated from adult acute services.

The ICB reviewed the recommendations at their Board meeting on 26 January 2023. The ICB Board noted the report and all the recommendations within the report were agreed; however, with regards those recommendations to be overseen by the CMAST Committees in Common the Board removed from the recommendations the sentence 'the starting point for realising the opportunities identified in this review should be the 6 organisations within Liverpool' – and amended this to say that 'CMAST will be required to agree a priority programme'. The implementation plan and associated timescales were also agreed.

The Trust Board received the report on 2 February 2023. The Board noted the report and committed to ongoing support for and active participation in the new system-owned programme, previously known as Future Generations.

The purpose of this paper is to provide the Council of Governors with an update regarding the outcomes of the review and the associated recommendations agreed by the ICB.

MAIN REPORT

1. Introduction and Background

Cheshire and Merseyside Integrated Care System (C&M ICS) were asked by NHS England to commission an independent review of the acute care model in Liverpool, with a view to identifying opportunities for greater collaboration between acute and specialised trusts that will improve clinical hospital-based services in terms of clinical quality, efficiency, and effectiveness. An independent consultancy firm, Carnall Farrar, commenced this work in August 2022. Day to day oversight of the work was provided by the One Liverpool Partnership Board. Liverpool Women's Hospital NHS Trust staff engaged fully and transparently with the team from Carnall Farrar throughout the review process.

The final report (Appendix 1) was received by the Cheshire and Merseyside Integrated Care Board (C&M ICB) at its meeting held in public on 26 January 2023, alongside a series of recommendations, an implementation plan and associated timescales (detailed below). The recommendations will impact next steps for the Trust's Future Generations Programme as well as ongoing partnership work to reduce the risks arising from the Trust's isolated site. The ICB noted the report at their Board meeting on 26 January 2023 agreed with the recommendations.

The purpose of this paper is to provide the Trust Board with an update regarding the outcomes of the review and the associated recommendations approved by the ICB.

2. Review Scope and Methodology

The organisations primarily in scope of the review were the six specialist and acute providers that are part of the Liverpool Place:

- Alder Hey Children's NHS FT
- Clatterbridge Cancer Centre NHS FT
- Liverpool Heart and Chest Hospital NHS FT
- Liverpool University Hospitals NHS FT
- Liverpool Women's Hospital NHS FT
- The Walton Centre NHS FT.

Agreed deliverables for the work were as follows:

- To make a clear and compelling case for greater collaboration.
- Identify priorities for collaboration and the reasons why.
- Develop a blueprint for the collaborative opportunities to be implemented.
- To articulate the conditions for success, setting out the supporting arrangements to be put in place.
- To produce an implementation roadmap to deliver the blueprint.

The review commenced with engagement with approximately 300 people through a series of individual interviews, group discussions with each of the acute and specialist provider executive teams and hospital management groups, a GP engagement session, and survey responses from over 150 senior staff from across Liverpool. Liverpool Women's Hospital staff were well represented within the survey following good engagement and a high number of responses submitted.

Data analysis was then carried out to sense check and evidence the hypotheses and views expressed during engagement.

The outputs of the discovery work were tested and refined through a series of workshops, with 12 opportunities identified. Those opportunities are:

1. Improving physical and mental health by strengthening ways of working with PCNs and neighbourhood teams and providing more anticipatory care, especially for people with long term conditions and complex lives.
2. Creating socially inclusive training and employment opportunities for the Liverpool City Region, leveraging anchor institution status to address local deprivation.
3. Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, Royal Liverpool, and Springfield Park (Alder Hey) sites.
4. Levelling-up performance on cancer and cardiovascular disease to address health inequalities.
5. Providing timely access to high-quality elective care by making efficient use of existing estates and assets.
6. Solving clinical sustainability challenges affecting women's health in Liverpool.
7. Combining expertise in clinical support services to provide consistent services across the city.
8. Developing world-leading services in Liverpool by realising the collaborative potential in innovation, research and clinical trials.
9. Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff.
10. Achieving economies of scale in corporate services.
11. Building on and integrating digital investments to unlock innovative approaches to delivering care and achieving commitments to environmental sustainability.
12. Making best use of resources to secure financial sustainability for all organisations in Liverpool.

Liverpool Women's Hospital has been strongly engaged with review process, robustly advocating for women's services in Liverpool and Cheshire and Merseyside. The work carried out as part of the Future Generations Programme enabled the Trust to share a broad range of evidence, data, and information.

3. Report Recommendations

The report recommendations (which can be viewed in full in Appendix 1) primarily concern governance and programme arrangements required to deliver the 12 opportunities. The consensus of the One Liverpool Partnership Board is that of the twelve opportunities, there are three critical priorities to take forward immediately to address the challenges with greatest risk and opportunity within the Liverpool system. These are:

- Solving the clinical sustainability challenges affecting women's health in Liverpool.
- Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at the Aintree, Broadgreen and Royal Liverpool Hospital sites.
- Significant opportunities to achieve economies of scale in corporate services.

It is recommended that a detailed programme of work should be produced, building on existing programmes where appropriate and creating new mechanisms where required to ensure delivery; for example, Joint Committees between specific providers based on shared sites.

The recommendations concerning the clinical sustainability challenges affecting women's health in Liverpool are as follows:

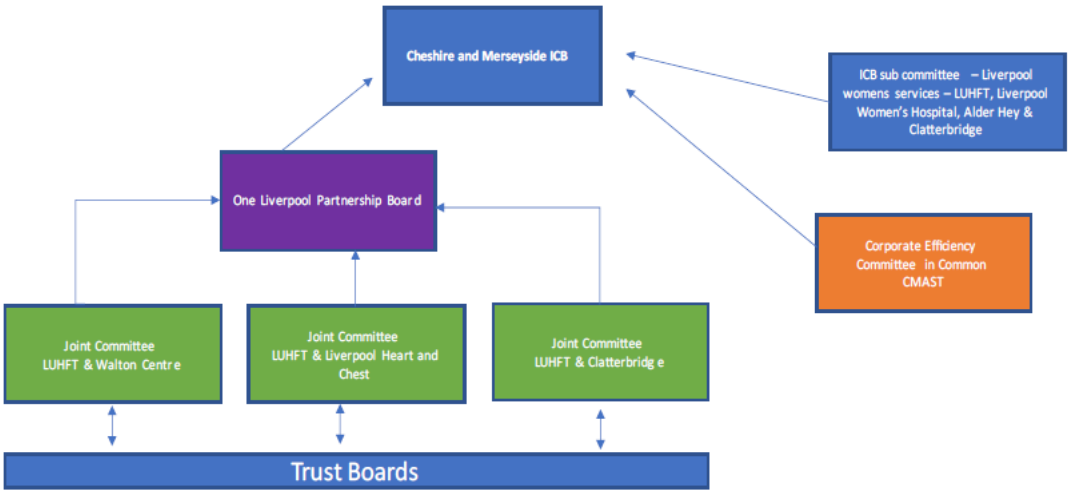
The current programme of work, the Future Generations Programme, led by Liverpool Women's Hospital NHS FT should be reset as a system priority. The opportunity to solve clinical sustainability challenges for women's health should be taken forward as an ICB-led service change programme, in line with best practice requirements for service reconfiguration. To support this, we recommend:

1. *A sub-committee of the ICB to be established to oversee the programme of work, including at minimum representation from Liverpool Women's Hospital NHS FT, Liverpool University Hospitals FT, Clatterbridge Cancer Centre NHS FT and Alder Hey Children's NHS FT. These organisations will need to identify dedicated*

clinical and managerial leadership to engage deeply in the programme with partners, with external stakeholders, with patients and the public and within their own organisations with staff.

2. *A director of the ICB be identified as the joint-SRO of the programme and chair the sub-committee leading the work.*
3. *A clinical joint-SRO to be identified who can work on the programme three days per week and chair the clinical working group. This individual should be experienced in service change with experience in a relevant clinical area, and independent of any of the organisations in Cheshire and Merseyside.*
4. *The finance director of the ICB to chair the finance, analytics and estates working group which will develop and review the economic and financial modelling, including capital requirements.*
5. *A dedicated team to be identified to support the programme, with the expertise needed to meet the different requirements of the programme such as clinical evidence and research, communications and engagement, finance, analysis and estates and capital development. This team should be hosted by the ICB reporting to the lead ICB director.*
6. *A reset work programme be created and agreed by January.*
7. *An operating model between the Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT should be developed to optimise partnership working and short-term mitigation of risks, led by the existing Partnership Board.*

The governance arrangements resulting from the review are represented in the figure below:



Monthly reporting from the new Joint Committees into the One Liverpool Partnership Board will provide assurance on delivery of the recommendations. The One Liverpool Partnership Board will, in turn, report quarterly to the ICB. The ICB subcommittee for women's services will report monthly into the ICB.

The ICB reviewed the recommendations at their Board meeting on 26 January 2023. The report was noted and all the recommendations within the report were agreed; however, with regards those recommendations to be overseen by the CMAST Committees in Common the Board removed from the recommendations the sentence 'the starting point for realising the opportunities identified in this review should be the 6 organisations within Liverpool' – and amended this to say that 'CMAST will be required to agree a priority programme'. The implementation plan and associated timescales were also agreed.

Next Steps and Implications for Liverpool Women's Hospital

While all recommendations have some relevance for Liverpool Women's Hospital and the landscape in which it delivers care to women, babies, and families, the recommendations regarding the clinical sustainability challenges affecting women's health in Liverpool will have the greatest impact.

The Trust first established its Future Generations Programme in 2014/15, to address the clinical risks and issues which arise as a result of its isolated location. The findings of the independent Liverpool Clinical Services Review are in keeping with those of the Future Generations Programme. Since the Programme was first established, the Trust has been working determinedly in partnership with organisations from across the system (both providers and commissioners) to identify a solution and mitigate risks as far as possible. As part of this work, the Trust and partners have worked together to demonstrate that the risk does not simply relate to Liverpool Women's Hospital, rather it impacts the whole of the Cheshire and Merseyside system, and beyond, and that any solution must also be system-owned. This position has now been validated by the independent Liverpool Clinical Services Review.

Next steps from the ICB's implementation plan for women's health are summarised below:

Action	Lead	Deadline
1. Women's Health		
Establish a sub-committee of the ICB to oversee the programme to develop service change proposals for the future configuration of services: • Agree terms of reference and membership • Agree that Raj Jain chairs the sub committee	SRO, supported by ICB Governance lead	31/01/23
Agree that Christine Douglas is the Executive SRO for the programme	ICB CEO	31/01/23
Appoint an independent Clinical SRO	ICB Medical Director	28/02/23
Review existing governance in place – align or stand down if appropriate	SRO	31/01/23
Establish working groups for finance/estates/capital, engagement, clinical research/evidence.	SRO	24/02/23
Identify resources with the right skill mix and experience to support the programme, hosted by the ICB	SRO	24/02/23
Develop an operating model between the Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT to optimise partnership working	LUHFT & LWH	31/03/23
Define the work programme and timescales for delivery	SRO	28/02/23
Establish monthly reporting to the ICB, aligned to the ICB Board cycle	SRO	28/02/23

4. Conclusion and Recommendations

The Liverpool Clinical Services Review was completed in December 2022. A final report has been published which identified 12 opportunities for collaboration, of which three were prioritised. One of the priorities was solving the clinical sustainability challenges affecting women's health in Liverpool. Alongside recommendations regarding the programme and governance arrangements required to deliver all opportunities identified, the report recommends that the Trust's Future Generations Programme, first established in 2014/15, is reset as a system priority. The ICB reviewed the recommendations at their Board meeting on 26 January 2023. The ICB Board noted the report and all the recommendations within the report were agreed.

The Trust Board received the report on 2 February 2023. The Board noted the report and committed to ongoing support for and active participation in the new system-owned programme, previously known as Future Generations.

The Council of Governors is asked to

- receive the report
- note the recommendations within the Liverpool Clinical Services Review
- note the Board's response to the report

NHS
Cheshire and Merseyside

Liverpool Clinical Services Review

An independent review of acute and specialist provider collaboration in Liverpool

Final version
18 January 2023

Contents

Purpose of the document

This document outlines the outputs of the Liverpool Clinical Services Review, commissioned by the Cheshire and Merseyside Integrated Care Board (ICB), and delivered by CF. The Cheshire and Merseyside Integrated Care System (ICS) was asked by NHS England (NHSE) to commission an independent review of the acute care model with a view to identifying opportunities that will improve hospital-based clinical services in terms of their quality, efficiency, and effectiveness.

The focus of the review and consequently this document is primarily on the six acute and specialist trusts: Alder Hey Children's NHS Foundation Trust; Clatterbridge Cancer Centre NHS Foundation Trust; Liverpool Women's Hospital NHS Foundation Trust; Liverpool Heart and Chest Hospital NHS Foundation Trust; Liverpool University Hospitals NHS Foundation Trust; and The Walton Centre NHS Foundation Trust. The Trusts operate as part of the Liverpool place-based partnership, led by the One Liverpool Partnership Board. Other partners core to One Liverpool include general practice, Mersey Care NHS Foundation Trust, and Liverpool City Council.

The review took was conducted over a 16-week period from August to December 2022, broadly following an Appreciative Inquiry (Ai) approach before deep-diving into priority areas. The outputs of this engagement are summarised in this document, which covers the case for greater acute and specialist provider collaboration, the priorities for action, the conditions needed for success, and the recommendations of the review.

Executive summary

CF was commissioned in August 2022 by the Cheshire and Merseyside Integrated Care Board (ICB), with day-to-day oversight from the One Liverpool Partnership Board, to undertake an independent review that identified and detailed how to realise collaborative opportunities for the acute and specialist trusts to optimise the acute care model for Liverpool.

The new Health and Care Act 2022 includes a set of legislative changes to enable health and care to work more closely together. Provider collaboratives are a key component of delivering system working, being one way in which providers work together to plan, deliver, and transform services. National guidance has mandated that all trusts providing acute and mental health services are expected to be part of one or more provider collaboratives.

Like ICSs all over the country, NHS Cheshire and Merseyside became a statutory organisation on 1 July 2022 and is now responsible for the health and care of over two and half million people across nine places. Liverpool is a place-based partnership in the Cheshire and Merseyside ICS, and major city in England. A significant proportion of the people of Liverpool live in deprivation, with 58.4% of households classified as being deprived to some degree, and/or with poor health and wellbeing. This contributes to the people of Liverpool living on average two and a half years less than people in the rest of England. Progress on closing this gap has stagnated in recent years and the gap between the most affluent and most deprived groups has widened. Much of the morbidity and early mortality is avoidable. Despite significant improvement over the last 20 years, the rate of avoidable mortality in Liverpool has remained consistently 50% above the national rate.

Organisations in Liverpool have collectively developed a 5-year strategy, One Liverpool, which runs from 2019 to 2024. Its aim is to deliver better population health and wellbeing in Liverpool, and it represents a whole system approach to delivering change that engaged Liverpool City Council, the local NHS and other key public and voluntary sector partners in its development. The One Liverpool strategy is part of the Liverpool City Plan and focuses on the positive and transformative actions that the health and care system will take together and with the people of Liverpool to improve population health and reduce health inequalities. In this context, the independent review was commissioned to complement this strategy and accelerate provider collaboration in recognition of the opportunity to optimise the acute care model and deliver financial sustainable services.

The review engaged over 300 people through individual interviews, group discussions with each of the acute and specialist provider executive and hospital management teams, a GP engagement session with PCN clinical leads, and over 150 senior staff from across Liverpool who contributed via a staff survey.

Through this engagement, twelve opportunities emerged that, together, form the strategic agenda for collaboration between the acute and specialist providers. These opportunities are additive to pre-existing priorities and will in some cases require wider partnerships to deliver on them. They outline a holistic and systematic requirement for collaboration between the acute and specialist providers themselves, and collectively with Mersey Care, PCNs, and the local authority, but also the academic institutions in Liverpool and other stakeholders. The twelve collaboration opportunities are:

1. **Improving physical and mental health by strengthening ways of working with PCNs and neighbourhood teams and providing more anticipatory care, especially for people with long term conditions and complex lives** – Liverpool has a higher burden of long-term conditions, in particular cardiovascular disease, and chronic obstructive pulmonary disease, and multimorbidity than the

national average. The current consequence of this is an increased use of hospital-based services, which reactively manage deterioration and acute exacerbation. There is a significant improvement opportunity by proactive, anticipatory management of conditions to improve health, avoid acute exacerbations and the need for hospital-based services.

2. **Creating socially inclusive training and employment opportunities for the Liverpool City Region, leveraging anchor institution status to address local deprivation** – People living in Liverpool are more disengaged from the labour market with long-term unemployment rates twice that of the rest of England. Once employed, however people living in Liverpool have better weekly earnings than in other areas. With NHS organisations being one of the major employers, their role within this opportunity is evident in providing wider economic benefits in terms of job offerings. Colleagues clearly described the opportunity to collaborate on shared apprenticeship and school leaver programmes for the local community. There is an imperative opportunity to support local people to gain and remain in employment, taking collective action to address local deprivation.
3. **Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, and Royal Liverpool sites** – There are challenges with both timely access and poor outcomes in the urgent and emergency care pathways. Emergency inpatient services across Liverpool are more commonly provided from only one of the city's five acute sites compared to other areas which means that when people need specialist care, they frequently require transfer to another site and their care becomes fragmented. For some specialties and conditions, this results in long lengths of stay in the emergency department and inpatient lengths of stay that are double the national average. This is associated with increased mortality and poorer outcomes for patients. There can even be significant delays in care when this is delivered between different providers occupying the same hospital site. There is an opportunity to embrace collaboration, and in doing so share best practice, drive up collective quality and performance standards and standardise pathways to ensure optimum emergency care delivery across the city.
4. **Levelling-up performance on cancer and cardiovascular disease to address health inequalities** – Cancer is the city's largest cause of premature deaths. There has been a large increase in referrals and consequently the number of people on the cancer patient tracking list from the pre-pandemic baseline. Additionally, the review found stark inequalities in cancer diagnosis. Patients diagnosed with cancer in the Emergency Department last year were between 2 and 6 times more likely to be an ethnic minority than white, and we know these late-stage diagnoses are likely to have a significant impact on survival rates. Similarly for cardiovascular disease, which is largely preventable through a healthy lifestyle and the early detection and control of risk conditions, there are significant gaps in diagnosis and treatment across Liverpool. There is an opportunity to address late diagnosis of cancer and cardiovascular disease, and inequalities in access which requires a place-based approach involving primary care and local government, working at PCN level to implement culturally sensitive targeted interventions, taking account of local needs.
5. **Providing timely access to high-quality elective care by making efficient use of existing estates and assets** – Elective waiting lists have grown across Liverpool by a third every year since 2019 and this has been further exacerbated by the impact of the pandemic. While all trusts in Liverpool have seen an increase in the number of people waiting for treatment, Liverpool University Hospitals NHS Foundation Trust has faced very challenging circumstances with both a significant elective 18 week and 104+ week backlog across multiple specialities. All organisations in the city have theatre capacity that could be used more effectively as a shared asset to provide timely access to high quality elective care.
6. **Solving clinical sustainability challenges affecting women's health in Liverpool** – Overwhelmingly, the most important challenge stakeholders identified as needing to be addressed was the clinical sustainability of services for women and the clinical risk in the current model of care. Specifically, seven

of twelve co-dependencies for maternal medicine centres and therefore for consultant-led obstetric services are not currently met at the Crown Street site. This results in fragmentation of services for women and babies, with some requiring ambulance transfer to other providers to receive the care they need. This, given the clinical circumstances necessitating the transfer, carries an inherent risk, and also result in mothers and babies being separated. There is an imperative opportunity and shared will amongst the acute and specialist providers to respond to the current case for change, developing a future care model to ensure the best possible care for women and babies across Liverpool.

7. **Combining expertise in clinical support services to provide consistent services across the city** – Stakeholders have spoken enthusiastically about the collaboration that already takes place for delivering clinical support services, both within the city, such as Liverpool Clinical Laboratories; and as part of the ICS, such as Cheshire and Merseyside Radiology Imaging Network (CAMRIN). There was widespread recognition that there was opportunity for further collaboration to combine expertise in clinical support services in order to address workforce challenges and make efficient use of resources. Examples of this include diagnostic imaging and the ability to address the workforce challenges, pharmacy and the sustainability of its workforce, and further consolidation of pathology services including resetting existing partnerships to maxmise value.
8. **Developing world-leading services in Liverpool by realising the collaborative potential in innovation, research, and clinical trials** – Over the years, the research and education infrastructure of Liverpool has had healthy investment, with significant resources available across the city region. Stakeholders almost universally reflected that there were opportunities to leverage this infrastructure to develop world-leading services for the city – primarily by delivering data-enabled clinical trials and establishing a hub to act as a single point of planning and operations for delivering clinical trials.
9. **Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff** – Health and social care is the largest employer in the Liverpool City Region, employing 117,000 people. Across the six organisations, around 25,000 people were employed in 2021/22, many of whom live in Liverpool, and £1.29bn was spent on workforce costs in 2021/22. According to senior staff, the biggest challenge to ongoing service delivery is recruitment and retention of staff. Colleagues also consistently described how competition between Trusts magnifies this challenge and the benefits that collaborative working could have in addressing these issues. Opportunities included an integrated training and development offer, implementing staff passports, standardising policies, collective workforce planning, and joint recruitment, working together to create a strong employer brand to improve recruitment and retention rates and reduce recruitment costs.
10. **Achieving economies of scale in corporate services** – Across all organisations in Liverpool, £132.4 million is spent on corporate services (2021/22) and the majority of trusts spent more on corporate services per £100 million income than other Trusts. Collaborative working between the trusts would encourage a uniform approach to services and to the delivery of corporate services, freeing up resources by doing a greater number of tasks once between the organisations. As well as reducing cost and duplication, maximising this opportunity allows expertise across the city to be shared and leveraged for the benefit of all. This opportunity could be rapidly realised in transactional areas where services are process and system based including HR services such as recruitment checks, finance administration and IT support.
11. **Building on and integrating digital investments to unlock innovative approaches to delivering care and achieving commitments to environmental sustainability** – There has been significant investment in digital systems across the city with some organisations achieving international recognition for their efforts, but there is more work to do in order to bring all organisations up to the same standard. More than ten EPR and PAS systems are in use across organisations in Liverpool and despite some organisations using the same software company, the systems do not deploy functionality that allows

for interoperability. There is an opportunity to increase the overall level of interoperability between information and data systems to support the more effective delivery of care across organisational boundaries.

12. **Making best use of resources to secure financial sustainability for all organisations in Liverpool** – Currently, NHS organisations in Liverpool are in financial deficit with an aggregated reported deficit position of £12.3 million at YTD (August 2022/23), which is expected to deteriorate further over the rest of the financial year. The Cheshire and Merseyside ICS is set to see its allocation reduced by circa £350 million over the coming years and this sets the context for needing to stabilise the current position and prepare for the future challenge ahead. Throughout the review, colleagues have reflected on the financial pressures and sustainability challenges faced in Liverpool and how opportunities to collaborate could seek to address these challenges. Each of the opportunities outlined in the case for collaboration have either a direct or indirect financial benefit that organisations can realise.

Several of these opportunities are already being taken forward as part of implementing the One Liverpool strategy via the programme of work led by Liverpool Health Partners, and through ICS-wide programmes led by Cheshire and Merseyside Acute and Specialist Trusts (CMAST) and the Cancer Alliance. In these areas, the ongoing work can be supplemented by the findings and opportunities identified in this review.

The One Liverpool Partnership Board agreed that the review should move on to address the most critical issues facing the system, which are longstanding clinical risks for women's health, current financial sustainability, and operational pressures for emergency care. Two priorities were aligned upon as a core focus for collaboration: 1) Solving clinical sustainability challenges affecting women's health in Liverpool and 2) Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, and Royal Liverpool sites.

In pursuing these opportunities, we recommend that:

1. The twelve opportunities in the case for collaboration should be adopted by the six acute and specialist providers in Liverpool as their strategic agenda for working together. For five of the opportunities, wider partnerships are required, which should be forged to ensure progress, specifically:
    a. Improving physical and mental health by providing more anticipatory care (opportunity 1) requires working through the One Liverpool Partnership with General Practice, Liverpool City Council and Mersey Care FT,
    b. Levelling-up performance on cancer to address health inequalities (opportunity 4) requires working through a place-based partnership endorsed by the Cheshire and Merseyside Cancer Alliance,
    c. Work with all existing partners of the Liverpool Health Partners to pursue the research and innovation agenda (opportunity 8) and additionally include Liverpool City Council and Applied Research Collaboration North West Coast. This effort could be expanded to include interested providers across Cheshire and Merseyside ICB,
    d. The longer-term digital agenda (opportunity 11), which requires working through the Cheshire and Merseyside ICB as part of the Digital Programme,
    e. To solve clinical sustainability challenges affecting women's health (opportunity 6), work with the Cheshire and Merseyside ICB (see recommendation 4).

2. For the further five opportunities there is a synergy with the agenda of the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative and consequently the work should be undertaken in

the view of the Collaborative and in line with its governance. The starting point for realising the opportunities identified in this review should be the six organisations in Liverpool. Only once tangible progress is made within this scope should it be broadened to a wider geography. This includes:

a. Address elective care waits and backlog (opportunity 5) through the Elective Recovery and Transformation Programme,
b. Combine expertise in clinical support services (opportunity 7), in part through the Diagnostics Programme,
c. Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff (opportunity 9) through the Workforce Programme,
d. Realise economies of scale in corporate services (opportunity 10) through the Efficiency at Scale workstream of the Finance, Efficiency & Value Programme, and
e. Making best use of resources to secure financial sustainability for all organisations in Liverpool (opportunity 12) through the Finance, Efficiency & Value Programme.

3. A rolling programme should be established, building on relevant pre-existing programmes, to take forward the opportunities for implementation. Overall, it will take a number of years to realise the potential benefits from this effort. The work should start by leveraging efforts already underway. Pre-existing programmes should incorporate the findings of the review into their ongoing work by undertaking a stocktake of existing workstreams, specifically:
   a. Levelling-up performance on cancer and cardiovascular disease to address health inequalities (opportunity 4) requires working through a place-based partnership endorsed by the Cheshire and Merseyside Cancer Alliance and the Liverpool Cardiology Partnership respectively,
   b. Provide anticipatory care to improve physical and mental health (opportunity 1) through the Complex Lives and Long Term Conditions Segments, of the One Liverpool Programme.

4. The current programme of work, the Future Generations Programme, led by Liverpool Women's Hospital NHS FT should be reset as a system priority. The opportunity to solve clinical sustainability challenges for women's health should be taken forward as an ICB-led service change programme, in line with best practice requirements for service reconfiguration. To support this, we recommend:
   a. A sub-committee of the ICB to be established to oversee the programme of work, including at minimum representation from Liverpool Women's Hospital NHS FT, Liverpool University Hospitals NHS FT, Clatterbridge Cancer Centre NHS FT and Alder Hey Children's NHS FT. These organisations will need to identify dedicated clinical and managerial leadership to engage deeply in the programme with partners, with external stakeholders, with patients and the public and within their own organisations with staff.
   b. A director of the ICB be identified as the joint-SRO of the programme and lead the work.
   c. A non-executive director of the ICB to be identified to chair the sub-committee.
   d. A clinical joint-SRO to be identified who can work on the programme for a dedicated period every week and chair the clinical working group. This individual should be experienced in service change with experience in a relevant clinical area, and independent of any of the organisations in Cheshire and Merseyside.
   e. The finance director of the ICB to chair the finance, analytics and estates working group which will develop and review the economic and financial modelling, including capital requirements.
   f. A dedicated team to be identified to support the programme, with the expertise needed to meet the different requirements of the programme such as clinical evidence and research, communications and engagement, finance, analysis and estates and capital development. This team should be hosted by the ICB reporting to the lead ICB director.

g. A reset work programme be created and agreed by January.
h. An operating model between the Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT should be developed to optimise partnership working and short-term mitigation of risks, led by the existing Partnership Board.

5. Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies should also be immediately prioritised for delivery. A programme of work should be established which implements the three new pathway elements proposed by this review: 1. fast-tracking, 2. passporting, and 3. in-reach. The overall aim of this work should be to ensure each hospital site in Liverpool delivers optimal care and efficiency, uninhibited by organisational boundaries. This should include creating integrated clinical teams on each site with joint ways of working. In taking this forward, we recommend:
   a. Clinicians should be at the forefront of the development of this approach and leads should be identified from each organisation and each site, to oversee the work and facilitate broad engagement with staff.
   b. There should be early engagement with General Practice, Mersey Care FT, and the North West Ambulance Service NHS Trust to incorporate pre- and post-hospital elements of the pathway.
   c. An operating model for each site should be developed, ensuring highest quality clinical pathways, clear accountability, and optimised site-based working. This should be underpinned by demand and capacity analysis.
   d. Building on the financial analysis undertaken as part of this review, a target financial model should be developed and agreed linked to 5c. This should reset financial flows and ensure overall efficiencies are realised including in respect to reduced length of stay and reduced interhospital ambulance transfers.
   e. Three joint committees should be established with delegated authority from the relevant trusts for site-based operations. These arrangements should oversee the design and delivery of the new operating models as well as business-as-usual operations, which will likely give rise to further improvement opportunities. The three committees should include at least one non-executive director and executive director from each organisation as well as a site-based leadership team. The committees should comprise of:
      i. Liverpool University Hospitals FT and Liverpool Heart and Chest Hospital FT for the Broadgreen site
      ii. Liverpool University Hospitals FT and The Walton Centre FT for the Aintree site
      iii. Liverpool University Hospitals FT and Clatterbridge Cancer Centre NHS FT for the Royal Liverpool site
   f. To progress the work, a dedicated team supporting all three joint committees should be established that provides capacity to systematically work through the operating model on each site, undertaking design work and modelling for the pathway and service transformation. This team should be led by a dedicated senior individual working across organisational boundaries on behalf of all organisations.

6. To provide overall Liverpool system oversight and review of performance on delivering high quality emergency care with aligned incentives and funding, two committees-in-common should be established involving relevant executives and non-executives from Alder Hey Children's NHS FT, Clatterbridge Cancer Centre NHS FT, Liverpool Heart and Chest Hospital NHS FT, Liverpool University Hospitals NHS FT, Liverpool Women's Hospital NHS FT, The Walton Centre NHS FT, Mersey Care FT, and General Practice Liverpool. These committees-in-common should meet quarterly and cover:

a. Quality – reviewing the effectiveness and quality of emergency care using shared data and analysis and determining further improvements required, and
b. Finance – reviewing overall financial effectiveness and establish effective incentive and risk sharing mechanisms.

7. To progress at pace Boards of relevant organisations should receive proposed terms of reference, including delegations, accountability, and escalation arrangements, for the governance groups set out in the recommendations 4, 5 and 6 in their January meetings. A proposal for how the programme(s) of work is resourced should also be included to ensure the appropriate team and leadership needed to deliver.

8. A communications and engagement plan should also be developed and agreed by all organisations. The aim should be to communicate the findings of the review and its recommendations and engage staff, patients, and the public on the next steps. Engagement on the future programme of work as well as open communications in respect to progressing the recommendations should be embedded into how this is taken forward.

Introduction and context

Like ICSs all over the country, NHS Cheshire and Merseyside became a statutory organisation on 1 July 2022 and is now responsible for the health and care of over two and half million people across nine places. Places are coterminous with local authority boundaries in Cheshire East, Cheshire West, Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington, and Wirral. The ICS includes 18 NHS trusts, 355 GP practices in 50 PCNs and 590 community pharmacies that provide services for people in Cheshire and Merseyside, and in some cases beyond.

The geography has areas of substantial wealth and others of substantial deprivation. 33% of the population live in the most deprived 20% of neighbourhoods in England. The Index of Multiple Deprivation shows that Knowsley is the second most deprived borough in England and Liverpool the third. Knowsley also has the highest proportion in England of its population living in income deprived households (tied with Middlesborough), equating to one in four of all households. Even within the wealthier areas in the region, there is substantial deprivation and associated poor health – while 31% of neighbourhoods in Cheshire West and Chester are in the top two income deciles, 16% of neighbourhoods are in the lowest income deciles.

The vision for the ICS is for "everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live longer". Its mission is to do this by working together, as equal partners, to support seamless, person-centred care and tackle health inequalities by improving the lives of the poorest fastest. In support of this vision and mission, the ICS has four strategic objectives, which are to:

- Improve population health and healthcare
- Tackle unequal outcomes and access
- Enhancing productivity and value for money
- Support broader social and economic development

Within Cheshire and Merseyside, place-based partnerships – led by Place Directors – have freedom to design and deliver services according to local need. This includes understanding and working with communities, joining up and co-ordinating services around the needs of people, addressing social and economic factors that influence health and wellbeing, and supporting quality and sustainability of local services.

Liverpool and its population

Liverpool is a major city in England and one of the Core Cities, along with Belfast, Birmingham, Bristol, Cardiff, Glasgow, Leeds, Manchester, Newcastle, Nottingham, and Sheffield. It is the 8th largest city by population size and is home to 565,000 people, including 119,000 children and young people, 332,000 working age adults, and 50,000 people over the age of 70. Liverpool has relatively less ethnically diverse communities compared to the other Core Cities, with 86% of population identifying as White British.

This population of Liverpool is expected to grow by 10% to 2043, which is 2% greater than the growth expected nationally. The group expected to see the largest growth, by 60%, is the 80+ group, which is slightly lower than the 70% growth seen nationally for this age group.

Liverpool has the greatest extent of deprivation in England as measured by the Index of Multiple Deprivation (IMD), with two in three people living in deprivation, and eight in every hundred people living in the most deprived one percent of the country. With respect to income, Liverpool is the 4th most deprived local authority, and the 5th most deprived with respect to employment and living environment.

The pertinence of this is characterised by the growing body of evidence showing that population health is determined to a great extent by social, environmental, economic, political, and cultural factors (the social determinants of health as set out in Figure 1). As a result, health follows a social gradient; a higher social position, whether measured by education, income, or occupational status, is associated with better health and longevity. The accumulation of positive and negative effects of social, economic, and environmental conditions on health and wellbeing throughout life contributes to inequalities in health.[1]

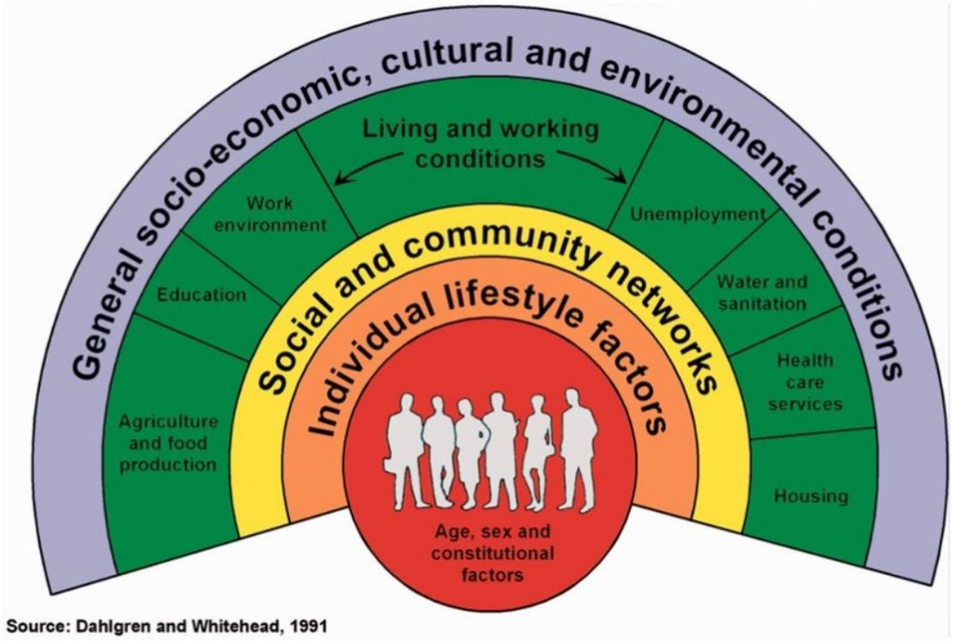


Figure 1: Dahlgren-Whitehead rainbow model of social determinants of health

In that context, the negative impact of deprivation affects people in Liverpool even before they are born. Babies are born to mothers in poorer health, who are twice as likely to smoke during early pregnancy and less likely to take folic acid supplements. Services in Liverpool have responded to this heightened risk by providing earlier access to maternity to more mothers than other places in England. The number of mothers who are smoking falls from 21.5% in early pregnancy to 11.3% at the time of delivery (compared to 17.1% and 12.4% respectively for the rest of England). However, this does not fully mitigate the impact of a poorer start in life for children. Babies are more likely to be low birth weight (7.3% compared to 6.9% nationally) and more likely to die as neonates (3.0 deaths per 1,000 live births compared to 2.8 nationally). This continues to affect children and young people in Liverpool throughout their life course. They are more likely to be overweight or obese at reception (26.8% compared to 23.0% nationally) with the gap increasing further by year 6 (41.2% compared to 35.2% nationally). They are more likely to live in dysfunctional families and have lower educational attainment than elsewhere in the country with only 44% of pupils achieving >Grade 5 in English and Maths at GCSE compared to 51.9% nationally.

As adults, lifestyle factors that contribute to improved health and wellbeing such as physical activity rates and healthy eating are all lower in Liverpool compared to the rest of the country. For example, 27% of

[1] Public Health England and the UCL Institute of Health Equity; Psychosocial pathways and health outcomes: Informing action on health inequalities (2017); (accessed on 20/09/2022) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/647709/Psychosocial_pathways_and_health_equity.pdf

adults are physically inactive compared to 22% in England. The environment people live in is also particularly challenging. In Liverpool, there are greater levels of air pollution, and households are more likely to suffer fuel poverty and live in overcrowded conditions. Children and adults also live in a city with the highest rates of violent crime in England; three times as many hospital admissions are due to violence than the England average.

More people also engage in health-harming behaviours. Adults are more likely to smoke and drink over 14 units of alcohol per week. Consequently, Liverpool has one of the highest rates of alcohol related hospital admissions in England with higher proportion of dependent drinkers not in treatment than the rest of England. People are also more likely to misuse and abuse drugs with two and half times as many deaths from drug misuse in Liverpool compared to the national average.

All these factors together, contribute to men and women in Liverpool living on average two and a half years fewer than the people in the rest of England, with the progress to close the gap stagnating in recent years. This gap is wider still between the most affluent and most deprived people living in Liverpool with men and women in Everton spending 18 and 17 fewer years of their lives respectively in good health compared to men and women living in Church.

Much of this morbidity and mortality is avoidable and despite significant improvement over the last 20 years, the rate of avoidable mortality in Liverpool has remained consistently 50% above the national rate. This represents an additional 740 people dying every year in Liverpool with the leading causes of these deaths being cancer, cardiovascular disease, and respiratory disease.

The cost-of-living crisis is also expected to have a negative impact on physical and mental health, with more than half of British people[2] already reporting a negative health effect from increased food, heating, and transport costs. In the short term, there will be an increased demand for health and care services and in recognition of this, the Combined Authority has earmarked £5 million to provide voluntary and community sector support[3]. In the longer term, the situation will likely exacerbate the existing health inequalities, making them starker still.

This context provides an opportunity for organisations in Liverpool to work together to improve outcomes, health and wellbeing for people living and working in Liverpool.

Collectively the six acute and specialist organisations in Liverpool provide local acute hospital services to the people of Liverpool and the surrounding areas including Sefton and Knowsley. Liverpool based providers also support service provision at neighbouring District General Hospitals such as Southport and Ormskirk Hospital NHS Trust. All organisations in Liverpool also provide specialist tertiary services for the wider Cheshire & Merseyside ICS, the North West of England, Isle of Man and North Wales, and train future staff for a significantly wider footprint. Several organisations, namely Alder Hey Children's NHS FT, Liverpool Heart and Chest Hospital NHS FT, the Hewitt Fertility Centre and fetal medicine services at the

[2] BMJ; Rising cost of living is damaging people's health, says royal college, 2022. https://www.bmj.com/content/377/bmj.o1231?ijkey=8666283869e9198ad1ceb17bf009f6ab08e86913&keytype2=tf_ipsecsha

[3] Liverpool City Combined Authority, 2022. https://www.liverpoolcityregion-ca.gov.uk/4-7m-cost-of-living-support-prioritised-as-liverpool-city-regions-44m-shared-prosperity-fund-plans-revealed/

Liverpool Women's Hospital NHS FT, and The Walton Centre NHS FT, have a national and international reputation that attracts quaternary referrals.

In this context, organisations in Liverpool have collectively developed a 5-year strategy, One Liverpool, which runs from 2019 to 2024. Its aim is to deliver better population health and wellbeing in Liverpool, and it represents a whole system approach to delivering change that engaged Liverpool City Council, the local NHS and other key public and voluntary sector partners in its development. The One Liverpool Strategy is part of the Liverpool City Plan and focuses on the positive and transformative actions that the health and care system will take together and with the people of Liverpool to improve population health and reduce health inequalities. In support of that, it has four objectives: 1. Targeted action on inequalities, at scale and with pace; 2. Empowerment and support for wellbeing; 3. Radical upgrade in prevention and early intervention; and 4. Integrated and sustainable health and care services. The strategy commits to being all age, all ethnicity, physical and mental health, aimed at empowering residents, improving equity and outcome focused.

Provider collaboration as a strategic enabler

The new Health and Care Act 2022 has a set of legislative changes to enable health and care to work more closely together. The intention is that there is a duty to collaborate, promoting joint working across healthcare, public health, and social care. The duty will apply to both NHS organisations and local authorities with a focus on reducing competition, removing the legislation that hinders collaboration and joint decision-making. Provider collaboratives are a key component of delivering system working, being one way in which providers work together to plan, deliver, and transform services. National guidance has mandated that all trusts providing acute and mental health services are expected to be part of one or more provider collaboratives by April 2022.

By working effectively at scale, providers can properly address unwarranted variation and inequality in access, experience, and outcomes across wider populations, improve resilience in smaller trusts, and ensure that specialisation and consolidation occur where this will provide better outcomes and value. Meeting these challenges is essential to delivering recovery from the pandemic and can only be achieved by providers working together with a shared purpose. The experiences of existing provider collaboration and the successful ways that providers have worked together to respond to the pandemic have demonstrated the specific types of benefits of scale that can be delivered including[4]:

- Reductions in unwarranted variation in outcomes and access to services,
- Reductions in health inequalities,
- Greater resilience across systems, including mutual aid, better management of system-wide capacity and alleviation of immediate workforce pressures,
- Better recruitment, retention, development of staff and leadership talent, enabling providers to collectively support national and local people plans,
- Consolidation of low-volume or specialised services, and
- Efficiencies and economies of scale.

In identifying, promoting, and championing the benefits of collaboration, NHS England have encouraged providers to build on local successes through provider collaborative structures and now, also require

[4] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf

all providers to be part of a collaborative. This policy imperative is seen as a mechanism to ensure providers support the delivery of the triple aim through:

- Aligning priorities,
- Supporting establishment of the Integrated Care System (ICS) with the capacity to support population-based decision-making, and
- Directing resources to improve service provision.

In Cheshire and Merseyside, there are two provider collaboratives: Cheshire and Merseyside Acute and Specialist Trust (CMAST) and Mental Health, Community and Learning Disability Collaborative (MHLDSC). The acute and specialist providers are part of CMAST, which in addition to the triple aim priorities, has identified a number of complementary functions that the collaborative can and should perform:

- Prioritising key programmes for delivery on behalf of the system, and
- Creating an environment of innovation, challenge, and support in order to deliver improved performance and quality of service provision.

Following the success of a number of CMAST initiatives and the establishment of the NHS Cheshire and Merseyside ICB, CMAST's ways of working have been formalised through a Joint Working Agreement, which has passed through each of the Trust Boards. The acute and specialist trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision-making structures. Each organisation has agreed to establish a committee that has functions delegated to it from its respective Trust which shall work in common with the other CMAST Committees in Common, but which will each take its decisions independently on behalf of its own Board. The CMAST Committees in Common will act collectively through the CMAST Leadership Board.

Through this Joint Working agreement, CMAST will pursue several immediate and short-term programmes of work to ensure the coordination of an effective provider response to current system and NHS priorities including ongoing pandemic response, NHS service restoration and elective recovery, support, and mutual aid, sharing best practice, increasing standardisation, and reducing variation.

The health and care landscape of Liverpool, particularly the acute sector, is unusual with six separate acute NHS organisations serving the local population. The complexity of the landscape is exacerbated by the range of specialist hospitals and services, and the varied financial positions and spectrum of care quality ratings across providers. Consequently, there is greater provider and system fragmentation within the Liverpool boundary. In the context of national policy on provider collaboration, there is a greater opportunity for working together differently and hence the review has focused on opportunities where the benefits to staff, patients and the wider healthcare system can be realised.

Stakeholders spoke extensively about the foundations for closer collaboration that have been set in Liverpool, particularly as a result of managing the Covid-19 pandemic response. During that time, a sense of shared purpose helped to accelerate collaboration and draw on the collective strengths of all partner organisations. A range of clinical examples of previous and current collaboration were cited including the work of the Liverpool Neonatal Partnership, mutual aid during the pandemic between organisations such as the use of paediatric ITU capacity at Alder Hey Children's NHS FT for adults, and stroke services between Liverpool University Hospitals NHS FT and The Walton Centre NHS FT. Additionally there were some limited examples of risk sharing between organisations, specifically for spinal services between Liverpool University Hospitals NHS FT and The Walton Centre NHS FT, and haemo-oncology services between Liverpool University Hospitals NHS FT and The Clatterbridge Cancer Centre NHS FT. Beyond clinical collaboration,

colleagues described opportunities that had been realised in the establishment of CIPHA as a population health management platform across Cheshire and Merseyside, and sharing of new internationally recruited nurses between Liverpool Heart and Chest Hospital NHS FT, The Walton Centre NHS FT, and Liverpool University Hospitals NHS FT.

The engagement that has taken place to date has clearly highlighted an enthusiasm for collaboration, and to build on the existing strengths within the organisations and the ongoing mutual aid arrangements that exists between organisations.

Purpose and scope of the review

CF was commissioned in August 2022 by the Cheshire and Merseyside Integrated Care Board (ICB), NHS Cheshire and Merseyside, with day-to-day oversight from the One Liverpool Partnership Board, to undertake an independent review of the acute care model with a view to identifying opportunities that will improve clinical hospital-based services in terms of clinical quality, efficiency, and effectiveness. The original terms of reference for the review can be found in Annex 1.

The organisations primarily in scope of the review were the six NHS Trusts that are part of the Liverpool Place: Alder Hey Children's NHS FT, Clatterbridge Cancer Centre NHS FT, Liverpool Heart and Chest Hospital NHS FT, Liverpool University Hospitals NHS FT, Liverpool Women's Hospital NHS FT, and The Walton Centre NHS FT.

Other partners core to One Liverpool include general practice, Mersey Care FT, and Liverpool City Council. The North West Ambulance Service (NWAS), the University of Liverpool and Liverpool John Moores University are also key partners to the six acute and specialist providers.

At the outset of the work, colleagues requested a reset of the scope of work. In particular, colleagues felt that the starting point for the review needed to articulate the significant collaborative efforts that were already underway. The revised objectives of the review were to identify and detail how to realise opportunities that optimise the acute care model for Liverpool including co-designing seamless pathways of care for those using services, which provide high quality and safe care, improving equity and integration in terms of access and outcomes, making best use of resources to create long term financial and clinical sustainability and maximising the wider potential of Liverpool City Region.

This revised scope was then socialised through a set of meetings and agreed by One Liverpool Partnership Board on 2 August.

The deliverables agreed were:

- A case for collaboration that sets out the context for, and drivers of, deeper collaboration, the priorities that have been chosen for collaboration and reasons why,
- A blueprint for collaborative opportunities that sets out detail on how to realise the collaboration opportunities chosen and identified areas of challenge and requirements to overcome,
- An articulation of the conditions for success which describe the supporting arrangements that will need to be in place to achieve the domains of collaboration outlined in the case for collaboration, and
- An implementation roadmap which sets out the steps needed to deliver the blueprint and support conditions for success.

Approach to the review

The approach to the review was one of Appreciative Inquiry (Ai), which is an established method to facilitate change that seeks to build on what is already working well. Collaboration opportunities were identified through exploring where strengths can be harnessed, where challenges are shared and where individual challenges need to be addressed collaboratively.

The review was conducted in full recognition of the NHS Long Term Plan, the One Liverpool Strategy, and the strategies of the six organisations. In support of that, over 50 documents were reviewed and considered as part of the review.

The terms of reference highlighted the need to engage with a range of stakeholders, including those beyond the primary scope of the review. The discovery phase of the work engaged almost 300 people with 70 individual interviews, group discussions with each of the acute and specialist provider executive teams and hospital management groups that engaged over 50 people, a GP engagement session with eight PCN clinical leads, and over 150 senior staff from across Liverpool contributing via a staff survey.

The engagement was supplemented by extensive data analysis to sense check and evidence the hypotheses and views expressed in the interviews, discussions, and survey outputs.

The outputs of the discovery work were reflected back, tested, and refined in a series of joint sessions – a small group discussion, a system-wide workshop and as part of a One Liverpool Partnership Board discussion in September 2022. The opportunities that have been identified vary in their detail, reflecting the constraints of the process.

The full interview list can be found at Annex 2 and covers both those people engaged through one-to-one and group discussions. The survey was anonymous. Participants in the workshops and boards meetings, which engaged in the overall findings reflected in this report are also listed in Annex 3.

Representatives from each organisation agreed the next phase of the work should move on to address the most critical issues facing the system, which are the longstanding clinical risks for women's health, current financial sustainability, and operational pressures for emergency care. They also wanted to push recommendations to a tangible level of detail on a subset of opportunities, as opposed to a broad-brush approach on many. Consequently, a gateway review including prioritisation took place as part of a One Liverpool Partnership Board discussion.

For the prioritised opportunities, a series of task and finish groups, involving clinical colleagues from all organisations, was held to work through the detail of the opportunity, with a system workshop to check and challenge the outputs. Participants in each task and finish group are listed in Annex 4 and for the workshop in Annex 3.

The roadmap for pursuing the opportunities was explored in a smaller roundtable discussion and confirmed at the One Liverpool Partnership Board discussion in November 2022. Participants of both meetings are listed in Annex 3.

The rest of this document sets out the case for greater acute and specialist provider collaboration, the priorities for action, and the conditions needed for success, and includes the recommendations of the review.

The case for greater acute and specialist provider collaboration

Twelve collaboration opportunities have emerged through the engagement and collectively these make up the strategic agenda for collaboration between the acute and specialist providers. These opportunities are additive to pre-existing priorities and will in some cases require wider partnerships to deliver on them. They outline a holistic and systematic requirement for collaboration between the acute providers themselves, and collectively with Mersey Care, PCNs, and the local authority, in particular, but also the academic institutions in Liverpool and other stakeholders.

Improving physical and mental health by providing more anticipatory care, especially for people with long term conditions and complex lives, through strengthened relationships with primary care

Liverpool has a higher burden of long-term conditions and multimorbidity than the national average. The consequence of this is an increased use of hospital-based services, which reactively manage deterioration and acute exacerbation as opposed to the proactive anticipatory management that could avoid use of hospital-based services. Liverpool also has one of the highest rates of unplanned admissions for chronic ambulatory sensitive conditions, with an additional 365 people a year admitted to hospital compared to the rest of the country. Much of this activity is from relatively small groups of the population - people with Complex Lives and long-term conditions.

Around 45% of the population have one or more long-term condition (LTC). People with LTCs account for 60% of all A&E attendances, 85% of all hospital admissions, 92% of mental health contacts and 91% of all community contacts. The long-term conditions that affect people living in Liverpool at a higher rate to the rest of England are chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), obesity, and depression. In Liverpool, there are 80,000 people with high blood pressure, 17,800 people with coronary heart disease and 17,400 with chronic obstructive pulmonary disease. The prevalence of these conditions is similar to the national average although many of these conditions will be co-existing, increasing the burden of disease. Throughout the engagement colleagues reflected on the younger presentation and extent of multi-morbidity in Liverpool.

In Liverpool people with complex lives represent 1% of the population but account for over £43 million spent every year on health and care services, or around 5% of the total locally commissioned expenditure on acute and community and services. They are people who have either:

- One or more physical condition, and one or more mental health condition, and one or more of either homelessness, substance and/or alcohol abuse, history of offending, high intensity use of A&E, history of being looked after, or domestic abuse,
- Or regardless of physical or mental health, three or more from - homelessness, substance and/or alcohol abuse, history of offending, high intensity use of A&E, history of being looked after, or domestic abuse.

People with Complex Lives are twice as likely to use acute hospital services than others and more than ten times as likely to use mental health services. As well as being more likely to access services, the average use of services is also significantly higher for those with Complex Lives, with 2.5 emergency department attendances per year compared to 0.3 for the rest of Liverpool, and 8 mental health contacts per year compared to 0.4.

Colleagues spoke passionately about the significant opportunities for collaboration to provide holistic, preventative, and anticipatory care for people in Liverpool and expressed a strong desire to work in

partnership with primary care to deliver this care. Many of the foundational elements needed, such as an integrated dataset, are already in place in Liverpool through CIPHA and so collaborative effort on population health management could have significant impact. Work to set up multi-disciplinary neighbourhood teams and provide integrated care must begin now for benefits to be realised in the future.

In pursuit of this opportunity, the acute and specialist providers in Liverpool should continue work collaboratively with system partners to support the development of effective place-based partnerships as part of the One Liverpool programme of work to deliver holistic, anticipatory care through multi-disciplinary neighbourhood teams that take targeted action at PCN-level. The CORE20plus5 approach should also be embedded into the One Liverpool strategy and delivery methodology to ensure that prevention and addressing health inequalities are core to the programme of work.

For long term conditions, an anticipatory model of care should be developed and implemented that encompasses case finding, care planning, structured education and self-management, and access to specialist opinion involving a health and social care multi-disciplinary team at a PCN level. For people with complex lives, the anticipatory model should be supplemented by care planning and navigation / co-ordination, rapid response, reablement and a healthy living environment. The One Liverpool Programme already has programmes of work related to both segments and these opportunities should be taken forward by the relevant Segment delivery groups.

Making place-based partnerships a priority ensures that the needs of local populations, at place and neighbourhood level, are being recognised by leveraging collective expertise, insight, and relationships. The objectives of a place-based partnership centre on improving the quality, co-ordination and accessibility of health and care services and this needs to be a focus in order fully to respond to the case for collaboration.

Creating socially inclusive training and employment opportunities for the Liverpool City Region, leveraging anchor institution status to address local deprivation

The position of NHS organisations as major employers and anchor institutions in the Liverpool City Region emphasises the role of a hospital beyond the direct patient care benefits that they deliver. Having a hospital within the community generates wider economic benefits as a result of the jobs it offers. It is also a focal point which can help partnerships between healthcare organisations and communities responding to the wider social determinants of health.

People living in Liverpool are more disengaged from the labour market with long-term unemployment rates twice that of the rest of England (3.9 people per 1,000 working age people in Liverpool vs. 1.9 in England). One in ten people receive Employment and Support Allowances compared to one in twenty in the rest of the country. This is even starker for those with long term health or mental health conditions with more relatively disengagement in the labour market than in the rest of the country.

One consequence of this lack of employment is that Liverpool has the greatest extent of deprivation in the country: two thirds of people in Liverpool are in the most deprived 30% of people nationally, and 8% are in the most deprived 1%. Income deprivation affects four in ten children in Liverpool, the fourth highest rate in the country after Middlesbrough, Knowsley, and Hartlepool. The lack of money (or low income) has been shown to have the strongest impact on children's cognitive, social-behavioural, educational attainment and

health outcomes, independent of other factors[5]. The consequence is increased risk of social and economic disadvantage in early adulthood, which includes lower earnings, higher risk of unemployment or spending time in prison (men) and becoming a lone parent (women)[6,7].Once employed, however people living in Liverpool have better weekly earnings (£480) than in other Core Cities (£465).

There is an imperative to support local people to gain and remain in employment, taking collective action to address local deprivation. Specifically, stakeholders described energy around creating socially inclusive training and employment opportunities through apprenticeship and preceptorship programmes for the Liverpool City Region. While many organisations offer a small number of such programmes already, the collective efforts of the acute and specialist providers in Liverpool could scale and significantly extend the reach of the ongoing work. Many other systems are already working collaboratively on socially inclusive employment to address local workforce challenges, by pooling and making use of unused apprenticeship levies and jointly procure training programmes for apprentices that could be replicated in Liverpool.

Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, and Royal Liverpool sites

Urgent and emergency pathways in Liverpool are one of the greatest points of pressure for the city, frequently cited by stakeholders as the most significant issue after the sustainability of women's health services in Liverpool. There are challenges with both timely access and poor outcomes, and performance has worsened since the onset of the covid pandemic. In most places access is falling short of national standards, especially with respect to emergency department waits.

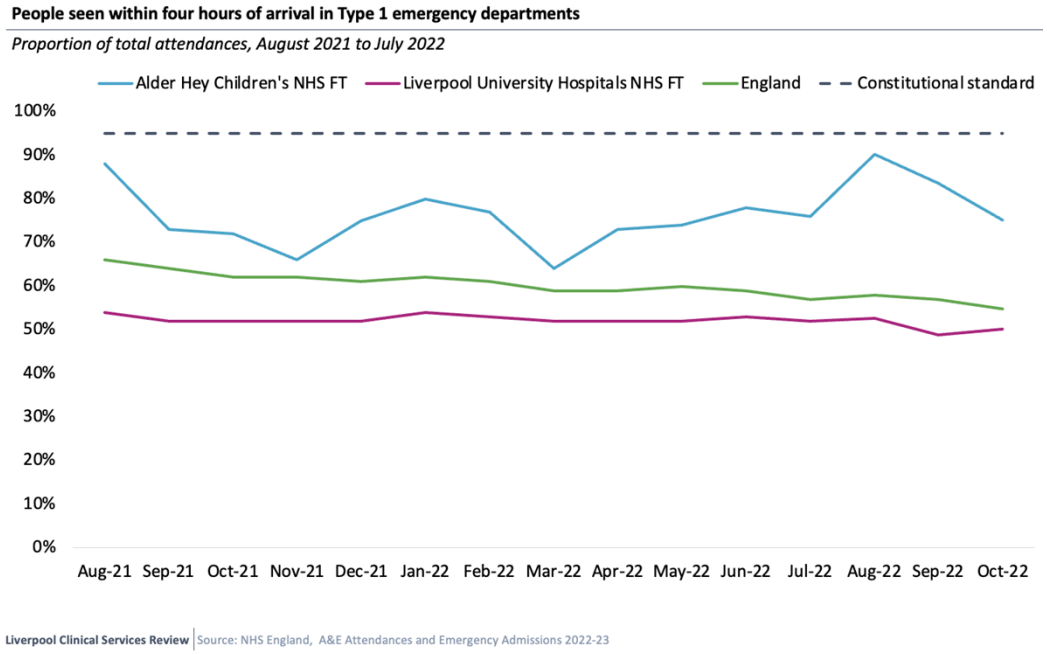


Figure 2: Four hour performance by organisation

[5] Cooper K and Stewart K. Does money affect children's outcomes? An update. London: Centre for Analysis of Social Exclusion; 2017. http://sticerd.lse.ac.uk/dps/case/cp/casepaper203.pdf (accessed 24/10/2022)

[6] Gregg P, Harkness S and Machin S. Child poverty and its consequences. York: Joseph Rowntree Foundation; 1999. www.jrf.org.uk/report/child-poverty-and-its-consequences (accessed 24/10/2022)

[7] Gregg P, MacMillan L and Vittori C. Nonlinear estimation of lifetime intergenerational economic mobility and the role of education. Department of Quantitative Social Science working paper no. 15-03. London: Institute of Education; 2015. http://repec.ioe.ac.uk/REPEc/pdf/qsswp1503.pdf (accessed 24/10/2022)

Liverpool University Hospitals NHS FT sees 52% of people within four hours of arrival at an emergency department. This is 43% below the constitutional standard, and 9% below the national average as set out in Figure 2.

Emergency inpatient services across Liverpool are more commonly provided from only one of the city's five acute sites compared to other areas, with some notable exceptions, which are non-interventional cardiology, respiratory and haematology services. This means that when people need specialist care, they frequently require transfer to another site and their care may become fragmented in some places. For some specialties and conditions, this results in long lengths of stay in the emergency department (Figure 3) and inpatient lengths of stay that are double the national average. This is associated with increased mortality and poorer outcomes for patients.

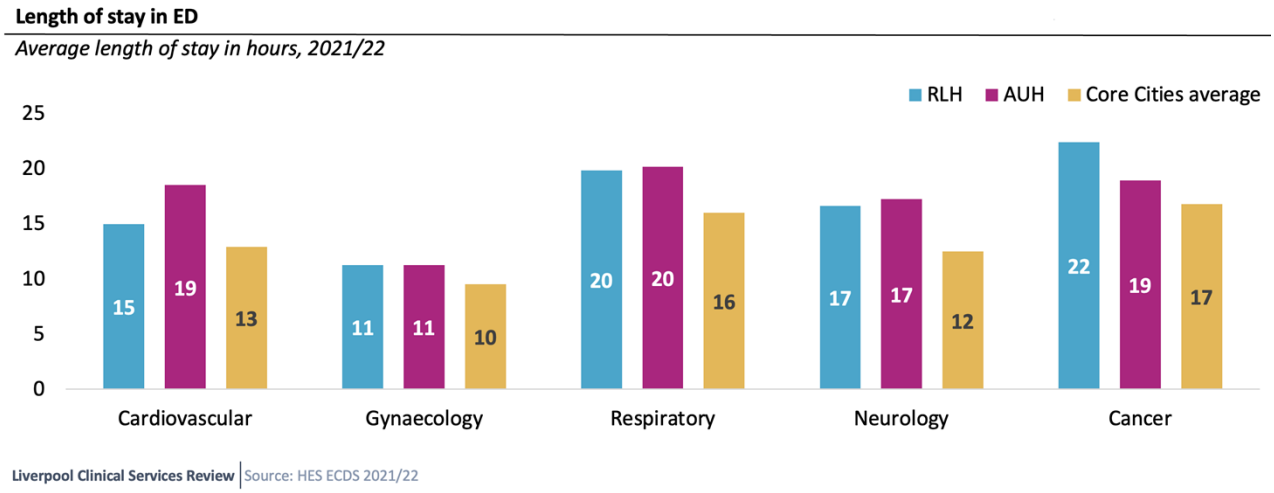


Figure 3: average length of stay in the emergency department by speciality

A specific example of this is care for non-ST elevation myocardial infarctions (NSTEMI). Liverpool has the fifth highest rate of death attributed to heart disease in England, whilst NHS Cheshire and Merseyside ICB is ranked 40 of 42 for access to invasive investigation for NSTEMI within 72 hours of hospital admission. When we consider length of stay for those with a NSTEMI, patients admitted to Aintree University Hospital or Royal Liverpool Hospital who are subsequently transferred to Liverpool Heart and Chest Hospital NHS FT have on average a combined length of stay that is double the length of stay of those who are admitted directly.

NSTEMI is an example of fragmented care and through the engagement it was clear that there were several other groups of people that were not having their emergency needs met through the existing pathways including women, people with head injuries and people with mental health needs.

Opportunities exist across a spectrum of collaboration. This includes sharing best practice, data and information, standardising quality, and performance standards, creating rotational posts and shared roles between organisations, standardising pathways, and ensuring robust protocols and procedures are in place, networking services and consolidating services. Stakeholders agreed it was important to consider this opportunity in more detail to understand where greater collaboration could have the most impact.

Levelling-up performance on cancer and cardiovascular disease to address health inequalities

Cancer is the city's largest cause of premature deaths with 605 deaths under the age of 75 in 2020, representing around a third of all premature deaths in Liverpool.

The impact of the pandemic on cancer care has been significant. The number of people referred for a cancer assessment has grown by 134% over the last 2 years and the number of people on the cancer waiting list has increased by 220% as shown in Figure 4. The 62-day backlog has increased by 241% compared to the pre-Covid baseline, with progress to work off the backlog worsening in recent months with progress to clear the 104-day cancer backlog also having stagnated recently.

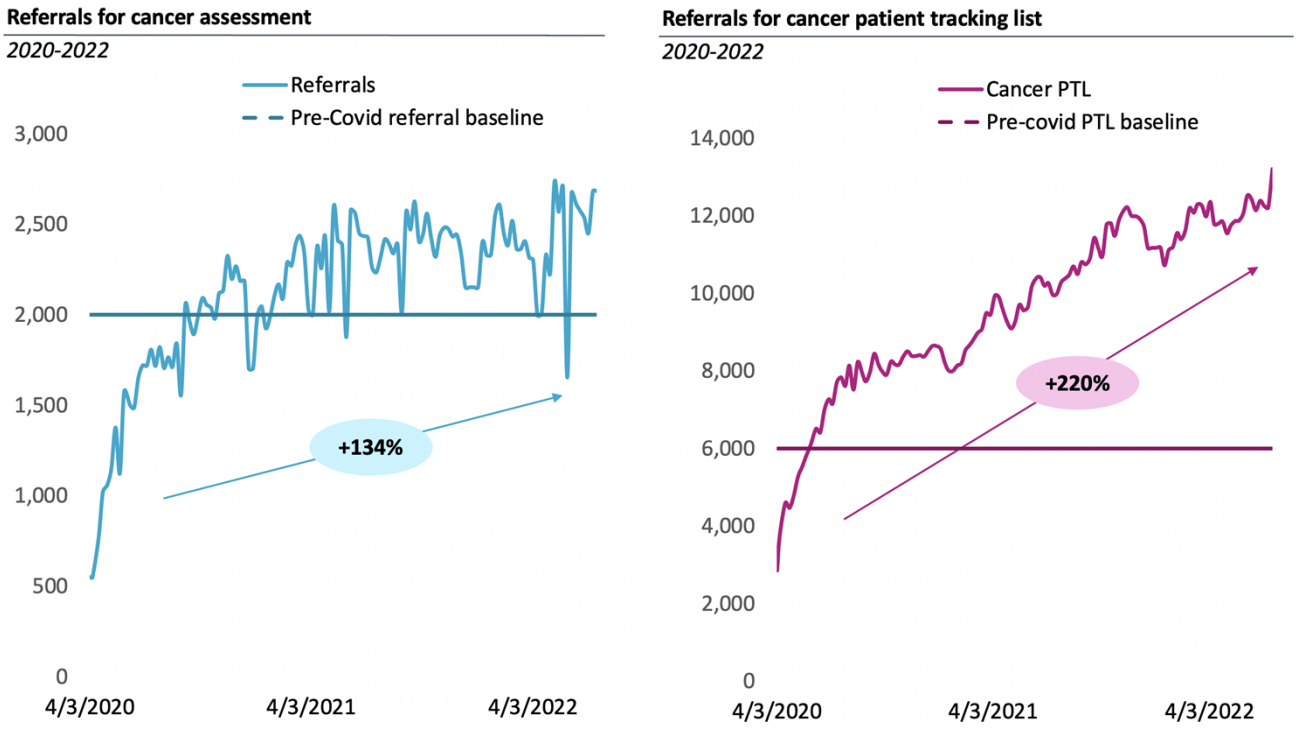


Figure 4: cancer assessment and patient tracking list referrals for Cheshire and Merseyside

This is a significant increase from the pre-pandemic baseline and collaboration between organisations needs to ensure that capacity is directed effectively between planned care backlog clearing efforts. The Cheshire and Merseyside Cancer Alliance is responsible for taking forward cancer recovery efforts including reducing waiting times for diagnosis and treatment, improving awareness of the symptoms of cancer, providing personalised care, and focusing on prevention to stop cancer from developing in the first place.

Every week, three people are diagnosed with cancer in the Emergency Department at the Royal Liverpool Hospital, and this cohort of patients also exposes some clear inequalities - patients diagnosed with cancer in the Emergency Department last year were between 2 and 6 times more likely to be from an ethnic minority than white. We know that cancers diagnosed in ED are likely to be in later stages of disease progression and there is likely to be an impact on survival rates as a consequence. Action to address late diagnosis of cancer and inequalities in access requires a place-based approach involving primary care and local government, working at PCN level to implement culturally sensitive targeted interventions, taking account of local needs. This approach should be endorsed by the Cancer Alliance and could be rolled out to other places in the Cheshire and Merseyside ICS.

Similarly, there are opportunities in cardiovascular disease, which is the second biggest cause of premature mortality in Liverpool, with around 400 deaths a year of people aged 75 and under from all cardiovascular causes. Liverpool has the fifth highest rate of death attributed to heart disease in England and the ninth highest from acute myocardial infarction for men. Cardiovascular disease is considered to be largely

preventable through a healthy lifestyle and the early detection and control of risk conditions; atrial fibrillation (AF), high blood pressure (hypertension, BP) and high cholesterol (the 'ABC' of CVD prevention). While significant progress has been made in diagnosis atrial fibrillation, gaps in hypertension and high cholesterol diagnosis and early treatment exist with only 58.5% of the expected people with high blood pressure diagnosed and of those diagnosed only 57% being treated in accordance with NICE guidelines. Cardiovascular disease and its early diagnosis are associated with deeply embedded inequalities in Liverpool and is the most significant contributor to the gap in life expectancy between the most and least deprived in Liverpool, accounting for 21% of the difference in 2021.

As with cancer care, action to address late diagnosis of cardiovascular disease and inequalities in access requires a place-based approach involving primary care and local government, working at PCN level to implement culturally sensitive targeted interventions, taking account of local needs. This approach should be endorsed by the Liverpool Cardiology Partnership and could be rolled out to other places in the Cheshire and Merseyside ICS.

Providing timely access to high-quality elective care by making efficient use of existing estates and assets

Elective waiting lists have grown across Liverpool by a third every year since 2019 as shown in Figure 5. This rate is expected to increase even further as the post-COVID recovery or 'bounceback' in referrals continues to be seen. While all trusts in Liverpool have seen an increase in the number of people waiting for treatment, Liverpool University Hospitals NHS FT has faced very challenging circumstances with both a significant elective 18 week and 104+ week backlog across multiple specialities. As of July 2022, 49% of patients were seen within 18 weeks with 9,869 waiting more than 52 weeks for treatment at Liverpool University Hospitals NHS FT, and 62 people waiting more than 104+ weeks as of June 2022. Waits of this nature mean that patients are living with painful conditions for longer, and recent research[8] has shown that those who wait more than 6 months for elective surgery will have a 50% increased chance of worse outcomes – a far shorter period than the 52 weeks many patients have waited already.

[8] Cisternas, Alvaro F.a; Ramachandran, Roshnia,*; Yaksh, Tony L.b; Nahama, Alexisa Unintended consequences of COVID-19 safety measures on patients with chronic knee pain forced to defer joint replacement surgery, PAIN Reports: November/December 2020

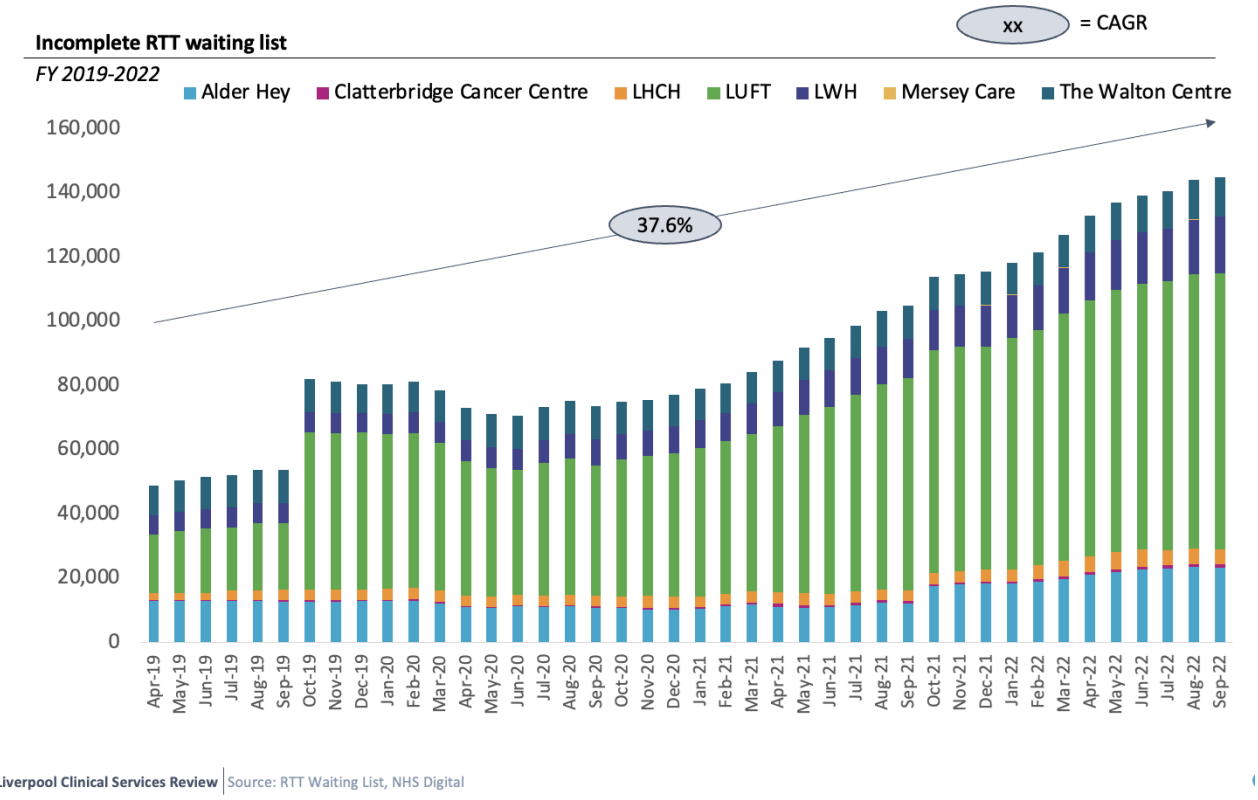


Figure 5: incomplete referral to treatment waiting list

Working through the elective backlog will be long-term challenge, given the continued 'bounceback' and the size of the current waiting list. The service changes set out by Liverpool University Hospitals NHS FT following its formation seek to create a split between elective and emergency activity, concentrating the former at Broadgreen. Implementation of this new configuration will not be immediate and, beyond this there is also an opportunity in the short to medium term to think about how to make efficient use of existing estates and assets across the city.

Following the pandemic, the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) mobilised a programme of work focusing on elective recovery efforts. The programme seeks to recover activity levels to pre-Covid levels and exceed them, reduce the waiting list and treatment backlogs, and transform pathways to deliver resilient pathways in the longer term.

Within Liverpool, all organisations in the city have physical theatre capacity that could be used between organisations more effectively to provide timely access to high quality elective care. An example of this in practice during the pandemic was the provision of ophthalmic surgery at the Crown Street site. Collaboration at the Liverpool footprint should be pursued alongside CMAST efforts on the basis that the any negative impact to access to care is minimal between these providers, and currently represents an underutilisation of system capacity.

Providing an increase to the level of elective capacity, where patients have a far lower risk of their procedure being cancelled or postponed due to emergency pressures, provides greater resilience in the system. This benefit is conferred when it is needed most, during periods of particularly high demand, such as winter, when elective performance typically suffers. In addition to the patient benefit, the ability to provide protected elective services offers more effective and attractive training opportunities and a potential opportunity to consider repatriation of activity from outside of Liverpool. There are also central

incentives for ICSs to recover elective activity to above pre-pandemic levels and collaborative efforts within and even beyond acute and specialist providers in Liverpool would support collectively achieving the funding available through the Elective Recovery Fund.

Solving clinical sustainability challenges affecting women's health in Liverpool

Overwhelmingly, the most important challenge stakeholders identified as needing to be addressed was clinical sustainability of services for women in Liverpool and the associated clinical risk. The Liverpool Women's Hospital NHS FT is a maternal medicine centre, has a world-leading reproductive medicine unit, and provides tertiary services across its full portfolio of specialities. The Liverpool Women's Hospital NHS FT main hospital site at Crown Street is isolated from other adult services in Liverpool meaning it is less able to manage acutely ill or rapidly deteriorating patients, women with complex surgical needs and significant medical co-morbidities. There is a lack of specialist expertise on site to render assistance, intensive care facilities and critical care outreach services, 24-hour laboratory services to support diagnosis, monitoring and intervention, therapies and recovery support, a blood transfusion laboratory suitable for the management of major haemorrhage, and imaging facilities to support timely diagnosis. Specifically, seven of twelve co-dependencies for maternal medicine centres (and therefore for consultant-led obstetric services) are not currently met at the Crown Street site. Additionally of the 1,132 standards for service delivery, currently 118 are not met by the Liverpool Women's Hospital NHS FT, and 75 of these are not met as a consequence of being on an isolated site.

Services should be co-located in the same hospital
Adult critical care
General and obstetric anaesthetics
Neonatology: L3
Emergency general surgery
Acute medicine
Acute stroke
General cardiology
Interventional radiology
X-ray
Obstetric ultrasound
Urgent access to CT scan
Emergency haematology and biochemistry

Services do not meet recommendations

Service provision inconsistent

Services meet recommendations

Figure 6: co-dependencies met for maternal medicine centre and consultant-led obstetric unit

Similarly, other adult acute sites in Liverpool do not have co-located women's services and are therefore less able to meet women's medical needs, including women who are pregnant, when they present at the emergency department or who are inpatients at other sites.

A number of groups are particularly impacted by the configuration of services across sites:

- Women with complex conditions who need specialist care while pregnant as their birth is classed as 'high-risk'
- Pregnant women needing intensive care while giving birth
- Babies requiring complex surgery after birth followed by specialist neonatal care

- Women needing intensive care while undergoing surgery for a gynaecological issue
- Women with complex conditions who need acute medical or surgical input
- Women admitted to LWH with acute medical or surgical problems needing general or specialist opinion
- Women with complex gynaecological issues requiring surgery and those with gynaecological cancers requiring surgery

The consequence of this is that women and babies are transferred by ambulance between sites to receive the care they need. LWH has the one of highest rate of transfers in the country for mothers and their babies with 11 transfers for every 1,000 discharges.

LWH is the only specialist obstetric and gynaecology service provider in the country in such an isolated position. This has created a significant gender inequality in access to services and suboptimal quality of care for women and their families, as well as increased risks for clinical and care staff to manage, both at the Crown Street site and other acute sites across Liverpool. The current risks have a multitude of impacts including difficulties in recruitment and retention, particularly for gynaecologists and anaesthetists, and an inability to meet national care standards. They are also driving increased clinical negligence costs for LWH with maternity CNST costs per £100m the highest in the country by a significant margin, over and above what those costs that are driven by the case mix and highly specialised service provision at the Liverpool Women's Hospital NHS FT.

While many risks have been mitigated or worked around, stakeholders spoke extensively about their concerns for the safety of women and babies whose condition deteriorates while within the hospital and the subsequent risk of being transferred across the city.

Combining expertise in clinical support services to provide consistent services across the city

Stakeholders have spoken enthusiastically about the collaboration that already takes place for delivering clinical support services, both within the city, such as Liverpool Clinical Laboratories, and as part of the ICS, such as Cheshire and Merseyside Radiology Imaging Network (CAMRIN). There was widespread recognition that there was still scope for further collaboration to combine expertise in clinical support services. The imaging and pathology networks sit within the overarching CMAST Diagnostic Programme, which brings together all diagnostic networks, including endoscopy, Community Diagnostic Centres, physiological testing, primary care diagnostics and digital in diagnostics. This dedicated programme of work is focused on diagnostics with focus on driving forward and facilitating collaboration, improving productivity, reducing waiting and reporting times, and ensuring only clinically appropriate tests are carried out.

Diagnostic imaging

Diagnostic tests, both imaging and reporting, have seen increased waiting times in 2022 compared to 2021 for six week waits, which reached a peak of 45% of the waiting list, and 13 week waits, which reached a peak of 25% of the waiting list.

Trusts within Cheshire and Merseyside have been working collaboratively since they joined together to procure their Radiology Information System (RIS) and Picture Archiving Communication Software (PACS) in 2012. This approach was ground-breaking and the first of its type in England and it is now seen as the gold standard for imaging networks. Since 2016, 12 Trusts across the ICS have come together to work on a large-scale change programme to improve services for patients and staff. Opportunities continue to exist to unify

systems as well push innovative practice further in this space including implementing the use of AI at scale in radiology.

One of the biggest challenges facing the service is the scale of the workforce challenge and while work is ongoing at the ICS level, stakeholders identified opportunities for further collaboration, specific to the acute and specialist Trusts in Liverpool. Joint radiology training posts and appointments between the organisations in Liverpool were thought to be valuable to support recruitment and retention of staff.

As with elective backlogs, collaboration to address 6- and 13-week backlogs for diagnostic imaging services at the Liverpool footprint should be pursued alongside CMAST efforts on the basis that the any negative impact to access to care is minimal between these providers, and currently represents an underutilisation of system capacity. These opportunities should be taken forward specifically by the Imaging workstream and the Imaging Network Management Group which forms part of the CMAST Diagnostic Programme.

Pathology

There is significant work underway to develop the Cheshire and Merseyside Pathology Network and consolidate pathology services across the footprint. The direction of travel has been consolidation of pathology services to concentrate expertise and deliver targeted investment to strengthen a regional pathology network. Following the formation of Liverpool University Hospitals NHS FT, Liverpool Clinical Laboratories (LCL) developed as a successful partnership between three organisations: Liverpool Heart and Chest Hospital NHS FT, Liverpool University Hospitals NHS FT, and Liverpool Women's Hospital NHS FT. LCL employs over 500 staff and processes the sixth highest volume of laboratory tests in England.

Stakeholders expressed that there was an opportunity for other organisations to take part in LCL and support its ambition to become a centre of excellence for clinical diagnostic and investigation services. To realise this opportunity, ways of working between existing organisations in the collaboration as well as any new partners need to be reset and worked through.

This opportunity should be taken forward specifically by the Pathology workstream and the Pathology Network Management Group of the CMAST Diagnostic Programme.

Pharmacy

Currently acute and specialist organisations in Liverpool collectively spend £11.4 million on pharmacy services for the city. Some organisations provide their services separately to one another, including having duplicated services on the same site. Colleagues described the pharmacy workforce as being particularly fragile due to increasing workloads and a lack of funding and opportunity for training opportunities for pharmacists.

The Transfers of Care Around Medicines initiative between Cheshire and Merseyside trusts and community pharmacies has saved £11 million over three years and an estimated 6,008 bed days[9] through medication reviews after discharge in the community. This collaboration is believed to be the fastest and widest roll-out of any such initiative in England, demonstrating the scope for further collaboration in this space.

[9] https://www.pharmacynetworknews.com/health-nhs/cheshire-and-merseyside-pharmacies-help-save-nhs-11-million

For future collaboration, stakeholders identified opportunities similar to those for radiology, with joint appointments as an opportunity to address the sustainability and resilience of the pharmacy workforce. This would enable better training opportunities for pharmacy staff with a broader range of experience and specialisms, which would in turn support recruitment and retention.

Colleagues also thought there would be benefit in pursuing a partnership model similar to the LCL to provide a single pharmacy function across Liverpool, recognising that collaboration on pharmacy services for the Aintree and Broadgreen sites already exists. Leveraging the scale of this service would enable pharmacists to spend more time on clinical services, and less time on infrastructure or back-office services[10]. This in-turn would allow pharmacist to drive medicines optimisation on wards in hospitals, thereby securing better outcomes for patients and better value for money.

Developing world-leading services in Liverpool by realising the collaborative potential in innovation, research, and clinical trials

Over the years, the research and education infrastructure of Liverpool has had healthy investment, with significant resources available across the city region. Stakeholders almost universally reflected that there were opportunities to leverage this infrastructure. There are two NIHR funded Clinical Research Facilities (CRF) in the city, one at the Royal Liverpool Hospital and the other at Alder Hey Hospital. These are two of 28 research facilities across the UK funded by the NIHR, and Alder Hey's CRF is one of two exclusively for paediatric patients in the country. Funding for these facilities has been granted until 2027. Organisations in Liverpool are estimated to have a combined income of c.£104 million annual for research and development in 2021/22, of which £31.6 million is Trust based and £73 million is allocated to academic institutions.

The acute and specialist trusts in Liverpool work in partnership to deliver the Liverpool CRF with 26 beds at the Liverpool University Hospitals NHS FT, units at the Clatterbridge Cancer Centre NHS FT, and at the Liverpool Heart and Chest Hospital NHS FT. The CRF at the Royal Hospital sites has more than doubled in size from 12 beds to 26 beds as part of the move to the new hospital. The CRF was instrumental in responding to the COVID-19 pandemic, working in partnership with academics at the University of Liverpool and Liverpool School of Tropical Medicine to test and develop vaccines and medicines to combat the virus.

As well as the CRF, organisations in Liverpool are involved in wider research collaboration. Examples include:

- Liverpool has an Experimental Cancer Medicine Centre (ECMC), which is a collaboration between the University of Liverpool (Liverpool Clinical Trials Centre and Good Clinical Practice Laboratory Facility) and The Clatterbridge Cancer Centre NHS FT
- The Clatterbridge Cancer Centre NHS FT is also part of a Biomedical Research Centre (BRC) with The Royal Marsden NHS FT, The Institute of Cancer Research (ICR), and City, University of London, which is the only BRC specifically focused on cancer

[10] Department of Health and Social Care, 2015. Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

- The Liverpool Centre for Cardiovascular Science (LCCS) has also been formed as a strategic research platform between University of Liverpool, Liverpool Heart and Chest Hospital Trust, Liverpool John Moores University and Liverpool Health Partners
- The Liverpool Neuroscience Biobank at The Walton Centre (LNBW) was established to promote multidisciplinary basic and translational neuro-oncology and neurology research working in Liverpool and within the Brain Tumour North West Collaboration.

Despite the investment in clinical research, clinical trial participation per 100,000 of the population in Liverpool is lower than Core City peers. Clinical research brings significant benefits to the patient population and studies have shown that Trusts with the best emergency mortality outcomes were those that were most active in clinical research[11]. A systematic review by the Health Services and Delivery Research programme, suggested that engagement with clinical research by individuals and healthcare organisations increased the likelihood of a positive healthcare performance.

The NIHR-INCLUDE commission, which sought to address the lack of representation in health and care research, identified the socio-economically disadvantaged, unemployed, and those on low income as under-represented groups in research[12,13]. Liverpool presents an opportunity to enhance research for such under-represented groups. People living in the city have some of the most challenging social issues in the UK, which means there also is a chance for research to make an impact on health where it is needed most.

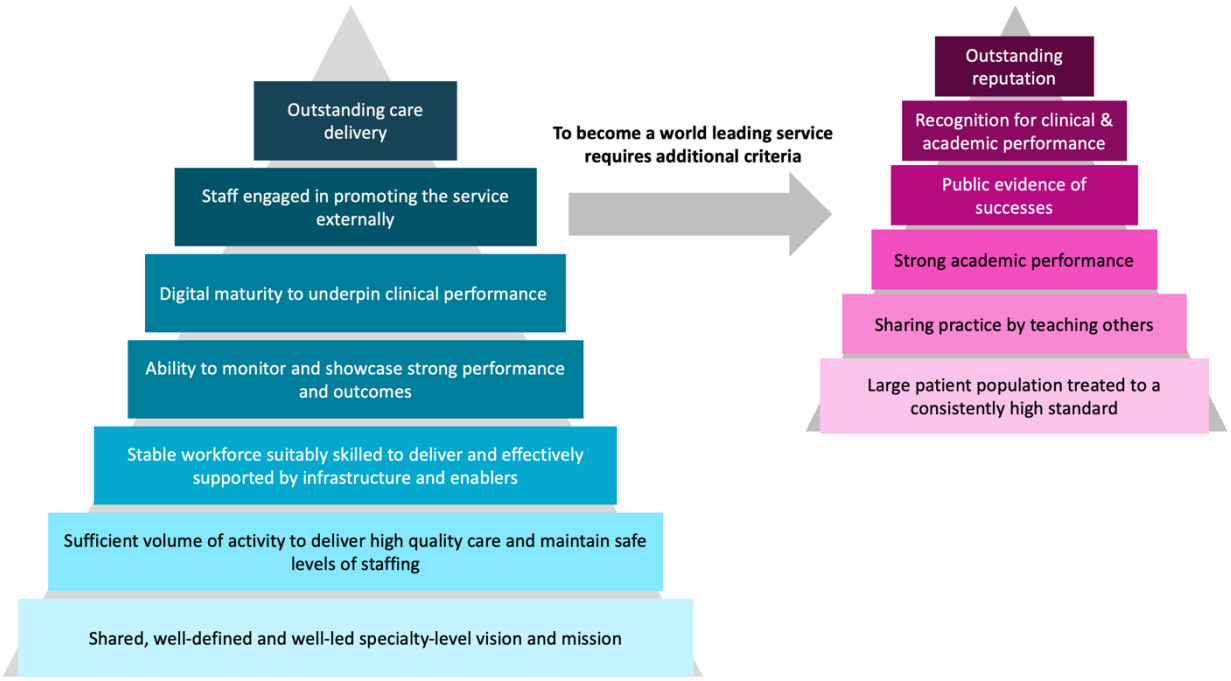


Figure 7: world-leading services framework

[11] Research Activity and the Association with Mortality, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4342017/

[12] NIHR (2020) Improving inclusion of under-served groups in clinical research: Guidance from the NIHR-INCLUDE project. UK: NIHR. Available at: www.nihr.ac.uk/documents/improving-inclusion-of-under-served-groups-in-clinical-research-guidance-from-include-project/25435 (date accessed: 21/10/2022)

[13] NIHR (2020) Ensuring that COVID-19 Research is Inclusive: Guidance from the NIHR CRN NIHR-INCLUDE project. UK: NIHR. Available at: www.nihr.ac.uk/documents/ensuring-that-covid-19-research-is-inclusive-guidance-from-the-nihr-crn-include-project/25441 (date accessed: 21/10/2022)

In addition, being able to harness the research and innovation potential across the Trusts is vital in fulfilling the criteria to becoming world leading services. The 'Outstanding' reputation that many of the acute and specialist Trusts have for service delivery from the CQC can be built upon to deliver world-leading services. A strong academic strategy will support delivery of the world leading services by attracting research funding and investment, talent, and driving quality as set out in Figure 7.

The research and innovation agenda for the city should be pursued through a refreshed scope of the Liverpool Health Partners (LHP), working with all existing partners and additionally include Liverpool City Council and Applied Research Collaboration North West Coast. The refreshed scope of the LHP should consider:

- Delivering data-enabled clinical trials from end-to-end by using routine data rapidly to identify potential trial recruitment pools, recruiting participants through a single point of entry, and tracking them through a trial using data collected from routine sources and telemedicine
- Establishing a hub to act as a single point of planning and operations for organisations interested in running a clinical trial in Liverpool, supported by spokes that support recruiting participants and facilitating ongoing monitoring

Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff

Health and social care is the largest employer in the Liverpool City Region, employing 117,000 people. Across the six organisations, around 25,000 people were employed and £1.29bn was spent on workforce costs in 2021/22. As a result, the workforce agenda between the acute and specialist trusts is significant and has far reaching consequences into the community.

According to senior staff, the biggest challenge to ongoing service delivery is recruitment and retention of staff (Figure 8). This reflection is supported by data and is seen to manifest in several ways:

- The turnover rate for medical staff is relatively high, ranging between 20% to 35% across the Trusts, with four of the six organisations having a rate above the national median of 30%.
- Staff motivation shows room for improvement with staff reporting on or below average motivation scores in five out of six organisations.
- Satisfaction with training programmes is also variable across Liverpool with overall satisfaction lower than the national average at four out of six organisations.
- Use of bank and agency staff is high, and competition for capacity in the same staff groups leads to often escalating rates paid out to staff and subsequently disproportionate spend on agency and bank rates.

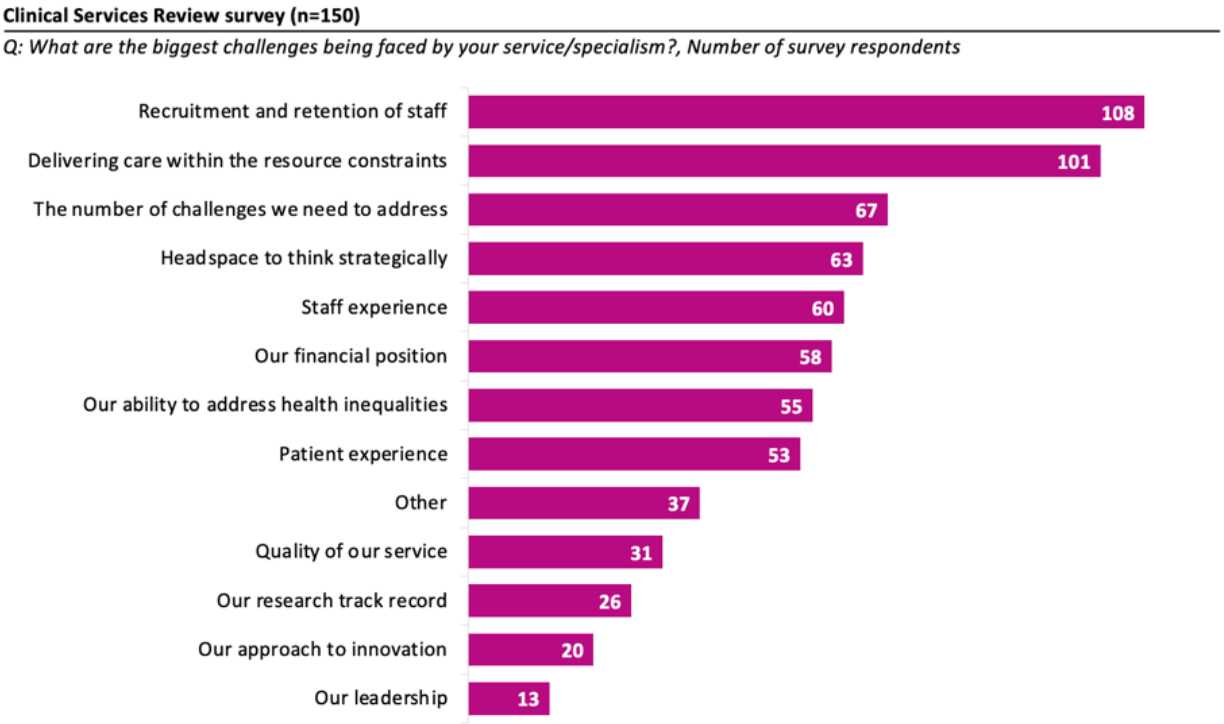


Figure 8: Liverpool Clinical Services Review survey - biggest challenges faced by your service responses

Colleagues also consistently described how competition between Trusts magnifies this challenge in particular in relation to staff groups that are common to all organisations, such as theatre staff.

To address these issues, stakeholders described a host of different opportunities in this space to work collaboratively to attract and retain talent at all levels. These included an integrated training and development offer, implementing staff passports, standardising policies, collective workforce planning, and joint recruitment. Working together to create a strong employer brand could improve recruitment and retention rates, reduce recruitment costs, and increase pride amongst staff.

A consistent theme in the opportunities described was the opportunity to integrate training, education, and development for staff. The collective scale and the diversity of work within the organisations allow for a greater range of programmes, and more varied training opportunities to be offered to all staff. Colleagues also described how each organisation had its own leadership development training and that a joint programme in this space could support colleagues to lead for collaboration. Colleagues also felt that implementing staff passporting mechanisms would not only improve often lengthy mandatory and staff training requirements, allowing faster recruitment, but would enable the movement of staff seamlessly between sites and support filling gaps in staffing at other organisations.

Working together could allow all organisations to set a single set of policies and prices for temporary staffing, allowing for a more consistent level of spend between them particularly given financial constraints. Work to set up a collaborative bank also has the potential to release significant savings, as well as bring greater flexibility of working for staff.

Through CMAST, there is an existing Workforce Programme focused on addressing system workforce pressures and leading on workforce development that should support the implementation of this

opportunity. In the longer term, recognising the inherent challenge for the health and social care workforce as a whole, organisations in Liverpool should work together to standardise workforce models and proactively identify roles that will be particularly difficult to recruit for. This should be done in conjunction with the implementation of new proactive models of care that provide preventative and anticipatory care.

Achieving economies of scale in corporate services

Another area where stakeholders were able to clearly articulate the potential for closer working was corporate services and leveraging the expertise across organisations and economies of scale in doing so. Across all organisations in Liverpool, £132.4 million is spent on corporate services (2021/22) and the majority of trusts spent more on corporate services per £100 million income than trusts in the Core Cities as shown in Figure 9. In 2020/21[14], all organisations in Liverpool spent more on finance and HR corporate functions for every £100 million of income earned than the national lower quartile.

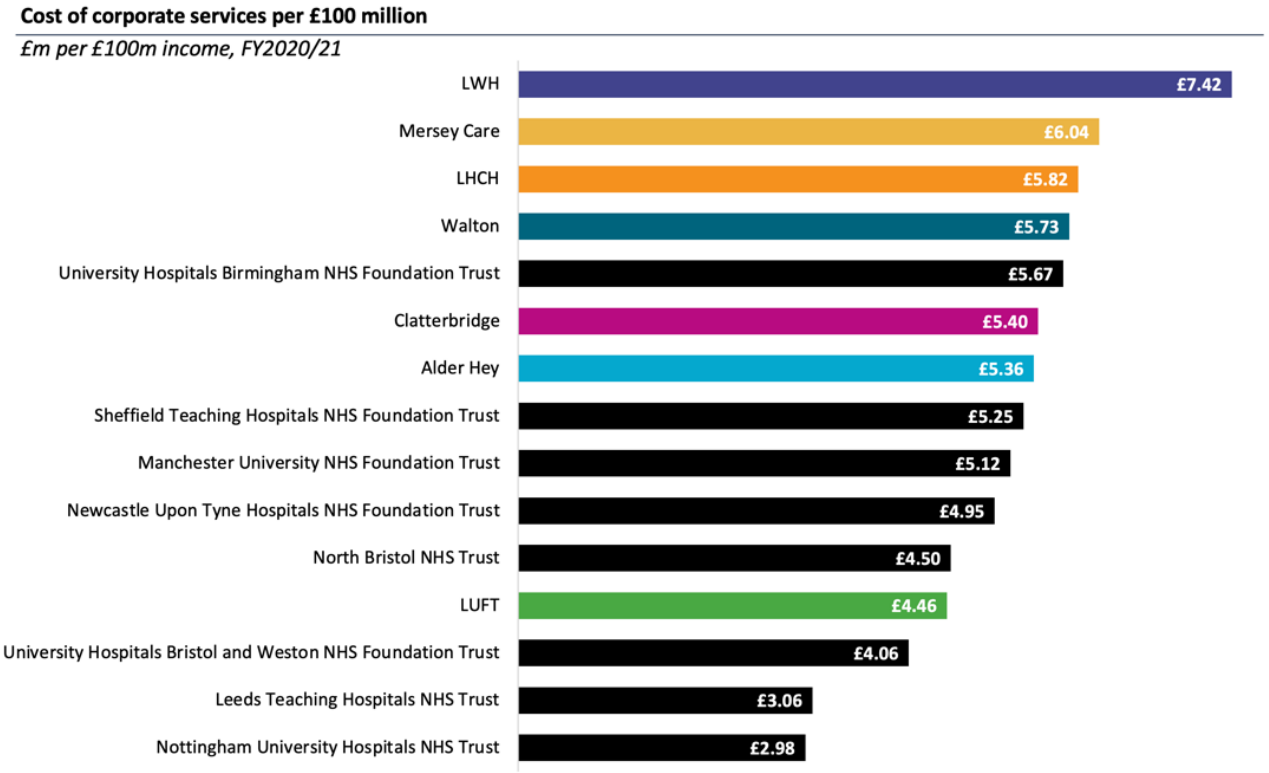


Figure 9: cost of corporate service per £100 million income by organisation

Post-covid there is more collaboration than ever, with a joint procurement function having been set up between The Walton Centre NHS FT, Clatterbridge Cancer Centre NHS FT, Alder Hey Children's NHS FT and Liverpool Heart and Chest Hospital NHS FT. There are also opportunities to build on, including the joint digital service that has been established between Alder Hey Children's NHS FT and Liverpool Heart and Chest Hospital NHS FT. Scaling these collaborative efforts further and applying them to other corporate services including HR, Finance, Estates and Facilities and IM&T has been recognised as a point of focus in addressing the financial challenges faced by the system. Specifically, collaborative working between the trusts would encourage a uniform approach to the delivery of corporate services, freeing up resource by

[14] Note: these figures pre-date the collaboration on procurement and the Clatterbridge Cancer Centre currently hosts the Cheshire and Merseyside Cancer Alliance along with other ICS function which inflates their position.

doing a greater number of tasks once between the organisations. As well as reducing cost and duplication, maximising this opportunity allows expertise across the city to be shared and leveraged for the benefit of all.

The case for collaborating on transactional services that could be more efficiently done once for all organisations is made clearly through payroll, in recognition of the work already undertaken on behalf of the system by St Helens and Knowsley Teaching Hospitals NHS Trust. This could be expanded to other areas where services are process and system based including HR services such as recruitment checks, finance administration and IT support, and should be addressed at pace.

With respect to facilities such as catering, colleagues also felt there would be significant benefit, both operational and financial, in joint procurement of services to leverage the scale of multiple organisations in the negotiation of contracts. Taking this further still, stakeholders saw an additional opportunity to support local economic growth by jointly procuring these services with local organisations, or potentially even bringing the services in-house with a host organisation to lead this.

In working these opportunities through, the different models for collaboration and consolidation of corporate services should be considered from retaining in-house functions and hosting to fully outsourcing services to external providers.

An existing programme of work pursuing this opportunity is being led by the Cheshire and Merseyside Acute and Specialist Provider Collaborative, through the Efficiency at Scale workstream of the Finance, Efficiency & Value Programme. The specific opportunities outlined in this opportunity should also be considered as part of realising the opportunity to deliver the emergency pathway (opportunity 3).

Building on and integrating digital investments to unlock innovative approaches to delivering care and achieving commitments to environmental sustainability

The Long-Term Plan is explicit about the need for digitally enabled care to become mainstream, and stakeholders across Liverpool are enthusiastic about the potential benefits of drawing on a greater range of digital solutions to support patient care.

There has been significant investment in digital systems across the city with some organisations achieving international recognition for their efforts, but there is more work to do in order to bring all organisations up to the same standard. More than ten EPR and PAS systems are in use across organisations in Liverpool which limits interoperability, and even where organisations are using the same software company, functions to support interoperability have not been deployed or are not made use of. Currently only Alder Hey Children's NHS FT and the Clatterbridge Cancer Centre NHS FT have invested in HL7 Fast Healthcare Interoperability Resource application programming interfaces.

While there is longstanding agreement that a place-based or system-based approach should be taken for EPR procurement in line the with national process that has been set up, re-procurement of services is still a way into the future for some organisations. Stakeholders spoke extensively about the opportunity to ensure that current procurement efforts are aligned to collective future ambitions and are future proofed for interoperability.

Alongside EPR systems, colleagues also describing the host of other software used such as Sunquest ICE for pathology services that are currently not deployed across all organisations. A specific example cited was at the Broadgreen site where pathology information such as blood test results are not visible between Liverpool University Hospitals NHS FT and Liverpool Heart and Chest Hospital NHS FT.

Digital solutions can also be put in place to support more anticipatory care closer to the home. Mersey Care NHS FT hosts the largest telehealth service in Europe and the service currently supports around 2,000 patients a day with long-term conditions such as COPD, diabetes, and heart failure across its catchment, with significant success in terms of outcomes for patients and reducing hospital visits. The benefits of using the service were particularly apparent for many stakeholders during the pandemic. However, colleagues also described these services as being underutilised in Liverpool and saw opportunity for clinical teams to work together to make better use of existing services and to expand their scope to meet the needs of local people.

A longer-term commitment for the city has been to implement a shared care record. The Share2Care record has been developed as Cheshire and Merseyside's Local Health and Care Record, providing a repository for key documentation through E-xchange. However as of December 2020, some organisations in Liverpool do not publish or view data using this platform including the Liverpool Women's Hospital NHS FT, some sites of the Liverpool University Hospitals NHS FT, Mersey Care NHS FT, and primary care. This should be resolved and pursued at a system level, docking into the ICB Digital Programme to ensure that there is consistency across the ICS.

Making best use of resources to secure financial sustainability for all organisations in Liverpool

Currently, NHS organisations in Liverpool are in financial deficit with an aggregated reported deficit position of £12.3 million at YTD (August 2022/23), which is expected to deteriorate further over the rest of the financial year.

The Cheshire & Merseyside ICS allocation per head to NHS organisations remains higher than all other core cities with the overall allocation due to decrease by c.£300 million over the coming years. Alongside this the new Specialised Commissioning allocation will mean that Cheshire and Merseyside will be allocated £50 million less income from specialised commissioning. Local government in Liverpool and across Cheshire and Merseyside has also seen one of the largest decreases in real terms spending power since 2010 with a decrease of £700 per head of the population.

This sets the context for needing to stabilise the current position before it deteriorates further and start to prepare for the future challenge ahead. Throughout the review, colleagues have reflected on the financial pressures and sustainability challenges faced in Liverpool and how opportunities to collaborate could seek to address these challenges. Each of the opportunities outlined have either a direct or indirect financial benefit that organisations can realise:

i. Colleagues spoke extensively about reducing cost through supporting more proactive anticipatory models of care, and reducing the number of high-cost interventions required in hospital
ii. Reducing duplication of effort and excess lengths of stays associated with fragmentation of emergency pathways
iii. All trusts have an opportunity to increase theatre utilisation and elective productivity, which would allow for more treatment to be delivered at a lower cost

iv. Increasing the elective throughput will help to prevent conditions from worsening and requiring more expensive care in the long-term
v. Increasing elective throughput will also help to keep profitable procedures within the NHS, rather than allowing them to go to the private sector
vi. Improving cancer and cardiovascular care to promote earlier diagnostics, will allow for earlier interventions, which are generally less expensive
vii. Reducing the number of transfers needs for women and babies across Liverpool to access services by resolving co-dependencies
viii. Reducing the level of spend on bank and agency staff by supporting staff recruitment, retention and health and wellbeing
ix. Improving the research offer will allow for greater income to be received from clinical trials and attract investment from life science companies. It will also contribute to improving the reputation of the organisations, which can also attract further investment for the city
x. Improving digital investment in care models will support more proactive and less expensive models of care
xi. Doing a host of corporate activities once between organisations will free up resource to be directed and invested elsewhere

In responding to the case for collaboration, we recommend:

The twelve opportunities in the case for collaboration should be adopted by the six acute and specialist providers in Liverpool as their strategic agenda for working together. For four of the opportunities, wider partnerships are required, which should be forged to ensure progress, specifically:

a. Improving physical and mental health by providing more anticipatory care (opportunity 1) requires working through the One Liverpool Partnership with General Practice, Liverpool City Council and Mersey Care NHS FT,
b. Levelling-up performance on cancer and cardiovascular disease to address health inequalities (opportunity 4) requires working through a place-based partnership endorsed by the Cheshire and Merseyside Cancer Alliance and the Liverpool Cardiology Partnership respectively,
c. Work with all existing partners of the Liverpool Health Partners to pursue the research and innovation agenda (opportunity 8) and additionally include Liverpool City Council and Applied Research Collaboration North West Coast. This effort could be expanded to include interested providers across Cheshire and Merseyside ICB,
d. The longer-term digital agenda (opportunity 11), which requires working through the Cheshire and Merseyside ICB as part of the Digital Programme,
e. To solve clinical sustainability challenges affecting women's health (opportunity 6), work with the Cheshire and Merseyside ICB (see recommendation 4).

For the further five opportunities there is a synergy with the agenda of the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative and consequently the work should be undertaken in the view of the Collaborative and in line with its governance. The starting point for realising the opportunities identified in this review should be the six organisations in Liverpool. Only once tangible progress is made within this scope should it be broadened to a wider geography. This includes:

a. Address elective care waits and backlog (opportunity 5) through the Elective Recovery and Transformation Programme,
b. Combine expertise in clinical support services (opportunity 7), in part through the Diagnostics Programme,
c. Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff (opportunity 9) through the Workforce Programme,
d. Realise economies of scale in corporate services (opportunity 10) through the Efficiency at Scale workstream of the Finance, Efficiency & Value Programme, and
e. Making best use of resources to secure financial sustainability for all organisations in Liverpool (opportunity 12) through the Finance, Efficiency & Value Programme.

Priorities for action

Several opportunities are already being taken forward by programmes of work as part of implementing One Liverpool, the Liverpool Health Partners, and as ICS-wide programmes of work through CMAST and the Cancer Alliance. In these areas there is ongoing work, which can be supplemented by the findings and opportunities identified in this review.

To take the prioritised programmes of work forward, we recommend:

A rolling programme should be established, building on relevant pre-existing programmes, to take forward the opportunities for implementation. Overall, it will take a number of years to realise the potential benefits from this effort. The work should start by leveraging efforts already underway. Pre-existing programmes should incorporate the findings of the review into their ongoing work by undertaking a stocktake of existing workstreams, specifically:

a. Address inequalities in cancer diagnosis (opportunity 4) through the Early Detection workstream and Health Inequalities and Patient Engagement Programme, of the Cheshire and Merseyside Cancer Alliance, and
b. Provide anticipatory care to improve physical and mental health (opportunity 1) through the Complex Lives and Long Term Conditions Segments, of the One Liverpool Programme.

As transformational change becomes business as usual, priorities should be reassessed and agreed.

Colleagues agreed that the review should move on to address the most critical issues facing the system, which are longstanding clinical risks for women's health, current financial sustainability, and operational pressures for emergency care. Two priorities were aligned upon as a core focus for collaboration in the coming period:

1. Solving clinical sustainability challenges affecting women's health in Liverpool
2. Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, and Royal Liverpool sites

The collective financial challenge faced by Liverpool was considered to be underpinning and should be threaded through all collaboration opportunities. This was explicitly considered as part of realising the two opportunities prioritised and the opportunity benefit is articulated throughout this document.

Solving clinical sustainability challenges affecting women's health in Liverpool

In exploring this opportunity, it was recognised that extensive work has been ongoing for a number of years to set out the case for change and develop a set of recommendations for service change, including work to prepare for a public consultation. Between 2015 and 2017, an extensive programme of work was undertaken, led by the Liverpool Clinical Commissioning Group, supported by the Liverpool Women's Hospital NHS FT, and involving significant engagement from system partners on a pre-consultation business case to explore options for the future of health services for women and babies in the city.

The challenges prompting this work remain and have been reviewed by external independent bodies including the Northern England Clinical Senate. These independent views have universally recognised that services would become unsustainable and potentially unacceptable within the next 5 years, and consequently there is a system imperative to resolve this issue.

The current work, led by the Liverpool Women's Hospital NHS FT and supported by system-wide stakeholders and the Liverpool Place colleagues, as part of the Future Generations programme, has been focused on formalising existing joint working arrangements with Liverpool University Hospitals NHS FT and implementing further mitigating actions through a Partnership Board. These actions have included redevelopment of the existing neonatal unit, investment to increase 24/7 consultant cover and planning for a 24/7 on-site transfusion laboratory at Crown Street by April 2023.

The future programme of work to realise the women's health opportunity will need to follow the latest national guidance on service change and should be pursued as an ICB-led service change programme. In parallel to this, recognising the timescale of any service change programme, the ongoing work to continue to mitigate and address risks must be continued and strengthen through the existing Partnership Board arrangements. To deliver this, an operating model between the Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT should be developed to optimise partnership working and short-term mitigation of risks. In so doing, there should be a recognition of the costs associated with these measures, driven by the unique nature of the service model, and financial support for this should be worked through with the ICB.

The service change work should begin by reconfirming and strengthening the current case for change. In responding to the challenges set out by the case for change, opportunities and best practice care models should be developed that set out how care could be delivered in the future. To deliver the future care model, service change will likely be required, by which we mean what services can be accessed and where. In following this process, extensive clinical engagement will be needed, as well as engagement from finance, estates, and information colleagues. Any potential service change implications would require the ICB to undertake an options appraisal process.

Service change and the requirement to consult is complex with no clear definitions in law. 'Substantial' changes to NHS service provision (how, where or when) mandate consultation with relevant Local Authorities who then determine the need for public consultation or not. Early engagement is key.

If an options appraisal process is recommended to consider the proposed service changes, it would need to follow best practice and requirements on service reconfiguration. As part of this process any interdependencies with other services will be considered as well as the potential impact of proposed service changes on population groups with protected characteristics. The outputs of the options appraisal process would be described in a pre-consultation business case (PCBC) which would set out the benefits and limitations of the options compared to the status quo. We would recommend that the Strategic Outline Case, which will describe the high-level business case for the changes and estimated capital and revenue requirements, is also drafted alongside the PCBC.

The ICB may then need formally to consult the public on any proposed service changes. Any decision to consult would require formal approval of the ICB Board, who would consider in public the PCBC. Before consultation on each preferred option, the financial proposal should be assessed for capital and revenue impact and only implementable and sustainable options (in service, economic and financial terms) should be offered for public consultation. Capital funding requirements of > £15 million mandate confirmation of affordability before consultation is launched.

Public consultation allows the public to comment on the options proposed and in support of this, a consultation document is produced. Input from the public information can be captured through holding events or through asking for responses online, for instance via a survey. Concurrently, an Outline Business Case (OBC) should be drafted to set out the preliminary information on the proposed options. Feedback from the public consultation, alongside internal views on the preliminary outline business case should be used to refine the options proposals and provide basis for any extra analysis to be performed. These alterations should be incorporated into A Decision-Making Business Case (DMBC) to refine and detail the preferred option and include detailed financial and implementation planning. To complete the process, a Full Business Case (FBC) should be produced to explain in detail the planned solution and how it matches service requirements and constraints, through the latest evidence and analysis. It should also show that the most economically advantageous offer is being proposed and is affordable.

There are a number of benefits that could be realised from service change and are important for people, staff, and the wider healthcare system. Optimal clinical co-location of services would result in improved patient safety, outcomes, and experience, through enhanced provision of clinical necessary services. It would support staff satisfaction, recruitment, and retention, ensuring that the organisation is an attractive and fulfilling place to work and that there are opportunities to upskill staff in multi-disciplinary teams (MDTs) though managing complex cases, providing access to an experienced workforce and development opportunities through close working with other specialities. Furthermore, co-location would expand the development of world-leading services for women and babies in Liverpool building on the existing research portfolio and strengthening the resilience of the workforce.

As well as resolving critical clinical and workforce issues through service change, there are several quantifiable opportunity benefits that may be possible to realise should there be a change in how services are provided. These include:

- Reducing maternity clinical negligence costs (CNST) at Liverpool Women's Hospital NHS FT which are significantly higher than peers at £2.3 million per 1,000 births. With the assumption that service provision would be enhanced and reduce risk, clinical negligence costs could reduce over a period time with the recurrent benefit equivalent to between £4.9 million to reach the peer median and £6.1 million to reach the upper quartile.
- Reducing soft facilities management costs at Crown Street depending on the resulting service provision there. Based on the assumption that 24/7 care may no longer be provided at the site, there would be an opportunity benefit of around £1.6 million
- Reducing the number of interhospital transfers needed between Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT for women who need critical or specialist care, would have an opportunity benefit equivalent to £155,000 (through 229 transfers in 2019/20) which would not be cash-releasing
- Reducing the length of stay for people staying in hospital who subsequently need transfer has opportunity benefit based on 2019/20 activity equivalent to £65,825, although due to the occupancy rates at Liverpool University Hospitals NHS FT, we would not expect that this benefit would be cash-releasing.

Further benefits could also be realised by a change to service model as the current model of care has required significant investment to be made in workforce for example for additional rotas and capital for additional diagnostic capacity such as a CT scanner. Some of these investments could be unwound and efficiencies gained if the service model were to change in the long-term. In the short-term this investment

needs to continue to continue delivery of safe and effective services, and ongoing financial support should be worked through with the ICB.

To take forward this priority opportunity, we recommend that:
The current programme of work, the Future Generations Programme, led by Liverpool Women's Hospital NHS FT should be reset as a system priority. The opportunity to solve clinical sustainability challenges for women's health should be taken forward as an ICB-led service change programme, in line with best practice requirements for service reconfiguration. To support this, we recommend:

a. A sub-committee of the ICB to be established to oversee the programme of work, including at minimum representation from Liverpool Women's Hospital NHS FT, Liverpool University Hospitals FT, Clatterbridge Cancer Centre NHS FT and Alder Hey Children's NHS FT. These organisations will need to identify dedicated clinical and managerial leadership to engage deeply in the programme with partners, with external stakeholders, with patients and the public and within their own organisations with staff.
b. A director of the ICB be identified as the joint-SRO of the programme and lead the work.
c. A non-executive of the ICB to be identified to chair the sub-committee.
d. A clinical joint-SRO to be identified who can work on the programme for a dedicated period every week and chair the clinical working group. This individual should be experienced in service change with experience in a relevant clinical area, and independent of any of the organisations in Cheshire and Merseyside.
e. The finance director of the ICB to chair the finance, analytics and estates working group which will develop and review the economic and financial modelling, including capital requirements.
f. A dedicated team to be identified to support the programme, with the expertise needed to meet the different requirements of the programme such as clinical evidence and research, communications and engagement, finance, analysis and estates and capital development. This team should be hosted by the ICB reporting to the lead ICB director.
g. A reset work programme be created and agreed by January.
h. An operating model between the Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT should be developed to optimise partnership working and short-term mitigation of risks, led by the existing Partnership Board.

Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, and Royal Liverpool sites

For emergency pathways, each hospital site in Liverpool should deliver optimal care and efficiency, uninhibited by organisational boundaries. The task and finish process for this opportunity recognised that for urgent and emergency care, there are a number of co-dependencies for services that are not met by current service delivery in Liverpool.

The core emergency department offer at the Royal Liverpool and Aintree sites does not benefit from on-site access to gynaecology and interventional cardiology services, necessitating interhospital transfer for some patients. More critically, the Major Trauma Centre at the Aintree site does not have on-site access to gynaecology, neonatology, obstetrics, thoracic or cardiac surgery. Although it also does not have access to acute paediatric services, this is mitigated by Alder Hey Children's Hospital NHS FT being the Major Trauma Centre for children and young people aged under 16 and providing access to specialist paediatric services on site, meeting all co-dependency requirements. For children aged between 16 and 18, colleagues

discussed the option of considering them as part of the scope of this opportunity, however this group represented small volumes and therefore effort was prioritised to addressing other groups first.

Two groups of users emerged: those for whom critical co-dependent services are not available on the site they are receiving care, and those for whom collective expertise and existing co-adjacencies could be further leveraged. For each, colleagues described an ambition for emergency pathways that enable people seeking urgent and emergency care to avoid unnecessary transfers between sites and organisations, minimising delays and providing timely access. This would also reduce repetition for people accessing services and duplication of effort for staff, by providing the right information at the right time for people, their carers and staff and making use of digital innovation and technology as far as possible. Colleagues aspired to deliver a pathway that facilitates joint ways of working within and between organisations and allows for proactive planning for onward care, thinking holistically about the person at every stage including presentation.

Guided by this ambition existing pathways for groups where needs are currently sub-optimally met were mapped and redesigned across eight pathways. Common themes between the redesigned pathways were identified and articulated into three additional pathway elements for how care should be delivered in the future. They are fast-tracking, passporting, and in-reach. Each element has specific benefits which are set out below.

Fast-tracking
When people with an emergency need require care, they either present directly or are conveyed by ambulance to either the Royal Liverpool or Aintree emergency departments, where they are assessed and often admitted to receive initial care before clinical teams determine they require specialist treatment and care at a different site. This results in long wait times both in the emergency department and as an inpatient awaiting transfer.

Fast-tracking allows for people to be directly conveyed or rapidly directed to the best place of care for their primary condition either through a rapid transfer protocol or access to specialist opinion using a digital platform to determine whether direct conveyance to hospital is appropriate. Fast tracking protocols already exist for a number of pathways, for example major trauma and stroke protocols directly to Aintree site, and STEMI direct conveyance to Liverpool Heart and Chest Hospital NHS FT.

Implementing fast-tracking will ensure that people receive streamlined and appropriate specialist care in a timely fashion, meeting their needs more effectively and reducing the need for transfers when they are critically unwell. Direct conveyance to the most appropriate setting will improve morbidity and potentially mortality.

Colleagues agreed that this opportunity should be initially implemented for cardiology services including acute coronary syndromes and arrythmias, and for neurology services specifically moderate head injuries.

This pathway change will reduce emergency department attendances to Liverpool University Hospitals NHS FT. If this model was in place in 2021/22, 577 cardiology, 118 cardiac and thoracic surgery, and 348 neurology attendances could have been avoided, equivalent to a potential saving of £175,000. As a consequence, spells at Liverpool University Hospitals NHS FT would also be avoided as patients attend the specialist centre directly. If this model was implemented in 2021/22, 411 cardiology spells, 110 cardiac and

thoracic surgery spells and 211 neurology spells would have been avoided with an opportunity benefit of £1.77 million.

There will also be a reduction in the number of interhospital transfers needed between Liverpool University Hospitals NHS FT and specialist trusts. For 2021/22, the numbers of transfer avoided would have been 577 cardiology and 118 cardiac and thoracic surgery transfers between Liverpool University Hospitals NHS FT and Liverpool Heart and Chest Hospital NHS FT and 91 neurology transfers between Liverpool University Hospitals NHS FT and The Walton Centre NHS FT. The potential opportunity benefit is £204,000.

Passporting

Some groups of people with an emergency need have access to a specialist advice service which can sign-post them to the correct service. For example, people with cancer have access to an oncology helpline. In some instances, people can be directly admitted to the Clatterbridge Cancer Centre Clinical Decisions Unit for assessment and treatment of their condition, however existing conveyancing protocols mean those attending by ambulance can currently only be taken to emergency departments at the Royal Liverpool or Aintree sites.

Passporting allows people with a known condition to bypass A&E and reach the most appropriate place for their primary need. In practice, this means having an agreed written care plan that can be easily located and accessed by any health care professional (for example by keeping it in the fridge) and implemented should an emergency need related to the known condition arise. This passport gives them 'priority' or direct access into the service they require. Passporting could result in a variety of alternative outcomes:

- People and their families or carers would have clear signposting should an emergency need arise
- Paramedics can directly convey to the appropriate service, notifying the relevant on-call team ahead of time
- Paramedics can access specialist advice from the relevant on-call team if there is uncertainty about the best conveyance destination
- Where direct access to services would not be appropriate, the passporting mechanism could alert the relevant team that the person is being taken to A&E so that relevant information can be shared, and ongoing specialist support provided

Implementing passporting will improve experience of care, safety, and outcomes by providing appropriate specialist care for people in the right place by specialist multidisciplinary teams who can comprehensively meet their needs. These teams will be guided by an individualised care plan and will only carry out relevant tests and diagnostics.

Colleagues agreed that the first areas to implement passporting would be for people with cancer and for people readmitted within 14 days of a stay in hospital. This pathway change has the potential to reduce emergency department attendances to Liverpool University Hospitals NHS FT. If this model was in place in 2021/22, 143 cancer attendances could have been avoided and 134 spells for cancer, equivalent to an opportunity benefit of £529,000. This would have been accompanied by a reduction in the number of interhospital transfers needed between Liverpool University Hospitals NHS FT and Clatterbridge Cancer Centre NHS FT and reduced length of stay. In 2021/22, the numbers of transfers avoided could have been up to 48, resulting in an additional opportunity benefit of £12,000, with the reduction in beds equivalent to 1.7 beds across the year and an opportunity benefit of £193,000.

In-reach

When someone with an acute need also has co-morbidities, they often require expert advice to optimise the management of their co-morbidities along with their acute presentation. Consultants can currently make consultant-to-consultant referrals for advice, however there are often delays in providing this and at times it will not come until post-discharge. Advice can be sought from colleagues informally but there is no established mechanism for this.

In-reach provides multi-disciplinary team input for people with a known condition who attend the hospital and need specialist advice for their known condition (which is not their primary need). In-reach means specialist advice can be easily and quickly obtained by other teams. This can happen through a variety of means which can reach any site if needed:

- through an "advice and guidance" service: a digitally enabled service manned by a dedicated specialist in which requests can be logged and responded to within a defined time period, via telephone or message depending on what is most appropriate.
- virtual consultation: based on the advice and guidance service, virtual consultations can be set up if recommended. This mechanism should leverage existing digital capabilities and models used for virtual appointments but in an acute inpatient setting.
- in person consultation: based on contact through the advice and guidance service, the dedicated specialist can easily move between sites to provide in person consultations where necessary.

In-reach improves the experience and care that people receive by ensuring this is holistic and that co-morbidities are proactively managed in the context of an unrelated acute presentation. This can contribute to a reduced length of stay as there is timelier access to specialist opinion and people, their carers and staff will have greater confidence in management and treatment plans. In-reach also creates an environment for further learning opportunities and cross-fertilisation of expertise and knowledge across professions and specialities. Models for in-reach already exist for some specialist services across the city for example cancer services.

This pathway change has the potential to reduce overall length of stay as people with multiple co-morbidities in Liverpool have a significantly higher length of stay than the national average. Those with fewer co-morbidities had a similar length of stay to the national average indicating where people have multiple co-morbidities, there would be a benefit from in-reach. If the in-reach model had been in place in 2021/22, 4,603 bed days or 12.6 beds could potentially have been saved, which is equivalent to an opportunity benefit of £1.3 million.

Colleagues agreed that in-reach should be implemented for all people with comorbidities across all sites beginning with those with diabetes to test the concept, and then rapidly rolled out for other conditions. This pathway should be implemented in all areas where sufficient demand exists across organisations to realise a cumulative benefit of the service.

To deliver these, an operating model for each site should be developed to include implementing processes to create joint teams across sites, ensuring clear clinical pathways and accountability, and optimising site-based working. This includes:

- Ring-fencing capacity for additional fast-tracking and passporting services,
- Sharing physical capacity, for example ITU beds, to enable elective activity to continue without being displaced by emergency pressures,
- Sharing diagnostic capacity such as x-ray machines and scanners to provide timely access,

- Making best use of staff experience and expertise, for example creating joint appointments to provide specialist input across sites, and
- Consolidating teams that could be shared, for example through having a single medical emergency team for each site and a shared discharge support team
- Clinical support services sharing physical capacity and workforce, for example a shared pharmacy service for the site with a single overnight rota for pharmacy.

Colleagues identified several priority pathways where these three pathway elements could be applied, with a view to maximising the impact of the opportunity:

- All sites should implement passporting for people with cancer and people readmitted within 14 days of a stay in hospital and in-reach for people with comorbidities, for this purpose defined as people with an HRG complication or comorbidities score (CC) of 10 and above.
- At Broadgreen site, focus should initially be on rapid implementation of fast-tracking for cardiology services including acute coronary syndromes and arrythmias; strengthening the STEMI pathway as well as setting up a pathway for direct conveyance of NSTEMI and pacing.
- At the Aintree site, colleagues should initially focus on fast tracking for moderate head injuries, as well as reviewing the effectiveness of the stroke pathway which has recently been implemented.
- At the Royal site, effort should be directed at developing passporting for people with cancer who could be seen directly at the CCC.

Implementing joint clinical working will also bring synergies in operations on each site and there are examples of inefficient use of resources that represent opportunities for non-clinical integration. As organisations collaborate to implement new clinical pathways, they should also embrace this broader agenda. These include:

- Digital: resolving interoperability of systems to ensure information can be shared and diagnostics such as pathology and radiology do not need to be duplicated,
- Corporate services: in support of joint operations on sites, shared HR, finance, strategy, and estates functions that work across organisations on sites, and
- Facilities management: where there is duplication of services on sites for both hard and soft facilities management services, for example catering, portering and security services.

The site-based operating models will have financial benefits over and above those set out for the clinical pathways in particular where services can be consolidated across sites to provide shared teams. The opportunities relevant to each site need to be systematically and holistically worked through to determine the full scale and scope of the site-based model.

We recommend that:

Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies should also be immediately prioritised for delivery. A programme of work should be established which implements the three new pathway elements proposed by this review: 1. fast-tracking, 2. passporting, and 3. in-reach. The overall aim of this work should be to ensure each hospital site in Liverpool delivers optimal care and efficiency, uninhibited by organisational boundaries. This should include creating integrated clinical teams on each site with joint ways of working. In taking this forward, we recommend:

a. Clinicians should be at the forefront of the development of this approach and leads should be identified from each organisation and each site, to oversee the work and facilitate broad engagement with staff.
b. There should be early engagement with General Practice, Mersey Care FT, and the North West Ambulance Service NHS Trust to incorporate pre- and post-hospital elements of the pathway.
c. An operating model for each site should be developed, ensuring highest quality clinical pathways, clear accountability, and optimised site-based working. This should be underpinned by demand and capacity analysis.
d. Building on the financial analysis undertaken as part of this review, a target financial model should be developed and agreed linked to 5c. This should reset financial flows and ensure overall efficiencies are realised including in respect to reduced length of stay and reduced interhospital ambulance transfers.
e. Three joint committees should be established with delegated authority from the relevant trusts for site-based operations. These arrangements should oversee the design and delivery of the new operating models as well as business-as-usual operations, which will likely give rise to further improvement opportunities. The three committees should include at least one non-executive director and executive director from each organisation as well as a site-based leadership team. The committees should comprise of:
    i. Liverpool University Hospitals FT and Liverpool Heart and Chest Hospital FT for the Broadgreen site
    ii. Liverpool University Hospitals FT and The Walton Centre FT for the Aintree site
    iii. Liverpool University Hospitals FT and Clatterbridge Cancer Centre NHS FT for the Royal Liverpool site
f. To progress the work, a dedicated team supporting all three joint committees should be established that provides capacity to systematically work through the operating model on each site, undertaking design work and modelling for the pathway and service transformation. This team should be led by a dedicated senior individual working across organisational boundaries on behalf of all organisations.

This opportunity and the resulting recommendations form one part of the urgent and emergency care pathway and should be seen as additive to the other system initiatives such as efforts to reduce attendances and redirect demand to primary and community settings. Colleagues reflected on the urgent emergency pressures currently faced by the system and felt there were two particular areas of focus: community urgent and emergency care, and flow and discharge pathways. Prior to the pandemic, the North Mersey review of urgent care provision concluded there was a need for an integrated UTC model to be developed to support delivery of same day and urgent care needs of local people and connect seamlessly with other parts of the emergency pathway. There is a need to reset and reinvigorate this work in order to address urgent and emergency demand that continues to put pressure on organisations. At the

other end of the emergency pathway, colleagues also felt that there was a need to work together on improving flow and discharge along with community and social care to reduce the number of people in hospital who did not need have the criteria to reside. During the review period, colleagues also reflected on the need for a review of community and mental health services and capacity, reflecting on the long waits in the emergency department and in hospital for in-reach and onward care.

All organisations involved in the urgent and emergency pathway need a forum in which they can review system effectiveness with a shared data view and to make decisions about improving quality and safety of the emergency pathway as well as optimising the use of overall resources. Committees in Common create a mechanism for doing this by allowing two or more organisations to meet in the same place at the same time to discuss the same topics yet remain distinct and take their own decisions. The benefit of this arrangement is that it allows each organisation to retain control but is supportive of collaboration. It also reduces administrative burden and is an efficient decision-making process.

We recommend that:
To provide overall Liverpool system oversight and review of performance on delivering high quality emergency care with aligned incentives and funding, two committees-in-common should be established involving relevant executives and non-executives from Alder Hey Children's NHS FT, Clatterbridge Cancer Centre NHS FT, Liverpool Heart and Chest Hospital FT, Liverpool University Hospitals FT, Liverpool Women's Hospital NHS FT, The Walton Centre FT, Mersey Care FT, and General Practice Liverpool. These committees-in-common should meet quarterly and cover:

a. Quality – reviewing the effectiveness and quality of emergency care using shared data and analysis and determining further improvements required;
b. Finance – reviewing overall financial effectiveness and establish effective incentive and risk sharing mechanisms.

Conclusion and next steps

In conclusion, this report sets the direction and short-term priorities for further collaboration between the acute and specialist trusts in Liverpool. In describing these benefits, stakeholders also caveated these opportunities by highlighting several conditions that would need to be in place for them to be realised. The case for collaboration provides a basis for long term strategic efforts between acute and specialist providers in Liverpool and creates the shared vision and goal needed for collaboration.

Several elements were thought to be foundational including developing governance for collaborative decisions, sharing information, and having an interoperable digital environment, having an underpinning financial framework, and communicating and engaging clearly.

Developing the governance arrangements to support collaborative decisions making will be required for enduring collaboration. This will include outlining clear ways of working, which align the decision-making structures of organisations. Both the proposed joint committees and committees in common work in support of this condition. In aligning the operating models in the collaboration, the relationship between the collaboration and the wider provider collaboratives within the ICS need to be clarified.

Sharing of information and performance data was considered to be an important enabling factor in decision making and in providing clarity to issues that require collaboration. To ensure the smooth movement of

patients between sites and organisations, shared clinical information and a digital environment for staff, which supports movement between organisations.

Colleagues also described the uncertainty around how the financial flows will settle with the ICS, and how risk is managed within that can get in the way of clinical decision making that would support collaboration. In order to address this, creating effective incentives and risk sharing mechanisms for finance were thought to be important.

Critically, in recognition of the considerable scope of these opportunities, colleagues described needing strong clinical and non-clinical leadership to take forward the work, reflecting the significant mindset shifts that are needed. Stable leadership provides staff with clear direction and draws professionals together around a shared vision for the future, which is central to co-ordinating transformation across several sites and functions. Leadership oversight should be proportionate to the scope of the initiative that is being delivered.

Protecting time and creating dedicated capacity for collaboration will create the headroom needed to transform services and the way that organisations and people work together, ensuring that operationally pressures do not hinder progress. To make best use of this capacity, it was agreed that prioritising efforts and phasing delivery of the work was needed to make the biggest impact, rather than trying to collaborate on many things simultaneously. For some of the more significant opportunities that have been outlined, this will require a substantial commitment.

Overwhelming colleagues talked about the need for trusted relationships between partners as the basis for collaboration. Relationships have been improving over time; COVID helped to accelerate progress However, colleagues also highlighted that they would need to continue building trusted relationships, putting collaboration ahead of organisational sovereignty.

The collaborative opportunities that have been identified are considerable in scale and scope. Stakeholders have often been able to describe with enthusiasm the potential benefits of deeper collaboration.
There has been significant energy to engage in the process so far with a collective willingness and motivation to act on the findings of the review. To build on this momentum, action to implement the recommendations of the review needs to be taken swiftly and without delay, and should be resourced commensurate to their scope.

We recommend that:
To progress at pace Boards of relevant organisations should receive proposed terms of reference, including delegations, accountability, and escalation arrangements, for the governance groups set out in the recommendations 4, 5 and 6 in their January meetings. A proposal for how the programme(s) of work is resourced should also be included to ensure the appropriate team and leadership needed to deliver.

A communications and engagement plan should also be developed and agreed by all organisations. The aim should be to communicate the findings of the review and its recommendations and engage staff, patients, and the public on the next steps. Engagement on the future programme of work as well as open communications in respect to progressing the recommendations should be embedded into how this is taken forward.

Liverpool Women's
NHS Foundation Trust

Jargon Buster

We know that the language used in healthcare can sometimes be quite confusing, especially when acronyms are concerned. To make life a little easier, we will try to ensure that we spell out acronyms in full at first mention and then put the abbreviation in brackets, for example, Strategic Clinical Network (SCN) in our reports and minutes.

We've also put together a list of acronyms that you might see throughout our documentation. If you spot a gap, please email our Trust Secretary on mark.grimshaw@lwh.nhs.uk.

The following webpage might also be useful - https://www.england.nhs.uk/participation/nhs/

A		
A&E	Accident & Emergency	hospital department specialising in the acute care of patients who arrive without a prior appointment with urgent or emergency trauma
AC	Audit Committee	a committee of the board – helps the board assure itself on issues of finance, governance and probity
AGM	Annual General Meeting	a meeting to present and agree the trust annual report and accounts
AGS	Annual Governance Statement	a document which identifies the internal controls in place and their effectiveness in delivering effective governance
AHP	Allied Health Professionals	health care professions distinct from dentistry, optometry, nursing, medicine and pharmacy e.g. physiotherapists, radiographers, speech therapists and podiatrists
AHSC	Academic Health Science Centre	a partnership between a healthcare provider and one or more universities
AHSN	Academic Health Science Network	locally owned and run partnership organisations to lead and support innovation and improvement in healthcare
ALOS	Average Length of Stay	the average amount of time patients stay in hospital
AMM	Annual Members Meeting	a meeting that is held every year to give members the opportunity to hear about what the trust has done in the past year; could be part of the AGM
AO	Accountable Officer	senior person responsible and accountable for funds entrusted to their trust; for NHS provider organisations this person will be the chief executive
ALB(s)	Arms Length Bodies	an organisation that delivers a public service but is not a ministerial government department; these include HEE, HSCIC, HRA, HTA, NHSE, NICE, Monitor, NHSBSA, NHSBT, NHSI, NHSLA, MHPRA, CQC, PHE (See individual entries)
	Agenda for Change	the NHS-wide grading and pay system for NHS staff, with the exception of medical and dental staff and some senior managers; each relevant job role in the NHS is matched to a band on the Agenda for Change pay scale

B		
BAF	Board Assurance Framework	the key document used to record and report an organisation's key strategic objectives, risks, controls and assurances to the board
BCF	Better Care Fund	this fund creates a local single pooled budget to incentivise the NHS and local government to work more closely together in local areas
BMA	British Medical Association	trade union and professional body for doctors
BAME	Black Asian Minority Ethnic	terminology normally used in the UK to describe people of non-white descent
BoD	Board of Directors	executive directors and non-executive directors who have collective responsibility for leading and directing the trust
	Benchmarking	method of gauging performance by comparison with other organisations

C		
CAMHS	Child and Adolescent Mental Health Services	specialise in providing help and treatment for children and young people with emotional, behavioural and mental health difficulties
CapEx	Capital Expenditure	an amount spent to acquire or improve a long-term asset such as equipment or buildings. Typically, capital is raised via a loan, but it can come from reserves and is paid back/written off over a number of years from revenue income. This is a contrast with revenue spend which is always from in-year income
CBA	Cost Benefit Analysis	a process for calculating and comparing the costs and benefits of a project
CBT	Cognitive Behavioural Therapy	a form of psychological therapy used mostly in depression but increasingly shown to be a useful part of the treatment for schizophrenia
CCG	Clinical Commissioning Group	groups of GPs, clinicians and managers who are responsible for commissioning local health services in England (all GP practices must belong to a CCG)
CDiff	Clostridium difficile	a bacterial infection that most commonly affects people staying in hospital
CE / CEO	Chief Executive Officer	leads the day-to-day management of a foundation trust, is a board member and the accountable officer for the trust.
CF	Cash Flow	the money moving in and out of an organisation
CFR	Community First Responders	a volunteer who is trained by the ambulance service to attend emergency calls in the area where they live or work
CHC	Continuing Healthcare	Whereby those with long-term or complex healthcare needs qualify for social care arranged for and funded by the NHS
CIP	Cost Improvement Plan	an internal business planning tool outlining the Trust's efficiency strategy
CMHT	Community Mental Health Team	A team of mental health professionals such as psychiatrists,

		psychologists, social workers, community psychiatric nurses and occupational therapists, who work together to help people manage and recover from mental illness.
CoG	Council of Governors	the governing body that holds the non-executive directors on the board to account for the performance of the board in managing the trust, and represents the interests of members and of the public
COO	Chief Operating Officer	a senior manager who is responsible for managing a trust's day-to-day operations and reports to the CEO
CPD	Continuing Professional Development	continued learning to help professionals maintain their skills, knowledge and professional registration
CPN	Community Psychiatric Nurse	a registered nurse with specialist training in mental health working outside a hospital in the community
CQC	Care Quality Commission	The independent regulator of all health and social care services in England
CQUIN	Commissioning for Quality and Innovation	a sum of money that is given to providers by commissioners on the achievement of locally and nationally agreed quality and improvement goals
CSR	Corporate Social Responsibility	A business practice which incorporates sustainable goals, usually positive impacts on environmental, economic and social factors, into a business model
CT	Computed Tomography	A medical imaging technique
CFO	Chief Finance Officer	the executive director leading on finance issues in the trust
CNST	Clinical Negligence Scheme for Trusts	The Clinical Negligence Scheme for Trusts (CNST) handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) in England currently belong to the scheme.
	Caldicott Guardian	A board level executive director responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian

D		
DBS	Disclosure and barring service	conducts criminal record and background checks for employers
DBT	Dialectical behavioural therapy	A type of psycho-therapy, or talk therapy, which has been developed from CBT to help those experiencing borderline personality disorder
DGH	District General Hospital	major secondary care facility which provides an array of treatment, diagnostic and therapeutic services, including A&E
DHSC	Department of Health and Social Care	the ministerial department which leads, shapes and funds health and care in England
DN	Director of Nursing	The executive director who has professional responsibility for services provided by nursing personnel in a trust

DNA	Did Not Attend	a patient who missed an appointment
DNAR	Do Not Attempt Resuscitation	A form issued and signed by a doctor, which tells a medical team not to attempt CPR
DPA	Data Protection Act	the law controlling how personal data is collected and used
DPH	Director of Public Health	a senior leadership role responsible for the oversight and care of matters relating to public health
DTOCs	Delayed Transfers of Care	this refers to patients who are medically fit but waiting for care arrangements to be put in place so therefore cannot be discharged
	Duty of Candour	a legal duty on hospital, community, ambulance and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm

E		
E&D	Equality and Diversity	The current term used for 'equal opportunities' whereby members of the workforce should not be discriminated against because of their characteristics. This is promoted by valuing diverse characteristics in a workplace.
ED(s)	Executive Directors *or* Emergency Department	senior management employees who sit on the trust board *or* alternative name for Accident & Emergency department
EHR	Electronic Health Record	health information about a patient collected in digital format which can theoretically be shared across different healthcare settings
EOLC	End of Life Care	support for patients reaching the end of their life
EPR	Electronic Patient Record	a collation of patient data stored using computer software
ESR	Electronic staff record	A collation of personal data about staff stored using computer software

F		
FFT	Friends and Family Test	a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care
FOI	Freedom of Information	the right to ask any public sector organisation for the recorded information they have on any subject
FT	Foundation Trust	a public benefit corporation, which is a legal body established to deliver healthcare to patients / service users and has earned a degree of operational and financial independence
FTE	Full Time Equivalent	a measurement of an employees workload against that of someone employed full time e.g. 0.5 FTE would be someone who worked half the full time hours
FTSU	Freedom to speak up	An initiative developed by NHS Improvement to

		encourage NHS workers to speak up about any issues to patient care, quality or safety
	Francis Report	the final report, published in 2013, of the public inquiry into care provided by Mid Staffordshire NHS FT chaired by Sir Robert Francis QC

G

GMC	General Medical Council	the independent regulator for doctors in the UK
GDP	Gross Domestic Product	the value of a country's overall output of goods and services
GDPR	General Data Protection Regulations	The legal framework which sets the guidelines for collecting and processing personal information from individuals living in the European Union

H

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

		which aims to understand the needs and experiences of NHS service users and speak on their behalf.

I		
IAPT	Improved Access to Psychological Therapies	an NHS programme rolling out services across England offering interventions approved by the National Institute of Health and Care Excellence for treating people with depression and anxiety disorders
IG	Information Governance	ensures necessary safeguards for, and appropriate use of, patient and personal information. Key areas are information policy for health and social care, IG standards for systems and development of guidance for NHS and partner organisations
ICP	Integrated Care Pathway	a multidisciplinary outline of care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through diagnosis and treatment to positive outcomes
ICS	Integrated Care system	Groups of NHS providers, commissioners and local authorities working together to improve health and care in the local area
ICT	Information Communications Technology	an umbrella term that includes any communication device or application, encompassing: radio, television, cellular phones, computer and network hardware and software, satellite systems, as well as the various services and applications associated with them
ICU *or* ITU	Intensive Care Unit Intensive therapy unit	specialist unit for patients with severe and life threatening illnesses
IP	Inpatient	a patient who is hospitalised for more than 24 hours
IT	Information Technology	systems (especially computers and telecommunications) for storing, retrieving, and sending information
IV	Intravenous	treatment which is administered by injection into a vein

K		
KLOE(s)	Key Line of Enquiries	detailed questions asked by CQC inspectors which help to answer the five key questions to assess services: are they safe, effective, caring, responsive and well-led?
KPIs	Key Performance Indicators	indicators that help an organisation define and measure progress towards a goal
	King's Fund	independent charity working to improve health and health care in England

L		
LD	Learning Disability	a disability which affects the way a person understands information and how they communicate
LGA	Local Government Association	the national voice of local government in England and Wales. It seeks to promote better local government and maintains communication between officers in different local authorities to develop best practice
LOS	Length of Stay	a term commonly used to measure the duration of a single episode of hospitalisation

M		
M&A	Mergers & Acquisitions	mergers bring together two or more bodies to form a new legal entity and disband the merging bodies. acquisitions are take-overs of one body by another
MD	Medical Director	a member of the board who has a clinical background and has professional responsibilities for doctors and dentists in the trust
MHPRA	Medicines and Healthcare Products Regulatory Agency	an executive agency of DHSC which is responsible for ensuring that medicines and medical devices work and are acceptably safe
MIU	Minor Injuries Unit	A unit which treats injuries or health conditions which are less serious and do not require the A&E service
MoU	Memorandum of Understanding	describes an agreement between two or more parties
MRI	Magnetic Resonance Imaging	a medical imaging technique
MRSA	Methicillin-Resistant Staphylococcus Aureus	a bacterium responsible for several difficult-to-treat infections in humans
MSA	Mixed Sex Accommodation	wards with beds for both male and female patients

N

NAO	National Audit Office	an independent Parliamentary body in the United Kingdom which is responsible for auditing central government departments, government agencies and non-departmental public bodies. The NAO also carries out Value for Money audits into the administration of public policy
NED	Non Executive Director	directors who are appointed, but not employed by the trust; they have no executive responsibilities and are responsible for vetting strategy, providing challenge in the boardroom and holding the executive directors to account
NHSBSA	NHS Business Services Authority	a Special Health Authority of DHSC which provides a range of services to NHS organisations including: NHS Prescription Services, NHS Pensions, Help With Health Costs, Student Services, NHS Dental Services, European Health Insurance Card, Supplier Management (including NHS Supply Chain) and NHS Protect
NHSBT	NHS Blood and Transplant	a Special Health Authority of DHSC responsible for providing a reliable, efficient supply of blood, organs and associated services to the NHS
NHSE	NHS England	an executive non-departmental public body with a mandate from the Secretary of State to improve health outcomes for people within England
NHSI	NHS Improvement	The Independent regulator of NHS Foundation Trusts
NHSLA	NHS Leadership Academy	national body supporting leadership development in health and NHS funded services
NHSP	NHS Professionals	provides bank (locum) healthcare staff to NHS organisations
NHSX		A unit designed to drive the transformation of digital technology in the NHS
NICE	National Institute for Health and Care Excellence	provides national evidence-based guidance and advice to improve health and social care
NIHR	National Institution for Health Research	The largest funder of health and social care research in the UK, primarily funded by the Department of Health and Social Care
NMC	Nursing and Midwifery Council	nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
	Never Event	serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. NHS England defines the list of never events every year

	NHS Digital	The information and technology partner to the NHS which aims to introduce new technology into services
	NHS Providers	NHS Providers is the membership organisation for NHS public provider trusts. We represent every variety of trust, from large acute and specialist hospitals through to community, ambulance and mental health trusts.
	Nolan Principles	key principles of how individuals and organisations in the public sector should conduct themselves comprising of: selflessness, integrity, objectivity, accountability, openness, honesty, leadership. Set by the Committee for Standards in Public Life, an independent advisory non-departmental public body set up to advise the prime minister on ethical standards
	NHS Resolution	not-for-profit part of the NHS which manages negligence and other claims against the NHS in England on behalf of their member organisations. Also, an insurer for NHS bodies
	Nuffield Trust	independent source of evidence-based research and policy analysis for improving health care in the UK, also a charity

O

OD	Organisational Development *or* Outpatients Department	a systematic approach to improving organisational effectiveness *or* a hospital department where healthcare professionals see outpatients (patients which do not occupy a bed)
OOH	Out of Hours	services which operate outside of normal working hours
OP	Outpatients	a patient who is not hospitalized for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment
OPMH	Older People's Mental Health	mental health services for people over 65 years of age
OSCs	Overview and Scrutiny Committees	established in local authorities by the Local Government Act 2000 to review and scrutinise the performance of public services including health services
OT	Occupational Therapy	assessment and treatment of physical and psychiatric conditions using specific activity to prevent disability and promote independent function in all aspects of daily life

P		
PALS	Patient Advice & Liaison Service	offers confidential advice, support and information on health-related matters to patients, their families, and their carers within trusts
PAS	Patient Administration System	the automation of administrative paperwork in healthcare organisations, particularly hospitals. It records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient
PbR	Payment by Results or 'tariff'	a way of paying for health services that gives a unit price to a procedure
PCN	Primary care network	A key part of the NHS long term plan, whereby general practices are brought together to work at scale
PDSA	Plan, do, study, act	A model of improvement which develops, tests and implements changes based on the scientific method
PFI	Private Finance Initiative	a scheme where private finance is sought to supply public sector services over a period of up to 60 years
PHE	Public Health England	a body with the mission to protect and improve the nation's health and wellbeing and reduce health inequalities
PHSO	Parliamentary and Health Service Ombudsman	an organisation which investigates complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England
PICU	Psychiatric Intensive Care Unit *or* Paediatric Intensive Care Unit	a type of psychiatric in-patient ward with higher staff to patient ratios than on a normal acute admission ward *or* an inpatient unit specialising in the care of critically ill infants, children, and teenagers
PLACE	Patient-Led	Surveys inviting local people going into hospitals as
	Assessments of the Care Environment	part of a team to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance
PPI	Patient and Public Involvement	mechanisms that ensure that members of the community --- whether they are service users, patients or those who live nearby – are at the centre of the delivery of health and social care services
PTS	Patient Transport Services	free transport to and from hospital for non-emergency patients who have a medical need

	Primary Care	the first point of contact with the NHS for most people and is delivered by a wide range of independent contractors, including GPs, dentists, pharmacists and optometrists, it also includes NHS walk-in centres and the NHS 111 telephone service

Q

QA	Quality assurance	monitoring and checking outputs to make sure they meet certain standards
QI	Quality improvement	A continuous improvement process focusing on processes and systems
QIA	Quality Impact Assessment	A process within NHS trusts which ensures the quality of service is systematically considered in decision- making on service changes
QUI	Qualities and Outcomes Framework	The system for performance management and payment of GP's in the NHS

R

R&D	Research & Development	work directed towards the innovation, introduction, and improvement of products and processes
RAG	Red, Amber, Green classifications	a system of performance measurement indicating whether something is on or better than target (green), below target but within an acceptable tolerance level (amber), or below target and below an acceptable tolerance level (red)
RGN	Registered General Nurse	a nurse who is fully qualified and is registered with the Nursing and Midwifery Council as fit to practise
RoI	Return on Investment	the benefit to the investor resulting from an investment of some resource. A high RoI means the investment gains compare favourably to investment cost. As a performance measure, RoI is used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments.
RTT	Referral to Treatment Time	the waiting time between a patient being referred by a GP and receiving treatment

S		
SALT	Speech and Language Therapist	assesses and treats speech, language and communication problems in people of all ages to help them better communicate
SFI	Standing Financial Instructions	Policy used for the regulation of the conduct of an NHS trust in relation to all financial matters
SHMI	Summary Hospital Level Mortality Indicator	reports mortality at trust level across the NHS in England using standard and transparent methodology
SID	Senior independent Director	a non-executive director who sits on the board and plays a key role in supporting the chair; the SID carries out the annual appraisal of the chair, and is available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair
SIRO	Senior Information Risk Officer	a senior manager who will take overall ownership of the organisation's information risk policy
SITREP	Situation Report	a report compiled to describe the details surrounding a situation, event, or incident
SLA	Service Level Agreement	an agreement of services between service providers and users or commissioners
SoS	Secretary of State	the minister who is accountable to Parliament for delivery of health policy within England, and for the performance of the NHS
SRO	Senior Responsible officer	A leadership role which is accountable for the delivery and outcome of a specific project
STP	Sustainability and Transformation Partnership	Partnerships formed between local councils and NHS services to help plan and run services, and agree system-wide priorities
SUI	Series Untoward Incident / Serious Incident	A serious incident which resulted in one or more of the following: unexpected or avoidable death, a never event, a prevention of organisation's ability to continue to deliver healthcare services, abuse, or loss of confidence in a service
SWOT	Strengths, Weaknesses, Opportunities, Threats	a structured planning method used to evaluate the strengths, weaknesses, opportunities and threats involved in a project or in a business venture
	Secondary Care	NHS health service provided through hospitals and in the community

T		
TTO	To Take Out	medicines to be taken away by patients on discharge

	Tertiary Care	healthcare provided in specialist centres, usually on referral from primary or secondary care professionals

V

VTE	Venous Thromboembolism	a condition where a blood clot forms in a vein. This is most common in a leg vein, where it's known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE)
VfM	Value for Money	used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it both acquires and provides, within the resources available to it

W

WLF	Well Led Framework	a set of indicators that seek to identify how well led an organisation is, also used as a framework for board governance reviews
WRES	Workforce Race Equality Standard	a metric to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of black and minority ethnic (BME) board representation
WTE	Whole-time equivalent	See FTE

Y

YTD	Year to Date	a period, starting from the beginning of the current year, and continuing up to the present day. The year usually starts on 1st April for financial performance indicators