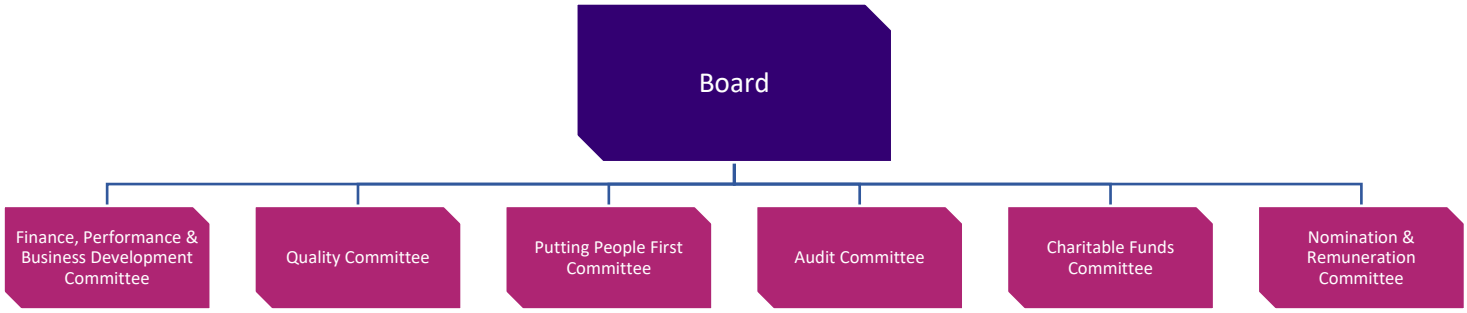
Liverpool Women's
NHS Foundation Trust

Trust Board

6 April 2023, 09.30am
Boardroom, LWH & Virtual, via Teams



Liverpool Women's
NHS Foundation Trust

Trust Board

Location	Boardroom, LWH & Virtual via Teams
Date	6 April 2023
Time	9.30am

Item no. 23/24/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
		PRELIMINARY BUSINESS			
001	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	0930 (5 mins)
002	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
003	Minutes of the previous meeting held on 2 February 2023	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
004	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
005	Patient / Staff Story – Hewitt Fertility Centre	To receive	Presentation	Chief People Officer	0935 (20 mins)
006	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	0955 (5 mins)
007	Chief Executive Report (inc. register of sealings)	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	1000 (5 mins)
		MATERNITY			
008a	Maternity Improvement Update	For assurance	Presentation	Chief Nurse	10.05 (20 mins)
008b	Perinatal Quality Surveillance & Safety	For assurance	Written	Chief Nurse	
		QUALITY & OPERATIONAL PERFORMANCE			
009a	Chair's Reports from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	10.25 (50 mins)
009b	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	
009c	Bi-annual staffing paper update, July 2022-December 2022 (Q2 & Q3)	For assurance	Written	Chief Nurse	
009d	Learning from Deaths – Quarter 3 2022/23	For assurance	Written	Medical Director	

009e	Guardian for Safe Working Hours Quarterly Report – Q3 2022/23	For assurance	Written	Medical Direcor	
PEOPLE					
010a	Chair's Report from the Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	11.15 (30 mins)
010b	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	
010c	Staff Survey 2022 – Key Themes and Headlines	To receive	Written	Chief People Officer	
010d	EDI Reports for Publication	To receive and approve	Written	Chief People Officer	
BREAK – 10 mins					
Board Thank You – 5 mins					
FINANCE & FINANCIAL PERFORMANCE					
011a	Chair's Reports from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1200 (30 mins)
011b	Chair's Reports from the Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
011c	Chair's Report from the Charitable Funds Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
011d	Finance Performance Review Month 11 2022/23	For assurance - To note the current status of the Trust's financial position	Written	Chief Finance Officer	
BOARD GOVERNANCE					
012a	Corporate Objectives 2022/23: Final Outturn Review	For approval	Written	Chief Executive	1230 (20 mins)
012b	Board Assurance Framework	For assurance	Written	Trust Secretary	
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
013	Trust Board Terms of Reference	For approval	Written	Trust Secretary	Consent
014	Board Committee Annual Reports, 2023/24 cycles of business and Terms of Reference	For approval	Written	Trust Secretary	
CONCLUDING BUSINESS					

015	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1250 (5 mins)
016	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
017	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
018	Jargon Buster	For reference	Written	Chair	

Date of Next Meeting: 5 May 2022

1255 - 1305	*Questions raised by members of the public*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Liverpool Women's NHS Foundation Trust

Meeting attendees' guidance

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

Before the meeting

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

General considerations:

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

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

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

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

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

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

At the meeting

General Considerations:

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

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

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

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

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

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

Attendance

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

After the meeting

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

Standards & Obligations

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

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

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

Page 129 Handbook to the NHS Constitution 26th March 2013

Liverpool Women's
NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held in the Boardroom and Virtually via Teams at 09.30am on 2 February 2023

PRESENT

Robert Clarke	Chair
Kathryn Thomson	Chief Executive
Jenny Hannon	Chief Finance Officer / Executive Director of Strategy & Partnerships
Louise Martin	Non-Executive Director
Zia Chaudhry MBE	Non-Executive Director
Dr Lynn Greenhalgh	Medical Director
Dianne Brown	Chief Nurse
Michelle Turner	Chief People Officer / Deputy Chief Executive
Gloria Hyatt MBE	Non-Executive Director
Tracy Ellery	Non-Executive Director / Vice-Chair
Sarah Walker	Non-Executive Director
Jackie Bird MBE	Non-Executive Director
Prof. Louise Kenny CBE	Non-Executive Director / SID
Gary Price	Chief Operating Officer

IN ATTENDANCE

Matt Connor	Chief Information Officer
Kate Walsh	Physiotherapy Manager and Clinical Lead
Gillian Walker	Patient Experience Matron
Heledd Jones	Head of Midwifery (to item 202a)
Jackie Sudworth	Public Governor
Peter Norris	Public Governor
Denise Richardson	Member of the Public
Lesley Mahmood	Member of the Public
Felicity Dowling	Member of the Public
Teresa Williamson	Member of the Public
Gordon Lorimer	Member of the Public
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:
None noted

Core members	**Feb 22**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb 23**
Robert Clarke - Chair	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Kathryn Thomson - Chief Executive	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Dr Susan Milner - Non-Executive Director / SID	✓	✓	✓	✓	Non-member							
Tracy Ellery - Non-Executive Director / Vice-Chair	✓	✓	✓	✓	✓	✓	A		✓	✓	✓	✓
Louise Martin - Non-Executive Director	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓

Tony Okotie - Non-Executive Director	✓	✓	✓	✓	A	Non-member						
Prof Louise Kenny - Non-Executive Director	A	A	A	✓	✓	A	✓		A	A	✓	✓
Eva Horgan – Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Marie Forshaw – Chief Nurse & Midwife	✓	✓	✓	A	✓	✓	Non-member					
Dianne Brown – Chief Nurse	Non-member						✓		✓	✓	✓	✓
Gary Price - Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓		✓	A	✓	✓
Michelle Turner - Chief People Officer	✓	✓	✓	A	✓	✓	✓		✓	✓	✓	✓
Dr Lynn Greenhalgh - Medical Director	✓	A	A	✓	✓	✓	✓		✓	✓	✓	✓
Zia Chaudhry – Non-Executive Director	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Gloria Hyatt – Non-Executive Director	✓	✓	✓	✓	✓	✓	A		✓	✓	A	✓
Sarah Walker – Non-Executive Director	✓	✓	✓	A	✓	A	A		A	✓	✓	✓
Jackie Bird – Non-Executive Director			✓	A	✓	✓	✓		A	✓	✓	✓
Jenny Hannon - Chief Finance Officer / Executive Director of Strategy & Partnerships	Non-member										✓	✓

22/23/	
193	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. There were no apologies or declarations of interest.
194	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
195	**Minutes of the previous meeting held on 12 January 2023** The minutes of the Board of Directors meeting held on 12 January 2023 were agreed as a true and accurate record.
196	**Action Log and matters arising** Updates against actions log were noted.
197	**Service Outline – C-GULL Research** Dr Christine Cornforth provided an update on the progress being made with the C-GULL (Children Growing Up in Liverpool) study. It was noted that there had been good progress made with the following enabling factors: regulatory approvals, site work, information systems and staffing (both from the University of Liverpool and Liverpool Women's Hospital). In terms of engagement, action had been taken to reach out to other trusts within the region together with GPs and health centres. In addition, contact had been made with the LWH satellite sites to support community recruitment and follow up. In term of communications a working group had been established across various partners. A patient information tool and animation that could be used by midwives either in clinic or out in the community when speaking with women about the study was shared with the Board. This would also be available online.

	Attention was drawn to two additions to the programme that would be implemented over the next six months. This included the PEAPOD - a system for neonates that used whole body densitometry to determine body composition (fat and fat-free mass) in infants. The second addition related to the Milk, Microbes, mental health, and me enhancement funding of £7M that was recently awarded by Wellcome Trust. This would enhance the C-GULL programme of research – undertaking a detailed investigation into how early life nutrition and gut-microbiota colonization affected later mental health outcomes. The Medical Director noted that to date, the study had adopted a collaborative approach with a joint view of risks and solutions. The project was an example of how partnership working could help to address some of the fundamental challenges facing the city. Non-Executive Director, Jackie Bird, asked if there would be career pathways for research midwives post study. The Medical Director confirmed that funding continued to be sought for a nursing and midwifery research talent pipeline. Non-Executive Director, Prof. Louise Kenny noted that there would be numerous opportunities for master's degree and PhD level research emerging from the project. Non-Executive Director, Gloria Hyatt, queried what the tangible benefits of the C-GULL study would be. Prof. Louise Kenny stated that there hadn't been a similar study undertaken for twenty years and the updated data provided would enable clinicians and policy makers to track and identify the determinants of disease and other issues to inform effective treatments and interventions. The Board thanked Dr Christine Cornforth for her attendance and noted the update. *Kate Walsh, Physiotherapy Manager and Clinical Lead* and Gillian Walker*, Patient Experience Matron, joined the meeting*
198	Patient Story The Physiotherapy Manager introduced the story noting that a 72-year-old patient had initially presented at their GP with bladder issues. A referral was made to the Trust, and they had been treated effectively following a diagnosis of vulvovaginal atrophy. However, the patient continued to experience discomfort and was referred to the physiotherapy team. During consultation, the patient relayed that whilst most symptoms had gone, they had continued to experience discomfort during sexual activity. This was having a significant impact on the patient's wellbeing and mental health. The Physiotherapy manager noted that such issues tended to be 'taboo' and rarely discussed during consultations. Through active listening and being aware of the patient's context, the issue was able to be raised and with intervention, this had most likely avoided continuing visits to the GP and onward referrals. The Physiotherapy Manager noted that she had reflected on this case and had started to share learning across the Trust. Information had also been placed on patient boards in waiting rooms which was helping to generate conversations during consultations. Non-Executive Director, Sarah Walker, stated that this was an example of the importance of listening to patients and being empathetic to all aspects of their wellbeing. The Medical Director noted such a story served as an important reminder, during a time of recovery and waiting list challenges, that moving patients through a pathway quickly was not always the most effective method for maximising patient experience or overall efficiency. The Chief People Officer queried if there were ways that the Trust could be engaging with patients whilst they were awaiting their appointment or consultation. The Physiotherapy Manager confirmed that bitesize education work was underway with primary care partners. The Chair thanked the Physiotherapy Manager for presenting the story and noted that it was a useful example of how the Trust could tangibly deliver on the aims set out in the Women's Health Strategy published by NHS England.

	The Board noted the patient story and extended thanks to the patient for sharing their experience.
199	**Chair's announcements** The Chair noted that a Council of Governor's meeting was scheduled for 9 February 2023 and that the two main items for consideration were the Trust's response to the East Kent Maternity Report and the Liverpool Clinical Services Review. A Council of Governor's Nomination & Remuneration Committee had been held at the end of January 2023 to receive a mid-year review of Non-Executive Director performance.
200	**Chief Executive's report** The Chief Executive presented the report which detailed local, regional, and national developments. The Chief Executive noted that she had been asked by the Chief Constable of Merseyside Police to deliver a speech at the Chief Constable's Commendation Ceremony in January 2023. There were 114 recipients of awards, all of whom were truly inspiring from many ranks of the police, police staff, members of the public and members of RNLI. It was highlighted that 22 members of Merseyside Police received a commendation for the contribution they made to the incident at the women's hospital in November 2021. The Chief Executive welcomed back Jenny Hannon to the Board following her appointment as Chief Finance Officer (commenced 1 January 2023). The Board of Directors noted the Chief Executive update.
201a	**Director of Midwifery Update** The Chief Nurse provided an outline of the Director of Midwifery role and noted the following key programmes of work currently being undertaken: • Clinical and professional leadership • Exploring the wider determinants of health that impact pregnant women • Women and patient experience – working to co-produce new ways of working • Research and education The Chief Nurse asserted that the Director of Midwifery had made significant progress since their appointment (July 2022) and had helped to challenge thinking and culture with a positive intent. The Chair remarked that it was important for the Trust to have visibility of the outputs from the role after making the decision to invest. The Medical Director noted that the Director of Midwifery undertook regular visits and walkrounds of the various maternity teams and units and had developed an understanding of the experiences of these teams and individuals. Non-Executive Director, Zia Chaudhry sought clarification on the interdependencies between the Director of the Midwifery and Head of Midwifery roles. The Chief Nurse explained that the latter was operational and the former more strategic. As both post holders were relatively new to the organisation, they had been able to bring new ways of working and a fresh perspective. The Board noted the update.
201b	**Maternity Staffing report 1st July- 31st December 2022** The Board received the report which outlined the requirements of the Maternity Incentive Scheme (MIS) Year 4, Safety Action 5 (SA5). The report (which covered the six-month period from 1 July 2022 to 31 December 2022) set out the Trust's position in the context of midwifery staffing. The Chief Nurse noted that MIS Year 4, SA5 required that trusts demonstrate an effective system of midwifery workforce planning. The recognised evidence-based tool within Maternity Services was

	Birth Rate Plus (BR+). A Birth Rate Plus audit was completed in 2021, with the final report received in the Trust in February 2022. The Chief Nurse stated that in addition to BR+ compliance, the Trust had other mechanisms for supporting safe maternity staffing e.g., fill rates completed and monitored daily. Vacancy rates were outlined, and it was noted that trajectories for both sickness absence and turnover were showing positive signs. Attention was drawn to section 5 of the report which reported on planned vs actual staffing rates. It was confirmed that staffing levels were assessed on a four hourly basis. Following receipt of instruction from NHS England regarding the cessation of Continuity of Carer targets, the Trust had continued to maintain four teams, with further roll out paused. The available teams were targeted to areas and individuals of high risk. The reporting of staffing 'red flags' continued to be encouraged and there was a focus on addressing the underlying issues – often utilising quality improvement methodology. It was noted that there were emerging risks with maternity staffing particularly relating to the Maternity Assessment Unit (MAU) which was having a negative impact on the face-to-face maternity triage within 30 minutes metric (internally established as part of a quality improvement programme). In response, the Trust had adjusted the staffing model to ensure there was additional capacity and for this to include a supernumerary shift leader. Non-Executive Director Louise Martin noted that there were several references in the report to increasing complexity and acuity of women and requested that future reports provide additional evidence to substantiate the assertions made. Louise Martin continued to ask if there was an action plan in place to respond to the challenges of providing a 24/7 telephone triage at the MAU. It was confirmed that an action plan was in place and that a midwife had been 'ringfenced' to be present to answer calls at MAU. The Chief People Officer stated that it was encouraging to see the downward trend on turnover and queried if there was a breakdown of the staff involved and if it was understood what was driving the improvement. The Head of Midwifery reported that increased flexibility in working patterns was having an impact and that there had been a reduction in the number of Band 6 midwives leaving the Trust. Additional work was planned with Band 6 midwives to understand their work experience and how this could be improved. The Chair asked if the maternity team were reviewing patient flow 'holistically', noting that improvements in one area, often reduced pressure in another. The Head of Midwifery noted that there was a current Quality Improvement project on maternity base as it was understood that reducing pressures in this area would have a positive impact throughout the whole care pathway, particularly at MAU. The Chief Nurse added that a 'balanced scorecard' for maternity services was in development and that this would start to report to the Quality Committee and the Board. The Chief Executive noted that there had been a clear impact of the Head of Midwifery's leadership since being in post. The Board received the report. *Heledd Jones, Head of Midwifery left the meeting*
202a	Chair's Reports from the Quality Committee The Board considered the Chair's Reports from the Quality Committee meetings held on 19 December 2022 and 23 January 2023. The Committee Chair, Non-Executive Director Sarah Walker, noted a number of issues discussed at the Committee had been received by the Board. Particular attention during December 2022 and

	January 2023 had been given to CNST Year 4 compliance and performance challenges with the MAU triage. In December 2022, the Committee received a detailed position update in relation to blood sampling errors. The analysis of data identified that most errors were related to specimen collection, specimen quality and labelling. An improvement plan was shared with the Committee which would support the aim to reduce pathology sample and collection errors to <1% of all samples, which would be in line with published figures and represent a 50% improvement. The Committee had been assured by the actions and improvements underway. In January 2023, the Committee received a detailed review in relation to in-utero transfer rates at The Trust compared to St Mary's Hospital. The work demonstrated positive partnership working with the Northwest ODN. The Board of Directors received and noted the Chair's Reports from the Quality Committee meetings held on 19 December 2022 and 23 January 2023.
202b	Quality & Operational Performance Report The Board considered the Quality and Operational Performance Report. The Chief Operating Officer noted that the format of the report had been updated to align with the Making Data Count methodology The Chief Operating Officer noted that performance during December 2022 and January 2023 had been challenged due to on-going industrial action. The Trust continued to respond to the drive to eliminate the number of patients waiting above 72 weeks by the end of March 2024. Progress was being made towards this aim, supported by additional 'insourced' capacity. The Trust was working to ensure that a sustainable model of improvement was in place that would include additional capacity and increased efficiency. It was noted that the additional investment into 'insourcing' additional capacity had been made following a clear consideration of the tolerance of the Trust's risk appetite for quality (low) and financial performance (moderate). The Chief Operating Officer reported that it would be likely that the Trust would be asked to provide mutual aid across the system and the wider region. Non-Executive Director Tracy Ellery noted that there would be a challenge in balancing the need to support the system with meeting internal targets. The Chief Nurse reported that the main driver behind the increased number of serious incidents related to a decision made in August 2022 to include incidents relating to the isolated site within the criteria. It was clarified that serious incidents were reported as 'open' when they were being investigated rather than being overdue. The Medical Director noted the need to improve VTE performance and that work was underway to drive such improvements, sharing lessons on effective practice from different areas. The Board of Directors received and noted the Quality & Operational Performance Report.
202c	Mortality and Learning from Deaths Report Quarter 2, 22/23 The Board received the report which presented the mortality data for quarter two and the learning from deaths information for quarter one. In quarter two there were the following deaths: • Adult deaths – 1 (unexpected) • Direct Maternal Deaths – 0 • Stillbirths 7 (rate 3.6/1000) • Neonatal deaths 15 inborn (rate 7.2/1000 inborn births) + 2 deaths from postnatal transfers

	It was noted that the stillbirth rate remained on a downward trajectory, although caution of interpretation due to small numbers was warranted. There had been an increase in neonatal mortality resulting from nine babies whose deaths were due to congenital anomalies. The MBRRACE report for extended perinatal mortality in 2020 was published in October 2022. The data within this report demonstrated that the Trust was a negative outlier for stillbirth, perinatal and extended perinatal deaths. The high neonatal mortality rate during 2022/23 had previously been reported to the Quality Committee and to the Board with assurance regarding clinical care provided via the NWODN review of neonatal mortality. The Board of Directors noted: • number of deaths in the Trust's care • number of deaths subject to case record review • number of deaths investigated under the Serious Incident framework • number of deaths that were reviewed/investigated and as a result considered due to problems in care • themes and issues identified from review and investigation • actions taken in response, actions planned and an assessment of the impact of actions taken. • Compliance with SA1 for the MIS of CNST.
203a	Chair's Report from the Putting People First Committee The Board considered the Chair's Report from the Putting People First Committee meeting held on 16 January 2023. The Committee Chair, Non-Executive Director Gloria Hyatt, noted the following key issues: • Industrial action on 15 and 20 December 2022 by the RCN passed without incident and was preceded by positive partnership working to agree services exempted from strike action which included maternity and neonatal services. Whilst a range of outpatient and inpatient procedures within gynaecology were rescheduled, impact on patients was minimised as far as possible. Risks of potential further industrial action was noted. • The Committee received a presentational update alongside the Audit and Sickness Report presenting the current position within the Trust following the implementation of the Employee Attendance and Wellbeing policy in March 2022. The Committee noted comments from staff users across the divisions who had been applying the policy. A discussion was held regarding whether the principle of removing the short-term sickness 'triggers' had been effective and should be continued. It was agreed to continue with the principles of the well-being policy, however, with an offer of more structure to managers in the form of 'well-being' notices. • Although some areas of improvement had been demonstrated since the mandatory audits undertaken in October and November 2022, mandatory training compliance continued to be a significant risk and limited assurance was taken from the report. The Committee noted the recommendation to receive an update from Divisional representatives including trajectories, plans to improve the position, and escalation steps if required. The Board of Directors received and noted the Chair's Report from the Putting People First Committee meeting held on 16 January 2023.
203b	Workforce Performance Report The Chief People Officer drew attention to mandatory training performance, noting that significant challenges continued to be experienced in maternity mainly because of sickness levels. There had been challenges in relation to the delivery of aseptic non-touch and resus level 2 training. Focus was being given to these areas and assurance on progress would be reported to the next Putting People First Committee.

	Non-Executive Director, Jackie Bird, queried how the Trust could be assured that clinical practice was safe whilst challenges persisted with mandatory training. The Chief People Officer confirmed that a focus on clinical mandatory training was being prioritised at a divisional level and areas of the greatest risk to patient safety were being given particular attention. In terms of sickness absence, a recent audit had identified that timely return to work interviews from managers was the most effective intervention to prevent further absences. This was being prioritised with managers and compliance would be monitored via the Divisional Performance Review process. Non-Executive Director, Louise Martin, noted in some instances a significant number of staff reported into one line manager and asserted that this was impeding effective management. It was suggested that a review of the Trust's organisation structure should be undertaken. Chair's Log: To undertake a review of the ward management structure to ensure that it enables effective management relationships. The Board noted the workforce performance report.
203c	Race Equity Declaration of Intent The Chief People Officer reminded the Board that the Trust had a strategic objective to drive towards becoming one of the most inclusive organizations in the NHS. The Board had previously agreed that the initial priority area of focus will be Racial Equity. The report set out the Trust's Declaration of Intent regarding Racial Equity, namely, to foster an environment where colleagues, patients, their friends, and families, from all backgrounds, could thrive - free from discrimination, inequity, unfairness, and prejudice. To enable this, the Trust would strive to remove bias – unconscious or otherwise – from policies and processes and root out bullying, harassment, and other unacceptable behaviours. The Equality, Diversity and Inclusion Sub-Committee would have operational oversight on progress with oversight provided by the Putting People First Committee. Work would also be taken to ensure that when refreshed, the clinical and quality strategy, patient experience strategy and people strategy aligned with the statement. Non-Executive Director, Zia Chaudhry, asked if the statement was aligned with the wider system aims. The Chief People Officer reported that there was a high level anti-racist commitment at a system level and once further detail was available, the Trust would respond to align its work. The following points were made by the Board: • That it would be important that genuine action emerged from the Statement of Intent o Potential examples discussed included: ▪ Improving translation services ▪ Ensuring that all communities were included in research projects e.g. C-GULL ▪ Applying positive action in recruitment • That the Trust's commitment should be both to staff and patients • That there is clarity around the targets for representation being pursued by the Trust The Board resolved to: • endorse the Statement of Intent • Agree to its publication on the Trust website and social media • Require the Putting People First Committee to have oversight of the development of the programme of work required to deliver the commitment to Race Equity and to provide assurance to the Board of progress or deviation from plan • Note the opportunity to align intent and actions through the review and refresh of the People, Clinical & Quality and Patient Experience Strategies.

204a	**Chair's Reports from the Finance, Performance and Business Development Committee** The Board considered the Chair's Reports from the FPBD Committee meetings held on 19 December 2022 and 23 January 2023. The Committee Chair, Non-Executive Director Louise Martin, highlighted the following key issues: • The Committee had given significant attention to the Trust's financial position and were cognisant of the on-going pressures. The Committee recognised that patient safety and quality was the Trust's foremost priority and time was taken at each meeting to understand the potential competing issues. • The Committee received the annual update against third-party service provider controls. The report identified risks in relation to third party SLA controls and recommended actions to improve assurance in a timely manner. The Committee was concerned regarding the current level of assurance and agreed the recommended actions. It was requested that the issue be added to the risk register and that a progress update be provided in three months. • Risks in relation to funding for the Community Diagnostic Centre (CDC) for 2022/23 remained. The Trust had been asked to undertake a re-profiling exercise, based on activity and services delivered during H1. The Trust awaited an outcome from the regional and national team in relation to funding for 2022/23. The Committee highlighted significant concerns in relation to the financial viability of the CDC and risks that the CDC Programme posed upon the Trust. • The Committee received a positive presentational update in relation to the Theatre Utilisation quality improvement programme. The Committee commended the approach undertaken by the leadership team within the CSS Division to improve the Theatre Service, as demonstrated by the presentation and corroborated by consultant colleagues. • The Committee received the Neonatal Capital Programme Build benefits realisation report noting that the Neonatal Redevelopment Programme had successfully delivered against its' objectives and delivered material benefits for staff, babies and families. The Board of Directors received and noted the Chair's Reports from the FPBD Committee meetings held on 19 December 2022 and 23 January 2023.
204b	**Finance Performance Review Month 9 2022/23** The Chief Finance Officer presented the Month 9 2022/23 finance performance report which detailed the Trust's financial position as of 31 December 2022. It was noted that at Month 9, the Trust was reporting a £1,481k deficit year to date (YTD). This was £2,143k off plan and was supported by £12,814k of non-recurrent items. The forecast out-turn (FOT) before further recovery actions was a £1,385k deficit, £1,911k worse than plan, after inclusion of £4,801k of additional recovery actions. This position and the expected non-achievement of plan has been shared with the Integrated Care System (ICS). On-going meetings were taking place between the Trust and ICB colleagues. The cash balance at 31 December 2022 was £8,293k. Preparations were being made to apply for Provider Revenue Support funding in February 2023 to enable the Trust to continue to meet its liabilities as they fell due. The impact on the 2023/24 financial position was being assessed. The Chief Finance Officer stated that the financial sustainability issues that had been raised as part of the Future Generations strategy were starting to manifest. Non-Executive Director, Tracy Ellery, remarked that a significant amount of work had been undertaken by the finance team to ensure that there was a thorough understanding of the Trust's financial position and the key drivers of the deficit. It was noted that this was key to the Trust's credibility for delivering on the FOT. Non-Executive Director, Gloria Hyatt, asked what the implications of being in a deficit position would be. The Chief Finance Officer explained that there would be a reduction of financial autonomy and an

	increase in external oversight. The need to borrow cash would also have an additional financial impact. It was noted that the FPBD Committee would continue to monitor the position closely and the on-going impact into the 2023/4 financial year. The Board of Directors: • Noted and received the Month 9 2022/23 Finance Performance Review
205	Board Assurance Framework The Board of Directors received the Board Assurance Framework. The Trust Secretary explained that the BAF risks had been discussed at the aligned Committees during January 2023. The Trust had been managing the impact of industrial action throughout 2022 whilst maintaining a BAF score of 20. Moving into 2023, it was likely that industrial action began to be co-ordinated across the various unions and sectors. This could pose a severe and acute challenge to the Trust on those days, potentially to the extent which disrupts business to a 'catastrophic' extent (as defined by the risk descriptors in the Risk Management Strategy). Whilst this remains a possibility, there was a proposal that the Trust should rate this risk as a '25' – the most highly rated risk on the BAF. A detailed discussion was held regarding this proposal. It was stated that an escalation of the risk score would require remedial action to be taken and it was queried if the current position warranted this. It was asserted that further consideration was required before deciding on whether to escalate the risk rating. A motion was tabled that the Executive Team should be tasked with reviewing the evidence and potential impact of escalating the score. A vote was held on the motion, and this was carried. Therefore the proposal to move BAF risk 1.2 to score 25 was not supported at this time. Chair's Log: For the Executive Team to review the evidence and potential impact of escalating the score for BAF risk 1.2, making a recommendation back to the Putting People First Committee. The Board reviewed and received the BAF Risks.
206	Liverpool Clinical Services Review The Chief Finance Officer reported that 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 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 report recommended that the Trust's Future Generations Programme, first established in 2014/15, be reset as a system priority. This recommendation was in keeping with the Trust's work within the Programme over several years to demonstrate the system impacts of those risks which arise because of the Trust's location, isolated from adult acute services. The Board of Directors resolved to: • receive the report • note the recommendations within the Liverpool Clinical Services Review • commit to ongoing support for and active participation in the new system-owned programme, previously known as Future Generations.

	The following items were considered as part of the consent agenda
207	**Emergency Preparedness, Resilience & Response Core Standards Annual Assurance Board Report** The Board received a summary of the NHSE EPRR Core Standards assurance process and Trust compliance outcomes. This had been discussed at the FPBD Committee. The Board of Directors accepted the assurance that effective systems of control were in place in relation to achieving compliance to the NHSE EPRR Core Standards.
208	**Review of risk impacts of items discussed** The Chair identified the following risk items: • Maternity workforce • Potential impact of industrial action • Performance against the 72 week wait target • The Trust's 2022/23 financial position and longer term sustainability challenges.
209	**Chair's Log** The following Chair's Logs were noted: • For the Executive Team to review the evidence and potential impact of escalating the score for BAF risk 1.2, making a recommendation back to the Putting People First Committee. • For the Putting People First Committee to undertake a review of the ward management structure to ensure that it enables effective management relationships.
210	**Any other business & Review of meeting** None noted. **Review of meeting** It was agreed that there had been examples of positive and constructive challenge during the meeting.
211	**Jargon Buster** Noted.

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
6 April 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
1 December 2022	22/23/163b	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	For the MVP Chair to be invited to undertake a development session with the Board regarding patient involvement and engagement.	Trust Secretary	~~Mar 23~~ June 23	On track	MVP to be invited to June workshop to coincide with wider discussion on 'how the Trust listens (to patients)'
1 September 2022	22/23/097f	Safeguarding Annual Report	To receive a safeguarding case study and actions taken by the Trust at a future Board development session	Chief Nurse	March 23	Complete	Scheduled for development session – April 2023

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	02.02.2023	For the Executive Team to review the evidence and potential impact of escalating the score for BAF risk 1.2, making a recommendation back to the Putting People First Committee. Executive Lead: All Executives	Executive Team	February 2023	Closed	Update provided to March 2023 PPF Committee
Delegated	02.02.2023	To undertake a review of the ward management structure to ensure that it enables effective management relationships. Executive Lead: Chief People Officer	PPF	May 2023	Open	

Liverpool Women's
NHS Foundation Trust

CEO Report

Trust Board
April 2023

Executive Summary:

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

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

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

Section A - *Internal*

New permanent CT Scanner now fully operational at Liverpool Women's

Our latest exciting news is that our new permanent CT Scanner has been installed and has fully operational from February 2023. This new permanent CT Scanner will give patients in the community access to diagnostics much earlier than they would have had before and will also reduce transfers for LWH patients who would ordinarily have to go over to the Royal Liverpool Hospital for such tests. In addition, this will not only benefit Liverpool Women's patients but many others across the region who are waiting for diagnostic care including patients from Liverpool University Hospitals (LUHFT), Liverpool Heart and Chest (LHCH) and Clatterbridge Cancer Centre (CCC). The permanent CT scanner is located within Imaging, accessible via the main Outpatients Department.

You can watch a short video clip of Medical Director, Lynn Greenhalgh and Chief Operating Officer, Gary Price giving a sneak preview of the CT Scanner before it became operational. Click here to watch the video clip

We are also pleased to announce that our new permanent MRI scanner is now installed within the CDC. The MRI is beginning to see its first few patients but will not be fully operational until next month. These permanent scanners are a fantastic addition to the Imaging Department and mean that we can now scan our own Liverpool Women's patients as well as continuing to support partner Trusts.

Our mobile CT and MRI scanners (located outside the main building by the patient car park) will leave site on Friday this week. This means that the outside of the hospital site will look a little different to what you will be used to. Removal of the mobile scanners will take place on Friday evening. During this time Estates will be cordoning off certain carpark spaces and the company removing the scanners will be waiting until the carpark has emptied out before they start the removal. Disruption will be kept to a minimum so you should not encounter any issues accessing the site.

Although the removal of the mobile scanners is a positive step to make way for our permanent CT and MRI scanners on site, it is worth noting that our mobile units have enabled us to scan over 9,000 patients, over the last 12 months while building works have been taking place on our new imaging suite.

This update is the latest milestone of the CDC project as it approaches completion. We are also pleased to welcome NHS England next week to see the developments that have taken place. We will send a further communication out over the next couple of weeks with full details and further updates.

Trust Seal

In line with paragraph 118 of the Trust's Standing Orders, there is a requirement to report all sealings to the Board of Directors on an annual basis. The report should contain details of the seal number, the description of the document and date of sealing. The seal was utilised three times during 2022/23:

173 – Lease relating to Car Park in the NW Corner of Mulgrave St and Selbourne St, Liverpool between Liverpool City Council and the Trust – 3 May 2022.

174 – MRI LWH, Magnetom Sola between Siemen's Healthcare Limited and LWH – 14 March 2023

Two pending documents:

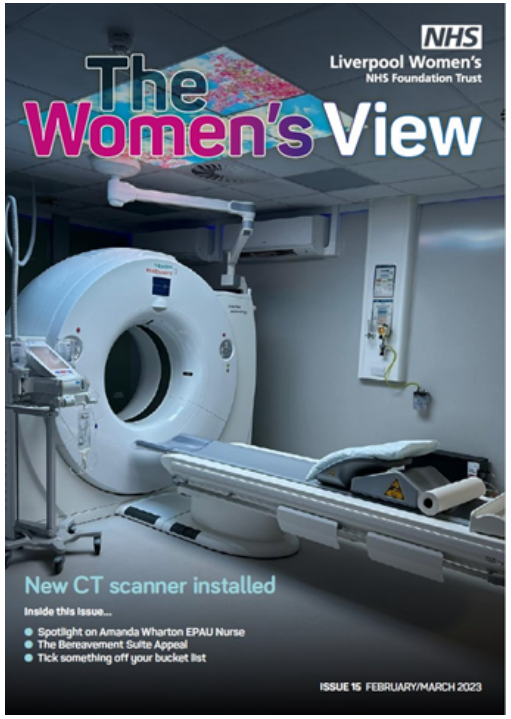
- *Renova Developments Ltd LIFT Underlease for part of St Chad's Centre between Community Health Partnerships Ltd and LWH*
- *Crown Street Enhancements Stage 4 Contract – Tilbury Douglas*

Section A - *Internal*

Liverpool Women's Trust magazine February – March

Inside this edition…New CT scanner installed | Spotlight on Amanda Wharton EPAU Nurse | The Bereavement Suite Appeal | Tick something off your bucket list

https://www.liverpoolwomens.nhs.uk/media/4539/issue-15-v3-final.pdf



Liverpool Women's 'In the News'

Liverpool midwife delivering Merseyside babies for over 30 years

Top 50 Inclusive Employers

LWH has made an improvement in its position in the Top 50 Inclusive employers list.

Link with LFC Foundation – Honeysuckle FC

LFC Foundation's mental-health team have joined forces with the Honeysuckle Bereavement service at LWH to create a football team specifically for bereaved dads and men who have experienced baby loss. Honeysuckle FC provides a safe environment for men to spend some time enjoying physical activity while allowing them to feel that they have the support of not only clinical staff but from their team mates too.

If you've been affected by baby loss and are interested in joining the group, please email mark.Henderson@liverpoolfc.com or marie.kellher@lwh.nhs.uk

Section A - *Internal*

Showcase Celebrating the Pioneering Research Undertaken at Liverpool Women's Hospital

Liverpool Women's Hospital were delighted to host a Research Showcase event on 27 March 2023, celebrating the pioneering and innovative research taking place across the Trust and promoting our supportive and engaging research culture.

The Showcase welcomed presentations from our multi-disciplinary workforce including senior researchers, post graduates, PhD student and early career researchers representing the wealth of talent we have here at Liverpool Women's. We explored a diverse range of research topics in a series of short presentations and also highlighted some exciting new research proposals.

The event provided a fantastic networking opportunity to engage and raise awareness of the cutting edge research being delivered across the Trust in collaboration with our academic and industry partners.

The programme included the launch of our new Research Strategy and introduce our exciting plans for research career opportunities for our Nursing, Midwifery and Allied Health Processional workforce.

The impact of the Trusts research can be seen in the local region and extends across the international stage. Our forward-thinking ethos, active engagement and collaboration with partner organisations helps to ensure the research we deliver is relevant, cutting-edge and of value to our diverse population.

NIHR Senior Research Leader Programme for Nurses and Midwives

The National Institute for Health Research (NIHR) is launching a Senior Research Leader Programme for nurses and midwives, building on the success of the recently concluded 70@70 Senior Nurse and Midwife Leaders programme. The new three-year programme aims to empower more senior nurses and midwives to increase research capacity and capability and support their development as future research leaders. The 70@70 programme implemented over 300 different research initiatives, increased the support and leadership of research by nurses and midwives, and helped meet the research leadership needs of individual NHS organisations. The new programme aims to realise the untapped potential of many more senior nurses and midwives, placing them at the forefront of healthcare research and raising their profile in the wider research community. According to Dr Catherine Henshall, the NIHR Associate Director of Nursing and Senior Research Leader Programme Director, research-active organisations achieve better clinical outcomes for patients and are more likely to retain their workforce.

The programme received a large number of strong applications, highlighting the widespread dedication, commitment and talent within nursing and midwifery research. Each application was assessed by three reviewers, to assist the Selection Panel in their decision making. Only 15 applications were accepted and two members of LWH staff were successful – Yana Richens and Diane McCarter.

Section B - *Local*

NHS Cheshire and Merseyside Blog

Although the calendar tells us we have now edged into Meteorological Spring, health and care services across Cheshire and Merseyside remain firmly in 'winter mode'.

Across the board, services continue to experience high demand and, while the situation has recently stabilised, too many patients are still delayed in accessing timely assessment and treatment.

There remains more than 1,000 people in hospital across Cheshire and Merseyside who are medically-fit for discharge, which equates to roughly 1 in 6 of all hospital beds.

To help improve patient flow, we are taking a range of actions including:

- Ensuring all possible capacity across the health and care system is utilised
- Supporting hospital discharge processes and working to ensure more care packages are available in the community
- Continuing to invest in virtual wards to support more people to be treated out of hospital

While A&E and acute hospital services typically receive primary focus, it is equally important to improve patient flow in inpatient mental health services and primary care settings too.

With this in mind, we warmly welcome imminent national recovery plans for primary care (and the support this will bring for practices) as - although general practice is currently delivering 110% of the care they delivered pre-pandemic - patient access continues to be a real challenge.

Of course, the current picture across Cheshire and Merseyside remains complicated by ongoing NHS Industrial Action - but we respect the right of NHS staff to take action.

I would, however, like to put on record my thanks to service managers at every level for their continued hard work to help maintain safe levels of care and good relationships with staff.

The Royal College of Nursing recently paused planned industrial action amid ongoing talks between trade unions and the Government so we remain hopeful that a resolution can be found.

Graham Urwin - Chief Executive

Full March 2023 update available here

Section B - *Local*

Cheshire & Merseyside Acute and Specialist Trust (CMAST) Board Briefing – March 2023

The Leadership Board met on 3 March and discussed a number of key system issues:

A discussion on preparations for and considerations associated with upcoming junior doctors industrial action took place. The discussion provided an opportunity for system leaders to be updated on discussions amongst Trust Medical Directors and promoted the need for clarity with the public, partners and workforce, consistency of approach and response and the paramount importance of patient safety. System communications will be led by the ICB Medical Director and cascaded to Trust Medical Directors.

An update was received on progress toward achievement on the elimination of patients waiting greater than 78 weeks for treatment by the end of March 2023. Solid progress was being made, however, industrial action was noted to be a destabilising factor and risk to delivery. The Board was also briefed on implementation of the Mutual Aid Hub whose priorities included minimising variation in access and inequalities across Cheshire and Merseyside and will, going forward, include the coordination of shared, equitable access to the independent sector.

The group also discussed progress in responding to the Liverpool Clinical Services Review. The principles previously discussed by CMAST were reiterated: the need to respond to the review's recommendations; the need for this to be done in sight of partners; and for wider system implications to be considered. The conclusions of a national visit were also shared which had provided assurance on progress and the collaborative approach to system delivery within C&M. Finally, the group noted that the first meeting of the ICB led aspect of the review and related to Women's Health had taken place and that as well as CMAST members being present in their own right at this committee CMAST was represented through the appointment of the Wirral Trust Medical Director following an ICB request.

The Leadership Board were informed that CMAST had been successful in its bid to the Provider Collaborative Innovators Scheme. The offer includes access to national policy development, peer support and a bespoke support offer which is to be confirmed.

CMAST Leadership Board will also meet at the end of the month in order to avoid Easter bank holidays in April

NHS Cheshire and Merseyside Integrated Care Board meeting

The NHS Cheshire and Merseyside Integrated Care Board met at the The Department, Lewis's Building, between 9am-12pm on Thursday, March 30th.

https://www.cheshireandmerseyside.nhs.uk/media/zvidjdnk/icb-board-public-agenda-papers-300323_compressed.pdf

Section B - *Local*

Interim Liverpool Place Director

Jan Ledward, Place Director for Liverpool, is leaving NHS Cheshire and Merseyside to join Liverpool University Hospitals (LUHFT) as Executive Director for Strategy and Partnerships. Mark Bakewell, current ICB Deputy Director of Finance, has been appointed as Place Director for Liverpool on an interim six-month basis

Mark joined the NHS more than 20 years ago, and has worked in finance roles for a number of different organisations. He joined NHS Liverpool CCG in 2016, and was appointed as Chief Finance and Contracting Officer in 2018, a role that was later extended to also cover NHS Knowsley CCG.

Mark's significant Liverpool knowledge and experience will be invaluable to continued Place development while a permanent appointment is made.

Section C - *National*

North West Black, Asian and Minority Ethnic Assembly Statement

Please see the letter attached in the appendix to this report which is calling on people in positions in power and privilege to step up in order to make sure that the NHS in our region deals with the structural and institutional barriers that result in ethnic inequalities in access, experiences, and outcome. This is following a recent judgement published by an employment tribunal that found that a senior black nurse employed by NHS England had been treated unfavourable because of her race and because she was willing to speak up.

2023 local elections: considerations for NHS providers

This briefing sets out considerations for NHS foundation trusts and trusts in the period of time known as the pre-election period leading up to the 2023 local government elections. It highlights the practical implications around providers' activities, including in relation to integrated care systems (ICSs), and with regard to communication during the pre-election period. It also covers the requirements on central and local government, the civil service and arm's length bodies during the pre-election period to maintain political impartiality in carrying out their public duties and ensuring that public resources are not used for the purposes of political parties or campaign groups.

https://nhsproviders.org/resources/briefings/briefing-on-2023-local-elections-pre-election-period-considerations-for-nhs-providers

Spring Budget 2023

On 15 March 2023, Jeremy Hunt, delivered his Spring Budget setting out measures which will help grow the economy and improve labour market activity. The measures announced include:

- An expansion of childcare provision, including 30 hours a week of free childcare for 38 weeks a year, for eligible working parents of children aged 9 months to 3 years.
- Reforms to support disabled people and those with long term health conditions back into work, such as the removal of the Work Capability Assessment and the introduction of a new Universal Support programme.
- An extension to the government's Energy Price Guarantee to provide support to households for a further three months to the end of July.
- Landmark changes to the pension tax system, including abolishing the Lifetime Allowance and an increase to the Annual Allowance from £40,000 to £60,000.

NHS Providers' briefing outlines the key policy announcements as well as our analysis of the implications for the health and care sector.

https://nhsproviders.org/media/695273/ndb-spring-budget-2023.pdf

Section C - *National*

NHS provider licence updates

This licence sets out regulations for all providers of NHS services to ensure patients get the best possible care. NHS England are to issue modified licences to trusts and foundation trusts following consultation. Modifications come into effect from 1 April (from Monday, please see the provider licence webpage). Updates reflect current statutory and policy requirements and support providers to work effectively as part of ICSs. The Board will receive a more detailed update on this at the May 2023 Board meeting.

Arrangements for delegation and joint exercise of statutory functions- Guidance for integrated care boards, NHS trusts and foundation trusts

This statutory guidance provides an overview of the new collaborative working arrangements that are possible between NHS organisations and local Government following commencement of the Health and Care Act 2022 (the '2022 Act'), with further technical guidance in the supporting annexes.

The new legislation is generally permissive, allowing delegation and joint arrangements to develop and evolve in ways that best suit the needs of patients and the public. The guidance therefore explains what delegation and joint working arrangements are permitted by the legislation, and when these can be used. This enables organisations to sense check that their proposed delegation or joint exercise of any statutory functions is done lawfully and in accordance with the principles of good governance, and adheres to any expectations in this guidance that have been placed on their delegation or joint exercise.

NHS England board update and maternity delivery plan briefing

The board also approved a new three-year delivery plan for maternity and neonatal services, and has written to all trusts with maternity and neonatal services to set out the key themes of the report.

The plan has identified 12 objectives across four themes, bringing together actions from recent national reports into maternity as well as the NHS long-term plan and maternity transformation programme. The themes are:

- Listening to and working with women and families with compassion
- Growing, retaining and supporting the workforce
- Developing a culture of safety, learning and support
- More personalised and equitable care.

See the next day briefing outlining the key actions in the report and offering NHS Providers' view. https://nhsproviders.org/media/695391/next-day-briefing-on-the-nhs-england-three-year-maternity-plan.pdf

Ref 20230328 RB HH

Chairs and Chief Executives
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North West region

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By email

28 March 2023

Dear all

North West Black, Asian and Minority Ethnic Assembly Statement

A recent judgement published by an employment tribunal found that a senior black nurse employed by NHS England had been treated unfavourably because of her race and because she was willing to speak up. This case is yet another reminder of exactly where the healthcare system is on tackling racism and race inequality. NHS England Chief Executive Amanda Pritchard has stated her commitment to using the outcome of the tribunal to deliver actions so that others do not face the same or similar experience. Sadly, we know that this case is not an isolated one.

The recently published Workforce, Race Equality Standard (WRES) data for 2022 for the North West (NW) shows an increase in ethnic minority staff experiencing harassment, bullying or abuse from patients, relatives and the public in last 12 months; this is 26.4% for Black, Asian and Minority Ethnic colleagues compared to 24.2% for white staff. The representation of ethnic minority staff at board level for the NW data is 10.8%, whilst there has been a fall at exec board level to 6.8% from 7.6%; representation in the overall workforce is 14.8%.

We are writing to you as co-Chairs of the North West Black, Asian and Minority Ethnic Assembly (the Assembly) to call on you all as people in positions of power and privilege to step up in order to make sure that the NHS in our region deals with the structural and institutional barriers that result in ethnic inequalities in access, experiences, and outcomes.

Racism and discrimination have a harmful impact on individuals and communities. In the NHS this materialises as lack of appropriate treatment for health problems; poor quality and discriminatory treatment by healthcare staff; lack of high-quality ethnicity data monitoring; inadequate interpreting services for those who cannot speak English confidently; and avoidance of seeking help for health problems due to fear of racist treatment.

To root out racism, we need to critically appraise our organisational culture from top to bottom.

The North West Black Asian and Minority Ethnic Assembly was initially formed by over 70 senior NHS leaders in response to the disproportionate impact of the Covid-19 pandemic on racially minoritised colleagues and communities, to act as a critical friend and through our

network of senior leaders to push our clear stated ambition is for the NHS in the North West to be Anti-Racist and at the forefront of challenging and tackling racism.

We in the Assembly are in no doubt that tackling racism needs to be a fundamental leadership responsibility for everyone. We as assembly members urgently call on all NHS leaders across the North West;

- To commit to taking sustained action and demonstrating visible leadership on addressing racism in all its forms – interpersonal, structural, and institutional
- To prioritise addressing race inequalities in health and care both as a system and within their own organisations
- For integrated Care Boards to demonstrate a strong competence in the understanding of causes of racism and the impact this has on people's lives
- Connect with their staff by talking openly, creating an environment of compassion, respect, and safety, and to share experiences and learning from each other

As an Assembly we are keen to work with NHS England and leaders from across the North West to provide support, share insights, lived experiences of racism and inequality along with good practice and call on you to look at how you can engage with the Assembly and use the expertise of our members on this important issue.

Yours faithfully

Evelyn Asante-Mensah OBE

Chair, Pennine Care Foundation Trust And North West, Black Asian and Minority Ethnic Assembly

Richard Barker CBE

Regional Director (North West)

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/008b***		**Date: 06/04/2023**	
Report Title	**Perinatal Quality Surveillance & Safety**			
Prepared by	***Angela Winstanley Quality & Safety Matron*** ***Heledd Jones, Head of Midwifery*** ***Vicky Clarke, Family Health Divisional Manager***			
Presented by	***Dianne Brown – Chief Nurse.***			
Key Issues / Messages	*The Family Health Division requests that Trust Board receive this paper and seek assurance that perinatal quality safety is a key Divisional priority, and this report provides sufficient evidence of our ongoing compliance and progress with the implementation of a perinatal quality dashboard and framework.*			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	To note the assurances provided in the report.			
Supporting Executive:	***Dianne Brown – Chief Nurse***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	Mar 23	Chief Nurse	Further detail was requested on the following (to be included in the Board paper) – • Update on timelines for completion of the maternity assessment tool • Further assurance regarding the management of risk • Additional clarity regarding the trajectory of completion of mandatory training

EXECUTIVE SUMMARY

In December 2020, following the publication of the Ockenden Report, Trusts were mandated to develop and implement a new quality surveillance model.

implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk)

A prerequisite of the model is to highlight trusts that require support before serious issues occur to enable proactive management and support. The Implementation of a new quality surveillance model seeks to provide consistent and methodical oversight of all services, specifically maternity services. The model has been developed to provide ongoing learning and insight, and to inform ongoing improvements in the delivery of perinatal services.

Provider Trusts and their Boards, supported by the senior maternity and neonatal triumvirate and the board-level perinatal safety champion at its centre, ultimately remain responsible for the quality of the services provided and for ongoing improvement to these. As the commissioners of maternity care, CCGs also have a statutory role to improve quality, safety and outcomes for their patients.3 The quality model supports trusts and CCGs to discharge their duties, while providing a safety net for any emerging concerns, trends or issues that are not quickly identified and addressed.

As part of the guidance, the development of a locally agreed dashboard was mandated to include, as a minimum, the measures set out within the screenshot below. This enables the drawing out of locally collected intelligence to monitor maternity and neonatal safety at board meetings. This dashboard should form part of the discussion held at Board Level with respect to maternity and neonatal safety issues, as set out within the national guidance.

Select Trust:

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:

Maternity Safety Support Programme	Select Y / N:	If No, enter name of MIA

	2021											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data monitoring tool												
Findings of review all cases eligible for referral to HSIB.												
Report on: •The number of incidents logged graded as moderate or above and what actions are being taken •Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training •Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite , gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.												
Service User Voice feedback												
Staff feedback from frontline champions and walk-abouts												
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust												
Coroner Reg 28 made directly to Trust												
Progress in achievement of CNST 10												

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annuallly)	
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	

1. Define the issue

Maternity Incentive Scheme Year 4 2021.

The requirement for Trust Boards to implement this locally agreed dashboard, is a required standard for the Maternity Incentive Scheme (MIS) (October 2021). The dashboard should be presented to the Trust Board by the Board Level safety Champions, monthly. Evidential requirements as laid out within the MIS guidance require that discussions surrounding safety intelligence are taking place at Board level.

Actions Taken.

The Family Health Division and Information Team have developed a robust and comprehensive perinatal quality surveillance dashboard, which will be presented for assurance at Quality Committee monthly as set out in the national requirements.

This dashboard will then be presented to frontline, clinical staff in a variety of methods, utilising social media platforms, safety huddles, governance, dashboard and ward and department meetings. This initiative will be led by the Quality & Safety Matron, supported by Maternity and Neonatal safety champions.

The Family Health Division review the KPIs within the below Power BI report on a monthly basis at the FHDB Meeting.

Maternity Clinical Dashboard New - Power BI

Maternity Division Board Report

Perinatal Quality Surveillance Highlight Report

March 2023 (January & February Data).

Contents	

Introduction

In December 2020, following the publication of the Ockenden Report, Trusts were mandated to plan and implement a new quality surveillance model. implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk)

This model proactively seeks to identify trusts that require support before serious issues arise. Implementation of a new quality surveillance model seeks to provide for consistent and methodical oversight of all services, specifically including maternity services. The model has also been developed to gather ongoing learning and insight, to inform improvements in the delivery of perinatal services. Provider Trusts and their Boards, supported by the senior maternity and neonatal triumvirate and the board-level perinatal safety champion at its centre, ultimately remain responsible for the quality of the services provided and for ongoing improvement to these. As the commissioners of maternity care, ICBs also have a statutory role to improve quality, safety and outcomes for their patients. The quality model supports trusts and ICBs to discharge their duties, while providing a safety net for any emerging concerns, trends or issues that are not quickly identified and addressed.

Purpose of the Report

As part of the guidance, the development of a locally agreed dashboard was mandated to include, as a minimum. This dashboard enables the drawing out of locally collected intelligence to monitor maternity and neonatal safety at board meetings. This dashboard should form part of the discussion held at Board Level with respect to maternity and neonatal safety issues, as set out within the national guidance. This report will also provide an overview of key quality & safety workstreams and performance and will cover the current position on clinical outcomes for women and babies against the national safety agenda. This report

will firstly be sighted within the Family Health Division within further scrutiny at the Quality Committee, with further discussion at every Trust Board with the Executive and Non-executive Safety Champions.

Executive Summary

Successes

- Ongoing successful recruitment of newly qualified midwives
- Established preceptorship programme & development of a posteptorship programme to support continued development of Band 6 MW
- Investment and Recruitment of ACP's and Physician Associate roles
- Investment in Governance team restructure with successful recruitment
- Staff engagement and participation in ongoing improvement initiatives – *"Clinically Led, Operationally supported"*
- Newly appointed SLT leadership team - shared purpose/leadership to coherently respond to the emerging maternity unit challenges
- Appointment to Director Of Midwifery role – 1st in C&M

Key Messages

- Increased use of technology to manage performance / Realtime reporting of sit reps and breaches
- Increased staffing for MAU 24/7 and ongoing recruitment
- Recruitment to senior roles within Family Health Division including; Lead governance managers and Transformation Programme Manager, Various Specialist Midwives roles including Diabetes, Consultant Midwife and FMU Lead Midwife
- Ongoing SLT review of Maternity Base staffing and innovation in use of roles to support (RN/Ward based Pharmacy Techs)
- Review of workstreams included within the Transformation Programme
- Scoping of how to reconfigure Estate and clinical processes to support improved flow
- Ockenden - implementation of MIAA recommendations, structured approach adopted for National Maternity Self Assessment evidence gathering and scrutiny
- Co-production of patient information with MVP and our patients as our partners to promote engagement/inclusion community wide/diverse views
- Ongoing Human Factors training

Emerging Issues

- CQC – Section 29A notice and LWH response
- Limited capacity of MVP to support improvement work
- **Continuity of Care-** Revised model of care being considered to address some of the ongoing workforce challenges, whilst maintaining safe, patient focused services. This will be done in collaboration with COC service leads and MVP and Trust Safety Champions

Liverpool Women's NHS Foundation Trust

Maternity Clinical Dashboard.

Section 2: Integrated Performance Metrics

Excellent - Celebrate & Learn

KPI	Target	P	A	V
Antenatal Infectious Disease Screening - HIV, Hep B, Syphilis Coverage	>=95%	100.00 %		
Antenatal Sickle Cell and Thalassaemia Screening - Coverage	>=95%	99.65%		
Never Events - Maternity	0	0		
New Hospital Acquired Pressure Ulcers Cat 2 - Maternity	<=	0		
Pregnant women with a BMI >= 35 at booking offered advice	>= 90%	94.94%		
Rostered Cons on DS (Hrs per Wk)	>60	166.5		
Smoking - Interventions to maternity patients at 12 weeks	>= 95%	100.00 %		
Smoking - Offer of referral to Smoking Cessation Services	>= 95%	100.00 %		
Venous Thromboembolism (VTE) - Maternity	>= 95%	96.88%		

Good - Celebrate & Understand

KPI	Target	P	A	V
3rd and 4th Degree Tears	3.5% NMPA baseline (3.2-4.1 95%confidence interval)	2.90%		
3rd and 4th Degree Tears - Instrumental Births	<=7.8%	7.58%		
3rd and 4th Degree Tears - Vaginal Births	<=3.6%	1.29%		
Antenatal Sickle Cell and Thalassaemia Screening - FOQ Completion (ST3)	>=95%	96.10%		
Brachial Plexus Injury (Erbs Palsy)	TBA	0.00%		
Breastfeeding Initiation	>= 55%	63.03%		
Complaints: Number of Action plans received - Maternity	100%	100.00 %		
Complaints: Number Received - Maternity	<= 15	2		
Coroner Reg 28 Made to Trust		0		
Data Quality Maturity Index – APC	>= 99	99.0		
Data Quality Maturity Index – MSDS	>= 99	99.0		
Data Quality Maturity Index – OP	>= 99	99.6		
Discharge Summaries to be sent from Ward Areas to General Practice within 24 hours. - Maternity	>= 95%	98.65%		

Good - Celebrate & Understand

KPI	Target	P	A	V
Fetal Anomaly Scan - Undertaken between 18 and 20 Weeks	>= 95%	99.14%		
HSIB Actions Returned		2		
Induction Attendance Rate (Corporate) - Maternity	> = 90%	95.74%		
Infection Control: Clostridium Difficile	0	0		
Maternity Services: Percentage of Black, Asian or Mixed women at 28 weeks on a CoC pathway	>=	58.16%		
Maternity Services: Percentage of women at 28 weeks on a CoC pathway	>=	22.79%		
Maternity Services: Percentage of women in bottom decile of deprivation at 28 weeks on a CoC pathway	>=	25.32%		
MRI / CT Filed Reports - Maternity		50.00%		
New Hospital Acquired Pressure Ulcers Cat 3 - Maternity	<=	0		
New Hospital Acquired Pressure Ulcers Cat 4 - Maternity	<=	0		
Newborn Hearing Screening: Timely Assessment (NH2) - Reporting 1 Qtr Behind	> = 90%	92.86%		
NHSE / NHSI Safety Alerts Outstanding	0	0		
Outpatient Activity delievered Remotely - Maternity		12.84%		
Outpatients: DNA Rates: Follow-up - Maternity	<= 16%	11.85%		
Patients with PPH >1500ml who had a blood transfusion		5.56%		
Peer Support - Pregnant women informed of service	>= 95%	100.00 %		
Pressure Ulcers: Demonstrate a reduction (Hospital Aquired)	0	0		
Professional Registration Lapses - Maternity	0	0		
Provision of Epidural in Labour		18.20%		
Sepsis: Deaths	0	0		
Serious Untoward Incidents: Open - Maternity	<5	3		
Super Numerary DS Shift Leader	100%	100.00 %		
Total number of women attended by anaesthetist after request for an epidural within 60 minutes	>=90%	94.57%		
Women whom have seen a midwife by 12 weeks (+ 6 days)	>= 92%	94.94%		
Women whom have seen a midwife by 9 weeks (+ 6 days)		56.17%		

Average - Investigate & Understand

KPI	Target	P	A	V
Antenatal Sickle Cell and Thalassaemia Screening - Tiredness (ST2)	>=58%	45.46%		
Data Warehouse Availability - % of days the data warehouse has updated overnight	>= 96%	90.00%		
Fetal Anomaly Scan - Number rescanned by 23 Weeks	>= 98%	95.05%		
Friends & Family Test: Maternity % positive - Q1 Antenatal	95%	100.00 %		
Hepatitis B Coverage (ID3) (Reporting 1 Qtr Behind)	>= 90%	99.27%		
Hypoxic Encephalopathy (Grade 2,3)	TBA	1		
Induction Attendance Rate (Local) - Maternity	> = 90%	83.21%		
Magnesium Sulphate	>= 95%	100.00 %		
MAU - Face to face Maternity Triage within 30 Mins	>= 95%	97.68%		
Midwifery Sickness WTE		59.7		
Midwifery Vacancy WTE		9.74		
Number of Adjusted stillbirths per 1,000 total births		5.77		
Number of stillbirths > 37 weeks per 1,000 total births		3.85		
Outpatients: DNA Rates: New - Maternity	< 8%	7.72%		
Outpatients: First Appointment Cancelled by Hospital - Maternity	<= 10%	9.36%		
Outpatients: Subsequent Appointment Cancelled by Hospital - Maternity	<= 10%	14.68%		
Peer Support - Breastfeeding women contacted by team during stay	>= 90%	91.26%		
Postpartum hysterectomy	TBA	0		
Reduction in number of incidences of Cord pH < 7	<= (4.3 / a births)*1000	0.46%		
Returns To Theatre (exc EVACS) - Maternity	<= 0.7%	0.00%		
Serious Untoward Incidents: Number of SUI's with actions outstanding - Maternity	0	0		
Skin to Skin Contact of 1 hour minimum	>= 80%	83.42%		
Total number of women attended by anaesthetist after request for an epidural within 30 minutes	>=60%	84.78%		

Concerning - Investigate

KPI	Target	P	A	V
Blood Transfusions		1.36%		
Caesarean Section - Delayed	0	40.91%		
Caesarean Section - Elective Rate		16.73%		
Caesarean Section Category 2 - Delayed	0	53.52%		
Complaints: Response Rates - Maternity	100%	0.00%		
Data Quality Maturity Index – Overall Score	>= 99	93.3		
Emergency Caesarean Section Births Undertaken Post Failed Instrumental Delivery		0.77%		
Flu Vaccinations offered to Pregnant Women	>= 90%	73.73%		
Forceps Births	<=	7.50%		
Friends & Family Test: Maternity % positive	95%	80.00%		
Friends & Family Test: Maternity % positive - Q2 Birth	95%	77.78%		
Friends & Family Test: Maternity % positive - Q3 Postnatal Ward	95%	80.00%		
Friends & Family Test: Maternity % positive - Q4 Postnatal Community	95%	75.00%		
Haemorrhages > 1,500 ml	2.7% (2.1-3.5)	3.52%		
Inborn term babies admitted to NICU	<= 5%	4.93%		
Instrumental Births	<=	12.69%		
Intensive Care Transfers Out (Rolling 12 Months) - Maternity		1		
LBB: Percentage women receiving personalised care plan	>= 100%	97.26%		
Local Mandatory Training Compliance - Maternity	>= 95%	66.06%		
LocalSIPs Complete in Theatre - Maternity	>= 100%	88.75%		
Mandatory Training Compliance - Maternity	>= 95%	83.91%		
Midwifery Sickness Percentage		8.91%		
Midwifery Vacancy Percentage		17.06%		
Newborn & Infant Physical Examination: Coverage (NP1)	>=95%	94.81%		
Newborn Blood Sampling - Avoidable repeat tests	<=2%	4.26%		
Newborn Hearing Screening: Coverage (NH1) - Reporting 1 Qtr Behind	>= 98%	96.03%		
Number of PALS/PALS+		46		
Number of stillbirths per 1,000 total births		7.69		

Concerning - Investigate

KPI	Target	P	A	V
Number of Maternity Incidents over 30 Days		29		
Referral time to fetal medicine centre	>= 95%	92.31%		
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales - Maternity	100%	0.00%		
Sickness - Maternity	<= 4.5%	8.91%		
Turnover - Maternity	<= 13%	95.36%		
Ventouse Births	<=	5.19%		
Women whom received 1 to 1 Care when in established labour (>= 4cm dilation)	>= 100%	99.82%		

Very Concerning - Investigate & Take Action

KPI	Target	P	A	V
Caesarean Section - Emergency Rate		23.85%		
Caesarean Section - Total Section Rate		39.33%		
Clinical Mandatory Training Compliance - Maternity	>= 95%	66.56%		
PCR Rate - Maternity	>= 90%	49.88%		

Investigate & Understand

KPI	Target	P	A	V

Section 3: Medical KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023
3rd and 4th Degree Tears																		
Performance	3.33%	4.09%	3.17% ↑	3.54% ↑	2.43%	2.61%	2.92%	2.43%	1.55%	1.20%	2.16%	2.09%	1.02% ↓	2.70%	2.85%	1.10%	2.54%	2.90%
Numerator	14	17	13	13	10	9	11	9	6	4	8	8	4	10	10	4	9	9
Denominator	420	416	410	367	412	345	377	371	388	332	370	383	392	370	351	362	355	310
3rd and 4th Degree Tears - Instrumental Births																		
Performance	6.10%	6.06%	5.56%	5.49%	7.14% ↑	8.57% ↑	7.69% ↑	6.17% ↑	3.95%	1.41%	3.53%	1.23%	2.78%	4.44% ↓	6.25%	3.66%	3.23%	7.58%
Numerator	5	6	4	5	6	6	6	5	3	1	3	1	2	4	4	3	2	5
Denominator	82	99	72	91	84	70	78	81	76	71	85	81	72	90	64	82	62	66
3rd and 4th Degree Tears - Vaginal Births																		
Performance	2.14%	2.64%	2.20% ↑	2.18% ↑	0.97%	0.87%	1.33%	1.08%	0.77%	0.90% ↓	1.35% ↓	1.83%	0.51%	1.62%	1.71%	0.28%	1.97%	1.29%
Numerator	9	11	9	8	4	3	5	4	3	3	5	7	2	6	6	1	7	4
Denominator	420	416	410	367	412	345	377	371	388	332	370	383	392	370	351	362	355	310
Brachial Plexus Injury (Erbs Palsy)																		
Performance	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Numerator	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Denominator	677	652	660	620	653	555	588	597	648	607	633	660	658	648	593	614	625	516
Caesarean Section - Delayed																		
Performance	40.00%	20.00%	37.50%	14.29%	17.65%	24.00%	27.27%	28.57%	25.81%	31.71%	34.48% ↑	24.14% ↑	10.53%	23.53%	4.76%	18.18%	22.58%	40.91%
Numerator	8	2	6	3	3	6	6	6	8	13	10	7	2	8	1	4	7	9
Denominator	20	10	16	21	17	25	22	21	31	41	29	29	19	34	21	22	31	22
Caesarean Section - Elective Rate																		
Performance	16.64% ↓	17.38%	18.77%	17.17%	14.29%	17.71%	16.19%	16.83%	15.03%	17.87%	17.19%	18.40%	16.94%	16.77%	18.43%	17.10%	19.30%	16.73%
Numerator	113	114	125	107	94	99	96	101	98	109	110	122	112	109	110	106	121	87
Denominator	679	656	666	623	658	559	593	600	652	610	640	663	661	650	597	620	627	520
Caesarean Section - Emergency Rate																		
Performance	21.94%	19.21%	19.52%	23.27%	22.49%	20.75%	20.24%	20.83%	25.15%	28.03%	24.84%	23.68%	23.15%	26.00% ↑	22.61% ↑	24.35% ↑	24.40% ↑	23.85% ↑
Numerator	149	126	130	145	148	116	120	125	164	171	159	157	153	169	135	151	153	124
Denominator	679	656	666	623	658	559	593	600	652	610	640	663	661	650	597	620	627	520
Caesarean Section - Total Section Rate																		
Performance	37.70% ↓	35.83% ↓	37.84% ↓	39.64%	35.93%	37.39%	36.16%	36.84%	39.38%	44.98%	41.47%	41.47%	39.38%	41.92% ↑	40.27% ↑	40.20% ↑	42.67% ↑	39.33% ↑
Numerator	256	234	249	241	231	206	213	217	252	273	260	270	254	267	236	244	262	201
Denominator	679	653	658	608	643	551	589	589	640	607	627	651	645	637	586	607	614	511
Caesarean Section Category 2 - Delayed																		
Performance	60.67%	50.00%	55.42%	55.81%	54.26%	56.67%	47.14%	58.02%	63.33%	59.78%	52.94%	46.32%	53.61%	57.30%	51.47%	56.99%	57.50%	53.52%
Numerator	54	41	46	48	51	34	33	47	57	55	45	44	52	51	35	53	46	38
Denominator	89	82	83	86	94	60	70	81	90	92	85	95	97	89	68	93	80	71

NHS
Liverpool Women's

Medical KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023
Coroner Reg 28 Made to Trust																		
Performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Numerator																		
Denominator																		
Emergency Caesarean Section Births Undertaken Post Failed Instrumental Delivery																		
Performance	0.88%	1.07% ↓	0.90% ↓	0.96% ↓	1.37% ↓	0.89% ↓	1.85%	1.33%	0.46%	0.66%	0.94%	1.36%	0.76% ↓	0.92% ↓	0.34% ↓	0.97% ↓	0.48% ↓	0.77% ↓
Numerator	6	7	6	6	9	5	11	8	3	4	6	9	5	6	2	6	3	4
Denominator	679	656	666	623	658	559	593	600	652	610	640	663	661	650	597	620	627	520
Forceps Births																		
Performance	7.51%	8.69%	6.61%	7.54%	8.36%	8.59%	6.24%	7.50%	6.90%	5.74%	9.38%	6.49%	7.26%	7.38%	5.86%	7.42%	6.06% ↓	7.50% ↓
Numerator	51	57	44	47	55	48	37	45	45	35	60	43	48	48	35	46	38	39
Denominator	679	656	666	623	658	559	593	600	652	610	640	663	661	650	597	620	627	520
Haemorrhages > 1,500 ml																		
Performance	4.14%	3.37%	4.26%	2.96%	4.20%	4.54%	3.74%	4.58%	3.59%	3.62%	4.47%	5.07%	2.95%	2.67%	3.24%	2.97%	3.91%	3.52%
Numerator	28	22	28	18	27	25	22	27	23	22	28	33	19	17	19	18	24	18
Denominator	676	653	658	608	643	551	589	589	640	607	627	651	645	637	586	607	614	511
HSIB Actions Returned																		
Performance	1	1	1	0	1	0	0	1	1	0	1	0	3 ↑	0	0	0	0	2
Numerator																		
Denominator																		
Hypoxic Encephalopathy (Grade 2,3)																		
Performance	4	3	0	2	1	1	1	1	1	2	0	1	1	0	0	1 ↓	4	1
Numerator																		
Denominator																		
Inborn term babies admitted to NICU																		
Performance	5.56%	5.02%	7.53%	5.28%	5.40%	4.54%	5.51%	3.87%	7.47%	4.84%	5.66%	6.27%	4.25%	5.76%	4.77%	4.43%	4.47%	4.93%
Numerator	35	30	46	29	32	23	30	21	44	26	32	38	25	34	25	25	25	23
Denominator	629	598	611	549	593	507	544	543	589	537	565	606	588	590	524	564	559	467
Instrumental Births																		
Performance	12.08%	15.09%	10.81%	14.61%	12.77%	12.52%	13.15%	13.67%	11.66%	11.64%	13.44%	12.22%	11.78%	13.85%	10.72%	13.23%	9.89%	12.69%
Numerator	82	99	72	91	84	70	78	82	76	71	86	81	72	90	64	82	62	66
Denominator	679	656	666	623	658	559	593	600	652	610	640	663	611	650	597	620	627	520
Magnesium Sulphate																		
Performance	83.33%	100.00%	85.71%	100.00%	66.67%	100.00%	100.00%	66.67%	100.00%	100.00%	90.91%	90.00%	100.00%	85.71%	75.00%	66.67%	66.67%	100.00%
Numerator	5	10	6	5	2	5	7	10	9	4	10	9	10	6	6	6	2	7
Denominator	6	10	7	5	3	5	7	15	9	4	11	10	10	7	8	9	3	7
MRI / CT Filed Reports - Maternity																		
Performance	0.00%	0.00%	0.00%	100.00%	0.00%		50.00%			80.00%				50.00%	0.00%	50.00%		
Numerator	0	0	0	2	0		1			4				1	0	1		
Denominator	4	1	1	2	1		2			5				2	1	2		

Medical KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023
Number of Adjusted stillbirths per 1,000 total births																		
Performance	1.47	4.57	7.61	3.21	6.07	0	6.75	1.7	6.13	3.28	6.25	4.74	0	1.54	3.35	8.06	1.59	5.77
Numerator																		
Denominator																		
Number of stillbirths > 37 weeks per 1,000 total births																		
Performance	0	1.52	1.5	0	0	0	0	1.67	0	1.64	0	0	0	0	0	4.84 ↑	0	3.85
Numerator																		
Denominator																		
Number of stillbirths per 1,000 total births																		
Performance	2.95	6.1	9.01	4.82	9.1	7.16	10.12	5	6.13	4.92	10.94	4.52	4.54	3.08	6.7	9.68	3.19	7.69
Numerator																		
Denominator																		
Outpatient Activity delievered Remotely - Maternity																		
Performance	14.34%	13.20%	14.52%	12.73%	15.45%	12.73%	14.22%	13.91%	13.46%	11.93%	11.02%	13.18%	13.52%	12.83%	14.46%	13.84%	14.62%	12.84%
Numerator	520	438	533	420	537	407	546	479	542	432	390	525	522	503	591	471	580	463
Denominator	3,627	3,318	3,670	3,300	3,476	3,198	3,840	3,443	4,026	3,622	3,539	3,982	3,861	3,922	4,086	3,403	3,967	3,607
Patients with PPH >1500ml who had a blood transfusion																		
Performance	28.57%	27.27%		11.11%	3.70%	23.33%	17.39%	3.70%	8.70%	9.52%	25.93%	10.00%	30.00%	12.50%	5.26%	11.76%	37.50%	5.56%
Numerator	8	6		2	1	7	4	1	2	2	7	3	6	2	1	2	9	1
Denominator	28	22		18	27	30	23	27	23	21	27	30	20	16	19	17	24	18
Postpartum hysterectomy																		
Performance	1	1	0	2 ↑	0	0	0	1	0	1	0	0	1	0	0	0	0	0
Numerator																		
Denominator																		
Reduction in number of incidences of Cord pH < 7																		
Performance	0.29%	0.63%	0.93%	1.34%	0.79%	0.93%	0.52%	1.03%	0.32%	1.01%	0.65%	0.31%	0.47%	0.79%	0.69%	1.00%	0.62%	0.40%
Numerator	2	4	6	8	5	5	3	6	2	6	4	2	3	5	4	6	5	2
Denominator	679	639	647	599	632	538	581	580	631	592	612	643	638	630	576	600	608	503
Returns To Theatre (exc EVACS) - Maternity																		
Performance	0.33%	0.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00% ↓	0.00% ↓	0.31%	0.00%	0.31%	0.00%	0.00%	0.71%	0.68%	0.00%	0.00%
Numerator	1	2	0	0	0	0	0	0	0	1	0	1	0	0	2	2	0	0
Denominator	304	302	302	300	287	269	280	263	317	319	320	319	311	340	283	294	307	242
Ventouse Births																		
Performance	4.27%	5.79%	3.90%	5.94%	3.95%	3.94%	6.41%	5.50%	4.46%	5.74%	3.75%	5.43%	3.03%	4.77%	4.02%	5.65%	3.67%	5.19%
Numerator	29	38	26	37	26	22	38	33	29	35	24	36	20	31	24	35	23	27
Denominator	679	656	666	623	658	559	593	600	652	610	640	663	661	650	597	620	627	520

Section 4: Patient Experience KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023
Complaints: Number of Action plans received - Maternity																		
Performance	100.00%	100.00%	100.00%		100.00%	100.00%	100.00%	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Numerator	2	4	1		2	1	3	1		3	3	1	3	5	4	2	1	1
Denominator	2	4	1		2	1	3	1		3	3	1	3	5	4	2	1	1
Complaints: Number Received - Maternity																		
Performance	2	4	3	2	0	1	1	3	2	5	4	5	3	1	2	2	2	2
Numerator																		
Denominator																		
Complaints: Response Rates - Maternity																		
Performance		20.00%	0.00%		50.00%	0.00%	33.33%	0.00%		33.33%	33.33%	0.00%	33.33%	33.33%	50.00%	50.00%	0.00%	0.00%
Numerator		1	0		1	0	1	0		1	1	0	1	2	2	1	0	0
Denominator		5	1		2	1	3	1		3	3	1	3	6	4	2	1	1
Friends & Family Test: Maternity % positive																		
Performance	76.28%	81.52%	81.20%	85.27%	80.14%	84.09%	79.28%	83.00%	89.47%	78.33%	83.76%	80.83%	83.87%	85.53%	85.98%	85.16%	75.95%	80.00%
Numerator	119	150	108	110	117	111	88	83	85	94	98	97	26	136	92	109	120	28
Denominator	156	184	133	129	146	132	111	100	95	120	117	120	31	159	107	128	158	35
Friends & Family Test: Maternity % positive - Q1 Antenatal																		
Performance	84.00%	80.95%	88.24%	86.67%	94.12%	92.31%	100.00%	90.91%	100.00%	100.00%	93.75%	90.91%	100.00%	84.21%	88.89%	90.00%	100.00%	100.00%
Numerator	42	17	15	13	16	12	11	10	11	17	15	10	2	16	8	9	8	3
Denominator	50	21	17	15	17	13	11	11	11	17	16	11	2	19	9	10	8	3
Friends & Family Test: Maternity % positive - Q2 Birth																		
Performance	73.85%	80.33%	88.89%	83.72%	79.63%	87.04%	80.00%	93.55%	89.47%	71.43%	85.71%	79.59%	90.00%	86.67%	87.80%	86.84%	88.71%	77.78%
Numerator	48	49	40	36	43	47	28	29	34	25	42	39	9	52	36	33	55	7
Denominator	65	61	45	43	54	54	35	31	38	35	49	49	10	60	41	38	62	9
Friends & Family Test: Maternity % positive - Q3 Postnantal Ward																		
Performance	70.73%	74.14%	74.47%	88.24%	72.50%	81.40%	74.36%	83.87%	88.46%	79.49%	78.95%	75.00%	88.89%	84.31%	80.49%	81.13%	85.45%	80.00%
Numerator	29	43	35	45	29	35	29	26	23	31	30	27	8	43	33	43	47	12
Denominator	41	58	47	51	40	43	39	31	26	39	38	36	9	51	41	53	55	15
Friends & Family Test: Maternity % positive - Q4 Postnatal Community																		
Performance		93.18%	75.00%	80.00%	82.86%	77.27%	76.92%	78.26%	85.00%	72.41%	78.57%	87.50%	70.00%	86.21%	93.75%	88.89%	30.30%	75.00%
Numerator		41	18	16	29	17	20	18	17	21	11	21	7	25	15	24	10	6
Denominator		44	24	20	35	22	26	23	20	29	14	24	10	29	16	27	33	8
Number of PALS/PALS+																		
Performance	46	52	44	32	44	42	31	27	26	40		45	44	36	48	21	46	
Numerator																		
Denominator																		

Section 5: Midwifery KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023
Antenatal Infectious Disease Screening - HIV, Hep B, Syphilis Coverage																		
Performance	98.63%	99.72%	100.00%	100.00%	100.00%	99.86%	99.63%	100.00%	100.00%	100.00%	100.00%	99.86%	99.72% ↑	100.00% ↑	100.00% ↑	100.00% ↑		
Numerator	719	716	723	604	698	719	806	585	714	691	658	727	717	640	707	575		
Denominator	729	718	723	604	698	720	809	585	714	691	658	728	719	640	707	575		
Antenatal Sickle Cell and Thalassaemia Screening - Coverage																		
Performance	98.21%	99.86%	99.86%	99.03%	100.00%	100.00%	99.75%	100.00%	99.86%	99.71% ↑	100.00% ↑	99.59% ↑	99.58% ↑	99.84% ↑	99.86% ↑	99.65% ↑		
Numerator	714	719	725	614	699	724	808	583	715	689	656	721	713	635	712	572		
Denominator	727	720	726	620	699	724	810	583	716	691	656	724	716	636	713	574		
Antenatal Sickle Cell and Thalassaemia Screening - FOQ Completion (ST3)																		
Performance	92.71%	92.82%	82.50%	90.63%	93.43%	94.53%	93.10%	89.48%	74.70%	99.71%	96.47%	92.69%	94.86%	96.13%	94.59% ↑	97.84% ↑	96.10% ↑	
Numerator	649	685	627	600	654	709	756	553	552	686	656	659	701	721	559	589	690	
Denominator	700	738	760	662	700	750	812	618	739	688	680	711	739	750	591	602	718	
Antenatal Sickle Cell and Thalassaemia Screening - Timliness (ST2)																		
Performance	36.43% ↓	39.30% ↓	45.92% ↓	48.04%	44.00%	40.53%	52.34%	42.39%	50.20%	53.20%	55.29%	52.04%	59.27%	56.86% ↑	55.16% ↑	62.13% ↑	45.40%	
Numerator	255	290	349	318	308	304	425	262	371	366	376	370	438	427	326	374	326	
Denominator	700	738	760	662	700	750	812	618	739	688	680	711	739	751	591	602	718	
Breastfeeding Initiation																		
Performance	63.10%	64.34%	63.03%	60.79%	58.64%	61.90%	62.92%	64.12%	63.95%	61.70%	62.73%	61.27%	62.60%	62.22%	61.76%	62.97%	59.80%	63.03%
Numerator	407	406	399	355	363	325	358	370	392	356	377	386	390	387	344	369	360	312
Denominator	645	631	633	584	619	525	569	577	613	577	601	630	623	622	557	586	602	495
Flu Vaccinations offered to Pregnant Women																		
Performance		82.46%	81.23%	80.93%	78.80%	73.17%	40.14%	22.42% ↓	29.86% ↓	36.59% ↓	38.17% ↓	41.19% ↓	68.19%	80.36% ↑	81.34% ↑	77.43%	79.72%	73.73% ↑
Numerator		611	610	522	580	551	336	141	221	266	263	318	506	532	593	446	617	508
Denominator		741	751	645	736	753	837	629	740	727	689	772	742	662	729	576	774	689
Hepatitis B Coverage (ID3) (Reporting 1 Qtr Behind)																		
Performance	98.44%			99.27%														
Numerator	1,961			2,036														
Denominator	1,992			2,051														
LMS:Percentage women receiving personalised care plan																		
Performance	96.19%	96.80%	96.81%	96.17%	96.64%	94.78%	92.57%	93.56%	95.48%	96.35%	94.30%	95.65%	96.93%	95.96%	96.07%	96.03%	96.74%	97.20% ↑
Numerator	757	726	745	627	718	726	785	596	719	712	662	747	725	642	709	557	742	659
Denominator	787	750	754	652	743	766	848	637	753	739	702	781	748	669	738	580	767	678

Midwifery KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023
Maternity Services: Percentage of Black, Asian or Mixed women at 29 weeks on a CoC pathway																		
Performance	47.96%	39.60%	41.58%	37.89%	37.23%	59.46%	37.72%	41.90%	51.85%	48.11%	36.00%	41.94%	40.86%	39.81%	43.75%	42.86%	47.93%	56.16%
Numerator	47	40	42	36	35	44	43	44	56	51	36	39	38	41	42	42	58	41
Denominator	98	101	101	95	94	74	114	105	108	106	100	93	93	103	96	98	121	73
Maternity Services: Percentage of women at 29 weeks on a CoC pathway																		
Performance	19.91%	17.85%	20.52%	20.52%	18.72%	25.22%	16.85%	18.51%	21.68%	20.21%	16.01%	18.77%	18.92%	19.36%	16.94%	19.46%	20.07%	22.79%
Numerator	126	113	134	126	114	143	107	114	142	134	106	119	109	121	103	114	122	129
Denominator	633	633	653	614	609	567	635	616	655	663	662	634	576	625	608	586	608	566
Maternity Services: Percentage of women in bottom decile of deprivation at 29 weeks on a CoC pathway																		
Performance	26.40%	22.26%	24.78%	23.62%	21.68%	28.90%	23.33%	22.07%	25.87%	26.57%	19.10%	21.81%	24.13%	20.00%	19.74%	23.89%	20.58%	25.32%
Numerator	80	69	84	77	67	89	70	66	89	93	64	70	69	67	60	75	64	78
Denominator	303	310	339	326	309	308	300	299	344	350	335	321	286	335	304	314	311	308
MAU - Face to face Maternity Triage within 30 Mins																		
Performance	63.86%	69.60%	85.90%	68.82%	76.10%	79.80%	68.74%	65.27%	63.78%	69.49%	61.17%	53.82% ↓	55.59% ↓	60.38% ↓	63.01% ↓	56.94% ↓	59.52% ↓	97.68%
Numerator	744	1,115	1,097	949	780	964	1,082	902	937	846	819	781	776	820	799	771	825	1,262
Denominator	1,165	1,602	1,277	1,379	1,025	1,208	1,574	1,382	1,469	1,422	1,339	1,451	1,396	1,358	1,268	1,354	1,386	1,292
Newborn & Infant Physical Examination: Coverage (NP1)																		
Performance	92.68%	94.30%	94.38%	92.41%	95.09%	93.67%	95.79%	95.42%	92.11%	92.51%	92.94%	93.82%	94.83%	93.21%	94.85%	94.63%	94.81%	
Numerator	636	612	621	572	620	524	569	562	595	568	592	622	624	604	553	582	603	
Denominator	687	649	658	619	652	560	594	589	646	614	637	663	658	648	583	615	636	
Newborn Blood Sampling - Avoidable repeat tests																		
Performance	3.57%	3.10%	3.98%	3.19%	3.00%	4.64%	3.28%	5.05%	2.62%	3.07%	3.05%	3.44%	2.81%	2.25% ↓	2.06% ↓	4.55%	4.28%	
Numerator	28	22	28	22	21	28	20	34	17	20	22	24	20	15	13	29	28	
Denominator	784	710	703	689	700	604	609	673	648	651	721	698	711	667	632	637	654	
Newborn Hearing Screening: Coverage (NH1) - Reporting 1 Qtr Behind																		
Performance	97.31%			96.40%			94.58%			96.03%								
Numerator	1,699			1,822			1,571			1,768								
Denominator	1,746			1,890			1,661			1,841								
Newborn Hearing Screening: Timely Assessment (NH2) - Reporting 1 Qtr Behind																		
Performance	91.03%			90.91%			90.57%			92.86%								
Numerator	71			80			48			78								
Denominator	78			88			53			84								

Midwifery KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023
Peer Support - Breastfeeding women contacted by team during stay																		
Performance	90.20%	91.06%	90.00%	83.70%	93.62%	94.53%	92.58%	92.95%	95.41%	92.38% ↑	93.57% ↑	94.17% ↑	90.24%	91.63%	88.37%	84.98%	91.26%	
Numerator	221	214	216	190	220	190	212	211	208	206	233	226	222	219	190	198	188	
Denominator	245	235	240	227	235	201	229	227	218	223	249	240	246	239	215	233	206	
Peer Support - Pregnant women informed of service																		
Performance	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Numerator	422	396	400	388	414	374	374	368	385	377	407	414	389	391	359	363	367	
Denominator	422	396	400	388	414	374	374	368	385	377	407	414	389	391	359	363	367	
Pregnant women with a BMI >= 35 at booking offered advice																		
Performance	93.24%	98.65%	93.24%	92.42%	93.51%	87.95%	93.18%	96.61%	93.15%	98.86%	96.39%	93.83%	98.68%	94.87%	98.61%	100.00%	95.00%	94.94% ↑
Numerator	69	73	69	61	72	73	82	57	68	87	80	76	75	74	71	56	76	75
Denominator	74	74	74	66	77	83	88	59	73	88	83	81	76	78	72	56	80	79
Pressure Ulcers: Demonstrate a reduction (Hospital Aquired)																		
Performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Numerator																		
Denominator																		
Referral time to fetal medicine centre																		
Performance	72.22%	53.33%	58.06%	66.67%	86.36%	50.00%	54.55%	56.25%	86.96%	76.19%	52.38%	69.23%	94.12%	56.25%	66.67%	84.62%	75.00%	92.31%
Numerator	13	8	18	10	19	10	6	9	20	16	11	9	16	9	14	11	12	12
Denominator	18	15	31	15	22	20	11	16	23	21	21	13	17	16	21	13	16	13

Section 6: Workforce KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023
Clinical Mandatory Training Compliance - Maternity	75.12% ↑	73.08% ↑	71.61% ↑	70.42% ↑	56.41%	68.39%	68.09%	64.11%	62.91%	63.53% ↓	62.27% ↓	63.02% ↓	61.91% ↓	63.93% ↓	64.94% ↓	63.57% ↓	64.81% ↓	66.56% ↓
Induction Attendance Rate (Corporate) - Maternity	95.00%	95.00%	96.00%	95.00%	94.00%	93.00%	93.00%	92.00%	94.00% ↓	93.00% ↓	94.40% ↓	94.82% ↓	94.82% ↓	95.30%	94.92%	94.38%	95.89%	95.74%
Induction Attendance Rate (Local) - Maternity	99.00%	98.00%	98.00%	96.00% ↑	92.00%	96.00%	96.00%	94.00%	94.00%	92.00%	91.67%	92.64%	92.64%	93.09%	92.37%	90.73%	84.83%	83.21%
Local Mandatory Training Compliance - Maternity	67.00% ↓	59.00% ↓	58.00% ↓	56.00% ↓	56.41% ↓	55.38% ↓	58.60% ↓	57.16% ↓	54.56% ↓	59.70% ↓	64.22%	64.38%	65.53%	66.58%	71.35% ↑	71.45% ↑	66.88% ↑	66.08% ↑
Mandatory Training Compliance - Maternity	79.00%	71.00%	72.00%	70.37%	72.83%	73.75%	73.56% ↓	72.93% ↓	74.45% ↓	77.69%	76.82%	78.88%	78.04%	78.73%	80.05%	74.61%	81.26%	83.91%
Midwifery Sickness Percentage		13.31%	12.63%	15.26%	16.37% ↑	11.45% ↑	9.64%	9.69%	9.65%	9.68%	11.00%	10.53% ↓	9.58% ↓	9.92% ↓	10.60% ↓	12.41%	11.59%	8.91%
Midwifery Sickness WTE	50.7																	
Midwifery Vacancy Percentage		5.32%	8.72%	7.84%	2.46%	2.00%	4.10%	13.20%	13.20%	17.00%								
Midwifery Vacancy WTE	9.74																	
Professional Registration Lapses - Maternity	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rostered Cons on DS (Hrs per Wk)	91 ↓	91 ↓	91 ↓	91 ↓	91 ↓	91 ↓	91 ↓	106.5	106.5	106.5	106.5	106.5	106.5 ↑	106.5 ↑	106.5 ↑	106.5 ↑	106.5 ↑	106.5 ↑
Sickness - Maternity	14.11%	13.31%	12.63%	15.26% ↑	16.37% ↑	11.45% ↑	11.95% ↑	9.69%	9.65%	9.68%	11.25%	10.53%	9.58% ↓	9.92% ↓	10.60% ↓	12.41%	11.59%	8.91%
Super Numerary DS Shift Leader	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Turnover - Maternity	12.00% ↓	13.00% ↓	12.00% ↓	13.00% ↓	13.00% ↓	13.00% ↓	14.00% ↓	13.00% ↓	14.00% ↓	12.00% ↓	11.80% ↓	11.38% ↓	11.12% ↓	10.30% ↓	10.19% ↓	9.45% ↓	8.82% ↓	95.30% ↑

Midwifery KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023
Number of Maternity Incidents over 30 Days																		
Performance	161	376	97	119	121	120	234	221	273	204	256	498	348	308			14	26
Numerator																		
Denominator																		
Skin to Skin Contact of 1 hour minimum																		
Performance	83.56%	83.78%	79.09%	83.22%	82.40%	80.09%	96.56%	86.26%	78.47%	77.42%	76.21%	77.52%	80.88%	78.86%	79.01%	79.21%	77.34%	83.42%
Numerator	457	439	416	382	426	346	393	408	390	360	364	407	406	410	359	381	372	332
Denominator	547	524	526	459	517	432	407	473	497	465	484	525	502	520	443	481	481	398
Smoking - Interventions to maternity patients at 12 weeks																		
Performance	96.12%	94.06%	93.95%	98.73%	98.82%	98.73%	98.80%	97.44%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.33%	98.90%	100.00%
Numerator	99	95	94	78	84	78	82	76	110	86	82	91	99	67	90	59	90	67
Denominator	103	101	95	79	85	79	83	78	110	86	82	91	99	67	90	60	91	67
Smoking - Offer of referral to Smoking Cessation Services																		
Performance	96.12%	94.06%	97.89%	97.47%	98.82%	97.47%	98.80%	97.44%	99.09%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.33%	98.90%	100.00%
Numerator	99	95	93	77	84	77	82	76	109	86	82	91	99	67	90	59	90	67
Denominator	103	101	95	79	85	79	83	78	110	86	82	91	99	67	90	60	91	67
Venous Thromboembolism (VTE) - Maternity																		
Performance	93.09%	95.48%	96.70%	95.44%	95.58%	93.21%	95.51%	92.86%	97.69%	98.21%	97.58%	96.36%	98.14%	97.88%	98.62%	98.05%	98.85%	96.88%
Numerator	701	676	674	649	671	577	638	637	678	660	685	689	686	693	642	652	687	589
Denominator	753	708	697	680	702	619	668	686	694	672	702	715	699	708	651	665	695	608
Women whom have seen a midwife by 12 weeks (+ 6 days)																		
Performance	93.96%	95.10%	96.55%	96.20%	92.98%	91.13%	94.17%	93.37%	94.76%	94.68%	93.93%	95.28%	96.24%	97.73%	95.70%	96.79%	93.48%	94.94%
Numerator	607	602	616	532	583	596	694	493	597	588	557	626	614	560	601	483	618	563
Denominator	646	633	638	563	627	654	737	528	630	625	593	657	638	573	628	499	661	593
Women whom have seen a midwife by 9 weeks (+ 6 days)																		
Performance	53.68%	60.54%	61.47%	60.00%	52.65%	51.79%	59.26%	49.28%	54.59%	55.91%	59.71%	60.34%	62.94%	63.75%	60.08%	65.45%	46.77%	56.17%
Numerator	416	448	461	387	387	391	496	310	404	407	412	467	467	422	438	377	362	387
Denominator	775	740	750	645	735	755	837	629	740	728	690	774	742	662	729	576	774	689
Women whom received 1 to 1 Care when in established labour (>= 4cm dilation)																		
Performance	98.61%	99.61%	99.37%	98.14%	98.33%	98.98%	96.56%	98.97%	99.22%	99.14%	98.99%	98.31%	99.60%	98.41%	99.33%	99.30%	99.82%	
Numerator	498	505	475	422	529	387	393	480	509	344	490	640	503	494	445	570	561	
Denominator	505	507	478	430	538	391	407	485	513	347	495	651	505	502	448	574	562	

Section 7: Other KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023
Blood Transfusions																		
Performance	1.63%	1.39%	0.31%	0.66%	0.47%	1.81%	1.18%	0.85%	1.25%	1.15%	1.74%	1.08%	1.23%	0.47%	0.51%	1.32%	2.43%	1.38%
Numerator	11	9	2	4	3	10	7	5	8	7	11	7	8	3	3	8	15	7
Denominator	674	646	655	609	645	553	593	589	640	608	633	651	651	638	583	607	617	507
Data Quality Maturity Index – APC																		
Performance	99.9	100	100	99.9	100	100	99.9	99.9	99.9	100	99.9	99.9	99.9	100	99.9			
Numerator																		
Denominator																		
Data Quality Maturity Index – MSDS																		
Performance	99.9	99.9	99.9 ↑	99.8	99.8	99.8	99.8	99.8	99.8 ↓	99.8 ↓	99.8 ↓	99.9	99.9	99.8	99.9			
Numerator																		
Denominator																		
Data Quality Maturity Index – OP																		
Performance	99.5	99.5	99.5 ↓	99.5 ↓	99.5 ↓	99.5 ↓	99.5 ↓	99.5 ↓	99.5 ↓	99.5 ↓	99.5 ↓	99.5 ↓	99.6	99.6	99.6			
Numerator																		
Denominator																		
Data Quality Maturity Index – Overall Score																		
Performance	92.2	91.5	92.3	92.7	93.5	93.7	93.6	93.3 ↑	93.5 ↑	93.4 ↑	93.5 ↑	93.5 ↑	93.5 ↑	93.3 ↑				
Numerator																		
Denominator																		
Data Warehouse Availability - % of days the data warehouse has updated overnight																		
Performance	95.45%	95.24%	90.91%	90.48%	95.00%	90.00%	91.30%	100.00%	100.00%	90.00%	95.24%	90.91%	95.45%	100.00%	90.91%	95.00%	95.24%	90.00%
Numerator	21	20	20	19	19	18	21	19	21	18	20	20	21	21	20	19	20	18
Denominator	22	21	22	21	20	20	23	19	21	20	21	22	22	21	22	20	21	20
Discharge Summaries to be sent from Ward Areas to General Practice within 24 hours. - Maternity																		
Performance	93.42%	96.74%	96.15%	95.61%	95.93%	96.81%	97.88% ↑	80.51%	79.50% ↓	80.13% ↓	96.69% ↓	96.14%	98.17%	94.85%	97.98%	98.51% ↑	97.76% ↑	98.65% ↑
Numerator	639	652	624	588	590	546	599	475	508	492	614	623	642	608	583	595	610	511
Denominator	684	674	649	615	615	564	612	590	639	614	635	648	654	641	595	604	624	518
Fetal Anomaly Scan - Number rescanned by 23 Weeks																		
Performance	92.31%	98.18%	100.00%	100.00%	97.01%	100.00%	100.00%	98.53%	75.29% ↓	98.73%	100.00%	100.00%	98.89%	97.92%	100.00% ↑	98.81% ↑	94.32%	95.05%
Numerator	60	54	60	70	65	54	96	67	64	78	93	63	89	94	83	83	83	96
Denominator	65	55	60	70	67	54	96	68	85	79	93	63	90	96	83	84	88	101
Fetal Anomaly Scan - Undertaken between 18 and 20 Weeks																		
Performance	90.64%	99.46%	100.00%	99.61%	99.65%	100.00%	99.80% ↑	100.00% ↑	96.29%	99.29%	99.42%	100.00%	99.03%	99.41%	99.63%	99.59%	99.14%	
Numerator	484	551	513	513	566	481	497	526	545	556	518	440	511	502	541	489	578	
Denominator	534	554	513	515	568	481	498	526	566	560	521	440	516	505	543	491	583	

Dashboard Responses.

Very Concerning – Investigate & Take Action.		
Metric	**Position**	**Response from FHD Senior Leadership Team**
Clinical Mandatory Training Compliance	66.56% (Target ≥ 95%)	• Family Health Division has been in business continuity plan status (BCP) from December 22 to February 23 due to ongoing staffing challenges which has been a symptom of poor compliance. • Junior Doctors strike has been a contributory factor to poor compliance in March and will be on the 13th April 2023. • All training has now been reinstated and additional training days allocated for financial year 2023/24. • Staff who are out of date with clinical mandatory training are allocated to attend MPMET and Fetal Surveillance training as a priority, together with staff returning to work from periods of long-term absence and maternity leave. • Trajectory to achieve Trust compliance by Q3 FY 23/24.
Caesarean Section – Emergency Rate Caesarean Section – Total Section Rate	23.85 % (No target set) 39.33% (No target set)	• There is no national mandated target therefore it is difficult to measure as there is no baseline information available

PDR Rate	49.98% (Target ≥ 95%)	• All MW Line Managers has been tasked with providing a date for PDR completion by March 23. • HRBP and HOM have meetings scheduled with all MW Leaders to compile a plan for all staff to achieve compliance. This will then be monitored monthly and will feature as a standard agenda item on Family Health Divisional Board.

Midwifery Red Flags – February 2023.

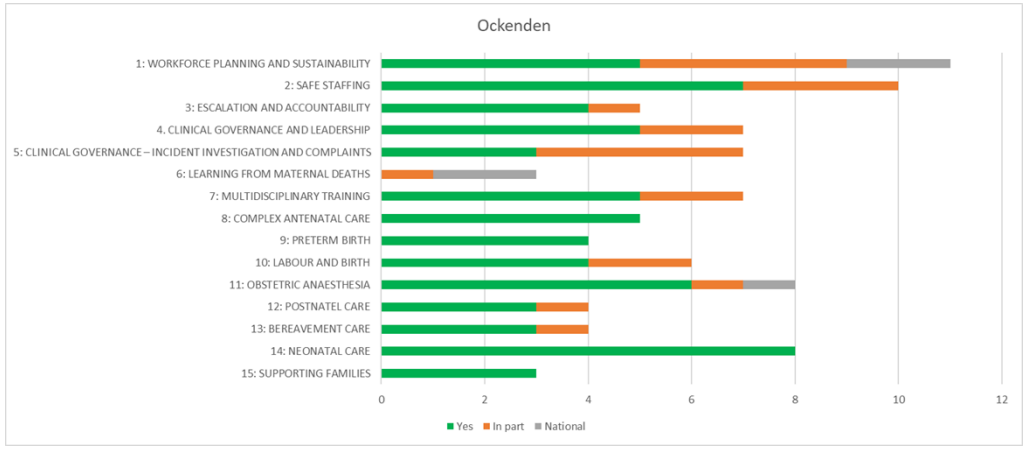
Midwifery Red Flag	Number Reported on Ulysses	Actions Taken.
Delayed or Time Critical Activity	**0**	All staff are encouraged to recognise and report midwifery red flags using the Ulysses System and the maternity managers strive to close incidents in a timely fashion. Midwifery Red flags are monitored two hourly by the Maternity Bleep holder, with data and governance oversight maintained through the Divisional Maternity Governance and Risk Committee. The Head of Midwifery provides a detailed narrative of midwifery red flags within the Bi-annual Midwifery Safe Staffing Paper. A SOP is under development for the management and governance of Midwifery Red Flags that will be ratified in March 2023. In February and system update to Ulysses was executed enabling smarter reporting of MRF events as a cause group.
Missed or Delayed Care	**0**	
Missed medication during admission	**0**	
Delay of 30 Mins in providing pain relief	**0**	
Delay >30mins between presentation & triage.	**4**	
Full clinical examination not carried out when presenting in Labour	**0**	
Delay >2hrs between admission and beginning of IOL process	**2**	
Delayed recognition of and action on abnormal vital signs	**0**	
Any occasion of inability to provide continuous 1:1 care in labour	**3**	

Delay >4hrs of ongoing IOL	**10**	- Insufficient Midwifery Staffing on Divisional Risk Register, e risk Number 1705, HOM Lead. - Weekly and Daily Roster Oversight Management by HOM, I and Managers. - Exec Led E-Roster Challenge sessions. - Proactive management of staff sickness and RTW - Use of Escalation and Divert Policy where required, includir non-clinical registrants and Continuity of Care MW. - NHSP and Agency use. - Medical Review and Escalation of delay to Senior Obstetric 104 Bleep Holder. - Ongoing recruitment and retention programme - Compliance to Birth Rate Plus Report Jan 2022.
	TOTAL	
	19	

Maternity Safety Breakdown – January to March 2023.

HSIB Referral Details:	January 2023 – Therapeutically Cooled – Planned maternal request IOL, developed sepsis flags in labour, some issues with documentation identified. Required terbutaline in labour for hyperstimulation of uterine activity, but further administration not given when required. Issue identified with differencing maternal heart rate from fetal heart rate. Occasions of incorrect terminology in the categorization of the CTG. Management of subsequent emergency bradycardia and expeditated birth could have been more effectively led. Immediate actions identified include LOTW in terbutaline use, review of CTG training competency. Ongoing HSIB investigation. February 2023 – Intrapartum Stillbirth - Booked at Trust 2, cardiac abnormality on 20 weeks USS, seen in FMU. Transfer of care to LWH and planned IOL at 39 weeks. IOL commenced. Antepartum hemorrhage and loss of fetal heart whilst in IOL process. Query Placental abruption Query Vasa Praevia. Referred to HSIB as per Intrapartum Stillbirth guidance for referral. Immediate actions identified: Documentation in K2 when attending FMU requires upload to K2. Ongoing investigation with HSIB.

STEISS and SUI Events	January 2023 – Maternal transfer to ITU – Postnatal transfer to ITU following 19-week pregnancy loss. Acutely unwell with sepsis, required inotropic support and increasing 02 requirement. Prompt recognition of sepsis, decision for ITU transfer was entirely appropriate and senior level medical management was involved. February 2023 – Identification of omission of Anti D. – Review of incident from June 2022 where vials of Anti D had been found in fridge, due diligence found that corresponding patient did not have anti d administered. SUI ongoing. March 2023 – Postnatal Venous Thromboembolism requiring admission to RLUH – issues identified lack of assurance around thromboembolism stocking provision in antenatal period, incorrect and incomplete VTE assessments on some occasions, missed opportunity to re-weigh patient at 36 weeks, incorrect dosing of LMWH at postnatal discharge.
Perinatal Stillbirth Mortality.	Number of Stillbirth (Excluding Terminations of Pregnancy) in January 2023**: 2** - 23+0 Week Antenatal SB – attended for Anatomy USS at 22+3 weeks and IUFD identified - Full PMRT Review planned. - 31+6 Week Antenatal SB – antenatal Obstetric Hemorrhage at home – attended with IUFD – Full PMRT Review planned. Number of Stillbirth (Excluding Terminations of Pregnancy) in February 2023**: 3** - 25+4-week Antenatal SB – - 38+3-week Intrapartum SB – As above – will be subject to HSIB review and Full PMRT Review. - 38+2-week Antenatal SB – Reduced fetal movements at community appointment – MAU – IUFD. Full PMRT Review planned. All perinatal deaths in January & February 2023 have been reported to MBRRACE and will be subject to a full MDT review with an extern member. Details and actions plan of every death are detailed in the Regional Quarterly Mortality Report presented by the Deputy Medic Director at Quality Committee and Trust Board.
Ockenden Update	Several actions relate to SI's, PSIRF is due to be implemented in the Trust in September 23 this will result in the SI threshold being removed. The Corporate Governance Team are managing this piece of work and will update the Trust Board accordingly. MIAA undertook an audit in Quarter 3 of the Trust compliance with essential actions rated as Green. Three recommendations were included in the audit report, one was to review the 65 essential actions rated as Green to apply check and challenge, as this process was not in place prior to implementation of Workstream 1. Two of the audit recommendations have been completed and the third is in progress as the 65 actions rated as Green are being discussed at the Ockenden workstream meeting with application of check and challenge. HoM attended the Trust Audit Committee on the 23rd March to provide a progress update on the management responses.



FHD Risk Register.

Maternity services currently have 33 Risks open in the Trust Risk register:

- 1 x Red/Extreme Risk – MAU Triage, ensuring that all women who present to MAU are triaged within 30mins of attendance. Current performance 99%. Performance and clinical incidents submitted from MAU are reviewed weekly at the improvement Group.
- 27 x Amber/High Risks- all with controls in place and reviewed in the allocated timeframes
- 4 x Yellow/Moderate Risks with controls in place and reviewed in the allocated timeframes
- 2 x Green/Low Risks with controls in place and reviewed in the allocated timeframes

Risk Register management and review is a standing agenda item at the Maternity Risk Meeting, where risks and new risks are considered and discussed, and issues highlighted for escalation to FHDB and divisional quadrumvirate.
Closed and completed risks are agreed and overdue reviews of risk highlighted.
Current performance (March 2023)

- There are no overdue risk status requiring review.
- All Maternity Risk descriptions have been updated to reflect condition, cause, and consequence descriptors
- All maternity risk owners have been updated to reflect change in management personnel within the division.
- Maternity Division are proactively working through outstanding risk register actions and seeking evidential assurance of those actions completed.

Maternity Incentive Scheme	**Progress against the Year 4 Maternity Incentive Scheme (CNST):** Full compliance with Year 4 CNST was declared at January 2023 Trust Board meeting with the sign of template submitted to NHSR. The Division await the release of the Year 5 scheme guidance and will action upon receipt.
Women's. Feedback and MVP.	The Family Health Division has regular interaction with its MVP Chair and regular service user feedback sessions are carried out to help inform future service developments. The most recent service user engagement event took place on 18th November 23 and specific details around outputs are highlighted below. All points were considered, and a detailed response was provided, to feedback to participating service users. ***Review whether routine antenatal scans are being carried out on time or not. If they are, ensure that service users receive clear communication about the expected timeframes for routine scans.*** **Response:** For the most part, we aim to have dating scans between 12 and 14 weeks, although this will happen a little later if women book late. This is in line with National expectations and Guidelines. Letters are sent out to the address provided inviting women for their USS, including date, time, and location. If there is particularly short notice, this information is relayed through a text message service to the phone number provided at booking. ***Review midwifery staffing levels on the postnatal ward.*** **Response:** There is currently a significant amount of work on the Maternity Base to not only improve the quality of staffing, but to improve the patient journey and experience. We have an ongoing rolling recruitment programme to invite Midwives to join LWH and additional staffing support is being sought from Physician Associates, Health Care Assistants, Maternity Support Workers and BAMBI's (Breast feeding support). Safe staffing levels are reviewed on a 4 hourly basis throughout the day and night and reallocation of staff occurs to manage periods of particularly high activity. ***Ensure that all service users are made aware of how to access mental health support, at every contact with a healthcare professional ('making every contact count' approach).*** **Response:** We are required to ask about women's mental health at every antenatal and postnatal visit. Referrals to the PNMH team are reviewed by the Perinatal Mental Health Midwives and liaison with Silver Birch and Mersey Care occur as required. We have an established Perinatal Mental Health team within the Trust who provide annual updates to our clinical staff and provide support to Midwives who would like to support women who warrant referral.

Ensure that MAU & Mat Base staff are encouraged to communicate regularly with service users who are awaiting admission/induction/other treatment about waiting times and the overall progress of their care plan.

Response: Following our recent CQC inspection, a lot of work has been focused on improving the standard of care within our MAU department. This includes a higher number of staff available 24 hours a day, and a new white board which highlights waiting times. This allows for escalation measures to be put in place, preventing a time breach. The senior leadership team have oversight of MAU activity to ensure the new strategies are remaining implemented appropriately.

The introduction of 'Intentional Rounding' has also been introduced, whereby a senior midwife walks though waiting areas to ensure that everyone waiting is comfortable to do so and answers any questions people may have.

The Maternity Base has benefitted from an additional Senior leader, in addition to the Ward Manager and Matron, to support the ward improvement plan. The plan aims to improve waiting times and discharge processes, making them more efficient, resulting in women being discharged home with reduced delay.

Review the support and training that is provided to volunteers in respect of baby loss, as well as supporting service users with emotional/mental health difficulties more widely.

Response: Due to the very nature of baby loss being such a sensitive concept, our women would usually only receive care from a registered and trained medical or clinical practitioner, rather than a volunteer.

We currently have a well-established team who deal with all aspects of baby loss. The Honeysuckle Midwives work closely with intrapartum clinicians to provide training and education, as well as acting as the lead clinician for women experiencing baby loss. Ongoing care for these families is also provided by the Honeysuckle Team who offer families the opportunity to stay in contact with the Trust and provide ongoing support through charity organisations (Sands).

Review the emotional support provided by the Honeysuckle team and wider hospital staffing for families who sadly experience baby loss.

Response: The Honeysuckle Team offer a compassionate service to manage the complexities of baby loss in an emotionally supportive way. Families have direct contact with the Honeysuckle Team during this difficult time and may use the Family room to spend time with their baby whilst arrangements are made for cremation / burial.

Staff can also access support from Senior Midwives and Professional Midwifery Advocates for those staff who require support of this nature.

<table>
<tr><td></td><td></td></tr>
<tr><td>Maternity Self-Assessment Tool.</td><td>This Safety Self-assessment tool has been designed for NHS maternity services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the trust's maternity quality improvement and safety plan and so keep the trust board and commissioners aware of their current position.

The tool has been developed in response to national review findings, and recommendations for good safety principles within maternity This version of the tool has been further influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme and the areas CQC found to be outstanding in other maternity services across England.

The Division continue to use an appreciative enquiry framework to complete this self-assessment tool. The Senior Leadership Team is supported by a Project Manager in its completion. Weekly meetings are being held to review the evidence for each of the 194 questions/actions.

To date 18 have been reviewed and 176 are yet to be reviewed. A tracking spreadsheet is being maintained to capture the rationale for the ratings and record sign off. Trajectory in place to review all actions by end of Quarter 1 FY 23/24.

<table>
<tr><td></td><td>Red</td><td>Amber</td><td>Green</td><td>TBC</td></tr>
<tr><td>2022 Review</td><td>36</td><td>88</td><td>70</td><td>0</td></tr>
<tr><td>2023 Review</td><td>0</td><td>10</td><td>8</td><td>176</td></tr>
</table>
</td></tr>
<tr><td>Family Health Safety Champions walkarounds.</td><td>Quarterly safety Champions Paper presented to Quality Committee in February 23.

Safety Champion walkarounds continue to take place within clinical areas. DB, AW and RMc recently visited Delivery Suite, noted the difficulties with the transfer of an Acutely ill patient requiring transfer to RLUH for interventional radiology; The Chief Nurse acknowledged the difficulties faced by the clinical team and assisted with the arrangements for transfer. A case review of a patient journey is planned, to further inform future service developments.

Safety Champions have visited maternity base and noted the ongoing ward-based improvements being made with regards to</td></tr>
</table>

	safety huddles and handovers. Safety Champions have been sighted on the developments and improvements implemented within MAU both pre and post CQC visit and are pleased to see the improvements made within the unit, specifically the demonstrable improvement and compliance of women triaged < 30 minutes. Discussions were carried out with staff who reported that the MAU felt much safer since the CQC visit and that the increased staffing model on the unit has resulted in a much safer environment. Further safety Champion workarounds are planned to take place.

Conclusion

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

The data provided within this report is monitored monthly and features on the Family Health Divisional Board meeting agenda and includes review and monitoring of compliance against all Maternity KPIs that are included within the Maternity Power BI dashboard.

In addition to the above internal assurance process data is submitted externally to the Northwest Coast Regional Dashboard monthly. Any areas of concern which are highlighted as outliers are returned to Maternity Senior Leadership Team for further analysis and review by Clinical Director to identify areas for improvement and to share learning.

Quality Committee Chair's Highlight Report to Trust Board
20 February 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• Informed that the Care Quality Committee (CQC) had raised concerns in relation to triage times within MAU during the CQC inspection visit on 24 and 25 January 2023. An action plan in response had been prepared and would be monitored to ensure improvements demonstrated ahead of 24 March 2023.
• The Committee received the Quality and Regulatory Update noting key issues and emerging concerns. A Serious incident in relation to the discharge process undertaken for colposcopy patients over 50-years of age was discussed. The Committee noted the appropriate action taken to address the incident and requested the findings of the Task and Finish Group be presented when finalised.
• The Committee noted the following matters from the Quality Performance Report:
  ○ Spike in TCI: percentage cancelled by hospital for non-clinical reasons linked to recent industrial action. All patients affected had been contacted
  ○ 6-week wait diagnostic test performance: improvement demonstrated during January 2023 and on track to achieve the national target of 95% by March 2023
  ○ Gynaecology Emergency Department: position maintained in January 2023. Action taken to drive improvement included additional nursing presence at night to cover junior doctor gaps
  ○ Cancer performance: attainment towards the pre-pandemic position for 62-day remains challenging. Late referrals continue to be a source of difficulty and requires system support to review pathways
• The Committee considered the Maternity Assessment Unit (MAU) Improvement project and the Birmingham Symptom specific Obstetric Triage System (BSOTS) implementation update. It was noted that as of February 2023, within Cheshire and Merseyside no single provider had managed to implement BSOTS fully or sustain it entirely once in place primarily due to lack of midwifery and medical staffing. The trust had committed actions to increase workforce in both medical and midwifery to support improvement works within MAU. It was confirmed that a national 12-month implementation plan was underway to implement BSOTS and noted that elements required further discussion and agreement with the Integrated Care Board due to aspects of the model currently not commissioned. The Committee would receive a monthly update to monitor progress.
	• The Committee received the Quality performance report and noted recommendations to seek further assurances in relation to the A&E maximum waiting time of 4 hours, clinical mandatory training performance with a focus on patient safety, and complaints response rates.
	• Preparation was ongoing in relation to the CQC well-led review planned to take place on 21-23 February 2023.
	• Noted ongoing work to strengthen the Trust's divisional governance arrangements. The Committee acknowledged continued Audit Committee oversight of divisional governance arrangements.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• The Committee noted positive movement against the 78+week target and the 65+ week wait target since the introduction of Medinet to outsource identified patient appointments. It was noted that if the Trust maintained the use of Medinet it could clear the waiting list for 65+ week wait ahead of the national trajectory and to the benefit of patients. The case to continue investment would be taken to the Finance, Performance and Business Development Committee. • The Committee received the Family Health Divisional Safety Champions quarterly report noting positive application of the model to communicate safety intelligence and escalate safety issues where necessary. • The Committee had been assured by the Learning from Deaths quarterly report (Quarter 3, 2022/23) • Positive progress against Local Safety Standard for Invasive Procedures (LocSSIPs) implementation noted. • The Committee approved the revised RD&I Strategy noting the refreshed format and aims. It was agreed that the Committee should receive an update against the implementation plan during Quarter 2, 2022/23. Formal launch of the Strategy was noted to tale place on 27 March 2023 as part of the Research Showcase Event. • Received assurance from the Safeguarding quarterly report that effective safeguarding processes were in place and followed.	• The Committee approved the Research Development and Innovation Strategy 2023- 2028
Summary of BAF Review Discussion (Board Committee level only)	
• The Committee reviewed the related BAF risks. No risks closed on the BAF for Quality Committee. • Informed that the Care Quality Committee (CQC) concerns regarding MAU triage times would need to be reflected within the BAF and would be incorporated into discussions for the 2023/24 BAF. • Noted significant work to be undertaken in relation to patient experience and associated strategies which would strengthen BAF risk 3.1. Completion date aim March 2023. • Noted robust and challenge debate in relation to the risk score of BAF risk 1.2 Workforce (PPF Committee owned BAF risk) based on the numerous expected industrial action and subsequent impact on services. The Executive Committee had recommended that the risk score should remain at 20 (consequence 5, likelihood 4), based on evidence of strong working relationships it was believed to be inappropriate to escalate the likelihood to 5. The recommendation would be taken to the Putting People First Committee in March 2023 and to Trust Board in April 2023. • Noted the refreshed RD&I Strategy 2023 – 2028 would be used to inform BAF risk 5.1: Failure to progress our research strategy and foster innovation within the Trust and potentially reduce the risk score.	
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Appropriate discussion dedicated to identified reports • Common understanding of issues shared • Efficient meeting	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
173.	Review of BAF risks: Quality related risks	Assurance	179.	Mortality and Perinatal Report (Learning from Deaths) Quarter 3, 2022/23	Assurance
174.	Sub-Committee Chair Reports	Assurance	180.	LocSSIPs Quarterly Assurance Report Quarter 3, 2022/23	Assurance
175.	Quality Performance Report Month 10, 2022/23	Assurance	181.	Research Development & Innovation Strategy 2023-2028	Approval
176.	Quality and Regulatory Update	Assurance	182.	Divisional Governance Maturity	Information
177.	Maternity Assessment Unit Update	Information	183.	Safeguarding Quarterly Report, Quarter 3 2022/23	Information
178.	Family Health Divisional Safety Champions – Q3 2022-23 Report	Information			

3. 2022 / 23 Attendance Matrix

Core members	April	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie, Non-Executive Director	✓	✓	✓	**NM**							
Susan Milner, Non-Executive Director	✓	**A**	**NM**								
Louise Kenny, Non-Executive Director	**A**	✓	✓	A	✓	✓	✓	✓	✓	A	
Sarah Walker, (Chair) Non-Executive Director	**NM**	✓	✓	A	✓	**A**	✓	✓	✓	✓	
Gloria Hyatt, Non-Executive Director	**NM**	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Jackie Bird, Non-Executive Director	**NM**	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Marie Forshaw, Chief Nurse and Midwife	✓	✓	✓	✓	NM						
Gary Price, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Lynn Greenhalgh, Medical Director	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	
Eva Horgan, Chief Finance Officer	✓	✓	✓	✓	✓	A	✓	✓	NM		
Michelle Turner, Chief People Officer	✓	✓	✓	✓	A	A	✓	✓	✓	✓	
Nashaba Ellahi, Deputy Director of Nursing & Midwifery	✓	✓	✓	A	✓	A	✓	✓	A	A	
Philip Bartley, Associate Director of Quality & Governance	✓	✓	✓	A	✓	A	A	A	✓	✓	
Dianne Brown, Chief Nurse	NM				✓	✓	✓	✓	✓	✓	
Jenny Hannon, Chief Finance Officer	NM								✓	A	

Quality Committee Chair's Highlight Report to Trust Board
27 March 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• The Committee noted the following matters from the Quality Performance report:
  ○ Significant poor performance with cancer targets:
  ➢ Poor performance against the 62-day cancer target; 13.5 breaches in January 2023 due primarily to delays with diagnostics and results. Hysteroscopy capacity and delays in Histology results are documented risks on the Gynaecology Divisional Risk Register and have been raised to Corporate Risk Committee. Weekly PTL meetings to escalate and unblock issues with senior management oversight would continue.
  ➢ 78-week target – significant risk to achieving target of zero by end of March 2023 due to periods of industrial action and patient choice. The Trust aims to clear all 78+ week patients by the end of April 2023. Most providers in the region noted that they are projecting 78+ week breaches at the end of March 2023.
  ○ MAU triage performance update
  ○ A&E maximum waiting times of 4 hours demonstrated a worsening trend and the Committee was concerned with the commentary provided. Additional assurance was requested.
• The Committee received a verbal update on a recent maternal death of a patient who had been admitted to GED with pain, transferred to critical care at LUFT for surgical treatment, and subsequently died. The ICB and PLACE had been informed, and a coroners post-mortem undertaken. The Trust had completed its 72-hour review and the HSIB would investigate the case, followed by an internal investigation. Members of the workforce involved in the case had been offered psychological support. A wider discussion was held in relation to the outcomes of transfers off site and the appropriate destination for patients from the ambulance service. It was noted that lookback reviews have been commissioned to consider critical care transfers and maternal deaths.
	• The Committee received an update since the recent CQC site inspection.
	• The Committee received the plan for an interim (6-month) suspension of the Midwifery Continuity of Carer (MCoC) model at the Trust. The rationale for the proposed model was presented noting the aim to release midwifery staffing to support safe staffing levels in inpatient areas whilst also maintaining an element of enhanced support for the most vulnerable women who are currently allocated to the MCoC pathway. The update included the proposal to safely transition to the revised model of care. The associated workforce had been included in the discussions. The Committee noted that submission of a risk assessment would have been beneficial to the Committee for assurance purposes.
	• The Committee noted continued progress with Maternity Transformation programme initiatives, with a specific focus on Maternity Assessment Unit (MAU) and the ongoing actions taken, to consistently maintain compliance of reviewing women within a 30-minute triage target when attending the MAU.
	• The Risk Management Strategy 2023/24 was received to recommend approval to the Trust Board. The Strategy had recently been considered by the Audit Committee (March 2023) and recommended amendments. The Committee also provided feedback noting that the Strategy did not reflect longer term ambitions for risk management and impact on safety, and should perhaps be a three-year strategy as opposed to an annual update. The Committee agreed to defer Board approval from April to May 2023. An updated Strategy would be presented to the Committee in April 2023.
	• The Committee requested additional consideration in relation to the risk appetite statements for 2023/24 aligned to its terms of reference prior to recommending approval to the Trust Board.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	Decisions Made
• The Committee took assurance from the Sub-Committee Chair reports. The Committee noted the amount of information and detail provided within these reports and asked the chair authors to demonstrate the impact of actions taken, the check and challenge undertaken and how evidenced within the Sub-Committee meetings to improve assurance to the Committee. (ALL) • The Committee received the Quality and Regulatory monthly update. Six serious incidents had been reported since the last report, investigations are ongoing and would be reported through the Integrated Governance Reporting to the Committee with a focus on how learning has been embedded. The Committee was asked to consider whether the information in relation to the claims / legal cases provided within the report was sufficient. The Committee advised that the purpose of information into this Committee is for assurance purposes and not operational and recommended legal advice is taken on how to share claims information appropriately. (ALL) • The Committee received an update against the implementation of the new quality surveillance model as mandated nationally. The surveillance model seeks to provide for consistent and methodical oversight of all services, specifically including maternity services. The model has also been developed to gather ongoing learning and insight, to inform improvements in the delivery of perinatal services. The Committee was assured by the overview of key quality & safety workstreams and performance that perinatal quality safety is a key divisional priority.	• The Committee agreed the Committee Annual Report, Business Cycle for 2023/24 and the Terms of Reference and recommends approval to the Trust Board.

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the related BAF risks. No new risks or strategic threats identified, and no risks closed on the BAF for Quality Committee.
- Noted a significant review of the BAF is scheduled to take place – it is likely that there will be a push to reduce the number of BAF risks to help provide greater clarity on the key strategic risks facing the Trust.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Appropriate discussion dedicated to identified reports
- Common understanding of issues shared
- Efficient meeting

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
192.	Review of BAF risks: Quality related risks	Assurance	198.	Maternity Assessment Unit (MAU) Update	Information
193.	Sub-Committee Chair Reports	Assurance	199.	Risk Management Strategy Annual Review for 2023/24	Information

194.	Quality and Regulatory Update	Assurance	**200.**	Risk Appetite Statement – Quality Committee	Approval
195.	Quality Performance Report Month 11, 2022/23	Assurance	**201.**	Corporate Objectives year-end review and objective setting for 2023/24	Information
196.	Perinatal Quality Surveillance & Safety	Assurance	**202.**	Committee Effectiveness Review Terms of reference and Workplan	Approval
197.	Implementing a Revised Model of Care for Midwifery Continuity of Care (MCoC)	Information			

3. 2022 / 23 Attendance Matrix

Core members	April	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie, Non-Executive Director	✓	✓	✓	**NM**							
Susan Milner, Non-Executive Director	✓	**A**	**NM**								
Louise Kenny, Non-Executive Director	**A**	✓	✓	A	✓	✓	✓	✓	✓	A	✓
Sarah Walker, (Chair) Non-Executive Director	**NM**	✓	✓	A	✓	**A**	✓	✓	✓	✓	✓
Gloria Hyatt, Non-Executive Director	**NM**	✓	✓	✓	✓	✓	✓	✓	✓	✓	**A**
Jackie Bird, Non-Executive Director	**NM**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Marie Forshaw, Chief Nurse and Midwife	✓	✓	✓	✓	NM						
Gary Price, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lynn Greenhalgh, Medical Director	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓
Eva Horgan, Chief Finance Officer	✓	✓	✓	✓	✓	A	✓	✓	NM		
Michelle Turner, Chief People Officer	✓	✓	✓	✓	A	A	✓	✓	✓	✓	✓
Nashaba Ellahi, Deputy Director of Nursing & Midwifery	✓	✓	✓	A	✓	A	✓	✓	A	A	✓
Philip Bartley, Associate Director of Quality & Governance	✓	✓	✓	A	✓	A	A	A	✓	✓	✓
Dianne Brown, Chief Nurse	NM				✓	✓	✓	✓	✓	✓	✓
Jenny Hannon, Chief Finance Officer	NM								✓	A	✓

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**23/24/009b**		**Date: 06/04/2023**	
Report Title	**Quality & Operational Performance Report**			
Prepared by	***Gary Price, Chief Operating Officer, Dr Lynn Greenhalgh, Medical Director and Dianne Brown, Chief Nurse***			
Presented by	***Gary Price, Chief Operating Officer***			
Key Issues / Messages	***For assurance – To note the latest performance measures***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – If no – please outline the reasons for deviation.			
	The Board is asked to note the assurances within the Month 11 Quality and Operational Performance Report.			
Supporting Executive:	***Gary Price, Chief Operating Officer***			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*			
Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒			
Strategic Objective(s)			
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☐	To participate in high quality research and to deliver the most ***effective*** Outcomes	☒
To be ambitious and ***efficient*** and make the best use of available resource	☒	To deliver the best possible ***experience*** for patients and staff	☒
To deliver ***safe*** services	☒		
Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)			
Link to the BAF (positive/negative assurance or identification of a control / gap in control)		Comment:	

5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Finance, Performance and Business Development Committee	March 23	COO	Detailed in Chair's Report
Quality Committee	March 23	COO	Detailed in Chair's Report
Putting People First Committee	March 23	CPO	Detailed in Chair's Report

Performance Report Contents

Appendix 1: Assurance & Variation Icons Descriptions

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

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

Appendix 2: Assurance Category Descriptions

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

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report

March 2023

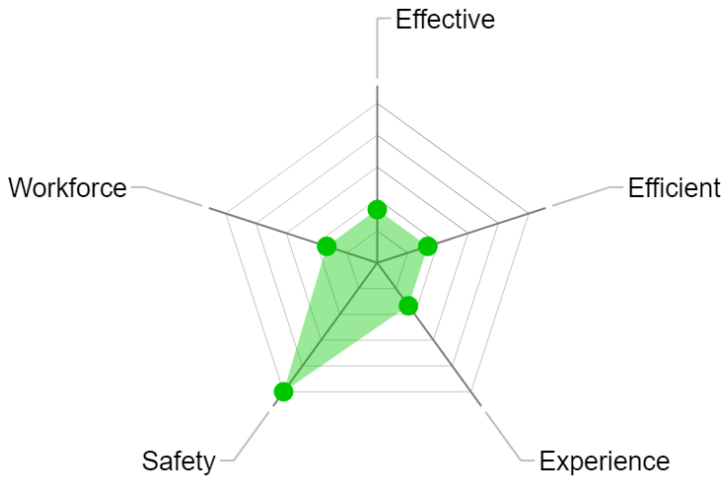
Section 1: Assurance Radar Charts by Trust Values

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

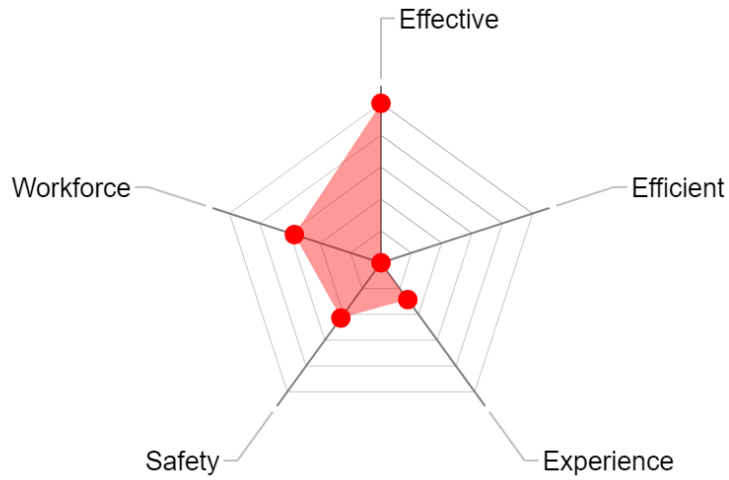
KPIs Passing Target for Six Months	7
KPIs Failing Target	16
KPIs Hit and Miss	9
KPIs No Target	2

KPIs Improving Variation	4
KPIs Concerning Variation	6
KPIs Common Cause Variation	24

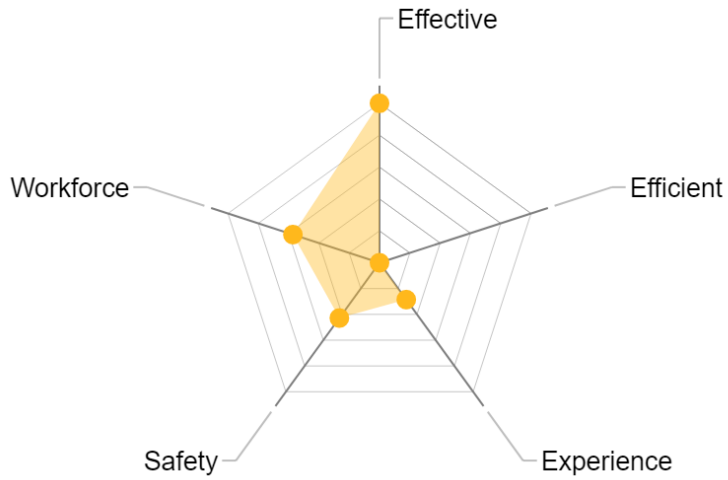
Consistently Passing



Consistently Failing



Hit and Miss



Section 2: Integrated Performance Metrics

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

Excellent - Celebrate & Learn

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 104 Weeks	<=	0	0	P	L

Good - Celebrate & Understand

KPI	Target < or >	Target	P	A	V
Cancer: 2 Week Wait	>=	>= 93%	92.59%	?	H
Complaints: Number Received	<=	<= 15	7	P	
Financial Sustainability Risk Rating: Overall Score	<=	3	3	P	
Infection Control: Clostridium Difficile	<=	0	0	P	
Infection Control: MRSA	<=	0	0	P	
MAU - Face to face Maternity Triage within 30 Mins	>=	>= 95%	97.68%	?	H
NHSE / NHSI Safety Alerts Outstanding	<=	0	0	P	
Turnover Rate	<=	<= 13%	10.94%	P	

Average - Investigate & Understand

KPI	Target < or >	Target	P	A	V
Neonatal Deaths per 1000 live Births	<=		3.9		
Cancer: 62 Day Screening Referrals (Percentage)	>=	>=90%	0.00%	?	
Diagnostic Tests: 6 Week Wait	>=	>= 99%	92.44%	?	
Friends & Family Test: In-patient/Daycase % positive	>=	95%	96.55%	?	
Never Events	<=	0	0	?	
Proportion of patient activity with an ethnicity code	>=	>=96%	95.46%	?	
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	>=	100%	71.43%	?	
Serious Untoward Incidents: Number of SUI's with actions outstanding	<=	0	0	?	

Integrated Performance Metrics

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

Concerning - Investigate

KPI	Target < or >	Target	P	A	V
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	>=	>= 95%	85.05%	F	
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	>=	>=85%	0.00%	F	
Cancer: 28 Day Faster Diagnosis	>=	>= 75%	42.01%	F	
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	>=	>=96%	60.87%	F	
Clinical Mandatory Training Compliance	>=	>= 95%	79.94%	F	
Friends & Family Test: A&E % positive	>=	95%	94.29%	F	
Friends & Family Test: Maternity % positive	>=	95%	80.00%	F	
Mandatory Training Compliance	>=	>= 95%	91.79%	F	H
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	>=	>= 80%	41.54%	F	
Sickness Absence Rate	<=	<= 4.5%	6.50%	F	
Venous Thromboembolism (VTE)	>=	>= 95%	92.81%	F	
Overall size of Elective Waiting List	<=		18032		H

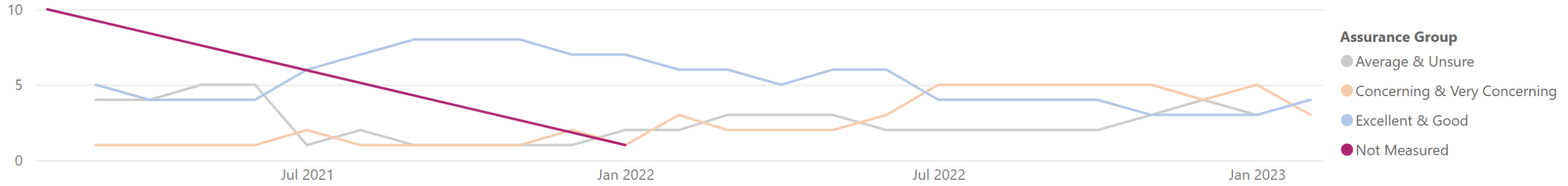
Very Concerning - Investigate & Take Action

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 52 Weeks	<=	0	2128	F	H
18 Week RTT: Incomplete Pathway > 78 Weeks	<=	0	165	F	H
Cancer: 104 Day Breaches	<=	0	8	F	H
Serious Untoward Incindents: New (Rolling per year)	<=	24 /year	42	F	H
Serious Untoward Incindents: Open	<=	<5	24	F	H

Investigate & Understand

KPI	Target < or >	Target	P	A	V

Section 3: To deliver **Safe** Services

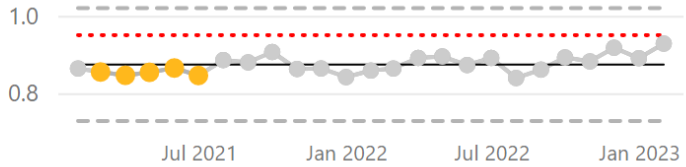


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Infection Control: Clostridium Difficile	Good	February 2023	0	<=	0			
Infection Control: MRSA	Good	February 2023	0	<=	0			
MAU - Face to face Maternity Triage within 30 Mins	Good	February 2023	>= 95%	>=	97.68%			
NHSE / NHSI Safety Alerts Outstanding	Good	February 2023	0	<=	0			
Neonatal Deaths per 1000 live Births	Average	February 2023		<=	3.9			
Never Events	Average	February 2023	0	<=	0			
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	Average	February 2023	100%	>=	71.43%			
Serious Untoward Incidents: Number of SUI's with actions outstanding	Average	February 2023	0	<=	0			
Venous Thromboembolism (VTE)	Concerning	February 2023	>= 95%	>=	92.81%			
Serious Untoward Incindents: New (Rolling per year)	Very Concerning	February 2023	24 /year	<=	42			
Serious Untoward Incindents: Open	Very Concerning	February 2023	<5	<=	24			

To deliver **Safe** Services - Exceptions

Venous Thromboembolism (VTE) - Medical Director

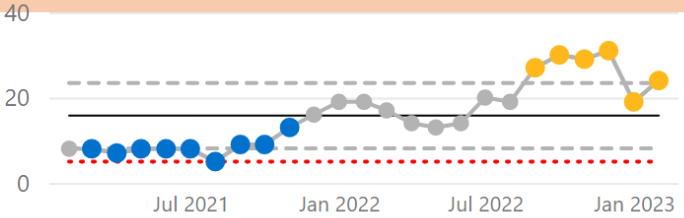
Assurance Category	Concerning
Date	February 2023
Target	>= 95%
Target < or >	>=
Performance	92.81%
Assurance	F
Variation	



The KPI is below target due to compliance within Gynaecology. There is an upward trend in compliance through regular communication to non compliant clinicians. With DigiCare the process for VTE assessments will be simplified and within a single system for clinicians to document.

Serious Untoward Incidents: Open - Chief Nurse

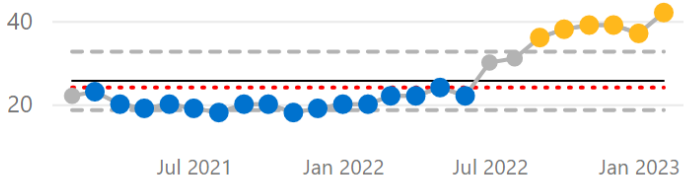
Assurance Category	Very Concerning
Date	February 2023
Target	<5
Target < or >	<=
Performance	24
Assurance	F
Variation	H



There are currently 24 open SUI's across the Trust as follows:
3 - CSS
3 - Maternity
3 – Neonates
15 – Gynaecology
Within gynaecology, a number of investigations relate to future generations.
A number of investigations are being finalised for submission to the ICB and the Corporate Team are closely monitoring the length of time that SUI investigations remain open from StEIS reporting to submission and any extension requests are considered by the Chief Nurse via the Corporate Team.

Serious Untoward Incidents: New - Chief Nurse

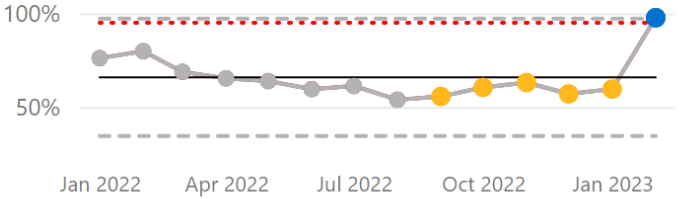
Assurance Category	Very Concerning
Date	February 2023
Target	24 /year
Target < or >	<=
Performance	42
Assurance	F
Variation	H



7 new SIs, 4 in Gynae, 1 in Maternity and 2 in Neo. All have had the appropriate 72 hour review and assigned investigating officers in line with policy. The increasing rolling number of SIs is being reviewed to identify any emerging themes of repeat causality and associated learning. The deep dive into Serious Incidents will be reported through Safety and Effectiveness

MAU - Arrival to Triage within 30 Mins - Chief Operating Officer

Assurance Category	Good
Date	February 2023
Target	>= 95%
Target < or >	>=
Performance	97.68%
Assurance	?
Variation	H



The Trust has seen a significant improvement in triage time since February which forms part of the maternity transformation programme. The programme is now focussed on sustainability of this metric. In February for women waiting under 15 minutes to triage performance was 76.93%.

To deliver Safe services - Safer Staffing

February 2023					
WARD	Fill Rate Day % RN/RM *	Fill Rate Day % Care staff **	Fill Rate Night % RN/RM *	Fill Rate Night % Care staff **	Supporting narrative (RN/RM = *; Care staff = **)
Gynae Ward	92%	86%	146%	100%	*Staffing fill rates for days shift in February are reflective of RN vacancy and sickness. The bed occupancy on the inpatient ward and the HDU allowed for movement of RN from HDU to support the ward. All shifts are sent out to NHSP bank to cover shortfalls. Over fill rates continue on nights to allow for senior nurse cover to rotate between ward and GED.
Induction & Delivery Suites	81%	87%	93%	98%	*Safe staffing required the Maternity bleep holder to redeploy RM to maintain clinical safety and prioritise 1:1 care in labour. On occasions redeployment of staff from the Mat Base, and escalation of CoC Midwives as per policy was required. Vacant shifts are requested to be filled with bank.
Maternity & Jeffcoate	94%	94%	82%	91%	*/**All vacant shifts requested to be filled with bank. The Maternity bleep holder redeployed staff to maintain clinical safety to areas of high acuity and to ensure appropriate discharge flow to release capacity and ensure safe care maintained across maternity services.
MLU	82%	61%	82%	75%	*/**There were no episodes of closure during the month, occupancy was reduced which allowed the safe delivery of Intrapartum and early postnatal care.
Neonates (ExTC)	96%	93%	99%	77%	*/**Fill rates are reflective of occupancy and acuity and have allowed safe staffing to be maintained.
Transitional Care	21%	139%	43%	114%	*/**Fill rates are reflective of occupancy on the TC and have allowed safe staffing to be maintained.

To deliver Safe services - Safer Staffing

Gynaecology: February Fill Rate

Fill rate – February staffing fill rate is reflective of the current RN vacancy position and the increase this month of short-term sickness. This is further challenged with maternity leave; safe staffing has been maintained by the ability to flexibly rotate RN across the division. Low bed occupancy of 39.36% in HDU has enabled the team to support the ward inpatients, the fill rate 146% RN on nights is the reflection of senior RN cover rotating between GED and inpatient area.
Attendance/ Absence – February sickness rate is reported as 9.10%, with 100% attributed to short-term sickness which is managed through the sickness and absence policy
Vacancies – RN vacancies of 1.91wte.
Red Flags – There are no Red Flags reported for February
Bed Occupancy –February Inpatient Bed Occupancy was recorded as 40.95%
CHPPD – 8.8%

Neonates: February Fill Rate

Fill-rate –February has continued to be a busy month on the NICU in relation to acuity. Staffing has been less challenging this month with a noticed decreased in sickness. Safe staffing and fill rates are reflective of acuity and occupancy. There has been a use of Bank but less than previous months, staff continue to provide flexibility by swapping and changing shifts with non-cot side staff working clinically. NWNODN and specialist commissioners have recognised the increase acuity and activity.
Attendance/Absence – February sickness ran at 4.79 %, this was down from January by 2.57%. Short term sickness sits at 47.77% with long term sickness making up 52.23%. Covid sickness and covid special leave made up less than 0.2% of sickness. Maternity leave has reduced again this month to 10.97 WTE and turnover sits at 8.96% well below the Trust threshold.
Vacancies – Vacancy rate remains low. Substantive Matron post went to advert, ANNP posts advertised, only 1 wte of 3 wte posts recruited too.
Red Flags – No red Flags
Bed Occupancy – Unit occupancy has run at 80.4% this is up on previous two months by approximately 2%. However, acuity remains high. IC continues to run above the 80% standard at 85.7%, but down on last month by 5.4%. HD activity up from to 69.9% to 86.2%. There was an increase in LD activity 73.6% this is up by 5.5%. TC activity has increased from 48.4 %to 61.2%, up 12.8% on last month.

To deliver Safe services - Safer Staffing

Maternity: February Fill Rate

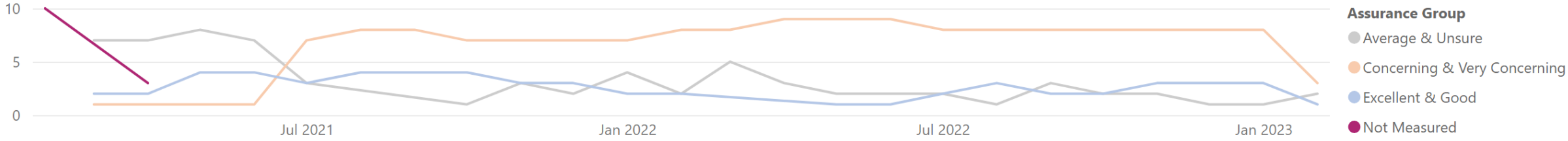
Fill-rate – Following a requirement to increase the midwifery staffing numbers in the MAU, agency use has occurred intermittently alongside business continuity plans being enacted to support safe staffing levels in all areas of Maternity. Throughout the reporting period MLU was able to remain open supporting flow through all clinical areas. Specialist midwives including those on secondment were recalled and have been rostered into clinical rota gaps to support safe staffing, with a requirement to escalate CoC On call midwives as per internal escalation policy when reporting Midwifery red flags. Maternity continued to undertake a 4-hourly activity /acuity review, which allows senior midwifery staff to maintain safety by rotating staff to the areas of highest clinical need.

Attendance/Absence – Maternity continues to report levels of sickness above the trust threshold of 4.5% which is calculated in the headroom, within its midwifery and support staff group. Maternity sickness is reported at 8.42% for registered midwives and 11.46% for support staff within month. This continues being a downward trajectory from previous month. Maternity has a higher rate of LT sickness than ST sickness (25%STS versus 74%LTS), with the top reasons for short term absence being cough/cold. It was noted that there was a decrease in STS across all staff. Ward managers/matrons have individual sickness reviews, and maternity are planning return to work programmes with all LT employees to facilitate appropriate returns to work. Maternity leave equates to 13.44wte all of whom are within the Registered Midwives staffing group.

Vacancies – Vacancies at the end of Month 11 for Band 5 and Band 6 Midwives equated to 26.17wte against current funded establishment, with 5.52wte currently undergoing recruitment checks. Maternity services have planned a Midwifery Open Day on the 18 March 2023 aimed at Newly Qualified or Early Career Midwives, this forms part of our recruitment and retention strategy in ensuring a supportive Preceptorship pathway and demonstrating career and professional development opportunities at LWH. Additionally, we continue to engage with the NW collaborative developing a pipeline for internationally educated Midwives to work at LWH following completion of OSCE and registration with the UK NMC.

Red Flags - February highlighted 19 Midwifery Red Flags were reported via the Ulysses system, which included 3 instances of 1:1 care not being provided for a short period of time during labour until staff could be redeployed. All cases were reviewed by the Intrapartum Matron and presented at Maternity Risk meeting. The remainder red flags related to 4 triage breaches of >30mins and 2 delays between presentation and IOL of >2hrs and 10 local red flags of ongoing delay >4hours of IOL. Work is ongoing to ensure the robust data collection and reporting of Red Flags. The data reflected in the Perinatal Quality Surveillance paper presented at Quality Committee in March 2023 contained errors in numbers of red flags reported which has since been corrected to 19 as above.

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

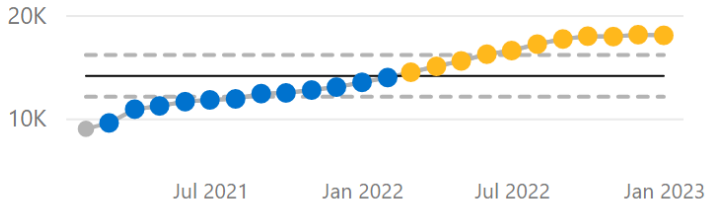


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
18 Week RTT: Incomplete Pathway > 104 Weeks	Excellent	February 2023	0	<=	0			
Cancer: 2 Week Wait	Good	January 2023	>= 93%	>=	92.59%			
Cancer: 62 Day Screening Referrals (Percentage)	Average	November 2022	>=90%	>=	0.00%			
Diagnostic Tests: 6 Week Wait	Average	February 2023	>= 99%	>=	92.44%			
Proportion of patient activity with an ethnicity code	Average	February 2023	>=96%	>=	95.46%			
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Concerning	February 2023	>= 95%	>=	85.05%			
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Concerning	January 2023	>=85%	>=	0.00%			
Cancer: 28 Day Faster Diagnosis	Concerning	January 2023	>= 75%	>=	42.01%			
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Concerning	January 2023	>=96%	>=	60.87%			
Overall size of Elective Waiting List	Concerning	January 2023		<=	18032			
18 Week RTT: Incomplete Pathway > 52 Weeks	Very Concerning	February 2023	0	<=	2128			
18 Week RTT: Incomplete Pathway > 78 Weeks	Very Concerning	February 2023	0	<=	165			
Cancer: 104 Day Breaches	Very Concerning	January 2023	0	<=	8			

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

Overall size of Elective Waiting List - Chief Operating Officer

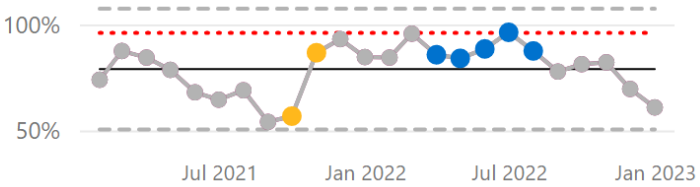
Assurance Category	Concerning
Date	January 2023
Target	
Target < or >	<=
Performance	18032
Assurance	
Variation	H



Elective waiting list has grwon following pandemic and increase in patient referrals. Elective Recovery plan in place to reduce numbers of patient waiting, increase number of patient clock stops. Insourcing of Gynaecology Outpatients commenced 21st January, demonstrating small reduction. Projected to decrease further in February and March as Insourcing will continue through Q4

Cancer: 31 Days from Diagnosis to 1st Definitive Treatment - Chief Operating Officer

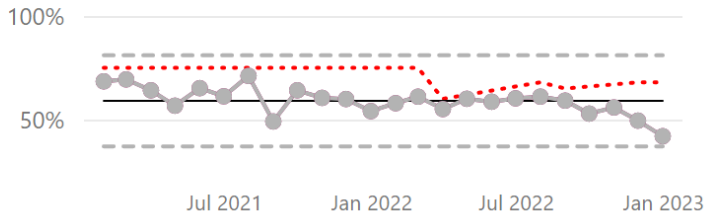
Assurance Category	Concerning
Date	January 2023
Target	>=96%
Target < or >	>=
Performance	60.87%
Assurance	F
Variation	



January has been a challenge due to numbers of referrals and complexity of patients. Increased oversite and support has been given to the cancer team in order to improve this target

Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

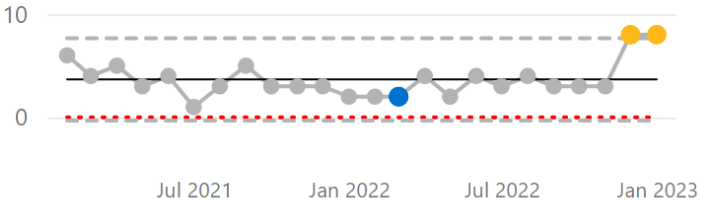
Assurance Category	Concerning
Date	January 2023
Target	>= 75%
Target < or >	>=
Performance	42.01%
Assurance	F
Variation	



Standard impacted by Hysteroscopy capacity, delays with diagnostics at other providers and receiving Histology results from LCL - pathology provider. Workforce challenges and increase in demand impacting standard. Pathway developments in progress to reduce referrals and demand to Hysteroscopy. New escalation SOP introduced with LCL to expedite results for Cancer patients in March 2023

Cancer: 104 Day Breaches - Chief Operating Officer

Assurance Category	Very Concerning
Date	January 2023
Target	0
Target < or >	<=
Performance	8
Assurance	F
Variation	H

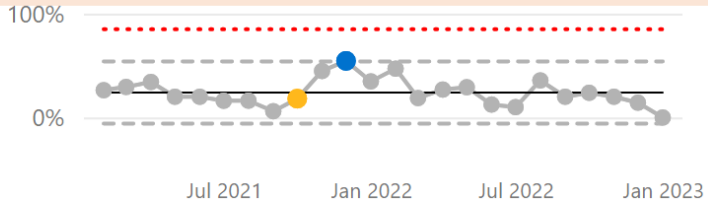


There are a number of patients waiting over 104 days with many still awaiting a decision to treat. External and internal diagnostics pressures are contributing to the position plus patients are also requiring a more detailed pre op assessment due to co-morbidities. Extra activity has been sourced at weekends to help reduce the internal ambulatory delays. Cancer team are tracking and escalating as required via the weekly cancer PTL meeting

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

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

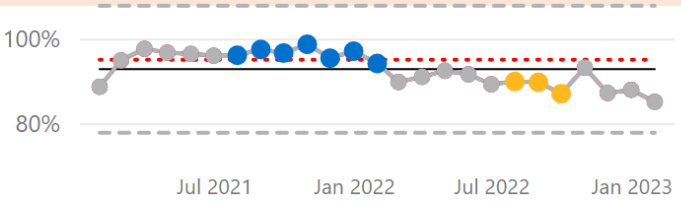
Assurance Category	Concerning
Date	January 2023
Target	>=85%
Target < or >	>=
Performance	0.00%
Assurance	F
Variation	



A number of factors including diagnostic delays, late referrals, complexity of patients and hysteroscopy capacity impacted this performance. Further detail and explanation was taken through March quality committee with a plan for mitigation and improvement. This KPI has since increased through February as has the unvalidated position for March. Weekly Executive oversite of this position now takes place until improvement is sustained.

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

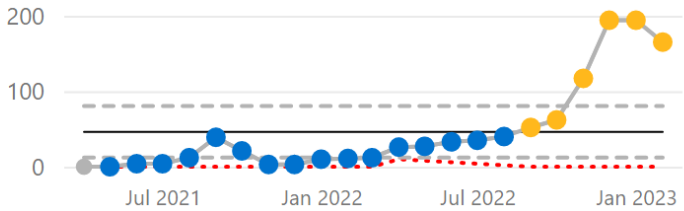
Assurance Category	Concerning
Date	February 2023
Target	>= 95%
Target < or >	>=
Performance	85.05%
Assurance	F
Variation	



Performance continues to remain consistent between 85-90%. Long term sickness is proving challenging and the number of attendnaces has increased by 12%. This has been escalated to the deputy medical director, medical staffing lead and clinical directors. Additional medical staffing requested through the annual planning process.

18 Week RTT: Incomplete Pathway > 78 Weeks - Chief Operating Officer

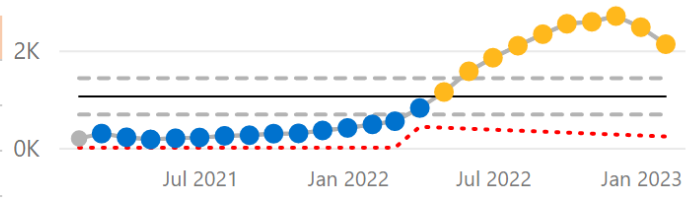
Assurance Category	Very Concerning
Date	February 2023
Target	0
Target < or >	<=
Performance	165
Assurance	F
Variation	H



78+ week waits have now started to reduce as a result of the impact of Insourcing. Additional capacity for non admitted patients is resulting in more patients being discharged after first appointment, capacity released to Gynaecology consultants to treat long waiting patients. Daily and weekly monitoring taking place will see continued reduction in March with target of 0 for end of March. Significant risk to this compliance due to Industrial Action and patient choice to wait longer

18 Week RTT: Incomplete Pathway > 52 Weeks - Chief Operating Officer

Assurance Category	Very Concerning
Date	February 2023
Target	0
Target < or >	<=
Performance	2128
Assurance	F
Variation	H



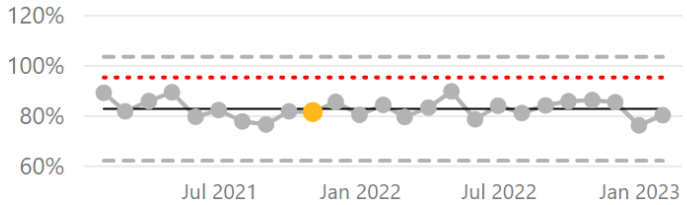
Section 5: To deliver the best possible **Experience** for patients and staff

KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Complaints: Number Received	Good	February 2023	<= 15	<=	7			
Friends & Family Test: In-patient/Daycase % positive	Average	February 2023	95%	>=	96.55%			
Friends & Family Test: A&E % positive	Concerning	February 2023	95%	>=	94.29%			
Friends & Family Test: Maternity % positive	Concerning	February 2023	95%	>=	80.00%			

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

Friends & Family Test: Maternity % positive - Chief Nurse

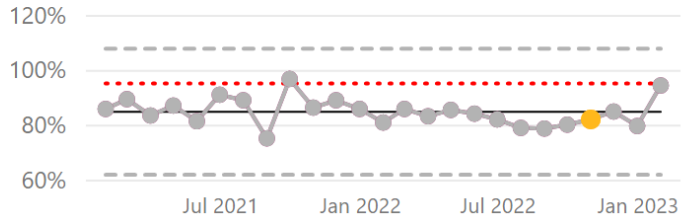
Assurance Category	Concerning
Date	February 2023
Target	95%
Target < or >	>=
Performance	80.00%
Assurance	
Variation	



Patient feedback discussed at Mat Base (Maternity ward) Maternity Assessment Unit and Induction of Labour improvement groups. Areas for improvement include regular administration of pain relief on maternity ward and provision of information for women whom are undergoing induction of labour. As part of the IOL improvement group an IOL midwife co-ordinator post JD has been developed and the post is to be advertised. Patient feedback is also discussed with the Chair of the MVP at the weekly meeting

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

Assurance Category	Concerning
Date	February 2023
Target	95%
Target < or >	>=
Performance	94.29%
Assurance	
Variation	



Even though the percentage falls slightly short of the target 95% it is evident that there has been a marked improvement in positive feedback, in January the score was 79.51% this month we've seen an increase of 14.78% taking the score to 94.29%. Likely the previous actions following such poor compliance are now coming to fruition.

KPI Lineage & Data Quality Overview

Metric Description	WE SEE	DQ Kite Mark	Board	FPBD	Quality	PPF	Family Health Division	CSS Division	Gynaecology Division	Maternity Clinical
18 Week RTT: Incomplete Pathway > 104 Weeks	Effective	5	Y	Y	Y				Y	
18 Week RTT: Incomplete Pathway > 52 Weeks	Effective	5	Y	Y	Y					
18 Week RTT: Incomplete Pathway > 78 Weeks	Effective	5	Y	Y	Y				Y	
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Effective	5	Y	Y	Y				Y	
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Effective	5	Y	Y	Y				Y	
Cancer: 104 Day Breaches	Effective	5	Y	Y	Y				Y	
Cancer: 2 Week Wait	Effective	5	Y	Y	Y				Y	
Cancer: 28 Day Faster Diagnosis	Effective	5	Y	Y	Y			Y	Y	
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Effective	5	Y	Y	Y				Y	
Cancer: 62 Day Screening Referrals (Percentage)	Effective	5	Y	Y	Y				Y	
Clinical Mandatory Training Compliance	Workforce	5	Y		Y	Y				
Complaints: Number Received	Experience	5	Y		Y					
Diagnostic Tests: 6 Week Wait	Effective	5	Y	Y	Y			Y	Y	
Financial Sustainability Risk Rating: Overall Score	Efficient	5	Y	Y						
Friends & Family Test: A&E % positive	Experience	5	Y		Y				Y	
Friends & Family Test: In-patient/Daycase % positive	Experience	5	Y		Y				Y	
Friends & Family Test: Maternity % positive	Experience	5	Y		Y		Y			Y
Infection Control: Clostridium Difficile	Safety	5	Y		Y					
Infection Control: MRSA	Safety	5	Y		Y					
Mandatory Training Compliance	Workforce	5	Y		Y	Y				
MAU - Arrival to Triage within 30 Mins	Safety	5	Y	Y	Y		Y			Y
Neonatal Deaths per 1000 live Births	Safety	5	Y				Y			
Never Events	Safety	5	Y		Y					
NHSE / NHSI Safety Alerts Outstanding	Safety	5	Y		Y		Y			Y
Overall size of Elective Waiting List	Effective	5	Y					Y	Y	
Proportion of patient activity with an ethnicity code	Effective	5	Y	Y					Y	
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescale	Safety	5	Y		Y					
Serious Untoward Incidents: Number of SUI's with actions outstanding	Safety	5	Y		Y				Y	
Serious Untoward Incindents: New	Safety	5	Y		Y				Y	
Serious Untoward Incindents: Open	Safety	5	Y		Y					
Sickness	Workforce	5	Y		Y	Y				
Turnover	Workforce	5	Y			Y				
Venous Thromboembolism (VTE)	Safety	5	Y		Y					
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Workforce		Y	Y	Y	Y				

Board of Directors

COVER SHEET

Agenda Item (Ref)	*23/24/009c*		**Date: 06/04/2023**	
Report Title	Bi-annual staffing paper update, July 2022-December 2022 (Q2 & Q3)			
Prepared by	Nashaba Ellahi, Deputy Director of Nursing and Midwifery			
Presented by	Nashaba Ellahi, Deputy Director of Nursing and Midwifery			
Key Issues / Messages	*The Bi-annual Nursing, Midwifery and Allied Health Professional (AHP) staffing report is provided to the Board of Directors after being presented to the Putting People First (PPF) Committee on 20 March 2023. The report sets out the Liverpool Women's NHS Foundation Trust (LWH) position in the context of the National Nursing, Midwifery and AHP workforce challenges..*			
Action required	Approve ☐	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): NA			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is asked to note the contents of the paper and take assurance of the actions undertaken to effectively manage and provide safe staffing within Nursing, Midwifery and AHP to support the delivery of safe care.			
Supporting Executive:	Dianne Brown, Chief Nurse			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1.2 Failure to recruit and maintain a highly skilled and engaged workforce	Comment: Risk score of 20; target 16
Link to the Corporate Risk Register (CRR) – CR Number: The below are service level risks, however for context are highlighted. **FH (Maternity)** Risk number: 1705 – midwifery staffing "insufficient midwifery staffing levels as recognised by birth rate plus. Risk score of12; target 6 **Gynaecology** Risk number: 2256 – Risk to staff the Telephone Triage Line (GED). Risk score of 12; target 3 Risk number: 2395 - OPD ambulatory staffing Risk score of 15; target 12 **CSS** Risk number: 2549 – Staff shortages in the Imaging Dept. Risk score of 12; target 12 Risk number: 2579 – Staffing for CDC. Risk score of 12; target 5 Risk number: 2519 – Risk to staffing the X-Ray on call rota. Risk score of 12; target 10 Risk number: 2546 – Reduction of staff in genetic counselling. Risk score of 12; target 4	Since the previous reporting period the following risk scores have reduced: **1705** – risk score previously 20 **2549** – risk score previously 20 **2579** - risk score previously 15 **2519** - risk score previously 15

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Putting People First	20.03.23	G.Hyatt	Approved

EXECUTIVE SUMMARY

The Bi-annual Nursing, Midwifery and Allied Health Professional (AHP) staffing report is provided to the Board of Directors after being presented to the Putting People First (PPF) Committee on 20 March 2023. The report sets out the Liverpool Women's NHS Foundation Trust (LWH) position in the context of the National Nursing, Midwifery and AHP workforce challenges. This report covers the period from July 2022 to December 2022 (Quarter 2 and Quarter 3). The report provides assurance that there are robust systems and processes in place throughout the year to monitor and manage Nursing, Midwifery and AHP staffing requirements. The PPF Committee were assured with the triangulation of information presented and noted the divisional level detail in several appendices (since removed), which were discussed, supported, and demonstrated divisional oversight and actions being taken to address and improve safe staffing.

The report presented highlights the following areas for discussion and noting during the reporting period (July 2022 – December 2022):

- Vacancy rate (Dec 2022) is 10.12%, with Maternity reflecting the greatest vacancies. Overall vacancy rate remains high due to several business cases previously approved and Trust Board commitment to over-recruit in Maternity.
- Maternity leave fluctuates between 34.52-41.65wte on maternity leave per month, with Dec 2022 recorded the highest in the reported period at 41.65wte.
- Sickness has been above threshold of 4.5% with Dec 2022 reflecting 11.12%, (9.45% non-covid related sickness).
- Long-term (LT) sickness rates have shown improvement within NMC/HCA staff groups over the past 12 months. Dec 2022 highlights LT sickness at 52.20% (NMC), 51.70% (HCA) and 53.09% (AHP).
- Turnover is high in small teams as reflected in AHP workforce, however NMC combined Trustwide remains under 13% threshold.
- Age profile has marginally shifted due to recruitment activity in divisions. Relatively static position of staff who can retire now or in next five years.
- Dec 2022 reflects Staff Training and Personal Development Review performance measures were not met. Overall, in the last 12 months there has been little evidence of sustained improvement across all Trustwide performance indicators.
- Clinical Incidents (391) related to staffing or staff sickness were noted highest in Maternity Services with 311. Red Flag events (273) were all reported from Maternity services. There were 27 Serious Incidents of which 16 related to single site or staffing challenges.
- Patient experience – 40 comments (from 5217) comments received in Friends and Family Test (FFT) mentioned staffing numbers or staffing shortages in the patients' experience. 107 comments (from 3223) relating to the Trust question "please tell us anything we could have done better" also related to staffing numbers or staff shortages.
- Complaints – 40 formal complaints received with 5 complaint categories relating to staffing levels, 1 was not upheld, with the remainder 4 under investigation. One PALS+ recorded (from 35) in relation to staffing in the issue raised. 4 PALS cases (from 1174) noted staff shortages in issues raised. 57 Compliments were received.
- Staff experience – 25 reported violence and aggression incidents, all relating to non-physical violence or aggression towards staff. No themes or trends identified across incidents.
- Recruitment and Retention – ongoing recruitment across the Trust continues with successful early recruitment of Midwives that commenced in October 2022. LWH continues to participate in International Recruitment (IR) in Theatres and Midwifery, with 3 Nurses and 2 Midwives who arrived in Q3. Further 13 international recruits expected before 31 March 2023 (5 Nurses, 8 Midwives).

All Divisions receive data as reflected above that is owned and reviewed at Divisional Board.

MAIN REPORT

1. Introduction

To provide the Board of Directors with a six-monthly update of the 2022/2023 staffing establishment reviews in relation to the Nursing, Midwifery and Allied Health Professional (AHP) workforce requirements. To report against the workforce requirements identified in 2022/2023 to achieve safe staffing across services within the Trust.

2. Background

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

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

The annual comprehensive Nursing and Midwifery workforce planning skill mix review was underway in Quarter 1 (2022/2023) ahead of budget setting to effectively inform any changes before staffing establishments are reviewed and signed off by the Chief Nurse and Trust Board.

The bi-annual Nursing and Midwifery staffing report details the Trusts position against the requirements of NICE guidance for adult wards (2014); NICE Guidance for maternity settings (2015), NQB Safer Staffing Guidance (2016) and NHSI, Developing Workforce Safeguards (2018).

The Trust Board receives twice-yearly staffing review papers; one which confirms a complete Nursing and Midwifery establishment review was undertaken via Divisional overviews (appendices 4-6, within PPF paper which is analysed) and a further comprehensive staffing report to ensure workforce plans are still appropriate across the clinical workforce, allowing for seasonal variance to be captured and reviewed appropriately.

Additionally, separate twice-yearly Midwifery staffing oversight reports are presented to Trust Board that update on staffing/safety issues, as a requirement for the Maternity Incentive Scheme, Year Four, Safety Action 5. Neonatal services report staffing to Trust Board yearly in line with Clinical Negligence Scheme for Trusts (CNST) requirements.

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

Developing Workforce Safeguards (NHSI, 2018) additionally recommends:

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

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

Table 1: National Quality Board (2016)

3. Workforce planning - Setting evidenced based establishments

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

The licence for SNCT was acquired by the Trust in July 2021 to use within Gynaecology in-patient ward ahead of the annual workforce planning review. Following training, Liverpool Women's Hospital participated in beta-testing of the Safer Nursing Care Tool within Gynaecology supported by NHSI. The results of the tool demonstrated that ward level care was level 0 (recognising patients require hospitalisation and ward level care) and High Dependency unit acuity level as 1B (patients who are in a stable condition but are dependent on nursing care to meet most or all activities of daily living). As a result of the findings the Nursing workforce for the Gynaecology Ward is under review and the division is exploring the development of an enhanced care facility to reduce the requirement for high dependency beds.

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

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

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

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

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

From April 2016, following the Carter Review all Trusts were required to publish staffing fill rates of RN/RM and Care Staff by hours and percentages (Actual versus Planned) and CHPPD via the Strategic Data Collection Service (SDCS), run by NHS Digital. A summary of the submission is uploaded onto the Trust website each month. Appendix 1 highlights data submitted from July 2022-December 2022.

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

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

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

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

4. Operational oversight of staffing and acuity-based care

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

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

4.1 Temporary Staffing

Since 22nd November 2021, NHS Professionals (NHSP) service commenced in the Trust. Operational oversight on a weekly basis continues and allows early resolution to issues arising. Early commencement of actions to reduce agency expenditure are in place.

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

- NHSP attendance at twice daily staffing meetings to support priority shift allocation
- NHSP team proactively manage agencies and cancellations
- Review and agree competitive incentives through NHSP Operational Group to support increase in fill rate
- NHSP Recruitment Team who will support with Bank Only recruitment
- Maternity roster management/forward view meeting to support decision making on shifts escalating to agency

NHSP continue to have a specific focus on Bank recruitment. The following is a summary of activity during Q2/Q3:

- NHSP reviewed agency cascade and removed higher cost agencies/ negotiated lower rates with agencies.
- Weekly updates on agency spend provided to directorates/divisions.
- Weekly engagement ward walks from NHSP local team including seasonal promotional events to reward bank workers and encourage substantive staff sign up
- Engagement with ward managers and matrons to maximise positive booking behaviours (encouraging high lead time and minimising bank member cancellations)
- Worked with HealthRoster to support successful rollout of Allocate Software
- Bank midwife sponsored adverts on Indeed for Liverpool Region
- Continued within Northwest region to promote LWH to current bank staff registered with NHSP

All new starters broken down by role and recruitment type from July 2022-December 2022 are noted in Table 2. The figures reflect a reduction of numbers of staff from previous reporting period (Jan 2022-June 2022 total recruitment of 112 versus July 2022-December 2022 equating 70). The Q2/Q3 decreased position is mainly due to the TUPE period ending within the previous reporting period as those staff were newly added to the NHSP system.

Roles	Bank	Multi-post Holder (MPH)	Total
HCAs Band 2&3	45	4	49
Midwives	2	4	6
Nurses	5	9	14
Theatres	0	1	1
Total	52	18	70

Table 2: Number of individuals added new to NHSP Bank between July 2022-December 2022

The performance of bank and agency demand and fill rate by directorate/division is reflected in Appendix 2. For comparison and a reflection of the NHSP journey from the previous reporting period, 12-month graphs are presented.

The graphs reflect overall that there has been an increase in demand as is typical throughout the year. Demand hours volume increased by 9.3% comparing Q4 (21/22) & Q1 (22/23) with Q2 & Q3 (22/23). During Q2/Q3 reporting Bank fill volume increased by 3.3% and Agency fill volume decreased by 32.4%. Utilisation demonstrates an average of 318.6 bank workers booking shifts each month during Q2/Q3 which reflects an increase on average by 8.8 bank members compared to previous 6 months reporting period.

The Trust has invested in the interface from Allocate Software as this enables unfilled shifts to be sent directly from HealthRoster to NHSP and then once filled they will interface to HealthRoster. Following a successful pilot of testing the interface between the systems, this has now been configured across all units managed on HealthRoster, apart from the 'Theatres' unit. We initially faced some challenges when testing all elements of the 'Theatres' roster interface, however these are being resolved and it is anticipated this unit will be live from April 2023.

5. Trustwide Nursing, Midwifery and AHP Workforce Measures (January 2022-June 2022 data; Q4 & Q1 position)

5.1 Vacancy position

The data highlights the vacancy position in December 2022 (Table 3) for Nursing, Midwifery and AHP of 105.53wte, which is a reduction from previous reporting period (136.65 in June 2022). This demonstrates a vacancy rate of 10.12%. Reassuringly, the vacancy rate has reduced from the previous reporting period (June 2022) where it was 13.32% with 16.36wte less budgeted staff compared to that in December 2022. The increase in budgeted WTE reflects agreed business cases and uplifts to establishments in the areas of Imaging and Theatres to support future proofing services requiring additional staffing resource to meet demands. Maternity vacancy rate reflects the additional Trust Board investment into staffing that has been supported, seeing 35.73wte newly qualified midwives commence in October 2022 with further recruited to commence later in the financial year. Five international recruits were welcomed to the Trust during Q3 within Theatres and Midwifery (3 Nurses, 2 Midwives), with a further thirteen expected to commence before the end of the financial year (5 Nurses, 8 Midwives).

All divisions are actively recruiting to their vacancy positions.

The vacancy position of 105.53wte is largest in Family Health Division combined with 66.57wte (Maternity, 44.05wte and Neonatal, 22.52wte), followed by CSS Division (35.44wte) and Gynaecology Division including Hewitt Fertility Centre (3.52wte).

Sum of Wte Budget	Sum of Wte Contracted	Sum of Wte Actual	Sum of Vacancies
1042.1	936.57	946.08	105.53

Table 3: December 2022 Trustwide vacancy position

5.2 Maternity Leave

Table 4 highlights the rolling and relatively static position of staff on maternity leave across each staff group and Trustwide. The group of staff with the largest maternity leave are those who are registered midwifes or nurses.

	Jul-22			Aug-22			Sep-22			Oct-22			Nov-22			Dec-22		
Maternity Leave	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Overall for All 3 Staff Group (WTE)	5.11	35.51	1.00	3.11	31.41	0.00	4.00	31.86	0.00	3.00	35.47	0.84	4.00	31.89	0.00	5.00	35.81	0.84
	41.52			34.52			35.86			39.31			35.89			41.65		

Table 4: Maternity leave

5.3 Sickness absence

The sickness absence over the reported six-month period (Table 5) has remained high and above the Trust threshold of 4.50%, with the largest combined peak across all staff groups in December 2022 at 11.12%, compared to that in the previous reporting period of 13.97% (January 2022). The lowest combined overall sickness rate was seen in November 2022 (8.85%) in the last six months.

Covid-19 related sickness saw a peak in July 2022 (3.26%), otherwise has remained under 2% and much improved overall from previous reporting period.

The overall percentage of sickness across the 3 staff groups in December 2022 is 11.12% and further breakdown of this illustrates the following:

- 9.45% was all non-covid related sickness
- 1.67% was covid-19 related sickness
- 0% was covid -19 special leave (this is not calculated in the sickness recorded)

	Jul-22			Aug-22			Sep-22			Oct-22			Nov-22			Dec-22		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Sickness	14.43%	8.21%	13.77%	13.68%	7.52%	11.71%	14.91%	6.66%	11.04%	15.44%	7.80%	10.88%	12.86%	7.47%	9.99%	16.35%	9.52%	9.37%
Overall Absence of All 3 Staff Group		9.95%			9.19%			8.86%			9.74%			8.85%			11.12%	
COVID Sickness	3.91%	3.09%	2.49%	1.86%	1.42%	1.08%	2.13%	0.88%	0.86%	3.01%	1.29%	0.00%	1.86%	1.02%	1.11%	2.04%	1.54%	1.86%
Overall Absence of All 3 Staff Group		3.26%			1.51%			1.18%			1.66%			1.22%			1.67%	
Sickness WITHOUT COVID Sickness	10.52%	5.12%	11.28%	11.82%	6.10%	10.63%	12.78%	5.78%	10.18%	12.42%	6.51%	10.88%	11.00%	6.45%	8.88%	14.31%	7.98%	7.51%
Overall Absence of All 3 Staff Group		6.69%			7.68%			7.68%			8.08%			7.63%			9.45%	
COVID Special Leave	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Overall Absence of All 3 Staff Group		0.00%			0.00%			0.00%			0.00%			0.00%			0.00%	
Trust Target 4.50%																		

Table 5: All sickness absence

5.4 Long-term and short-term sickness

Sickness over the six-month period reflects that long-term sickness continues to remain the greatest challenge across all staff groups, similar to previous reporting period. July 2022 (Table 6) shows the lowest long-term sickness rate for NMC staff group in the last 12 months (2022) at 51%, with December 2022 highlighting the lowest long-term sickness for HCA at 51.70% within the last 12 months (2022). AHPs reflect significantly high long-term sickness (August 2022, 93.21%), this is reflective of AHP's being a relatively small cohort of staff, which skews the data to appear disproportionately elevated when reviewing.

	Jul-22		Aug-22		Sep-22		Oct-22		Nov-22		Dec-22	
	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
NMC Staff Group Trust Total	49%	51%	39.27%	60.73%	33.40%	66.60%	47.15%	52.85%	47.64%	52.36%	47.80%	52.20%
HCA Staff Group Trust Total	32%	68%	37.84%	62.16%	23.35%	76.65%	32.21%	67.79%	31.44%	68.56%	48.30%	51.70%
AHP Staff Group Trust Total	26%	74%	6.79%	93.21%	14.59%	85.41%	9.77%	90.23%	36.17%	63.83%	46.91%	53.09%

Table 6: Long-term and short-term sickness proportions

5.5 Turnover

The Trust turnover threshold is 13%. The position has fluctuated over the last six months (Table 7) with the AHP workforce reflecting higher turnover than threshold. This is due to AHPs being a relatively small cohort of staff in small teams which artificially raises the percentage of turnover when the numbers of leavers may be only 1-2 staff. NMC staff groups have remained at or under threshold for the past 12 months whereas HCA staff group has been over threshold in November and December 2022 over the last year.

	Jul-22			Aug-22			Sep-22			Oct-22			Nov-22			Dec-22		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Staff Group Trust Total	10%	11%	19%	12%	12%	16%	13%	12%	19%	12.14%	11.66%	22.97%	13.62%	11.20%	21.89%	13.74%	10.42%	21.47%
Trust Target 13%																		

Table 7: Turnover

5.6 Age profile

Table 8 reflects the position overall across all NMAHP staff groups. The age profile in the staff groups overall have marginally shifted over most of the age bands, with recruitment of midwives commencing in September/October 2022 seeing an increase in headcount in age bands. There remains a risk in Nursing and Midwifery (NMC/HCA) to those

who may retire now or in the next five years, with the numbers within relevant age bands remaining relatively static since previous reporting.

Headcount	Jul-22			Aug-22			Sep-22			Oct-22			Nov-22			Dec-22		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
<=20 Years	3	0	0	3	0	0	4	0	0	4	0	0	3	0	0	3	0	0
21-25	26	56	1	26	56	1	28	60	1	36	69	1	30	71	1	25	73	1
26-30	30	85	5	29	81	5	28	78	5	30	84	4	30	85	4	33	85	4
31-35	27	115	11	23	119	11	24	120	11	28	124	12	25	128	10	24	130	10
36-40	31	91	6	31	91	7	34	96	6	32	100	4	33	96	5	34	94	5
41-45	24	98	7	24	92	7	25	89	8	27	94	8	27	93	9	27	93	9
46-50	29	68	4	28	72	3	25	69	3	28	69	4	27	74	5	27	76	6
51-55	31	82	5	33	80	6	33	85	5	31	81	6	29	80	6	29	79	6
56-60	27	82	5	28	83	5	28	81	4	28	82	4	28	85	4	25	83	4
61-65	27	36	1	27	36	1	27	35	1	28	37	1	26	37	1	29	39	1
66-70	4	2	0	4	2	0	4	3	0	4	2	0	6	2	0	5	3	0
>=71 Years	0	1	0	0	1	0	0	1	0	0	1	0	0	1	0	1	1	0
Total	259	716	45	256	713	46	260	717	44	276	743	44	264	752	45	262	756	46
Total of all 3 Staff Groups	1020			1015			1021			1063			1061			1064		

Table 8: NMAHP age profile data

6. Trustwide Nursing, Midwifery and AHP Training and Personal Development Review (January 2022-June 2022)

Across all staff groups it can be seen (Table 9) that the achievement and performance of training (MT, CMT, LMT) and Personal Development Reviews (PDRs) has been a fluctuating position across the six-months. Trust thresholds for indicators are as follows:

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

Over the reporting period it is evident that targets were generally not achieved except for the AHP staff group that met the target of Mandatory Training for 3 months (August-October 2022) with HCA staff group meeting target for Mandatory Training in October 2022. Overall, in the last 12 months, there is no evidence of sustained improvement across all Trustwide performance indicators, with December 2022 reflecting none of the indicators have been met across all staff groups. However, it does not reflect where small teams in divisions have met targets within the reported periods. Divisional updates reviewed at PPF (within appendix 4-7, Bi-annual NMAHP staffing paper presented at PPF) reflected average target compliance within division and actions being taken to support a focus on improvement.

	Jul-22				Aug-22				Sep-22				Oct-22				Nov-22				Dec-22			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
NMC Staff Group Trust Total	76.38%	72.24%	86.62%	81.54%	78.03%	73.49%	88.88%	77.10%	77.57%	73.85%	87.98%	75.54%	79.17%	74.48%	88.24%	75.75%	79.06%	76.58%	88.65%	78.03%	77.55%	77.41%	85.90%	76.54%
HCA Staff Group Trust Total	82.13%	76.68%	94.18%	80.37%	82.01%	76.43%	94.63%	74.77%	83.62%	75.74%	94.22%	73.93%	85.33%	76.16%	95.10%	74.40%	84.98%	80.05%	94.09%	76.35%	85.73%	82.52%	93.56%	72.33%
AHP Staff Group Trust Total	88.57%	90.51%	94.79%	88.89%	91.44%	89.58%	96.10%	82.05%	94.66%	88.00%	95.68%	82.86%	79.17%	94.51%	96.19%	73.53%	90.40%	92.86%	94.44%	80.00%	86.43%	91.57%	93.27%	67.57%

Table 9: Training and PDR data

7.0 Measurement of Quality of Care

7.1 Clinical Incident Reporting

The Trust has a local incident reporting system (Ulysses) that staff access to report any patient safety incident that is unintended or unexpected which could have (near miss) or did lead to harm, allowing the organisation to investigate,

learn and take action to prevent re-occurrence. Incidents related to staffing levels are an example of incidents reported. The caveat to all incidents exists that validation and possible re-categorisation of cause groups may alter from when an incident was initially reported. This occurs following the review and closing of the incident by the division and merging subsequent upload to the National Reporting and Learning System (NRLS) by the Corporate Governance Team, therefore the data presented is still subject to potential minor changes, however, reflects an accurate record when downloaded.

The number of Trustwide clinical incidents reported within the last six months (July 2022-December 2022) can be seen in Table 10. The data further highlights the incidents related to staffing levels and/or staff sickness affecting staffing levels and is drawn from the overall incidents reported within the timeframe.

Of the total clinical incidents related to staffing, Family Health Division had the largest volume of 313; (Maternity, 311 Neonatal, 2), Clinical Support Services (CSS) Division reported 24 and Gynaecology Division reported 54.

Since previous reporting period (January 2022-June 2022) all but one area (CSS) saw a rise in the number of clinical incidents relating to staffing, with Maternity seeing the greatest rise (95), then Gynaecology division (17) and Neonatal (1). The increased incident reporting in Maternity reflects the multi-factorial challenge faced with gross unavailability.

Reporting Period June 2022- December 2022
Total clinical incidents reported = 3613
Total staffing levels/staff sickness incidents reported related to clinical incidents (combined divisions) = 391

Table 10**:** Trustwide overview of incidents

7.2 Red flag events

NICE guidance (2014, 2015) recommends that the Trust have a mechanism to capture “red flag” events (Appendix 3). The Trust has incorporated the reporting of red flag events into the Trust incident reporting system. Incidents can be triangulated against acuity and dependency and planned versus actual staffing levels for the day. Triangulation of data assists with informed decision making related to staffing.

There were 273 (previously 174) red flags reported between July 2022 – December 2022 which is an increase of 99 since the previous reporting period with all the red flags reported from Maternity services.

On closer analysis of reported red flags in Maternity between July 2022 – December 2022, the 3 highest reported red flags following appropriate review are related to the delay in ongoing process of induction of labour >4 hours (150), delay of 30 minutes or more between presentation and triage (73) and occasions where one midwife is not able to provide continuous 1:1 care and support during established labour not met (21).

In November 2022 a Maternity ‘Red Flag Deep Dive’ review was undertaken by the Deputy Director of Nursing and Midwifery and presented to the Putting People First Committee (PPF) and Safety and Effectiveness Committee (S&E) in December 2022. The deep dive was commissioned to understand the high numbers of red flags reported within Maternity services. It was identified that a compounding factor for high reporting related to the introduction of a locally adopted red flag (delay >4 hours during ongoing induction of labour) which is permissible. The introduction reflects Maternity services desire to adopt a positive reporting culture by raising awareness of delays in induction of labour and to provide an appropriate obstetric review of women which is reflected of the Induction of Labour Guideline (v9.1). The review identified a series of recommendations supported by PPF and S&E, including the local red flag adopted be kept with a request for closer oversight of red flags via Divisional Performance Review in addition to Maternity Clinical Risk meeting.

To ensure patient safety, all women waiting for a bed on delivery suite or for an available midwife to provide 1:1 care in labour receive care as per Induction of Labour Guidelines (v9.1). This means that women are cared for in an induction of labour bay with care overseen by a midwife. Women waiting for transfer to delivery suite for ongoing

induction of labour are subject to a twice daily multi-disciplinary review to prioritise case-based need. The Maternity bleep holder and the Multi-Disciplinary Team review inductions of labour who are scheduled to come in the following day to identify and pre-empt any areas of challenge. All red flags are reviewed in Maternity Clinical Risk meeting.

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

7.3 Serious Incidents

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

There was a total of twenty-seven serious incidents (SIs) in the Trust between July 2022-December 2022, which is an increase from previous reporting period where the Trust had 12 SIs. Of the twenty-seven SIs, ten occurred in Maternity of which nine related to risks associated with being a single site or staffing (6 Diverts (staffing); 2 related to CT and critical care (single site); 1 related to MAU triage delay (staffing)). Neonates had two SIs (1 related to an invasive procedure and 1 an unexpected death) and neither was impacted by staffing or single site risk.

Gynaecology Division had ten SIs of which seven related to single site challenge (4 related to a lack of joint operating capacity with Liverpool University Hospital Foundation Trust (LUHFT), 1 related to a critical care transfer, 1 related to MRI results delay and 1 related to transfer to LUHFT for CT). CSS division reported five SIs of which one was declared as a Never Event (retained foreign object, detected, and removed whilst patient anaesthetised). None of the CSS SIs/Never Event noted single site or staffing as a contributory factor.

7.4 Patient Experience - Friends and Family Test (FFT)

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

A total of **5217** "Overall Experience" comments were received during the period July 2022 to Dec 2022.

Of these **286** (5.9%) comments were received by patients noting themselves as "displeased". Of these displeased comments **40** (14%) mentioned staffing numbers/shortages in their description of their experience. These mainly related to Maternity but did cover other areas as well. The common theme of these continues to be a lack of support on the ward which the patients attributed to being understaffed.

The FFT asks patients "please tell us anything we could have done better". In the period from July 2022 to December 2022, **3223** comments were left in this section covering both Pleased and Displeased results. Of these **107** (3.3%) identified staffing numbers/shortages as something that needed to be improved, this is a similar volume to that reported in the previous reporting period. The majority of these related to Maternity services, mainly attributed to Maternity Base with common themes such as:

- waiting for pain relief/call bells/support
- delayed discharge
- Patients being concerned about the wellbeing of staff due to workload.

Gynaecology themes were:

- Waiting time for clinic appointments
- Waiting times in GED

7.5 Complaints, Concerns and Compliments

There were **40** formal complaints received in the Trust during July 2022– December 2022 which was an increase of four from previous six months (36). These contained 288 individual categories of concerns that required investigation within these 40 complaints, an increase of 73 individual concerns from the previous reporting period. An average of 7 categories of concerns raised per complaint (previously 6). Response rates for these complaints answered in timeframe agreed with the complainants stands at 50% compliance for this reporting period (previously 52%). There were 5 complaint categories where staffing levels were raised specifically. After investigation one was found to be "not upheld", the other 4 are still currently under investigation.

There were **35** PALS+ recorded during the reporting timeframe (an increase of 20 previously) with **one** of these cases noting staffing in the issue raised. There were **1174** PALS cases noted within July 2022 – December 2022 which is an increase from the previous reporting period (899). There were **4** PALS case noted where shortages of staff were noted as the issue raised (2 in previous reporting period). These are reported into relevant divisions who review and respond.

There was a total of **57** compliments Trustwide received (via PALS) within the timeframe which broadly covered general satisfaction of the service provided, which includes staff groups and individuals. Compared to the previous reporting period this is an increase 8 compliments. Of the 57 compliments the clinical divisions breakdown is: Gynaecology, 22; Maternity, 27; and CSS, 6. The remainder were in more than one area or in corporate services. All compliments, where possible when individuals are identified, are shared with the individual and their manager/leaders.

7.6 Staff Experience

Recognising that there can be challenges working in busy clinical roles at LWH, several interventions are in place to support staff and managers. We recognise safe staffing is the single most important determinant of employee morale, closely followed by supportive line management. LWH has implemented several strands of work to support the working lives of staff. The following is an appraisal of action being taken:

Health and Wellbeing – The LWH Staff Support Service has now gone live. This service is led by a Consultant Psychologist and provides access to trauma focused psychological support and preventative training, as well as providing listening forums and counselling services. We have two Wellbeing Coaches who are focused on delivering Health and Wellbeing Conversations and practical support to staff in maternity, as well as supporting with wider health and wellbeing initiatives such as the 'Know your Numbers' health and wellbeing days. Following Covid, Occupational Health and physiotherapy are returning to the LWH site.

Leadership and Management Programme – The Trust runs three leadership and management programmes which are accredited by the Chartered Management Institute. Over 100 staff have either completed or are currently engaged on a programme

- Aspiring leaders – Colleagues at the start of their leadership journey or considering leadership in their future career (anyone)
- First Line Emerging Leaders – New leaders or existing leaders who need to further skills and knowledge and learn the fundamentals of leadership
- Middle to Senior Leaders – Senior established Leaders looking to progress into more senior leadership roles

Flexible Working - Representatives from Nursing and Midwifery have been engaged in a task and finish group looking at how we can give staff more autonomy and ownership over their working pattern. Two surveys with staff have been conducted, and unlimited requests has been trialled within maternity and is being rolled out in other clinical areas.

Breaks Audits - Breaks continue to be closely monitored, with a programme of ongoing audits and feedback on progress at Professional Forum. The next update is due to be received before the end of the financial year.

The Trust continues to facilitate *Trust forums* designed to support staff or enable them to share their views. Commitment of attendance from NMAHP'S is seen for the *Great Place to Work Group* and *Schwartz Rounds.* A focus on improved internal communication has taken place with the launch of '*3 key messages'*, a mix of Trust, divisional and local communications which is disseminated to staff through huddle and handover. Staff Survey action plans focus on 3 key areas of improvement and are tracked through Divisional Boards. 'Big Conversations' take place 2 or 3 times a year and is an opportunity for colleagues at all areas to have a voice and be part of making positive changes.

7.7 Staff reported incidents (Violence and Aggression)

During July 2022–December 2022 the number of reported incidents related to verbal or physical acts of violence or aggression against NMAHP staff is recorded as **25**. This is a reduction of 7 when compared with the previous reporting period (32). Of the 25 incidents none of the incidents related to physical violence, there were no trends or themes as all related to individual circumstances. Security was requested to attend on 9 occasions.

The breakdown of the 25 reported incidents in current reporting period (July 2022-December 2022) reflects gynaecology services, 12; Neonates, 5; Maternity, 4 and CSS with 3.

There is continued emphasis on hearing staff views to make improvements on the experience of health and wellbeing and reporting of violence at work.

8.0 Attraction, Recruitment and Retention

The Learning and Development Facilitator in the Trust has a role in supporting the Trust attraction, recruitment, and retention plans. They do this in the following ways:

- Widening participation – aimed at people who may not possess academic qualifications yet have the attitude and values congruent to the NHS by supporting people and providing opportunities for development
- Acorns/Cadets – providing placements to 16–19 year old college students studying a Level 3 Extended BTEC Diploma in Healthcare considering a career in the NHS. The Trust offers 5 placements and of the 5 who completed in July 2022, 3 were successful in gaining places to undertake Paediatric, Adult Nursing and Midwifery training. The interviews allowed students to draw upon their placements and experience at LWH.
- Work Experience – previously suspended due to Covid-19, however, this briefly re-opened in July 2022 for one school (year 12&13 students) to trial paperwork. Of the students who attended success can be measured in the following ways in what they went on to do: 3 Adult Nursing, 1 Mental Health Nursing, 1 trainee at Heart and Chest Hospital, 1 on Health and Social Care course, 1 Special Education Needs Teaching. Feedback from the school is that LWH work experience was a factor for success. Plans in place for opening fully to work experience at LWH after Easter 2023.
- Apprenticeships – two places filled for OPD Apprenticeships commencing in September 2022, appointed from within the Trust, of which one staff member was enabled to apply after attending maths lessons on site following this they obtained a Maths GCSE qualification.
- Recruitment fairs – the Trust actively attends and participates in fairs to share opportunities to communities on job availabilities. During July 2022-December 2022 the Trust attended an event in October 2022 at the University of Liverpool. This event was to inform students about careers across the NHS and posts available/how to apply, with on this occasion and increased focus on Finance and HR careers and jobs.

LWH continues to engage and support plans within the North-West Maternity Region on International Recruitment (IR) as part of a collaborative bid hosted by Wrightington, Wigan and Leigh NHS FT. LWH also continues to recruit International Theatre Nurses through Cheshire International Recruitment Collaborative (CIRC).

The current position reflects that during July 2022-December 2022 five IRs arrived (3 nurses, 2 midwives) with an expected thirteen (5 nurses, 8 midwives) to commence at the Trust before 31st March 2023. On arrival to LWH all IRs have a full onboarding programme.

Ongoing recruitment of newly qualified nurses and midwives continues as students qualify and in line with vacancy position across all divisions. In Maternity recruitment of newly qualified midwives has been undertaken in the reporting period with approximately 35.73 wte (38 headcount) newly qualified midwives commencing in October 2022. In addition to the recruitment of newly qualified staff, rolling adverts for posts across all divisions continues to attract experienced nurses, midwives and AHPs until they reduce or resolve their vacancy position.

LWH was previously successful in bidding for two sources of NHSI funding to be used to support Midwifery and Health Care Support Workers (HCSW) retention and ongoing support for 6-12months. The retention team in place completed pieces of work and analysis including completion of a scoping exercise to assess training and development needs of HCSWs, generic interview questions for use in the Trust when interviewing HCSWs, pastoral support and learning to cohorts of HCSW staff through the Care Certificate. The retention lead midwife additionally supported stay interviews with midwives, onboarding and was an active member of the flexible working group. The retention lead midwife additionally completed a project to establish how support is offered to staff who are on long-term sick leave, with a view to accomplishing a smoother return to work for affected staff. Recommendations have been integrated into Maternity. The Band 3 HCSW has been retained and integrated into OD&L team to support on-going development of HCSWs, due to positive feedback and achievements made to date.

In July 2022 the Trust received correspondence from NHS England (as did all Trusts) highlighting the vital role nursing and midwifery staff play in ensuring the delivery of safe and effective healthcare. Two principles were highlighted within the correspondence relating to the People Promise to support the retention of nurses and midwives. One principle related to targeted interventions for different career stages and the second to adopt a bundle approach to deliver sustained gains. The Deputy Director of Workforce and the Deputy Director of Nursing and Midwifery have been working through the self-assessment retention tool that underpins retention and identifies the biggest gaps to formulate a baseline to how the Trust measures. With support from the Heads of NMAHP an improvement action plan will be progressed to enable the Trust to focus on those evidence-based interventions that have the greatest impact on the retention of nurses and midwives.

9.0 Actions and recommendations:

The following actions are proposed during next six months (July 2022-December 2022):

- Succession planning across all divisions in line with business planning cycle
- Continued focus to recruiting to vacancy position
- Divisions to set and review trajectories of improvement in Training and PDRs to be reviewed through monthly Divisional Performance Reviews
- Several actions related to ongoing work with NHSP such as:
    - Rolling adverts with focus on full bank recruitment and increase substantive staff registration
    - Attendance at future jobs fairs in region and attend any relevant LWH recruitment events.
- Continued focus on the nursing and midwifery self-assessment tool/retention improvement and action plan
- Continued joint working with Head of OD&L and Deputy Director of Nursing and Midwifery to develop Chief Nurse sponsorship and enrichment opportunities

10.0 Conclusions

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

The Board of Directors are requested to agree and support the actions and recommendations highlighted in Section 9.0 of the report.

Furthermore, the Board of Directors are requested to take assurance that divisional oversight and actions to address areas of challenge is in place as reported at PPF Committee. Specifically noting that Maternity services report staffing twice yearly directly to the Board of Directors to fulfil requirements as outlined by The Maternity Incentive Scheme (MIS) Year 4, Safety Action 5. Neonatal services provide Board of Directors with a yearly Clinical Negligence Scheme for Trusts (CNST) compliance report.

Appendix 1 – CHPPD and Actual versus Planned Fill Rates

The NHS Digital Return via Strategic Data Collection Service (SDCS) - Safe Staffing Fill Rate each month are noted as per below from July 2022–December 2022. The data is presented monthly to Trust Board via the Integrated Performance Report, supported by a detailed narrative and triangulation of information from the Heads of Nursing and Midwifery.

July 2022

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	87.6%	83.9%	92.3%	100.0%
Induction & Delivery Suites	79.0%	73.1%	121.0%	93.5%
Maternity & Jeffcoate	72.4%	85.1%	77.9%	88.1%
MLU	61.3%	41.9%	73.4%	54.8%
Neonates (ExTC)	101.0%	96.8%	103.4%	79.0%
Transitional Care	54.8%	103.2%	93.5%	41.9%

August 2022

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	76.6%	76.3%	111.3%	100.0%
Induction & Delivery Suites	85.1%	78.5%	90.6%	91.9%
Maternity & Jeffcoate	70.5%	73.3%	65.4%	82.1%
MLU	63.7%	67.7%	68.5%	77.4%
Neonates (ExTC)	102.5%	87.1%	105.9%	64.5%
Transitional Care	58.1%	106.5%	87.1%	80.6%

September 2022

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	74.2%	88.9%	118.3%	100.0%
Induction & Delivery Suites	79.2%	80.0%	83.8%	105.0%
aternity & Jeffcoate	67.1%	78.6%	73.8%	85.0%
MLU	58.3%	60.0%	70.8%	63.6%
Neonates (ExTC)	102.1%	76.7%	98.6%	93.3%
Transitional Care	36.7%	116.7%	83.3%	63.3%

October 2022

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	89.9%	93.5%	127.4%	100.0%
Induction & Delivery Suites	82.6%	88.2%	73.7%	103.2%
Maternity & Jeffcoate	77.2%	91.2%	74.9%	89.1%
MLU	70.2%	71.0%	73.4%	67.7%
Neonates (ExTC)	104.2%	61.3%	104.1%	62.9%
Transitional Care	38.7%	116.1%	74.2%	90.3%

November 2022

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	87.5%	83.3%	128.3%	103.3%
Induction & Delivery Suites	84.9%	83.3%	82.3%	100.0%
Maternity Base & Jeffcoate	97.1%	87.5%	84.3%	82.5%
MLU	87.5%	90.0%	75.8%	80.0%
Neonates (ExTC)	101.9%	91.7%	103.2%	81.7%
Transitional Care	23.3%	116.7%	63.3%	76.7%

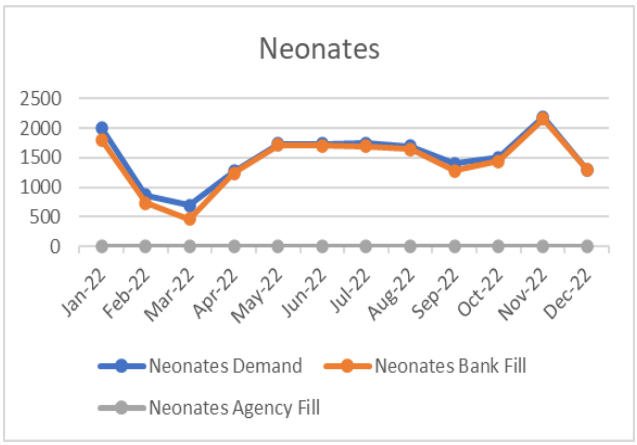
December 2022

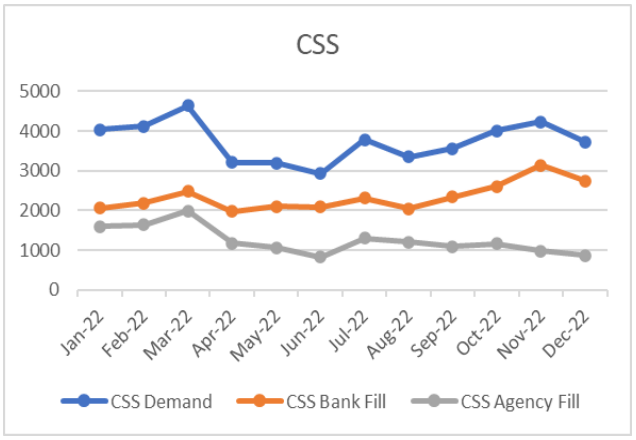
WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	80.6%	87.1%	135.5%	96.8%
Induction & Delivery Suites	81.5%	86.0%	80.1%	98.4%
Maternity Base & Jeffcoate	88.5%	68.5%	75.1%	75.8%
MLU	69.4%	67.7%	69.4%	71.0%
Neonates (ExTC)	99.0%	83.9%	100.0%	66.1%
Transitional Care	64.5%	71.0%	71.0%	58.1%

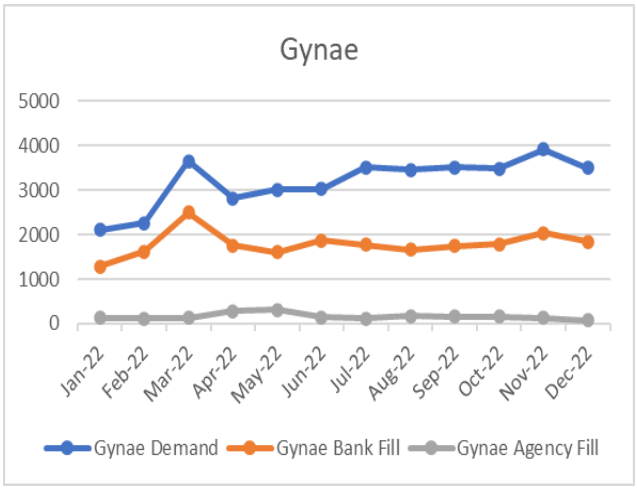
CHPPD

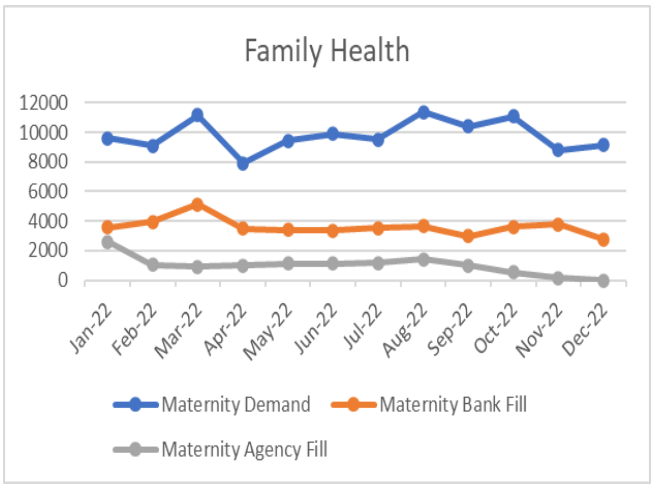
CHPPD	July 22	August 22	September 22	October 22	November 22	December 22
Trust wide	8.1	7.4	7.4	7.8	8.2	8.4

Appendix 2: NHSP January 2022- December 2022 Bank and Agency demand and fill rates by Directorate/Division









Appendix 3: NICE Guidance on Red Flag Events

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

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

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

Other midwifery red flags may be agreed locally.

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

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

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
    - Pain: asking patients to describe their level of pain level using the local pain assessment tool.
    - Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
    - Placement: making sure that the items a patient needs are within easy reach.
    - Positioning: making sure that the patient is comfortable, and the risk of pressure ulcers is assessed and minimised.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered

nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).

- Less than 2 registered nurses present on a ward during any shift.

Other nursing red flag events may be agreed locally.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/009d*		**Date: 06/04/2023**	
Report Title	Mortality and Learning from Deaths Report Quarter 3, 22/23			
Prepared by	Lidia Kwasnicka, Gynaecologist; Ai-Wei Tang, Consultant Obstetrician; Rebecca Kettle, Consultant Neonatologist and Chris Dewhurst, Deputy Medical Director.			
Presented by	Lynn Greenhalgh, Medical Director			
Key Issues / Messages	The Board is asked to review the contents of the paper and take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	It is it is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths. In addition, as per The Learning from Deaths framework requirements the Board are requested to note: • number of deaths in our care • number of deaths subject to case record review • number of deaths investigated under the Serious Incident framework • number of deaths that were reviewed/investigated and as a result considered due to problems in care • themes and issues identified from review and investigation • actions taken in response, actions planned and an assessment of the impact of actions taken. • the care issues identified in the antenatal management from referring trusts. It is recommended that a review of antenatal care findings from the previous PMRT reviews is undertaken and if any common themes identified that this is presented to the local maternity system			
Supporting Executive:	Lynn Greenhalgh, Medical Director			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*					
Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☒		
Strategic Objective(s)					
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒	To participate in high quality research and to deliver the most ***effective*** Outcomes	☒		
To be ambitious and ***efficient*** and make the best use of available resource	☒	To deliver the best possible ***experience*** for patients and staff	☒		
To deliver ***safe*** services	☒				
Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)					
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks*		Comment: N/A			
Link to the Corporate Risk Register (CRR) – CR Number:		Comment: No			

EXECUTIVE SUMMARY

This "Mortality and Learning from Deaths" paper presents the mortality data for Q3 2022/23 with the learning from the reviews of deaths from Q2 2022/23. The 'learning' can take some time after the death occurs due to the formal processes and MDT review process that occur. This results in the learning being presented a quarter behind the data.

In quarter 3 there were the following deaths:

Adult deaths	**0**
Direct Maternal Deaths	**0**
Stillbirths	**8 (excluding ToP)**
Neonatal deaths	**16 (including 8 in-utero transfers and 1 post-natal transfer)**

The stillbirth rate remains lower this year than last year but there is an increase in this quarter to 4.3/1000 live births. Due to small numbers, full year data should be reviewed to determine any trends. Benchmarking data is presented for Q3 which shows that LWH stillbirth rate is below the average for similar sized maternity services.

There was an increase in Neonatal mortality. This resulted from 10 babies whose deaths resulted from congenital anomalies. International network benchmarking data is presented for 2021 neonatal mortality. This risk adjusted mortality for 2021 was the lowest it has been since this benchmarking commenced.

Learning from PMRT reviews is presented with more detailed information relating to the reviews in the paper.

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

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

MAIN REPORT

This is the quarter 3 2022/23 mortality report for adults, stillbirths and neonates. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust. This is in accordance with recommendations by the National Quality Board "National Guidance on Learning from Deaths" and the Care Quality Commission. It outlines the work taking place operationally and being overseen by the Safety and Effectiveness Sub - Committee and Quality Committee. The paper also provides the evidence required for the Maternity Incentive Scheme (MIS) which was recommenced on May 6th 2022.

The data presented in this report relates to Q3 2022-23. The learning relates to deaths in Q2 2022-23. This is due to the multidisciplinary review of deaths not occurring in the quarter when the death occurred.

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

1 Adult Mortality

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

1.1 Obstetric Mortality Data Q3 2022/23

There were no direct maternal deaths (deaths within 42 days of delivery) in Q3.

1.2 Learning from Obstetric Mortality Data Q2 2022/23

In Q3 2021/22, there was one death of a woman who died approximately 8 weeks after delivery. This case is subject to a Coronial investigation and, as per the requirements of the Ockenden review, a multiagency review has been completed. The Coroner's inquest was due to take place in late November 2022 but has been adjourned to a later date. The internal SI has been completed with learning included in the previous Q2 report. The outcome from the Coroner's investigation will be included in this report when available.

1.3 Gynaecology Mortality data Q3 2022/23

There was 0 deaths within Gynaecology Oncology in Q3 2022/23.

1.4 Learning from Gynaecology Mortality Q2 2022/23

There were no deaths to review from Q2 2022/23. There was one death of a woman who had surgery at LWH before being transferred to LUFHT where she later died. This death is reported as an LUFHT death but is subject to a joint SI that will complete in February 2023. Learning form the SI will be presented in the Q4 report. This death is also subject to a coronial investigation

2 Stillbirths

2.1 Stillbirth data

There were 8 stillbirths, excluding terminations of pregnancy (TOP) in Q3 2022/2023. This has resulted in an adjusted stillbirth rate of 4.3/1000 live births for Q3.

STILLBIRTHS	Feb-22	Mar-22	Apr-22	May - 22	June-22	July-22	Aug-22	Sept-22	Oct-22	Nov-22	Dec-22	Jan-22	Q3 Cases (Oct-Dec)	TOTAL 2022/23 (until Jan)
Total Stillbirths	4	6	3	4	3	7	3	2	**3**	**4**	**6**	2	**13**	**37**
Stillbirths (excluding TOP)	**0**	**5**	1	4	2	3	3	1	**1**	**2**	**5**	**1**	**8**	**23**
Births	561	595	601	652	613	643	657	659	**649**	**596**	**619**	613	**1864**	**6302**
Overall Rate /1000	7.1	10.1	3.3	6.1	4.9	10.9	4.6	3.0	**4.6**	**6.7**	**9.7**	3.3	**7.0**	**5.9**
Rate (excluding TOP)/1000	**0**	**8.4**	1.7	6.1	3.3	4.7	4.6	1.5	**1.5**	**3.4**	**8.1**	**1.6**	**4.3**	**3.6**
Pregnancy loss 22-24 weeks	0	1	0	0	0	0	0	1	**1**	**1**	**1**	1	3	5

Table 1 Stillbirth rates > 24 weeks for 2022-23

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

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

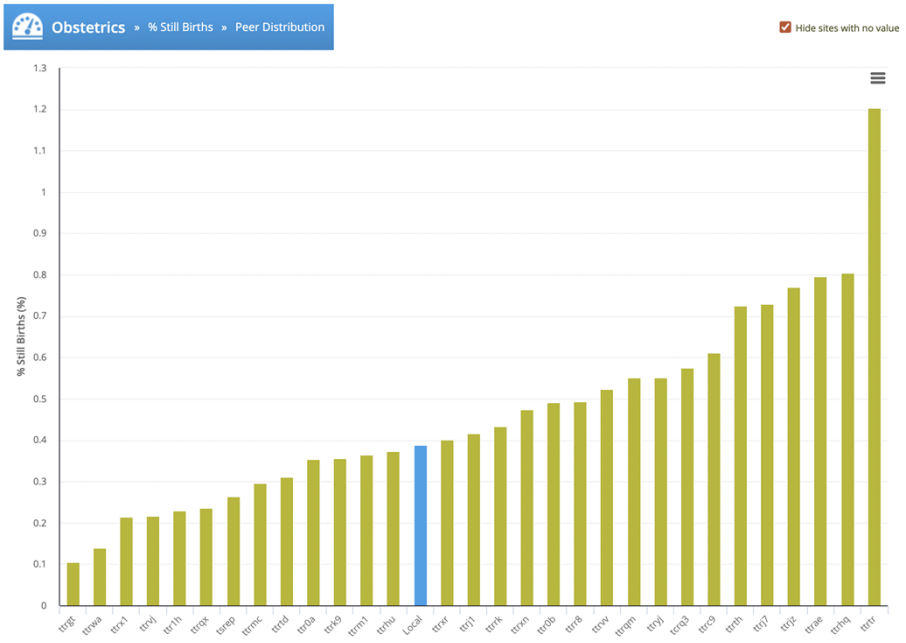


Figure 1. Stillbirth data for Q3 with LWH benchmarked against other large maternity services (>7000 deliveries) for Q3 2022-23. The blue bar is LWH data demonstrating the observed rate is below the average.

The stillbirth rate for Q3 22/23 has increased from Q1 and 2 but is lower than the average rate seen in 2021/22. The stillbirth rate in the first three quarters 2022-23 is also lower than seen on 2021-22. This is reassuring but assurance will only be provided with full year data due at the end of Q4. There were three pregnancy losses (excluding TOP) born between 22 – 24 weeks gestational age.

Two women (3 Stillbirths as 1 set of twins) were of non-white ethnicity, and both did not speak English as their first language

2.1 Learning from Stillbirth reviews Q2 2022-23 N=8

All eligible cases underwent a full multidisciplinary team PMRT review with external clinician presence in 6/8 reviews. Care from across the antenatal and intrapartum period was subject to clinical and managerial scrutiny. All bereaved parents were invited to be involved in the review process by submitting comments and questions via the Honeysuckle Team for discussion at the MDT Review

The reviews of Q2 stillbirths (N=8) demonstrated that 3 cases (38%) had no antenatal care issues identified, and 4 (57%) had care issues identified which would not have changed the outcome of the pregnancy. There was one case where care issues were identified which may have affected the outcome of the pregnancy. This related to the time interval between ultrasound scanning for fetal growth. This case has been subject to a 72-hour review and is proceeding as a formal review of care to maximise any potential learning.

Half of the cases identified issues with postnatal care. The issues, learning and action plans are included in the appendix Q3 SB report. They include not completing all stillbirth investigations and patient experience due to lack of HDU support on delivery suite, inability to provide one to one care and acuity on MAU not facilitating the ability for the woman to be triaged in a private side room as is routine practice.

Grade	Care in antenatal period	Percentage (%)	Care provided after Stillbirth	Percentage (%)
A	3	37.5	4	50
B	4	50	4	50
C	1	12.5	0	0
D	0	0	0	0

Table 3 PMRT review panel grading of care provided in cases of Stillbirth (N=8)

Learning from Q2 in the provision of antenatal care includes:

- Ensuring the neonatal team are included in the morning maternity base safety huddle and utilise the joint extreme prematurity proforma
- Arranging serial growth scans so that the time interval is 3-4 weekly.
- Develop a management pathway for counselling and review in cases of arthrogryposis

Actions that are completed from areas of learning from previous quartiles include:

- Joint Obstetric and Neonatal counselling formed part of the maternity base improvement plan, and there is now a morning safety huddle in the ward, where the neonatal team are informed of cases requiring joint counselling
- Palliative care team has been granted access to K2 which allows them to document intrapartum and postnatal management plans, and attach relevant documents into the electronic notes.
- Complex FMU cases discussed in the MDT will have a detailed management plan (including intrapartum management) from 32 weeks gestation, which are uploaded onto K2.
- LOTW sent on: importance to send cord blood gas for analysis in situations of adverse outcomes; to complete ‘pregnancy loss’ referral to ensure subsequent appointments are cancelled accordingly; and for PN readmission to be reviewed by most senior clinician, and for investigations to be arranged on site if possible

Ongoing actions that are in progress include:

- Capacity and demand review of services in FMU, including the multiple pregnancy service
- Review of bereavement services to increase staffing levels to be able to have a 7 day service
- Upskilling of midwives to improve provision of HDU care in Delivery Suite

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

3. Neonatal Mortality

3.1 Neonatal mortality Data Q3 2022/23

Neonatal deaths can be reported in several ways. The population can include in-born babies only, LWH booked pregnancies or all babies cared for in LWH (including babies transferred to LWH from other care providers). Deaths may be those within 28 days (reported in MBRRACE), those occurring prior to discharge from the NICU and those who die following transfer to another hospital. The data may include or exclude babies with congenital anomalies. The table below presents the total mortality at LWH, and mortality for those babies born at LWH in a rolling 12-month period.

	Jan-22	*Feb-22*	*Mar-22*	*Apr-22*	*May-22*	*Jun-22*	*Jul-22*	*Aug-22*	*Sep-22*	*Oct-22*	*Nov-22*	*Dec-22*	*Total*
Total Mortality	2	3	3	*3*	*7*	*3*	7	3	4	5	5	6	51
INBORN Neonatal Mortality	**2**	**3**	**3**	***2***	***4***	***3***	**5**	**3**	**4**	**5**	**5**	**5**	**44**
BORN + DIED LWH Neonatal Mortality Rate / 1000LB	---	---	---	---	---	---	---	---	---	*1*	*2*	*3*	
Births	659	561	595	*602*	*654*	*613*	632	658	652	649	596	619	7490
INBORN Neonatal Mortality Rate/1000LB	**3.0**	**5.3**	**5.0**	***3.3***	***6.1***	***4.9***	**7.9**	**4.5**	**6.1**	**7.7**	**8.3**	**8.1**	**5.9**

Table 4: NICU Mortality by month for the past 12 months.

Quarter	NMR all babies	NMR *in born*
Q4 (21_22)	4.4	4.4
Q1 (22_23)	7.0	4.8
Q2 (22_23)	7.2	6.2
Q3 (22_23)	8.6	8.0

Table 5: Neonatal Mortality Rate per quarter

In this quarter there was a total of 16 deaths. 10/16 (63%) of these babies were born following an in-utero transfer from another hospital provider. 1/16 was a postnatal transfer (6%). The cause of death was attributed to congenital anomalies in 8/16 (50%) of deaths. Prematurity (<28 weeks) was the cause in 5/16 babies (32%).

10/16 (63%) of babies who died were from the most deprived decile as per postcode data.

Benchmarking data is available for 2021 mortality from the Vermont Oxford Network. This is an international network of 1400 neonatal unit of which LWH NICU is a member. The outcome for infants born less than 1500g (Very Low Birth weight) infants is compared. In 2021, the risk adjusted mortality for the LWH cohort was within the expected range, with the observed mortality being the closest since participation in the network began (1.2).

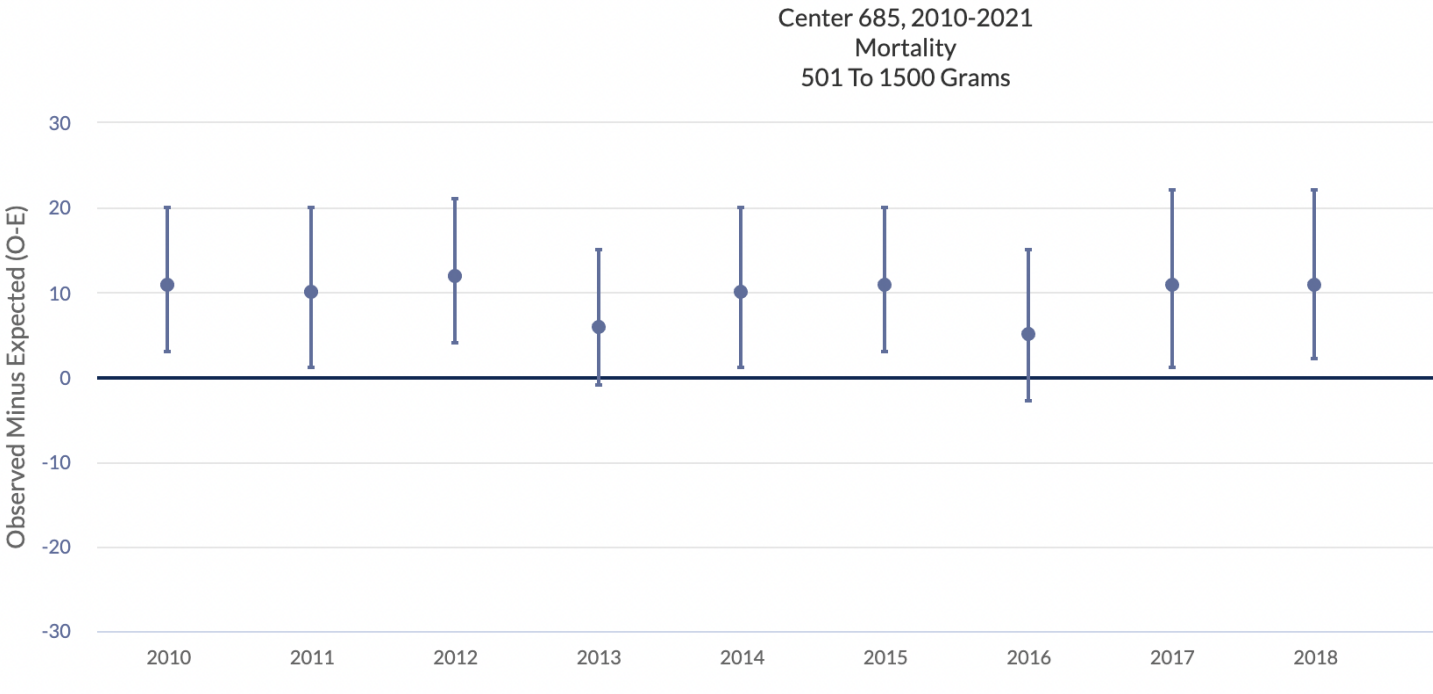


Figure 3. Observed vs expected mortality for VLBW infants at LWH since 2010. The vertical line indicates the 95% confidence interval for the standardised mortality rate. If the line crosses the 0

horizontal line (as in 2013, 2016 and 2021) it demonstrates that the observed infant mortality is within the expected range.

3.3. Learning from neonatal mortality reviews for Q2

There were 12 deaths subject to a PMRT review. There were no cases identified with care issues which were likely to have made a difference to the outcome. There were 3 (25%) cases where care issues were identified in the antenatal care in other organisations that may have affected the outcome. These is similar to last quarter where 5/12 cases identified antenatal care issues related to care provided from referring organisations. The author recommends that a review of antenatal care findings from the previous PMRT reviews is undertaken and if any common themes identified that this is presented to the local maternity system.

One case was subject to an SI review as neonatal care issues may have made a difference to the outcome. This SI has concluded (STEIS 2022-17258) with several lessons learned regarding the management of endotracheal tubes, intubation, resuscitation, documentation, and management. The SI report includes recommendations for practise for teams and individuals with an action plan monitored through the neonatal integrated governance meeting.

There were three cases (19%) identified where antenatal care issues may have made a difference to outcome. This related to communication issues. There were 7/16 (44%) incidents of neonatal care that may have made a difference to the outcome. Airway management was identified in 3 of these with an ongoing QI project underway to address this issue.

Other Learning included the following:

- Unplanned extubation continue but the QI project has now commenced to aim to reduce this.
- Skin injuries in extremely preterm infants with plan to revise the extreme preterm pathway to include changing stas probe regularly and not to use ECG leads.
- Consultant team reminded of importance of documenting parental discussions

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

4. Recommendations

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

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care

- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.

5. Appendices

- Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report – Q3 (Oct – Dec 2022)
    - Available to Board members via Admin Control Supporting Documents folder.

Liverpool Women's NHS Foundation Trust

Trust Board

Agenda Item	***23/24/009e***		**Date: 06/04/2023**	
Report Title	**Guardian for Safe Working Hours Quarterly Report – Q3 2022/23**			
Prepared by	***Rochelle Collins, Medical Workforce Manager***			
Presented by	***Lynn Greenhalgh, Medical Director***			
Key Issues / Messages	The Guardian of Safe Working Hours (GoSWH) is required to report quarterly to the Trust Board and Sub Board Committee as per the 2016 contract. The report covers aggregated exception reports, fines levied, data on rota gaps, locum usage, other relevant data, and qualitative narrative on good practice or persistent concern for the period of 1 October – 31 December 2022.			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	To be assured that the hours and templates are safe and compliant in each service and in line with the junior doctor contract.			
Supporting Executive:	***Lynn Greenhalgh, Medical Director***			

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

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

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1.2 Failure to recruit and retain key clinical staff	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	**Date**	**Lead**	**Outcome**
PPF	**Mar 23**	**Medical Director**	

EXECUTIVE SUMMARY

The Board is advised:

- rota establishment continues to fluctuate throughout the year with robust processes in place to mitigate the use of high-cost agency locums wherever possible by using internal bank, doctors in training and ANNPs
- The services work less remotely, virtually and via telephone
- During this reporting period, Q3 2022/23 the service continued to operate with a reduced number of senior PGD's due to a combination of maternity leave and long term sickness.
- Redesign of the Tier 1 rota to provide additional weekend daytime cover working on the wards
- Feedback has been positive about the introduction of a hot week for the Tier 1 and tier 2 doctors ensuring continuity of care on the maternity wards.

Exception reports continued to be submitted; eight exception reports were submitted six submitted on extra hours worked and one for natural breaks and one for staffing levels. The service reviewed the Foundation Year 1 work schedule.

During this reporting period the O&G service received the GP information for the forthcoming rotation (Q4) and it is apparent that there will a number of gaps due to maternity leave, LTFT working and adjusted duties where Doctors cannot work outside Monday to Friday 0900 – 1700. The 3 Foundation Year 3 doctors have resigned form their posts (end date Feb 23) this is not unusual as FY3 posts are designed for 6 months. This has resulted in the rota being reduced to a 19 slot rather than 22. Essentially, this means there are 19 doctors required for the rota rather than 22.

Due to this change being a service need, the service has agreed to honour any annual leave already booked by doctors remaining at the Trust after Feb 23.

The Board is asked to take assurance that the current rotas are compliant and PGD's are rostered in line with their contract.

The Board is asked to note the GOSW is currently away from the Trust therefore the GSWH may include further information from Q3 in her next report should it not be include in this report.

REPORT

1. Introduction

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

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

This report covers all of the above for the reporting period 1st October – 31st December 2022 and relates to the final quarter of the year.

2. Guardian Report

2.1. Aggregated exception reports including outcomes

During this quarter, 7 exception reports were made, all from O&G PGDs.

Period	Specialty	Grade	Reason	#exceptions	No: hours	other	Outcome
Q3	O&G	ST3+	Hours	3	3.5		In discussion
	Neonates	ST3	Hours	4	4		In discussion

2.2. Details of fines levied

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

2.3. Data on rota gaps

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

It is essential for the Trust to continue to recruit fixed term research posts and locally employed doctors who are either out of programme or in between training as these doctors not only support the rotas but also gain excellent opportunities to research to enable them to apply for sub specialist posts in the future. In April and August, the O&G GP doctors, and in May and August the anaesthetic doctors all rotated; the Neonates doctors rotated in March and September.

As noted previously due to the staffing in rotations to fluctuate throughout the year there can be long term gaps such as maternity leave, vacant posts and long term sickness to short term gaps such as ad hoc sickness and phased returns after a period of prolonged absence. The majority of these gaps are mainly covered by locum shifts from the current cohort of doctors in training, trust employed doctors and ANNPs, however during this reporting period there has been a notable increase in the number of agency doctors used to cover gaps. This is thought to be due to the current doctors feeling burnt out.

Trainees requiring extra support (TRES)

The service is also supporting a number of trainees requiring extra support (previously known as DID – doctors in difficulty). The additional locally employed doctors within this year's workforce allows for flexibility within rostering, ensuring these doctors are fully supported with a 'buddy' during out-of-hours working.

In the current rotation (august – august) there is one doctor on the tier 1 requiring additional support due to health issues. A senior doctor was able to return to work at LWH after a period of 2 years. The doctor is being well supported by the service and recently received equipment to assist her whilst at work.

As noted in previous reports, it is a contractual requirement to share work schedules including template rotas and pay elements with PGDs eight weeks in advance of their placement. As noted previously, one doctor has now progressed to ST3 and works independently on the tier 2 rota whilst one ST2 doctor remains on the tier 2 rota supported by other ST3+. This doctor remains doubled up out to hours to ensure there is no risk to patient safety and the doctor is not put into a position where they are asked nor expected to work above their own competencies.

2.4. Data on locum usage

The below tables give context to the number of unsocial shifts requiring a doctor or ANNP to work, the number of gaps in each month and who covered the shift.

Anaesthetics

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training/bank/trust Dr cover	Consultant cover	Unfilled
Oct 22	120	15	15	0	0
Nov 22	120	5	5	0	0
Dec 22	120	12	12	0	0

Of the locum shifts in Q3, all shifts were covered by the current junior doctor cohort undertaking additional shifts, bank doctors, and Trust doctors. During this reporting period, no shifts remained uncovered due to short term sickness.
The gaps were mainly a consequence of sickness and rota gaps.

Neonates

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training Dr's/ANNPs cover	Consultant cover	Unfilled
Oct 22	168	17	17	0	0
Nov 22	168	22	22	0	0
Dec 22	168	16	16	0	0

Of the 55 locum shifts in q3, all shifts were covered by the current junior doctor cohort undertaking additional shifts, ANNPs, bank doctors. During this reporting period, no shifts remained uncovered due to short term sickness.

Genetics

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

Obstetrics and Gynaecology

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training/bank/trust Dr cover	Agency Locum cover	Consultant cover	Unfilled
Oct 22	252	48	42	5	1	0
Nov 22	252	56	52	3	1	0
Dec 22	252	59	56	0	1	2

Of the 163 additional shifts, bank doctors, Trust doctors and consultants and agency doctors. There has not been a significant increase in the number of gaps compared to the last report. The gaps remain consistent.

3. Other relevant data

There are no other issues, concerns or particular data sets to report at this point.

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

All services continue to cover locum shifts within the PGD and ANNP workforce. There has been a significant reduction in the number of agency bookings in O&G. This is the main due to Trust doctors picking up additional shifts and the rota team managing the gaps. However, with the increase in the number of shifts being worked by PGDs there is still a risk of burn out. This situation will continue to be monitored.

All services continue to engage with PGD's and offer supportive and safe environments for doctors to work. The doctors have access to the Guardian of Safe Working Hours/Medical Staffing and the Freedom to Speak up Guardian.

The O&G service redesigned the Tier 1 rota to enable additional weekend cover to both the maternity and gynaecology wards to support the discharging of patients.

After reviewing the Ockenden report, it was evident there was a lack of continuity of care from the OGD workforce with regards to maternity in patients. This resulted in a 'hot week' being established in the roster ensuring the same tier 1 and tier 2 (F2 – ST5) attends patients on the ward and MAU between Monday to Friday. The Tier 2 doctor supports the ward round consultant during the morning and covers MAU in the afternoon. The tier doctor supports the wards in the morning and supports the tier 2 doctor on MAU in the morning.

The O&G service reviewed the rota slots in this Qtr and made a decision to move some slots to ensure better coverage and reduce the tier 1 rota from 22 slots to 19 due to a decrease in the number of doctors expected in February 2023. Although every effort has been made to mitigate gaps the FY3 doctors recruited are unlikely to commence in post until Qt1 of 2023/24.

There is also a Trust-wide medical workforce group in place to review the medical workforce and potential supporting roles such as physician assistants. The group has also requested for the O&G service to review the current rota templates to ensure the templates are fit for purpose.

5. Conclusion

The Board is advised:

- should the rota establishment fluctuate throughout the year there are robust processes in place to mitigate the use of high-cost agency locums wherever possible by using internal bank, doctors in training and ANNPs
- The services will continue to monitor gaps and recruit where possible
- There has been an increase in the number of consultants acting down to cover PGD gaps.

This report advises the Board that doctors in training are safely rostered and enabled to work hours that are safe and in compliance with their contract. It is also important to recognise that the doctors continue to be supported during their time at LWH.

6. Recommendations

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

Putting People First (PPF) Committee Chair's Highlight Report to Trust Board
20 March 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• Received a further update on compliance rates across the divisions for mandatory training with a focus on those that have not previously completed training or out of date by significant periods. Improvements had been demonstrated in areas although maternity and medical staffing remain a risk. The Education Teams and Divisions continue to actively work towards improvements. It was noted that the Quality Committee had requested a follow-up report on non-compliance of clinical mandatory training in response to this audit to consider potential risks to patient safety.
• Noted significant risk in relation to the Post Graduate Doctor (PGD) workforce due to increasing frequency of rotation of PGDs and the GP trainees causing increased difficulty with the complexity of the patients at LWH; an increasing number of staff working less than full time; and a significant number of gaps on the on-call rotas which are a challenge to manage. A gap analysis of the PGD workforce has been started to inform the workforce required to close the gap, not all of whom will be medical.
• The Committee considered the proposal and impact of implementing 24/7 resident consultant cover. There was a robust challenge and debate in relation to prioritisation of schemes against safety, financial, workforce and reputational requirements. The Committee did not approve the proposal based on the current financial position of the Trust and recognised competing priorities. It was noted that all future investment requests will need to be fully evaluated from a financial and quality perspective as part of a costed business case. This will be part of operational planning for 2023/2024.
	• The following matters were noted from the Chief People Officer Update:
	  ○ workforce plan is required to be submitted to the ICB by 22 March 2023. Test and challenge meetings are underway with divisions to understand significant cost pressures identified within the plan prior to submission.
	  ○ Fair and Just Culture engagement and training had continued despite operational pressures.
	  ○ GMC progression of doctors report had highlighted persistent inequalities in medical education, in particular poorer outcomes for UK graduates of black or black British heritage. An action plan would derive from this report and be monitored by the ED&I Committee.
	• The Committee received an overview of key themes of the 2022 NHS Staff Survey. The results demonstrated an encouraging trend of slight improvement across all themes, against a backdrop of national deterioration. Similar to other years, the Trust benchmarked more favourably when compared to Acute Trusts than against the official comparator group of Acute Specialist Trusts. The Committee commented that better use of social media to publicise results would be beneficial. The results of the survey will be used to develop divisional annual plans and inform development of the new People Strategy. A Big Conversation event will be held in April 2023 for senior managers and staff to feedback ideas for improvements.
	• The Committee noted that the EDI Annual Report was being drafted and would be circulated for approval to the ED&I Sub-Committee prior to publication on the Trust website by the 01 April 2023.
	• The Committee received the proposed Equality Objectives for 2023 – 27 for workforce and patients. The current Equality Objectives for the Trust expire on 31 March 2023. There is a requirement for the Equality Objectives to be approved and published on the Trust website. A discussion in relation to the narrative and measurability of the objectives led to the Committee pausing approval to allow suggested amendments to be made and to submit amended version to the Trust Board in April 2023 for approval.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• Received a positive staff story from a member of the Gynaecology workforce. She described how her experience differed from working in a General District Hospital to a Specialist Trust; the work undertaken to educate the team on the importance of accreditation and successful achievement of Gold Ward standard; and supported rotation of staff to other departments internally and at larger trusts to improve skills and awareness of the gynaecology workforce. (WELL LED) • The Committee took assurance from the Gynaecology workforce assurance report which demonstrated a grip on workforce challenges. Specific note was given to successful	• The Committee requested amendments to the Equality Objectives 2023-27 and the updated report to be submitted to the Trust Board for consideration and approval prior to publication on the Trust website. • The Committee agreed the risk appetite statements for 2023/24 aligned to its terms of reference and recommend approval to the Trust Board. • The Committee agreed the Committee Annual Report, Business Cycle for 2023/24 and the Terms of Reference and recommends approval to the Trust Board.

recruitment to key leadership roles, positive engagement with the leadership training, effective partnership working with neighbour trusts for complex surgery, two BBAS Gold accredited areas and one silver award, and improved teamwork and cross cover across the division. (ALL)

- The Committee received the annual review of performance against the Communications, Marketing and Engagement Strategy 2021-24. (WELL LED)
- Took positive assurance from the Workforce Performance Report noting positive upward trends in PDR and mandatory training compliance and sickness rates. (ALL)
- Noted the Medical Appraisal and Revalidation report covering Quarter 3, 2022/23. (ALL)
- The Committee received the Guardian of Safe Working Hours report covering Quarter 3, 2022/23. The rota establishment continues to fluctuate throughout the year with robust processes in place to mitigate the use of high-cost agency locums wherever possible by using internal bank, doctors in training and ANNPs. The GFSWH also noted the service had continued to operate with a reduced number of senior PGD's during Quarter 3, as noted within the 24/7 consultant cover report. (ALL)
- The Committee had been assured by the contents of the bi-annual safer staffing review and noted the actions undertaken to effectively manage and provide safe staffing within Nursing, Midwifery and AHP to support the delivery of safe care. (ALL)
- Assurance provided from the workforce engagement update noting that it remains a key priority into 2023/24. The introduction of the Big Conversation had been a productive mechanism to reach a large number of staff in a short space of time. (ALL)
- Received the Gender Pay Gap data for 2021/22. Levels had remained relatively static over a number of years, however the staff survey data had indicated that there is more work required to understand the perception of the female workforce. The Committee requested that the data was refined to include additional information ahead of publication on the Trust website on 01 April 2023. (WELL LED)
- The Committee noted the year-end outturn against the Corporate Objectives aligned to its terms of reference. (ALL)

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the PPF aligned BAF risks. No changes to risks scores were recommended. No risks closed.
- Noted robust challenge and debate in relation to the risk score of BAF risk 1.2 Workforce, based on the numerous expected industrial action and subsequent impact on services. The Executive Committee had recommended that the risk score should remain at 20 (consequence 5, likelihood 4). Based on current evidence it was believed to be inappropriate to escalate the likelihood to 5. The Committee supported the recommendation and would recommend to the Trust Board in April 2023.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Robust discussion

2. Summary Agenda

No.	Agenda Item	Purpose	Rating	No.	Agenda Item	Purpose	Rating
112.	Board Assurance Framework (BAF): Workforce related risks	Assurance		121.	Guardian of Safe Working Hours (Junior Doctors) Quarterly Report Quarter 3	Assurance	
113.	Staff Story	Information		122.	Bi-Annual Safer Staffing Review (Q2&Q3)	Assurance	

2

114.	Workforce Assurance Report: Gynaecology Division	Assurance		**123.**	Staff Survey 2022 – Key Themes and Headlines	Information	
115.	Chief People Officer Report	Information		**124.**	Workforce Engagement – Big Conversations 2022 and 2023	Assurance	
116.	Communications, Marketing and Engagement Strategy Annual Review	Information		**125.**	Equality, Diversity and Inclusion a) Annual Report b) Equality Objectives 2023 – 2027 c) Gender Pay Gap	Assurance	
117.	Workforce KPI Dashboard Report	Assurance		**126.**	Review of Risk Appetite Statement	Approval	
118.	Mandatory Training Audit Progress Report divisional updates against the mandatory training compliance	Information		**127.**	Corporate Objectives 2022/23: Designated PPF Objectives Year-end Outturn	Information	
119.	24/7 resident consultant working in at LWH	Approval		**128.**	PPF Committee Effectiveness: Committee Annual Report, Terms of Reference Review, & Business Cycle 2023/24	Approval	
120.	Medical Appraisal & Revalidation Quarterly Report	Information		**129.**	Sub Committee Chair Reports & Terms of Reference	Assurance / Approval	

3. 2022 / 23 Attendance Matrix

Core members	May	Jun	Oct	Nov	Jan	Mar
Susan Milner, Non-Executive Director	✓		NM			
Gloria Hyatt, Chair, Non-Executive Director	✓	✓	✓	✓	✓	✓
Louise Martin, Non-Executive Director	✓	✓	✓	✓	✓	✓
Zia Chaudhry, Non-Executive Director	✓	✓	✓	✓	✓	✓
Michelle Turner, Chief People Officer	✓	✓	✓	✓	✓	A
Marie Forshaw, Chief Nurse & Midwife	✓	✓	NM			
Dianne Brown, Interim Chief Nurse	NM		✓	✓	✓	A
Gary Price, Chief Operations Officer	✓	✓	✓	✓	A	✓
Claire Deegan, Deputy Chief Finance Officer	A	✓	NM			
Linda Haigh, Interim Deputy Chief Finance Officer	NM		✓	✓	✓	A
Liz Collins, Staff Side Chair	✓	✓	✓	✓	✓	✓
Dyan Dickins, MSC Chair	✓	✓	A	✓	A	A

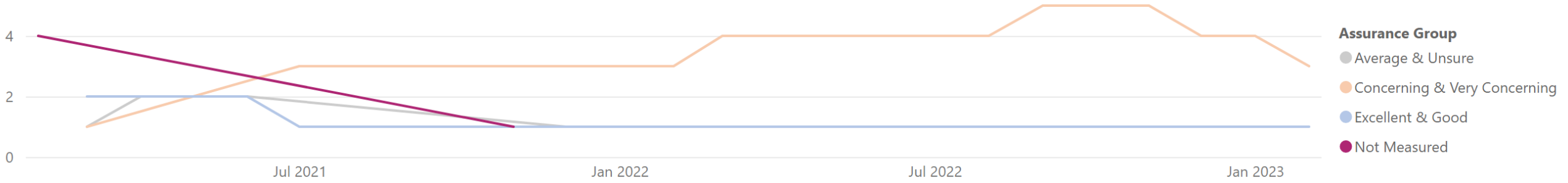
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) Non-Member (NM) *Non-quorate meetings highlighted in greyscale*

Liverpool Women's
NHS Foundation Trust

Trust Board

Workforce Performance Report
March 2023

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

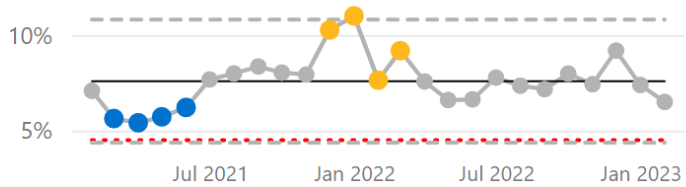


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Turnover Rate	Good	February 2023	<= 13%	<=	10.94%	P		
Clinical Mandatory Training Compliance	Concerning	February 2023	>= 95%	>=	79.94%	F		
Mandatory Training Compliance	Concerning	February 2023	>= 95%	>=	91.79%	F	H	
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Concerning	January 2023	>= 80%	>=	41.54%	F		
Sickness Absence Rate	Concerning	February 2023	<= 4.5%	<=	6.50%	F		

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

Sickness - Chief People Officer

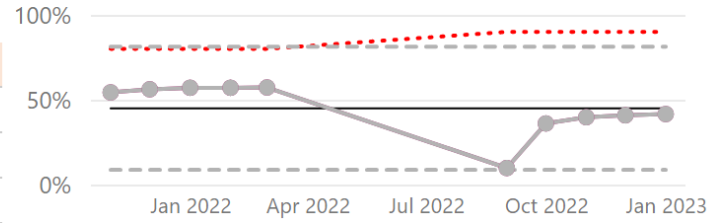
Assurance Category	Concerning
Date	February 2023
Target	<= 4.5%
Target < or >	<=
Performance	6.50%
Assurance	F
Variation	



Month 10 saw sickness absence reduce significantly by 0.88%, despite LTS increasing by 3.06% over the same period. The overall figure now stands at 6.50%.
The key focus for managers across the Trust in on completing and recording RTW meetings, and utilising the meetings with staff specified in Trust policy, where appropriate.
Health and Wellbeing Conversations have now been made a competency and assigned to all staff's records; this will act as an annual reminder to undertake the conversations

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

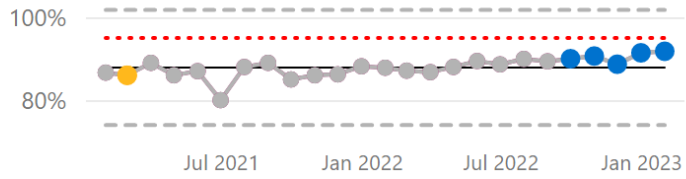
Assurance Category	Concerning
Date	January 2023
Target	>= 80%
Target < or >	>=
Performance	41.54%
Assurance	F
Variation	



Flu vaccine walkabout clinics continue across the Trust. National uptake for flu vaccine = 54%. LWH uptake for flu vaccine = 47%. Flu vaccine stock expires at end of June 23.

Mandatory Training Compliance - Chief People Officer

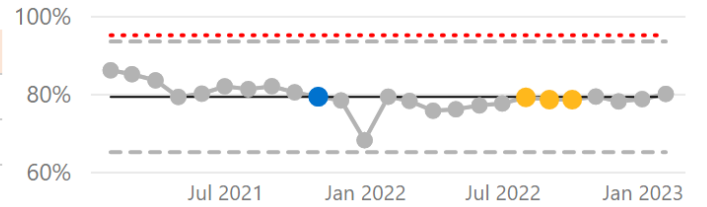
Assurance Category	Concerning
Date	February 2023
Target	>= 95%
Target < or >	>=
Performance	91.79%
Assurance	F
Variation	H



Mandatory training is at its highest rate since June 2020, at 91.79%, with most areas making good progress towards target. Maternity remains a concern, training was impacted due to all training being stood down in month 10&11 due to business continuity. The PEF team are developing a training recovery plan.
Those individuals who have competencies that expired over 12 months ago, or have never been completed are now being prioritised re) both individual compliance and assurance for patient safety

Clinical Mandatory Training Compliance - Chief People Officer

Assurance Category	Concerning
Date	February 2023
Target	>= 95%
Target < or >	>=
Performance	79.94%
Assurance	F
Variation	



Clinical Mandatory Training is currently at 79.94% its highest rate since Oct 21.
Validation sessions continue and reminder emails are still going out on a weekly basis to remind staff of expiring or expired training within their matrix. As with core mandatory training, those individuals who have competencies that expired over 12 months ago, or have never been completed are now being prioritised re) both individual compliance and assurance for patient safety.

COVER SHEET				
Agenda Item (Ref)	*23/24/010c*		Date: 06/04/2023	
Report Title	Staff Survey 2022 – Key Themes and Headlines			
Prepared by	Rachel London, Deputy Director of Workforce			
Presented by	Rachel London, Deputy Director of Workforce			
Key Issues / Messages	***The paper provides an overview of the key themes of the NHS Staff survey 2022***			
Action required	Approve ☐	Receive ☒	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): NA			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to note the contents of the paper and the performance of the Trust in this important national survey and consider any further actions required to embed and continue the trend of improvement.			
Supporting Executive:	Michelle Turner, Chief People Officer			

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

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

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) 1.2 Failure to recruit and retain key clinical staff	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: 1704	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
PPF	Mar 23	CPO	Recommended for Board consideration.

EXECUTIVE SUMMARY

The paper provides an overview of the key themes of the 2022 NHS Staff Survey. The NHS Staff Survey is the most important set of metrics in the measurement of staff satisfaction in the NHS. At Liverpool Women's we saw an encouraging trend of improvement across all themes, against a backdrop of national deterioration. We have been highlighted nationally as the joint most highly improved Trust in England for the Staff Engagement score.

MAIN REPORT

1. Introduction

The NHS Staff Survey is one of the largest workforce surveys in the world and has been conducted every year since 2003 and asks NHS staff in England about their experiences of working for their respective NHS organisations. The survey provides essential information to employers and national stakeholders about staff experience across the NHS in England. Metrics from the staff survey are used to measure the progress of the organisation against its strategic objective of developing a highly motivated and engaged workforce.

The 2022 National Staff Survey was conducted from September to December 2022, with the results being published nationally in March 2023. As in previous years, the Trust surveyed all its staff rather than just the required minimum sample. We achieved a very positive response rate of 60%, an improvement on the 2021 survey where the response rate was 53% and a top quartile response rate, although the number of Medical staff completing the survey decreased by 13% to 46%.

The NHS Staff Survey is one of the main ways we get to hear how staff are feeling and is used in addition to the *Let's Talk* surveys which run 3 times per year, the twice yearly '*Big Conversation'* and the *Great Place to Work Group*, as well as local and divisional forums to hear the views of staff.

As in previous years, our comparator group is 'Acute Specialist Trusts' (a group of 13) and we are benchmarked against these organisations, despite the majority of our services being akin to an acute Trust.

Since 2021, the survey questions have been aligned with the *NHS People Promise*, which sets out in the words of NHS staff the things that would most improve their working experience.

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

In addition to previous key themes:

- Staff engagement
- Morale

2. National Picture

More than 630,000 staff responded to the NHS staff survey a 46 per cent response rate, down from 48 per cent in 2021. The overall trends showed a decrease in staff satisfaction. The proportion of staff in England who are thinking of leaving reached a five-year high, with more than 30% saying they often thought about leaving, and 17% said they wanted to leave as soon as they could find another job. More than one-third of staff said they felt burnt out due to

their work, and 45% reported having felt unwell as a result of work-related stress in the last 12 months, compared with 40% in 2019.

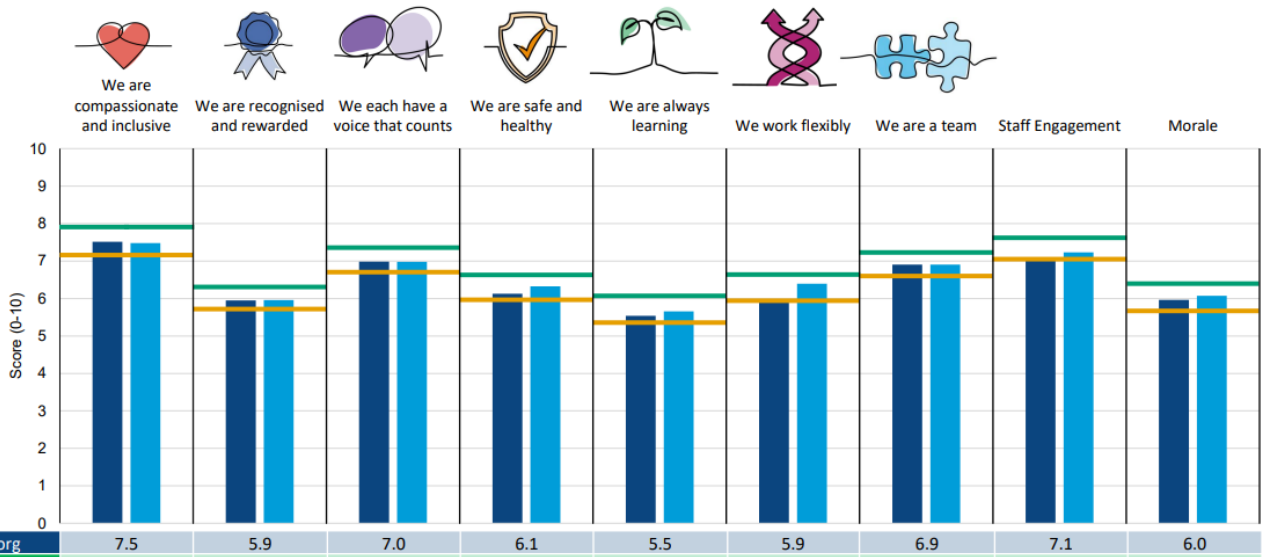
3. Summary of Results

Overall, at Liverpool Women's, there have been improvements in a majority of areas and no areas of deterioration.

People Promise elements	2021 score	2021 respondents	2022 score	2022 respondents	Statistically significant change?
We are compassionate and inclusive	7.3	784	7.5	952	Significantly higher
We are recognised and rewarded	5.9	783	5.9	953	Not significant
We each have a voice that counts	6.8	772	7.0	943	Significantly higher
We are safe and healthy	6.1	766	6.1	952	Not significant
We are always learning	5.3	747	5.5	917	Significantly higher
We work flexibly	5.8	773	5.9	946	Not significant
We are a team	6.7	780	6.9	950	Significantly higher
Themes					
Staff Engagement	6.9	783	7.1	953	Significantly higher
Morale	5.8	783	6.0	954	Not significant

LWH is compared to other 'Acute Specialist' Trusts (a group of 13) and we benchmark less favourably when compared to this group, as the table below indicates:

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.5	5.9	7.0	6.1	5.5	5.9	6.9	7.1	6.0
Best	7.9	6.3	7.4	6.6	6.1	6.6	7.2	7.6	6.4
Average	7.5	6.0	7.0	6.3	5.7	6.4	6.9	7.2	6.1
Worst	7.2	5.7	6.7	6.0	5.4	5.9	6.6	7.1	5.7
Responses	952	953	943	952	917	946	950	953	954

The **staff engagement score** is made up of questions about involvement, motivation and advocacy, including whether a staff member would recommend their organisation as a place to work or have care. LWH saw the joint greatest improvement for *all Trusts in England* for our Staff Engagement score from **6.9 to 7.1.** It should be noted that we have previously scored higher on staff engagement but encouraging that the score had returned to those levels.

The table below compares our overall Staff Engagement score to a range of Trusts within our own region, as well as Birmingham Women's and Children's, an organisation providing the most similar services. This shows that whilst we have made significant progress this year, we are not performing as highly as local specialist Trusts, although we are above the average score of 6.8 for Acute Trusts.

Trust	**Staff Engagement Score**
Liverpool Heart and Chest	7.6
Walton Centre	7.2
St Helen's and Knowlsey	7.2
Clatterbridge	7.2
LWH	**7.1**
Alderhey	7.1
Mersey Care	7
Birmingham Women's and Children's	6.9
Warrington and Halton	6.8
WUTH	6.7
Southport and Ormskirk	6.5
Countess of Chester	6.4
LUHT	6.4

4. **Where have we done better?**

- More staff recommend Liverpool Women's as a place to work, 56.6% in 2021 to 61.6% in 2022
- 71.6% of staff would recommend the Trust as a place to have care compared with 69% last year, although the best performing organisation scored 92%
- Staff feel they are treated fairly when they are involved in an incident or error (61.7% to 64.3%)
- More staff feel they have opportunities for career development (50.3% to 56.2%)
- Overall support from line manager has improved
- Overall teamworking has improved
- Staff feel able to make suggestions to improve their team or department and are involved when changes are being made (50.1% to 58.3%)
- More people feel safe to speak up (61.3% to 67.5%)

5. Where do we need to improve?

- Satisfaction with level of pay has decreased from 27.6% to 27.1%
- More staff are feeling burnt out and exhausted from their work
- As in previous years staff are still saying their PDR does not help them do their job, only 20.9% of staff found it helpful.
- Flexible working- although there has been an improvement in people getting a work life balance, feeling able to talk to their immediate manager about flexible working, only 50% of staff are satisfied with the opportunities for flexible working (the same as 2021).
- Fewer staff felt they had the necessary materials and supplies to do their work (58.4% compared to 64.2%).
- There has been an increase in staff reporting experiencing discrimination on the basis of ethnic background, gender and religion (though a decrease for disability and sexual orientation).

6. Divisional Headlines

Gynaecology had a 14% increase in their response rate to 63%, and improvements in the areas of speaking up and Health and Wellbeing

Areas of improvement

- My immediate manager takes a positive interest in my health and wellbeing **6.7% improvement**,
- I feel safe to speak up about anything that concerns me in this organisation **4.5% improvement,**
- **t**he people I work with are understanding and kind to one another **3.9% improvement**, The team I work in often meets to discuss the team's effectiveness **3.7% improvement**,
- My immediate manager asks for my opinion before making decisions that affect my work **3% improvement**,
- I look forward to going to work **2.7% improvement**

Areas requiring review

- There are enough staff at this organisation for me to do my job properly **3.2% lower** than trust average
- Teams within this organisation work well together to achieve their objectives **7% lower** than trust average,
- I would recognise my organisation as a place to work **6% lower** than trust average

Family Health

Neonatal had an increase of 14% in their response rate to 75% and **Maternity** had an increase in their response rate of 12% to 42%.

Key areas of improvement

- I would recommend my organisation as a place to work (**10.15% improvement**),
- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (**6.37% improvement**),
- The team I work in has a set of shared objectives (**5.36% improvement**).

Areas requiring review

- Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? (**0.7% decrease**),
- My organisation takes positive action on health and well-being (**2.4% increase** with 47.4% overall positive response),
- I would recommend my organisation as a place to work (**10.15% increase** with 52.2% overall positive response)
- I would feel secure about raising concerns about unsafe clinical practice (6.6% improvement with overall positive response rate at 80.6%)

Clinical Support

There was a 67% response rate for CSS division an increase of 14% from 2021

Key areas of improvement included:

- I would recommend my organisation as a place to work **10% improvement**,
- My immediate manager encourages me at work **11% improvement**,
- I look forward to going to work **8% improvement**,
- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation **4.4% improvement**

7. Actions taken to improve staff experience over the last 12 months

At a Trust level there have been a number of interventions with the aim of improving staff experience, retention and engagement.

- 48 staff have completed a Management and Leadership Programme
- All managers offered a coach or mentor
- Launch of Staff Support service giving access to on site psychological support and introduction of wellbeing coaches
- Investment in new roles – such as Advanced Practitioners and Physicians Associates, Deputy Ward Manager roles, and Out of Hours Site Managers
- New ways of working in clinical areas such as discharge coordinators
- Flexible working opportunities increasing – all areas of maternity can make unlimited requests
- Improvements to mandatory training reporting, data and validation
- Manager checklist to help onboarding of new starters
- More support from volunteers in clinical areas
- Preceptorship programme to support and retain our newly qualified midwives
- Menopause Club and Wellbeing Days in clinical areas
- Departmental Staff Apps to improve communication in Neonatal
- Growth of the Great Place to Work Group where staff can share good practice and make suggestions about improving staff experiences
- Growth of the REACH and DAWN staff networks for staff from racially minoritised groups or who have disabilities
- Award of 34th place in Inclusive Companies Award
- Banding increases for Health Care Support Workers and roll out of the Care Certificate and career development pathways
- Improvements to staff facilities including staff rooms and rest areas.
- New policies to give staff more time off and support for fertility treatment and in the event of baby loss

8. Next steps

Divisions already have access to the results for their areas and will use this information to develop divisional annual plans which will include their top 3 areas for improvement.

Staff Survey actions are tracked through Divisional 'People Plans' and this approach will continue in 22/23 to ensure all workforce actions are managed centrally. Themes from the staff survey will impact on the HR team operational priorities for the year and the development of the new People Strategy.

There will be a Big Conversation on **18th and 19th April 2022** where every department will be visited by a senior manager and staff can feedback their ideas for improvements

9. Recommendations

The Board is asked to note the contents of the paper and the performance of the Trust in this important national survey and consider any further actions required to embed and continue the trend of improvement.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/010d***		**Date: 20/03/2023**	
Report Title	**EDI Reports for Publication**			
Prepared by	**Rachel Cowley, Head of Culture and Employee Experience**			
Presented by	**Rachel London, Deputy Director of Workforce**			
Key Issues / Messages	As a public sector body, we are governed by the Equality Act 2010 and the Public Sector Equality Duty (PSED) in relation to our equality duties. As part of the PSED the Trust is required to publish reports for EDS 2022, EDI Annual Report and Equality Objectives. The Trust is also required to publish Gender Pay Gap report on the website, to meet the Government requirements for Gender Pay Gap reporting. The purpose of this report is to demonstrate the Trust's achievements in 2022/23 in relation to EDI and the plans for 2023/24. In addition, the required reports are included as appendices for approval for publication on the Trust website.			
Action required	**Approve ☒**	**Receive ☒**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): n/a			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	The reports included as appendix 1-4 of this report have been received and commented on by the EDI Committee and PPF Committee, all required amendments to papers have been made. The Trust Board is asked for approval of the reports for publication on the website.			
Supporting Executive:	**Michelle Turner, Chief People Officer**			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*							
Strategy ☐	Policy ☒	Service Change ☐	Not Applicable ☐				
Strategic Objective(s)							
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒	To participate in high quality research and to deliver the most ***effective*** Outcomes	☒				
To be ambitious and ***efficient*** and make the best use of available resource	☐	To deliver the best possible ***experience*** for patients and staff	☐				
To deliver ***safe*** services	☒						
Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)							
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks*		Comment:					

1.1 Failure to be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	
Link to the Corporate Risk Register (CRR) – CR Number: no suitable matching risks reported	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
PPF	March 23	CPO	- Equality Objectives – measures made more 'SMART' - Gender Pay Gap – added graphs detailing the staff groups for each quartile along with summary of what these new graphs show

EXECUTIVE SUMMARY

As a public sector body, we are governed by the Equality Act 2010 and the Public Sector Equality Duty (PSED) in relation to our equality duties. As part of the PSED the Trust is required to publish reports for EDS 2022, EDI Annual Report and Equality Objectives.

The Trust is also required to publish Gender Pay Gap report on the website, to meet the Government requirements for Gender Pay Gap reporting.

The purpose of this report is to demonstrate the Trust's achievements in 2022/23 in relation to EDI and the plans for 2023/24. In addition, the required reports are included as appendices for approval for publication on the Trust website.

REPORT

1. Reporting Requirements

In meeting our legal duties set out in the Equality Act 2010 the following reports are required to be published on the Trust Website:

- EDS 2022 (appendix 1)
- EDI Annual Report (appendix 2)
- Equality Objectives (appendix 3)
- Gender Pay Gap (appendix 4)

2. EDI Achievements in 2023

Liverpool Women's has made great strides in Equality, Diversity and Inclusion, and continues to progress across the Trust. Some of the highlights in the past 12 months include:

- **Inclusive Companies IT 50 list** (inclusive top 50 employers list) 7 place improvement in the from 41st to 34th most inclusive employer in the Inclusive Top 50 list for 2022
- **Top 10 performing Trusts nationally in 4 of WRES indicators** - top performing in 2 of these indicators
- **EDI Committee** chaired by Chief People Officer meets every other month, where Divisional progress against Strategic ambitions are monitored
- **Data cleanse** – commenced in January 2023 with a positive response from workforce
- **Resources for Inclusion** – race inclusion and embracing difference and neurodiversity, both lists of resources have been promoted and are available for staff in library and online
- **Board and Leadership development** – commissioned expert to commence discussion on LWH journey in EDI and becoming an Anti-Racist organisation
- **Diverse interview panel members** – aligning with regional NW work in relation to this, commenced work in 2023 for a diverse panel member for all Senior roles (Band 8A and above), expanding progress with this in 2023
- **Inclusive and Compassionate Leadership training** – launched a module which has been included in the Trust's Leadership Development Programme
- **Established positive community engagement** – Patient Experience Matron has developed close links with groups such as the Deaf Society, Brain Society and Pakistani

Centre. EDI Manager has expanded these links with the Maternity Voices Partnership and local refugee charities

- **Patient Experience and Engagement Facilitator** – a new role developed to support the Patient Experience team, leading on improving the experience and engagement of patients
- **Patient and Staff Lived Experience Stories** – continued learning shared at our Equality, Diversity & Inclusion Committee, Putting People First Committee and Trust Board meetings
- **Supported interns with disabilities** – ensuring they are ready for work when they become school leavers
- **Armed Forces Covenant** – signed the covenant and have Bronze accreditation, currently working towards Silver accreditation
- **Reciprocal mentoring programme** – trained Trust Board and first cohort of staff, ambition in 2023 to match mentor relationships and expand the programme taking learning outcomes from motoring relationships
- **Anti-racism declaration of intent** – released statement in February 2023 with the fundamental goal of fostering an environment where people from all backgrounds can thrive, free from discrimination, inequity, unfairness and prejudice
- **Guaranteed interview for racially minoritised candidates** – introduced this as a double tick process similar to the one available for candidates with a disability
- **Change in language** – no longer using the outdated term of BME / BAME instead using the term 'racially minoritised' and the inclusion network name changing to REACH (Race, Ethnicity And Cultural Heritage)
- **Launched a Menopause Club in 2022** – for our staff who are experiencing symptoms. The club is run by in-house specialists in menopause and offers support around 'hot topics' followed by brief consultations and treatment plans on headed paper that can be shared with GP's
- **Launched an inclusion network for LGBTQ+ staff** – new network launched to support staff from the LGBTQ+ community and opened this to allies, the Pride@LWH network launched in February 2023 and current focus is on Pride at Liverpool 2023 event
- **Inclusion network reporting into Committees –** All inclusion networks have chairs identified and these report into and attend the EDI Committee meetings, terms of reference will be developed in 2023 for each of the networks
- **Supporting our Staff and their Families with Women's Health** – launched a support programme for all staff in relation to women's health, recognising men have family, friends, colleagues and direct reports who may require support. This includes support on menopause, endometriosis, pregnancy loss, premature births and fertility treatment. Changes have been made to Trust policy to allow extended time off for fertility treatment, pregnancy loss and premature births
- **Launch of new Staff Support Service** – in 2022 a new in-house service was launched to provide staff support in relation to support staff with the emotional and psychological demands of their role. This is lead by Consultant Psychologist with a speciality in trauma support
- **An interpreter on wheels has been procured** and following successful pilot, more units have been procured to support translation services for people who do not communicate in English.

- **Continuity of Carer teams have been deployed in areas of high deprivation** and in areas where there are high numbers of people from racially minoritised backgrounds.
- There is an ongoing evaluation process for **Essential Parent App**, which provides a plethora of information for service users in 36 different languages.
- **Antenatal classes are being offered with midwives in different languages**. This includes Arabic and Tigrinya.
- Due to still births in high deprivation areas, the **Continuity of Carer teams are deployed to identified areas to support families in quitting smoking**.
- **The Non-English-Speaking Team (NEST) are facilitating clinics for non-English speaking women in Liverpool**, Sefton and Knowsley.
- NEST have been doing work to support service users with protected characteristics and also those who are in the Core20Plus5 and other health inequalities groups e.g., **caseloading vulnerable families, caring for women who have suffered from trafficking, asylum seekers. Also, women with recent refugee status, safeguarding, domestic abuse, isolation and housing issues.**
- The Transformation Lead in Outpatient Transformation recently produced the Trust DNA (Did not attend/was not brought) plan, combining all initiatives to reduce DNAs with inclusion of groups from all protected characteristics considered throughout. This plan was positively acclaimed by the ICS and presented at Cheshire & Merseyside Elective Recovery and Inequalities Group. The Trust DNA plan includes '**InTouch Check-In Kiosks'**. Kiosks are now online and being used-these allow check in from kiosks to reduce the line to reception, they also have multiple language selections to support users who may not have English as a first language, and deaf patients
- The Transformation Lead also successfully delivered on '**Waiting List Text Validation**'. This is where the Trust sends a text message/letter to the new patients on the waiting list over 52 weeks to ask about their condition and if they still require an appointment. The questionnaire has the capability to translate into 104 languages, with many of them spoken to increase inclusivity in our waiting list management and validation

3. EDI Achievements in 2023

The following plans are in place for EDI in 2023/24, all of which align to the Equality Objectives outlined for the Trust.

- We have an ambition to **develop a number of volunteers to careers roles to support maternity services**, with a view to supporting our strategic ambition to recruit from the Riverside population into these roles
- **We will be bringing counselling services in-house**, this will sit within the Staff Support Service and enhance the support overall for the mental wellbeing of staff
- **Development for Mental Health First Aiders** to ensure that they receive support and regular development from Consultant Psychologist, Assistant Psychologist and Health and Wellbeing Coaches
- There is an ambition to **substantially recruit Health and Wellbeing Coaches trustwide**
- There is ongoing work to **improve the reporting of EDI risks** through the risk register which will have oversight by the EDI Committee

- **Reporting of concerns relating to minoritised staff groups**, these may be concerns between staff and managers which are currently not recorded on risk management system – there will be a new, confidential and safe way of reporting these
- There is ongoing work **to develop a trauma informed care for staff** who experience racism
- Whilst the **data cleanse** in the last year was successful with a third of staff completing and returning, in 2022/23 there will be a concerted effort to improve staff declarations rates even further
- **Extension of e-learning package** to design and deliver specific ED&I training and education to all staff – improved knowledge will result in benefits for better staff and patient experience.
- **Education and celebration of the key EDI events**: Black History Month, Disability History Month, LGBT+ History Month and key faith observance days/festivals.
- **Exploration of how the Trust attracts local population to work at LWH**, utilising widening participation programmes and alternative ways to advertise and promote our job opportunities.
- **Exploring potential to report on Disability and Race pay gaps** on Trust website in addition to the Nationally required reports; Gender Pay Gap, Workforce Race Equality Standard, Workforce Disability Equality Standard and Equality Delivery System.
- Monitor the number of staff from racially minoritised backgrounds who attend the Liverpool Women's **Leadership Development Programme**
- **Monitor the use of the guaranteed interview scheme** for racially minoritised groups and diverse interview panels
- **Conduct an assessment of the physical environment** to identify any barriers that may hinder accessibility for people with "protected characteristics". The organisation will then take necessary measures to remove those barriers, such as providing wheelchair ramps, installing lifts, improving lighting, and ensuring signage is clear and easy to understand.
- **Provide training to staff on the Accessible Information Standard,** develop policies and procedures to ensure compliance with the standard, and providing accessible information to service users, such as easy-read information, braille, large print, and audio formats.
- **Identify service users' language needs**, providing trained interpreters and translators, ensuring staff are aware of their duty to offer interpretation and translation services, and providing translated information about Trust services.
- **Identify key community stakeholders**, establishing regular communication channels, and conducting regular engagement activities, such as community events, focus groups, and outreach programs.
- **Establish a health inequalities review group**, providing training to staff on identifying and addressing health inequalities, conducting regular health needs assessments, and developing and implementing action plans to address health inequalities.

4. Recommendations

The Trust Board are asked to note the achievements from 2022/23 and plans for 2023/24.

In addition the Trust Board are asked to approve the four attached reports for publication on the Trust Website in order to meet statutory requirement to publish these four reports.

Appendix 1 – EDS 2022 Report

EDS 2022 Report _ March 2023.pdf

Appendix 2 – EDI Annual Report

Equality and Diversity Annual Rep

Appendix 3 – Equality Objectives

TB - Equality Objectives 2023-27.d

Appendix 4 – Gender Pay Gap Report

TB Committee - Gender Pay Gap Rep

Liverpool Women's NHS Foundation Trust

Equality, Diversity and Inclusion Committee

COVER SHEET

Agenda Item (Ref)	***Secretary to complete***	**Date: 13/03/2023**
Report Title	**Equality Delivery System (EDS) 2022**	
Prepared by	**Lisa Shoko, EDI Manager & Rachel Cowley, Head of Culture and Staff Experience**	
Presented by	**Lisa Shoko, EDI Manager**	
Key Issues / Messages	The EDS is designed to encourage the collection and use of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and so to help NHS organisations meet the public sector equality duty (PSED) and to set their equality objectives. Government guidance was for all Trusts to publish a version of their EDS 2022 report by 28 February 2023. Due to this being a new format for reporting EDS, there were national considerations that there may be delays in completion and reporting within the timescales. There were delays in the national templates being released, this meant work could only commence from July 2022, losing three months in the process of collection of data and evidence. This report outlines how the new EDS process was implemented at LWH and how the patient service was selected for Domain 1. It also outlines the process for Domains 2 and 3, including engagement and scoring of all three Domains with the EDI Lead at the ICB. The report details the rationale behind a draft report being published on the Trust website for the deadline date of 28 February 2023 and provides a report for consideration by the EDI Committee in advance of Trust Board approval on 6 April 2023. The approved report will then replace the draft on the website, this is following guidance from the ICB EDI Leads.	

Action required	**Approve ☒**	**Receive ☐**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): n/a			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	The Committee are asked to consider and support the Equality Objectives for Workforce and to commit to responding electronically before the end of March in relation to the Patient Equality Objectives.			
Supporting Executive:	**Michelle Turner, Chief People Officer**			

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

Strategy ☒ Policy ☐ Service Change ☐ Not Applicable ☐

Strategic Objective(s)

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

To deliver ***safe*** services	☒		

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1.1 Failure to be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	Comment: Whilst this is a national NHS reporting requirement (EDS 2022) there is a link to our Trusts Strategic ambition and BAF risk in relation to being one of the most inclusive NHS organisations.
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

EXECUTIVE SUMMARY

The Equality Delivery System (EDS) is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice.

The EDS is designed to encourage the collection and use of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and so to help NHS organisations meet the public sector equality duty (PSED) and to set their equality objectives.

EDS 2022 implementation by NHS provider organisations is mandatory in the NHS Standard Contract. EDS 2022 implementation will continue to be a key requirement for all NHS commissioners. Detailed information on how to implement EDS 2022 is contained in the EDS 2022 Technical Guidance.

Government guidance was for all Trusts to publish a version of their EDS 2022 report by 28 February 2023. Due to this being a new format for reporting EDS, there were national considerations that there may be delays in completion and reporting within the timescales. There were delays in the national templates being released, this meant work could only commence from July 2022, losing three months in the process of collection of data and evidence.

This report outlines how the new EDS process was implemented at LWH and how the patient service was selected for Domain 1. It also outlines the process for Domains 2 and 3, including engagement and scoring of all three Domains with the EDI Lead at the ICB.

The report details the rationale behind a draft report being published on the Trust website for the deadline date of 28 February 2023 and provides a report for consideration by the EDI Committee in advance of Trust Board approval on 6 April 2023. The approved report will then replace the draft on the website, this is following guidance from the ICB EDI Leads.

REPORT

1. Introduction

The EDS was first launched for the NHS in November 2011. In November 2012, Shared Intelligence published their report 'Evaluation of the equality delivery system for the NHS' which looked at how the EDS had been adopted across NHS organisations. Based on this evaluation and subsequent engagement with the NHS and key stakeholders, a refreshed EDS, known as EDS 2, was made available in November 2013.

A review of the EDS2 was undertaken to incorporate system changes and take account of the new system architecture. Through collaboration and co-production and taking into account the impact of COVID-19, the EDS has been updated and EDS 2022 is now available for live testing during 2022/23.

The main purpose of the EDS was, and remains, to help local NHS systems and organisations, in discussion with local partners and local populations, review and improve their performance for

people with characteristics protected by the Equality Act 2010. By using the EDS 2022, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

EDS 2022 is aligned to NHS England's Long Term Plan and its commitment to an inclusive NHS that is fair and accessible to all. The EDS 2022 suite of documents and supporting resources are available at the bottom of this page.

Implementation of EDS 2022 is a requirement of both NHS commissioners and NHS provider organisations. In light of the inclusion of EDS 2022 in the NHS standard contract, NHS organisations should use the EDS 2022 reporting template to produce and publish a summary of their findings and implementation.

The EDS 2022 reporting template is designed to give an overview of the organisation's most recent EDS implementation. Once completed, the report should be accessible to the public, and published on the organisation's website.

All NHS providers are required to implement the EDS, having been part of the NHS Standard Contract from since April 2015 (SC13.5 Equity of Access, Equality and Non-Discrimination). In addition, NHS Commissioning systems are required to demonstrate 'robust implementation' of the EDS as set out in the Oversight Framework.

The completion of the EDS, and the creation of interventions and actions plans in response to the EDS findings, can contribute to NHS system and provider organisations achieving delivery on the CORE20PLUS5 approach, the five Health Inequalities Priorities, and addressing inequalities in elective recovery highlighted in the 22/23 guidance.

C&M Trusts have been guided by EDI Lead for NW network to publish on a more user-friendly template. Following guidance from the ICB EDI Leads the LWH report will include the national reporting template and embedded evidence. This will ensure we have met all necessary requirements in relation to EDS 2022 for publishing on the Trust's website and provide assurance through the Committee for completion of all three Domains and their outcomes.

2. Collation of data for EDS 2022

EDS is about how we are improving access to services for people who have protected characteristics.

In order to collate the data for EDS 2022 we:

- Provided an introduction to EDS 2022, technical guidance and scoring criteria
- Decided on two service line reviews with Patient Experience and EDI leads
- Process for collation of data was approved at Patient Involvement and Experience Sub-Committee
- Statistical evidence requested from the Informaion Team
- Socialised the process and evidence with the divisional managers
- Meetings were requested with divisional managers
- Qualitative evidence requested from divisional managers
- Identified gaps in statistical data - reviewed these gaps with the Information Team

2.1 Domain 1: Commissioned or Provided Services

In order to gather data and develop scores for domain 1, the following actions were taken:

- Dashboards have been developed on Power BI for both service line reviews which are Gynaecology (Cervical Cancer) and Maternity (Induction of Labour)
- The information has been shared with the Integrated Care Board (ICB) with the preliminarily agreed scores for the day – Gynaecology scored 3 in Domain 1 and Maternity scored 6 in Domain 1, which meant that our highest performing service was maternity. According to the national guidance we are only required to report on the best performing service out of the two.
- Engagement with patient EDI, engagement and experience colleagues will be going ahead in the coming weeks to finalise the scoring
- Outcomes will be fed back to the divisional managers to develop improvement plans
- Pre-liminary scores have been shared with the ICB in lieu of engagement activities
- Final approval of scores and evidence through EDI Committee

2.2 Domains 2 & 3 Workforce Wellbeing & Leadership

In order to gather data and develop scores for domains 2 and 3, the following actions were taken:

- Engagement with Head of Culture and Staff Experience in order to review domains and outcomes
- Regular meetings to ensure domain evidence and scoring is progressed with Head of Culture and Staff Experience
- Workforce scored 4 and Leadership scored 5
- Final approval of scores and evidence through EDI Committee

3. EDS 2022 – Draft report currently published on Trust website

Government guidance was for all Trusts to publish a version of their EDS 2022 report by 28 February 2023. Due to this being a new format for reporting EDS, there were national considerations that there may be delays in completion and reporting within the timescales. There were delays in the national templates being released, this meant work could only commence from July 2022, losing three months in the process of collection of data and evidence.

We did have an engagement session with ICB where some scores were queried due to a lack of evidence. Since then, additional evidence has been submitted from the Divisional teams, therefore we require support and additional scrutiny from the EDI Committee in relation to the self-assessment scoring.

In agreement with the ICB EDI Lead, LWH have published a draft version of the report on the Trust website. This is sufficient in meeting the regulated requirements, pending approval of the formal report at EDI Committee and Trust Board on 6 April 2023. Following the EDI Committee assurance on scoring, the report can be ratified by Trust Board and thereafter, the draft version on Trust website will be replaced with the approved report.

4. EDS 2022 – proposed report for ratification and publication on 7 April 2023 following EDI Committee comment and Trust Board approval

Whilst the NW EDI network lead suggested a user-friendly template, it is recommended by ICB EDI leads that the national reporting template is also available on the Trust website. Therefore, LWH propose to publish a user-friendly version of the report, with the national template included as an appendix should public wish to access the full detailed report.

Appendix 1 outlines the user-friendly version of the EDS 2022 report with the National reporting template and detailed evidence included as an appendix to the document.

5. Summary / Actions

It is acknowledged that there was a delay of three months in the EDS 2022 paperwork and technical guidance being made available to enable the work to commence to gather evidence. Whilst the EDS 2022 updates were presented at a number of Committees, including the Patient Information and Engagement Sub-Committee and EDI Committee, it has proved challenging to complete the complex national framework required to complete EDS 2022 and gather evidence to support scoring criteria.

Following an engagement session with ICB where some scores were queried due to a lack of evidence, additional evidence has been submitted from the Divisional teams. There are other C&M Trusts that were unable to meet the deadline of 28 February and following guidance from our OCB EDI Leads were have published a draft report on the Trust website pending approval of this report and scoring allocated to each Domain.

To ensure LWH is able to meet the publication dates for future EDS reports, the following actions have been taken:

- Divisional report template submitted for EDI at every EDI Committee, this will ensure evidence is easily accessible and a smoother process in developing the EDS domain outcomes
- Review annual workplans for the following meetings to ensure that deadline for 28 February is met for future EDS publications:
    - Patient Involvement and experience Sub Committee
    - Inclusion Forum
    - EDI Committee
    - Trust Board

Assurance can be taken that the EDI Manager and Head of Culture and Staff experience have already contributed to the workplans for the above-mentioned meetings and have developed a template for Divisional reporting, which will be reviewed at this meeting and future Committees.

6. Recommendations

The Committee are asked to consider and support the EDS 2022 Report templates attached, pending approval from Trust Board before publication of finalised version on the Trust's website.

Appendix 1: Proposed EDS 2022 report for ratification and publication on 7 April 2023

Liverpool Women's NHS Foundation Trust

Equality Delivery System 2022

Scoring

Each outcome is to be scored based on the evidence provided. Once each outcome has a score, they are added together to gain domain ratings. Domain scores are then added together to provide the overall score, or the EDS Organisation Rating. Ratings in accordance to scores are below The scoring system allows organisations to identify gaps and areas requiring action

Undeveloped activity – organisations score 0 for each outcome	Those who score **under 8**, adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – organisations score 1 for each outcome	Those who score **between 8 and 21**, adding all outcome scores in all domains, are rated **Developing**
Achieving activity – organisations score 2 for each outcome	Those who score between **22 and 32**, adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – organisations score 3 for each outcome	Those who score **33**, adding all outcome scores in all domains, are rated **Excelling**

EDS 2022 assessment programme and results

The Trust held 3 assessment events on:

- 23 December 2022 for EDS Domain 2
- 23 December 2022 for EDS Domain 3
- 16 January 2022 for EDS Domain 2
- 26 January 2022 for EDS Domain 1
- 13 March 2023 for EDS Domain 1

The Trust scored a combination of 16. This score rated the Trust overall the EDS 2022, as **Developing**

Individual scores, domain ratings and assessor recommended EDS 2022 actions, follow in this report

Service Selected for Domain 1

Maternity – Induction of Labour

We selected a service identified in the CORE20Plus5 and a more detailed report on EDS 22 can be found in Appendix 1 of this report.

Equality Delivery System (EDS) – Summary Results for Liverpool Women's NHS Foundation Trust, February 2022.

Our 2022 submission was assessed by internal and external stakeholders

Domain 1: Commissioned or provided services
Maternity Induction of Labour

Outcome		Undeveloped	Developing	Achieving	Excelling
1A.	Patients (service users) have required levels of access to the service		✔		
1B.	Individual patients (service user's) health needs are met			✔	
1C.	When patients (service users) use the service, they are free from harm			✔	
1D.	Patients (service users) report positive experiences of the service		✔		

Domain 1: Commissioned or provided services actions

- Collecting data on all protected characteristics and on marginalised groups identified in the Core20Plus5 e.g., deprived areas representing health inequalities
- Divisional reporting to EDI Committee of work being done to reduce health inequalities to monitor progress in equality, diversity and inclusion work related to service users
- Conducting an environmental access audit to identify barriers to accessing services for people with additional needs and improve the existing facilities e.g., support with disabilities, language etc.
- Improve consultation with marginalised groups that are accessing services through the support of service user groups and local community engagement leads.

Domain 2: Workforce Health and Wellbeing

Outcome	Undeveloped	Developing	Achieving	Excelling
2A When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions		✓		
2B When at work, staff are free from abuse, harassment, bullying and physical violence from any source		✓		
2C Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source			✓	
2D Staff recommend the organisation as a place to work and receive treatment		✓		

Domain 2: Workforce actions

- Review the process for reasonable adjustments to support staff including educating managers and staff on resources available through Access to Work
- Proposal to be developed with a focus on how we can support managers and staff with release for attendance at Inclusion meetings (Inclusion Forum and Staff Networks) and to support the development of key Inclusion events
- Development of health and wellbeing plan in relation to self-management of conditions such as obesity, asthma and COPD

- Ensure support sessions for staff to help with self-management of long-term conditions including signposting is informed by staff absence data and intelligence from annual Health and Wellbeing conversations
- Host listening events for staff who staff living in the local area and may access our services
- Communications to be developed to promote the different routes staff have to voice concerns in relation to abuse, harassment, bullying and physical violence from any source. This will include partnership working with staff side representatives, Freedom to Speak Up Guardians and HR team

Domain 3: Inclusive Leadership

Outcome	Undeveloped	Developing	Achieving	Excelling
3A Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities		✔		
3B Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed		✔		
3C Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients				✔

Domain 3: Inclusive Leadership actions

- Senior sponsorship of events put on by Pride, REACH and DAWN staff networks and the Inclusion forum
- Ensure that both ED&I and health inequalities are standing agenda items and discussed in board and all committee meetings, hearing lived experience stories and seeking assurance that actions are being progressed

- Ensuring that equality impact assessments are completed for all projects and policies and are signed off at the appropriate level where required including risk assessments and actions for marginalised groups
- Reporting of Equality Impact Assessments at EDI Committee and exception reporting to Board where risk identified that required immediate board attention
- Standing agenda item on EDI Committee where Divisional reports are presented utilising the workforce and patient EDI dashboards. Reports will provide evidence in relation to divisional progress with workforce EDI ambitions and how patient health inequalities are being addressed

Classification: Official

Publication approval reference: PAR1262

NHS Equality Delivery System 2022

EDS Reporting Template

Version 1, 15 August 2022

Contents

Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation	**Liverpool Women's NHS Foundation Trust**	**Organisation Board Sponsor/Lead**
		Michelle Turner, Chief People Officer
Name of Integrated Care System	NHS and Cheshire Integrated Care Board	

EDS Lead	Lisa Shoko, EDI Man\ger		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	23 December 2022 for EDS Domain 2 23 December 2022 for EDS Domain 3 16 January 2022 for EDS Domain 2 26 January 2022 for EDS Domain 1 13 March 2023 for EDS Domain 1		**Individual organisation**	Liverpool Women's NHS Foundation Trust
			Partnership* (two or more organisations)	
			Integrated Care System-wide*	NHS and Cheshire Integrated Care Board

Date completed	February 2023	**Month and year published**	February 2023

Date authorised	March 2023	Revision date	February 2024

Completed actions from previous year	
Action/activity	**Related equality objectives**

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Liverpool Women's NHS FT Trust Website https://www.liverpoolwomens.nhs.uk/about-us/ Acute Service **Locations:** Liverpool Women's NHS FT, Crown Street, Liverpool, L8 7SS (Main Site); Some Outpatient Clinics delivered out of Aintree University Hospital, Liverpool University Hospital NHS Foundation Trust, Lower Ln, Fazakerley, Liverpool, L9 7AL Community Clinics **Hours of Operation:** Community Midwives https://www.liverpoolwomens.nhs.uk/our-services/maternity/your-antenatal-care/community-midwives-contact-information/ Early Pregnancy Assessment Unit https://www.liverpoolwomens.nhs.uk/our-services/maternity/early-pregnancy-assesment-unit-epau/	1	Vicky Clarke

		Services Provided at Liverpool Womens: Our services - Liverpool Womens NHS Foundation Trust **Services Provided in Maternity:** Maternity - Liverpool Womens NHS Foundation Trust **Maternity Patient Information Leaflets:** Maternity Patient Information Leaflets - Liverpool Womens NHS Foundation Trust **Pregnancy Concerns** The following page provides support for birthing persons who are concerned about their pregnancy: If you are concerned - Liverpool Womens NHS Foundation Trust **My Pregnancy Notes** There is additional information available for women on My Pregnancy Notes which is available for pregnant women here: www.mypregnancynotes.com Further information in the attached PDF:  My Pregnancy Notes.pdf **Essential Parent App**		

		Liverpool Women's Hospital are also considering the Essential Parent App which has 37. Features of the app described above can be found in the attached PDF:  EP App content - 2022.pdf **Accessibility Information** Accessibility - Liverpool Womens NHS Foundation Trust In addition to this, My Pregnancy Notes and Liverpool Women's Website are accessible. The Liverpool Women's website has the capacity to adjust font size, language and contrast. National NHS Maternity support information is available: www.mypregnancynotes.com Continuity Hubs available here: Community Midwives Contact Information - Liverpool Womens NHS Foundation Trust		
	1B: Individual patients (service users) health needs are met	**Activity Information** – including length of stay, breakdown of activity by protected characteristic below: Induction of Labour Deliveries Report - Power BI Induction of Labour (2) Deliveries Report - Power BI	2	Vicky Clarke

		Reasonable Adjustments – we have a Reasonable Adjustment Policy for service users available on the intranet Individualised Care Planning and Birth planning – this is all done through www.mypregnancynotes.com including signposting to information for relevant support groups i.e., voluntary and faith groups, nutrition and hydration provision. Additional information can be found on Trust website here: https://www.liverpoolwomens.nhs.uk/our-services/maternity/preparing-for-birth/ **Continuity of Carer Monthly Data**  LWH COC Monthly Data.xlsx **NEST Team**  Evidence Outcomes (002).pdf **MVP Involvement**  MVP-Annual-Work-Plan-Template(1) Liv M\ **Maternity Transformation Board (context)**		

		Maternity Transformation Board		
	1C: When patients (service users) use the service, they are free from harm	**Maternity Assessment Unit Care Pathway** Maternity Assessment Unit Care **Emergency Caesarean Section Pathway** Emergency Caesarean Section Pat **Postnatal Care Planning** Postnatal Care Planning.pdf **Antenatal Risk Assessment incl. Booking Appointment Guideline** Antenatal Risk Assessment Including **Staffing incidents** FOI3484 Staffing Incidents.xlsx **Provision of Translation Services** The PDF document below shows translation services that were made Face to Face or through the telephone 2020-2022.	2	Vicky Clarke

		 FOI 3515 - Translation Services.p **Continuity of Carer Report**  CofC Outcomes Report .pdf **Stillbirths Thematic Review 2021-2022**  Stillbirths 2021-22 Thematic review.pdf **Nursing and Midwifery Staffing Levels** Nursing and Midwifery - Liverpool Womens NHS Foundation Trust **Maternity Dashboards** The Maternity dashboards are published on the Trust website and show monthly facts about care including births, babies, surgeries and research Maternity Dashboard - Monthly Facts - Liverpool Womens NHS Foundation Trust **Mortality**  FOI 3630 - Deaths.pdf  FOI 3519 Mortality.xlsx **NHS Staff Survey 2021**		

		NHS_staff_survey_2021_REP_full.pdf		
	1D: Patients (service users) report positive experiences of the service	**Positive Feedback – Interpreter on Wheels** INTERPRETER ON WHEEL PDF.pdf	1	Michelle Rushby
Domain 1: Commissioned or provided services overall rating			6	

Domain 1: Commissioned or provided services

Domain 2: Workforce health and well-being

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Annual health checks available for all staff as a drop in facility from our occupational health physicians. These allow opportunity for blood pressure tests, cholesterol tests, general well-being conversation and health promotion materials e.g., asthma, diabetes, nutrition, physical well-being, mental health, prostate care and women's health  Re_ Know your numbers week - LWH This was also circulated via our internal platform – weekly digest, however these are archived for this period of time. Annual health and well-being conversations take place for each member of staff with their line manager to support staff to remain healthy at work and consider any reasonable adjustments that may be required. LWH recently commenced recording of Health and Wellbeing conversations on ESR, however currently low numbers are recorded (report contains confidential data which we are unable to provide as evidence). As a result, this is also now recorded along with mandatory training and essential training on ESR clearly showing where staff are not compliant so they can actively engage with their managers to ensure this is completed a recorded on ESR.	1	Rachel Cowley

		LWH Staff Survey Results 2021.pdf Promote key well-being dates e.g., mental health awareness week, men's health, world menopause day, endometriosis week, world diabetes day, world COPD Day All Staff Email Invitation to Staff Mer Staff Menopause Cafe 2022 Poster.pdf		

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	The organisation takes a zero-tolerance approach to abuse, harassment, bullying or violence as outlined in the Trust policies for Equality and Human Rights, Resolution Policy.  FOI 2887 Equality and Human Rights Policy v  reported incidents of abuse _ hate from pat  EDI Risk Register and Reporting of Hate Inci All staff making any allegations of abuse or bullying will be supported by their managers, HR, Freedom to Speak Up Guardians and the organisation's senior leaders to ensure appropriate support is offered from the beginning of the process e.g., buddy system, weekly check-ins, well-being coaching/support. During Black History Month in October 2022, the Vice Chair of the Race, Ethnicity and	1	

		Cultural Heritage Network (REACH), EDI Leads and Freedom to Speak Up Guardians commenced the Black History Month Mini Conversations with a view to establish the impact in relation to abuse/harassment for racially minoritized colleagues. The evidence will inform the Trust's planned work to become an anti-racist organisation which is supported by the Trust Board and senior leaders. Workforce Race Equality Standard (WRES): annual reporting is a requirement for NHS organisations. NHS providers are expected to show progress against a number of indicators of workforce equality, which enables he comparison of racially minoritised staff and white staff. This is completed annually via a report format and an annual action plan. The metrics that are measured include total percentage of staff from racially minoritised groups, recruitment, disciplinary, career progression, non-mandatory training		

		opportunities, discrimination, harassment bullying and abuse, and board member representation. See the following link: Diversity, Inclusion & Human Rights - Liverpool Women's NHS Foundation Trust Workforce Disability Equality Standard (WDES): annual reporting is a requirement for NHS organisations. NHS providers are expected to show progress against a number of indicators of workforce equality, which enables the comparison of disabled staff and non-disabled staff. This is completed annually via a report format and an annual action plan. The metrics that are measured include total percentage of staff who report having a disability, recruitment, capability, career progression, harassment bullying and abuse, reasonable adjustment have been made, and board member representation. See the following link: Diversity, Inclusion & Human Rights - Liverpool Women's NHS Foundation Trust		

		Equality Delivery System (EDS): an annual reporting system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. See the following link: Diversity, Inclusion & Human Rights - Liverpool Womens NHS Foundation Trust		

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Zero tolerance approach to bullying, harassment and abuse with a new policy written in a fair and just culture approach  PPF Fair & Just Culture - September 2 Policy was renamed to Resolution Policy utilising new language with a focus on early action and support for staff Staff Networks are invited to contribute to all EDI action plans following national reporting criteria e.g., WRES, WDES. All EDI policies and procedures are equality impact assessed and staff networks have the ability to comment on these. See Equality and Human Rights Policy, Equality Impact Assessment Policy, Reasonable Adjustments Policy, Violence and Aggression Policy, Transitioning in the Workplace Policy Freedom to Speak Up Month with alternative options where they can access support and	2	Rachel Cowley/Kevin Robinson

		safely raise concerns. There are two Freedom to Speak Up Guardians, one of whom is from a racially minoritised background and is from a clinical background. The FTSUGs are embedded within the organisation and are members of relevant committees e.g., EDI Committee. FTSUGs have a slot on corporate introduction to explain their role and introduce themselves to new starters. The organisation works closely to Staff Side Chair and supports the Union Representatives to be impartial and where required, to work with partner organisations. Promotion ran during Anti-Bullying Week with a launch of the newly developed Values to Behaviours guidelines. This has been developed by staff through various focus groups and engagement events following the National Staff Survey results.		

		 Tri-fold values leaflet.pdf The Great Place to Work Group is a platform for staff voices and lived experiences to be heard, there is a staff representative from each team in attendance. We will upskill the Great Place to work representatives to become champions for ensuring that staff have another avenue to raise concerns relating to behaviours. The Trust Board and other Committees have agenda items for lived experiences of staff and patients from protected characteristics. This is an opportunity to listen and learn, making improvements and positive change to practice.		

	2D: Staff recommend the organisation as a place to work and receive treatment	56.7% of staff would recommend the Trust as a place to work, whilst 69.1% would recommend the Trust as a place to receive treatment. See image below:  Survey Question Domain 2.pdf National Staff Survey which has action plans for each division with a focus on improving the staff experience with a view to improving our score in relation to being a great place to work. The experiences of staff from different protected characteristics is highlighted within the Staff Survey results which are submitted to the Trust Board and Divisional Leaders. Following the National Staff Survey results, the Trust developed a number of engagement initiatives outlined below and included in the attached PPF Committee paper.	1	

		 PPF Staff Engagement Report _ We launched a Great Place to Work Group as an engagement avenue, and an alternative pathway to hearing staff voices. This is chaired by a member of staff and the staff dictate the agenda. This reports into the PPF committee and up to the Trust board We have The Big Conversation, twice annually following the release of the Staff Survey results in April. This includes Executive Directors, Non-Exec Directors and senior leaders visiting each department/team n addition to this, focus groups are held for the following: ▪ Medics ▪ Nurses ▪ Midwives ▪ HCAs ▪ Admin Staff ▪ Racially Minoritised Staff		

		▪ Staff with Disabilities and long-term conditions 1. In The Big Conversation, staff make suggestions for how we can improve. Following this, actions are developed and fed into divisional staff survey plans. The September Big Conversation checks progress on these actions, ensuring that they are appropriate and allows opportunity to identify new emerging themes from our staff. The Let's Talk Quarterly Survey measures engagement within the organisation including whether we are a great place to work and whether staff would recommend us. This gives divisions a pulse check as to how well they are progressing with their divisional plans and how well they are being received HR Business Partners map sickness and absence data. This is reported at performance review and divisional board monthly. Following this senior leadership team within each division		

		work alongside the HR Business Partner to ensure appropriate support is offered to individuals to enable staff to positively manage their health and well-being which in turn supports retention within the organisation.		
Domain 2: Workforce health and well-being overall rating			5	

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Executive Directors have commenced the improvement of knowledge through our Liverpool Women's Resource for Race Inclusion. This includes the completion of Layla F Saad's Me and White Supremacy book and accompanying workbook to challenge their own experiences of race and broaden their knowledge in this area. Following the completion of the workbook they will participate in a focus group led by the Equality and Inclusion Manager along with promotional videos for their senior leadership team (including our medical staff) and organisation wide. Equality, Core20Plus5, Health inequalities and EDS are standing items in all committee meetings including Trust Board Executive Directors, Putting People First Committee and Quality Committee. The Trust's Equality, Diversity and Inclusion Committee reports into the Putting People First Committee with a Chair's report outlining key actions and any risk for both workforce EDI and patient EDI. Currently a key topic being worked on is reducing health inequalities in Maternity, in particular admissions.  Health Inequalities Dashboard.pdf  98c. TB WRES WDES report 2022.docx  221003 PPF Meeting Pack October 2022 Fir Staff Network Chairs are in attendance at EDI Committee and have recently been	1	Rachel Cowley

		asked to provide a Chairs report to the Committee for an update of progress of work within their network. Currently our Staff Networks are not sponsored by Executive Directors, and this is something the organisation will consider in the coming months to ensure the activities and events are championed by an Executive Lead. However, they do engage with our senior leaders through the EDI Committee on a bi-monthly basis. Trust Board and Senior Leaders have received development sessions from an external professional, Sandra Pollock OBE. The development sessions were designed to expand their knowledge around the complexities surrounding EDI in particular issues of race and racism.  LWH Leadership Forum - Sandra Pollo Some of the ongoing at the Trust focusses on supporting staff to expand their understanding and knowledge through cascading of information and learning from our senior leaders and Executive Directors. The aim of the above pieces of work has been with a focus to the organisation becoming an anti-racist organisation.		

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Both Equalities and Health Inequalities are discussed at Trust Board and other committee meetings on a regular basis. Actions are recorded in the minutes and/or action trackers. These are reported on and followed up at subsequent meetings.  2. Sept 2022 Board agenda draft 1.1.doc  98c. TB WRES WDES report 2022.docx The Trust acknowledge that the Equality Impact Assessments for projects and policies, whilst signed off at senior level are not normally reported through Trust Board or other formal committees. As a result of this a new EIA process and policy was approved in October 2022 where all EIAs are considered at the EDI Committee which meets bi-monthly and is chaired by our CEO, Kathryn Thompson. In addition, the new EIA process allows clear reporting of any risks identified or project and policies to be escalated directly to the Trust Board.	1	

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Trust Board and Senior Leaders monitor and ensure implementation of actions relating to the following: WRES, WDES, Gender Pay Gap and EDS 2022. These are all reported through senior leadership committees, discussed with staff inclusion networks and then ratified at Trust Board before publication on the Trust website. See the following link: Diversity, Inclusion & Human Rights - Liverpool Womens NHS Foundation Trust The new Equality Impact Assessments are signed off at senior level on a bi-monthly basis at EDI Committee and any identified risks are highlighted directly to the Trust Board for consideration, mitigation and future monitoring. Accessible Information Standard is included in an action tracker along with Reasonable Adjustments which is monitored and reported on through the EDI Committee where senior leaders ensure actions are implemented and embedded into everyday practice.  Action Log March 2022.xlsx There is ongoing work in Divisions to review data in relation to leavers from the Trust and the reasons for them leaving. This will inform an action plan to improve the retention of staff particularly those from protected characteristic groups.	3	

		The Trust has recently launched their **Supporting Our Employees and Their Families with Women's Health** programme of work. This supports all staff recognising that men can be impacted by women's health related issues and/or manage women within our workforce. This includes the following: • The Trust has signed up to **The Smallest Things, Employer with a Heart Charter,** which supports parents of premature babies. • As an **Endometriosis Friendly Employer,** the Trust is committed to developing a work environment and culture that enables employees to thrive at work. • The Trust has signed the **Miscarriage Association, Pregnancy Loss Pledge** committing to support staff through the distress of miscarriage As a result, the Trust policies have been amended to include additional time off and support to all staff.  All Staff Email Supporting our emplc Maternity Leave Policy This has been implemented and supported by all operational managers.		

Domain 3: Inclusive leadership overall rating	5	
Third-party involvement in Domain 3 rating and review		
Trade Union Rep(s):	**Independent Evaluator(s)/Peer Reviewer(s):**	

EDS Organisation Rating (overall rating):
Organisation name(s):
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
Lisa Shoko, EDI Manager	1
EDS Sponsor	**Authorisation date**
Michelle Turner, Chief People Officer	March 2023

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	To ensure our patients and service users within from our community have equity of access to our services regardless of protected characteristics	Collecting data on all protected characteristics and on marginalised groups identified in the Core20Plus5 e.g., deprived areas representing health inequalities	February 23
	1B: Individual patients (service users) health needs are met	To ensure patient health needs are met within each of our services and reduce health inequalities through regular monitoring and developing actions to ensure equity of access	Divisional reporting to EDI Committee of work being done to reduce health inequalities to monitor progress in equality, diversity and inclusion work related to service users	February 23

	1C: When patients (service users) use the service, they are free from harm	To ensure our site and services are accessible to all of our people, staff and patients	Conducting an environmental access audit to identify barriers to accessing services for people with additional needs and improve the existing facilities e.g., support with disabilities, language etc.	February 23
	1D: Patients (service users) report positive experiences of the service	To ensure that we engage with our patients to understand the needs of people in our community with protected characteristics and respond proactively to these needs	Improve consultation with marginalised groups that are accessing services through the support of service user groups and local community engagement leads	February 23

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	We will understand through health conversations the health needs of our staff and tailor support accordingly	Development of health and wellbeing plan in relation to self-management of conditions such as obesity, asthma and COPD	February 23
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	To ensure safe spaces are provided for staff to report any abuse, harassment, bullying and physical violence	Develop a mechanism on risk management reporting system (Ulysses) to enable a safe space for staff to quickly and easily report any hate incidents or bullying from any colleagues or managers Review the process for reasonable adjustments to support staff including educating managers and staff on resources available through Access to Work	February 23

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	To ensure that our staff have adequate support, and are signposted to the appropriate services to when from stress, abuse, bullying, harassment and physical violence	Ensure support sessions for staff to help with self-management of long-term conditions including signposting is informed by staff absence data and intelligence from annual health and wellbeing conversations Proposal to be developed with a focus on how we can support managers and staff with release for attendance at Inclusion meetings (Inclusion Forum and Staff Networks) and to support the development of key Inclusion events	February 23
	2D: Staff recommend the organisation as a place to work and receive treatment	To ensure that we engage with our staff groups to understand the needs of people in our community with protected characteristics and respond proactively to these needs	Communications to be developed to promote the different routes staff have to voice concerns in relation to abuse, harassment, bullying and physical violence Host listening events for staff who staff living in the local area and may access our services	February 23

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	To ensure monitoring of equality impact assessments and to continue to learn from both patient and lived experience stories through our EDI Committee, Putting People First Committee and Trust Board.	Ensure that both ED&I and health inequalities are standing agenda items and discussed in board and all committee meetings, hearing lived experience stories and seeking assurance that actions are being progressed Ensuring that equality impact assessments are completed for all projects and policies and are signed off at the appropriate level where required including risk assessments and actions for marginalised groups	February 23
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	To seek assurance that all necessary committees in agendas and minutes allow detail discussion in regard to EDI risks	Reporting of Equality Impact Assessments at EDI Committee and exception reporting to Board where risk identified that requires immediate board attention Develop regular risk reports from risk management system to EDI Committee to ensure all EDI risks and actions are progressed.	February 23

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	To ensure appropriate representation at key EDI events and divisional performance reporting through EDI committee so assurance can be given at Trust Board level.	Senior sponsorship of events put on by Pride, REACH and DAWN staff networks and the Inclusion forum Standing agenda item on EDI Committee where divisional reports are presented utilising the workforce and patient EDI dashboards. Reports will provide evidence in relation to divisional progress with workforce EDI ambitions and how patient health inequalities are being addressed	February 23

Patient Equality Team
NHS England and NHS Improvement
england.eandhi@nhs.net

Liverpool Women's
NHS Foundation Trust

Equality & Diversity Annual Report
2023

Contents

1.0 Our Aims, Vision & Values

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

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

1.1 Our Aims – We See

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

1.2 Our Vision

The vision for Liverpool Women's Hospital is to be the recognised leader in healthcare for women, babies, and their families and to become one of the most inclusive organisations in the NHS. Our ambitions are to be an outstanding employer and to provide an outstanding experience for our patients by delivering services safely, efficiently and with the best outcomes for patients

Our Aims	To develop a well led, capable, motivated and entrepreneurial workforce.	To be ambitious and efficient and make best use of available resources.	To deliver safe services.	To participate in high quality research to deliver the most effective outcomes.	To deliver the best possible experience for patients and staff.
Our Ambitions	We will be an outstanding employer.	We will deliver maximum efficiency in our services.	Our services will be the safest in the country.	Outcomes will be best in class.	Every patient will have an outstanding experience.

1.3 Our Values

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

1.4 Reasons to Be Proud

At Liverpool Women's Hospital we recognise the importance of language, and also recognise members of our local community and workforce who are from ethnically diverse backgrounds do not identify with the term BAME. In 2022, Liverpool Women's adopted new terminology, referring to ethnically diverse communities as racially minoritised. Using this language, we identify that there are racial inequities that are reinforced by the system. Ethnically diverse communities are not the minority, they are the majority. However, they are minoritised by the system.

To achieve our ambition to become one of the most inclusive organisations in the NHS we will
Treble the number of staff from racially minoritised backgrounds in leadership roles (band 7 and above) and ensure that our workforce matches the ward of Riverside in terms of the percentage (%) of staff from racially minorities backgrounds by 2025.

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

Be Brilliant.

At Liverpool Women's we want to **be brilliant**. Our Strategy 2021-25 outlines what we want to achieve as a Trust over the next few years and the work we do every day will help us to meet our objectives.

Be Kind.

The behaviour that makes achieving our strategy objectives possible is to **be kind**. Kindness underpins our Trust values of Care, Ambition, Respect, Engage, and Learn.

2.0 Context

2.1 Equality Objectives

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

- Create a workforce representative of the community we serve
- Ensure that we meet the communication needs of our patients
- Ensure that staff training & development promotes the values of inclusion and tolerance for all, whilst meeting the needs of all staff groups
- Develop the EDI agenda into the culture of existing meetings and committees
- Continue to engage with our patient and staff groups to understand further the needs of individuals with protected characteristics and respond proactively to identified needs

The Equality Objectives are currently being reviewed for period 2023 – 2027, these are currently being approved through the EDI Committee and will be published on the Trust website on 1 April 2023.

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

To support the Trust in progressing and achieving the above objectives they have been mapped to the EDS 2022 framework. EDS is a tool designed to help NHS organisations, in partnership with local stakeholders, to review and improve their performance for people with protected characteristics and marginalised groups (as defined by the Equality Act 2010), as well as other marginalised groups that are

disproportionately represented in health inequalities statistics and to support organisations in meeting the Public Sector Equality Duties.

3.0 Activity in 2022/23

3.1 Our EDI Ambition and Achievements in 2022/23

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

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

As outlined within the Trust Strategy 2021-25 LWH is

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

With ambitions to achieve this including:

- Trebling the number of staff from ethnic minority backgrounds in leadership roles (Band 7 and above) by 2022.
- Ensure our workforce matches the ward of Riverside in terms of % of staff from ethnic minority backgrounds by 2025.

In addition to this the Trust released a declaration of intent to become an anti-racist organisation. The statement defines anti-racism as "opposing racism through positive actions that purposefully identify, discuss, then challenge racism and the impact it has on our organisation, our systems and our people" with the fundamental goal of "fostering an environment where colleagues, patients, their friends and families, from all backgrounds, can thrive-free from discrimination, inequity, unfairness and prejudice". One of the positive actions that has been implemented successfully, is the introduction of guaranteed interviews for racially minoritised staff, which was already being offered to candidates with disabilities. Click here to read the full statement.

Liverpool Women's has made great strides in Equality, Diversity and Inclusion, and continues to progress across the Trust. Some of the highlights in the past 12 months include:

- **Inclusive Companies IT 50 list** (inclusive top 50 employers list) 7 place improvement in the from 41st to 34th most inclusive employer in the Inclusive Top 50 list for 2022
- **Top 10 performing Trusts nationally in 4 of WRES indicators** - top performing in 2 of these indicators

- **EDI Committee** chaired by Chief People Officer meets every other month, where Divisional progress against Strategic ambitions are monitored
- **Data cleanse** – commenced in January 2023 with a positive response from workforce
- **Resources for Inclusion** – race inclusion and embracing difference and neurodiversity, both lists of resources have been promoted and are available for staff in library and online
- **Board and Leadership development –** commissioned expert to commence discussion on LWH journey in EDI and becoming an Anti-Racist organisation
- **Diverse interview panel members –** aligning with regional NW work in relation to this, commenced work in 2023 for a diverse panel member for all Senior roles (Band 8A and above), expanding progress with this in 2023
- **Inclusive and Compassionate Leadership training –** launched a module which has been included in the Trust's Leadership Development Programme
- **Established positive community engagement –** Patient Experience Matron has developed close links with groups such as the Deaf Society, Brain Society and Pakistani Centre. EDI Manager has expanded these links with the Maternity Voices Partnership and local refugee charities
- **Patient Experience and Engagement Facilitator –** a new role developed to support the Patient Experience team, leading on improving the experience and engagement of patients
- **Patient and Staff Lived Experience Stories –** continued learning shared at our Equality, Diversity & Inclusion Committee, Putting People First Committee and Trust Board meetings
- **Supported interns with disabilities –** ensuring they are ready for work when they become school leavers
- **Armed Forces Covenant –** signed the covenant and have Bronze accreditation, currently working towards Silver accreditation
- **Reciprocal mentoring programme –** trained Trust Board and first cohort of staff, ambition in 2023 to match mentor relationships and expand the programme taking learning outcomes from motoring relationships
- **Anti-racism declaration of intent –** released statement in February 2023 with the fundamental goal of fostering an environment where people from all backgrounds can thrive, free from discrimination, inequity, unfairness and prejudice
- **Guaranteed interview for racially minoritised candidates –** introduced this as a double tick process similar to the one available for candidates with a disability
- **Change in language –** no longer using the outdated term of BME / BAME instead using the term 'racially minoritised' and the inclusion network name changing to REACH (Race, Ethnicity And Cultural Heritage)
- **Launched a Menopause Club in 2022 –** for our staff who are experiencing symptoms. The club is run by in-house specialists in menopause and offers

support around ‘hot topics’ followed by brief consultations and treatment plans on headed paper that can be shared with GP’s

- **Launched an inclusion network for LGBTQ+ staff –** new network launched to support staff from the LGBTQ+ community and opened this to allies, the Pride@LWH network launched in February 2023 and current focus is on Pride at Liverpool 2023 event
- **Inclusion network reporting into Committees –** All inclusion networks have chairs identified and these report into and attend the EDI Committee meetings, terms of reference will be developed in 2023 for each of the networks
- **Supporting our Staff and their Families with Women’s Health –** launched a support programme for all staff in relation to women’s health, recognising men have family, friends, colleagues and direct reports who may require support. This includes support on menopause, endometriosis, pregnancy loss, premature births and fertility treatment. Changes have been made to Trust policy to allow extended time off for fertility treatment, pregnancy loss and premature births
- **Launch of new Staff Support Service –** in 2022 a new in-house service was launched to provide staff support in relation to support staff with the emotional and psychological demands of their role. This is lead by Consultant Psychologist with a speciality in trauma support

3.2 Mental Health First Aiders (MHFA) and REACTMH

Work has continued throughout 2022/23 with staff who have been trained to become Mental Health First Aiders. MHFA training provides the skills to enable the ‘First Aiders’ to provide immediate support to other colleagues who feel they are developing a mental health issue, experiencing a worsening existing issue and/or experiencing a mental health crisis.

The training is available to all staff at all levels throughout the Trust and once trained, they are identified via a green badge displayed on their lanyard.

There are 113 trained MHFAs at LWH, this includes an additional 8 that were trained during 2022/23. There is 1 MHFA trainer at LWH and in 2022/23 charitable funds were secured for two wellbeing coaches to undertake training in 2023.

3.3 Staff Support Service

In 2022, Liverpool Women’s Hospital introduced the new and confidential **Staff Support and Trauma Informed Care** service designed to support staff experiencing difficulties related to their work.

The service is led by Dr Emma Evans, Consultant Clinical Psychologist and supported by two health and wellbeing coaches (Maternity Services). who will be offering support

i.e. workshops signposting, listening ear sessions from our health and wellbeing coaches (in maternity services), and psychological therapies.

This service is available to support staff with the emotional and psychological demands of their role, recognising the potential impact these demands may have on both personal and professional lives. The support will be confidential and is available face to face, by telephone or remotely.

3.3 Widening Participation

The Trust supports pre-employment programmes with the purpose of providing an opportunity to those within the community to experience what it is like to work both at the Trust and within the NHS. The programme also aims to enable those on the programme to be employment ready.

In 2022/23, successful programmes include;

- The organisation works in collaboration with Southport College. We provide 5 placements per school term for Acorns/Cadets, this is for 16 to 19 year olds who are doing a health and social care diploma that enables them to apply for one of the professions, nursing/midwifery
- There is ongoing work with supported interns at three schools including Childwall, Abbotts Lea and Sandfield Park along with OCS. These students have been with us since September in preparation for them looking for jobs. They are all neuro diverse, and some have physical disabilities.
- Liverpool Women's work with Thrive which is an organisation that supports young people who are care experienced and give them work experience opportunities. We currently have 3 in place, 2 of them do not have English as their first language so by being in the workplace, they are also improving their English
- School career events where we go to the schools to take part in their career's events where we promote the wide choice of jobs in the NHS and that there are many opportunities for everyone.
- There was a group of 10 students who visited the Trust in February to learn about the Trust and to meet professionals, non-clinical and clinic so that they are able to see the different career pathways that are available in the NHS.
- Working with Southport College, we have a maths and English tutor on site every week who support the apprentices but also provides lessons to staff who want to do standalone Maths and English. It can just be for personal satisfaction or can then enable them to apply for career development.
- Previously run very successful pre-employment programmes working with DWP and Southport College, giving opportunities to people who may not have worked for a long time for different reasons and who would struggle in the recruitment process. Many of them have been successful in getting jobs within the Trust at the end of the programme and some are now on apprenticeships. Looking to run another pre-employment programme within the next 6 months

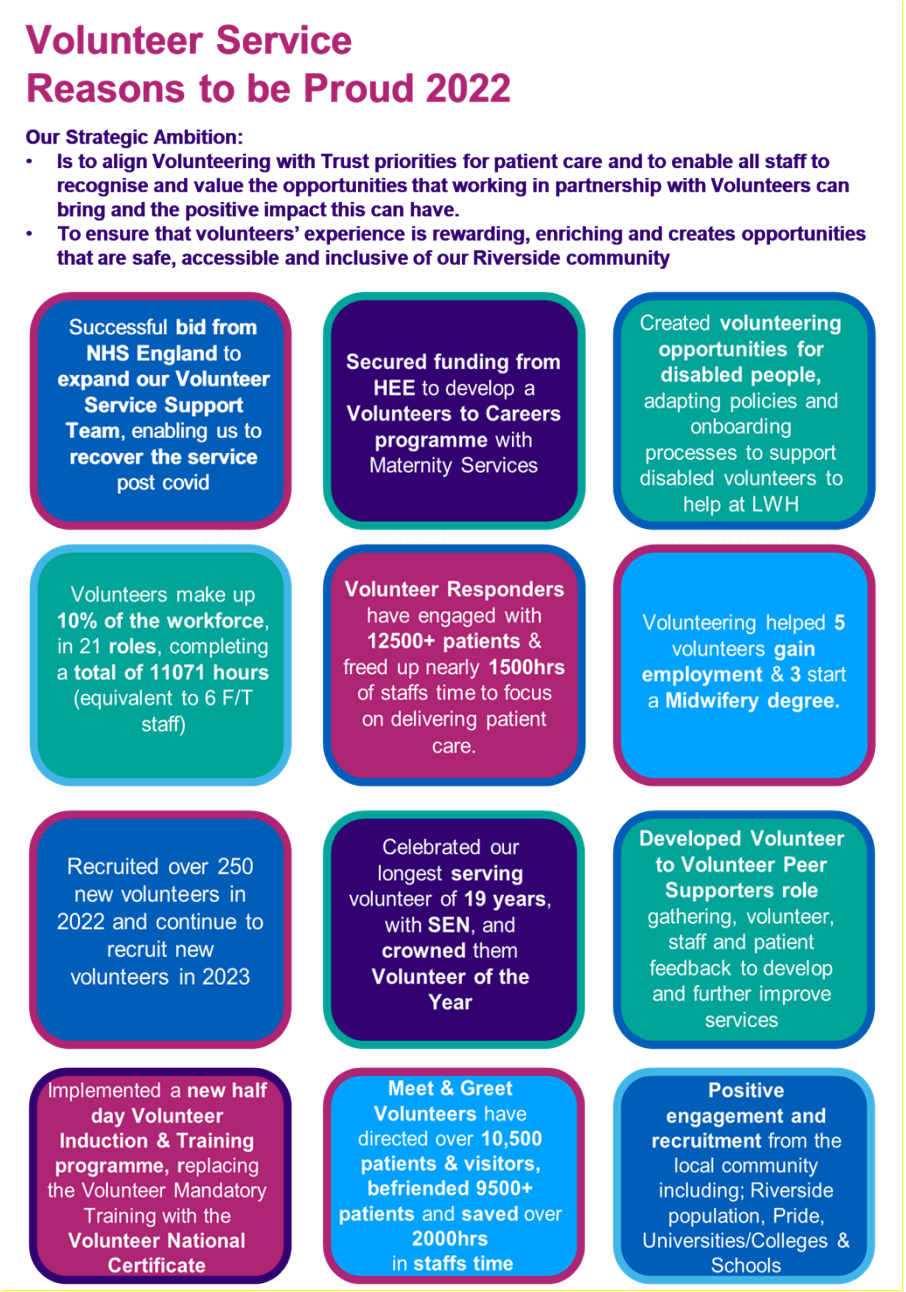
- Trust staff have took part in mock interviews in the local school for year 11, giving them feedback and advice as well as doing the interview.
- After successfully achieving the bronze standard for the Armed Forces covenant, we are looking to achieve silver and have a working group of staff looking at this including some staff who are ex forces.
- Apprenticeships are ongoing within the Trust and we have staff who have achieved apprenticeships in Operating Department Practitioner, Nursing associates, Finance, IT, Health and social care, Business admin, senior Leadership and Management. Looking at recruiting for midwifery apprenticeships.
- Work experience has been suspended due to Covid, it was reopened for a month in the summer and we 24 students on placement. Demand for places far outweighs capacity so been working with Liverpool Combined Region Careers Hub to make contact with local schools so that places are allocated via the schools to the students that show an interest in the NHS. This will ensure that a wide range of students are given an opportunity. Whole new programme put together which will be launched after Easter.

3.4 Volunteers Service

The infographic below details some of the achievements that the Volunteers have had in the past year. To become more inclusive the volunteers service engaged with disabled volunteers and staff experienced with working in SEN or who are parents of children with disabilities willing to support the inclusion of volunteers with disabilities. The service also engaged with organisations specialising in supported living and challenged themselves to be creative, flexible and adapted volunteer roles, policies and procedures appropriately.

In addition, the Volunteers Service provided:

- 1:1 support with the onboarding process, and or provide a personal experience with the support of the volunteer service instead of TRAC with the Recruitment Team
- Mandatory training for volunteers who do not have capacity to understand or complete the training do not have to do it, instead their support worker completes the training on their behalf. Volunteers with mild SEN are given support by the Volunteer. Team to complete the training. Aim is to convert training to Easy Read & Questions
- Buddying – extra support during shifts from another volunteer or member of staff, maintain that support until the disabled volunteer feels comfortable.



"Our disabled volunteers are a delight to work with, they are passionate, committed and dedicated to helping. Some of our longest serving volunteers are disabled. And our staff have embraced it without question or quibble".

Gina Barr, Voluntary Services Manager

3.5 Staff Inclusion Networks

Within the Trust there are a few networks that colleagues are invited to join for peer-to-peer support who also have the aim of fostering a diverse and inclusive workplace aligned with the values of the Trust. These networks include the newly renamed Race, Ethnicity and Cultural Heritage (REACH) network, previously known as the BAME staff network and the Disability and Wellbeing Network (DAWN) previously known as the Disability staff network and PRIDE @ LWH which was introduced this year. The aforementioned meet quarterly.

REACH network colleagues from racially and ethnically diverse communities, and in the past year, notably delivered a report led by the Vice Chair during Black History

about the experiences of race/racism by staff in the organisation. This resulted in an organisational response to actively engage with learning about race/racism including considerations of how to staff, service users and families accessing our services.

DAWN network colleagues which includes staff with physical disabilities, neurological and long term conditions have also made some notable conditions, particularly in supporting ongoing work focussing on reasonable adjustments and access to work.

Both of these networks have also supported ongoing work to develop Resources for Inclusion which is to support learning across the organisation about the lived experiences of people with different protected characteristics.

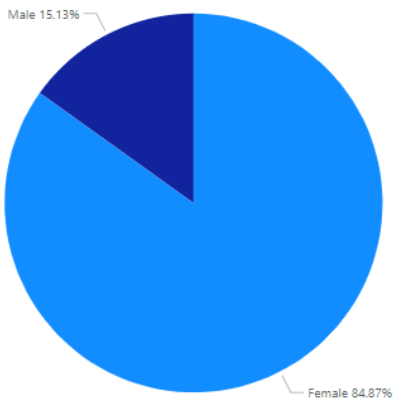
PRIDE@LWH, a recently established group has been working towards Pride in Liverpool and celebrating the successes that we have had at Liverpool Women's supporting LGBTQ+ service users and staff. The groups include LGBTQ+ staff and allies.

We also have the Menopause Club. This is a support that was developed through Health and Wellbeing where internal specialists including consultants advise people at different stages i.e., perimenopause, menopause and postmenopause. In the last year, these specialists have also provided rapid consultations for staff at Liverpool Women's.

4.0 Patient Profile

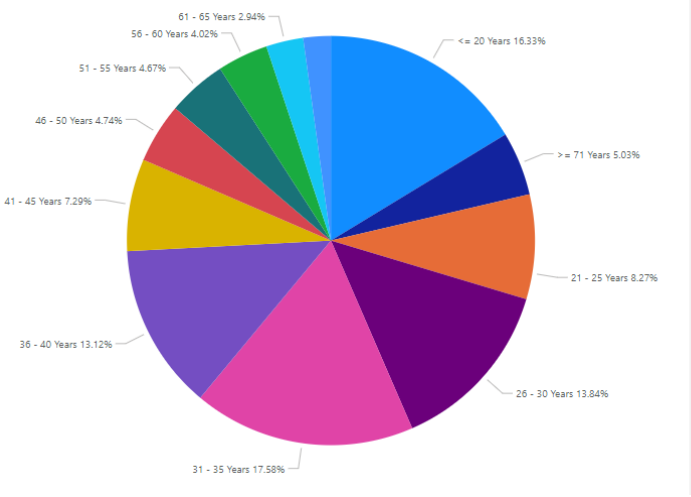
4.0 Patient Profile

Between April 2022 and March 2023 Liverpool Women's NHS Foundation Trust treated 68,908 patients, of which 58,469 were female equating for 84.85% of all patients, to be expected due to the nature of Liverpool Women's services.
The Trust treated 10,420 males who equated for 15.12% of patients; this was mainly within our fertility and neonatal departments.



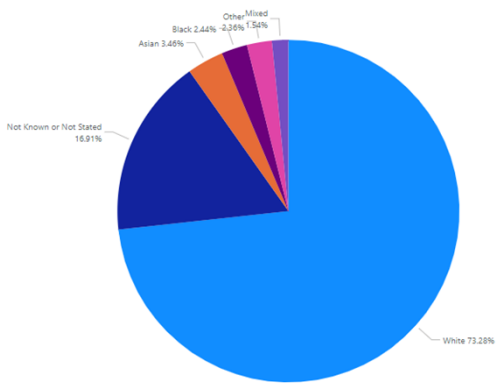
Financial Year	Gender	Patient Profile	%GT Patient Profile
2022-23	Female	58469	84.87%
2022-23	Male	10420	15.13%

Figures show the main ages of patients are between the ages of 21 – 45 which accounts for 60.09% of all patients, with 31 – 35 equating for the larges group ar 17.59% which is 12,119 patients



Age Profile	Patient Profile	% Patient Profile
<= 20 Years	11255	16.33%
>= 71 Years	3468	5.03%
21 - 25 Years	5694	8.26%
26 - 30 Years	9538	13.84%
31 - 35 Years	12119	17.59%
36 - 40 Years	9039	13.12%
41 - 45 Years	5019	7.28%
46 - 50 Years	3266	4.74%
51 - 55 Years	3216	4.67%
56 - 60 Years	2766	4.01%
61 - 65 Years	2028	2.94%
66 - 70 Years	1500	2.18%

The main ethnicity of patients is white with 73.28% which equates to 50,496 patients. 16.91% do not wish to disclose their ethnicity or ethnicity of unknown which is 11,653 patients.



Ethnic Group	Patient Profile	%GT Patient Profile
White	50496	73.28%
Not Known or Not Stated	11653	16.91%
Asian	2387	3.46%
Black	1683	2.44%
Other	1627	2.36%
Mixed	1062	1.54%

The table below shows the wide range of cultural backgrounds of our patients

5.0 Patient and Carer Experience and Service Improvement related to EDI

- An interpreter on wheels has been procured and following successful pilot, more units have been procured to support translation services for people who do not communicate in English.
- Continuity of Carer teams have been deployed in areas of high deprivation and in areas where there are high numbers of people from racially minoritised backgrounds.
- There is an ongoing evaluation process for Essential Parent App, which provides a plethora of information for service users in 36 different languages.
- Antenatal classes are being offered with midwives in different languages. This includes Arabic and Tigrinya.
- Due to still births in high deprivation areas, the Continuity of Carer teams are deployed to identified areas to support families in quitting smoking.
- The Non-English-Speaking Team (NEST) are facilitating clinics for non-English speaking women in Liverpool, Sefton and Knowsley.
- NEST have been doing work to support service users with protected characteristics and also those who are in the Core20Plus5 and other health inequalities groups e.g., caseloading vulnerable families, caring for women who have suffered from trafficking, asylum seekers. Also, women with recent refugee status, safeguarding, domestic abuse, isolation and housing issues.
- The Transformation Lead in Outpatient Transformation recently produced the Trust DNA (Did not attend/was not brought) plan, combining all initiatives to reduce DNAs with inclusion of groups from all protected characteristics considered throughout. This plan was positively acclaimed by the ICS and presented at Cheshire & Merseyside Elective Recovery and Inequalities Group. The Trust DNA plan includes ‘InTouch Check-In Kiosks’. Kiosks are now online and being used-these allow check in from kiosks to reduce the line to reception, they also have multiple language selections to support users who may not have English as a first language, and deaf patients
- The Transformation Lead also successfully delivered on ‘Waiting List Text Validation’. This is where the Trust sends a text message/letter to the new patients on the waiting list over 52 weeks to ask about their condition and if they still require an appointment. The questionnaire has the capability to translate into 104 languages, with many of them spoken to increase inclusivity in our waiting list management and validation

5.1 Engagement for Service Users

The Patient Experience and Engagement Facilitator who will be working closely with the Patient Experience Matron and EDI Lead for the Trust to improve service user involvement and engagement. There is also the development of the new Patient and Public Engagement Group (PPEG) which is schedule for early in 2023.

The PPEG will be responsible for:

- Providing stakeholder input and feedback on Liverpool Women's FT plans and strategies across any aspect of the Trust's business and services
- Providing a confidential forum for the testing of ideas and developments
- Being a 'readers panel' for public facing documents, social media campaigns and website content
- Advising on how best to engage with patients, stakeholders and wider public
- Supporting external communications and engagement activities as appropriate
- Sharing individual and stakeholder perspectives to inform plans and strategies

To support this great commitment to engage with service users there have been events and activities across the trust with stakeholders including community engagement leads and service users. Some of the events include:

- Chinese New Year, Cultural Celebrations with the involvement of senior leaders from third, health and social care and pollical sectors
- Chinese New Year, Health and Well-being Celebrations with an exhibition of art and health and social information for publicity
- Merseyside Society for Deaf People Liaison Manager attended Trust Board during Deaf Awareness Week in May 22 and was invited by the Trust Chief Information Officer and Chair of the Meditech User Network to be a speaker at the conference in September 2023.
- Liverpool Maternity Voices Partnership held a listening event at the Al Rahma Mosque in December with the Muslim Women's Network Baby and Toddler Society. This enabled service users who were Muslim women who live in Liverpool and are or recently accessed services to provide direct feedback.
- The Honeysuckle Bereavement Team have been engaging with dads in Anfield supported by Liverpool Football Club. They meet bi-monthly for 3 hours and activities include playing football, health and well-being session and a member of the Honeysuckle Bereavement Team are available for drop in advice and support.
- Community midwives have been engaging with Dads in the Community – Everton in the Community Group, offering support to dads which includes signposting and referrals into the group which is supported by LWH.
- Great Day of Inclusive Practice took place in February. This was a day of presentations to share best inclusive practice when engaging with groups that are from marginalised groups followed by a workshop with those in attendance to breakdown the reasons service users DNA (Do Not Attend). This informed a broader Trust DNA Plan developed by the Transformation Lead. Feedback reflected that the event was "psychologically safe and informative".

The day was opened by the Chief Nurse, and attended by nurses, EDI, community and engagement leads, lecturers and students to discuss topics such as disproportionate health outcomes in racially marginalised groups, refugees, immigrants and other topics such as women's maternal health, deprivation, mental health and maternity, support for transgender reproductive choices.
Speakers in attendance were from Liverpool John Moores University, Silver Birch Hubs, Improving Me, Central Liverpool Primary Care Network, Refugee Women Connect, Liverpool Women's NEST and Hewitt Fertility Centre to name a few.

5.2 Secret Shopper

The secret shopper concept was introduced in February 2023. To allow us to see our services from the perspective of a service user's perspective – providing a fresh eyes approach in obtaining feedback.

The first secret shopper at LWH was a wheel-chair user on a supported internship programme. They produced a video of environmental barriers that were encountered when out and about across the ground floor of the Trust. The secret shopper was able to provide an understanding on barriers from a lived experience perspective.

The findings support the reasons why an environmental access audit of premises will be undertaken in line with obligations under the Equality Act 2010. The secret shopper gave a presentation at EDI Committee and will also be involved in this audit.

5.3 Supporting Patients with Additional Needs

- To promote engagement, a forum of service users with additional needs who have accessed and received care provided by the Trust has been established through the Maternity Voices Partnership.

- This forum provides constructive challenge and scrutiny from a patient perspective regarding how we deliver care for those with additional needs.

- The forum also provides guidance and insight on the skills, behaviours and attitudes needed by our workforce to meet the needs of both patients and their carers/families.

- On or following discharge, patient feedback is collated using an adapted 'Easy read' patient/carer questionnaire styled to assess a number of indicators specific to patients with a disability. These findings are reviewed, analysed and presented on a quarterly basis. On an annual basis these findings are compared against the Trust Friends and Family Test (FFT) scores for patients without additional needs.

6.0 Measures & Objectives

6.1 Gender Pay Gap Report (2022)

Gender pay gap reporting regulations require UK employers in the public sector with 250+ employees to disclose workforce details in relation to their gender pay gap based on a single date each year, namely 31 March. As such, the gender pay gap report gives a snapshot of the gender balance within an organisation. It measures the difference between the average earnings of all male and female employees, irrespective of their role and/or seniority.

The full 2022 Gender Pay Gap report for the Trust can be found on the Trust website (https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/).

6.2 Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) was most recently submitted on 30th August 2022, in line with the national deadline.

The latest WRES data reflects that band distribution has not changed with the majority of ethnic minority staff holding clinical Band 5, Band 6 and Band 7 posts. The highest banded non-clinical role remains the same as 2019, one individual at Band 8a. The highest banded clinical role (excluding medics) remains one individual at Band 8b.

Medical staff figures remain static at 34 staff disclosed ethnic minority background on ESR in both 2020 and 2021. There are 12 staff from Agenda for Change payscales who have not disclosed on ethnicity on ESR and 23 staff from Medical grades who have not disclosed ethnicity on ESR. Board member and non-Executive Director data for ethnic minority staff remains static at 1 person in non-Executive Director role.

Relative likelihood of being appointed from interview if an applicant is of ethnic minority background has increased from 41.67% in 2020 to 52.70% in 2021. On reviewing the data this can be attributed to the increase in ethnic minority staff being shortlisted and appointed, however some of these may have been appointed in year and not yet commenced in post, in addition turnover is not taken into account for the national reporting figure.

For the last 3 years there have been no staff from ethnic minority background staff entering the formal disciplinary process.

It is positive to see the reduction in the number of staff from an ethnic minority background stating they have experienced harassment, bullying or abuse from staff, this has reduced from 33.9% to 23.9%, compared to their white colleagues reporting 18.0% this year. However, whilst this figure is lower than the national average for ethnic minority staff (28.7%) it remains a concern that nearly a quarter of ethnic minority staff experience bullying or harassment from their colleagues at Liverpool Women's.

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

A WRES action plan for the coming year is available to view which takes into account the above noted key findings from the latest WRES submission and this can be found at on the Trust website (https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/).

6.3 Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) was introduced in 2019 and entails a set of specific measures/metrics that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. The deadline for this data submission was successfully met on 31st August 2021.

The data shows that there are 285 staff from Agenda for Change (AfC) payscales who have not disclosed disability status on ESR (status unknown) and 20 staff from Medical grades who have not disclosed on ESR.

In terms of band distribution, there are 2 disabled staff above band 8a in non-clinical roles, and 1 disabled staff above band 8a in clinical roles. This is an increase from a zero return for previous
reporting year. There are no staff disclosing a disability in medical roles.

In terms of recruitment, non-disabled candidates are 1.67 times more likely to be appointed from shortlisting stage than disabled candidates which is a positive position compared to previous year where non-disabled candidates were 2.32 times more likely to be appointed. 25 disabled staff applied for a job at the Trust in 20/21 which is a decrease from the previous year (32) however only 12 were appointed. Disabled staff are 8.92 times more likely to enter the formal capability process than non-disabled staff.

It is concerning that the number of disabled staff (21.3%) state they have experienced bullying, harassment or abuse in the workplace compared to non-disabled colleagues (11.9%), though this is lower than the national average for disabled staff (25.4%). Disabled staff are slightly more likely to report it (55.8%) than non-disabled (46.8%). A positive improvement from 83% in previous year, 89.3% of disabled staff believes the Trust provides equal opportunities for career progression compared to 90.3% of non-disabled employees

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

7.0 Policies

In 2022 reviewed the Equality and Human Rights Policy and introduced the Transitioning in the Workplace Policy and the Caring for Transgender Patients Policy which were developed by the Cheshire and Merseyside Integrated Care Board. The Trust also introduced the Use of Interpreters Policy which was supported by the Merseyside Society for Deaf People Liaison Manager.

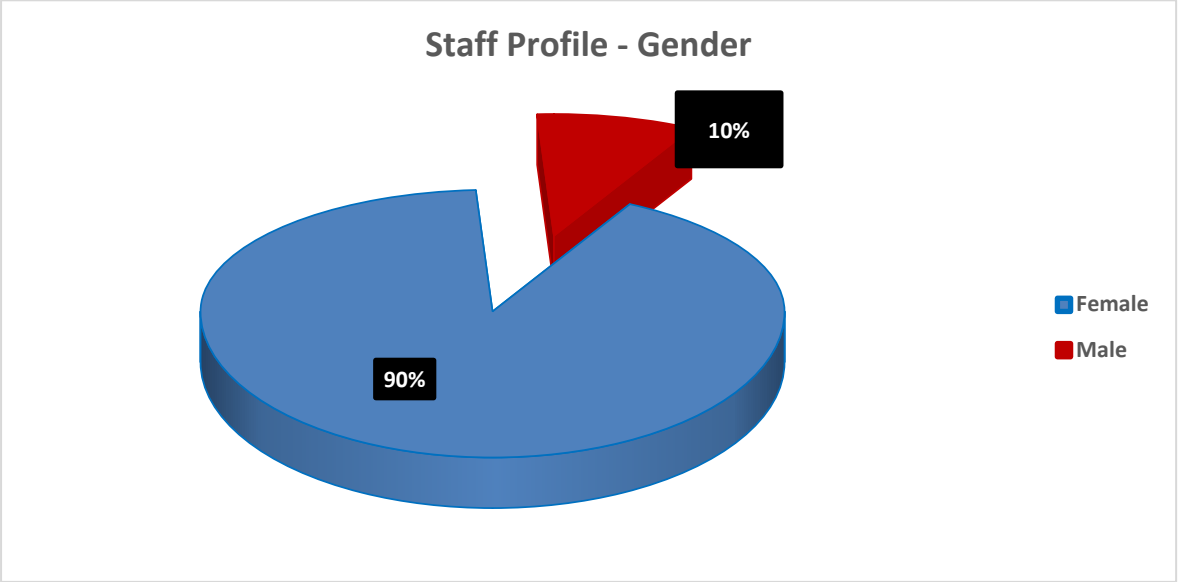
In addition, we conducted a review of our Equality Impact Assessment policy to include considerations for health inequalities, Core20Plus5 and protected characteristics under the Equality Act 2010. The new equality impact assessment format challenges staff to consider how any changes in the organisation may adversely impact people from marginalised groups and the opportunity to mitigate any inequities that are identified at an early stage.

8.0 Staff Profiles

Headcount for the workforce as of February 2023 stood at 1756 which is an increase of 185 staff from 2021.

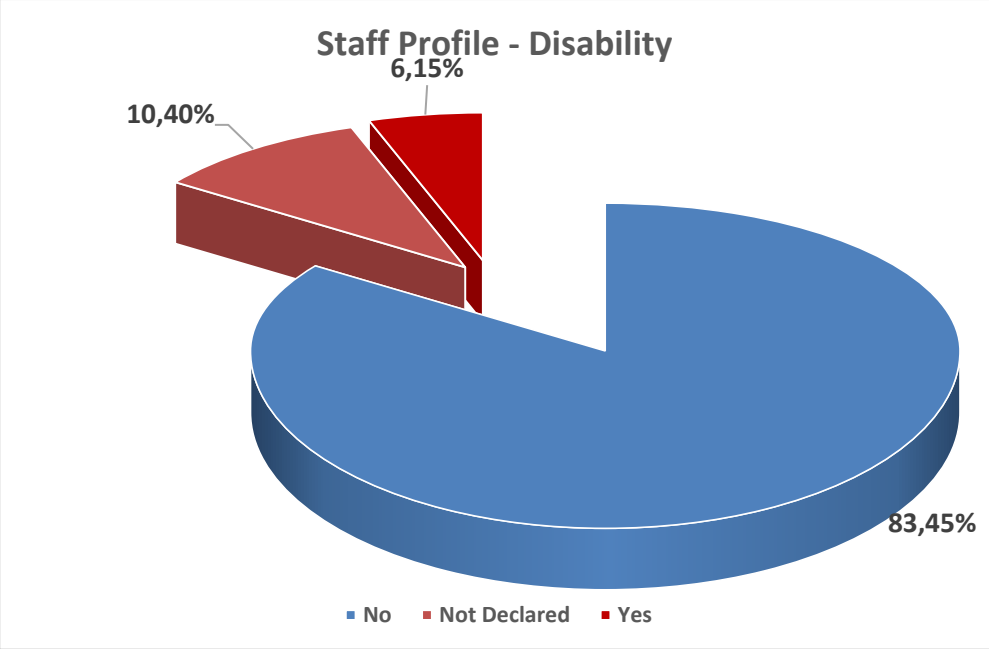
8.1 Staff Profile – Gender

Liverpool Women's NHS Foundation Trust has an 90% female workforce which equates to 1576 colleagues.



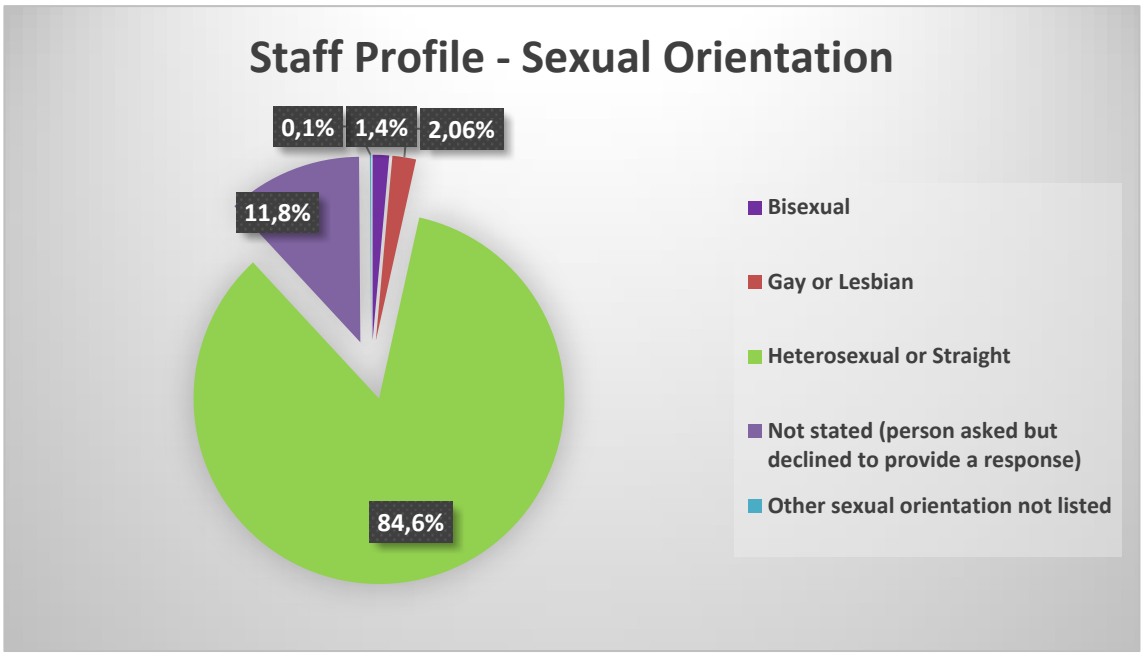
798 staff are in the Nursing and Midwifery staff group; 99% of this group are female.

8.2 Staff profile – Disability



The figures relating to disability declarations 83.45% of colleagues state they do not have a disability and 6.15% state that they do. 10% of colleagues declined to provide an answer to the question and therefore not providing a full representation of disability within our colleague base. Further information can be found in the Trust WDES report which can be found via https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/

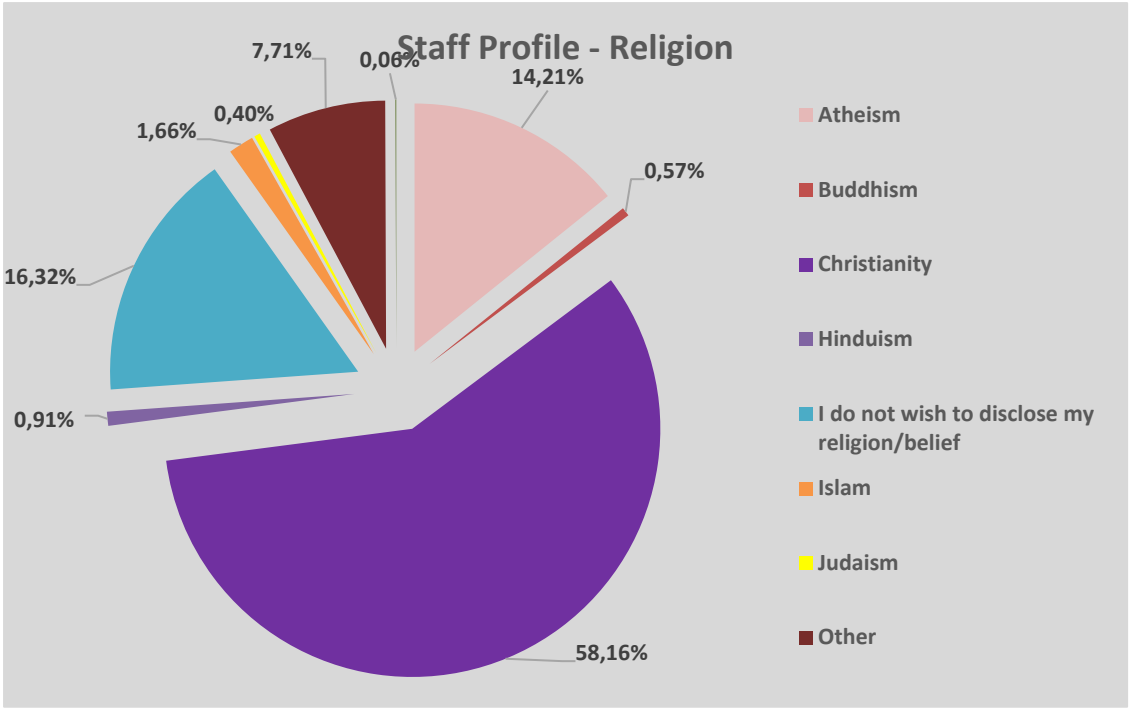
8.3 Staff profile – Sexual Orientation



84.6% of colleagues define their sexual orientation as Heterosexual; this remains comparative to last year in which 81.47% of colleagues reported the same. Those identifying as Gay or Lesbian account for 2.06% of the staff group.

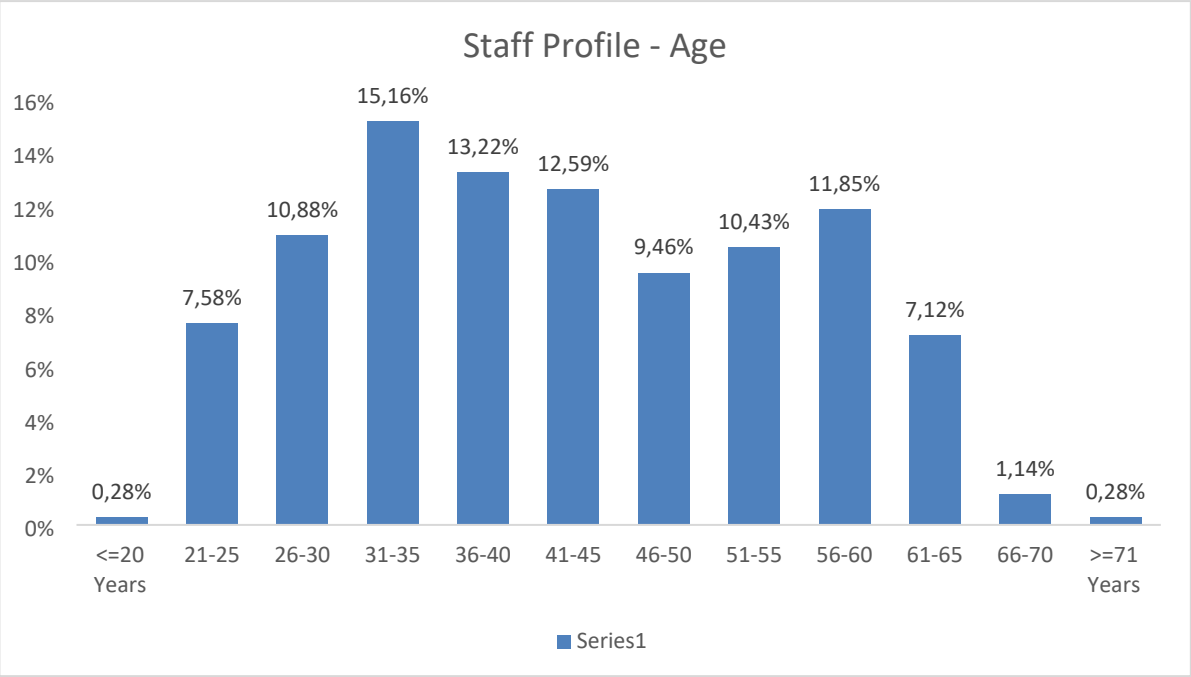
As with disability declarations, the above does not provide a full representation of colleagues' orientation as 11.8% declined to provide an answer.

8.4 Staff profile – Religion



1,019 or 58.16% of colleagues define their religious beliefs as Christian, followed by Atheism equating for 12.06%. As with previous declarations this does not provide a full representation of colleagues' orientation as 16.32% declined to provide an answer.

8.5 Staff profile – Age



The main body of the staff profile is made up between age groups 31 – 40 and between 51 – 60 which shows although we have a high level of younger staff, we have a high level of staff who are nearing retirement age. Work is on-going to develop those staff, so we do not loose valuable experience and knowledge when staff retire.

9.0 Plans for 2023/24

This report has provided an update on many of the activities and actions that have taken place in 2022/23 across the Trust.

There is board level commitment to review the Trust approach to Equality, Diversity and Inclusion in its entirity; the Trust has an ambition to be amongst the most inclusive NHS organsiations in the UK in creating an inclusive culture that harnesses and encourages diverse leadership at all levels in the organisation.

- We have an ambition to develop a number of volunteers to careers roles to support maternity services, with a view to supporting our strategic ambition to recruit from the Riverside population into these roles
- We will be bringing counselling services in-house, this will sit within the Staff Support Service and enhance the support overall for the mental wellbeing of staff
- Development for Mental Health First Aiders to ensure that they receive support and regular development from Consultant Psychologist, Assistant Psychologist and Health and Wellbeing Coaches

- There is an ambition to substantially recruit two Health and Wellbeing Coaches trustwide
- There is ongoing work to improve the reporting of EDI risks through the risk register which will have oversight by the EDI Committee
- Reporting of hate incidents between staff and managers which is currently not recorded on risk management system – there will be a new, confidential and safe way of reporting these
- There is ongoing work to develop a trauma informed care for staff who experience racism
- Whilst the data cleanse in the last year was successful with a third of staff completing and returning, in 2022/23 there will be a concerted effort to improve staff declarations rates even further
- Extension of e-learning package to design and deliver specific ED&I training and education to all staff – improved knowledge will result in benefits for better staff and patient experience.
- Education and celebration of the key EDI events: Black History Month, Disability History Month, LGBT+ History Month and key faith observance days/festivals.
- Exploration of how the Trust attracts local population to work at LWH, utilising widening participation programmes and alternative ways to advertise and promote our job opportunities.
- Exploring potential to report on Disability and Race pay gaps on Trust website in addition to the Nationally required reports; Gender Pay Gap, Workforce Race Equality Standard, Workforce Disability Equality Standard and Equality Delivery System.
- Monitor the number of staff from racially minoritised backgrounds who attend the Liverpool Women's Leadership Development Programme
- Monitor the use of the guaranteed interview scheme for racially minoritised groups and diverse interview panels
- Conduct an assessment of the physical environment to identify any barriers that may hinder accessibility for people with "protected characteristics". The organisation will then take necessary measures to remove those barriers, such as providing wheelchair ramps, installing lifts, improving lighting, and ensuring signage is clear and easy to understand.
- Provide training to staff on the Accessible Information Standard, develop policies and procedures to ensure compliance with the standard, and providing accessible information to service users, such as easy-read information, braille, large print, and audio formats.
- Identify service users' language needs, providing trained interpreters and translators, ensuring staff are aware of their duty to offer interpretation and translation services, and providing translated information about Trust services.
- Identify key community stakeholders, establishing regular communication channels, and conducting regular engagement activities, such as community events, focus groups, and outreach programs.

- Establish a health inequalities review group, providing training to staff on identifying and addressing health inequalities, conducting regular health needs assessments, and developing and implementing action plans to address health inequalities.

10.0 Summary

This annual report collates some of the activities that have taken place in the last 12 months at the Trust. There is clear direction with regards to the Equality, Diversity and Inclusion strategy, with the Trust seeking to further develop the overall approach in 2022/23.

There are significant strides that have been taken to embed equality, diversity and inclusion in all areas to reduce health inequalities for service users and to ensure that staff are working in a supportive and inclusive work environment, as one of our ambitions is to become one of the most inclusive organisations in the NHS.

There will be a focussed commitment to the recruitment for minoritised groups, retention of all staff particularly those from minoritised groups, and development of staff from racially minoritised groups. There will be a continued effort to address the marginalisation of groups with protected characteristics under the Equality Act of 2010 and these ambitions are to ensure that we have a workforce that is representative of our local population to improve health outcomes for our service users. This is including diverse interview panels, opportunities for reciprocal mentoring and developing effective reporting mechanisms and support for any colleagues that may experience hate incidents in the workplace.

Furthermore, the organisation recognises the need to become more accessible for staff and service users, i.e., to review the reasonable adjustments and access work policies/procedures and the outcomes of the planned environmental access audit which will help us to ensure that staff are working safely and feel supported.

Finally, the organisation acknowledges that there is an increasingly diverse population in Liverpool and there is an ongoing work to improve the EDI training offer to give staff information and improve learning/skills in different areas of inclusion to support that.

It is important that the positive work that has been highlighted continues taking place for both staff and service user groups. It is equally important to recognise that this journey for the Trust is ever moving and changing to ensure the best possible experience for all. To support this development, it is vital to work in partnership with stakeholders including our local community in a collaborative approach to address the areas for improvement as highlighted in this report. It is equally important to engage with staff about their experiences accessing and/or working in our organisation through official and unofficial reporting mechanisms e.g. Managers, HR Business Partners, Freedom to Speak Up Guardians, Ulysses.

Liverpool Women's
NHS Foundation Trust

EXECUTIVE SUMMARY

We gather Equality Information about the 9 protected characteristics and other relevant information to help to analyse our positioning, to inform our decisions and to help develop our Equality Objectives related to Equality, Diversity and Human Rights.

This process helps us in our quest for securing fair treatment, inclusion and access to our services and employment, and to fulfil our requirements under the Equality Act 2010 and the Public Sector Equality Duty (PSED). Most importantly, under the Duty, we need to demonstrate that the Trust and our objectives, work towards becoming one of the most inclusive NHS organisations.

The current Equality Objectives for the Trust expire on 31 March 2023. This paper outlines the trusts proposed Equality Objectives for 2023-27 for Workforce and Patents.

REPORT

1. Introduction

In establishing our Equality Objectives we by utilising all the available evidence of our equality performance and then analysing shared themes from a number of information sources, including:

- Reviewing NHS information and stakeholder feedback from the Equality Delivery System (EDS 2022)
- Reviewing data from other statute workforce reports; Workforce Race Equality Standards (WRES), Workforce disability Equality Standards (WDES) and Gender Pay Gap reports
- Considering the Trust's Strategic objectives and intentions in relation to EDI
- Internal (staff) feedback regarding performance of, and priorities for the organisation, and feedback from the Staff Survey
- External (patients, partner organisations etc.) feedback regarding performance and priorities as part of the EDS engagement process and Feedback from previous patient surveys and from patient experience tools

Whilst there are many potential objectives, the Trust is keen to focus its efforts on a number of key priority areas, based on these providing the most benefit across all of the protected groups for our People, our patients/service users and workforce.

Our Equality objectives contribute to a wider goal for the Trust Strategic objective to drive towards becoming one of the most inclusive organisations in the NHS.

2. Workforce Equality Objectives

We have proposed a set of three workforce Equality objectives and three Patient Equality Objectives which cover the period April 2023 to March 2027. Each of these equality objectives is supported and strengthened by associated targets and actions.

In summary the proposed Equality objectives are:

1) We will focus on recruitment into the organisation and increasing diversity in entry level roles through targeted pre-employment programmes aimed at women in the L8 area and attraction of staff already in the NHS who want to progress in their careers
2) We will focus on supporting existing staff from racially minoritised backgrounds to progress into leadership roles through targeted career conversations, career plans and development programmes
3) We will focus on staff experience for all staff, particularly those from minoritised groups currently employed at LWH, ensuring these staff are retained within our teams
4) We will improve access to all services for the population that we serve
5) We will work in Partnership with People and Communities
6) We will reduce Health Inequalities of our Racially Minoritised people

A more detailed draft version of the objectives and associated actions to address these objectives are outlined within appendix 1 of this report.

3. Summary / Actions

There is a requirement for Equality Objectives for a five year period to be approved and published on the Trust website in order to fulfil our requirements under the Equality Act 2010 and the Public Sector Equality Duty (PSED), demonstrating that the Trust and our objectives, work towards three key aims of eliminating discrimination; advancing equality and fostering good relations.

Liverpool Women's NHS Foundation Trust

Appendix 1: Equality Objectives 2023-27

Overall Objective 1: We will focus on recruitment into the organisation and increasing diversity in entry level roles through targeted pre-employment programmes aimed at women in the L8 area and attraction of staff already in the NHS who want to progress in their careers						
Objective	**Actions**	**Link to other Indicators**	**Responsible Manager**	**Timescale**	**Measures**	**Status**
Improved engagement with community groups: Development of pre-employment programme / Volunteer to Career programme	Link with new Patient Experience and Engagement Facilitator and work collaboratively to agree which specific community groups we will work with to develop Widening Participation and Volunteers to Careers opportunities and through targeted programmes we will focus on attracting people from L8. Partner with local Refugee groups and charities to consider volunteer and working opportunities, offering functional skills qualifications and work experience opportunities	Trust Strategy / PPF Strategy	EDI Manager	August 2023	Audit of the number of people on widening participation and volunteers cohorts, including monitoring of protected characteristics, postcode and where they heard about the programmes (which community group).	

Advertise more widely in local community groups and remove practical barriers to applying for a job at the Trust	Accepting paper applications rather than online Introduce double tick for racially minoritised applicants and positive action at interview decision making stage For all new jobs develop accessible easy read 1-page summary of role descriptor with detailed job description attached LWH currently advertises roles on NHS jobs, Granby, Liverpool Combined Region and with Inclusive Companies recruitment platform. Continue to expand where we advertise roles within the L8 community and how we advertise	WRES / WDES / Trust Strategy / PPF Strategy	Head of Culture and Staff Experience / EDI Manager	September 2023	Quarterly Recruitment audits to monitor - where vacancies have been advertised - where applicants saw vacancy advertised - postcode of applicants - protected characteristics of applicants and whether they were successful in securing the post. Trust ambition to increase numbers of racially minoritised staff by 25% by 2025.	
Ensure we have diverse interview panels for bands 8A and above	Connect with the North West Equality Diversity Representative process Offer training opportunities to become a diverse panel member through staff Inclusion network	n/a	Head of Culture and Staff Experience / EDI Manager	March 2024	Achieve 100% diverse interview panels for band 8A and above roles and Medical roles, through Divisional reporting at EDI Committee	

	groups, Inclusion Forum and Great Place to Work Group. Deliver training and develop internal diverse interview panel group Refresh current recruitment training for all managers to ensure this includes inclusive elements of the recruitment process e.g. role of inclusive panel member, inclusive questions (to be asked at all interviews regardless of banding), additional assurance paperwork to be completed by inclusive panel member					
Offer of coaching and mentoring from our Executive Directors to NHS staff wanting to progress in their careers	Train all members of the inclusion networks in reciprocal mentoring and partner with Executive Director / Deputy Director Offer reciprocal mentoring to all staff with protected characteristics through the Great Place to Work Group Set up Quarterly learning sets to ensure positive elements	WRES / WDES	Head of Culture and Staff Experience / Assistant Director of Workforce	March 2024	Achievement of each Executive Director and their Deputies having at least 1 reciprocal mentoring relationship by March 2024.	

	discussed within mentorship relationships have been captured and are acted upon					
Engage with staff and local community groups to develop and embed Anti-Racist Strategy	Engage with staff and local community groups to develop and embed Anti-Racist Strategy ensuring that co-design and local community needs are met. Ensure Anti-racism statement of intent is included in all adverts, and once developed the Strategy documents to be accessible to candidates at application	WRES / Staff Survey	EDI Manager	September 2023	Website publication of Anti-racist Strategy following workforce and community engagement. Quarterly audit of adverts to ensure antiracism statement is included in 100% of job adverts.	
Make changes to internal recruitment processes	Survey of all candidates from minoritised backgrounds both successful and unsuccessful (every 8 weeks) to establish how the recruitment process could be improved Consider alternatives to interview process, allowing more practical evidence of competencies at recruitment stage Offer all candidates the interview questions that will be asked in	WRES / WDES	Head of Culture and Staff Experience / Assistant Director of Workforce And Divisional leaders (EDI Committee members)	September 2023	Annual audit the recruitment process and type of interview offered.	

	advance of interview e.g. emailed out to candidates 24 hours prior to interview Offer all minoritised candidates positive action mock interview in advance of their actual interview date Engage with the NHS E work in relation to racially minoritised recruitment.					
Objective 2: We will focus on supporting existing staff from racially minoritised backgrounds to progress into leadership roles through targeted career conversations, career plans and development programmes						
Objective	**Actions**	**Link to other Indicators**	**Responsible Manager**	**Timescale**	**Measures**	**Status**
Ensure Career conversations happen for all staff and ensure racially minoritised staff have access to places on the leadership development programme	Offer individual mentorship from the Director and Deputy Director of Nursing and Midwifery All racially minoritised staff who have identified in their career conversation during have ring fenced places on to relevant leadership programmes. Monitoring annual figures of racially minoritised staff accessing	WRES / Staff Survey / Trust Strategy/ PPF Strategy	Head of Culture and Staff Experience / Assistant Director of Workforce And Divisional leaders (EDI	March 2025	Audit the number of completed number of career conversations for racially minoritised staff through PDR reporting function. Achievement of 75% of staff stating that	

	Leadership development programmes through OD reports		Committee members)		the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age (2021 = 57.6%, 2022 = 61.1%)	
Ensure racially minoritised staff are developed ready to step into roles identified through succession planning	Offer leadership shadow opportunities for racially minoritised staff, to showcase different career leadership opportunities e.g. clinical / non-clinical leadership roles and learning about what these roles entail on a day-today basis Develop succession planning for roles where there are flight risks, and create developmental opportunities for racially minoritised staff for projects. Allowing the racially minoritised staff to be released from their existing roles for a percentage of the week to focus on personal development and exposure so	WRES / WDES / Trust Strategy / PPF Strategy	Head of Culture and Staff Experience / Assistant Director of Workforce And Divisional leaders (EDI Committee members)	March 2023	Annual audit of talent management through L&OD reporting.	

	they are ready when a role opportunity arises					
Objective 3: We will focus on staff experience for all staff, particularly those from minoritised groups currently employed at LWH, ensuring these staff are retained within our teams						
Objective	**Actions**	**Link to other Indicators**	**Responsible Manager**	**Timescale**	**Measures**	**Status**
Develop an in-house EDI training programme for all staff	Annual reports to be prepared from OD showing which groups of staff have accessed training in the previous quarter by protected group. This information to be correlated with the equality information disclosed by staff on ESR Ensure LD&A Awareness training is delivered to all staff Develop programme of training for all staff, considering alternative methods to ensure that staff have access through different methods that suit them and the demands on their time	Trust Strategy/ PPF Strategy	Head of OD / Head of Culture and Staff Experience / EDI Manager	August 2023	Twice annual audit from L&OD compliance data (in line with the L&OD Strategy for racially minoritised staff accessing training). 100% Compliance with essential EDI training.	

	Continue to develop **Resources for Inclusion,** expanding on the Resources for Race Inclusion to include other protected characteristics e.g. Resources for Embracing Difference and Neurodiversity, Resources for Pride Inclusion					
Develop and deliver Anti-Racism training to all staff	Deliver workshops and book club with the Executive Directors to continue the learning and conversation in relation to Anti-Racism Develop and deliver workshops for Senior Leadership Forum Regular messaging to staff to introduce what anti-racism is and why its important at LWH, considering support to staff in relation to racial trauma as we progress with communication and development of becoming an Anti-racist organisation Devise a programme and commence roll out of introductory training sessions with all teams	WRES/ Trust Strategy / PPF Strategy	EDI Manager	March 2024	Audit training and ensure 100% compliance for Leaders by March 2024. Achievement of 100% compliance for all staff across the Organisation by March 2025.	

Review of current reasonable adjustment process and how our staff access this	Ensure better understanding of what Access to Work can offer to staff and managers and how to support staff through this process Review of experience and support offered to staff with disabilities and long-term conditions in relation to reasonable adjustments process and make recommendations on how to improve this Develop a new stand-alone reasonable adjustments policy Include in all offer letters how candidate can apply to Access to Work to receive support with reasonable adjustments and specialist equipment in advance of commencing in post	WDES / Trust Strategy / PPF Strategy	Head of Culture and Staff Experience	March 2024	Development of new policy for Reasonable Adjustments. Audit effectiveness through new starter questionnaire and achievement of 90% in staff survey for question Has your employer made reasonable adjustment(s) to enable you to carry out your work (2022 = 69.4%)	
We will enhance our staff wellbeing offer, with a focus on engagement with our workforce to identify he key areas	We will use quantitative and qualitative information gathered from our staff surveys, Great Place to Work Groups, Staff Inclusion Networks and our Health and Wellbeing Conversations to develop a programme of Health and	Staff Survey / Trust Strategy / PPF Strategy	Head of Culture and Staff Experience Plus Divisional leaders (members of EDI Committee)	March 2024	Audit Staff Survey Engagement scores (2022 = 7.1) achieving a score of 7.6 by March 2025. Audit of ESR compliance with	

	Wellbeing support tailored to the needs of our workforce. We will have 100% compliance with Health and wellbeing conversations ensuring that all staff receive appropriate support and signposting to remain well at work We will develop our internal Staff Support Service, securing substantive health and wellbeing coach roles that will work across the organisation, to ensure our workforce is well equipped in relation to mental health and trauma support We will continue to support our staff with women's health developing the work in relation to supporting all staff (men and women) with education and support available through our policies and procedures. We will explore opportunities available within the hospital where we can better support our workforce with easier access for women's health matters e.g. smear tests, gynae clinics, etc				wellbeing conversations, achieving 100% by March 2023. Also monitor through EDI Committee divisional reporting and Partnership forum	

	We will continue to develop the Menopause Club to ensure support is accessible for all staff in relation to the menopause and signposting for those who are experiencing symptoms that are impacting on them (both men and women) We will develop our support to staff in relation to physical fitness and nutrition by promoting existing opportunities e.g. walking and running clubs, and developing new opportunities e.g. community dance in L8 for all staff and their families and LWH's L8 community friends. We will research weight management support opportunities for our workforce. We will also develop our staff pantry - location and items available with healthy and nutritious recipe ideas. Continue to improve staff facilities. - Staff room upgrades will continue to be considered and new equipment purchased as identified					

	e.g. microwaves, fridges and kettles - Review number of showers/changing facilities and lockers available and any upgrades required. - The staff conservatory and outside space will be refreshed and upgraded.					

Equality Objective 4: We will improve access to all services for the population that we serve						
Objective	**Actions**	**Link to other Indicators**	**Responsible Manager**	**Timescale**	**Measures**	**Status**
The organisation will promote equality for people with "protected characteristics" in ensuring the environment is fit for purpose by making necessary	The organisation will achieve this objective by conducting an assessment of the physical environment to identify any barriers that may hinder accessibility for people with "protected characteristics". The organisation will then take	This objective is in line with the organisation's commitment to promoting equality and ensuring that the physical environment is accessible and fit	Head of Estate ad Facilities/Head of Patient Experience	The organisation will achieve this objective within the next 12 months by conducting the accessibility audit, identifying barriers, and making necessary adjustments to the physical environment. The effectiveness of the objective will be reviewed regularly to ensure that the	The organisation will measure the effectiveness of this objective by conducting an accessibility audit and	

adjustments to the physical environment to remove any barriers that hinder accessibility and inclusivity.	necessary measures to remove those barriers, such as providing wheelchair ramps, installing lifts, improving lighting, and ensuring signage is clear and easy to understand.	for purpose for all service users, regardless of their protected characteristics.		physical environment remains fit for purpose for people with "protected characteristics".	collecting feedback from people with "protected characteristics". The aim is to achieve a minimum score of 80% on the audit and receive positive feedback from service users.	
The organisation will ensure that the Accessible Information Standard is implemented Trust wide by creating and implementing policies and procedures that promote accessible communication for people with disabilities.	The organisation will achieve this objective by providing training to staff on the Accessible Information Standard, developing policies and procedures to ensure compliance with the standard, and providing accessible information to service users, such as easy-read information, braille, large print, and audio formats.	This objective is in line with the NHS's commitment to providing equitable healthcare services for all service users, regardless of their disability status, and ensuring that they have equal access to healthcare information.	Head of Patient Experience/Access Manager	The organisation will achieve this objective within the next 12 months by implementing policies and procedures that promote accessible communication and providing training to staff. The effectiveness of the objective will be reviewed regularly to ensure that the organisation remains compliant with the Accessible Information Standard.	The organisation will measure the effectiveness of this objective by conducting regular audits to ensure that all service users are aware of their right to accessible information and that staff are	

					trained to provide accessible communication. The aim is to achieve a minimum score of 90% on the audit.	
The organisation will ensure equality of access to all Trust services for people who experience communication barriers because their first language is not English by providing interpretation and translation services in a timely manner.	The organisation will achieve this objective by identifying service users' language needs, providing trained interpreters and translators, ensuring staff are aware of their duty to offer interpretation and translation services, and providing translated information about Trust services.	This objective is in line with the NHS's commitment to providing equitable healthcare services for all service users, regardless of their language or cultural background, and ensuring that they have equal access to healthcare information.	Head of Procurement/Head of Patient Experience	The organisation will achieve this objective within the next 12 months by implementing a system to identify language needs of service users, providing training to staff, and providing interpretation and translation services in a timely manner. The effectiveness of the objective will be reviewed regularly to ensure that the organisation remains compliant with the objective.	The organisation will measure the effectiveness of this objective by conducting regular audits to ensure that all service users who require interpretation and translation services are provided with them in a timely and efficient manner. The	

					aim is to achieve a minimum score of 95% on the audit.	
Equality Objective 5: We will work in Partnership with People and Communities						
Objective	**Actions**	**Link to other Indicators**	**Responsible Manager**	**Timescale**	**Measures**	**Status**
The organisation is to build positive and enduring relationships with communities to improve services, support, and outcomes for people by identifying key community stakeholders and	The organisation will achieve this objective by identifying key community stakeholders, establishing regular communication channels, and conducting regular engagement activities, such as community events, focus groups, and outreach programs.	This objective is in line with the NHS's commitment to building and maintaining positive relationships with communities to ensure that healthcare services are responsive to the needs of local populations.	Head of Patient Experience	The organisation will achieve this objective within the next 24 months by establishing communication channels with key community stakeholders, conducting regular engagement activities, and reviewing the effectiveness of the objective through regular surveys. The effectiveness of the objective will be reviewed annually to ensure that the organisation remains committed to building positive and	The organisation will measure the effectiveness of this objective by conducting regular surveys to assess community satisfaction with the services provided and	

engaging with them on an ongoing basis.				enduring relationships with communities.	the support offered by the organisation. The aim is to achieve a minimum score of 80% on the survey.	
Equality Objective 6: We will reduce Health Inequalities of our Racially Minoritised people						
Objective	**Actions**	**Link to other Indicators**	**Responsible Manager**	**Timescale**	**Measures**	**Status**
The organisation will ensure that systematic differences in health between social groups are continuously reviewed and acted upon by implementing a regular review	The organisation will achieve this objective by establishing a health inequalities review group, providing training to staff on identifying and addressing health inequalities, conducting regular health needs assessments, and developing and implementing action	This objective is in line with the NHS's commitment to reducing health inequalities and ensuring that all people have access to equitable healthcare services, regardless of their	EDI Manager/Head of Patient Experience	The organisation will achieve this objective within the next 12 months by establishing a health inequalities review group, conducting regular health needs assessments, developing action plans to address health inequalities, and reviewing the effectiveness of action plans through regular audits. The effectiveness of the objective will	The organisation will measure the effectiveness of this objective by conducting regular audits to assess the effectiveness of action plans	

process that identifies health inequalities and creates action plans to address them.	plans to address health inequalities.	social status or background.		be reviewed annually to ensure that the organisation remains committed to reducing health inequalities.	developed to address health inequalities. The aim is to achieve a minimum score of 90% on the audit.	

Liverpool Women's
NHS Foundation Trust

Gender Pay Gap Report

2021/22

Rachel Cowley
Head of Culture and Staff Experience

30 March 2023

Gender Pay Gap Reporting Regulations

Gender pay gap reporting regulations require UK employers with 250+ employees to disclose their gender pay gap. The gender pay gap gives a snapshot of the gender balance within an Organisation. It measures the difference between the average earnings of all male and female employees, irrespective of their role or seniority.

The Disparity of Pay

The gender pay gap is often confused with equal pay. However, whilst both deal with the disparity of pay that women receive in the workplace compared to men, they tackle two different issues:

1. Equal pay means that men and women must be paid the same for carrying out work of equal value for the same employer, as set out in the Equality Act 2010.
2. The gender pay gap gives a snapshot of the gender balance within a hierarchy. It measures the difference between the average earnings of all men and women across an Organisation or the labour market, irrespective of their role. It is expressed as a percentage of men's average earnings.

Why there is a need for further pay reporting

Today, equal pay is widely understood as a basic requirement for all employers. But a simple equal pay audit that compares the pay of people doing the same work doesn't tell the full story of gender equality in employment.

For a responsible business that takes diversity and inclusion seriously, the gender pay gap reveals something far more interesting about our progress on female economic empowerment. There is a pernicious problem of gender imbalance in work in UK society.

It is possible to have an organisation with no equal pay issues and a huge gender pay gap, or an organisation with no gender pay gap and big equal pay issues.

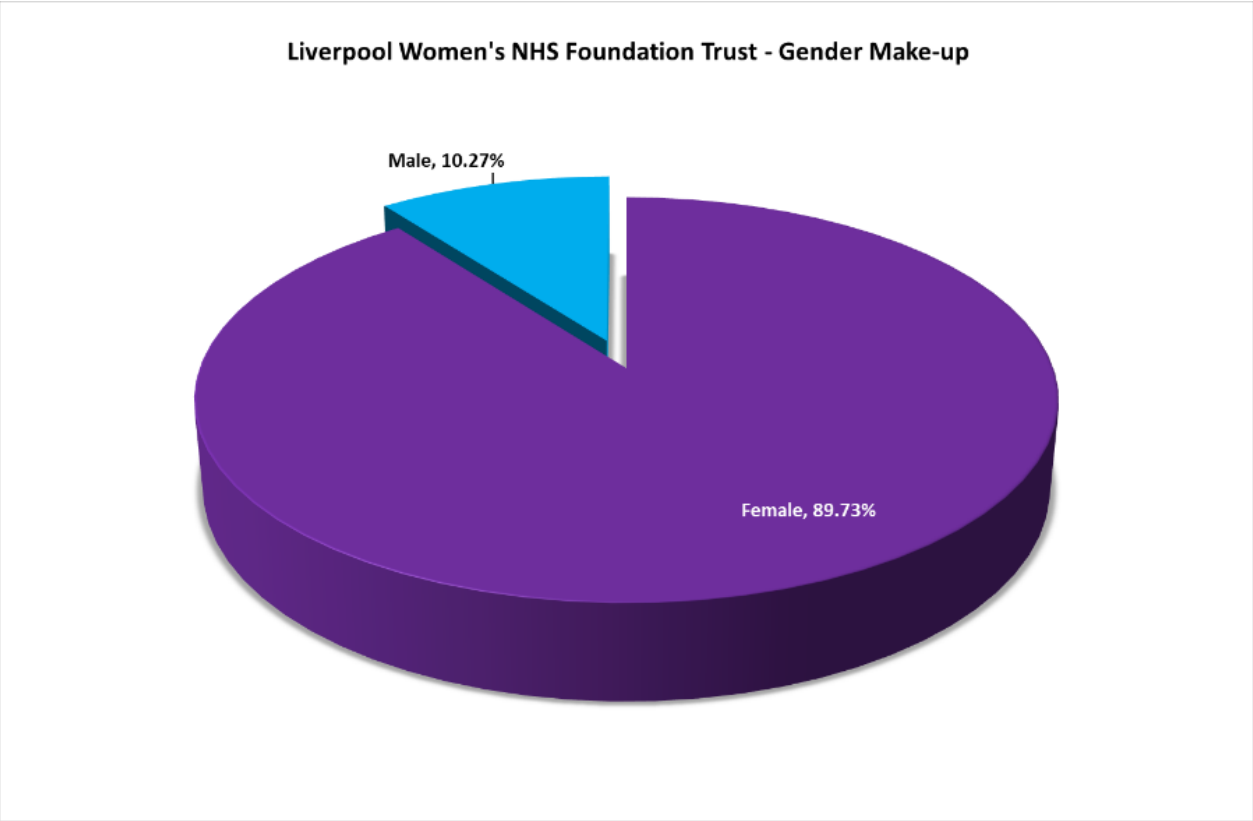
The Gender Pay Gap Indicators

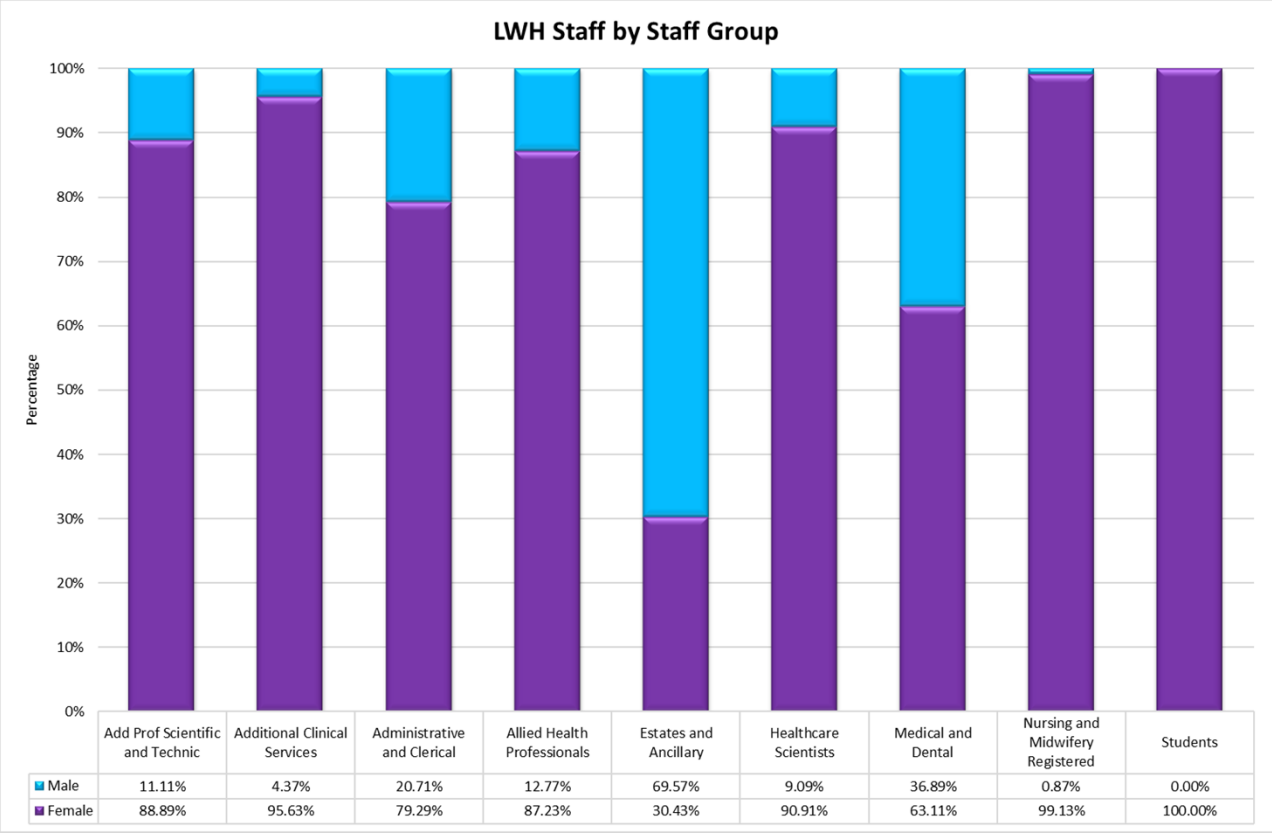
The legislation requires an employer to publish six calculations:

- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males receiving a bonus payment and potation of females receiving a bonus payment
- Proportion or males and females divided into four groups ordered from lowest to highest pay

Bonus pay elements are awarded as a result of recognition of excellent practice over and above contractual requirements.

The LWH Gender Pay Gap Position





	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Students
Male	11.11%	4.37%	20.71%	12.77%	69.57%	9.09%	36.89%	0.87%	0.00%
Female	88.89%	95.63%	79.29%	87.23%	30.43%	90.91%	63.11%	99.13%	100.00%

Key Points:

- Liverpool Women's NHS Foundation Trust is currently made up of 89.73% Women and 10.27% Men
- Due to the services provided (Obstetrics and Gynecology) the organisation is made up mainly of women
- The trust has 692 Nursing and Midwifery Registered staff of which 43% are Midwives. Of the 376 staff who are Midwives only 1 is male.

Average Hourly Rates

Gender	2022		2021		2020		2019	
	Avg. Hourly Rate	Median Hourly Rate	Avg. Hourly Rate	Median Hourly Rate	Avg. Hourly Rate	Median Hourly Rate	Avg. Hourly Rate	Median Hourly Rate
Male	£24.95	£19.96	£23.85	£19.09	£23.85	£19.09	£22.73	£18.05
Female	£19.04	£17.48	£18.48	£17.35	£18.48	£17.35	£16.68	£15.71
Difference	£5.91	£2.48	£5.37	£1.74	£5.37	£1.74	£6.05	£2.34

Average Hourly Rate of Gender Pay as a Mean Average 2022

23.7% Mean Gender Pay Gap

Average Hourly Rate of Gender Pay as a Median Average 2022

12.4% Median Gender Pay Gap

Key Points:

- The average hourly rate is calculated for each employee based on 'ordinary pay' which includes basic pay, allowances and shift premium pay.
- The average median rate is calculated by selecting the average hourly rate at the mid-point for each gender group.
- The percentage variance for the average hourly rate of pay is 22.51%. This calculation is based on the average hourly rate of female staff compared to male staff; because the average is calculated over different numbers of staff (there are 8 times more female staff), some variance is to be expected.

- The percentage variance for the median hourly rate of pay is 9.11%. This calculation is based on the average hourly rate at the mid-point for each gender group. When looking at the variance some consideration will need to be given to the variety of roles within the organisation.

- The difference in the average hourly rate decreased in 2020 and have remained relatively static since. There has been an increase in the difference in average hourly rate from 2021-2022 of £0.54.

Average Bonus Rates

Gender	Avg. Bonus Pay	Median Bonus Pay
Male	£10,924.34	£8,803.12
Female	£10,014.23	£6,032.04
Difference	£910.11	£2,771.08

Average bonus gender pay gap as a mean average

Average bonus gender pay gap as a median average

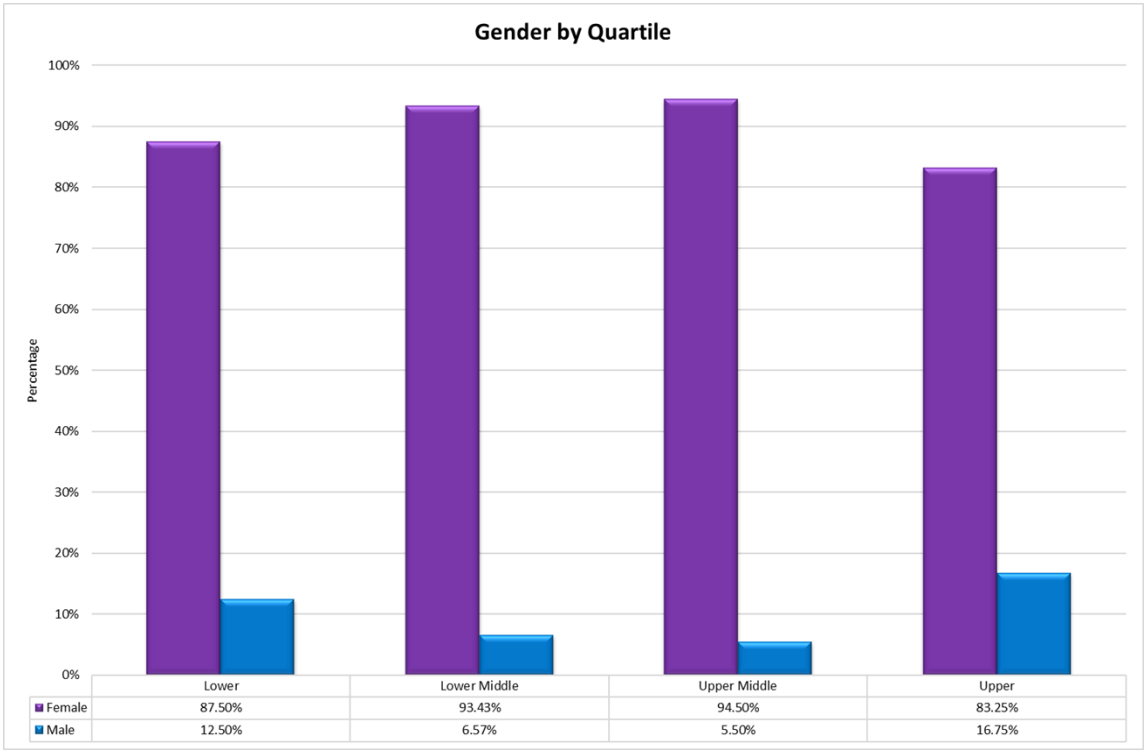
Proportion of males & females receiving a bonus payment

Mean Gender Bonus		Median Gender Bonus		Proportion Receiving Bonus	
Female	Male	Female	Male	Female	Male
£10,246.80	£11,365.24	£6,032.04	£8,803.12	0.59% (9 staff)	0.91% (14 staff)
Pay Gap: 9.84%		Pay Gap: 30.5%		1.50% Total Employees	

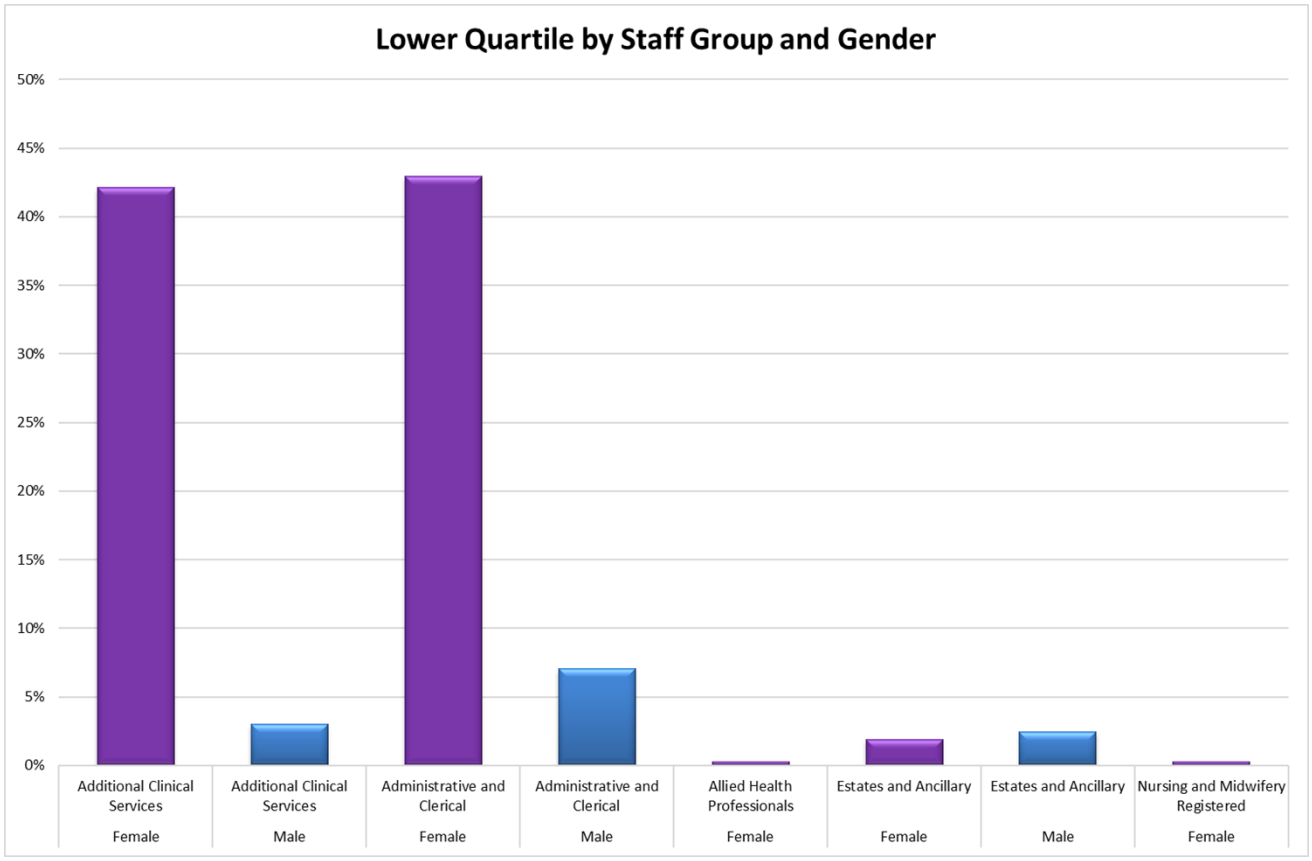
Key Points:

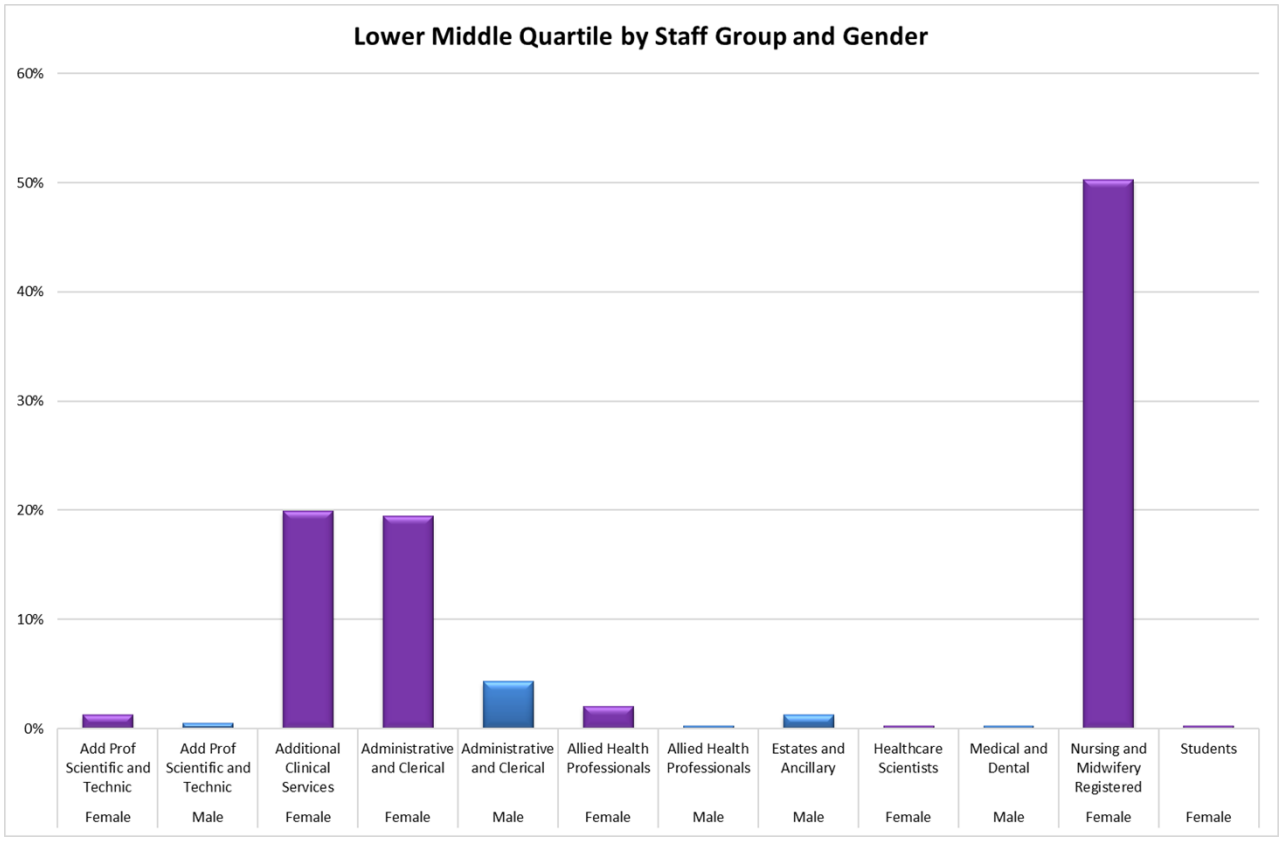
- This calculation expresses the number of staff receiving bonus pay as a percentage of the total number of staff in each gender group.
- As with the median hourly rate of pay, this is based on the mid-point of all staff receiving bonus pay.
- Bonus pay elements are awarded as a result of recognition of excellent practice over and above contractual requirements and have no gender bias.
- As an NHS organisation the only pay elements we have that fall under the bonus pay criteria are clinical excellence awards (consultants) which are only applicable to certain groups of medical staff which applies to 1.50% of all staff employed

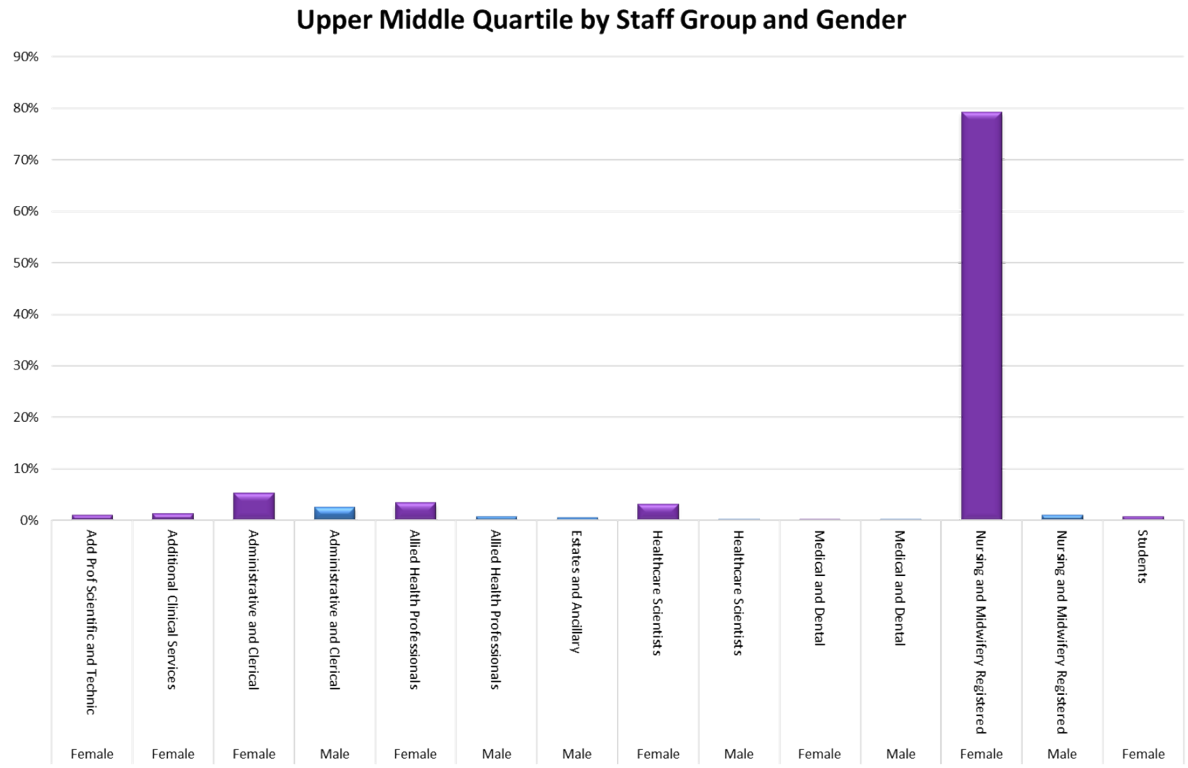
Proportion of males and females divided into four groups ordered from lowest to highest pay

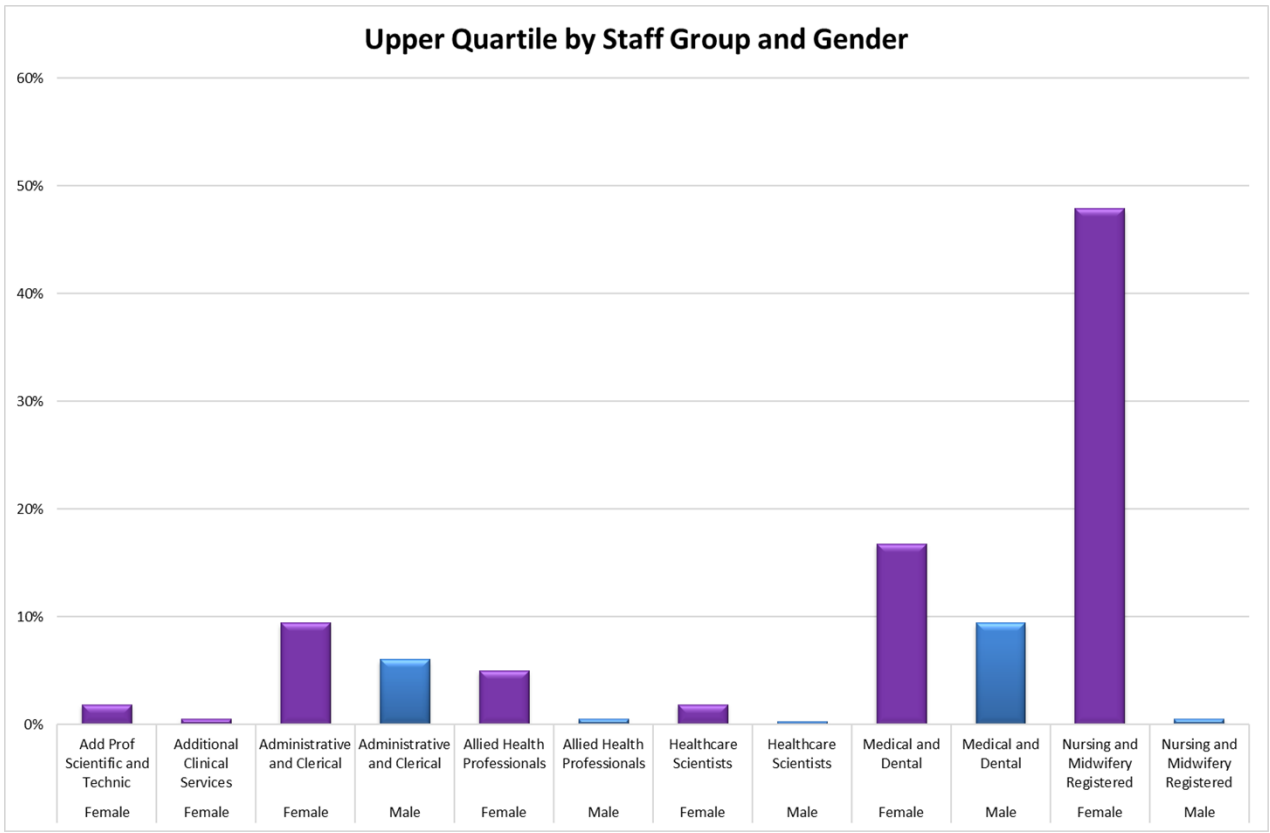


The following tables show each of the quartiles broken down by staff groups (purple is female staff and blue is male staff):






Upper Middle Quartile by Staff Group and Gender
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Add Prof Scientific and Technic
Female
Additional Clinical Services
Female
Administrative and Clerical
Female
Administrative and Clerical
Male
Allied Health Professionals
Female
Allied Health Professionals
Male
Estates and Ancillary
Male
Healthcare Scientists
Female
Healthcare Scientists
Male
Medical and Dental
Female
Medical and Dental
Male
Nursing and Midwifery Registered
Female
Nursing and Midwifery Registered
Male
Students
Female


Upper Quartile by Staff Group and Gender
60%
50%
40%
30%
20%
10%
0%
Add Prof Scientific and Technic
Female
Additional Clinical Services
Female
Administrative and Clerical
Female
Administrative and Clerical
Male
Allied Health Professionals
Female
Allied Health Professionals
Male
Healthcare Scientists
Female
Healthcare Scientists
Male
Medical and Dental
Female
Medical and Dental
Male
Nursing and Midwifery Registered
Female
Nursing and Midwifery Registered
Male

Key Points:

- In order to create the quartile information all staff are sorted by their hourly rate of pay, this list is then split into 4 equal parts

- When reviewing the quartile information it is important to take into account the types of roles available within the organisation and the different gender splits that occur within specific roles.

- The highest variances for the quartiles when compared to the overall trust value are in the middle quartiles.

- There is a higher proportion of female staff in the lower middle quartile and the upper middle quartile; included in this quartile are Nursing and Midwifery Registered staff groups that have a higher proportion of female staff, this is reflected in the calculation.

- The upper quartile has a higher proportion of male staff, demonstrated on the graphs for the upper quartile split by staffing group as medical and dental, and admin and clerical. There are also male staff in the following staffing groups; AHP,s Healthcare Scientists, and N&M Registered. The variance in the upper quartile is mainly due to significantly different gender splits in medical staffing and managerial roles in the trust; this is countered by a greater proportion of female staff in the scientific and nursing staff groups.

LWH Actions

Due to the nature of Liverpool Women's Hospital, the majority of staff are female and the majority of these are Midwives (43%). The data and graphs included in this report demonstrate that females are the highest proportion identified in all four quartiles of pay (lower to highest paid). Gender Pay Gap data for LWH has remain relatively static over a number of years, however staff survey data indicates that there is more work required to explore how our female workforce feel. Additional work in this area to be progressed in line with staff survey responses and actions developed in response to this.

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
20 February 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee was informed that the Month 10 YTD position remained off track against plan and was supported by non-recurrent items. It was not expected that the Trust could return to plan by March 2023 and the Trust had formally reported off plan, informing NHS England and the Integrated Care Board (ICB). • The cash balance was currently above the minimum level set out in the Treasury Management Policy as the ICB had provided cash support in December 2022. An application for revenue support (PDC) funding had been submitted to enable the Trust to repay the ICB for its cash support • The Committee received a progress update against the Recovery Plan for 2022/23, noting that it was significantly unlikely that the Trust would achieve the planned 2022/23 position. The Committee noted increasing costs in relation to staffing and resources in response to a recent CQC inspection visit. The Committee escalated concern of potential subsequent negative impact on the year-end forecast. • The Committee had a challenging debate in relation to the CDC business case for 2023/24. Due to varying risks in relation to activity, revenue and capital the Committee agreed that it was not in a position to make a recommendation to the Trust Board and was not fully committed to recommending a bid for continued funding 2023/24. Requests for additional detail and scenarios were requested to continue the discussion.	• The Committee received an update to the planning schedule for 2023/24 identifying the position and risks in relation to financial and operational planning. The Committee noted the submission schedule to the ICS. • The Committee received an update on the Trust's partnerships with NHS bodies, noting that building effective partnerships was critical for NHS organisations operating in the emerging health and care landscape. It was noted that, in future, partnership oversight would be provided by the Executive Committee with a quarterly report provided to the Trust Board for assurance. This would be reflected in the Committee workplan 2023/24.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• Received a presentational update on the 78+ week, 65+ week and 52+ week wait position and trajectory noting improvements demonstrated since initiating services with Medinet. The Access Recovery Board would continue to oversee developments against these targets. (ALL) • The Committee received a focussed update on productivity and efficiency within Maternity. (SAFE/RESPONSIVE/WELL LED) • The Committee received a progress update against delivery of the digiCare EPR programme, digiCare Digital Maternity (K2), GDE Programme and Information Governance noting demonstrable progress at pace. (SAFE/EFFECTIVE/RESPONSIVE/WELL LED) • Noted demonstrable progress against the Digital Generations Strategy 2020-2024 against each of the four key themes of the strategy. (ALL) • The Committee received an update on the Crown Street Enhancements (CSE) Programme noting positive progress towards delivery. The forecast outturn against project budget had improved this period as gainshare had further increased.	• The Committee recommends to the Trust Board to increase BAF Risk 2.1 Score to 20 • The Committee approved the Overseas Visitor Policy • To remove the Partnership Oversight from the Committee workplan as work remitted to the Executive Committee.
Summary of BAF Review Discussion (Board Committee level only)	

- The Committee reviewed the FPBD related BAF risks. No risks closed on the BAF for FPBD Committee.
- Noted a significant review of BAF Risk 2.1 which would be submitted to Trust Board in April 2023.
- Supported the proposal to increase the risk score of BAF Risk 4.3 from '16' to '20' as the likelihood of the Trust not achieving its 2022/23 plan had increased.
- Noted further consideration by the Executive Team on BAF Risk 1.2 (PPF owned risk) and noted the recommendation to maintain the current risk score of 20 (consequence 5, likelihood 4).

Comments on Effectiveness of the Meeting / Application of QI Methodology

- All matters on the meeting agenda discussed thoroughly

2.

3. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
190.	Review of BAF risks: FPBD related risks	Assurance	196.	Digital Generations Strategy 2020-2024 Bi-annual review	Assurance
191.	Finance Performance Report Month 10 2022/23	Information	197.	Partnership Oversight (quarterly)	Information
192.	Recovery Plan update – Month 10	Information	198.	Crown Street Enhancements Programme Update	Information
193.	Operational Performance Report Month 10 2022/23	Assurance	199.	Community Diagnostic Centre 2023/24 Case	Information
194.	Planning 2023/24 Update	Information	200.	Overseas Visitor Policy	Approval
195.	Digital Services Update	Assurance	201.	Sub-Committee Chair Reports	Assurance

4. 2022 / 23 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Louise Martin, Non-Executive Director (Chair)	✓	A	✓	✓	✓	A	✓	✓	✓	✓	
Tracy Ellery, Non-Executive Director	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	
Tony Okotie, Non-Executive Director	✓	✓	NM								
Sarah Walker, Non-Executive Director	✓	✓	✓	A	✓	A	✓	✓	✓	✓	
Eva Horgan, Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	NM		
Jenny Hannon, Chief Finance Officer	NM								✓	✓	
Kathryn Thomson, Chief Executive	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	
Gary Price, Chief Operations Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Marie Forshaw, Chief Nurse & Midwife	✓	✓	✓	✓	NM						
Dianne Brown, Interim Chief Nurse				NM	✓	✓	✓	✓	✓	A	

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

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
27 March 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee received a briefing paper on the Referral to Treatment (RTT) performance position with a particular focus on patients over 52/65/78 weeks. The Committee noted the trajectory of patients waiting over 78+ weeks expected to be treated by the end of March 2023 and the 25/26 number of breaches expected at the end of March 2023 against a national target of 0. Most providers in the region noted that they are projecting 78+ week breaches at the end of March, due to Industrial Action, Patient Choice and patients who are clinically unfit. There had been no indication of penalties. The Committee noted that the Trust aimed to see all 78+ week patients by the end of April 2023, whilst recognising the risk of Junior Doctor industrial action impacting upon this aim. • Risk of Junior Doctor industrial action planned to take place on 11 – 14 April 2023 on operational performance. • The Committee was informed that the Month 11 YTD financial position remained off track against plan and was supported by non-recurrent items. It was not expected that the Trust could return to plan by March 2023. As the Trust has reported off plan, the recovery protocol would be activated. The Finance Recovery Board continues to meet bi-weekly to consider the recovery possible in operational planning for 2023/24 and in the medium term. • The Committee received a position update to date in assessing the Crown Street Community Diagnostic Centre (CDC) and associated financial risks. The National Team had requested consideration towards a reduction in administration structure costs and structural costs. The Committee noted meetings in place to discuss the matter within the region and noted a planned site visit by NHSE. The Board of Directors would be kept updated with progress.	• Performance against the Better Payment Practice Code is at 85% cumulatively by value and 78% by volume of transactions against a 95% target. A plan is being created to improve performance towards the 95% target (subject to available cash) and would be presented to the Audit Committee and FPBD Committee to track improvements. • Received a presentational update on drivers of the deficit position impacted by CIP, CNST, investments in clinical safety, receipt of non-recurrent top-up income on an annual basis and underlying structural deficits. • The Executive Team had met to consider the 2023/24 workforce plans to reconsider current requirements. The importance to undertake Quality Impact Assessments and to effectively communicate the rationale to the workforce was noted. • The Committee received an update to the planning schedule for 2023/24. The planned submission to the ICS on 27.03.23 ahead of NHSE submission on 30.03.23 would be treated as a draft • Noted the work being undertaken by Liverpool providers to support efficiency savings across the health sector in the city. • Significant work undertaken to update contracts for pathology services. Once agreed the revised SLA, service specification and KPI's would be utilised to engage and inform expected levels of service provision.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• The Committee took assurance from the progress within the programme activities underway for digiCare EPR Programme, the digiCare Digital Maternity programme, and GDE. In relation to the EPR programme progress with testing and training was noted, nothing significant had been identified during this stage. A further phase of testing would commence early April along with training. The Committee recognised that the EPR programme was a significant organisational change programme although digitally led and represented a significant investment made by the Trust. (ALL) • The Committee noted the year-end outturn against the Corporate Objectives aligned to its terms of reference. (ALL) • The Committee received an update on the Crown Street Enhancements (CSE) Programme noting positive progress towards delivery and the introduction of the permanent MRI scanner onsite. (ALL) • Received and noted the current status of the Future Generations Programme. (ALL)	• The Committee agreed the risk appetite statements for 2023/24 aligned to its terms of reference and recommend approval to the Trust Board. • The Committee agreed the Committee Annual Report, Business Cycle for 2023/24 and the Terms of Reference and recommends approval to the Trust Board.

Summary of BAF Review Discussion (Board Committee level only)
• The Committee reviewed the FPBD related BAF risks. Noted no new risks or strategic threats and no risks closed on the BAF for FPBD Committee. • Noted the increase to the risk score of BAF Risk 4.3 from '16' to '20' had been approved by Trust Board. • Noted a significant review of the BAF is scheduled to take place – it is likely that there will be a push to reduce the number of BAF risks to help provide greater clarity on the key strategic risks facing the Trust.
Comments on Effectiveness of the Meeting / Application of QI Methodology
• All matters on the meeting agenda discussed thoroughly

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
210.	Review of BAF risks: FPBD related risks	Assurance	218.	Community Diagnostic Centre 2023/24 Case	Information
211.	Operational Performance Report Month 11 2022/23	Assurance	219.	Corporate Objectives Year-end Review	Information
212.	Finance Performance Report Month 11, 2022/23, including recovery plan	Information	220.	Review of Risk Appetite Statement 2023/24	Approval
213.	Drivers of the Deficit	Information	201.	FPBD Committee Effectiveness Annual Report	Approval
214.	Planning 2023/24 Update	Information	222.	Crown Street Enhancements Programme Update	Information
215.	Revenue and capital budget for 2023/24	Information	223.	Future Generations Update	Information
216.	Briefing report: Pathology services overview and the procurement strategy for provision of pathology & microbiology services	Assurance	224.	Sub-Committee Chairs Reports	Information
217.	Digital Services Update	Assurance			

3. 2022 / 23 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Louise Martin, Non-Executive Director (Chair)	✓	A	✓	✓	✓	A	✓	✓	✓	✓	✓
Tracy Ellery, Non-Executive Director	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓
Tony Okotie, Non-Executive Director	✓	✓	NM								
Sarah Walker, Non-Executive Director	✓	✓	✓	A	✓	A	✓	✓	✓	✓	✓
Eva Horgan, Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	NM		
Jenny Hannon, Chief Finance Officer	NM								✓	✓	✓
Kathryn Thomson, Chief Executive	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	A
Gary Price, Chief Operations Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Marie Forshaw, Chief Nurse & Midwife	✓	✓	✓	✓	NM						
Dianne Brown, Interim Chief Nurse				NM	✓	✓	✓	✓	✓	A	✓

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

Audit Committee Chair's Highlight Report to Trust Board
9 February 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• It was noted that there continued to be extensions granted to actions arising from internal and external audit recommendations. The Committee reiterated that it was vital that actions were allocated realistic timescales to avoid extensions and that actions should be assigned to job roles rather than named individuals. The Committee Chair requested that extensions start to be tracked with trajectories included. • The Committee noted an increase in tender waivers in comparison to the previous quarter (although lower in value). The Committee requested that alternative mechanisms to waivers be explored e.g. call-off orders to support the reduction in their use.	• It was noted that the Trust had developed a benchmarking process to assess divisional governance maturity. An update on this would be provided to the March 2023 Committee meeting. • The Trust's outgoing Chief Finance Officer (CFO)/Counter Fraud Champion (CFC) left the Trust on 31.12.22. The change of CFO nomination had been processed by the NHS Counter Fraud Authority (NHSCFA). A nomination had also been processed by the NHSCFA for the Trust's Head of Financial Services to take over the position of CFC. The CFC is required to undertake CFC online eLearning before the user account is made fully active. • Meetings had been held between the AFS and Head of Risk and Safety to discuss the progress of the fraud risk assessment work, to ensure that the identified risk areas are processed through the Trust's own risk management scoring mechanism to see whether that changes them, and whether any of the risks are required to be updated/included on the Trust's risk registers.
Positive Assurances to Provide	**Decisions Made**

• Five internal audit reports were received:
  ○ Data Quality (Substantial assurance level)
  ○ Estates (Substantial assurance level)
  ○ Assurance Framework (meets requirements)
  ○ Clinical Negligence Scheme for Trusts (CNST) (Assurance opinion – N/A)
  ○ NHSE Financial Sustainability (Assurance opinion – N/A)
• Whilst there had been delays to progressing two internal audit reviews (Quality Improvement Process – Operation in Practice & Listening to Patient Voice) it was asserted that the draft Head of Internal Audit Opinion would be ready for the March 2023 meeting.
• Assurance regarding the evidenced completion of audit actions was reported via the MIAA Internal Audit Follow Up Report and it was noted that good examples of third line assurance had been identified.
• The Committee was informed of continued awareness raising activity relating to anti-fraud.
• The newly appointed external auditor, Grant Thornton, outlined their approach to the 2022/23 audit. Work continued to progress with the handover process with KPMG and there remained confidence that the audit could be finalised ahead of the NHSE deadline at the end of June 2023. It was noted that there might be a need to split the value for money and accounts opinions depending on the outcome from the CQC inspection.
• The Committee was assured by a report outlining the preparation being undertaken towards the 2022/23 financial statements. The report included an update on the work undertaken to date to close out the ISA260 recommendations.
	• The Committee Chair requested that the HFMA Briefing – 'Streamlining Charitable Funds' be considered by the Charitable Funds Committee.
	• The Committee agreed to review the date of the next scheduled meeting, with a view of moving the date back from mid-January to the beginning of February. This would enable a potentially new external auditor to embed ahead of reporting to the Committee.
	• The Committee approved the £144 for losses and special payments

Comments on Effectiveness of the Meeting / Application of QI Methodology
• The quality of the Preparation of the 2022/23 Financial Statements report was commended and the external auditor noted that there had been noted challenge from the Committee members during the meeting.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
062	Follow up of Internal Audit and External Audit Recommendations	To receive and review an update of actions taken.	066	Preparation of the 2022/23 Financial Statements	For assurance
063	MIAA Internal Audit Reports a) Internal Audit Progress Report b) Internal Audit Follow Up Report c) Anti-Fraud Progress Report 2022/23 d) Insight Update	To note the contents and any recommendations from the report.	067	Board Assurance Framework (BAF)	To receive assurance
064	External Audit Progress Report and Sector update	To receive update	068	Chairs reports of the Board Committees	For assurance
065	Waivers Q3 Financial Year 2022/23	To note			

3. 2022 / 23 Attendance Matrix

Core members	June	July	October	February	March
Tracy Ellery	✓	✓	✓	✓	
Zia Chaudhry	✓	✓	✓	✓	
Jackie Bird	✓	✓	✓	✓	
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) *Non-quorate meetings highlighted in greyscale*					

Audit Committee Chair's Highlight Report to Trust Board
23 March 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Whilst robust assurance was provided on the Trust's data quality processes, the on-going challenge to data quality relating to the multiple clinical systems was highlighted. Noted that the implementation of Meditech expanse would significantly mitigate this risk. • The Committee received the external audit plan from Grant Thornton. Noted that materiality had been reduced to 1.8% as it was first year auditing the Trust's accounts (provides a greater level of detail). Significant risks identified for the audit included; Improper revenue recognition, fraud in expenditure recognition, management override of controls, valuation of land and buildings, opening balances and hosting arrangements. Assurance was provided that there had been an effective handover with the previous external auditor – KPMG, and that there had been positive engagement with the finance team. The external auditors were assured that they would be kept up-to-date on emerging findings from the Trust's recent CQC inspection. • Two out of the five internal audit reports were marked as 'limited assurance' – o Ockenden Review – issues highlighted related to the check and challenge of and the availability of the evidence underpinning actions taken against recommendations. o Intra NHS SLAs and Contracts Review - Overall, the review identified that controls relating to CSS Intra NHS SLAs and Contracts had not been designed appropriately and/or had not been operating effectively. • The Committee received an outline of performance to date on the Better Payment Practice Code (currently below 80% against 95% target) and the actions to improve performance in 2023/24.	• The Committee remitted a Chair's Log to both the FPBD and Quality Committee with to note the respective limited assurance reports (SLA to FPBD and Ockenden to Quality) • In reviewing the Internal Audit Plan for 2023/24, the Committee asked the Executive Team to consider whether additional quality spot checks should be added to the plan. • The Committee reviewed the Risk Management Strategy 2023/24 and requested that further work be undertaken to include longer term ambitions for risk management, particularly in relation to its role in improving patient safety. • The Committee was updated on work to improve the maturity of divisional governance arrangements. It was agreed that divisions would be invited on a rota basis from July 2023 onwards to update the Committee on their progress.
Positive Assurances to Provide	**Decisions Made**
• The Committee noted progress in reducing the number of outstanding internal and external audit recommendations. Assurance was provided that the Executive Team had been pro-active in rejecting extension requests when an appropriate reason could not be provided • Three out of the five internal audit reports received provided good levels of assurance 1) Risk Management (core controls) (high assurance) 2) Risk Management (Divisional and Corporate) (Substantial Assurance) and 3) Key Financial Controls (High Assurance). Updates were provided on on-going areas of work and the Committee was assured by the progress being made against the 2022/23 internal audit plan.	• The Committee approved the 2022/23 Anti-Fraud work plan • The Committee approved the areas of judgements in the accounts and agreed that the accounts would be prepared on a 'Going Concern' basis, whilst acknowledging the significant short-term and structural challenges to the financial position. • The Committee agreed to write off £5,637.28 of debt for the 2022/23 financial year. Noted that there were potentially some proposed debt write-offs from the Hewitt Centre. These are currently under review and will be finalised prior to year-end and reported to the next Audit Committee.

• A draft Head of Internal Audit Opinion was noted. This provided a draft substantial assurance opinion. The outstanding audits still to be completed as part of the 2022/23 programme are unlikely to change this draft opinion. • The Committee noted the MIAA Internal Audit Charter • The Committee received an anti-fraud progress update. Noted that the Trust was on track to receive a 'green rating' in the year-end report. • Noted that the interim external audit had been completed. No significant control issues highlighted although a higher sample would be taken in relation to payroll processes and record keeping, particularly for the approval of vacancies. No substantial risks had been identified for the Trust's Value for Money arrangements • The Committee reviewed the draft Clinical Audit Plan for 2023/24 and was assured that there were processes in place to manage clinical audit programme effectively. Lessons had been learned from previous years in terms of the volume of audits and the need to prioritise key areas.	• The Committee reviewed and recommended for approval to the Board the updated Terms of Reference and 2023/24 work programme. It was agreed that an item relating to ICS governance arrangements should be added to the programme.
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• The Deputy Director of Nursing (attending as an observer) commented that issues in the papers and the meeting had been clear and well presented.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
22/23/78	**Follow up of Internal Audit and External Audit Recommendations**	To receive assurance of actions implemented on a timely basis.	22/23/85	**Data Quality Assurance**	For assurance
22/23/79	**MIAA Internal Audit Reports** a) Internal Audit Progress Report b) Draft Head of Internal Audit Opinion 2022/23 c) Internal Audit Work Plan 2023/24 d) Internal Audit Charter e) Insight Update	To note the contents and any recommendations from the report.	22/23/86	**Risk Management Strategy Review**	For assurance
22/23/80	**Anti-Fraud** a) Progress Report 2022/23 b) Anti-Fraud Work Plan 2023/24	To note the contents and any recommendations from the report.	22/23/87	**Strengthening Divisional Governance**	For assurance
22/23/81	**External Audit Plan 2022/23**	To receive update	22/23/88	**Board Assurance Framework (BAF)**	For assurance
22/23/82	**Preparation of the 2022/23 Financial Statements**	For assurance	22/23/89	**Chairs reports of the Board Committees** a) Finance, Performance and Business Development Committee	Review of Chairs' reports for

				b) Quality Committee c) Putting People First Committee d) Charitable Funds Committee	overarching assurance.
22/23/83	**Better Payment Practice Code Update**	To receive	22/23/90	**Review of Committee Terms of Reference & Business Cycle 2023/24**	For approval.
22/23/84	**Draft Clinical Audit Forward Plan 2023-24**	To receive			

3. 2022 / 23 Attendance Matrix

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

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

Charitable Funds Committee Chair's Highlight Report to Trust Board
06 February 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee noted that the charity was currently £30k behind the year-to-date planned income to achieve the forecast income of £453k to year-end. • The Committee requested assurance that spending against outstanding charitable fund schemes would be achieved by year-end 2022/23. Executive Leads confirmed that the identified projects were moving at pace towards completion. • A number of discussions led back to the Fundraising Strategy review including a search for a Charity patron/ambassador, review of dormant funds, development of the three-year plan, and the risk profile and allocation of investments. It was confirmed that the Board of Trustees had met on the 03 November 2022 to discuss the strategy. Committee discussion had been deferred due to attendance and would be considered at the following meeting. • The Committee noted concerns in relation to the expenditure application process which required strengthening. The Committee noted the process review underway to address these concerns and requested that divisional oversight and approval be added to the process to ensure the applications align to divisional planning. The Committee also requested that application owners should attend the Committee meeting to present their applications and be available to respond to questioning.	• The Committee noted a bid for funding submitted to NHS Charities Together to support capacity building for the fundraising team. • A review of the expenditure application process for charitable funds was underway. • The newly identified charity related risks would be formatted to align with the BAF risk template. • The Committee received a review of the fundraising team costs. The Committee commissioned a costs and assumptions review for further assurance and clarity that spending on infrastructure does not exceed the funding raised.
Positive Assurances to Provide	**Decisions Made**
• The Committee received a reformatted report combining charity activity and finance in an integrated report. The proactive work of the finance and fundraising team towards appropriate expenditure and timescales and a review of processes was noted. • The Committee noted positive progress against fundraising appeals, notably the Bereavement Suite appeal, Strictly Event, and the Mona Lisa appeal. • Received a presentational update of investment performance noting that the investment fund showed a reduction of £113,682 year-to-date but investment value had made a modest increase during quarter 3. It was confirmed that investment restrictions included no direct investment in tobacco, armaments,	• The Committee declined a funding application for expenditure for equipment of a Mona Lisa Laser due to insufficient information provided. Additional detail in relation to the Mona Lisa Laser application was requested to be circulated for assurance and to seek Committee e-approval. • The Committee approved the list of Fund Signatories.

or oil and gas stocks. It was also confirmed that the Charity's current risk strategy towards investments remained appropriate.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Commented on the revised template of the fundraising and finance update allowing better integration of data.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
35.	Quarterly charity and finance integrated report	Information	**38.**	Authorisation of funding applications expenditure	Approval
36.	Investment Position Update	Information	**39.**	Review of Fund Signatories	Approval
37.	Review of expenditure - fundraising costs versus other	Information	**40.**	Fundraising Strategy 2022-2025 - *Item deferred*	Information

3. 2022 / 23 Attendance Matrix

Core members	June 2022	Sept 2022	Feb 2023
Tracy Ellery (Chair), Non-Executive Director	✓	✓	✓
Louise Martin, Non-Executive Director	✓	✓	✓
Jackie Bird, Non-Executive Director	✓	✓	✓
Eva Horgan, Chief Finance Officer	✓	✓	NM
Jenny Hannon, Chief Finance Officer	NM	NM	✓
Michelle Turner, Chief People Officer	A	A	✓
Chris Gough, Financial Accountant	✓	A	NM
Kate Davis, Head of Fundraising	✓	✓	A
Marie Forshaw, Chief Nurse & Midwife	✓	NM	NM
Dianne Brown, Chief Nurse	NM	A	✓

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**23/24/011d**		**Date: 06/04/2023**	
Report Title	**Finance Performance Review Month 11 2022/23**			
Prepared by	***Linda Haigh, Interim Deputy Chief Finance Officer***			
Presented by	***Jenny Hannon, Chief Finance Officer***			
Key Issues / Messages	***To receive the Month 11 financial position.***			
Action required	**Approve ☐**	**Receive ☒**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – If no – please outline the reasons for deviation.			
	The Board is asked to receive the Month 11 Financial Position..			
Supporting Executive:	***Jenny Hannon, Chief Finance Officer***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 4.1 Failure to ensure our services are financially sustainable in the long term	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Finance, Performance and Business Development Committee	27/03/2023	Jenny Hannon, Chief Finance Officer	The Committee received the report.

EXECUTIVE SUMMARY

At Month 11 the Trust is reporting a £3,898k deficit year to date (YTD) which is £4,469k off plan and is supported by £12,528k of non-recurrent items. The forecast out turn (FOT) is £1,655k deficit, £2,181k worse than plan, after inclusion of £5,053k of recovery actions.

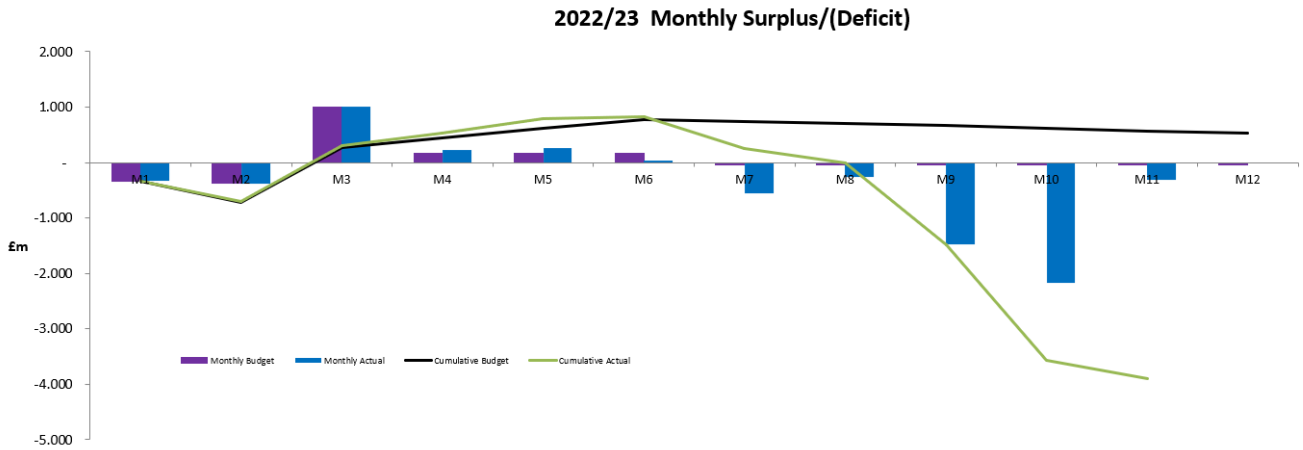
The cash balance at 28 February was £10,793k, including ICS cash support of £6m which has been repaid in March . Revenue support funding of £4.5m has been received to replace this.

	Plan	Actual	Variance	RAG	R	A	G
Surplus/(Deficit) YTD	£0.6m	-£3.9m	-£4.5m	↔	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast	£0.5m	-£1.7m	-£2.2m	↔	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	↔	*4*	*3*	*2+*
Cash	£5.9m	£10.8m	£4.9m	↑	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£5.1m	£4.6m	-£0.5m	↔	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£2.9m	£1.8m	-£1.1m	↔	*>10% off plan*	*Plan*	*Plan or better*
Elective Recovery Fund (net)	-£2.0m	-£1.1m	£0.9m	↔	*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£6.0m	£12.5m	£6.5m	↓	*>£0*		*<£0*
Capital Spend YTD	£8.5m	£7.0m	-£1.5m				

MAIN REPORT

1. Summary Financial Position

At Month 11 the Trust is reporting a £1,655k deficit FOT which is £2,181k off plan. The position includes £5,053k of recovery actions to March 2023 (see section 11). The graph below shows the in-month position against the plan.



2. Divisional Summary Overview

The Trust has again reported off plan in Month 11 and close financial management by divisions and budget holders is key to delivering this forecast. Work is continuing across the Trust in relation to this and the long term sustainability position given the recognised financial challenges faced by the Trust.

Family Health: In response to the first Ockenden report and revised Birth-rate plus review, maternity budgets were increased to reflect the additional staffing requirements. In addition to this, the division is overspent by £1,793k on pay YTD. The division has minimised agency usage through divisional manager approval controls. Non pay expenditure is £538k overspent YTD. Increased income is reducing the YTD variance.

Gynaecology: The division's contribution is £2,698k below plan YTD, with a £1,698k variance on pay and a £747k variance on Non pay YTD.

The division has been working to maximise activity to support elective recovery throughout the year.

Clinical Support Services: The division's contribution is £1,443k below plan year to date. Income is £1,695k below plan driven by CDC. Pay costs are below budget by £927k with a significant underspend on medical, driven by anaesthetic vacancies. The non-pay overspend is £733k YTD.

Agency: Agency spend across the Trust is £2,209k YTD and forecast at £2,309k for the full year.

Energy costs: Gas and Electricity prices have been fixed to March 2023 and FOT is estimated as £2,321k compared to a budget for electric and gas of £1,927k.

3. Elective Recovery Fund

The Trust is behind plan by £859k on ERF however it is not expected that this will be clawed back in year.

4. CIP

The Trust has a stretching efficiency programme for 2022/23. This is comprised of a core CIP programme at 3% of turnover (£4.2m) plus a non-recurrent efficiencies of £1.4m (vacancy factor) bringing the total to £5.6m. In Month 11 CIP is slightly (£510k) behind plan (£5,138k) YTD but slightly (£203k) ahead FOT plan £5,603k.

In Month 11 the trust is reporting FOT £1,115k behind the target for recurrent CIP (£2,874k). The trust will need to generate more recurrent CIP to improve sustainability for 2023/24.

Full detail is in the appendix.

No scheme has been implemented without consideration of QIA or EIA.

5. COVID-19

The Trust's covid related spend YTD at Month 11 is £238k. The FOT expenditure is £261k, £54k less than budget.

6. Cash and Borrowings

The cash balance at the end of Month 11 is £10,793k. This balance reflects the benefit of £6m being received from the ICS in December 2022 which has subsequently been repaid and replaced by central revenue cash support of £4.5m. Cash support is almost certain to be needed throughout 2023/24, subject to the outcome of final plans.

7. Capital Expenditure

The capital programme for 2022/23 was oversubscribed and only critical investments were funded. The capital budget was agreed at £8,820k. Capital spend to Month 11 is £7,032k, underspent by £1,480k but FOT is forecast to exceed the original plan which was subsequently supplemented by additional PDC capital awards. The Trust is forecasting to spend the full £8,820k plus £2,200k of additional PDC projects (frontline digitisation £1.9m and CAMRIN).

8. Balance Sheet

From Month 10 deferred income has reduced reflecting less CDC and LMNS monies held/repayable. Finance are working to address the increase in Trade payables and improve payment performance. Performance against the Better Payment Practice Code is at 85% cumulatively by value and 78% by volume of transactions. A plan is being created to improve performance towards the 95% target (subject to available cash).

Accounts Receivable debt at Month 11 is £2,525k vs £1,583k at Month 10 with the movement attributable to two large recent amounts owed. A strong focus remains on debt collection.

9. Forecast and Risks

The forecast outturn was reviewed at Month 11 with each division and corporate cost centre. £50k more recovery savings were added, and some pressures were offset to maintain the same position as forecast in Month 10. There are no further recovery items identified to improve or mitigate the outturn. While the Trust continues to hold the forecast at Month 11 this lack of flexibility will make it difficult to mitigate the impacts of any pressures and additional staffing requirements and costs towards the end of the financial year.

10. Recovery

The original Recovery Plan estimated gross savings of £5.3m. As at Month 11, the Trust has achieved a total of £5.0m savings from the plan. No further savings are anticipated this financial year. A summary to Month 11 is given below.

Division	Original plan to FPDB, Board, ICB November 2022	Revised M11 Recovery plans	M11 Cumulative Recovery	Remaining recovery M10
FAMILY HEALTH	- 1,061	- 2,579	- 2,579	-
GYNAECOLOGY	- 955	- 688	- 688	-
CLINICAL SUPPORT SE	- 773	- 364	- 364	-
CORPORATE	- 2,498	- 1,422	- 1,422	-
TOTAL TRUST	- 5,287	- 5,053	- 5,053	-

£50k of recovery was added to the forecast in M11, as the estimated value of specialised commissioning funding was confirmed. This recovery was offset by small increases in other pressures.

The Finance Recovery Board continues to meet bi-weekly to develop financial improvements in operational planning for 2023/24 and support long term financial sustainability issues.

11. BAF Risk

The BAF contains two risks 4.1 (Failure to ensure services are financially stable in the long term) and 4.3 (Failure to deliver the agreed 22/23 Financial plan). These are scored at 20 and 20 respectively and kept under regular review.

12. Conclusion & Recommendation

The Board is asked to receive the Month 11 position.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M11

YEAR ENDING 31 MARCH 2023

Liverpool Women's
NHS Foundation Trust

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M11
YEAR ENDING 31 MARCH 2023

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	3,794
(b) PDC + Interest Payable + Loans Repaid	2,640
CSC Ratio = (a) / (b)	**1.44**
NHSI CSC SCORE	**2**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25	
LIQUIDITY	
(a) Cash for Liquidity Purposes	(19,137)
(b) Expenditure	130,478
(c) Daily Expenditure	426
Liquidity Ratio = (a) / (c)	**(44.9)**
NHSI LIQUIDITY SCORE	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)	
I&E MARGIN	
Deficit (Adjusted for donations and asset disposals)	3,878
Total Income	(134,068)
I&E Margin	**-2.9%**
NHSI I&E MARGIN SCORE	**4**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)	
I&E MARGIN VARIANCE FROM PLAN	
I&E Margin (Actual)	-2.90%
I&E Margin (Plan)	0.40%
I&E Variance Margin	**-3.30%**
NHSI I&E MARGIN VARIANCE SCORE	**3**
Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%	
Note: NHSI assume the score of the I&E Margin variance from Plan is a 1 for the whole year	
AGENCY SPEND	
YTD Providers Cap	765
YTD Agency Expenditure	2,209
	189%
NHSI AGENCY SPEND SCORE	**4**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%	
Overall Use of Resources Risk Rating	**3**

Note: scoring a 4 on any of the metrics will lead to a financial override score of 3.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M11
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE	Month 11			YTD			YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income									
Clinical Income	(11,434)	(12,242)	808	(125,575)	(127,126)	1,551	(137,008)	(140,644)	3,635
Non-Clinical Income	(623)	(660)	37	(6,781)	(6,942)	161	(7,404)	(7,547)	142
Total Income	**(12,057)**	**(12,902)**	**845**	**(132,356)**	**(134,068)**	**1,712**	**(144,413)**	**(148,190)**	**3,778**
Expenditure									
Pay Costs	6,921	7,693	(772)	74,800	80,823	(6,022)	81,856	88,431	(6,575)
Non-Pay Costs	2,816	3,168	(352)	30,960	31,685	(724)	33,641	33,575	66
CNST	1,637	1,604	33	18,004	17,971	33	19,640	19,608	33
Total Expenditure	**11,373**	**12,464**	**(1,091)**	**123,764**	**130,478**	**(6,714)**	**135,137**	**141,614**	**(6,477)**
EBITDA	**(684)**	**(438)**	**(246)**	**(8,592)**	**(3,590)**	**(5,001)**	**(9,275)**	**(6,576)**	**(2,699)**
Technical Items									
Depreciation	521	501	20	5,733	5,415	318	6,254	5,902	352
Interest Payable	2	2	1	27	25	1	29	27	2
Interest Receivable	(1)	(47)	46	(11)	(203)	192	(12)	(240)	228
PDC Dividend	207	291	(84)	2,272	2,309	(38)	2,478	2,600	(122)
Profit/Loss on Disposal or Transfer Absorption	0	(0)	0	0	(58)	58	0	(58)	58
Total Technical Items	**729**	**747**	**(18)**	**8,020**	**7,488**	**532**	**8,749**	**8,231**	**518**
(Surplus) / Deficit	**45**	**309**	**(264)**	**(571)**	**3,898**	**(4,469)**	**(526)**	**1,655**	**(2,181)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2a
INCOME & EXPENDITURE HOSTED SERVICES: M11
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE £'000	Month 11 Budget	Month 11 Actual	Month 11 Variance	YTD Budget	YTD Actual	YTD Variance	YEAR Budget	YEAR Forecast	YEAR Variance
Income									
Clinical Income	(115)	62	(177)	(1,260)	(3,061)	1,802	(1,374)	(3,317)	1,943
Non-Clinical Income	0	0	0	0	20	(20)	0	20	(20)
Total Income	**(115)**	**62**	**(177)**	**(1,260)**	**(3,041)**	**1,782**	**(1,374)**	**(3,298)**	**1,924**
Expenditure									
Pay Costs	0	195	(195)	0	1,132	(1,132)	0	1,321	(1,321)
Non-Pay Costs	115	(258)	372	1,260	1,909	(650)	1,374	1,977	(603)
Total Expenditure	**115**	**(62)**	**177**	**1,260**	**3,041**	**(1,782)**	**1,374**	**3,297**	**(1,923)**
(Surplus) / Deficit	**0**	**(0)**	**0**	**0**	**(0)**	**0**	**0**	**(0)**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M11
YEAR ENDING 31 MARCH 2023

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR Actual	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	435	471	(36)	4,698	5,020	(321)	5,133	5,498	(366)
Medical	1,884	1,926	(42)	20,187	22,016	(1,829)	22,205	24,042	(1,836)
Nursing & Midwifery	3,076	3,328	(253)	33,764	34,358	(594)	36,840	37,548	(708)
Healthcare Assistants	509	571	(62)	5,590	5,856	(266)	6,099	6,379	(280)
Other Clinical	287	540	(253)	2,666	3,044	(378)	2,953	3,538	(585)
Admin Support	731	784	(53)	7,895	8,321	(426)	8,626	9,117	(492)
Agency & Locum	0	73	(73)	0	2,209	(2,209)	0	2,309	(2,309)
Total Pay Costs	**6,921**	**7,693**	**(772)**	**74,800**	**80,823**	**(6,022)**	**81,856**	**88,431**	**(6,575)**
Non Pay Costs									
Clinical Suppplies	689	849	(161)	7,647	9,071	(1,424)	8,404	9,688	(1,284)
Non-Clinical Supplies	284	152	132	3,093	1,598	1,495	3,174	593	2,581
CNST	1,637	1,604	33	18,004	17,971	33	19,640	19,608	33
Premises & IT Costs	1,000	939	62	11,069	9,514	1,555	12,069	10,309	1,761
Service Contracts	842	1,227	(385)	9,151	11,501	(2,350)	9,994	12,986	(2,992)
Total Non-Pay Costs	**4,452**	**4,771**	**(319)**	**48,964**	**49,655**	**(692)**	**53,281**	**53,183**	**98**
Total Expenditure	**11,373**	**12,464**	**(1,091)**	**123,764**	**130,478**	**(6,714)**	**135,137**	**141,614**	**(6,477)**

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
COVID EXPENDITURE: M11
YEAR ENDING 31 MARCH 2023

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR Actual	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	3	0	3	34	1	33	38	1	36
Medical	0	0	0	0	(0)	0	0	(0)	0
Nursing & Midwifery	12	0	12	133	1	132	145	1	144
Healthcare Assistants	0	(0)	0	0	15	(15)	0	15	(15)
Other Clinical	0	0	(0)	0	(0)	0	0	(0)	0
Admin Support	0	4	(4)	0	77	(77)	0	85	(85)
Agency & Locum	0	0	0	0	0	0	0	0	0
Total Pay Costs	**15**	**4**	**11**	**168**	**94**	**73**	**183**	**102**	**81**
Non Pay Costs									
Clinical Suppplies	0	36	(36)	0	53	(53)	0	63	(63)
Non-Clinical Supplies	11	(0)	11	121	12	109	132	15	117
CNST	0	0	0	0	0	0	0	0	0
Premises & IT Costs	0 -	2	2	0	78	(78)	0	81	(81)
Service Contracts	0	0	(0)	0	0	(0)	0	0	(0)
Total Non-Pay Costs	**11**	**35**	**(24)**	**121**	**143**	**(23)**	**132**	**159**	**(27)**
Total Expenditure	**26**	**39**	**(12)**	**288**	**238**	**51**	**315**	**261**	**54**

Note that the values above include £4k YTD related to Vaccination and LAMP Testing expenditure which should both be reimbursed.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M11
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR - Internal Budget	YEAR - Internal Actual	YEAR - Internal Variance
Maternity									
Income	(4,156)	(4,177)	21	(45,720)	(46,792)	1,072	(50,260)	(51,456)	1,196
Expenditure	2,237	2,404	(167)	24,589	26,076	(1,487)	26,826	28,500	(1,674)
Total Maternity	**(1,919)**	**(1,773)**	**(146)**	**(21,131)**	**(20,716)**	**(415)**	**(23,435)**	**(22,957)**	**(478)**
Neonatal									
Income	(1,767)	(2,400)	633	(19,440)	(20,605)	1,165	(21,351)	(23,119)	1,768
Expenditure	1,313	1,423	(109)	14,447	15,298	(852)	15,760	16,639	(879)
Total Neonatal	**(454)**	**(978)**	**524**	**(4,994)**	**(5,307)**	**313**	**(5,591)**	**(6,480)**	**889**
Division of Family Health - Total	**(2,373)**	**(2,751)**	**378**	**(26,125)**	**(26,023)**	**(102)**	**(29,026)**	**(29,437)**	**411**
Gynaecology									
Income	(2,022)	(1,890)	(132)	(22,218)	(21,867)	(351)	(24,425)	(24,049)	(377)
Expenditure	1,293	1,509	(215)	14,430	16,050	(1,621)	15,926	17,706	(1,780)
Total Gynaecology	**(728)**	**(381)**	**(347)**	**(7,789)**	**(5,817)**	**(1,972)**	**(8,499)**	**(6,343)**	**(2,156)**
Hewitt Centre									
Income	(751)	(764)	13	(8,261)	(8,359)	98	(9,228)	(9,365)	137
Expenditure	732	751	(19)	8,047	8,871	(824)	8,779	9,633	(854)
Total Hewitt Centre	**(19)**	**(13)**	**(6)**	**(214)**	**512**	**(726)**	**(449)**	**268**	**(717)**
Division of Gynaecology - Total	**(748)**	**(395)**	**(353)**	**(8,003)**	**(5,304)**	**(2,698)**	**(8,949)**	**(6,075)**	**(2,874)**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	1,019	948	71	10,771	10,713	58	11,790	11,720	70
Total Theatres	**1,019**	**948**	**71**	**10,771**	**10,713**	**58**	**11,790**	**11,720**	**70**
Genetics									
Income	(13)	4	(17)	(139)	(125)	(15)	(152)	(140)	(13)
Expenditure	174	166	8	1,852	1,642	210	2,026	1,824	201
Total Genetics	**161**	**170**	**(9)**	**1,713**	**1,517**	**196**	**1,874**	**1,685**	**189**
Other Clinical Support									
Income	(734)	(1,033)	299	(8,030)	(6,350)	(1,681)	(8,793)	(6,951)	(1,843)
Expenditure	881	1,187	(306)	9,683	9,699	(16)	10,564	10,847	(282)
Total Clinical Support	**147**	**155**	**(7)**	**1,653**	**3,349**	**(1,696)**	**1,771**	**3,896**	**(2,125)**
Division of Clinical Support - Total	**1,327**	**1,272**	**55**	**14,136**	**15,580**	**(1,443)**	**15,434**	**17,301**	**(1,866)**
Corporate & Trust Technical Items									
Income	(2,728)	(2,579)	(149)	(29,807)	(33,012)	3,205	(31,577)	(36,408)	4,831
Expenditure	4,568	4,762	(194)	49,226	52,657	(3,431)	53,591	56,274	(2,684)
Total Corporate	**1,840**	**2,183**	**(343)**	**19,419**	**19,645**	**(225)**	**22,014**	**19,866**	**2,148**
(Surplus) / Deficit	**45**	**309**	**(264)**	**(571)**	**3,898**	**(4,469)**	**(526)**	**1,655**	**(2,181)**
Of which is hosted;									
Income	(115)	62	(177)	(1,260)	(3,041)	1,782	(1,374)	(3,298)	1,924
Expenditure	115	(62)	177	1,260	3,041	(1,782)	1,374	3,297	(1,923)
Total Corporate	**0**	**(0)**	**0**	**0**	**(0)**	**0**	**0**	**(0)**	**0**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **6**
CIP: M11
YEAR ENDING 31 MARCH 2023

Scheme	Target	Actual	Variance	Target	Actual	Variance	Target	FOT	Variance
Procurement and Non Pay	155	215	60	1,680	1,633	-47	1,835	2,118	283
Estates utilisation	34	12	-22	378	136	-242	412	148	-264
Staffing and skill mix	173	145	-29	1,904	1,562	-342	2,078	2,157	79
Medicines Management	3	0	-3	28	0	-28	30	0	-30
Service Developments	0	0	0	0	0	0	0	0	0
Theatre Efficiency	23	0	-23	345	0	-345	369	0	-369
Technology Driven Efficiencies	9	3	-6	97	32	-65	106	35	-71
Income	68	75	7	706	1,265	560	773	1,348	574
Other Savings Plans	0	0	0	0	0	0	0	0	0
Total	**465**	**450**	**-15**	**5,138**	**4,629**	**-510**	**5,603**	**5,806**	**203**

Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
BALANCE SHEET: M11
YEAR ENDING 31 MARCH 2023

BALANCE SHEET £'000	YEAR TO DATE Opening	M11 Actual	Movement
Non Current Assets	101,380	102,876	1,496
Current Assets			
Cash	11,192	10,793	(399)
Debtors	5,929	10,608	4,679
Inventories	523	802	279
Total Current Assets	**17,644**	**22,203**	**4,559**
Liabilities			
Creditors due < 1 year - Capital Payables	(4,849)	(1,617)	3,232
Creditors due < 1 year - Trade Payables	(18,362)	(21,528)	(3,166)
Creditors due < 1 year - Deferred Income	(4,157)	(15,727)	(11,570)
Creditors due > 1 year - Deferred Income	(1,561)	(1,532)	29
Loans	(1,525)	(1,219)	306
Loans - IFRS16 leases	(49)	(32)	17
Provisions	(3,889)	(893)	2,996
Total Liabilities	**(34,392)**	**(42,548)**	**(8,156)**
TOTAL ASSETS EMPLOYED	**84,632**	**82,531**	**(2,101)**
Taxpayers Equity			
PDC	70,713	72,509	1,796
Revaluation Reserve	12,749	12,749	0
Retained Earnings	1,170	(2,727)	(3,897)
TOTAL TAXPAYERS EQUITY	**84,632**	**82,531**	**(2,101)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CASHFLOW STATEMENT: M11
YEAR ENDING 31 MARCH 2023

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	(1,824)
Depreciation and amortisation	5,416
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	5,851
Net cash generated from / (used in) operations	**9,443**
Interest received	139
Purchase of property, plant and equipment and intangible assets	(10,183)
Proceeds from sales of property, plant and equipment and intangible assets	58
Net cash generated from/(used in) investing activities	**(9,986)**
PDC Capital Programme Funding - received	1,796
Loans from Department of Health - repaid	(306)
Interest paid	(25)
PDC dividend (paid)/refunded	(1,321)
Net cash generated from/(used in) financing activities	**144**
Increase/(decrease) in cash and cash equivalents	**(399)**
Cash and cash equivalents at start of period	11,192
Cash and cash equivalents at end of period	**10,793**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding
Loans from Department of Health - Capital (ITFF) - 2.0% Interest Rate	5,500	(4,281)	1,219
Loans from Department of Health - Capital (Neonatal) - 2.54% Interest Rate	14,572	(14,572)	0
Loans from Department of Health - Revenue - 1.50% Interest Rate	14,612	(14,612)	0
Total	**34,684**	**(33,465)**	**1,219**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 9
CAPITAL EXPENDITURE: M11
YEAR ENDING 31 MARCH 2023

CAPITAL EXPENDITURE	Year to Date			FOT		
£'000	Plan	Actual	Variance	Plan	Actual	Variance
Estates	800	457	343	800	625	175
Capital Projects	4,525	3,816	709	4,527	4,683	(156)
IM&T	554	1,011	(457)	718	1,128	(410)
IM&T	2,211	1,377	834	2,211	2,131	80
IM&T	422	371	51	564	2,453	(1,889)
Grand Total	8,512	7,032	1,480	8,820	11,020	(2,200)

Note 1: The Capital Expenditure is shown on an "Accruals" basis based on the date of receipt of the capital item by the Trust. This figure differs to the capital expenditure figure shown in the cashflow statement which is on a "Cash" basis.
Note 2 : Variances in the Board Pack are the true FOT for the year, however the variances reported in the NHSI M5 return are all zero as FOT has been reported as plan for each line.

Note 3: Actual FOT exceed plan due to additional PDC projects (front line digitisation £1.9m and CAMRIN)

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2023/24/012a*		Date: 06/04/2023	
Report Title	Corporate Objectives 2022/23: Final Outturn Review			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	Executives			
Key Issues / Messages	***The report provides the final outturn position for the 2022/23 Corporate Objectives.***			
Action required	Approve ☐	Receive ☒	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is asked to note the performance / progress to date against the 2022/23 Corporate Objectives.			
Supporting Executive:	Executive Team			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Comment: N/A
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment: N/A

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
N/A			

EXECUTIVE SUMMARY

The Board of Directors reviewed the corporate objectives 2022/23 at its meeting on 5 May 2022 and formally approved them.

The cycle of periodic review involves the Committees and the Board reviewing progress on the Corporate Objectives on a six-monthly basis. This report provides the final outturn position.

Consideration of the corporate objectives have been given by each of the respective Board Committees, and they are now presented to the Board for noting.

It is intended to report the draft Corporate Objectives for 2023/24 at the April 2023 Committees (Putting People First via email) ahead of Board approval in May 2023. For any 2022/23 objectives that remain outstanding, scrutiny will be provided on the appropriateness of taking these forwards as 2023/24 objectives. Any actions not taken forward will be allocated to other fora for continued oversight.

Recommendation

The Board is asked to note the performance / progress to date against the 2022/23 Corporate Objectives.

MAIN REPORT

Liverpool Women's
NHS Foundation Trust

Corporate Objectives

2022 – 2023

Our Vision

To be the recognised leader in healthcare for women, babies and their families

Our shared vision at Liverpool Women's is simple and has withstood the test of time. It is underpinned by a shared set of values based around the needs of our people. We encourage these behaviours in all our staff, partners and volunteers to make sure our values are delivered in the same way, every day, to every person we care for.

Our Values	**Care**	**Ambition**	**Respect**	**Engage**	**Learn**

We have a set of five strategic aims which are central to all of our strategies and plans, and through working with patients, staff, governors and our partners we have developed a series of ambitions to push those aims one step further, helping us create the mind-set we need to achieve our vision and be outstanding in everything we do:

Our Aims	To develop a well led, capable, motivated and entrepreneurial workforce.	To be ambitious and efficient and make best use of available resources.	To deliver safe services.	To participate in high quality research to deliver the most effective outcomes.	To deliver the best possible experience for patients and staff.
Our Ambitions	We will be an outstanding employer.	We will deliver maximum efficiency in our services.	Our services will be the safest in the country.	Outcomes will be best in class.	Every patient will have an outstanding experience.

Our partnerships with other providers and organisations across the city are central to delivering our aims; we know we need to work together to make this happen.

NHS
Liverpool Women's
NHS Foundation Trust

Key	Complete	On track	Risks identified but on track	Off Track

To develop a Well Led, capable, motivated, and entrepreneurial Workforce					
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**12 month update**
Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	To progress year on year towards the organisational goal of 25% of our leadership workforce (Band 7 and above) being from an ethnically diverse background. This will require the Trust recruiting to 10 leadership roles each year between 2022-2025 (moving from 23 to 33 in 2022/23).	CPO	Putting People First Strategy	PPF	The original corporate objective has been modified to increase by 10 leadership roles each year until 25% of our leadership workforce is made up of colleagues from a racially minoritised background Between April 2022 and January 2023, staff in these roles increased from 25 to 31. Whilst not achieving the target of 10, this remains good progress towards it therefore this objective has been rated on track.
	To work in partnership with health, education, local authority and community partners to increase the number of employees from an ethnic minority background by 5% year on year to ensure we achieve Riverside representation by 2025, moving from 11% to 16% in 2022/23.	CPO	Putting People First Strategy	PPF	Riverside ethnicity as detailed in a CCG report 2018 states 23.4% of the population are not white British/Irish, the fourth highest level in the city and 4.4% are 'other ethnic group (including Arab)' ethnicity. Currently **9%** of the LWH workforce is from a racially minoritised background, therefore further working in partnership with health, education, local authority and community partners is needed to increase the number of employees from a racially minoritised background by 5% year on year to ensure we achieve Riverside representation by

					2025. This represents a significant challenge, therefore this objective has been rated as 'at risk'.
Recruit and retain key clinical staff	Demonstrate improvement from the 2021 NHS Staff survey in relation to staff engagement measures.	CPO	Putting People First Strategy	PPF	The 2022 Staff Survey showed some positive improvements. The Staff Engagement Score improved from 6.9 to 7.1 which is classed as a statistically significant increase. Structures put in place over the last 12-18 months to improve staff engagement including *Big Conversations, Let's Talk Surveys, Great Place to Work Group and Divisional Key Messages* are becoming embedded, and Staff Engagement is a key objective in all Divisional People Plans (local workforce strategies).
	24/7 consultant obstetric workforce and 8am-12pm (twilights) for anaesthetic workforce by 2023	MD	Medical Workforce Strategy	PPF	24/7 resident neonatal consultant cover was achieved in January 2021 24/7 resident gynaecological consultant cover is not deemed necessary. Twilight obstetric cover achieved since July 2022. 4 more obstetric consultants required to move to 24/7 resident consultant cover. Once the correct number of staff are in place then there needs to be negotiation about the move and renumeration to 24/7 resident cover. This could be achieved by the end of 2023 however it has significant financial implications and may need to be phased differently. Anaesthetic Twilight consultant cover leading to 24/7 resident consultant cover. Twilight consultant cover will need approximately 7 WTE consultants. It is suggested that these are phased over the next

					couple of years and then the move to 24/7 resident cover considered once this is achieved. This will have a significant financial implication.

To deliver Safe services					
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**12 month update**
Progress our plans to build a new hospital co-located with an adult acute site	Complete refresh of business case for a new Liverpool Women's Hospital to reflect evolving models of care and system developments.	CFO	Future Generations Strategy	FPBD	The LCSR took place between September and December 2022. The review recommended that the Future Generations Programme be re-set as a system priority, led by a new sub-committee of the ICB Board, in line with best practice for service reconfiguration. Accordingly, the Trust's FG Programme paused for further work in December 2022, and the Trust is now supporting the work of the Women's Services Sub-Committee. This sub-committee is now responsible for developing service change proposal; however, the Trust will continue to contribute to this work.
Implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible,	Deliver the Crown Street enhancement work program (including CT and blood bank services) to time and to budget working with system partners to	CFO	Estates Strategy	FPBD	Bid for emergency capital funding was submitted by the Trust in early 2021 and re-submitted in July following a request from NHSI/E. Funding was approved in December 2021.

developing our facilities for the benefit of our patients as well as those across the system	ensure optimal patient benefit across the wider Cheshire and Mersey system.				Construction work for the permanent CT and MRI facilities substantially completed in December 2022. CT facilities became operational on 6 February 2023, with MRI due to commence w/c/ 20 March 2023. LWH inpatient pathways are now in place for CT imaging. The project to deliver 24/7 transfusion is expected to go live in 2023/24.
Develop our model of care to keep pace with developments and respond to a changing environment	Deliver the launch of Trust's EPR programme in line with established timescales.	CIO	Digital Generations Strategy	FPBD	Work is underway to deliver a launch date in July 2023. This has been monitored monthly by the FPBD Committee.
	Recover and restore services for our patients and those across Cheshire and Merseyside in line with the National Operational plan requirements for 2022/23.	COO	Our Strategy	FPBD	In 2022/23 the Trust has progressed with recovery from the Covid Pandemic by ensuring capacity is available to treat those patients waiting the longest and also the most urgent. The Trust has commenced three main programmes of work to improve outcomes and efficiency for our patients in the 2nd half of 2022/23. These being the Theatre Improvement Programme, Maternity Triage and Flow, and Outpatient Utilization In line with the national requirements no patients were waiting over 104 weeks by June 2022 and significant progress has been made in reducing the number of patients waiting 78 weeks by the end of March 2023. General diagnostic

					performance has improved significantly in line with national requirements General capacity has been challenged as suspected cancer referrals have consistently been high compared to previous years. The Trust has maintained good performance against the 2 week referral and 31 day treatment target, however the 62 day target has been a challenge that continues to be addressed through the partnership of the Cheshire and Mersey Cancer Alliance. Urgent Care 4 hour performance remains well above the national average, however the Trust is committed to continue to improve this further through local redesign.

To deliver the best possible Experience for patients and staff					
Strategic Aim	**Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**12 month update**
Deliver an excellent patient and family experience to all our service users	Actively seek and use the diverse views of, patients, their families, and our communities to design and deliver services that best meet their needs. To ensure that services are utilising the findings of this intelligence to identify areas for service improvement and that we	DON	Clinical & Quality Strategy	QC	The following work has progressed since previous reporting: • Merseyside Society for the Deaf – work ongoing with digital agenda within the Trust to improve accessibility. This includes working on the Outpatient transformation and text messaging.

	can demonstrate communication of the actions we have taken because of the feedback received.				• Ongoing 'Come talk to us' events – held at both sites, generating lots of feedback and captured onto the Ulysses system as PALS. • Maternity Improvement Task and Finish Group – improvements noted from the National Patient Survey, with on-going improvements captured within maternity patient experience action plans • Inpatient and Cancer National surveys, actions plans, and improvements made. • Maternity Voices Panel – working with the chair to act on feedback. Process has been set up to ensure feedback is distributed to the correct area of the Trust, actioned and then MVP can implement 'You said we did'. • Catering group – introduced new menus, crockery and cutlery following feedback from patients. Awaiting new breakfast and beverage trolleys. • Genomics waiting area and counselling rooms have been updated following feedback from patients, more improvements planned to include refreshment stations • Engagement events both internally and externally. • Secret Shopper introduced and currently looking at the environment, food tasting and adaptive cutlery. • Non-English Speaking Team (NEST) is established and working well.

					• Local surveys undertaken listening to the views of all patients. • Friends and Family comments acted on to produce 'you said we did' that are displayed Trust wide. • Stakeholder list developed and scheduled events. • Gynaecology Oncology Support Group – empowering ladies with cancer to have informed decision making. • Honeysuckle Bereavement support group – monthly meetings with bereaved patients/partners. • Trust compliance with Reasonable Adjustments Guidelines is monitored on a quarterly basis via the Integrated Safeguarding Quality Assurance Report. • For Q3 2022/23 data shows that all patients with additional needs, who were admitted for either a gynaecology procedure or antenatal care were assessed for reasonable adjustments, with 49% were requiring adjustments to their care pathway. This is a reduction when compared to Q2 2022/23 however no conclusions can be reached at this time due to a lack of comparative data and the nature of reasonable adjustments being individual to the needs of the person. • Of these, two patients required the support of the safeguarding team to co-ordinate significant adaptations to the admissions pathway

					The 2022 Learning Disability Improvement Standards (LD-IS) for NHS Trusts 2018 & Dementia-Friendly Hospital Charter (DFHC) 2018 Audit in 2022 found: • All patients included in the audit were appropriately identified, their individual needs recognised, and reasonable adjustments were applied, where necessary. • Reviewing the adjustments completed, 71% required unrestricted access to a relative or carer and in all cases the relative or carer fed back they were actively involved in all aspects of care planning. When asked to score how they were made to feel, 96% scored between nine and ten, with 10 being the best, which is above the Trust FFT overall score of 90%.
	To implement a formal governance and reporting structure for the implementation of the Ockenden Final Report recommendations. This will monitor and track progress allowing for robust assurance to be provided to the Quality Committee and Board ensuring that the organisation is fully sighted on its position.	DONM	Clinical & Quality Strategy	QC	Maternity Transformation Board in place with meetings held monthly receiving progress reports from 4 workstreams. Workstream 1-Ockenden, aims to achieve compliance with the 92 Essential Actions from Ockenden 2 Report. Of the 92 Essential Actions 5 actions relate to National workstreams. Of the remaining 87 EA position in LWH: • 23 Ambers (26%) • 64 Green (74%)

					The recent MIAA report raised the level of scrutiny and challenge in place along with evidence of the Green rated IEA's. The Ockenden workstream have completed the review of the Ambers and from April 2023 will be reviewing the Green rated actions. There is also an established process for updates & progress to be fed into the Trust Safety & Effectiveness Sub-Committee and then onto Quality Committee.

To be ambitious and Efficient and make best use of available resources					
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**12 month update**
Ensure our services are financially sustainable in the long term	Ensure efficient and effective use of all available resources, meeting agreed financial targets and working across the Cheshire and Mersey system for optimum outcomes for the region.	CFO	Finance & Sustainability 2021-2025	FPBD	The Trust is facing financial challenge in 2022/23 and has implemented a Recovery Programme in order to address this. Despite this, the Trust has reported off plan since M10 and is now forecasting a £2.2m adverse variance o plan for 2022/23. Close working with the ICB and provider partners is in place.

	Ensure the Trust has an updated, long term financial plan in place during 2022/23 to reflect recent and proposed regime changes, with clear views and actions in place in relation to long term sustainability.	CFO	Finance & Sustainability 2021-2025	FPBD	A long-term financial model has been produced but there remains uncertainty in the medium term in relation to inflation and other key assumptions. Plans for 2023/23 currently indicate a significant deficit, with an underlying structural deficit of c. £30m. The Trust has a clear understanding of the drivers of this deficit. To achieve long-term financial sustainability, the Trust will require external support and is working closely with ICS partners to address long term financial sustainability.
	Develop the Trust's commercial strategy during 2022/23 and pursue appropriate opportunities to maximise Trust income for the benefit of our patients	CFO	Finance & Sustainability 2021-2025	FPBD	The Trust's approach to commercial and international development is included in the Trust's draft finance, procurement, and sustainability strategy – including a risk appetite statement. The strategy will be recommended for approval in Q1 2023/24.

To participate in high quality research in order to deliver the most Effective outcomes					
Strategic Aim	Proposed Corporate Objective	Executive Lead	Relevant Strategy	Board Committee	12 month update

Expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	Maintain and develop key partnerships, ensuring robust governance structures are in place and effective reporting through the Trust's assurance framework.	MD	Our Strategy	FPBD	The Trust has several highly successful partnerships in place with a range of clinical networks, and with local Trusts, including with LUHFT & LHCH for CDC, Alder Hey for the Liverpool Neonatal Partnership, and Mersey Care for the provision of specific services and future development of estate. The Trust is also working closely with Place and the ICB regarding it's long-term strategy. Progress in developing partnerships and associated governance is now reported on a quarterly basis to the Executive Team, and an Executive Lead has been identified. The Trust's approach to partnership working needs to remain dynamic at present, to enable a flexible response to a changing environment. The LNP went through a quality assurance process whereby the Partnership self-assessed itself against a predefined set of criteria based on the Well Led CQC domain. This was then presented to NEDs from both Boards. An overarching Partnership Board with Alder Hey is forming to encompass the Liverpool Neonatal Partnership, Starting Well research programme, newly developing services and current services. The Partnership Board will also look at strategic programmes that have a shared strategic aim.
	Support the developing ICS for C&M and working with the system to	CEO	Our Strategy	FPBD	Executives from LWH have engaged with the new Executive team of the ICB and at Place regarding

	improve outcomes for Women's Health including Maternal and Neonatal care.				the Case for Change for the Future Generations strategy. This case for change has been discussed at ICB Board meetings and is now a programme of the ICB (with a new sub-committee in place). COO and MD chair a C&M Gold Command for maternity services on a weekly basis Through the LMS LWH has two clinical leads embedded within leadership structure for maternity and gynaecology Executives have engaged with their respective forums hosted via the ICB ie C&M MDs meeting and other execs have theirs as well CMAST programmes of work are also supported by Executives where appropriate including developmental days e.g CEO chairing (SRO) the workforce group. CMAST MDs and DoS recently agreed to prioritise gynae services at a joint workshop held in March 2023. The Trust is hosting a joint workshop with colleagues from primary care and public health in Liverpool to expand on the Trust's model of care work and to consider the impact on prevention, health inequalities and the role of primary care in women's services.

Progress our research strategy and foster innovation within the Trust	Provide clear evidence of senior nursing & midwifery research leadership, as per the Trust R&D strategy by March 2023	MD	Research & Innovation Strategy	QC	Good progress has been made towards delivery of this objective, with good support and engagement seen across the Trust. Specific examples include: -Three professors of midwifery attend the RD&I Committee (for UCLAN, Liverpool John Moors, LTSM), which has driven greater collaboration and willingness to progress nursing and midwifery-led research. -A joint research midwifery post has been developed with LSTN and commenced Jan 2022. -Trial ongoing re speculum for 3rd/4th degree tears - created opportunity for midwife PhD. -Meetings ha taken place with PEFs in Trust to make research placements available for nurses and midwives, to be implemented in 2022. A Nursing Midwifery and AHP Talent pipeline has been developed and a business case accepted to fund the pipeline. Research development opportunities will be offered in early 2023 for nurses midwives and AHPs. The Trust now has a Nursing Midwifery and AHP Talent Pipeline to encourage staff to into Research. The Trust now has two employees who were awarded status as NIHR Senior Research Leaders.

	Complete refresh of R&D strategy and progress year 1 objectives	MD	Research & Innovation Strategy	QC	Work to refresh the Trust's Research, Development and Innovation strategy has been underway for the past year. Recent consultation work regarding the strategy has been undertaken with a range of stakeholder groups, including the Trust's Council of Governors and representatives from all local universities. The R&D strategy was relaunched 27th March 2023
Fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Ensure all wards and key areas have ward accreditation completed (twice a year)	DONM	Clinical & Quality Strategy	QC	The BBAS framework provides wards and departments with an evidence based, coordinated set of standards which are tailored to each individual ward/area against which the quality and safety of care can be measured. The framework is supported by the Nursing Audits and KPI assurance framework. The standards are based on the Trusts Five Key Strategic Aims and Ambitions to support the Trust Vision to be outstanding in everything that we do, as well as the CQC`s assessment framework. To date a total of 9 areas have received a Baseline Assessment and one area has been reaccredited. A further 13 areas are scheduled for Baseline assessments and 5 areas are scheduled for reaccreditation.

					Recognition and sharing of best practice across the organisation is in progress for those areas who have achieved Gold status. A proposal for a Quality and Safety walkaround schedule which will provide additional assurance of standards is also under review.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/12b***		**Date: 06/04/2023**	
Report Title	**Board Assurance Framework**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***The report outlines any updates relating to the Board Assurance Framework and any key areas for consideration for the Board.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y ***If no – please outline the reasons for deviation.***			
	The Board requested to review the BAF risks and agree their contents and actions.			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

BAF discussed at FPBD, Putting People First and Quality Committees since previous version presented to Board in February 2023.

EXECUTIVE SUMMARY

The Board Assurance Framework (BAF) is a monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives, and to ensure it has appropriate oversight of the Trust's risk profile and risk management arrangements.

The BAF items are aligned to the Board's assurance committees, and since the last Board meeting these were reviewed and discussed during the January 2023 meetings.

MAIN REPORT

Introduction

The following report provides an update to Board members on the latest review of the BAF items.

The report is intended to allow the members of the Board to review any proposed changes or additions and agree them moving forward. The report is also an opportunity for the Board to make informed judgements as to the level of assurance that they can take and to identify any further action required to improve the management of the identified risks.

Process for reviewing BAF areas during the meeting

As the Board works through the agenda, members are requested to consider the BAF areas contained in Appendix 1 and the associated interdependent 15 and above risks / CRR risks. Keeping these risks in mind should support consideration of whether any assurances provided through the reports received could contribute to mitigation (or escalation) of the BAF risks. These can be noted when the BAF itself is discussed.

In addition, members should consider whether because of the review of assurances and/or identification of risks, whether there is a need to commission additional assurance to be reported to future Board and / or Committee meetings. In particular, the Board needs to ask itself whether it is attaining adequate assurance against its highest scoring risks i.e., are these areas of risk driving the Board and Committee agendas. Any information that has been discussed in the meeting that needs to be shared with other corporate governance meetings should be included in the Chair's Log.

Changes to BAF

The table below also outlines the changes made since the previous iteration.

1.1 Failure to be recognised as one of the most inclusive organisations in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)
• No updates to note
1.2 Failure to recruit & maintain a highly skilled & engaged workforce

- The Trust has been managing the impact of industrial action throughout 2022 whilst maintaining a BAF score of 20. Moving into 2023, it is likely that industrial action begins to be co-ordinated across the various unions and sectors. This will pose a severe and acute challenge to the Trust on those days, potentially to the extent which disrupts business to a 'catastrophic' extent (as defined by the risk descriptors in the Risk Management Strategy). Whilst this remains a possibility, there was a proposal that the Trust should rate this risk as a '25' – the most highly rated risk on the BAF. This was debated at the February 2023 Board, and it was voted that further consideration was required with additional triangulation ahead of a further discussion of increasing the risk score.

  A discussion was held by the Executive Team and a recommendation has been formed in which the score will remain at a '20' (consequence 5, likelihood 4). The fact that the impact of industrial action had been well mitigated to date and that the Trust retained strong relationships with staff and its union representatives meant that it was felt inappropriate to escalate the likelihood to a '5'. The PPF Committee agreed to maintain the score at '20'.

2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site

- This was significantly reviewed following the publication of the Liverpool Clinical Services Review. Two versions included at Feb 23 FPBD Committee to show previous iteration with updates and proposals for items to be removed / amended and a 'clean' version to illustrate how the risk could look if the changes are accepted. The Committee confirmed acceptance of the changes.

2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment

- No updates to note

2.3: Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system

- No updates to note

2.4: Major and sustained failure of essential IT systems due to a cyber attack

- No updates to note

3.1: Failure to deliver an excellent patient and family experience to all our service users

- No updates to note

4.1: Failure to ensure our services are financially sustainable in the long term

No updates to note
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
• No updates to note
4.3: Failure to deliver the agreed 2022/23 financial plan
• Agreed to increase score from '16' to '20' due to increased likelihood of financial plan not being achieved.
5.1: Failure to progress our research strategy and foster innovation within the Trust
• No updates to note
5.2: Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership
• No updates to note

New Risks or Strategic Threats

No new risks or strategic threats.

Closed Risks or Strategic Threats

No closed risks or strategic threats.

Ahead of the next meeting, a significant review of the BAF is scheduled to take place – it is likely that there will be a push to reduce the number of BAF risks to help provide greater clarity on the key strategic risks facing the Trust. Suggested risk areas are as follows:

- Clinical sustainability
- Financial sustainability
- Workforce
- Patient Experience
- Being an effective partner
- Digital

Recommendation

The Board requested to review the BAF risks and agree their contents and actions.

BOARD ASSURANCE FRAMEWORK 2022/2023

Trust Board – April 2023

Board Assurance Framework Key

Risk Rating Matrix (Likelihood x Consequence)					
Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Director Lead	
CEO	Chief Executive
CPO	Chief People Officer
COO	Chief Operating Officer
CFO	Chief Finance Officer
CIO	Chief Information Officer
CNM	Chief Nurse & Midwife
MD	Medical Director

Key to lead Committee Assurance Ratings	
	Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity - no gaps in assurance or control AND current exposure risk rating = target OR - gaps in control and assurance are being addressed
	Amber = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy
	Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each BAF Risk and also to identify any further action required to improve the management of those risks.

Board Assurance Framework: Legend	
Strategic Priority	The 2021/25 strategic priority that the BAF risk has been aligned to.
BAF Risk:	The title of the strategic risk that threatens the achievement of the aligned strategic priority
Rationale for Current Risk Score:	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk.
Strategic Threat:	What might cause the BAF risks to materialise
Provider Licence Compliance:	NHS Improvement provider licence conditions that align to the BAF risk providing assurance on compliance.
Controls:	The measures in place to reduce the risk likelihood or risk consequence and assist secure delivery of the strategic priority.
Assurances:	The measures in place to provide confirmation that the controls are working effectively in supporting the mitigation of the risk.
Gaps in Controls / Assurance:	Areas that require attention to ensure that systems and processes are in place to mitigate the BAF risk Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the BAF risk.
Required Action:	Actions required to close the gap in control/ assurance
Lead:	The person responsible for completing the required action.
Implemented By:	Deadline for completing the required action.
Monitoring:	The forum that will monitor completion of the required action.
Progress:	A RAG rated assessment of how much progress has been made on the completion of the required action.

Risk Descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long- term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on many patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day)	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days)	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff

			Low staff morale Poor staff attendance for mandatory/key training	Loss of key staff Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10– 25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?
The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Board Assurance Framework Dashboard 2022/2023

SA	BAF Risk	Committee	Lead	May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23Target
SA1 Workforce	1.1 Failure to be recognised as one of the most inclusive organisations in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	PPF	CPO	12 (I3 x c4)	12 (I3 x c4)	12 (I3 x c4)		⟷	8 (I2 x c4)
	1.2 Failure to recruit & maintain a highly skilled & engaged workforce	PPF	CPO	20 (I5 x c4)	20 (I5 x c4)	20 (I4 x c4)		⟷	16 (I4 x c4)
SA2 Safe	2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site	FPBD	CFO	15 (I3 x c5)	15 (I3 x c5)	15 (I3 x c5)		⟷	10 (I2 x c5)
	2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment	FPBD	COO	16 (I4 x c4)	16 (I4 x c4)	16 (I4 x c4)		⟷	12 (I3 x c4)
	2.3 Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	Quality	COO	20 (I4 x c5)	20 (I4 x c5)	20 (I4 x c5)		⟷	15 (I3 x c5)
	2.4 Major and sustained failure of essential IT systems due to a cyber attack	FPBD	CIO	20 (I4 x c5)	20 (I4 x c5)	20 (I4 x c5)		⟷	15 (I2 x c5)
SA3 Experience	3.1 Failure to deliver an excellent patient and family experience to all our service users	Quality	CNM	12 (I3 x c4)	12 (I3 x c4)	12 (I3 x c4)		⟷	12 (I3 x c4)
SA4 Efficient	4.1 Failure to ensure our services are financially sustainable in the long term	FPBD	CFO	20 (I5 x c4	20 (I5 x c4	20 (I5 x c4		⟷	16 (I4 x c4)
	4.2 Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	FPBD	MD	8 (I2 x c4)	8 (I2 x c4)	8 (I2 x c4)		⟷	8 (I2 x c4)
	4.3 Failure to deliver the agreed 2022/23 financial plan	FPBD	CFO			20 (I5 x c4)		N/A	16 (I4 x c4)
SA5 Effective	5.1 Failure to progress our research strategy and foster innovation within the Trust	Quality	MD	8 (I2 x c4)	8 (I2 x c4)	8 (I2 x c4)		⟷	4 (I1 x c4)
	5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Quality	CNM	12 (I3 x c4)	12 (I3 x c4)	12 (I3 x c4)		⟷	8 (I2 x c4)

BAF HEAT MAP


Consequence
Likelihood
1 Rare
2 Unlikely
3 Possible
4 Likely
5 Almost certain
5 Catastrophic
4 Major
3 Moderate
2 Minor
1 Negligible
2.1
2.4
2.3
1.2
4.2
5.1
1.1
3.1
5.2
2.2
4.3
4.1

Strategic Objective	SA1: To develop a well led, capable, motivated and entrepreneurial WORKFORCE
Committee:	Putting People First Committee
Risk Appetite:	Moderate

Principal risks (BAF)	Risk Score
1.1 Failure to be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	12 (3 x 4)
1.2 Failure to recruit & maintain a highly skilled & engaged workforce	20 (4 x 5)

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

2087 - No change in risk score since last review. Last reviewed 13/07/2022

2323 - No change in risk score since last review. Last reviewed 15/09/2022

1705 – No change in risk score since last review. Last reviewed 16/09/2022.

2491 – No change in risk score since last review. Last reviewed 08/03/2022

2549 – NEWLY ADDED. Last reviewed 17/10/2022

2467 – NEWLY ADDED. Last reviewed 11/10/2022

Ref	BAF x REF	Corporate Risk Register / High Scoring (15+) Risks	Risk Score
2443	1.2	Inability to recruit specialised allied health professions in a timely manner	16
1705	1.2	Insufficient midwifery staffing levels as recognised by birth rate place plus.	20
2424	1.2	Unable to meet safe staffing levels in line with BAPM requirements	15
2549	1.2	Staff shortages in the Ultrasound Team within the Imaging Department due to Vacancies and 5 staff members leaving in May & June 22	20
2467	1.2	Inability to recruit specialised allied health professions in a timely manner for blood bank	
2087 **(CRR)**	1.2	Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	16
2323 **(CRR)**	1.2	The Trust is currently non-compliant with standards 2,5,6 of the seven-day service standards (due to insufficient consultant numbers)	15
1704 **(CCR)**	1.2	Effective management systems are not in place or sufficient to ensure all employees complete and keep up to date with their mandatory training requirements.	12
2491 (CRR)	1.2	Noncompliance with mandated level of fit mask testers qualification, accreditation, and competency	15

BAF Risk 1.1: Failure to be recognised as one of the most inclusive organisation in the NHS with zero discrimination for staff and patients (zero complaints from patients, zero investigations)	**Lead Director:** CPO **Op Lead:** Deputy Director of Workforce	**Review Date: November 2022**

Strategic Priority: SA1: To develop a well led, capable, motivated and entrepreneurial workforce

Lead Committee: Putting People First

Provider Licence Compliance link(s):

N/A

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
12 (3 x 4)	12 (3 x 4)	12 (3 x 4)		⟷	8 (2 x 4)

Rationale for current risk score:

The Trust has several strong controls in place against this risk and can demonstrate effective performance in comparison with other NHS trusts. During 2021/22, for the first time, the Trust benchmarked within the top 50 inclusive places to work. However, this is an ambitious aim within the Trust's 2021-25 strategy and will require significant cultural change to achieve together with a continued and unrelenting focus. The Trust can also make progress on the mechanisms that it has in place to hear the views and voices from its diverse staffing and patient communities and ensure that these voices have an impact on service improvement and development.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Unable to create a workforce representative of the community we serve	Monitoring of applications for employment within the Trust throughout the recruitment & selection process over a 12-month period via TRAC reporting	Monitored by the EDI Lead and reported through the ED&I Action Plan	To ensure that there are robust processes in place to target advertising, work shadowing opportunities, pre-application training and offering career advice **(Action 1.1 / 1)** To simplify the EIA process **(Action 1.1 / 2)** To further widen opportunities for the local community to join the LWH workforce **(Action 1.1 / 3)** To continue to develop more diverse recruitment and selection processes **(Action 1.1 / 4)** Enhance availability and quality of training across all protected characteristics including disability and inter-sectionality (Action 1.1 / 5) Establishment and Declaration and Embedding of LWH as an Anti-Racist Organisation (Action 1.1 / 6) Development of ED&I Strategy (Action 1.1 / 7) Need to ensure that career conversations are being undertaken for all staff, particularly racially minoritized staff with a focus on their development and talent management	
	Links with community leaders established to improve under-representation	PPF Strategy and action plan – monitored by PPF Committee		
	Annual review of all employee relation casework to determine if staff are reporting any form of discrimination and to ensure that process is fairly/consistently applied across all staff groups (benchmark against local and national data, where possible)	WRES and WDES submissions		
	All HR policies have up to date equality impact assessments at the point of review, in line with the policy schedule	Policy schedule is currently on track with EIA's being requested as required		
	HR policies reviewed in line with fair and just culture	Policy review process reported to PPF		
	WDES and WRES action plan delivery in line with timescales presented from NHS England	WDES and WRES Action Plan submissions		
	Demographic tracking for training access	In place and monitored by Head of L&D OD		
	Establishment of staff inclusion Networks and work in collaboration with local Trusts to promote staff networks and LGBTQ Network to be launched in 2022.	Progress reported to PPF Committee		
	Reciprocal Mentorship Scheme developed	Feedback through Executive Team		
	Extension of e-learning package to design and deliver specific EDI training and education to all LWH staff	PPF Committee		
	Education and celebration of the key EDI events: Black History Month, Disability History Month, LGBT+ History Month and key faith observance days/festival	Staff Communications		
	Utilising widening participation programmes and alternative ways to advertise and promote our job opportunities to attract local population to work at LWH.	PPF Committee		
	Staff from diverse backgrounds having career conversations with manager	Review of appraisal process – PPF and feedback from staff inclusion networks		
	Updated EIA process and new policy	The EIA process is overseen by the ED&I sub-committee		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.1 / 1	Robust targeting of job adverts – engagement in health and careers fairs with local community groups for example Pakistani Centre, Al Ghazali Centre	Head of Culture, Inclusion, Wellbeing and Engagement	February 2023 (ongoing)	E&D Sub-Committee	Wellbeing Coach and Assistant Psychologist vacancies will be targeted via universities with specific focus on racially minoritised communities. Review piece with Patient Experience to identify and prioritise communities within which to target entry level roles. HCA and admin roles- specific careers event in Toxteth (small numbers of roles). Advertisement of key roles via Inclusive Companies jobs page in place. Supported internships for BAME individuals from the local area to commence in January 2023.
1.1 / 3	Establishment of mentoring scheme for 14/15 year olds in the L8 area to encourage them into the midwifery pathway	Head of Culture, Inclusion, Wellbeing and Engagement	~~September 2022~~ February 2023	E&D Sub-Committee	See 1.1/1
1.1 / 4	Exploration and implementation of more diverse recruitment and selection processes including diverse interview panels and alternative recruitment methods Diverse interview panels have commenced but are yet to be consistently applied to all senior roles.	Head of Culture, Inclusion, Wellbeing and Engagement	January 2023	E&D Sub-Committee	Targeted recruitment days in partnership with local authority to take place from early 2023 onwards.

		Employees with protected characteristics have been invited to take part in national training to participate in recruitment processes in other NHS Trusts.(COMPLETED)					
	1.1 / 9	Enhance availability and quality of training across all protected characteristics including disability and inter-sectionality	Head of Culture, Inclusion, Wellbeing and Engagement	December 2022	E&D Sub-Committee	Enhanced training for senior leaders developed, additional baseline training in development, additional training around neurodiversity etc required.	
	1.1 / 10	Establishment and Declaration and Embedding of LWH as an Anti-Racist Organisation	Head of Culture, Inclusion, Wellbeing and Engagement	January 2023	E&D Sub-Committee	See Board agenda – February 2023	
	1.1 / 11	Development of ED&I Strategy	Head of Culture, Inclusion, Wellbeing and Engagement	January 2023	E&D Sub-Committee	This will be included as a major strand of a revised PPF Strategy – to be developed in January 2023	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Unable to effectively engage with our patient and staff groups to understand further the needs of individuals with protected characteristics and respond proactively to identified needs	Patient information leaflets are up to date and accessible for all protected groups. Patient leaflets are on the website that can translate this information into various languages/ fonts and read aloud versions.	Annual audit of patient leaflets to ensure accessibility and usability	Need to create template for patient story capture and response at Divisional level and process to ensure consistent approach is sustainable over time **(Action 1.1 / 4**). To provide assurance regarding Patient Information Leaflet audit to PIEG on an annual basis (**Action 1.1 / 5**) Local ownership of FFT results to enable improvements to be created and implemented at a local level **(Action 1.1 / 6)** **Work being undertaken to review the pathway for trans patients going through fertility prior to the commencement of hormone therapy.**	
	Utilisation of the Health Inequalities data within power BI to lead work between the Patient Experience Team and the Cultural Liaison Midwife to target areas of disparity.	Updates from these associated actions are presented and updated through the Patient Involvement and Experience Subcommittee.		
	Engagement with local groups lead by the Patient Experience Matron to listen to the concerns and required adjustments and improvements desired. These include the local Muslim mosque and Merseyside Deaf society	Updates from these interactions, and any associated actions are presented and updated through the Patient Involvement and Experience Subcommittee.		
	FFT Data now included EDI monitoring to allow experience reviews to be compared between groups with and without a protected characteristic	Data is presented at Patient Involvement and Experience Subcommittee.		
	Enhanced communication and patient experience for people with disabilities coming for care at the Trust as part of Reasonable Adjustment activities	Personalised Maternity Care Budgets/ Maternity Early Adopter and Pioneer site – LMS Cheshire and Mersey Patients with learning difficulties, mental health or autism spectrum are allowed relatives to stay with them throughout their stay. Pro-active admissions for these groups with preadmission and discharge planning Admission procedures and assessments e.g. MUST /VTE/ FALLS / risk assessment Maternity Pre-operative assessments Development of a Supporting Patients with Additional Needs Strategy		
	Barriers removed to access/health inequalities to maternity services for all with specific focus to migrant and asylum-seeking women	Barriers identified and measures put in place to remove e.g. Presence of representatives from MRANG in the antenatal clinic to support asylum seekers		
	Role created in patient experience team to improve engagement with the local community groups	Outcomes and progress overseen by the PIESC and the ED&I sub-committee.		
	Regular Divisional reporting on protected characteristics for staff and their experience	Reported to the EDI sub-committee		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.1 / 5	To create template for patient story capture and response at Divisional level and process to ensure consistent approach is sustainable over time	Head of Audit, Effectiveness and Patient Experience	December 2022	Patient Involvement & Experience Sub-Committee	Patient Experience Matron is developing a process for the effective sharing of lessons from patient stories through to the Divisions
1.1 / 6	To provide assurance regarding Patient Information Leaflet audit to PIEG on an annual basis	Head of Audit, Effectiveness and Patient Experience	January 2023	Patient Involvement & Experience Sub-Committee	Audit currently being undertaken to review the accessibility of PILs in terms of language.
1.1 / 7	Local ownership of FFT results to enable improvements to be created and implemented at a local level	Head of Audit, Effectiveness and Patient Experience	January 2023	Patient Involvement & Experience Sub-Committee	The results are reporting through to Divisions but further work required before this can be moved to an embedded control

BAF Risk 1.2: Failure to recruit & maintain a highly skilled & engaged workforce

Lead Director: CPO
Op Lead: Deputy Director of Workforce

Review Date: January 23

Strategic Priority: SA1: To develop a well led, capable, motivated and entrepreneurial workforce

Lead Committee: Putting People First

Provider Licence Compliance link:

N/A

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
20 (4 x 5)	20 (4 x 5)	20 (5 x 4)		⟷	16 (4x4)

Rationale for current risk score:

The Trust has acute and chronic staffing challenges in several areas and a sickness absence rate which has been consistently above target. Staff engagement scores are below the average for peer organisations as measured by the Annual Staff Survey. Maternity staffing issues are acute and have been exacerbated by absence linked to the Covid pandemic and low morale. The Trust has seen an increase in turnover associated with staff opting to leave the service or take retirement. There are significant challenges associated with specialist obstetric anaesthesia recruitment and theatre staffing. Other impacting factors include insufficient numbers of doctors in training, national shortage of nurses & midwives, the clinical risk associated with an isolated site impacting on the recruitment & retention of senior specialist medical staff, the impact of pension tax changes, the ongoing pandemic challenges, and the associated recovery of elective activity.

The Trust has been managing the impact of industrial action throughout 2022 whilst maintaining a BAF score of 20. Moving into 2023, it is likely that industrial action begins to be co-ordinated across the various unions and sectors. This will pose a severe and acute challenge to the Trust on those days, potentially to the extent which disrupts business to a 'catastrophic' extent (as defined by the risk descriptors in the Risk Management Strategy). This has been assessed as remaining 'likely' rather than' almost certain' – hence the risk rating has remained static.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust.	Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff.	Monthly KPI's for controls.	Quality of appraisals requires further improvement and monitoring **(Action 1.2 / 1)** Further evidence required that robust plans are being reviewed regularly at Divisional Board level **(Action 1.2 / 2)** Mandatory Training Compliance is currently not at required levels **(Action 1.2/3)**	
	LWH 'People Promise' to launch in 2022 – bringing together key strands of people strategy including behavioural framework	PPF		
	Behavioural framework developed in partnership with staff in 2021	PFF Committee, In the Loop, Great Place to Work Group		
	Great Place to Work Group Launched as a cross section of staff committed to improving staff experience and a source of two way communication	Great Place to work minutes to PPF		
	Consultant revalidation process.	Outcomes reported to PPF and the Board		
	Reward and recognition processes linked to values.	Monthly KPI's for controls.		
	Pay progression linked to mandatory training compliance	Monthly KPI's for controls.		
	Targeted OD intervention for areas in need to support.	PPF Committee		
	New Leadership Programme and Talent Management framework in place.	Leadership & Talent Strategy		
	Programme of health and wellbeing initiatives including launch of LWH Staff Support Service, recruitment of LWH Psychologist and Wellbeing Coaches	Reported to PPF Committee		
	All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities.	Monthly KPI's for controls.		
	Workforce planning processes in place to deliver safe staffing.	Divisional Board and Divisional Performance Reviews		
	Shared decision making with JLNC and Partnership Forum.	Chair's Report to PPF Committee		
	Putting People First Strategy	Progress reported to PPF Committee		
	Guardian of Safe Working.	Report form Guardian of Safe Working		
	PDR training programme in place and PDR window for band 7 and above in N&M commenced in 2021	Monthly KPI's for controls.		
	Two Freedom to Speak Up Guardians (including representation from a diverse and clinical background)	Bi-annual Speak Up Guardian Reports.		
	Whistle Blowing Policy	Annual Report to PPF and Audit Committee		
	Regular Local Staff Surveys	Quarterly internal staff survey (Let's Talk)		
	Quarterly Trust wide listening events- Big Conversation	Reports and feedback from Big Conversation into the Board and Divisional Boards		
	Divisional oversight of Mandatory training	Trajectories monitored via Divisional Boards		
	Mandatory training quarterly validation	Assurance that MT competencies are assigned correctly via sign off from practice educators and Heads of Nursing		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.2 / 1	To review indicators showing direction of travel for the quality of appraisals	Deputy Director of Workforce	November 2022	PPF Committee	Audit to PPF November
1.2 / 2	To receive assurance that Divisional Boards are effectively reviewing and updating workforce plans	Deputy Director of Workforce	February 2023	PPF Committee	Workforce plans for medical and non-medical staff to be presented as part of the annual planning process. Quarterly reporting of ED&I elements of ESR is being undertaken.
1.2 / 3	To receive assurance that mandatory training compliance is increasing	Deputy Director of Workforce	November 2022	PPF Committee	Audit to PPF November

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Covid-19 pandemic & associated elective recovery has the ongoing potential to impact staff morale, wellbeing and retention	Staff working from home where appropriate, use of virtual meetings and enhanced IT provision Refreshed staff absence process and monitoring with increased flexibility Regular staff communications Listening Event for staff completed to consider what further action the Trust could take to ensure staff are protected as much as possible. Specific sessions held for staff with protected characteristics. Risk Assessments undertaken for shielding & vulnerable staff	PPF Committee Feedback from staff side	None noted.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
N/A					

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Insufficient numbers of administrative and clinical staff resulting in a lack of capability to deliver safe care, effective outcomes and organisational objectives.	Annually agreed funding contract with HEE	PPF Committee, HEN Visit	Further utilisation of the rota management system. E-Rostering System not fully utilised **(Action 1.2 / 3)** Requirement for assurance that workforce plans are reviewing regularly at Divisional Board level **(Action 1.2 / 4)** Requirement to respond effectively to Ockenden recommendations regarding staffing **(Action 1.2 / 5)** Clinical risks associated with isolated site impact upon recruitment & retention of specialist medical staff **(Action 1.2 / 6)**	
	Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer.	Lead Employer notifies the Trust of Gaps in local rotations, giving the Trust autonomy to recruit at a local level into these gaps		
	Effective electronic rota management system for AFC staff implemented with doctors implemented by early 2022	PPF Committee		
	Director of medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN	Quarterly reporting by Guardian of Safe Working, GMC Survey		
	Guardian of Safe Working Hours appointed in 2016 under new Junior Doctor Contract.	Quarterly reporting by Guardian of Safe Working.		
	Acting down policy and process in place to cover junior doctor gaps	Quarterly reporting by Guardian of Safe Working.		
	National Revalidation process ensuring competent staff.	Revalidation report to PPF Committee		
	Shared decision making and review of risk with JLNC.	Chair's Report to PPF Committee		
	Succession Planning and Talent Programmes	PPF Committee		
	NHSE/I leadership programme to reduce sickness	PPF Committee		
	Shared appointments with other providers	PPF Committee		
	Secured operating time at the LUH	PPF Committee		
	Increased consultant recruitment with incentives Neonatal Partnership	PPF Committee		
	Maternity introduction of ACP Midwives	PPF Committee		
	Work underway to ensure that the number of staff without a Covid-19 vaccine is minimised	PPF Committee		
	Flexible working programme	PPF Committee		
	Bi-annual safe staffing reports	PPF Committee and Board		
	Birth rate Plus Report	Board		
	NHSP utilisation for bank staff			
	Preceptorship for nursing and midwifery staff			
	Strategic Medical Workforce group established for short and medium term workforce planning	Chair's report into PPF		
	Industrial action working group			

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.2 / 3	E-rostering system for doctors - Allocate is implemented for O&G and work commenced for other specialties	Deputy Director of Workforce	November 2022	PPF Committee	Roll out of the e-rostering system Allocate for Neonatal and Anaesthetics is ongoing. Project resource has been identified to progress and this work will be completed by Autumn 22 – *evidence required to move this into controls.*
1.2 / 4	To provide evidence that robust workforce plans are being reviewed regularly at Divisional Board	Deputy Director of Workforce	~~September 2022~~ April 23	PPF Committee	Workforce planning is a regular item at each Divisional Board – the evidence of this is reported through to DPRs. More evidence required that this 'robust' and can demonstrate maturity. Will be assessed as part of Divisional Governance maturity assessment – propose that

						deadline is amended accordingly.	
	1.2 / 5	Respond to Ockenden recommendations relating staffing	Deputy Director of Workforce	September 2022	PPF Committee	See Maternity Staffing report on February 23 Board agenda for more detail. Funding to fulfil Ockenden staffing requirements not yet fully secured – negotiations continue as part of budget setting.	
	1.2 / 6	To ensure that staffing issues are included and noted as a key risk in discussions regarding the single site risk.	CPO	On-going	Board		

Strategic Objective	SA2: To deliver SAFE services
Committee:	Quality Committee & Finance, Performance & Business Development Committee
Risk Appetite:	Low

Principal risks (BAF)	Risk Score
2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site	15 (3 x 5)
2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment	12 (3 x 4)
2.3 Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	20 (4 x 5)
2.4 Major and sustained failure of essential IT systems due to a cyber attack	20 (4 x 5)

Risk and Controls Summary

2084 - No change in risk score since last review. Last reviewed 01/09/22

2085 - No change in risk score since last review. Last reviewed 19/07/2022

2086 - No change in risk score since last review. Last reviewed 13/07/2022

2316 - No change in risk score since last review. Last reviewed 16/09/22

2296 - No change in risk score since last review. Last reviewed 13/07/22

2321 – Reduced from 16 to 12. Last reviewed 15/09/2022

2469 – No change in risk score since last review. Last reviewed 15/07/2022

2470 – No change in risk score since last review. Last reviewed 14/09/2022

2468 – NEWLY ADDED. Last reviewed 11/10/2022

2572, 2599, 2598, 2604 – NEWLY ADDED. Last reviewed 22/09/2022

2627 – NEWLY ADDED. Last reviewed 03/10/2022

2385 – NEWLY ADDED. Last reviewed 16/09/2022

Ref	BAF x REF	Corporate Risk Register / High Level (15+) Risks	Risk Score
1961	2.2	Risk to patient safety, including risk of misdiagnosis, inaccurate reporting of imaging findings, and lack of evidence that imaging has been performed on PACS.	16
2397	2.2	Following a recent serious incident, there is a risk that patients will not be informed of abnormal imaging results from LWH or external organisations when the results are received at the Trust	16
2341	2.3	There is a risk that during the Covid-19 pandemic, adult patients who suffer a cardiac arrest will receive suboptimal resuscitation	16
2386	2.4 & 2.2	Risk of personal and sensitive information being compromised or being misused	15
2316	2.3	Risk of women needing to access emergency care with pregnancy complications and not being able to access advice or care at the point needed. Impact on the safety of patients, (physical/psychological harm)	16
2446	2.2	A number of patients who had been waiting for Gynaecology surgery (P4) and had pre-operative scans that were missed / not reviewed in time, subsequently had escalation of diagnosis and further management plan.	16
2468	2.2	The Trust is currently delivering a high number of complex programmes concurrently which have multiple interdependencies and tight deadlines. This includes CSE, CDH, K2, Meditech Expanse roll out.	16
2572, 2599, 2598, 2604	2.3	There is a lack of strategic leadership and robust procedures to ensure the safety of people and assets within the Crown Street and Knutsford sites due to the absence of a national security framework and as a result of a commissioned review of trust security	16 (15)
2627	2.2	CAMRIN Digital solutions being reviewed	16
2385	2.4	Risk of 95% of the Trust staff are not adequately trained in Information Governance, Confidentiality and Data Protection, which includes bank staff and volunteers	15
2579 (CRR)	2.2 & 2.3	Delay articulating the staffing model for CT and MRI provided by the CDC and impact on difficulties staffing the X-Ray on call rota	15
2084 **(CRR)**	2.3	Uncertainty of adequacy of 24/7 access to specialist input to support changing patient profiles and needs, new guidance and the Chief Medical Officer's recommendation of the specialist multidisciplinary team approach to treatment planning and co-ordination, including pre-operative, surgical and up to level 3 post-operative care for improved patient safety and improved outcomes.	6
2085 **(CRR)**	2.3	Uncertainty around access to dedicated diagnostic capacity and physiological measurement needed to support needs of a changing patient demographics and an increase in complex multiple comorbidities and meeting the pre-operative assessment standards of the AAGBI and the RCoA, to assess patients' clinical risk and plan for additional requirements for their safety and provide an optimal experience.	12
2086 **(CRR)**	2.3	Uncertainty about provision of adequate on-site Blood bank stocking all major blood products necessary to support the needs of the Maternity service.	9
2296 **(CRR)**	2.2 & 2.3	The LWH laboratory autoview analyser (the machine used to process Blood Group and Save samples on site) will no longer be supported as of 1st March 2020. This machine cannot continue to be used after this date.	9
2321 **(CRR)**	2.3	Due to the Trust not being located next to or with acute services, it is unable to meet the National Recommendations for Maternal Medicine	12
2469 **(CRR)**	2.3	Allocation of resources to carry out water safety checks and maintenance has failed to achieve required targets despite prioritising this work and reducing resources for other tasks	9
2470 **(CRR)**	2.3	Water cold water temperatures in the new NICU build are being recorded as 2% higher than hospital cold water temperatures.	9

BAF Risk 2.1: Failure to progress our plans to build a new hospital co-located with an adult acute site

Lead Director: CFO
Op Lead: Head of Transformation & Strategy

Review Date: November 2022

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

Integrated Care Condition

SCORE:

May 2022	Q2	Q3	Q4	Q 3 Q movement	2022/23 Target
15 (3 x 5)	15 (3 x 5)	15 (3 x 5)		⟷	10 (2 x 5)

Rationale for current risk score:

The Trust's services being located on an isolated site away from adult acute services, remains the most significant risk to the organisation. The Trust can demonstrate strong controls in relation to developing the clinical evidence base for the move and has achieved buy in from all significant stakeholders for the case for change. The Liverpool Clinical Services Review has resulted in the acceptance of the isolated site risks as a system priority with plans in place to manage through a newly established sub-committee of the ICB. There remains however no clear route to capital funding and there is not yet clarity regarding programme pace.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Inability to effectively communicate the case for change with the local community and receive buy-in to move project forward.	Future Generations Strategy Update	Future Generations Strategy has been included within refreshed overall corporate strategy and is a key supporting strategy within Trust strategic framework. *The Trust's public facing Future Generations documents will now be refreshed to reflect ICB leadership of the programme going forwards.*	Further communication required of strategy and Future Generations position within strategy with local community, patients and public, to be led by the ICB. Further work required to engage women and their families in option appraisal process and model of care development, to be led by the ICB. Extent of direct engagement with patients and the public by the Trust to be determined. Case for change and counterfactual case not yet shared with public. The Trust will need to decide whether to share its case for change (including the counterfactual case) with the public. Public consultation required – this must be led by commissioners. Lobby local politicians and MPs for support.	
	Continuing dialogue with regulators	Support for Expression of Interest submitted 9th September 2021 from C&M. Trust has shared EOI with C&M partners, positive support received Regional and national NHSE leaders have visited the Trust and been briefed about the case for change, including Amanda Doyle, Jackie Dunkley-Bent, Ruth May, Lesley Regan CFO has met with national Director of Capital, Chris Jackson CEO has met with Regional Director, Richard Barker *The majority of dialogue with regulators will be led by the ICB in future. Chair and CEO will maintain ongoing dialogue with relevant key stakeholders at both national and regional level, as appropriate.* Trust Communications Team has established good links with respective teams at Place and the ICB and will support any future communication and engagement activities regarding the programme.		
	Continuing partnership with Liverpool University Hospitals	Partnership with Liverpool University Hospitals in place and strengthening. Shared dashboard and risk register under development. Shared review of relevant SIs.		
	Active management with all commissioners	Good meetings with ICB via Clinical Quality and Performance Group (CQPG) Relationships with key ICS stakeholders established Escalation of risks of isolated site to system level The Trust is working closely with ICB to plan pre-consultation engagement, engagement with HOSCs and draft consultation timeline. Meetings held with CIC, Spec Comm, Cancer Alliance Steering Group and Programme Board, Adult CCN and LMS and have received unambiguous support for the case for change from all stakeholder groups. Meeting held with specialised commissioners to discuss management of non-compliance with standards, where no further action can be taken by the Trust to mitigate non-compliance. Case for Change and Counterfactual Case presented to Shadow ICB in June 2022. Current LWH risk presented to ICB in August 2022. LWH MD is maintaining contact with ICB MD regarding level of clinical risk. LCSR commissioned and completed January 2023. Recommendations accepted. Programme re-set as system priority. *Active engagement with commissioners ongoing via newly established sub-committee of ICB.*		

	Future Generations Programme re-set as a system priority	The LCSR concluded in January 2023 and recommended that the programme is taken forward as a system priority, led by a specific sub-committee of the ICB, with two joint SROs, supported by a programme team. Sub-committee will involve commissioners, LWH, Alder Hey, Clatterbridge and Liverpool University Hospitals in refreshing the case for change and in engaging with other key partners.				

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.1 / 8	Maintain relationships with key ICS personnel	Medical Director	September 2022 - Ongoing	Board	
2.1/20	Refresh Future Generations Case for Change public facing documents	Associate Director of Strategy, Head of Communications	May 2023	Board	
2.1/21	Site visit at LWH with Graham Urwin, Raj Jain, David Sloman and Andrew Morris.	Medical Director	March 2023	Board	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Inability to effectively communicate the case for change with the local community and receive buy-in to move project forward.	Future Generations Strategy Update	Future Generations Strategy has been included within refreshed overall corporate strategy and is a key supporting strategy within Trust strategic framework. *The Trust's public facing Future Generations documents will now be refreshed to reflect ICB leadership of the programme going forwards.*	Further communication required of strategy and Future Generations position within strategy with local community, patients and public, to be led by the ICB. Further work required to engage women and their families in option appraisal process and model of care development, to be led by the ICB. Extent of direct engagement with patients and the public by the Trust to be determined. Case for change and counterfactual case not yet shared with public. The Trust will need to decide whether to share its case for change (including the counterfactual case) with the public. Public consultation required – this must be led by commissioners. Lobby local politicians and MPs for support.	
	Discussion of the case for change with MPs and local politicians	The Trust has held a series of briefing meetings with local MPs to explain the case for change and ask for their support. Ongoing dialogue and engagement as appropriate.		
	Comms and Engagement Activities	The Trust is working closely with ICB to plan pre-consultation engagement, and draft consultation timeline. Outcomes of previous engagement exercises has been reviewed - currently updating publicly available information. *The ICB is responsible for formal public engagement, the Trust. Trust Communications Team has established good links with respective teams at Place and the ICB and will actively participate in any future communication and engagement activities regarding the programme.*		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.1 / 7	Lobby systems and MPs for active support	Head of Communications and Marketing	September 2022 - Ongoing	Board	
2.1 / 17	Present case for change and counterfactual case at public Board meeting	Medical Director	TBC	Board	
2.1 / 18	Comms and engagement campaign and public engagement activities to support consultation, options appraisal, model of care development	Head of Communications and Marketing	July 2022 – ongoing	Board	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Failure to secure capital funding to progress our plans to build a new hospital co-located with an adult acute site	Submission of Expression of Interest to New Hospital Building Programme	Expression of interest submitted September 2021 Support for Expression of Interest submitted 9th September 2021 from C&M. Trust has shared EOI with C&M partners, positive support received Update received February 2023 – no decision regarding the 8 hospitals has been made.	No clear route to sufficient capital funding for a new build – access to capital is a pre-requisite for public consultation Lack of system support outside of Cheshire and Mersey to secure the capital case WHH scheme prioritised in C&M LWH scheme 6th priority across North West Funding option not yet agreed No progress in receipt of funding and delivery of new hospital schemes already approved under New Hospitals Programme	

	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status	
	2.1/ 19	Approval of EOI (external control of this by NHSE/I)	Chief Finance Officer	Date unknown, outside of LWH control	Board		

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Lack of control over programme pace and direction	Active participation in ICB sub-committee	Sub-committee of the ICB has been established with joint SROs. Trust has made suggestions regarding appropriate clinical SRO. Trust will actively engage with programme once established.	Formation of ICB sub-committee creating delays and repetition in programme. Ability to hold other participating organisations to account regarding timescales. Clarity needed regarding route of assurance for LWH Board regarding programme progress. ICB programme resource not yet clear.	
	Continued management and monitoring of isolated site risks	On going monitoring and management of risks caused by isolated site. Regular reports to the Board.		
	Information sharing	The Trust will share with the ICB all information and intelligence produced to date as part of the Future Generations Programme, as requested, including the continued monitoring of the isolated site risks. The Trust will support the ICB by carrying out analysis and information gathering where requested.		
	Continuing partnership with Liverpool University Hospitals	Partnership with Liverpool University Hospitals in place and strengthening. Shared estates modelling work underway.		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.1/3	Refreshed estates modelling and schedule of accommodation for new build, reviewed as part of planned estates workshop with LUHFT and Carnall Farrar.	Associate Director of Strategy Director of Estates and Facilities, LUHFT	March 2023	Board	

BAF Risk 2.2: Failure to develop our model of care to keep pace with developments and respond to a changing environment

Lead Director: COO
Op Lead: Deputy COO

Review Date: November 22

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
16 (4 x 4)	16 (4 x 4)	16 (4 x 4)		⟷	12 (3x4)

Rationale for current risk score:

The lack of an EPR (and as a corollary, having in place a disparate number of systems), remains a significant risk to the organisation because information is spread across disparate systems leading to information being incomplete, hard to find in a timely manner and a potential for inaccuracies due to manual transfer of information. However, there is evidence of pro-active mitigating controls and progress being made in the procurement and subsequent implementation of an integrated Meditech EPR system. The Trust can demonstrate evidence of being open and responsive to change in service development and delivery, but further work can be done to strengthen the approach to horizon scanning and longer term, strategic planning at a Divisional level.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Trust's current clinical records system (paper and Electronic) are sub-optimal.	Approved Digital Generations Strategy	Quarterly risk assessments completed FPBD Committee overview and scrutiny Digital Hospital Committee oversight Approved EPR Business case which define clear direction and preferred solution. EPR programme board chaired by MD Independent lessons learnt Positive review MIAA Critical Application Audit (rolling programme across trust systems) Reporting into Audit Committee and Digital Hospital Group	Multiple Clinical Systems issues remain **(Action 2.2 / 2)** Ability of clinical staff to engage with the system development due to time and financial impact **(Actions 2.2 / 1, 2.2 / 3, 2.2 / 4)** ICS wide Shared Care Record programme not fully implemented/ active programme of work**)**	
	Approved Meditech Expanse Business Case			
	Maintenance of present system			
	Development of individual / service solutions e.g. PENs (Gynaecology) and Staff training			
	Incident reporting			
	Tactical solutions including the implementation of K2 Athena system			
	Exchange/LHCRE enables for patent information sharing			
	Virtual Desktop technology to aid staff working flexibly.			
	Additional network resilience for LUHFT supplied systems (K2/PENS/CRIS) to reduce risk of unplanned systems downtime			
	PACS upgrade removes a separate login for that system, reducing multiple systems issues.			
	Task and Finish group established to ensure that clinical investigation undertaken at external trusts have been actioned accordingly.	Safety and Effectiveness Sub-Committee		
	Appropriate task and finish groups established as required by Safety and Effectiveness sub-committee	Safety and Effectiveness Sub-Committee		
	Digital clinical leadership business case developed	Digital Hospital Sub-Committee		
	Optimisations to K2 system and refinements implemented	Digital Hospital Sub-Committee		
	Ongoing review of systems and mitigations quarterly	FPBD & QC		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.2 / 1	Develop staff communication plan for new system	CIO	December 2022	Digital Hospital Committee oversight	The comms plan is completed and signed off at EPR Programme Board. It is a living document that will evolve during the course of the programme.
2.2 / 3	Issue appropriate communication to all staff in relation to digital development by multiple means and forms	CIO	January 2023	Digital Hospital Committee oversight	This is largely being achieved through the CAGE, and Ops engagement, aswell as business process mapping workshops. What we still lack is dedicated comms officer to issue regular comms and the adoption of change agents. We expect both to be completed by end of Jan, following funding.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Clinical service strategies that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities	Operational 'Plans on a page' for Divisions – incorporates horizon scanning section Operational planning process Availability of data on service trends and demographics Workforce plans	Divisional Board meetings Operational plans and budgets Divisional Boards Divisional Boards	To improve horizon scanning processes to constantly review and update plans on a page **(Action 2.2 / 7)** To understand commissioning priorities emerging from developing ICS **(Action 2.2 / 7)** To ensure that Divisions are fully utilising data to understand changing service demands **(Action 2.2 / 8)** To ensure that workforce plans are informed by trends and data led intelligence. **(Action 2.2 / 9)**	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.2 / 8	To ensure that Divisions are fully utilising data to understand changing service demands	Deputy COO	~~September 2022~~ April 2023	Executive Team	5 year transformational plans include section on horizon scanning to support future planning – further evidence required that data is being utilised as effectively as possible to support this. Updated performance reports will support this. Suggest that deadline is amended to reflect the need to assess the maturity of this process.
2.2 / 9	To ensure that workforce plans are informed by trends and data led intelligence.	Deputy COO	~~September 2022~~ April 23	Executive Team	See action 1.2 / 4

BAF Risk 2.3: Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system

Lead Director: Chief Operating Officer
Op Lead: Head of Strategy & Transformation

Review Date: November 2022

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Quality Committee

Provider Licence Compliance link:

N/A

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
20 (4 x 5)	20 (4 x 5)	20 (4x5)		⟷	15 (3 x 5)

Rationale for current risk score:

The Trust's services being located on an isolated site away from an acute centre, remains the most significant risk to the organisation and to patient safety. Good progress is being made on mitigating measures to make the Crown Street site safer with a number of significant capital projects either completed, underway or planned. It should be acknowledged that the impact of this risk cannot be fully mitigated whilst the Trust operates on an isolated site, and that following the implementation of the actions outlined below, the Trust does not believe that any further mitigation is possible. This view was recently confirmed by an independent review undertaken by the Northern England Clinical Senate, in February 2022.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Location, size, layout and accessibility of current services do not provide for sustainable integrated care or safe and high-quality service provision.	Programme for a partnership in relation to Neonates with AHCH has been established.	Neonatal partnership updates provided to the Board	Transfers are often subject to delay due to the Trust being considered a 'place of safety'. Transfer of adults requires accompanying clinical staff, which can lead to staffing pressures on the ward. **(Action 2.3/2)** Onsite and partnership mitigations cannot fully address the clinical risk - this can only be achieved through co-location. Arrangements not formally agreed and underpinned by detailed SLA. **(Action 2.3/3)** Lack of 24/7 transfusion laboratory on site leads to delay in patients receiving transfusion. **(Action 2.3/4, 2.3/5)** Emerging clinical standard leading to potential loss of services and increase in difficulty in relation to recruitment of consultants. Twilight cover to be in place from April 2022 (Maternity) and January 2022 (Neonates). There remains an on-going challenge in relation to Anaesthetics recruitment. **(Action 2.3/6)** Financial and workforce constraints for delivery of additional facilities on site. **(Action 2.3 / 1)** Construction works not yet complete to accommodate new FMU, colposcopy suite, CT & MR Imaging suites – due to complete December 2022 **(Action 2.3/8)** 24/7 transfusion laboratory not yet established – aim for completion September 2022 **(Action 2.3/4)** Colposcopy decant not yet complete – aim for completion June 2022 **(Action 2.3/9)** Full CDC Services not yet implemented **(Action 2.3 / 10)** Signed SLA with LUHFT required **(Action 2.3 /3)**	
	£15m capital investment in neonatal estate to address infection risk	IPC Reports		
	Transfer arrangements well established for neonates	Transfers out monitored by Partnership		
	Transfer arrangements for adults	Transfers out monitored at HDU Group		
	Formal partnership and board established with Liverpool Universities Hospitals with respect to: -Diagnostics -Medical and surgical expertise -Intensive care facilities -Theatre access at Liverpool Universities Hospitals for women with Gynae cancers -Provision of maternity expertise at LUHFT sites -Provision of Gynaecology expertise at LUHFT sites -Placenta accreta service, including specialist imaging and supervision of review from Sheffield Teaching Hospitals NHS FT	Partnership activity to report through to FPBD and Board on a quarterly basis		
	Blood product provision by motorised vehicle from nearby facility, with revised protocols in place to prioritise transport of blood products.	Serious incidents, should they occur are tracked and reported through the governance framework,		
	Investments in additional staffing inc. towards 24/7 cover - Maternity	Staff Staffing levels reports to board		
	Investments in additional staffing inc. towards 24/7 cover - Anaesthetics joint anaesthetic appointments with LUHFT	Staff Staffing levels reports to board		
	Investments in additional staffing inc. towards 24/7 cover – Gynaecology, including additional investment in ANP roles within GED	Staff Staffing levels reports to board		
	Investments in additional staffing inc. towards 24/7 cover - Neonates	Staff Staffing levels reports to board		
	Enhanced resuscitation training provision - Paediatric	Training compliance rates reported to PPF Committee		
	LWH appointed at C&M Maternal Medicine Centre	LWH working as part of NW Maternal Medicine Network		
	Enhanced resuscitation training provision - Adult	Training compliance rates reported to PPF Committee		
	Crown Street Enhancements Programme Board established to oversee: -Construction work required to accommodate new FMU, colposcopy suite, CT & MR Imaging suites (ongoing) -Implementation of Robotic Assisted Surgery (complete) -Implementation of 24/7 transfusion laboratory on site (ongoing) -Decant into and new ways of working within FMU (complete) -Decant into and new ways of working within colposcopy (ongoing)	Crown Street Enhancements Programme progress reviewed monthly at FPBD		
	Community Diagnostic Centre established at Crown Street, to include the following diagnostics with access for LWH patients: -Imaging – CT, MR, X-ray, ultrasound -Physiological – ECHO, ECG, BP monitoring, Spiro, FeNO, Sleep studies Mannitol -Phlebotomy -Pathology	Community Diagnostic Centre Oversight Group reviews progress on a fortnightly basis. Progress also reported to and monitored by regional CDC Programme Board. Mobile CT and respiratory testing operational.		
	Divisional Operational Plans completed	Divisional Boards		
	Use of telemedicine to facilitate consultations both at Crown Street and other sites	Divisional Boards		
	Historic controls still in place include: -Use of cell salvage& ROTEM -Innovative use of bedside clotting analysis and fibrinogen concentrates -Early order of blood products (high wastage)	Quality Committee		

	-Out of hours transfusion lab provided off-site by LCL Outreach midwife post -AN & Gynae outpatient service at Aintree Hospital -Gynaecology Tier 2 rota providing cover for LWH and Liverpool Place -Expanded role of anaesthetists to cover HDU patients and provide pain service -Additional pain service provided by Walton Centre, with psychologist input -Uoskilling of HDU staff -Joint clinics -SLAs in place for clinical support services from LUHFT -Ambulance transfer of patients for urgent imaging or other diagnostics not currently provided on site -Planned pre-op diagnostics provided off-site by LUHFT -Appointment of resus officers, upgrading of resus trolleys and provision of automated defibrillator trolleys -Existing informal links with partner organisations -ANP roles -Transfer of patients for urgent imaging and critical care -Theatre slots at LUHFT with access to colorectal surgeons -Purchase of sentinel node biopsy and 3D laparoscopic kit -ACHD Partnership				
	Progress being made in relation to building relationships with LUFT - Task and finish groups established, reporting into the Partnership Board with LUHFT setting out arrangements for partnership working across all four LWH and LUHFT sites	Partnership Board meetings and involvement in wider Estates Strategy Mapping of requirements from and interdependencies with LUHFT across all Trust specialties			
	Agreed funding for all mitigations on site are included in operational planning	FPBD (monthly oversight reports and detailed budget)			
	A telemedicine pilot has been implemented to provide additional support for pregnant women on ITU at the Royal Liverpool Hospital.	Single Site risk report – provided to July 2022 Board			
	SOP implemented for paediatric resus provision	Safety and Effectiveness Senate – received update in January 2022			
	Liverpool Clinical Services Review (LCSR) established	Engagement from appropriate Executives in designated working groups			

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.3 / 3	Detailed agreements to form part of SLA with LUHFT, clearly explaining routes of access and expectations of both organisations.	Deputy Chief Finance Officer	December 2022	Partnership Board, TBDG	The sub groups for the partnership have not determined the content of the SLA schedules yet
2.3 / 4	Project to establish 24/7 transfusion laboratory on site at Crown Street	Head of AHPs	March 2023	Crown Street Enhancements Programme Board, FPBD	Staffing continues to be an issue that requires resolution
2.3 / 5	Implement remote issue of blood products to minimise delay in transfusion	Head of AHPs	TBC (pending information from Liverpool Clinical Laboratories regarding training)	Crown Street Enhancements Programme Board, FPBD	Additional IT issues encountered
2.3 / 6	Continue to recruit to secure 24/7 Anaesthetics cover	Clinical Directors	January 2023	TBDG	
2.3 / 12	Complete construction of CT imaging suite	Associate Director of Strategy	December 2022	Crown Street Enhancements Programme Board, FPBD	
2.3 / 13	Complete construction of MR imaging suite	Associate Director of Strategy	February 2023	Crown Street Enhancements Programme Board, FPBD	
2.3 / 9	Project to manage decant and new ways of working within colposcopy	Deputy Divisional Manager for Gynaecology	November 2022	Crown Street Enhancements Programme Board, FPBD	Complete
2.3 / 10	Deliver CDC project plan to establish CDC services: -Imaging – CT, MR, X-ray, ultrasound -Physiological – ECHO, ECG, BP monitoring, Spiro, FeNO, Sleep studies -Phlebotomy	Deputy Chief Operating Officer	December 2022	CDC Oversight Group, FPBD	

BAF Risk 2.4: Major and sustained failure of essential IT systems due to a cyber attack

Lead Director: CIO
Op Lead: CIO

Review Date: November 2022

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: FPBD Committee

Provider Licence Compliance link:

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
20 (4x5)	20 (4x5)	20 (4x5)		⟷	15 (3x5)

Rationale for current risk score:

The Trust's Digital Services department places cyber security management at the core of operational activities, ensuring it maintains its Cyber Essentials standard. Various controls are implemented that are considered effective and this reduces the likelihood of a cyber-attack impact. However, if a cyber-attack was successful the impact would likely be catastrophic to Trust services, likely rendering digital systems that clinical services are increasingly dependent on, unavailable for a period of time. The Digital Services department continue to strengthen controls through process refinement and the introduction of security technologies. On the basis of this, the impact is considered catastrophic (5). Due to recent world events, the environment risk or likelihood for a cyber-attack has increased from possible (3) to likely (4) due to increased cyber threats from Russia. The NHS has reflected the increased threat through guidance issued to all NHS providers and arm's length bodies during March 2022.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective cyber controls and technology, inadequate investment in systems and infrastructure, failure in skills or capacity of staff or service providers, poor end user culture regarding cyber security and IT systems use, inadequate contract management. **Consequence: Reduced quality or safety of services, financial penalties, reduced patient experience, loss of reputation, loss of market share / commissioner contracts.**	Microsoft Windows security and critical patches applied to all Trust servers on all servers\laptops and desktop devices on a monthly basis. Network switches and firewalls have firmware updates as and when required installed. Wifi network firmware patches applied for Controllers and Access points. Mobile end devices patched as and when released by the vendor. Externally managed network service provider to ensure network is a securely managed with underpinning contract. Robust CareCert process to enact advice from NHS Digital regarding imminent threats. Network perimeter controls (Firewall) to protect against unauthorised external intrusion. Robust Information Governance training on information security and cyber security good practice. Regular staff educational communications on types of cyber threats and advice on secure working of Trust IT systems. Additional cybersecurity communications in relation to Covid phishing/ scams, advising diligence. Enhanced VPN solution including increased capacity to secure home working connections into the Trust. Review and updating of information security policies and home working IG guidance to support staff who are remote working. Malware protection identifies and removes known cyber threats and viruses within the Trust's network and at the network boundaries. Cyber Security Monitoring System identifies suspicious network and potential cyber threat behaviour. National CareCert alerts inform of known and imminent cyberthreats and vulnerabilities Mobile device management – providing enhanced security for mobile devices Cyber Security Strategy	Cyber Essentials Plus Standards/KPIs IMT Risk Management Meeting Digital Hospital Sub Committee Medical Devices Committee MIAA Cyber Controls Review Cyber Essentials Plus Accreditation Cyber Penetration Test NHS Care Cert Compliance	Lack of Cyber Security strategy **(Action 2.4 / 1)** Lack of Network Access Controls within the physical network **(Action 2.4 / 2)** Effective USB port control **(Action 2.4/ 3)** Lack of visibility of medical devices **(Action 2.4 / 4)**	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.4 / 2	Procure and implement Network Access Control (NAC) solution	CIO	March 2023	DHSC	Procured. Planning session with supplier scheduled 1st week of November. Implementation plan to follow with revised fully implemented date March 2023
2.4 / 3	Purchase and implement software for USB port control	CIO	March 2023	DHSC	Procured and solution is installed. Due to the invasive nature of the system, it is currently configured for monitoring mode. Assessment of the data collected to follow with port control policies to be implemented by March 2023
2.4 / 4	Improve grip, control and governance on medical devices	CIO	March 2023	Medical Devices / DHSC	Digital attendance at Medical Devices Committee. Asset inventory of medical devices under review. Funding for Digital solution to protect medical devices submitted to ICS in October.

Strategic Objective	SA3: To deliver the best possible EXPERIENCE for patients and staff
Committee:	Quality Committee
Risk Appetite:	Low

Principal risks (BAF)	Risk Score
3.1 Failure to deliver an excellent patient and family experience to all our service users	12 (3 x 4)

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

2430 - No change in risk score since last review. Last reviewed 14/09/2022.

2418 - No change in risk score since last review. Last reviewed 16/08/2022.

1966 - No change in risk score since last review. Last reviewed 12/09/2022.

2088 - No change in risk score since last review. Last reviewed 14/09/2022

2472 – NEWLY ADDED. Last reviewed 13/07/2022

2485 – NEWLY ADDED. Last reviewed 10/11/2021

2606 – NEWLY ADDED. Last reviewed 26/08/2022

2488 – NEWLY ADDED. Last reviewed 12/10/2022

Ref	BAF X REF	Corporate Risk Register / High Level (15+) Risks	Risk Score
2418	3.1	Lack of support and appropriate care for patients presenting with mental health conditions	16
2430	3.1	Network outlier for pre-term mortality - rate is higher than the national average	16
2427	3.1	Covid lockdown between March 2020 and July 2020 and then September 2020 and subsequently December 2020 to March 2021, resulting in prolonged wait for elective surgery for benign gynaecologic procedures	16
2350	3.1	Due to the need to reduce patient attendance / stop elective activity and adhere to social distancing as a result of Covid-19 a number of services within Gynaecology have had to cease or changes the way in which they are delivered	15
2304	3.1	Failure to achieve 31 day and 62 day national cancer targets, and having monthly 104 day breaches	16
2472	3.1	All twenty delivery suite beds (Hilrom) in use are not fit for purpose	20
2485	3.1	Limited access to MRI scan (currently 5-6 weeks wait) needed for cancer patient pre treatment (both surgical and radiotherapy treatment).	16
2606 (CRR)	3.1	failure to comply with national infection trajectory specifically in relation to E.coli bacteraemia	10
1966 **(CRR)**	3.1	Risk of safety incidents occurring when undertaking invasive procedures	12
2088 **(CRR)**	3.1	Lack of on-site specialist paediatric care and support services Neonatal surgery provision and Level 3 neonatal intensive care unit and lack of on-site provision for CT & MRI scanning and Blood bank and Transfusion Lab.	12
2488 (CRR)	3.1	Failure to meet clinical demand for red blood cells	9
2603 (CRR)	3.1	Current Intranet in poor condition and no longer fit for purpose	9

BAF Risk 3.1: Failure to deliver an excellent patient and family experience to all our service users

Lead Director: CN&M
Op Lead: Deputy Director of Nursing & Midwifery

Review Date: November 2022

Strategic Priority: SA3: To deliver the best possible EXPERIENCE for patients and staff

Lead Committee: Quality Committee

Provider Licence Compliance link:

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
12 (3 x 4)	12 (3 x 4)	12 (3 x 4)		⟷	12 (3 x 4)

Rationale for current risk score:

To improve further, it is imperative that the organisation ensures that it can listen to patient voices and the local community and ensure that services are responsive and can cater to differing needs. The evidence for how effective the organisation is undertaking this can be strengthened from the current position.

The Ockenden Final Report made several comments about the importance of trusts listening effectively to the patient voice and strengthening the Trust's approach to this will be a significant area of priority during 2022/23. Considering the importance of this and the fact that available controls / assurances remain limited in this area, the target score for 2022/23 has been set at '12' to reflect the current reality.

Following the operational pressures faced as a result of the COVID pandemic, a large number of patients had their treatment and appointments delayed as a result of changes to clinical capacity. This has led to an increasing number of patients waiting beyond 52 weeks to receive their treatment. Continued rises in referrals from Primary Care and an increasing backlog of patients to be seen has led to delays in care and deterioration of Trust performance in relation to national Referral to Treatment (RTT) standards

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Unable to adequately listen to patient voices and our local communities	Women, babies and their families experience strategy 2021 - 2026	Patient Involvement & Experience Sub-Committee review the progress against the Women's, Babies and Families Experience Strategy. This is undertaken in June of each year and any concerns are escalated to the Quality Committee via the Chairs report.	External MVP involvement in reviewing complaints processes All information should be reviewed by the Divisional Board prior to coming to PIESC Evidence how the divisions are using this data to influence their service design and improvements Recent patient/women's stories to Trust Board have highlighted that the Heads of Service have not always been aware of the story that was being shared, at Trust Board, that reflected on the care provided within their division. This has resulted in a lack of opportunity for senior presence at the Trust Board meeting to answer any questions and identify actions that have been put into place in relation to the patient/women's experience within their Care Group, this also shows lack of assurance patient stories are shared at local divisional level No set policy/process for Experience based co design policy to listen to patient voices when service changes are needed. QI projects need to be developed from patient voices and experience based co-design.	
	PALs and Complaints data	Patient Involvement & Experience Sub-Committee review PALs and Complaint data quarterly via the Themes and Trend report, and any concerns raised are escalated to the Quality Committee via the Chairs report.		
	Patient Stories to Board	The Trust Board Meeting has a patient/women's story to Board most months throughout the year.		
	Friends and Family Test	Patient Involvement & Experience Sub-Committee review the Friends and Family themes and trends quarterly. Friends and Family also form part of the Trust Performance report that each Division must review. More recently a new KPI regarding displeased comments has been added. This has given each area the opportunity to review displeased comments and act on them. This also enables the areas to display the 'you said we did' data out in the areas.		
	National Patient Surveys	Patient Involvement & Experience Sub-Committee review the results of the National Maternity Survey, National Inpatient Survey and the National Cancer Survey Annually. All surveys are also reviewed by the Trust Quality Committee.		
	Healthwatch feedback	Patient Involvement & Experience Sub-Committee have both Healthwatch Sefton and Healthwatch Liverpool on the group as active participants.		
	Social media feedback	Patient Involvement & Experience Sub-Committee review as part of the quarterly themes and trends reports as working with the Communications team all social media comments are sent through to PEX to review and action.		
	Membership feedback	Council of Governors		
	Patient Experience Matron in place to build relationships with local community leaders and mechanisms for hearing feedback on the Trust's services	Reports on community engagement and relationships via the Patient Involvement and Experience Sub-Committee and attends CoG Comms and Engagement Group to share experiences		
	Bespoke Patient Surveys	Patient Involvement & Experience Sub-Committee review ad hoc		
	Patient experience review reports produced by the Divisions and reported to PIESC	Patient Involvement & Experience Sub-Committee listen to the Patient Experience Strategy updates from each Division via the Patient Experience review paper and any patient experience intelligence that they have.		
	BBAS – Ward Accreditation Scheme	Safety and Effectiveness Sub Committee review the BBAS quarterly and any issues are escalated to the Quality Committee via the chairs report. Patient Experience Matron forms part of the accreditation team		
	PLACE assessment	Patient Involvement & Experience Sub-Committee review the outcomes form the PLACE assessment, this is also on the Quality Committee		
	MVP	Patient Experience Matron attends the MVP meetings and MVP chair is part of the circulation list for PIESC		
	Care Opinion	Patient Involvement & Experience Sub-Committee review the Friends and Family themes and trends quarterly,		
	Patient Experience Walkabouts	Patient Involvement & Experience Sub-Committee review the Friends and Family themes and trends quarterly,		

	Matron Walkabouts	Matrons' operation group reviews the feedback gained and issues escalated on the chairs report to the Nursing and Professional forum				
	Non-Executive Director Quality Walkabouts	Quality Committee review the results from each walkabout ??				
	Gap Reference	**Required Action**	**Lead**	**Implement By**	**Monitoring**	**Status**
	3.1 / 1	MVP to conduct a review of complaints process	Head of Audit, effectiveness, and Patient Experience	~~October 2022~~ March 23	Patient Involvement & Experience Sub-Committee	MVP chair linked in with the Deputy Head of Experience and the Patient Experience Matron. MVP chair also is now part of the Patient Involvement and Experience Distribution list and will attend meetings when available as works just 3 days per month. Suggested to amend deadline as new MVP Chair only in post from late 2022.
	3.1 / 2	Formal process implemented to track and monitor bespoke surveys requested.	Head of Audit, effectiveness, and Patient Experience	November 2022	Patient Involvement & Experience Sub-Committee	SOP developed and on the agenda for the Dec 22 Patient Involvement and Experience Sub Committee
	3.1 / 4	Development of a process to share the board presented patient stories to a wider audience such as divisional board and team meetings.	Patient Experience Matron. Head of Comms. Divisional Management Teams	December 2022	Patient Involvement & Experience Sub-Committee	The PEX matron and Deputy Chief Nurse have developed a SOP that will be used by each area with regards to Patient Stories.
	3.1 / 11	Divisional Boards to review Patient Experience Data prior to being reviewed by the Patient Involvement and Experience Sub Committee	Divisional Management Teams	~~Feb 23~~ May 23	Patient Involvement & Experience Sub-Committee	
	3.1 /12	To develop a SOP for Experience based co design to listen to patient voices when service changes are needed.	Head of Audit, effectiveness, and Patient Experience	Feb 23	Patient Involvement & Experience Sub-Committee	
	3.1 / 13	QI projects need to be developed from patient voices and experience-based co-design.	Quality Manager	Feb 23	Quality Improvement Group	

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
Failure to act on the feedback provided by patients, carers, and the local communities.	Managing Concerns and Complaints Policy	Complaints annual report is approved by Quality Committee and the Quarterly themes and trends report is discussed at Patient Involvement and Experience Sub Committee. The Integrated Governance report included Patient Experience data and is reviewed at Quality Committee.	MVP review needed of complaints actions and themes for improvement presented at PIESC No formal process in place to monitor the completion of complaint/ PALS+ action plans on the Ulysses system. Poor performance against Trust KPI for displeased FFT responses and you said we did in the areas and updating power bi No documented processes for all feedback received i.e., National Surveys, FFT PLACE assessments feedback	
	Annual Quality Schedule returns to the ICB (WELL-LED-01CARING-01)	The Quality schedule is reviewed by the ICB and this covers an annual submission for Well Led 01 and Caring 01. The reports are also discussed at the CQPG.		
	Women, babies and their families experience strategy 2021 - 2026	Patient Involvement & Experience Sub-Committee review the progress against the Women's, Babies and Families Experience Strategy. This is undertaken in June of each year and any concerns are escalated to the Quality Committee via the Chairs report.		
	KPI for displeased Friends and Family	Performance Reports are discussed at Quality Committee		
	KPI for Complaint responses	Performance Reports are discussed at Quality Committee		
	KPI for Complaint action plans	Performance Reports are discussed at Quality Committee		
	K041 national return	External to NHSE digital to monitor the complaints activity		

Gap Reference	**Required Action**	**Lead**	**Implement By**	**Monitoring**	**Status**
3.1 / 5	MVP to become involved in the review of information presented at PIESC	Head of Audit, Effectiveness and Patient Experience	October 2022	Patient Involvement & Experience Sub-Committee	MVP chair linked in with the Deputy Head of Experience and the Patient Experience Matron. MVP chair also is now part of the Patient Involvement and Experience Distribution list and will attend meetings when available as works just 3 days per month.
3.1 / 7	Improvement of compliance against Trust KPI relating to displeased comments in FFT and to ensure that Power BI is updated so the 'You said we did data' can be extracted	Divisional Management Teams	Feb 2023	Patient Involvement & Experience Sub-Committee	This is being monitored by the Patient Involvement and Experience Sub Committee and there are improvements in some areas.
3.1 / 14	To develop a SOP to document the process for when feedback is received and what needs to be completed in the Divisions.	Head of Audit, Effectiveness and Patient Experience	Feb 2023	Patient Involvement & Experience Sub-Committee	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Lack of clinical capacity and resources i.e. workforce, estate etc. to treat patients in a timely manner resulting in delays in treatment and deterioration in Trust Performance standards	Fortnightly Access Board meetings with Divisional Operational Teams and Information present monitoring key performance	FPBD and Board meetings	Gaps in effective delivery of Access Policy including training of staff associated with RTT pathway management Gaps in Standard Operating Procedures for management of patient pathways Timescales for delivery of key elective recovery programme actions 3.1/10 – Work to reconfigure the MLU estate to maximise efficiencies for IoL.	
	Daily monitoring of performance through Power BI dashboards – daily and weekly updates on key performance metrics	Integrated Performance Report		
	Weekly Patient Tracking List (PTL) meetings with Divisional Operational teams and Patient Access	Access Board		
	Elective Recovery Programme in place with workstreams to improve performance and reduce waits	FPBD Executive Team reporting		
	External validation programme of work reviewing all admitted and non-admitted pathways to ensure RTT guidance being applied correctly	Access Board		
	Review of Medical & Nursing job plans to ensure capacity in place to treat patients in a timely manner	Updates via Divisional Performance Reviews and Hospital Management Meetings		
	Cancer Committee – meets bi-monthly to review Cancer performance and track actions to improve performance	FPBD		
	Theatre Utilisation Group	Updates via Divisional Performance Reviews and Hospital Management Meetings		
	Text reminder service to reduce DNA's and ensure patients still require appointments – facility in place if they wish to change or cancel appointments	Monitoring through Access Board		
	Patient Initiated Follow-Ups – to minimise numbers of patients who no longer require follow up to release capacity	Monitoring through Access Board		
	Locum Consultant in place for Gynaecology to increase clinical capacity	Updates via Divisional Performance Reviews and Hospital Management Meetings		
	Sub-specialisation of Gynaecology and sub-specialty recovery plans in place to monitor actions/risks at a sub specialty level and establish performance trajectories to deliver improvements	Updates via Divisional Performance Reviews and Hospital Management Meetings/Access Board		
	Controls in place to monitor length of stay for women in induction of labour - Daily safety huddles - IoL metrics included on Executive and SLT live dashboards - C&M weekly maternity escalation cell	Bi-annual workforce report		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
3.1/8	Continue to provide updates to the Board regarding the Elective Recovery Plan through Divisional Performance Reviews and to FPBD on a monthly basis through the Integrated Performance Report	Deputy COO	On-going	Board	
3.1/ 9	Access Policy review and delivery of SOP's via Waiting List Management audit action plan	Patient Access Lead	December 2022	Access Board	
3.1/ 10	Work to reconfigure the MLU estate to maximise efficiencies for IoL.	FH Div Manager	January 2023	Exec DPR	

Strategic Objective	SA4: To be ambitious and EFFICIENT and make the best use of available resources
Committee:	Finance, Performance and Business Development Committee
Risk Appetite:	Moderate

Principal risks (BAF)	Risk Score
4.1 Failure to ensure our services are financially sustainable in the long term	20 (5 x 4)
4.2 Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	8 (2 x 4)
4.3 Failure to deliver the agreed 2022/23 financial plan	20 (5 x 4)

Ref	BAF X REF	Corporate Risk Register / High Level (15+) Risks	Risk Score
2621 (CRR)	4.1	The Trust's external auditors have informed LWH that they are unable to honour their commitment to undertake the 22/23 (and 23/24 and 24/25) external audits in line with national timelines. They can undertake the 22/23 audit, but this would be late.	8

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

2621 – NEWLY ADDED – Last reviewed 14/09/2022

Review 14/2/23:

Updated delivery date for action 4.1/1 to allow for outputs of 23/24 operational planning

Proposal to increase BAF risk 4.3 from 16 (4x4) to 20 (5x4) 'almost certain' given financial position at month 10 and overall assurance rating noted as 'red'.

updates to narrative (tracked changes)

BAF Risk 4.1: Failure to ensure our services are financially sustainable in the long term

Lead Director: CFO
Op Lead: Deputy CFO

Review Date: February 23

Strategic Priority: SA4: To be ambitious and EFFICIENT and make the best use of available resources

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
20 (5 x 4)	20 (5 x 4)	20 (5 x 4)		⟷	16 (4 x 4)

Rationale for current risk score:

The Trust has a well-defined and evidence backed case that whilst it remains on an isolated site, it is not financially sustainable. This position is worsening each year as the impact of prior capital investment, ongoing and increasing revenue investment in staying safe on site, and other pressures such as CNST premium costs and the costs of implementing Ockenden actions are added into the cost base. The financial regime is becoming more constrained into 2022/23 and beyond, as Cheshire and Merseyside are deemed above target funding and so has had a convergence factor in addition to the efficiency requirement applied.

The emerging Integrated Care System and region have a clear understanding of the Trust's underlying deficit however due to the overall constraints on the financial position are not able to guarantee that a shortfall in funding will not be in place. Additional funding may be available e.g., through Ockenden but is unlikely to be sufficient to meet the Trust's requirements. If deficits are in place year on year further cost will be added associated with revenue cash support.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Trust is not financially sustainable in the long term	5 Year financial model produced giving early indication of issues	5 Year plan approved (BoD Nov 2014) indicating long term sustainability issues Monitor site visit November 2015 Strategic Outline Case September 2017 Long Term Plan Submission Nov 19	Whilst plans are in place, there remains significant on-going uncertainty regarding the financial regime, introduction of Integrated Care Systems and consequent change in commissioning landscape and the impact of changing clinical requirements with resource implications. Model to be re-refreshed by July 2023. **(Action 4.1 / 1)**	
	Future Generations business case demonstrates the Trust is financially viable long term if the preferred option of co-location with an adult acute site is funded.	Future Generations Clinical Strategy and Business Plan (BoD Nov 15 – refreshed in 2020) Sustainability and Transformation Plan (FPBD, Jul 16) PCBC Approval (FPBD, Oct 16)	Implementation of business case is dependent on decision making external to the Trust (ICB, NHSE/I) Process of review now owned by ICB as part of Liverpool Clinical Services Review National CDEL Issue Lack of capital nationally Ongoing costs of maintaining safety on site while long term solution is enacted Additional work being undertaken to quantify financial benefits of co-location as part of latest review. **(Action 4.1 / 5)**	
	Early and continuing dialogue with NHSE/I and Cheshire and Merseyside ICS	Ongoing engagement through governance forums.	Deficit plan likely in 2022/23 and 2023/24. Significant financial challenge across C&M as a whole. Increasing costs (e.g. Ockenden) without income matching this. **(Action 4.1 / 4)**	
	Engagement in place with Cheshire and Mersey Partnership to review system solutions	Submission of Cheshire and Mersey STP capital bid Summer 2018 ranked no1 of schemes Active participation in C&M planning processes Trust Expression of Interest as part of New Hospital Programme has not been prioritised by Cheshire and Merseyside in 2021 but was mentioned as (joint) second priority in feedback.	Position potentially superseded by development of ICS Feedback to both ICS and North West region provided. Expression of Interest not ranked first in C&M. **(Action 4.1 / 5)**	
	Clinical Engagement and support for proposals	Northern Clinical Senate Report supporting preferred option both in 2017 and 2022. Ongoing Engagement through strategic development	ICB rather than Trust leading on development of proposals from January 2023	
	Reduction in CNST Premium by achievement of Maternity Incentive Scheme.	Process in place regarding CNST MIS. Prior achievement of MIS. Engagement with NHS Resolution and learning from claims and incidents. Direct engagement with NHS Resolution. Increased resource in Maternity to manage this.	Potential resourcing issues to manage this. Actual premium costs still increasing s despite achievement of years two and three of CNST Maternity Incentive Scheme.	
	Reduction in back officecorporate overheads costs and review of productivity	Oversight on costs at FPBD and Board Focus on benchmarking and efficiencies, including joint working where possible. ICS workstream in place	Requirement for resource in relation to recovery. Economies of scale Pace of change of system wide solutions	

	Development of Community Diagnostic Centre.	Upfront capital and revenue funding provided. Letter of comfort from ICS. Funding agreed for 2022/23 and general commitment to ongoing			Significant revenue implications on an ongoing basis, not directly related to LWH patients. No definitive ongoing revenue funding source in place) Reduction in 22/23 income . **(Action 4.1 / 8)**	
	Agreed financial plan for 2022/23 with NHSI/E and C&M	FPBD and Board (monthly reports)				
	Gap Reference	**Required Action**	**Lead**	**Implement By**	**Monitoring**	**Status**
	4.1/1	Refresh LTFM including updated co-location benefits and corporate assumptions.	CFO	July 2023	FPBD Committee / Board	Delayed due to delays in national timetable for planning 2022/23. – revised timescale required following operational planning completion
	4.1 /5	Work towards strategic outline case production and approval	CFO	January 2023	Board	Proposed deferral to link with LTFM completionSubject to outcome of Women's services as part of ICS Liverpool Clinical Services
	4.1 /6	Work with commissioners and ICS on revised financial models including population-based approach and Aligned Incentive and Payment contracts	CFO	March 2023	FPBD Committee	
	4.1 / 7	Ensure financial position well understood by regional team and clearly articulated.	CFO	March 2023	FPBD Committee	
	4.1 / 8	Agree ongoing funding model for Community Diagnostic Centre for financially viable delivery of services on behalf of C&M.	CFO	March 2023	FPBD Committee	

BAF Risk 4.2: Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	**Lead Director:** Medical Director **Op Lead:** Deputy COO	**Review Date:** November 22

Strategic Priority: SA4: To be ambitious and EFFICIENT and make the best use of available resources

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

Integrated Care

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
8 (2 x 4)	8 (2 x 4)	8 (2 x 4)		⟺	8 (2 x 4)

Rationale for current risk score:

The Trust has well defined partnerships and relationships with a number of key stakeholders. These have been strengthened and added to during the Covid-19 pandemic response. The regulatory and system landscape remains uncertain, and the Board will be looking for additional clarity on future arrangements (and the Trust's assured role in this) in order to mitigate this risk and work towards the target score and improve the overall assurance rating on the controls.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Conflicting priorities of clinical services for different providers and/or ineffective governance may lead to ineffective use of resources (clinical, financial, people) amongst ICS partners	Quarterly Partnership Reporting to FPBD and Board in 2022/23	FPBD and Board meetings	Governance arrangements are developing **(Action 4.2 / 1)** Governance arrangements are developing for LMS **(Action 4.2 / 2)**	
	Robust engagement with ICS discussions and developments through CEO and Chair	CEO Report updates to the Board		
	Evidence of cash support for the Trust's 2021/22 breakeven position	Trust budget agreed by the Board		
	Chair of the Maternity Gold Command for Cheshire and Merseyside	Executive Team reporting		
	C&M Maternal Medicine Centre	Chairs reports feed into the Maternity Transformation meetings		
	Neonatal partnership in place with Alder Hey	Regular updates to the Board		
	Partnership Board in place with LUHFT and involvement in wider Estates Plan	Updates provided to the Quality Committee and Board		
	Positive and developing relationship with Merseycare NHS FT	Updates provided to the FPBD Committee		
	LMS Hosting Arrangement	Updates provided to the Board		
	Finance Directors Group	Updates provides to the Executive Team and through the governance structure when appropriate		
	Health care partnership are using existing memorandum of understanding in relation to staff movement between local hospital at time of staffing need.	Agreed at Board		
	LWH have provided assistance to LUFT by taking over LWH non obstetric Ultrasound scanning activity	Mutual aid reported through to the Quality Committee and Board		
	LWH identified as Gynaecology Oncology Hub for Cheshire and Mersey.			
	Theatre sessions provided at LWH for other Trusts such as Colorectal for LUFT			
	Provision of mutual aid to NWAST by supporting staff testing on LWH site for them			
	Provision of Mutual aid to NWAST for staff Covid-19 vaccinations			
	Quarterly Partnership Report	FPBD Committee		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
4.2 / 1	Continue to provide updates to the Board regarding the development of the ICS, highlighting when decision points are likely	CEO	On-going	Board	
4.2 / 2	Development and embedding of governance arrangements for the LMS (one year review meeting held in April 2022) – agreed to build on SLA previously in place with CCG (now ICB)	COO	~~August 2022~~ November 2022	Board	Draft SLA developed – requires consultation and finalisation with the LMNS – now linked to wider work around SLAs (see FPBD Agenda – Jan 23)

BAF Risk 4.3: Failure to deliver the agreed 2022/23 financial plan

Lead Director: CFO
Op Lead: Deputy CFO

Review Date: December 22

Strategic Priority: SA4: To be ambitious and EFFICIENT and make the best use of available resources

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
N/A	N/A	20 (5 x 4)		N/A	16 (4 x 4)

Rationale for current risk score:

Like many NHS organisations, LWH is facing a significant financial challenge in 2022/23 and is at risk of not being able to deliver its financial plan. Whilst the Trust has been in deficit in the past, this has been agreed with regulators and planned for when it has happened. The 2022/23 plan is a small surplus position (£0.5m). As at Month 6 forecast out-turn (FOT) there was a £4m gap to achieving this to be bridged, even after assumptions on reducing run rate by further controls on agency and other spend. Despite recovery efforts at Month 10 it is forecast that the Trust will be unable to deliver the 22/23 agreed plan, reporting an adverse variance for the full year.

The likelihood of this risk has been increased to 'almost certain' from 'likely' as the Trust approaches the year end. Further work will be undertaken for 2023/24 and beyond to try to move the organisation to a more sustainable financial footing where this is possible, noting the structural, underlying deficit that is in place (see BAF Risk 4.1).

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Risk that the Trust will not deliver agreed plan in the 2022/23 financial year	Trustwide and divisional recovery plan in place.	Recovery plan with agreed actions in place; monitored through Financial Recovery Board, Executive Team and Finance, Performance and Business Development Committee and reported to Board.	Adherence to plan. A number of items need external input and agreement, e.g. additional income requests.	
	Monthly reporting and monitoring of position including taking corrective action where required. Sign off of budgets by budget holders and managers, and holding to account against those budgets Divisional performance reviews Working within ICS/system to ensure issues understood and Trust secures required amount of available funding.	FPBD Committee receives monthly reports, chair's reports from the Financial Recovery Board and specific recovery centred reports. Internal Audit- high assurance for all finance related internal audit reports in 2020/21, 2021/22 and 2022.13. External Audit – no amends to accounts and largely low rated recommendations in ISA260. Mitigations being worked up in case of identified risks materialising	Lack of contractual income position due financial framework in place following the Covid-19 pandemic, gap in baseline position and block payment compared to actual activity and cost, risk to CIP and income streams, timing of recovery and uncertainty over future regime. This is still the case in 2022/23 as block values are still based on this assessment. Reliance on Cheshire & Merseyside position and NHS Improvement/England national team to support proposed baseline adjustment for Elective Recovery Funding. Neonatal Service: Discussions are underway with commissioners about how this is to be managed, given the significant increase in activity and consequent staffing requirement above budget (action 4.3/3) Capital: A review is underway to ensure any obsolete assets are impaired, asset lives are reviewed, and all capital expenditure is captured. In addition, the capital plan for the remainder of the year is being reviewed line by line to see if there is anything that can be deferred to both reduce capital charges and also improve cash. This is subject to Quality Impact Assessment (QIA) (action 4.3/4) Productivity and Efficiency: There is a Productive Operating Theatre workstream underway, this will form part of CIP going forward. (action 4.3/5) Service Change: Any areas where service can be looked at, e.g. provision out of hours, is being looked at. This is subject to QIA (action 4.3/6). To prepare and plan for the impact on the 2023/ 24 planning process (4.3/7) Through the divisions and Financial Recovery Board to identify additional mitigating CIP both for CIP that is not delivering and also to mitigate forecast overspends. To work with the regional team to mitigate risk to CDC funding.	
	Agency and Premium Pay: There are a number of workstreams underway to reduce this spend. These include ensuring all approvals for usage are made by senior leaders, recruitment campaigns for permanent staff, a programme to support retention, management of sickness, removal of incentive payments and review of premium pay rates.	Agency use monitored weekly at Executive Team meetings and via regular meetings with the Divisions. Additional controls put in place		
	Deferral of Investment: A number of planned investments have been paused and will be reviewed as part of operational planning 2023/24.	Quality impact assessments have been undertaken to prevent deleterious effects of deferrals.		
	Income: A detailed look at all aspects of income has been undertaken and has already yielded some successes, e.g. updating arrangements and ensuring all billing is undertaken for service provided.	Outputs reported via FRB and FPBD.		
	Non Pay, Procurement and Contracts: Contracts have been looked at to ensure the Trust is not paying for any goods or services that are not required, and that prices charged are reasonable.	Outputs reported via FRB and FPBD.		
	Balance Sheet and Non-Recurrent Items: A full review of the balance sheet to ensure, for example, that accruals, provisions and deferred income has been appropriately released. In addition, a number of one off opportunities including sale of equipment have been identified.	Outputs reported via FRB and FPBD.		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
4.3/1	Production of and management of recovery plan	Chief Finance Officer	February 2023	FPBD Committee	
4.3/2	Ensure full CIP programme in place with relevant QIAs etc	Deputy Chief Finance Officer	March 2023	FPBD Committee	

		Ongoing. QIAs in place before schemes are put in place.					
	4.3/3	To undertake discussions with commissioners regarding the significant increase in neonatal activity	Chief Finance Officer	January 2023	FPBD Committee		
	4.3/4	To undertake review to ensure any obsolete assets are impaired, asset lives are reviewed, and all capital expenditure is captured.	Chief Finance Officer	February 2023	FPBD Committee		
	4.3/5	Productive Operating Theatre workstream to conclude	Deputy COO	February 2023	FPBD Committee		
	4.3/6	Review of potential service changes (subject to QIA)	Deputy COO	March 2023	FPBD Committee		
	4.3/7	To prepare and plan for the impact of exiting 22/23 with an underlying deficit on the 2023/24 planning process	Chief Finance Officer	March 2023	FPBD Committee		

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Risk that the Trust will not have sufficient cash resources in the 2022/23 financial year	Situation has been discussed with colleagues at the Integrated Care Board who have provisionally agreed to provide short term cash support in the form of: - Early payment of income due in year. - Regular payment of monthly income at an earlier date (1st instead of 15th of the month).	Updates provided to the FPBD Committee and the Board Application for National revenue cash support submitted February 2023	Exploring and securing a longer-term solution to long term sustainability. To maintain potential option of PDC revenue support. To continue discussions with ICB regarding provided or facilitated cash support.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
4.3/8	Subject to QIA to also explore the potential to defer capital expenditure in some areas.	Deputy Director of Finance	February 2023	FPBD Committee	

Strategic Objective	SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes
Committee:	Quality Committee
Risk Appetite:	High

Principal risks (BAF)	Risk Score
5.1 Failure to progress our research strategy and foster innovation within the Trust	8 (2 x 4)
5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	12 (3 x 4)

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

2456 – NEWLY ADDED. Last reviewed 14/09/2022

2232 - No change in risk score since last review. Last reviewed 21/09/2022.

2295 - No change in risk score since last review. Last reviewed 15/09/2022

2329 - No change in risk score since last review. Last reviewed 17/10/2022

2582 – NEWLY ADDED – Last reviewed 26/09/2022

Ref	BAF X REF	Corporate Risk Register / High Scoring (15+) Risks	Risk Score
2336	5.2	There is risk to the Trust, as it is not currently meeting the CQC Regulations and national guidance in relation to the care of children aged 18 and below within the Gynaecology services	15
2582	5.2	Failure to meet the governance and risk management requirements of the Family Health Division	16
2456	5.2	Delay in review of clinical incidents, outside of the parameters expected by the Trust policy, leading to failure to act on safety concerns, missed learning opportunities and delay in escalation of SUIs	15
2232 **(CRR)**	5.2	There is a risk that due to a number of causes the Trust is unable to meet the safety requirements related to Blood Transfusion	15
2295 **(CRR)**	5.2	Inability to achieve and maintain regulatory compliance, performance and assurance.	8
2329 **(CRR)**	5.2	There is a risk to the Trust is not meeting it requirements for the safe and proper management of medicines	12

BAF Risk 5.1: Failure to progress our research strategy and foster innovation within the Trust

Lead Director: MD
Op Lead: Director of Research

Review Date: November 2022

Strategic Priority: SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes

Lead Committee: Quality Committee

Provider Licence Compliance link:

N/A

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
8 (2 x 4)	8 (2 x 4)	8 (2 x 4)		⇔	4 (1 x 4)

Rationale for current risk score:

The Trust has a well-established and successful research process and has been particularly active in the support provided to the wider system during Covid-19. To strengthen this area and further mitigate this risk, the Trust should look to widen participation in research across the organisation making links explicit with quality improvement activity. There is also an opportunity to further enhance the Trust's research profile in the local system but also nationally and internationally.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
If high quality research staff cannot be engaged and retained, then research activities will not be fulfilled leading to challenges in recruitment and retention of staff, damage to reputation or withdrawal of funding	Excellent support continues to be provided to medical staff in identifying and nurturing talent, ensuring projects suggested by new researchers are feasible and of high quality and establishing mentorship for individuals who wish to have a research component as part of their future career.	The Trust in-house research management infrastructure continues to operate in a robust and efficient manner. Its performance can be demonstrated via various internal and external reporting mechanisms. Monitored via RD&I Subcommittee	Ongoing funding will be required to support the talent pipeline **(Action 5.1 / 1)**	
	Nursing, Midwifery and Allied Health Professional Talent pipeline developed to provide further support and development for non-medical workforce in relation to the research agenda.	Implementation of the talent pipeline will be monitored via the RD&I sub committee		
	The Trust has now appointed a Director of Midwifery who has a strong research background. She will support and facilitate midwifery research.	RD&I sub-committee (also attended by three Professors of Midwifery from the respective local universities)		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.1 / 1	To secure funding to support the talent pipeline	Medical Director	September 2022	Research and Development Sub-Committee	This is now awaiting review at the next Business Case Approval Meeting.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Continued engagement with the City-wide integrated approach to innovation is necessary in order to further promote, develop and innovation ideas from the Trust's workforce.	Engagement with Liverpool Health Partners	Regular innovative ideas are identified and supported, for example Life Start Trolley, Butterfly Pillow, Butterfly Shelf, parenteral nutrition product, speculum for the diagnosis of urogenital atrophy. Such ideas are supported in-house and via outsourced expert help and advice. Regular attendance at RD&I sub-committee by LHP theme leads	Further development of this strategic principle is required to enable the Trust to empower its staff in engaging with a City-wide integrated approach to innovation.	
	C-GULL programme of work commenced – staff recruited, building work underway, regulatory approval on track. Recruitment of first participant expected in late Autumn 2022.	R&D Sub-Committee Chair's Reports		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.1 / 2	Continue progress towards university hospital status application	Medical Director	March 2023	Research and Development Sub-Committee	

BAF Risk 5.2: Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership

Lead Director: CN&M
Op Lead: Assoc. Director of Governance and Quality

Review Date: November 22

Strategic Priority: SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes

Lead Committee: Quality Committee

Provider Licence Compliance link:

General Licence Condition 7

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
12 (3 x 4)	12 (3 x 4)	12 (3 x 4)		⟷	8 (2 x 4)

Rationale for current risk score:
The Trust has a current rating of 'requires improvement' for well-led from the most recent CQC inspection and received a warning notice regarding medicine management. Good assurance is in place regarding the Trust's response to this (supported by MIAA audit) and the warning notice being withdrawn. Further work required to refine process and to ensure that the Trust always remains 'inspection ready'.

The Trust was subject to an external well-led review and themes relating to effective lesson learning and establishing a quality improvement methodology were identified, mirroring findings from the CQC inspection and feedback from commissioners. Progress has been made in relation to both areas, but this needs to go further to achieve the target score.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
If the Trust fails to comply with the CQC fundamental standards and if actions arising from the CQC visit are not implemented at sufficient pace then clinical standards may not be met leading to significant patient harm, deterioration in patient outcomes, a failure to maintain a CQC rating of 'good' and a serious reputational risk to the Trust.	CQC Framework has been implemented – This includes a well-led framework, and the on-going development of the CQC self-assessment process including a review of previous CQC action pans. The Be Brilliant Accreditation Scheme (BBAS) launched in July 22.	Quality Committee Executive Team oversight Divisional Board and performance review meetings Trust Board	Number of policies and SOPs out of review date **(Action 5.2 / 2)** **The CQC self-assessment and BBAS programmes can duplicate each other. Findings from each may differ**	
	Horizon scanning for changes in the CQC's regulatory approach	Quality Committee		
	Engagement meetings with CQC and regular contact in between meetings with our CQC inspector.	Quality Committee		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 1	Amalgamation of the BBAS programme and CQC self-assessment Inspection framework to provide the trust with one single assessment framework which falls in line with CQC's new regulatory approach.	Deputy Director of Nursing & Midwifery	April 2023	Quality Committee	Development on-going and expected to be rolled out in April 2023
5.2 / 2	Ensure all policies and procedures are within their review date	Assoc. Director of Quality & Governance	December 2022	Quality Committee	The position had improved but further work required to ensure this becomes BAU. Governance dashboards are in the process of being developed to enable divisions and senior leaders to identify risk and areas for development, this includes an update on policies and procedures. In the interim a weekly report is provided to the Chief Nurse, COO and divisional SLTs prior to expected roll-out of the new dashboards in the New Year

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective understanding and learning following	Regular dialogue with regulators Incident reporting and investigation policies and procedures. MDT involvement in safety HR policies in relation to issues relating to professional and personal responsibility	Monthly CQRM MeetingMonthly reporting of incidents and management of action plans through Safety & Effectiveness Sub-Committee and quarterly via Quality Committee Reflection of risks and Corporate Risk Register and Board Assurance Framework CQC Assessment	Lack of testing of action plans following audits to ensure they lead embedded change – will be supported by ward accreditation once embedded **(Action 5.2 / 3)**	

significant events and evidencing improved practice and clinical outcomes.	Mandatory training in relation to safety and risk Serious Incident Feedback form Weekly Patient Safety Meeting for Serious Incidents and unexplained harm/injuries Safety is included as part of executive walk rounds. Risk Management Strategy Link on desktop of computer with a link to lesson learnt section of web page Use of the action planning module is to be embedded across all divisions Monthly Divisional Integrated Governance Reports that focus on the embedded changes in practice and learning . Approx. 30 staff have been through Route Cause Analysis and Investigative Officer Training in May and June 2022. Human Factors training in place	Annual Quality Account Report Shared learning page now live on the intranet The Governance team to use weekly meetings for review actions and ensure shared. Governance team to ensure oversight and reporting of progress Safety & Effectiveness Sub-Committee on a monthly basis Mandatory training compliance figures	Inconsistent completion and dissemination of actions and improvement plans – signs of improvement but with further work required. **(Action 5.2 / 4)** Lack of consistency between divisional governance meetings (noted in recent well-led report) **(Action 5.2 / 3)** Human Factors training compliance and availability **(Action 5.2 / 5)** Monitoring compliance with risk management training **(Action 5.2 / 7)** **The Divisional Integrated Governance Reports are still in their infancy and will be further developed at pace in collaboration between local and corporate teams (Action 5.2 / 3)**			

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 3	To ensure that Divisional Governance meetings and reporting are consistent and seek evidence of actions / lessons being embedded	Deputy COO	January 2023	Safety & Effectiveness Sub-Committee	Improvements have been made but remains on-going. Additional resource secured for project during September 2022
5.2 / 4	Develop better reporting from the Ulysses System including the introduction of divisional dashboards feeding into power BI. There is a continuing commitment to improving reporting using Ulysses. A recent development has been the agreement to cross-tabulate incidents and complaints using Ulysses using a formal process.	Associate Director of Quality & Governance	January 2023	Safety & Effectiveness Sub-Committee	Corporate Governance are working closely with Ulysses and the information team on this piece of work.
5.2 / 7	Governance team to monitor compliance levels with risk management training and highlight staff who are noncompliance to the Divisions and provide compliance update to Safety and Effectiveness Sub-committee.	Head of Risk & Safety	On-going	Safety & Effectiveness Sub-Committee	
5.2 / 13	Legal polices re claims and learning are being reviewed, revised and will be shared	Associate Director of Quality & Governance	January 2023	Safety & Effectiveness Sub-Committee	Revised policy to be presented to safety & effectiveness in Dec 22. Comments/suggestions are being sought from local teams at present.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective and / or ill-defined quality improvement methodology will result in the Trust missing opportunities to improve the safety, effectiveness and experience of care.	Quality Improvement training materials available on Trust Intranet Quality Improvement projects tracked Quality Account tracking key projects Quality Improvement Framework, policies and procedures have been developed and agreed	Training levels reported to the Quality & Clinical Audit Group Bi-Monthly via Quality Improvement Group Annual Quality Account Quality Improvement Group bi-monhtly Quality Committee once per quarter The number of QI projects submitted for approval to commence have significantly increased in Q2.	Opportunities to engage individuals in QI training limited, particularly during pandemic (Action 5.2 / 9) Evidence of QI projects being undertaken but not always 'formalised'. This has however improved in Q2. (Action 5.2 / 12) Lack of QI training to support colleagues across the trust, to both those in post and new starters. (Action 5.2 / 9) QI lead post has been vacant since July 22. (Action 5.2 / 8)	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 8	Continuous review of the trusts approach to QI to enable the planning of priorities identifying improvements required	Assoc. Director of Governance & Quality	On-going	Quality Committee	Recruitment to a new QI Manager role and a Quality Facilitator rolehas been completed. They are expected to start in post in January 23.
5.2 / 9	Increase levels of QI training	Assoc. Director of Governance & Quality	February 2023	Quality Improvement Group Quality Committee	Preliminary discussions have taken place with LD with a view to looking at the training offer trust wide including the trust induction.

						Each area within the trust has completed a QI TNA to give us a baseline of the QI knowledge & expertise available to us.	
	5.2 / 11	Establish what changes can be made to Ulysses to align the system better with the flow of QI projects.	Assoc. Director of Governance & Quality	February 2023	Quality Committee	Completed	
	5.2 / 12	To create a platform for completed QI projects to be showcased and shared trust wide.	Assoc. Director of Governance & Quality	February 2023	Quality Committee	Quality & Safety summit to commence in January 2023, refresh of QI with a shared vision to take our QI journey forward. This has been communicated to QIG and Quality Committee and Trust Board. The new QI manager will also bring further ideas upon their appointment to make this a reality.	

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/013*	**Date: 06/04/2023**		
Report Title	**Trust Board Terms of Reference**			
Prepared by	*Mark Grimshaw, Trust Secretary*			
Presented by	*Mark Grimshaw, Trust Secretary*			
Key Issues / Messages	***The Trust last reviewed the Board Terms of Reference at its meeting held on 7 April 2022. Whilst it is not a requirement to have a Board Terms of Reference, it is considered good practice and has been highlighted as a development point in the Trust's NHS Improvement Well-Led Framework Self-Assessment.*** ***No amendments are proposed but it is good practice to annually review the Terms of Reference.***			
Action required	**Approve ☒**	**Receive ☐**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	The Board is asked to: ***• Review and if deemed appropriate approve the terms of reference included as appendix 1***			
Supporting Executive:	*Mark Grimshaw, Trust Secretary*			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Comment:

Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
N/A			

EXECUTIVE SUMMARY

The Trust last reviewed the Board Terms of Reference at its meeting held on 7 April 2022. Whilst it is not a requirement to have a Board Terms of Reference, it is considered good practice and has been highlighted as a development point in the Trust's NHS Improvement Well-Led Framework Self-Assessment.

No amendments are proposed but it is good practice to annually review the Terms of Reference.

Recommendation

The Board is asked to:

- Review and if deemed appropriate approve the terms of reference included as appendix 1

Liverpool Women's
NHS Foundation Trust

Appendix 1:

BOARD OF DIRECTORS
TERMS OF REFERENCE

Role and Purpose:	The Terms of Reference describe the role and working of the Board of Directors (hereafter referred to as the Board) and are for the guidance of the Board, for the information of the Trust as a whole and serve as the basis of the Terms of Reference for the Board's own Committees. The Trust exists to 'provide goods and services for any purposes related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.' The Trust has a Board which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a Committee of directors or to the Chief Executive. The Board consists of Executive Directors, one of whom is the Chief Executive, and Non-Executive Directors, one of whom is the Trust Chair. The nominated deputy for the Chief Executive and Trust Chair, upon appointment to a substantive or acting up role, must be formally recorded in the minutes.
Duties:	The Board leads the trust by undertaking four key roles: • setting strategy; • supervising the work of the executive in the delivery of the strategy and through seeking assurance that systems of control are robust and reliable; • setting and leading a positive culture for the Board and the organisation; • giving account and answering to key stakeholders, particularly the Council of Governors. The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public. Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust). The practice and procedure of the meetings of the Board, and of its committees, are not set out here but are described in the Board's Standing Orders.

GENERAL RESPONSIBILITIES:

The general responsibilities of the Board are:

- to maintain and improve quality of care;
- to work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, effective, accessible, and well governed services for patients, service users and carers;
- to ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity;
- to ensure relationships are maintained with the Trust's stakeholders, regulators, public, governors, staff and patients, such that the trust can discharge its wider duties;
- to exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner;
- to ensure compliance with all applicable law, regulation and statutory guidance.

In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of non-executive and executive directors.

LEADERSHIP

The Board provides active leadership to the organisation by:

- ensuring there is a clear vision and strategy for the Trust that is well known and understood by stakeholders and is being implemented within a framework of prudent and effective controls which enable risk to be assessed and managed;
- ensuring the Trust is a good employer by the development of a workforce strategy and its appropriate implementation and operation;
- implementing effective Board and Committee structures and clear lines of reporting and accountability throughout the organisation.

STRATEGY

The Board:

- sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;
- monitors and reviews management performance to ensure the Trust's objectives are met;

- oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- develops and maintains an annual business plan, with due regard to the views of the council of governors, and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders;
- ensures that national policies and strategies are effectively addressed and implemented within the Trust.

CULTURE, ETHICS AND INTEGRITY

The Board:

- is responsible for setting values, ensuring they are widely communicated and adhered to and that the behaviour of the Board is entirely consistent with those values;
- promotes a patient-centred culture of openness, transparency and candour;
- ensures that high standards of corporate governance and personal integrity are maintained in the conduct of foundation trust business.

GOVERNANCE

The Board:

- ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance and appropriate codes of conduct, accountability and openness applicable to NHS provider organisations;
- ensures that all licence conditions relating to the Trust's governance arrangements are complied with;
- ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
- ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective and safe services taking account of patient and carer experiences and maintaining the dignity of those cared for;
- ensures that all the required returns and disclosures are made to the regulators;
- formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation trust business;

- agrees the schedule of matters reserved for decision by the Board of Directors;
- ensures that the statutory duties of the Trust are effectively discharged;
- Acts as corporate trustee for the Trust's charitable funds.

RISK

The Board:

- ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
- ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement in the development of care plans, the review of quality of services provided and the development of new services;
- ensures there are appropriately constituted appointment and evaluation arrangements for senior positions such as consultant medical staff and those reporting to executive directors.

COMMUNICATION

The Board:

- Ensures an effective communication channel exists between the Trust, its governors, members, staff and the local community.
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback.
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publicly through Board meetings in public and also via the Trust's website.

FINANCIAL AND QUALITY SUCCESS

The Board:

- Ensures that an effective system of finance and quality is embedded within the Trust.
- Ensures that the Trust operates effectively, efficiently and economically.
- Ensures the continuing financial viability of the organisation.
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved.
- Ensures that the Trust achieves the quality targets and requirements of stakeholders within the available resources.
- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

RESPONSIBILITIES OF BOARD MEMBERS

All Members of the Board:

- Have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not impact upon the particular responsibilities of the Chief Executive as the Accounting Officer.
- Have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

Role of the Trust Chair:

The Trust Chair is the guardian of the Board's decision-making processes and provides general leadership of the Board and the Council of Governors.

- Responsible for leading the Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.
- Reports to the Board and is responsible for the effective operation of the Board and the Council of Governors.
- Responsible for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives.

Role of the Chief Executive

- The Chief Executive reports to the Trust Chair and to the Board directly. All members of the management structure report either directly or indirectly to the Chief Executive.
- The Chief Executive is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.
- The Chief Executive is responsible for implementing the decisions of the Board and its Committees, providing information and support to the Board and Council of Governors.

Role of Executive Directors (EDs)

- Share collective responsibility with the Non-Executive Directors as part of a unified Board.
- Shape and deliver the strategy and operational performance in line with the Trust's strategic aims.

Role of Non-Executive Directors (NEDs)

- Bring a range of varied perspectives and experiences to strategy development and decision making.
- Ensure that effective management arrangements and an effective management team are in place.

- Hold the Executive Directors to account for performance of the operational responsibilities.
- Scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. NEDs should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.
- To take an active role in providing advice, support and encouragement to Executive Directors.

Role of the Senior Independent Director (SID)

- Is a Non-Executive Director appointed by the Board in consultation with the Council of Governors to undertake the role. Normally the SID will not be the Vice Trust Chair although this may be the case if the Board deems it necessary.
- Will be available to members of the Foundation Trust and to Governors if they have concerns which, contact through the usual channels of the Trust Chair, Chief Executive, Deputy Chief Executive, Director of Finance and Trust Secretary, has failed to resolve or where it would be inappropriate to use such channels.
- Has a key role in supporting the Trust Chair in leading the Board and acting as a sounding board and source of advice for the Trust Chair. The SID has a role in supporting the Trust Chair in his/her role as Trust Chair of the Council of Governors.

In addition to the duties described here, the SID has the same duties as the other Non-Executive Directors.

Role of the Trust Secretary

The Trust Board shall be supported by the Trust Secretary whose duties in this respect will include:

- agreement of the agenda, for Board and Board committee meetings, with the relevant Chair, in consultation with the Chief Executive;
- collation of reports and papers for Board and committee meetings;
- ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward;
- ensuring that board procedures are complied with;
- supporting the Chair in ensuring good information flows within and between the Board, its committees, the Council of Governors and senior management;
- advising the Board and Board committees on governance matters;

	• supporting the chair on matters relating to induction, development and training for directors

Membership:	The composition of the Board shall be:
	• A Non-Executive Chair
	• Not more than seven other non-executive Directors
	• Not more than seven executive Directors including:
	  ○ The Chief Executive (who is the Accounting Officer)
	  ○ Chief Finance Officer
	  ○ A registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984)
	  ○ A registered nurse or registered midwife.

Quorum:	Six Directors including not less than three executive Directors (one of whom must be the Chief Executive or another Executive Director nominated by the Chief Executive) and not less than three non-executive Directors (one of whom must be the Chair or the Vice Chair of the Board of Directors) shall form a quorum. An officer in attendance for an executive Director but without formal acting up status may not count towards the quorum. If a Director has been disqualified from participating in a discussion on any matter and/or from voting on any resolution by reason of declaration of a conflict of interest, that Director shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minute of the meeting. The meeting must then proceed to the next business.
Voting:	All questions put to the vote shall, at the discretion of the Chair, be decided by a show of hands save that no resolution of the Board of Directors shall be passed if it is opposed by all of the non-executive Directors present or by all of the executive Directors present. A paper ballot may be used if a majority of the Directors present so request. In case of an equality of votes the Chair shall have a second and casting vote. If at least one third of the Board members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot). If a Board member so requests, her vote shall be recorded by name.

	In no circumstances may an absent Director vote by proxy. Subject to Standing Order 59, absence is defined as being absent at the time of the vote. An officer who has been appointed formally by the Board to act up for an executive Director during a period of incapacity or temporarily to fill an executive Director vacancy, shall be entitled to exercise the voting rights of the executive Director. An officer attending the Board to represent an executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive Director. An officer's status when attending the meeting shall be recorded in the minutes. Where an executive Director post is shared by more than one person: • Each person shall be entitled to attend meetings of the Board • Each of those persons shall be eligible to vote in the case of agreement between them • In the case of disagreement between them no vote should be case • The presence of those persons shall count as one person.
Attendance:	The Board of Directors may agree that Directors can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting. Directors who are unable to attend a meeting shall notify the Secretary in writing in advance of the meeting in question so that their apologies may be submitted.
Frequency:	Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Secretary will publish the dates, times and locations of meetings of the Board in advance.
Accountability and reporting arrangements:	The Council of Governors is responsible for holding the Board to account, for example by attending Board meetings in public and meeting with the Trust Chair, Chief Executive and Committee Chairs on the day of Board meetings / Council of Governors' meeting. The agenda and minutes of Board meetings will be shared with the Council of Governors. The Trust Chair will be responsible for ensuring the Board of Directors adheres to its Terms of Reference and Annual Work Plan. The Board shall self-assess its performance following each board meeting.

	A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all directors and others as agreed with the Chair and Chief Executive from time to time.
Monitoring effectiveness:	The Board will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Board.
Reviewed by Board of Directors:	*6 April 2023*
Approved by Board of Directors:	*TBC*
Review date:	April 2024
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/14*	**Date: 06/04/2023**		
Report Title	**Board Committee Annual Reports, 2023/24 cycles of business and Terms of Reference**			
Prepared by	*Mark Grimshaw, Trust Secretary*			
Presented by	*Mark Grimshaw, Trust Secretary*			
Key Issues / Messages	*The report presents the following for review.* • *Committee Annual Reports for the Quality, Finance, Performance & Business Development, and Putting People First Committees* • *Committee Business Cycles for 2023/24 for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees* • *Committee Terms of Reference for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees*			
Action required	**Approve ☒**	**Receive ☐**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is asked to receive and if deemed appropriate approve the following documents: • *Committee Annual Reports for the Quality, Finance, Performance & Business Development, and Putting People First Committees* • *Committee Business Cycles for 2023/24 for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees* • *Committee Terms of Reference for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees*			
Supporting Executive:	*Mark Grimshaw, Trust Secretary*			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
PPF, FPBD, Quality, Audit Committees	March 2022	Committee Chairs	Documents reviewed and recommended for approval by the Board

EXECUTIVE SUMMARY

In line with best practice in other sectors, the Board's Committees have produced an Annual Report to the Board summarising their activities for the financial year 2022/23, setting out how they met their Terms of Reference. Similarly, to the previous year, this annual effectiveness review has been aligned with the Business Cycle and Terms of Reference review to ensure that the findings translate to improvements in practice.

The exceptions to the review process are the Audit and Nomination & Remuneration Committee – effectiveness reviews for these forums form part of the Annual Report.

Due to timings, the review of the Charitable Funds Committee will follow at a future meeting.

The Board is asked to receive and if deemed appropriate approve the following documents:

- Committee Annual Reports for the Quality, Finance, Performance & Business Development, and Putting People First Committees
- Committee Business Cycles for 2023/24 for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees
- Committee Terms of Reference for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees

Liverpool Women's NHS Foundation Trust

Finance, Performance & Business Development Committee

Annual Report 2022/23

Background

This report covers the period April 2022 to March 2023. There were 11 meetings held during this period – one more than the 10 scheduled meetings for the year. The explanation for this is detailed in the 'Areas for Development' section.

The Committee's responsibilities fall broadly into the following two areas:

Finance and performance

- Receive and consider the annual financial and operational plans and make recommendations as appropriate to the Board
- Review progress against key financial and performance targets
- Review on behalf of the Board, financial submissions (as reported in the Financial Performance Report) or others, as agreed by the Board, to NHS Improvement for consistency on financial data provided
- Review the service line reports for the Trust and advise on service improvements
- Provide oversight of the cost improvement programme
- Oversee external financing & distressed financing requirements
- Oversee the development and implementation of the information management and technology strategy
- Examine specific areas of financial and operational risk and highlight these to the Board as appropriate through the Board Assurance Framework
- To undertake an annual review of the NHS Improvement Enforcement Undertaking
- To review and receive assurance on the appropriateness of the Trust's Emergency Planning Resilience & Response processes and procedures.

Business planning and development

- Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities; reporting to the Board on the nature of those risks and opportunities and their effective management

- Advise the Board and maintain an oversight on all major investments, disposals and business developments

- Advise the Board on all proposals for major capital expenditure over £500,000

- Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy

Constitution

The Finance, Performance & Business Development Committee is accountable to the Board of Directors.

Membership during the year comprised:

- Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- Chief Executive
- Chief Finance Officer
- Chief Operations Officer
- Chief Nurse and Midwife

Meetings were also attended by other executives and senior management staff as appropriate.

The Committee's constitution allows for members to participate by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference. In the landscape post the Covid-19 pandemic, all meetings during 2022/23 were held on a hybrid basis with the option for members to meet on site in person or join the meeting virtually utilising Microsoft Teams.

The Terms of Reference requires that all members of the committee attend a minimum of 50% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2022/23, together with the names of senior management who were invited to attend during the year. All members attended 50% or more of the meetings during 2022/23 to date. This appendix will be updated post meeting so that a full 2022/23 picture can be provided to the Board.

Key achievements / activity

The Committee held one additional meeting in December 2022. The additional meeting was utilised to receive all regular monthly reports to maintain a focus on seeking assurance that the Trust was adequately monitoring the financial position moving towards year end.

Finance Performance Report
The Committee received this report at each scheduled meeting. The opportunity is taken to scrutinise any areas of note or challenge, particularly from the lens of the impact of financial performance on the income and cash position, Trust's CIP programme, capital schemes and expenditure. The Treasury Management update was included within the monthly financial reports to provide assurance on the strength of financial controls.

Due to the increasingly difficult financial position, the Committee also received focussed detailed reporting including, for example, recovery plan updates in relation to the 2022/23 financial plan, planning updates for 2023/24, and agency spend analysis.

The Committee noted that the Trust would be adopting the Health Financial Management Association (HFMA) self-assessment tool due to the significant financial challenge to achieve the 2022/23 plan and to support work on maintaining financial sustainability whilst delivering safe and effective patient care.

Operational Performance Report
The Committee received this report at each scheduled meeting. The Committee received regular updates on recovery and restoration trajectory to provide additional assurance that the Trust was working effectively to recover from the impact caused by the Covid-19 pandemic. The Committee was sighted on additional investment requirements in relation to improving the recovery position.

The Committee received focussed updates from divisional representatives during the year on, for example, recovery, utilisation of theatres and productivity in maternity. The Committee received a progress update against the Operational Plan.

Board Assurance Framework (BAF)
The Committee regularly reviewed the Board Assurance Framework risks assigned in line with the business cycle of activities. The Committee held discussions over the rating of specific risks attributable to the Committee noting that they were being managed appropriately. The Committee reported all changes to the BAF at the next following Board of Directors meeting for approval.

Post Implementation Review of Cost Improvement Programme (CIP)
The Committee noted that the full year post implementation review exercise had been undertaken as part of ensuring good governance and ensuring that lessons learnt from both successful and unsuccessful schemes. The Committee took assurance from proactive management of the 2021/22 CIP despite challenges and pressures during the year.

The Committee also received a mid-year post implementation review against the CIP schemes undertaken during 2022/23 to provide additional assurances to the Committee of grip and control throughout the challenging financial period.

Digital Services Update
The Committee received this report at each scheduled meeting and sought assurance throughout the year on the Trust's progress to move forward with an Electronic Patient Record solution, progress against Global Digital Exemplar (GDE) objectives (and benefits realisation) and cyber-security. In addition to these updates, the Committee also received focussed reports on EPR, including independent review findings and a Go-Live report as the Trust moves forward with implementation. The Committee also supported the contract award recommendation for the provision of a networked Picture Archiving Communication Software Solution (PACS).

Analytical Review – Annual Accounts 2021/22
The Committee received a detailed paper summarising the key financial statements and an analytical review undertaken on the key differences between the 2021/22 and 2021/20 accounts.

Review of Strategic Progress
Throughout the year, the Committee has been involved in the development of the Trust Corporate Strategy, supporting strategies development and progression, the Future Generations Programme, and alignment against the Integrated Care Board (ICB) Strategy.

Partnership Oversight
A quarterly summary report related to oversight of the Trust's partnership arrangements has been received as a new addition to the workplan for 2022/23, as a necessity to build effective partnerships and to work in collaboration to progress the objectives of the local Integrated Care System, as part of the regulatory framework.

Estates and Facilities Compliance
The Committee received the Estates and Facilities Annual Report 2021/22 and continued to receive and monitor compliance updates within the monthly operational performance report.

Crown Street Enhancement Programme
The Committee received monthly updates on Crown Street Enhancement Programme. The Committee sought and were provided assurances regarding the project governance in place and the strategic alignment, affordability and deliverability of the preferred option.

Community Diagnostic Centre Update
The Committee has received regular progress updates on the development of the scheme, including key challenges in relation to budget, funding and staffing throughout 2022/23 and accepted the chair reports from the Community Diagnostic Centre Oversight Group. The Committee received additional assurances, on behalf of the Trust Board, that appropriate procurement processes had been followed in the identification and selection of the supplier for an in-sourcing staffing solution for cross-sectional imaging services within the CDC.

Neonatal Capital Programme Build benefits realisation
The Committee received a benefits realisation update following completion of the neonatal capital build. The Committee noted the patient safety and quality benefits

realised from the implementation as a positive undertaking and conclusion of the programme.

Annual Business Case Post Implementation Reviews
As part of ongoing quality and process improvement, the Committee received the output from a Business Case Post Implementation Review for all cases from the 2021/22 financial year.

Communications, Marketing & Engagement Strategy 2021-24 Annual Review
The Committee received an overview of performance to date against the strategy ambitions and priorities ahead for the duration of 2022/23.

Emergency Planning Resilience & Response Annual review
The Committee received a summary report detailing the Trust's compliance to the NHSE/I Emergency Preparedness, Resilience and Response (EPRR) Core Standards based on a self-assessment.

Modern Slavery Act 2015 – Trust Statement
The Committee reviewed the Trust Statement of compliance against the Modern Slavery Act 2015 and authorised the statement to be published on the Trust's website.

Skills Development Network Accreditation
The Committee noted the ambition of the finance, procurement and digital teams towards implementation of the Skills Development Network Accreditation and had been assured by the current accreditation position and aspiration.

Delivery a Net Zero NHS and Trust Green Plans
The Committee received a presentational update detailing steps taken to date towards delivery against the Trust Green Plan, noting that it aligned with the Sustainable Development Assessment Tool and the required areas of focus.

LWH Market Share Intelligence Report
The Committee received an annual market share intelligence report. The data was provided from CHKS using national data provided by their market intelligence tool and did not cover all areas of Trust activity, for example it excludes neonatal and fetal medicine. The report had been shared with the divisional management teams to support operational planning in 2023/24.

Major Incident Update
In relation to the Trust response to the major incident declared on 14 November 2021, the Committee received an update of findings on the incident debrief report related to security management.

Assurance Third Party Service Provider Controls
The Committee received an annual update on the third-party service provider assurance, and controls. The review had identified significant risks in relation to oversight and governance of third-party SLA contracts and controls. The Committee will oversee a comprehensive review of the internal SLA process, in response to the findings in 2023/24.

Chair Log
The Committee had received and responded to a total of 6 chair actions received from the Trust Board and Board Committees during 2022/23 and delegated 3 chair actions to supporting groups to seek additional assurances.

Areas for Development

For the second time, an effectiveness survey was circulated to members of the Committee seeking feedback on the activity of the Committee during 2022/23. On the whole, the responses received were positive – the full results can be seen in Appendix 2.

One narrative comment received noted that "the committee should pay more attention to the risk with regard to operational targets. An example would be risk to delivery of 78 weeks." The operational performance reporting template has recently been improved to demonstrate risks more clearly. The Committee may wish to ask for additional narrative, to support discussion, be received at its meetings.

As noted above, the Committee has received quarterly updates related to oversight of the Trust's partnership arrangements. There has been a suggestion that this item might be better placed at the Executive Committee on a quarterly basis to report to the Trust Board (considering the key role the Executive Team has in partnership arrangements and monitoring).

The Committee has a strong track record in its approach to providing oversight to the Trust's financial and operational performance and this has been particularly pertinent during the pandemic (and will likely continue to be so). The Committee also has a role to seek assurance on the Trust's approach to business planning and development. Whilst there are examples of items considered that align with this role (e.g. Market Share Intelligence Report), there is more scope to develop this aspect, particularly in relation to receiving intelligence on market share. However, given the acute financial challenges faced by the Trust, this element of the Committee's role will likely continue to receive less focus than oversight of operational and financial targets and plans in 2023/24.

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in March 2022 and were approved by the Board in April 2022.

To align with the other Board Committees, it is recommended that the attendance requirement for members should be uplifted to attend a minimum of 75% of all meetings from 50%. The quorum requirements have been updated to align with those for other Board Committees.

The following meetings report directly into the Committee with a Chair's Report:

- Digital Hospital Sub-Committee
- EPPR Sub-Committee
- Crown Street Enhancement Programme Board
- Future Generations Project Group

- Premises Assurance Group
- Financial Recovery Board
- Community Diagnostic Centre Oversight

Opportunities to streamline and improve these reporting lines are being explored and will report to the April 2023 Committee.

Other housekeeping amendments had been made e.g. the membership has been revised to add the Chief Information Officer, updating of job titles, changes to reporting sub-committees, no other amendments are suggested.

The Terms of Reference is included at Appendix 3.

Proposed Amendments to the Committee Business Cycle

Each of the Committees established by the Board of Directors has an annual business cycle which is subject to review each year. The business cycle forms the 'core' agenda for Committee meetings throughout the year with scheduled business ensuring that the Committee discharges its responsibilities as set out in the Terms of Reference.

During 2022/23, there was evidence of the Committee utilising the business cycle effectively and receiving appropriate ad hoc escalation reports to review emerging issues.

The Finance, Performance & Business Development Committee last reviewed its annual business cycle in March 2022 and is therefore scheduled to complete a further review in order to set the business cycle for 2023/24.

All members of the Finance, Performance & Business Development Committee had the opportunity to participate in the annual review and propose any amendments to the business cycle and terms of reference during February 2023 by completing the committee effectiveness survey. The Committee members who responded did not make any suggested amendments to the business cycle or terms of reference.

In addition to the survey, discussions had been held between the Committee Chair, Chief Finance Officer and Trust Secretary to consider means to enhance Committee effectiveness.

During 2022/23, the following amendments to the business cycle were suggested and agreed:

- To add an annual progress update on Skills Development Network Accreditation at the Trust. Noted the ambition of the finance, procurement and digital teams towards implementation of the Skills Development Network Accreditation (as of May 2022).
- To remove from the workplan Neonatal Capital Programme Build benefits realisation as works completed
- To add progress update against the Health Financial Management Association (HFMA) Improving Financial Sustainability Checklist self-assessment

- The addition of a Post Implementation Review of Community Diagnostic Centre 2022/23

Other suggested additions / amendments:

- Market share intelligence: based on reporting during 2022/23 consider an annual update as opposed to bi-annual
- Addition of Security Management Annual Report (remitted from Quality Committee to the FPBD Committee)
- Biannual review of third-party contracts (as opposed to annual)
- Bi-annual digital strategy review: positive performance demonstrated against the strategy since implementation in 2020, requested submission of an annual review would be sufficient.

- Remove from workplan:
    - Learning from the major incident quarterly oversight reports. Any further learning would be included within the Emergency Planning Resilience & Response reporting.
    - Partnership Oversight – remit quarterly monitoring to the Executive Committee
    - Future Generations Steering Group as a reporting group. The Group had been stood down following the recommendations of the Liverpool Clinical Services Review agreed by the Integrated Care Board.

It is likely that key areas of attention during 2023/24 will be as follows:

- Monitoring the Trust's approach to managing a structural deficit and potentially a deficit 2023/34 plan
- Focus on operational targets and seek assurance on the work being undertaken to recover and restore services against established trajectories
- Focus on the impact of additional financial investment requests in-year
- Assessing the Trust's approach to partnerships, including those with the third sector
- Seeking assurance that benefits are being realised from the Trust's digital programmes
- Working to understand and provide assurance on income security and dynamics
- Considering the Trust's commercial approach and whether opportunities for additional sources of NHS and private income are being fully realised

The draft Business Cycle is included at Appendix 4.

Conclusion

In the final analysis, it is concluded that the Finance, Performance & Business Development Committee has achieved its objectives for the Financial Year 2022/23.

Louise Martin CHAIR
Finance, Performance & Business Development Committee
March 2023

Appendix 1

Finance, Performance & Business Development Committee, Attendance at Committee: April 2022 – March 2023

Core members	April 2022	May 2022	June 2022	July 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Louise Martin, Chair, Non-Executive Director	✓	A	✓	✓	✓	A	✓	✓	✓	✓	✓
Tracy Ellery, Non-Executive Director	✓	✓Chair	✓	✓	✓	Chair ✓	A	✓	✓	✓	✓
Tony Okotie, Non-Executive Director (until 30 June 2022)	✓	✓	A	NM							
Sarah Walker, Non-Executive Director	NM	✓	✓	A	✓	A	✓	✓	✓	✓	✓
Eva Horgan, Chief Finance Officer (until 31 Dec 2022)	✓	✓	✓	✓	✓	✓	✓	✓	NM		
Jenny Hannon, Chief Finance Officer/ Executive Director of Strategy & Partnerships (as of 01 Jan 2023)	NM						✓ NM	✓ NM	✓	✓	✓
Kathryn Thomson, Chief Executive	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	A
Gary Price, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Marie Forshaw, Chief Nurse and Midwife (until 31 August 2022)	✓	✓	✓	✓	NM						
Dianne Brown, Chief Nurse (as of 21 Dec 2022) Interim Chief Nurse (as of 01 Sept 2022)	NM				✓	✓	✓	✓	A	A	✓
Present (✓) Apologies (A) Representative (R) Non attendance (NA) Non Member (NM)											

Invited Attendees	Job Title	April 2022	May 2022	June 2022	July 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Robert Clarke	Chair	✓			✓	✓	✓	✓	✓	✓	✓	✓
Claire Deegan	Deputy Chief Finance Officer	✓	✓	✓	✓							
Linda Haigh	Interim Deputy Chief Finance Officer					✓	✓	✓	✓	✓	✓	✓
Mark Grimshaw	Trust Secretary	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matt Connor	Chief Information Officer	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓
Jen Huyton	Associate Director of Strategy	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓
Mike Ryan	Deputy Director of Estates & Facilities, LUFT	✓										
Andrew Duggan	Head of Communications, Marketing and Engagement	✓										
Lynn Greenhalgh	Medical Director	✓		✓		✓				✓		✓
Joe Downie	Deputy Chief Operating Officer		✓	✓		✓				✓		✓
Jackie Bird	Non-Executive	✓										
Beverly Ainsworth	Observer	✓										
Zia Chaudhry	Non-Executive	✓										
Gloria Hyatt	Non-Executive	✓										
Sarah Walker	Non-Executive	✓										
Michelle Turner	Chief People Officer	✓										✓
Claire Scott	Head of Strategic Finance		✓						✓	✓	✓	✓
Philip Moss	Head of Technology				✓							
Megan Binns	Observer, Graduate Management Trainee, CSS					✓				✓		
Matt O'Neill	Trust Security Lead					✓						
Zoe Delaney	CDC Operational Manager							✓		✓	✓	✓
Tom White	Deputy Divisional Manager – Clinical Support Services									✓		
Anil Bhalla	Consultant, Anaesthetics									✓		
Jen Deeney	Head of Nursing, Family Health									✓		
Danielle Burton	Deputy Divisional Manager, Family Health										✓	
Phil Bartley	Associate Director of Governance & Quality											✓

Finance, Performance & Business Development Committee Effectiveness Survey 2022/23

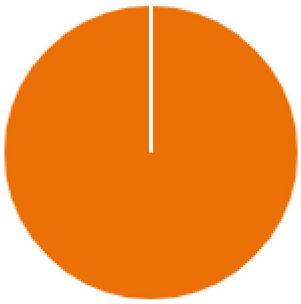
4	01:32	Active
Responses	Average time to complete	Status

1. I understand the duties of the committee.

Strongly agree	2
Agree	2
Disagree	0
Strongly disagree	0
Unable to answer	0

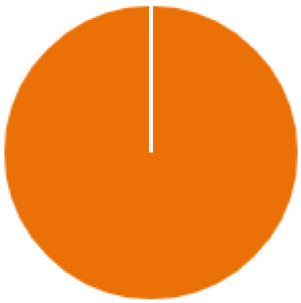
2. I believe the committee receives sufficient assurance to conclude upon its areas of responsibility

Strongly agree	0
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0



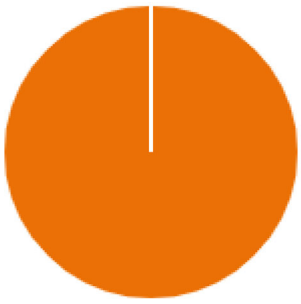
3. I am confident that the committee effectively monitors and scrutinises progress against the aligned strategies.

Strongly agree	0
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0



4. I am content that the committee is delivering the right level of assurance to the Board / Committee.

Strongly agree	0
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

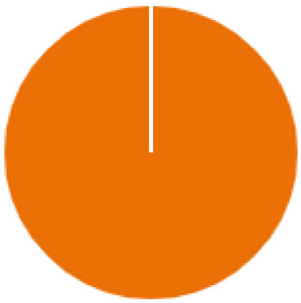


5. I believe that the committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management.

Strongly agree	1
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

6. I feel that the committee has the right balance of experience, attendance, knowledge and skills to fulfil its role.

Strongly agree	0
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

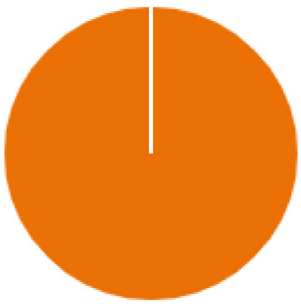


7. The committee has structured its agenda and work plan to cover its key responsibilities.

Strongly agree	1
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

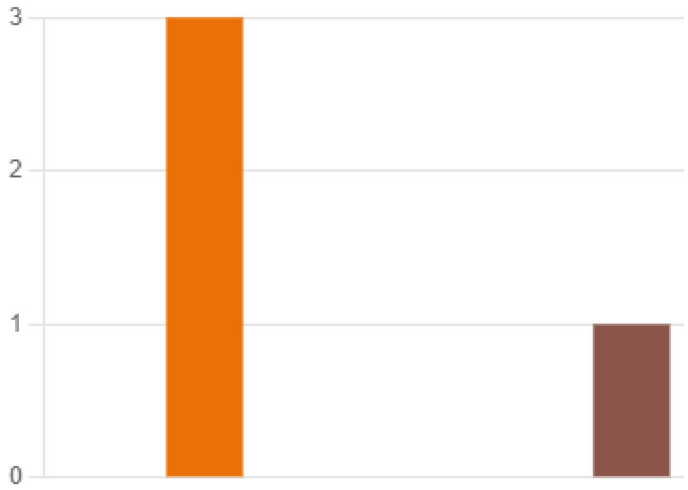
8. The current Committee work plan and focus of reports provides an opportunity to consider system priorities?

Strongly Agree	0
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0



9. Written reports received enable the Committee to hold informed discussions on key issues with clarity on the root causes of challenges, and a shared understanding of the pros and cons of the various options being put forward as potential solutions?

Strongly Agree	0
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0
Other	1



10. The committee is effectively chaired.

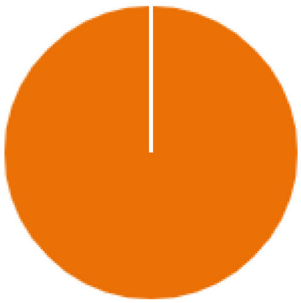
Strongly agree	0
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

11. All members of the committee are able to participate effectively.

Strongly agree	1
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

12. There is clarity in relation to the work of the committee and its interaction and alignment with other committees.

Strongly agree	0
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0



13. Any other comments, suggestions or actions.

1
Responses

Latest Responses

13. Any other comments, suggestions or actions.

1 Responses

ID ↑	Name	Responses
1	anonymous	The committee should pay more attention to the risk with regard to operational targets. An example would be risk to delivery of 78 weeks

Liverpool Women's NHS Foundation Trust

FINANCE, PERFORMANCE AND BUSINESS DEVELOPMENT COMMITTEE TERMS OF REFERENCE

Constitution:	The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Performance and Business Development Committee (the Committee).
Duties:	The Committee will operate under the broad aims of reviewing financial and operational planning, performance and business development. The Committee's responsibilities fall broadly into the following two areas: **Finance and performance** The Committee will: a. Receive and consider the annual financial and operational plans and make recommendations as appropriate to the Board. b. Review progress against key financial and performance targets c. Review on behalf of the Board, financial submissions (as reported in the Financial Performance Report) or others, as agreed by the Board, to NHS Improvement for consistency on financial data provided. d. Review the service line reports for the Trust and advise on service improvements e. Provide oversight of the cost improvement programme f. Oversee external financing & distressed financing requirements g. Oversee the development and implementation of the information management and technology strategy h. Examine specific areas of financial and operational risk and highlight these to the Board as appropriate through the Board Assurance Framework i. To undertake an annual review of the NHS Improvement Enforcement Undertaking. j. To review and receive assurance on the appropriateness of the Trust's Emergency Planning Resilience & Response processes and procedures. **Business planning and development** The Committee will: k. Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic

	business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management l. Advise the Board and maintain an oversight on all major investments, disposals and business developments. m. Advise the Board on all proposals for major capital expenditure over £500,000 n. Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors • Chief Executive • Chief Finance Officer • Chief Operations Officer • Chief Nurse ~~and Midwife~~ • Chief Information Officer Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	The quorum for the transaction of business shall be three members including at least two Non-Executive Directors ~~(one of whom must be the Chair or Vice Chair of the Committee)~~, and one Executive Director. The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of ~~50~~75% of all meetings. **b. Officers** Ordinarily the Deputy Director of Finance and Trust Secretary will attend all meetings. Other executive directors and officers of the Trust will be

	invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.
Frequency:	Meetings shall be held at least 10~~8~~ times per year. Additional meetings may be arranged if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.
Accountability and reporting arrangements:	The Finance, Performance and Business Development Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Finance, Performance and Business Development Committee.
Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) an Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • Emergency Planning Resilience & Response Sub-Committee • Digital Hospital Sub-Committee • Crown Street Enhancement Programme Board • ~~Future Generations Project Group~~ • Premises Assurance Group • Financial Recovery & Sustainability Sub-Committee

Edited November 2021 to add Premises Assurance Group as a reporting group

	• Community Diagnostic Centre Oversight
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by: Finance, Performance & Business Development Committee	*27 March 2023*
Approved by: Board of Directors	xx April 2023
Review date:	March 2024
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

Finance, Performance and Business Development Committee	BAF Link	Report up to Board	Exec Lead	WORKPLAN 2023/24											
				Quarter 1			Quarter 2			Quarter 3			Quarter 4		
				26 April 2023	31 May 2023	28 June 2023	26 July 2023	30 Aug	27 Sept 2023	25 Oct 2023	29 Nov 2023	20 Dec	31 Jan 2024	28 Feb 2024	27 Mar 2024
Standing Items															
Minutes of Previous meeting			TS	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Actions/Matters Arising			TS	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Chairs Report - Verbal			Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of Board Assurance Framework Risks		✓	CFO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Subcommittee Chairs reports & Terms of Reference: • Emergency Planning Resilience & Response Committee • Digital Hospital Sub-Committee • Crown Street Enhancement Programme Board • ~~Future Generations Project Group~~ • Premises Assurance Group • Financial Recovery Board • Community Diagnostic Centre Oversight			COO CIO CFO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of risk impacts of items discussed			CFO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Any other business			Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of meeting			Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
MATTERS FOR DISCUSSION & BOARD ACTION/DECISION															
To be ambitious and efficient and make best use of available resources															
Monthly Finance Performance review (Incl CIP)		✓	CFO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Monthly Operational Performance review		✓	COO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
~~Treasury Management Quarterly Report *(Part of finance performance review. Not a separate report)*~~			CFO	~~✓~~	-	-	~~✓~~			~~✓~~			~~✓~~		
Post Implementation Review of Cost Improvement Programme (CIP)			CFO		✓						✓ (H1)				
Review of unaudited Annual Accounts (prior Audit)		✓	CFO		✓										
Review of Strategic Progress			CFO	✓			✓			✓			✓		
Crown Street Enhancement Progress Review			CFO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Community Diagnostic Centre Oversight			COO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Post Implementation Review of CDC 2022/23			COO		✓										
~~Neonatal Capital Programme Build benefits realisation~~			CFO								~~✓~~				
Annual Business Case Post Implementation Reviews			CFO								✓				
Review Marketing Strategy			CPO							✓					
Digital Services Update			CIO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Digital Generations Strategy 2020-2024 ~~Bi-~~Annual review			CIO						~~✓~~ -					✓	
Information Governance Update			SIRO	✓			✓			✓			✓		
Revenue and capital budget for 2024/25		✓	CFO												✓
Operational Planning: Annual Operational Plan & Six monthly review		✓	COO		✓(OP)					✓ (BR)					~~✓(OP)~~

Finance, Performance and Business Development Committee	BAF Link	Report up to Board	Exec Lead	WORKPLAN 2023/24											
				Quarter 1			Quarter 2			Quarter 3			Quarter 4		
				26 April 2023	31 May 2023	28 June 2023	26 July 2023	30 Aug	27 Sept 2023	25 Oct 2023	29 Nov 2023	20 Dec	31 Jan 2024	28 Feb 2024	27 Mar 2024
Corporate Objectives: • Bi-annual (BR) & Year-end review (AR) • Objective Setting for 2023/24 (OS)		✓	TS/Exec	✓(OS)					✓ (BR)						✓(AR)
Emergency Planning Resilience & Response (EPRR) Annual Report		✓	COO	✓											
EPRR NHSE/I Annual Assurance Annual Report			COO								✓				
Analytical Review on Draft 2022/23 Accounts		✓	CFO		✓										
Annual Estates and Facilities Compliance Report			COO	✓											
Assurance regarding third party service provider controls (bi-annual)			CFO				✓						✓		
Delivery a Net Zero NHS and Trust Green Plans			COO	✓						✓					
~~Learning from the major incident (quarterly oversight)~~			COO	✓			✓		✓				✓		
Major procurement decisions (ad-hoc as necessary)			CFO												
Modern Slavery Act 2015 Annual review			TS								✓				
Skills Development Network Accreditation (annual)			CFO		✓										
~~Partnership Oversight (quarterly)~~			CFO		✓		✓				✓			✓	
Market share intelligence (~~bi~~ annual)			CFO				✓						✓		
Security Management Annual Report			COO		✓										
HFMA Improving Financial Sustainability Checklist self-assessment annual update			CFO							✓					
General Governance Arrangements															
Risk Appetite Statement for 2024/25		✓	CNM												✓
FPBD Committee Effectiveness Annual Report		✓	CFO												✓
FPBD Terms of Reference		✓	TS												✓
FBPD Business Cycle			TS												✓

COLOUR KEY

Deferred

Item considered as planned

Item considered following deferral

Q=Quarter WP=Work plan AR=Annual Report AP=Annual Plan OS=Objective Setting

Liverpool Women's
NHS Foundation Trust

Quality Committee

Annual Report 2022/23

Background

This report covers the period April 2022 to March 2023. There were 11 meetings held during this period.

The Committee's responsibilities fall broadly into the following three areas:

Strategy and Performance

a) Oversee the development and implementation of the Quality Strategy with a clear focus on upholding the tenants of quality (Governance, safety, patient experience and clinical effectiveness).

b) Ensure that the Quality Strategy and performance are consistent with the Trust's; Vision and strategic objectives and oversee any initiatives undertaken by the Trust that relates to the development and implementation of the Quality Strategy.

c) Review trends in patient safety, experience and outcomes (effectiveness) to provide assurance to the Board on performance and commission 'deep dives' as appropriate.

d) To receive assurance that action plans arising from in-patient, out-patient and other care related surveys are being undertaken and make recommendations to the Board as appropriate.

e) Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery.

Governance

f) Oversee the effectiveness of the clinical systems developed and implemented to ensure they maintain compliance with the Care Quality Commission's Fundamental Standards in relation to Quality, Safety, experience and effectiveness.

g) Obtain assurance of the Trust's ongoing compliance with the Care Quality Commission registration.

h) Review the controls and assurance against relevant quality risks on the Board Assurance Framework and provide assurance to the Board that risks to the strategic objectives relating to quality and safety are being managed and facilitate the completion of the Annual Governance Statement at year end.

i) Obtain assurance that the Trust is compliant with guidance from NICE (through receipt of an Annual Report) and other related bodies.

j) Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices from NHSI, the Care Quality Commission, the Health and Safety Executive and other external assessors.

k) Receive the annual clinical audit programme and provide assurance to the Board that clinical audit supports the Trust to provide safe and clinically effective patient care and obtain assurance that there is delivery against agreed annual clinical audit programme.

l) Implement and monitor the process for the production of the Trust's year end Quality Report before it is presented to the Trust Audit Committee and Board for formal approval.

m) Undertake an annual review of the Quality and Risk Management Strategies to ensure that they reflect all required priorities.

n) To have oversight of the Committees performance measures to ensure they are appropriate and provide assurance of compliance and escalate exceptions to Trust Board.

o) To review the proposed internal audit plan for all functions areas within the Committees remit e.g. Clinical Audit, Safety, Experience and Effectiveness.

p) Review the Trust's Research and Development Strategy and Innovation Strategy prior to their recommendation it to the Board of Directors.

q) Approving the terms of reference and memberships of its subordinate committees.

Overall

r) To approve any matters that, due to time constraints, could not be approved by the Board within the scope of the Committees areas of responsibility.

s) Referring relevant matters for consideration to other Board Committees as appropriate.

t) Considering relevant matters delegated or referred to it by the Board of Directors or referred by any of the Board Committees.

u) Escalating matters as appropriate to the Board of Directors.

v) Assurances will be provided from internal and external sources and will be included in a work plan approved by the Committee at the commencement of each financial year.

Constitution

The Quality Committee is accountable to the Board of Directors.

Membership during the year comprised:

- Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- *Medical Director
- *Chief Nurse and Midwife
- *Chief Finance Officer
- *Chief People Officer
- *Chief Operating Officer
- Deputy Director of Nursing and Midwifery
- Associate Director of Quality and Governance

Meetings were also attended by other executives and senior management staff as appropriate.

The Committee's constitution allows for members to participate by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference. Due to the ongoing Covid-19 pandemic, all meetings during 2022/23 had been held on a hybrid basis with the option for members to meet on site in person or join the meeting virtually utilising Microsoft Teams.

The Terms of Reference requires that all members of the committee attend a minimum of 75% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2022/23 together with the names of senior management who were invited to attend during the year. The majority of members attended 75% or more of the meetings during 2022/23. This appendix will be updated post meeting so that a full 2022/23 picture can be provided to the Board.

Key achievements / activity

The Committee held a meeting and workshop in December 2022. The additional meeting was utilised to receive targeted reports on the following:

- Maternity Incentive Scheme (CNST) Year 4 final paper: seeking assurance that the Trust was adequately achieving CNST scheme standards ahead of final submission
- Pathology Sampling and Collection Errors Update: seeking additional assurance since an update received in September 2022

The meeting in December 2022 was followed by a workshop session to focus on the Quality Dashboard and the reformatted quality performance metrics.

Performance Report
The Committee received this report at each scheduled meeting and received a revised performance report following approval at the December workshop session. The opportunity is taken to scrutinise any area of note challenge, particularly from the lens of the impact of the quality and safety of services. During the year, particular attention was given to the Telephone Triage system for patients, cancer pathway access and recovery and on the Maternity Assessment Unit towards the end of 2022/23.

Board Assurance Framework (BAF)
The Committee regularly reviewed the Board Assurance Framework risks assigned in line with the business cycle of activities. The Committee held discussions over the rating of specific risks attributable to the Committee noting that they were being managed appropriately. The Committee reported all changes to the BAF at the next following Board of Directors meeting for approval.

Clinical Negligence Scheme for Trusts (CNST)
Whilst there have been several amendments to CNST requirements and timescales throughout 2022/23, the Committee has continued to monitor compliance and progress against the 10 safety standards. This was in recognition that working towards the safety standards is an important quality objective and not just a compliance matter.

Ockenden Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust
From the publication of the report in December 2020, the Committee has continued to receive regular reports on the Trust's response to the Ockenden Review. The Committee's fundamental role has been to ensure compliance against the recommendations but to also consider wider issues such as effective lesson learning and patient involvement and engagement.

Integrated Governance Report
The Committee has continued to receive this as a quarterly report and the development of the document, and the information contained therein has been an iterative process. The introduction of monthly divisional integrated reporting had strengthened the process and content of the report. A continued focus to strengthen the evidence on outcomes was agreed.

Mortality Reporting and Learning from Deaths
The Committee received quarterly reports and improved report content following on from work undertaken during 2021/22. Appropriate data and evidence of lesson learning had been provided for the purposes and aims of the Committee. The Committee approved the Adult Mortality Strategy.

The Committee received key findings from the following reviews:

- Northwest Operational Delivery Network (NWODN) review to benchmark LWH Neonatal Unit against St Mary's Hospital (SMH)
- Thematic Review of Stillbirths in 2021/22
- Review to investigate in-utero transfer rates at LWH compared to SMH

Quality & Regulatory Update
The Committee continued to receive the CQC Insight Tool on a bi-monthly basis or as often as the CQC published their data. The tool comprises of information about the Trust which is analysed by the CQC to monitor services at provider, location, and core service level. The Committee also received the CQC Preparedness Framework for 2022/23 to support a strengthened approach to engage and raise awareness of staff of the inspection process.

Patient Surveys
The Committee received findings and recommendations in relation to national surveys undertaken at the Trust, for example the annual Maternity Picker Survey 2021 and the Hewitt HFEA Inspection 2022.

Robotic Assisted Surgery Update
The Committee received a presentational update in relation to Robotic Assisted Surgery introduced to the Trust in October 2020.

Future Generations and Isolated Site Risks
The Committee received an updated Case for Change and Counterfactual Case in May 2022. Isolated site risk updates provided oversight of programme works in collaboration with the Integrated Care Board and a coordinated approach to recording serious incidents attributable to the isolation of Trust services from other specialist services.

Security Management Annual Report
The Committee received the Security Management Annual Report 2021/22. There had been a refocus on security management since the major incident in November 2021, and a sub-group of Finance, Performance and Business Development (FPBD) Committee called Environment Safety Group (ESG) had been commissioned to oversee work identified from the Security Review. Future reports on Security Management would be reported through to the FPBD Committee as part of revised governance arrangements.

Imaging Department
The Committee received the findings of the external review undertaken in the Imaging Department into the workforce and leadership.

Lesson Learning and Serious Incidents
The Committee received regular updates on serious incidents and learning. In addition to the monthly and quarterly reporting the Committee also received the following incident reports: a retrospective thematic review of maternity serious incidents; a thematic analysis of the 2021/22 Healthcare Safety Investigation Branch (HSIB) case investigation reports; and an Imaging Department serious incident review.

Blood Sampling Update
Committee maintained oversight of the Blood Sampling errors since the matter was escalated and commissioned additional updates and trajectories to monitor the position. A detailed analysis was presented to the Committee at the additional meeting held in December 2022 and assurance of action and improvements taken.

Be Brilliant Accreditation Scheme Update
The Committee received an update against the newly launched Be Brilliant Ward Accreditation Scheme (BBAS) developed to bring together key measures of clinical care, operational performance, and governance into one overarching framework to enable a comprehensive assessment of quality, safety and, care at ward, department or team level.

Cost Improvement Programme (CIP) 2021/22 Post Implementation Review
The post implementation review against the Cost Improvement Programme 2021/22 had been shared with the Committee to demonstrate positive impact on quality of care and patient experience as a result of the CIP programme.

Abortion care providers response to NWROC 0273: B2156 and requirement to submit Abortion Notifications (DHSC Letter)
The Committee received a position update of the Trust response and adherence to national legislative changes introduced in relation to abortion care. The Committee was assured that evidence was being collated and that delivery of abortion care was in line with the current legislative changes.

Review of Clinical and Quality Strategy
The Committee reviewed the bi-annual clinical and quality strategy. The content of which would support the development of the Trust's Annual Quality Account.

Medicines Management Quarterly Assurance Reports
This has remained a key concern for the Committee following the CQC Warning Notice issued in 2020. Assurance of the effective management of medicines is received on a quarterly basis. The totality of work undertaken, and improvements achieved to date since the CQC warning notices was noted and the subsequent increased monitoring and oversight had been successfully identifying any potential further weaknesses.

Maternity Safety Champion Assurance Reports
The Committee receives quarterly reports from the maternity safety champion meetings and escalates any issues of note to the Board. The Safety Champion process has been an effective model to communicate safety intelligence and escalate safety issues where necessary.

Research & Development Annual Report and Strategy
The Committee received the annual Research and Development Report 2021/22 and was assured by the overview of compliance and governance assurance related to research activity. The Committee approved the Research Development & Innovation Strategy 2023-2028.

Infection Control
The Committee received the annual Infection Prevention and Control Report 2021/22 and the updated NHS England IPC Board Assurance Framework. The Committee was assured that the Trust was taking all actions reasonably practicable to ensure it is working to meet its responsibilities for Infection Prevention and Control in relation to Covid-19.

Local Safety Standard for Invasive Procedures (LocSSIPs)
Quarterly progress updates in relation to implementation of LocSSIPs with a focus on ensuring that LocSSIPs become an integral part of the electronic patient record across the organisation.

Health and Safety Annual Report
The Committee received the annual Health and Safety Report 2021/22 and was assured by the overview of compliance and governance assurance regarding the Health and Safety arrangements, activities, performance and improvements illustrated.

Divisional Governance Maturity
Committee support towards the strengthening of the Trust's divisional governance arrangements.

Chair Log
The Committee had received and responded to a total of 8 chair actions received from the Trust Board and Board Committees during 2022/23 and delegated 5 chair actions to supporting groups to seek additional assurances.

Areas for Development

For the second time, an effectiveness survey was circulated to members of the Committee seeking feedback on the activity of the Committee during 2022/23. Overall, the responses received were positive albeit mixed on certain questions – the full results can be seen in Appendix 2. There were mixed results on the following questions:

- Q8 - The current Committee work plan and focus of reports provides an opportunity to consider system priorities?

- Q9 - Written reports received enable the Committee to hold informed discussions on key issues with clarity on the root causes of challenges, and a shared understanding of the pros and cons of the various options being put forward as potential solutions?

The following narrative observations were provided on the survey:

- The quality of papers are variable and if they are not of the required standard this leads to the committee asking for more detail to try and establish assurance level.

- Quality of report writing continues to be an area for improvement, a concise lens on the 'so what' and awareness of appropriate comms for Execs v's division is required. More focus on outcomes.

- To ensure the template of papers allows for linkages to system and partners which will aid discussions and ensure that we are taking account of system objectives.

- I think the QC needs to refocus its workplan to ensure delivery of a focussed Quality Strategy that delivers clear improvements across health outcomes aligned to the ICB priorities. There is a need for enhanced triangulation with clinical leads across clinical outcomes.

- Progress has been made, but we need to focus on the continued improvements on report content, applicability to board, and the outcomes that need to be monitored.

The above observations had also been made by members of the Committee throughout the business of the Committee during 2022/23. These will be factored into the wider work that will support the refreshed governance and performance framework.

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in March 2022 and were approved by the Board in April 2022.

Other than housekeeping amendments e.g. additional regular attendees no other amendments are suggested.

Some thought has been given to the reporting of the Maternity Transformation Board e.g. should this report into an Executive led meeting rather than a Board Committee. Considering the need for the organisation to maintain a watching brief on maternity improvements, it is suggested to retain the current reporting structure.

The Terms of Reference is included at Appendix 3.

Proposed Amendments to the Committee Business Cycle

Each of the Committees established by the Board of Directors has an annual business cycle which is subject to review each year. The business cycle forms the 'core' agenda for Committee meetings throughout the year with scheduled business ensuring that the Committee discharges its responsibilities as set out in the Terms of Reference.

The Quality Committee last reviewed its annual business cycle in March 2022 and is therefore scheduled to complete a further review in order to set the business cycle for 2023/24.

All members of the Quality Committee had the opportunity to participate in the annual review and propose any amendments to the business cycle and terms of reference during February 2023 by completing the committee effectiveness survey. The Committee members who responded suggested the following amendments to the business cycle:

- a focus within the workplan to ensure delivery of the Quality Strategy that delivers clear improvements across health outcomes aligned to the ICB priorities.
- enhanced triangulation with clinical leads across clinical outcomes.
- allow for linkages to system and partners which will aid discussions and ensure that we are taking account of system objectives.

In addition to the survey, discussions had been held between the Committee Chair, Chief Nurse & Midwife, Medical Director and Trust Secretary to consider means to enhance Committee effectiveness.

During 2022/23, the following amendments to the business cycle were suggested and agreed:

- Legal Services Annual Report: proposed to go through the Safety & Effectiveness Sub-Committee for final review and any matters escalated as necessary to Quality Committee. In addition, ensure that legal updates continue to be provided within the Integrated Governance Report for Committee oversight.
- Annual Quality Report (review prior to Audit C/Board) & mid-year review: the mid-year review was added to the workplan in May 2022 and subsequently proposed to be removed as the content was included within the Clinical & Quality Strategy Bi-Annual Review.
- Future Generations: a monthly update was added to the workplan in July 2022 however it was subsequently agreed that updates in relation to isolated site risks should be included within the Board Assurance Framework report and specific reports submitted as required.
- Serious Incidents & Learning Report: proposed that monthly serious incident data should be included within the revised Quality Performance Report as of September 2022. Quarterly learning reports should be provided within the Integrated Governance Report for Committee oversight as of November 2022.
- Ockenden Report Update: proposed to move Ockenden updates into the Quality Performance Report as of September 2022 rather than a standalone update. Detailed reports could be submitted as required.
- Safeguarding Quarterly Report: proposed quarterly reporting to go through the Trust Safeguarding Sub-Committee for final review and any matters escalated as necessary to Quality Committee. Additionally, ensure that information in relation to the quarterly report continue to be provided within the Sub-Committee Chair Reports. It was subsequently requested by the Safeguarding Team to maintain submission of the quarterly reports direct to the Committee and they were reintroduced as of Quarter 3.
- CQC Insight Tool: incorporated into the Quality and Regulatory Update report on the workplan and removed as a separate report.
- Security Management Annual Report: security management remitted to the Finance, Performance & Business Development Committee

Other suggested additions / amendments:

- Equality, Diversity and Inclusion Update (bi-annual)

- Public Health agenda and Equalities (annual)
- Staff (Patient) Quality Experience Story (quarterly)
- Palliative and End of Life Care Report (bi-annual): this was new to the 2022/23 workplan but nothing had been received during the year.

During 2022/23, there had been markedly less additional items (above the agreed work programme) received by the Committee. This had been a significant issue during 2021/22 with over 30 additional reports being received and demonstrates better management of utilising the business cycle and receiving appropriate ad hoc escalation reports to review emerging issues.

It is likely that key areas of attention during 2023/24 will be as follows:

- To continue to oversee progress being made to improve waiting times for Trust services
- To seek robust assurance that the Trust is making progress in its approach to understand the patient experience (from all groups) and actively utilizing this intelligence to improve service delivery
- Continuing to ensure that lesson learning is in place with the effective 'closing of loops'.
- Providing assurance to the Board that the organisation is 'inspection ready' at all times
- To focus on refresh of the Quality Strategy that delivers clear improvements across health outcomes aligned to the ICB priorities
- To enhance triangulation with clinical leads across clinical outcomes via the maturity of the Divisional Governance arrangements and its alignment with the quality assurance agenda
- Ensuring that quality data is being utilised to identify and drive through improvement
- That the Trust's QI approach is maturing and embedding.
- That the Trust builds on research successes to be a 'leading voice' in women's health research.

The draft Business Cycle is included at Appendix 4.

Conclusion

In the final analysis, it is concluded that the Quality Committee has achieved its objectives for the Financial Year 2022/23.

Sarah Walker CHAIR
Quality Committee
March 2023

Appendix 1

Quality Committee, Attendance at Committee: April 2022 – March 2023

Core members	April	May	June	July	Sept	Oct	Nov	Dec	Jan	Feb	March
Tony Okotie, Non-Executive Director & Cttee Chair (until 31.05.22)	✓	✓	✓ in attendance	NM							
Susan Milner, Non-Executive Director (until 31.05.22)	✓	A	NM								
Sarah Walker, Non-Executive Director & Committee Chair (as of 01.06.22)	✓	✓	✓	A	✓	A	✓	✓	✓	✓	✓
Louise Kenny, Non-Executive Director	A	✓	✓	A	✓	✓	✓	✓	✓	A	✓
Jackie Bird, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gloria Hyatt, Non-Executive Director	NM	✓	✓	✓ C	✓	✓	✓	✓	✓	✓	A
Marie Forshaw. Chief Nurse and Midwife (until 31.08.22)	✓	✓	✓	✓	NM						
Dianne Brown, Chief Nurse (as of 21.12.22) Interim Chief Nurse (as of 01.09.22)	NM				✓	✓	✓	✓	✓	✓	✓
Gary Price, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lynn Greenhalgh, Medical Director	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓
Eva Horgan, Chief Finance Officer (until 31 December 2022)	A	✓	✓	✓	✓	A	✓	✓	NM		
Jenny Hannon, Chief Finance Officer (as of 01 January 2023)	NM								✓	A	✓
Michelle Turner, Chief People Officer	✓	✓	✓	✓	A	A	✓	✓	✓	✓	✓
Nashaba Ellahi, Deputy Director of Nursing & Midwifery	✓	✓	✓	A	✓	A	✓	✓	A	A	✓
Philip Bartley, Associate Director of Quality & Governance	✓	✓	✓	A	✓	A	A	A	✓	✓	✓
Present (✓) Apologies (A) Representative (R) Non attendance (NA) Non Member (NM)											

Invited Attendees	Job Title	April 2022	May 2022	June 2022	July 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023
Mark Grimshaw	Trust Secretary	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chris Dewhurst *nominated MD deputy	Deputy Medical Director						✓					
Robert Clarke	Chairman	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Kathryn Thomson	Chief Executive	✓	✓		✓		✓	✓		✓	✓	
Yana Richens	Director of Midwifery				✓	✓						
Angela Winstanley	Quality & Safety Midwife		✓	✓	✓		✓			✓		
Matt Connor	Chief Information Officer	✓	✓			✓	✓	✓	✓	✓	✓	✓
Louise Hardman	Research & Development Manager			✓							✓	
Michelle Rushby	Head of Audit, Effectiveness and Patient Experience	✓										
Joe Downie	Deputy Chief Operating Officer		✓	✓								
Beverly Ainsworth	Observer	✓										
Mohamed Otify	Consultant Gynaecologist		✓									
Alison Murray	Acting Head of Midwifery / Deputy Head of Midwifery		✓		✓							
Dianne Brown	Interim Associate Director		✓	✓	✓							
Jen Huyton	Head of Strategy and Transformation		✓									
Richard Haines	Consultant for Patient Experience		✓									
Matt O'Neill	Safeguarding Governance and Assurance Lead		✓									
Lowri Lloyd-Preston	Head of AHPs			✓		✓						
Claire Holroyd	Imaging Manager			✓								
Tim Neal	Director of Infection, Prevention & Control			✓								
Tracy Bryning	Health & Safety Manager			✓								
Megan Binns	Observer, Graduate Management Trainee					✓						
Tracy Ellery	Non-Executive Director				✓							
Allan Hawksey	Head of Risk and Safety				✓			✓	✓			
Alison Bedford Russell	Consultant Neonatologist				✓							
Rebecca Kettle	Consultant				✓					✓		
Rachel London	Deputy Director of Workforce						✓					

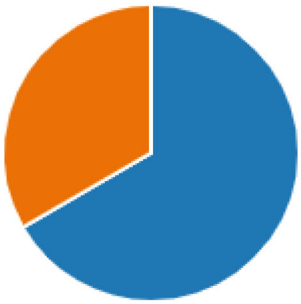
Rachel Gregoire	Scientific Director						✓					
Ellen Gerrard	DM CSS						✓					
Kerri Boyd	Observing						✓					
Jenny Hannon	Associate Director of System Partnership							✓	✓			
Richard Strover	Head of Information								✓			
Alice Bird	Clinical Lead, Maternity					✓			✓			
Heledd Jones	Head of Midwifery						✓		✓			✓
Alison Murray	Deputy Head of Midwifery								✓			
Jen Deeney	Head of Neonatal Nursing								✓			
Vicky Clarke	Divisional Manager, Family Health								✓			✓
Rebecca Holland	Quality & Safety Matron Gynaecology									✓		
Sarah Howard	Quality and Safety Matron, Family Health									✓		
Deborah Ward	Assistant Director of Nursing & Midwifery											✓

Quality Committee Effectiveness Survey 2022/23

6	07:28	Active
Responses	Average time to complete	Status

1. I understand the duties of the committee.

Strongly Agree	4
Agree	2
Disagree	0
Strongly disagree	0
Unable to answer	0



2. I believe the committee receives sufficient assurance to conclude upon its areas of responsibility

Strongly Agree	1
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0

3. I am confident that the committee effectively monitors and scrutinises progress against the aligned strategies.

Strongly Agree	2
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

4. I am content that the committee is delivering the right level of assurance to the Board / Committee.

Strongly Agree	2
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

5. I believe that the committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management.

Strongly Agree	2
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

6. I feel that the committee has the right balance of experience, attendance, knowledge and skills to fulfil its role.

Strongly Agree	3
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

7. The committee has structured its agenda and work plan to cover its key responsibilities.

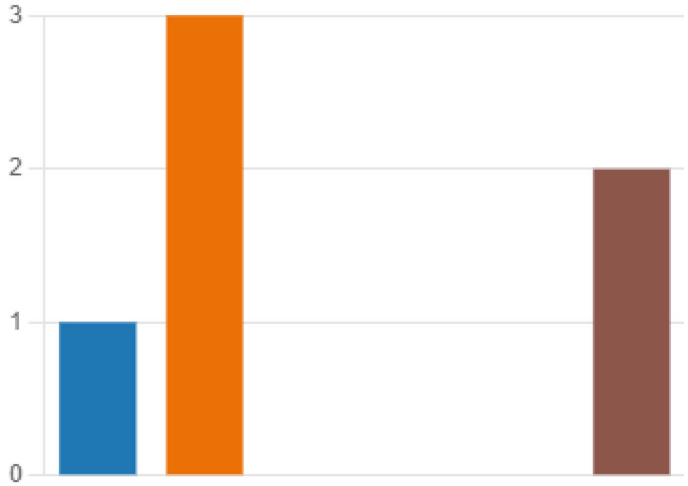
Strongly Agree	2
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

8. The current Committee work plan and focus of reports provides an opportunity to consider system priorities?

Strongly Agree	2
Agree	2
Disagree	2
Strongly disagree	0
Unable to answer	0

9. Written reports received enable the Committee to hold informed discussions on key issues with clarity on the root causes of challenges, and a shared understanding of the pros and cons of the various options being put forward as potential solutions?

Strongly Agree	1
Agree	3
Disagree	0
Strongly Disagree	0
Unable to answer	0
Other	2



10. The committee is effectively chaired.

Strongly Agree	2
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	1

11. All members of the committee are able to participate effectively.

Strongly Agree	2
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

12. There is clarity in relation to the work of the committee and its interaction and alignment with other committees.

Strongly Agree	3
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

13. Any other comments, suggestions or actions.

3
Responses

Latest Responses

"Progress has been made, but we need to focus on the contin...

"I think the QC needs to refocus its workplan to ensure delive...

9. Written reports received enable the Committee to hold informed discussions on key issues with clarity on the root causes of challenges, and a shared understanding of the

6 Responses

ID ↑	Name	Responses
1	anonymous	["Agree"]
2	anonymous	["The quality of papers are variable and if they are not of the required standard this leads to the committee asking for more detail to try and establish assurance level. "]
3	anonymous	["Agree"]
4	anonymous	["Agree"]
5	anonymous	["Quality of report writing continues to be an area for improvement, a concise lens on the 'so what' and awareness of appropriate comms for Execs v's division is required. More focus on outcomes"]
6	anonymous	["Strongly Agree"]

13. Any other comments, suggestions or actions.

3 Responses

ID ↑	Name	Responses
1	anonymous	To ensure the template of papers allows for linkages to system and partners which will aid discussions and ensure that we are taking account of system objectives.
2	anonymous	I think the QC needs to refocus its workplan to ensure delivery of a focussed Quality Strategy that delivers clear improvements across health outcomes aligned to the ICB priorities. There is a need for enhanced triangulation with clinical leads across clinical outcomes
3	anonymous	Progress has been made, but we need to focus on the continued improvements on report content, applicability to board, and the outcomes that need to be monitored.

QUALITY COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Quality Committee (QC) (the Committee).
Duties:	The Committee's responsibilities fall broadly into the following three areas: **Strategy and Performance** a) Oversee the development and implementation of the Quality Strategy with a clear focus on upholding the tenants of quality (Governance, safety, patient experience and clinical effectiveness). b) Ensure that the Quality Strategy and performance are consistent with the Trust's; Vision and strategic objectives and oversee any initiatives undertaken by the Trust that relates to the development and implementation of the Quality Strategy. c) Review trends in patient safety, experience and outcomes (effectiveness) to provide assurance to the Board on performance and commission 'deep dives' as appropriate. d) To receive assurance that action plans arising from in-patient, out-patient and other care related surveys are being undertaken and make recommendations to the Board as appropriate. e) Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery. **Governance** f) Oversee the effectiveness of the clinical systems developed and implemented to ensure they maintain compliance with the Care Quality Commission's Fundamental Standards in relation to Quality, Safety, experience and effectiveness. g) Obtain assurance of the Trust's ongoing compliance with the Care Quality Commission registration. h) Review the controls and assurance against relevant quality risks on the Board Assurance Framework and provide assurance to the Board that risks to the strategic objectives relating to quality and safety are being managed and facilitate the completion of the Annual Governance Statement at year end. i) Obtain assurance that the Trust is compliant with guidance from NICE (through receipt of an Annual Report) and other related bodies. j) Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices from NHSI, the Care Quality Commission, the Health and Safety Executive and other external assessors.

	k) Receive the annual clinical audit programme and provide assurance to the Board that clinical audit supports the Trust to provide safe and clinically effective patient care and obtain assurance that there is delivery against agreed annual clinical audit programme. l) Implement and monitor the process for the production of the Trust's year end Quality Report before it is presented to the Trust Audit Committee and Board for formal approval. m) Undertake an annual review of the Quality and Risk Management Strategies to ensure that they reflect all required priorities. n) To have oversight of the Committees performance measures to ensure they are appropriate and provide assurance of compliance and escalate exceptions to Trust Board. o) To review the proposed internal audit plan for all functions areas within the Committees remit e.g. Clinical Audit, Safety, Experience and Effectiveness. p) Review the Trust's Research and Development Strategy and Innovation Strategy prior to their recommendation it to the Board of Directors. q) Approving the terms of reference and memberships of its subordinate committees. Overall r) To approve any matters that, due to time constraints, could not be approved by the Board within the scope of the Committees areas of responsibility. s) Referring relevant matters for consideration to other Board Committees as appropriate. t) Considering relevant matters delegated or referred to it by the Board of Directors or referred by any of the Board Committees. u) Escalating matters as appropriate to the Board of Directors. v) Assurances will be provided from internal and external sources and will be included in a work plan approved by the Committee at the commencement of each financial year.
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors • *Medical Director • *Chief Nurse and Midwife • *Chief Finance Officer • *Chief People Officer • *Chief Operating Officer • Deputy Director of Nursing and Midwifery • Associate Director of Quality and Governance • Director of Midwifery • Head of Midwifery

	*or their nominated representative who will be sufficiently senior and have the authority to make decisions. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be three members including two Non-Executive Directors and one Executive Director (one of whom must be either the Medical Director or Director of Nursing and Midwifery or their deputy). The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	a) Members Members will be required to attend a minimum of 75% of all meetings. b) Officers The Trust Secretary shall normally attend meetings. Other executive directors (including the Chief Executive) and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall usually be held monthly (minimum of 10). Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.
Accountability and reporting arrangements:	The Quality Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members.

	The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Committee.
Reporting Committees/ Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • Safety and Effectiveness Sub-Committee • Patient Involvement & Experience Sub-Committee • Corporate Risk Sub-Committee • Trust Safeguarding Sub-Committee • Research and Development Sub-Committee • Maternity Transformation Board
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Quality Committee	27 March 2023
Approved by Board of Directors:	06 April 2023
Review date:	March 2024
Document owner:	Mark Grimshaw, Trust Secretary, Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

NHS
Liverpool Women's
NHS Foundation Trust

Quality Committee

	BAF Link	Executive Owner	Report up to Board	WORKPLAN 2023 / 24											
				Quarter 1			Quarter 2			Quarter 3			Quarter 4		
				25 April 2023	30 May 2023	27 June 2023	25 July 2023	29 Aug 2023 TBC	26 Sept 2023	24 Oct 2023	28 Nov 2023	19 Dec 2023 TBC	30 Jan 2024	27 Feb 2024	26 Mar 2024
Standing Items															
Minutes of Previous meeting		TS		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Actions/Matters Arising		TS		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Chairs Report - Verbal		Chair		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Monthly Quality Performance Report		COO	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of BAF risks		CNM	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Quality and Regulatory update – internal reviews (CQC assessments; CQC Insight Tool) and External guidelines, statute best practice etc. to be reported by exception		CNM		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of risk impacts of items discussed		Chair		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Any other business		Chair		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of meeting		Chair		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Annual Reports & Strategies															
Infection Prevention and Control Annual Report		CNM	✓			✓									
Annual Safeguarding Report		CNM	✓				✓								
Annual Health & Safety Report		COO	✓			✓									
Research & Development Annual Report		MD	✓			✓									
Research and Innovation Strategy and Review		MD	✓						✓					✓ (annual)	
Complaints Annual Report		CNM					✓								
~~Security Management Annual Report~~		COO			~~✓~~										
~~Legal Services Annual Report~~		CNM								~~✓~~					
Annual Quality Report (review prior to Audit C/Board) ~~& mid-year review~~		MD	✓		✓										
Review of Clinical & Quality Strategy (bi-annual)		MD				✓					✓				
NICE Annual Report		MD					✓								
Palliative and End of Life Care Report (bi-annual)		MD													
~~Future Generations (monthly *added July 2022*)~~		CFO					~~✓ NEW~~		~~✓~~	~~✓~~	~~✓~~		~~✓~~	~~✓~~	~~✓~~
Patient															
~~Serious Incidents & Learning Report~~		CNM	✓	~~✓ (Q4)~~	~~✓~~	~~✓~~	~~✓ (Q1)~~		~~✓~~	~~✓~~	~~✓ (Q2)~~		~~✓ (Q3)~~	~~✓~~	~~✓~~
Mortality and Perinatal Report (Learning from Deaths)		MD	✓		✓(Q4)				✓(Q1)		✓(Q2)			✓(Q3)	
Integrated Governance Assurance Report		CNM			✓ (Q4)		✓(Q1)			✓(Q2)				✓ (Q3)	
Medicines Management Assurance Report		MD			✓ (Q4)		✓(Q1)			✓ (Q2)			✓(Q3)		
LocSSIPs Quarterly Assurance Report		MD			✓ (Q4)		✓(Q1)			✓(Q2)				✓ (Q3)	
Seven Day Working Board Assurance – 6 monthly		MD		✓						✓					
~~Oekenden Report Update~~		CNM		~~✓~~		~~✓~~			~~✓~~		~~✓~~		~~✓~~		~~✓~~
Safety Champion Update (quarterly)		CNM		✓			✓			✓			✓		
Safeguarding Quarterly Report		CNM				✓ (Q4) 2022			✓ (Q1)		✓ (Q2)			✓ (Q3)	
Patient Survey/s (to be reported by exception)		CNM													
Equality, Diversity and Inclusion Update (bi-annual)		CNM													
Public Health Agenda and Equalities (annual)		CNM													
Staff (Patient) Quality Experience Story (quarterly)		CNM		✓			✓			✓			✓		
Risk															
Annual Review of Risk Management Strategy		CNM	✓												✓
Risk Appetite Statement – Quality Committee		CNM	✓												✓
General Governance Arrangements															
Ward Accreditation Scheme – annually		CNM								✓					
~~CQC Insight Tool *(bi-monthly)*~~		CNM			~~✓~~		~~✓~~		~~✓~~				~~✓~~		~~✓~~

Liverpool Women's NHS Foundation Trust

Quality Committee

	BAF Link	Executive Owner	Report up to Board	WORKPLAN 2023 / 24											
				Quarter 1			Quarter 2			Quarter 3			Quarter 4		
				25 April 2023	30 May 2023	27 June 2023	25 July 2023	29 Aug 2023 TBC	26 Sept 2023	24 Oct 2023	28 Nov 2023	19 Dec 2023 TBC	30 Jan 2024	27 Feb 2024	26 Mar 2024
CNST Progress Report		CNM		✓	✓				✓	✓	✓				✓
Clinical Audit work plan & annual report		MD		✓ (WP)					✓ (AR)						
Corporate Objectives: 6 monthly and year-end review & Objective Setting		TS	✓	✓ (OS)					✓ (mid-year review)						✓
Terms of reference review and business cycle		TS													✓
QC Committee Annual Report		TS													✓
Subcommittee chairs reports and Terms of Reference • Safety & Effectiveness Sub-Committee • Patient Involvement & Experience Sub-Committee • Corporate Risk Sub-Committee • Trust Safeguarding Sub-Committee • Research and Development Sub-Committee • (Maternity) Transformation Board				✓	✓	✓	✓		✓	✓	✓		✓	✓	✓

KEY CODE

Deferred

Item considered as planned

Item considered following deferral

Q=Quarter WP=Work plan AR=Annual Report AP=Annual Plan OS=Objective Setting

Liverpool Women's
NHS Foundation Trust

Putting People First Committee

Annual Report 2022/23

Background

This report covers the period April 2022 to March 2023. There were eight meetings held during this period of which two had been workshops. The September 2022 Committee was cancelled as this was the date of the State Funeral of Her Majesty Queen Elizabeth II. The meeting was rescheduled and took place early October 2022 therefore all matters could be approved within a timely manner. Subsequently the workshop planned to take place in October 2022 did not take place.

The aim of the Putting People First Committee is to develop and oversee the implementation of the Trust's People Strategy, providing assurance to the Board of Directors that this is achieving the outcomes sought and required by the organisation. The terms of reference of the Committee were reviewed in March 2022 and notes the Committee's duties as follows:

a. Developing and overseeing implementation of the Trust's People Strategy (integrated workforce, wellbeing and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process
b. Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee)
c. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce
d. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors
e. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues
f. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys
g. Reviewing and approving partnership agreements with staff side
h. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues
i. Monitor and evaluate compliance with the public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics

j. Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings
k. Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required.
l. Receiving and considering issues from other Committees when appropriate and taking any necessary action.

Constitution

The Putting People First Committee is accountable to the Board of Directors.

Membership during the year comprised of:

- Non-Executive Director (Chair)
- 2 other Non-Executive Director
- *Chief People Officer
- *Chief Nurse & Midwife
- *Chief Operating Officer
- Staff Side Chair
- Medical Staff Committee representative
- Senior Finance Manager

*or their nominated representative who will be sufficiently senior and have the authority to make decisions.

Meetings were also attended by other executives and senior management staff as appropriate.

The Committee's constitution allows for members to participate by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference. In the landscape emerging from the Covid-19 pandemic, all meetings during 2022/23 had been held on a hybrid basis with the option for members to meet on site in person or join the meeting virtually utilising Microsoft Teams.

The Terms of Reference requires that all members of the Committee attend a minimum of 75% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2022/23 together with the names of senior management who were invited to attend during the year. Most members attended 75% or more of the meetings during 2022/23.

Key achievements / activity

Workforce Key Performance Indicators (KPIs)
The Committee receives a regular report on the Workforce KPIs. Work has progressed throughout the year to improve the report to ensure that it better aligns with the key areas of focus within the workforce domain and a new workforce key performance indicator dashboard was introduced as of January 2023 to provide a more balanced and holistic reflection of workforce performance.

The key areas of attention during 2022/23 related to mandatory training compliance (particularly clinical safety issues) and sickness absence. The Committee monitored the efficacy of the change approach to managing short term absences and would continue to monitor into 2023/24 as the change process was embedded.

Leadership and Talent Strategic Framework
The Committees received an update against the Leadership and Talent Strategic Framework noting that the paper addressed the recommendation from the recent Grant Thornton Well-Led Review. The Committee noted a range of initiatives including career conversations, leadership programmes, and registration as an endorsed centre for the Chartered Institute of Management during the past year to progress the aims of the Leadership and Talent Management Strategic Framework.

Volunteer Strategy Achievements Annual Report
The Committee received the Volunteer Strategy Achievements Annual Report 2021/22, previously reported through to the Charitable Funds Committee. A staff story from a volunteer was received to provide insight on the role.

Age Profile and Standalone posts: Risks and Mitigations
The Committee received an overview of the age profile and stand-alone or highly specialist posts which could present a risk to service delivery and the actions in place to ensure service continuity.

Supporting the Health and Wellbeing of our staff, managers and leaders at LWH
The Committee received updates on initiatives that have been put into place during the past 12 months to support staff health and wellbeing, which included the introduction of health and wellbeing conversations and Wellbeing Coaches, Big Conversation events, enhancement of flexible working opportunities to improve employee experience and retention.

Guardian of Safe Working Hours (Junior doctors)
The Committee received quarterly reports on this area, and on occasion this has led to issues being escalated to the Committee for further action e.g. risks upon the junior doctors related to continued rota issues and gaps on the medical workforce which had also been highlighted within the Director of Medical Education Annual Report. The Committee received a Workforce Assurance report pertaining to the medical workforce at the Trust as a result. The Committee had been supportive of actions including additional consultant recruitment, establishment of the Medical Staffing Task and Finish Group and a Junior Doctor Working Group forum, and a significant review and redesign of the rota. The Committee will maintain this oversight into 2023/24 with onward reporting to the Board.

Recruitment Audit
The Committee received the results of a recruitment audit undertaken during 2022/23 against NHS Employment Check Standards. Mersey Internal Audit Agency also conduct a bi-annual audit of recruitment processes. The Fit and Proper Persons process sat in parallel for Board members and other designated individuals.

WRES and WDES Report 2022
The Committee receives the Workforce Race Equality Standard and Workforce Disability Equality Standard annual statutory reports.

Mandatory Training
The Committee maintained regular oversight of mandatory training receiving a deep-dive review in relation to mandatory training compliance from all divisions, audit results undertaken on Performance Development Reviews and Mandatory training, and updates within divisional workforce assurance reports. Particular attention was given towards prioritisation of clinical mandatory training. The Committee monitored progress against the identified actions from the reviews and audits and will continue to monitor the position closely into 2023/24.

Bi-Annual Safer Staffing Review
The Committee received a detailed bi-annual safer staffing review ahead of submission to the Trust Board. The Committee was assured by the continued monitoring to ensure that safe staffing was effectively managed by utilising a triangulated approach and through a series of actions, escalations, and mitigations to support delivery of safe patient care.

Fair and Just Culture Update
The Committee received a Fair and Just Culture update aligned with the Trust's 'Values to Behaviours' framework and human factors training.

Freedom to Speak Up
The Committee receives updates on the Trust's Freedom to Speak up processes, and analysis of Disciplinary, Grievance & Dignity at Work cases.

Outsourced Services Contract Review
The Committee received the annual Outsourced Services Contract Review as assurance that outsourced contracted services provided value for money, had been achieving KPI compliances and demonstrated effective collaborative work.

Staff Survey
The Committee received initial data from the 2022 Staff Survey and will receive a formal report including benchmarked data when published in 2023/24.

Staff Stories
To help support the triangulation of assurance sources, the Committee received a staff story at most meetings. For example, in November 2022, a junior doctor shared their experience undertaking an F3 role following completion of their foundation training programme.

PPF Workshops
The Committee held two workshops during 2022/23 to dedicate time into priority areas. During 2022/23 the following topics were discussed:

- Learning from feedback: how we can make Liverpool Women's a great place to work
- Refreshing our People Strategy 2019 – 2024, with a focus on Our People Ambition for Equality, Diversity & Inclusion at Liverpool Women's

Having this additional time to 'deep dive' into key risks and areas for development outside of a 'formal' meeting has been helpful and this is a practice that will continue into 2023/24.

Chair's Log
The Committee had received and responded to a total of 19 chair actions from the Trust Board and Board Committees during 2022/23, and delegated 4 chair actions to supporting groups to seek additional assurances.

Areas for Development

For the second time, an effectiveness survey was circulated to members of the Committee seeking feedback on the activity of the Committee during 2022/23. Overall, the responses received were positive – the full results can be seen in Appendix 2. There were mixed results on the following questions:

> Qu 8 - The current Committee work plan and focus of reports provides an opportunity to consider system priorities?
>
> Qu 11 - All members of the committee are able to participate effectively.

To respond to these comments, it is suggested that holding a committee development session with information on both of these aspects moving into 2023/24 would be helpful. The revision of the People Strategy should support Committee's focus on system priorities.

There was also a narrative comment provided that as the Committee does not rotate time/day of the week, clinical members are often unable to attend due to clinical commitments.

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in March 2022 and were approved by the Board in April 2022. It was proposed last year that the frequency of meetings increase from six to ten a year. This enabled the introduction of workshop sessions utilised for 'deep dive' reviews on priority areas to improve the flow of business as the 'People' agenda becomes increasingly prominent.

One suggested amendment is to specify in the membership that the 'Senior Finance Manager' is the Deputy Chief Finance Officer.

There has been updates made in respect to job titles and the reporting groups to the Committee – all shown highlighted yellow.

The draft Terms of Reference is included at Appendix 3.

Proposed Amendments to the Committee Business Cycle

Each of the Committees established by the Board of Directors has an annual business cycle which is subject to review each year. The business cycle forms the 'core' agenda for Committee meetings throughout the year with scheduled business ensuring that the Committee discharges its responsibilities as set out in the Terms of Reference.

The Putting People First Committee last reviewed its annual business cycle in March 2022 and is therefore scheduled to complete a further review in order to set the business cycle for 2023/24.

All members of the Putting People First Committee had the opportunity to participate in the annual review and propose any amendments to the business cycle and terms of reference during February 2023 by completing the committee effectiveness survey. Some minor amendments to the timetabling of reports had been requested by Committee members and the changes made. The Committee members who responded did not make any suggested amendments to the business cycle or terms of reference.

In addition to the survey, discussions had been held between the Committee Chair, Chief People Officer, Deputy Director of Workforce and Trust Secretary to consider means to enhance Committee effectiveness.

During 2022/23, the following amendments to the business cycle were suggested and agreed:

- Freedom to Speak Up Guardian updates – changed timetabling of bi-annual update to align with revised Temperature check survey schedule
- Due to timetabling it was agreed that the Freedom to Speak Up Guardian Annual Report (Whistleblowing Report) should be considered directly by the Trust Board

It is likely that key areas of attention during 2023/24 will be as follows:

- To continue to support the five-year People Strategy and seek progress reports on a regular basis.
- To analyse trend data arising from the monthly KPI data and workforce planning reviews and again identify and mitigate any risks.
- To seek assurance that progress is being made to improve the Trust's sickness absence and mandatory training rates
- To seek assurance that the actions identified from the 2022 Staff Survey are being progressed

- Seek assurance that the Trust is making progress against its Equality, Diversity and Inclusion objectives
- To respond to any emerging issues from the Trust's 2023 CQC inspection
- To ensure that robust assurance is available on an improving leadership and organisational culture
- Seeking assurance on robust short, medium and long-term workforce planning and risk mitigation.
- To ensure that the Trust is effectively participating in system programmes for workforce and that system priorities are reflected in the information reported to the Committee.

The draft Business Cycle is included at Appendix 4.

Conclusion

In the final analysis, it is concluded that the Putting People First Committee has achieved its objectives for the Financial Year 2022/23.

Gloria Hyatt CHAIR
Putting People First Committee
March 2023

Appendix 1

Putting People First Committee, Attendance at Committee: April 2022 – March 2023

Core members	**Job Title**	**May 2022**	**June 2022** **Workshop**	**July 2022**	**Sept 2022**	**Oct 2022**	**Nov 2022**	**Jan 2023**	**Feb 2023** **Workshop**	**March 2023**
Dr Susan Milner	Non-executive director (Chair until end May)	✓	**NM**		Meeting Cancelled	**NM**				
Gloria Hyatt	Non-Executive director (Chair)	✓	✓	✓		✓	✓	✓	✓	✓
Louise Martin	Non-Executive director	✓	✓	**A**		✓	✓	✓	✓	✓
Zia Chaudhry	Non-Executive director	✓	✓	✓		✓	✓	✓	✓	✓
Michelle Turner	Chief People Officer	✓	✓	✓		✓	✓	✓	✓	**A**
Marie Forshaw	Chief Nurse and Midwife	✓	✓	✓		**NM**				
Dianne Brown	Chief Nurse (as of 21.12.22) Interim Chief Nurse (01.09.22 – 20.12.22)	**NM**				✓	✓	✓	**A**	**A**
Gary Price	Chief Operating Officer	✓	**A**	✓		✓	✓	**A**	**A**	✓
Joe Downie*	General Manager (Representing COO)							✓ **R**		
Claire Deegan	Deputy Director of Finance	**A**	✓	**A**		**NM**				
Linda Haigh	Interim Deputy Director of Finance					✓	✓	✓	**A**	**A**
Dyan Dickins	Medical Staff Committee Chair	✓	✓	**A**		**A**	✓	**A**	**A**	**A**
Liz Collins	Staff Side Chair	✓	✓	✓		✓	✓	✓	✓	✓

Invited Attendees		**May 2022**	**June 2022 Workshop**	**July 2022**	**Sept 2022**	**Oct 2022**	**Nov 2022**	**Jan 2023**	**Feb 2023 Workshop**	**March 2023**
Mark Grimshaw	Trust Secretary	✓	✓	✓		✓	**A**	✓	✓	✓
Robert Clarke	Chairman	✓	✓	✓					✓	
Nashaba Ellahi	Deputy Director of Nursing & Midwifery			✓		✓	✓	✓		✓
Lynn Greenhalgh	Medical Director	✓	✓	✓		✓	✓	✓	✓	✓
Linda Watkins	Director of Medical Education	✓	**A**	✓		✓	✓	✓	✓	**A**
Kat Pavlidi	Guardian of Safe Working Hours	**x**		✓		**A**		**A**		
Matt Connor	Chief Information Officer			✓						
Rachel London	Deputy Director of Workforce	✓	✓	✓		✓	✓	✓	✓	✓
Rachel Cowley	Head of Culture and Staff Experience	✓	✓	✓		**A**	✓	✓	✓	✓
Rachel Reeves	HR Business Partner (Family Health)	✓	✓	✓		✓	✓	✓		✓
Angela Hughes	HR Business Partner (Gynae)	✓	✓	✓		**A**	**A**	✓		✓
Sarah Lucy Thomson	HR Business Partner (CSS)	✓	✓	✓		✓	✓	✓		✓
Kevin Robinson	Freedom to Speak Up Guardian	✓		✓		✓	✓	✓		✓
Kathryn Franey	Head of Learning & Development	✓	✓	**A**		✓	✓	✓	✓	**A**
Diane Taylor	Head of Nursing, Gynaecology	✓						✓		
Toni Gleave	Gynaecology	✓								
Gina Barr	Voluntary Services Manager	✓								
Melissa Lyndsey	Volunteer	✓								
Sheena Shah	Observer, HR Graduate Scheme	✓								
Danielle Burton	Deputy Divisional Manager, Family Health	✓								
Ellen Gerrard	Divisional Manager, CSS							✓		
Alison Carroll	Learning & Organisational Development Manager		✓							
Jaymi Whitehead	HR Advisor – Clinical Support Services & Hewitt Fertility Centre			✓				✓		

Jennifer Lloyd	Operational Support Manager, Family Health			✓						
Bheki Thomola	Head of Financial Management			✓						
Megan Binns	Observer, Graduate Management Trainee					✓				
Rachel Mavers	Matron					✓				
Danielle Burton	Deputy Divisional Manager					✓				
Alison Murray	Deputy Head of Midwifery					✓	✓			
Vicky Clarke	Divisional Manager, Family Health						✓			
Ben Greenfield	Junior Doctor						✓			
Asheni Fernando	Observer, Divisional Administrator						✓			
Jackie Robertson	Specialist Pelvic Health Physiotherapist							✓		
Heledd Jones	Head of Midwifery, Family Health							✓		
Jen Deeney	Head of Nursing, Family Health							✓		
Matthew Butcher	Divisional Manager, Gynaecology							✓		✓
Diane Cushion	Observer, Personal Assistant							✓		
Yana Richens	Director of Midwifery								✓	
Helen Chainey	Strategic Projects Manager								✓	
Natalie Lockett	Gynaecology Ward Manager, Inpatient and Day Ward									✓
Andrew Duggan	Head of Communications, Marketing & Engagement									✓
Lisa Shoko	Equality Diversity & Inclusion Project Manager									✓
Philip Bartley	Associate Director of Governance & Quality									✓

Putting People First Committee Effectiveness Survey 2022/23

5	02:18	Active
Responses	Average time to complete	Status

1. I understand the duties of the committee.

Strongly agree	2
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

2. I believe the committee receives sufficient assurance to conclude upon its areas of responsibility.

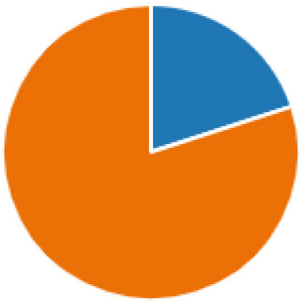
Strongly agree	1
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

3. I am confident that the committee effectively monitors and scrutinises progress against the aligned strategies.

Strongly agree	1
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

4. I am content that the committee is delivering the right level of assurance to the Board / Committee.

Strongly agree	1
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0



5. I believe that the committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management.

Strongly agree	1
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

6. I feel that the committee has the right balance of experience, attendance, knowledge and skills to fulfil its role.

Strongly agree	1
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

7. The committee has structured its agenda and work plan to cover its key responsibilities.

Strongly agree	2
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

8. The current Committee work plan and focus of reports provides an opportunity to consider system priorities?

Strongly agree	1
Agree	3
Disagree	1
Strongly disagree	0
Unable to answer	0

9. Written reports received enable the Committee to hold informed discussions on key issues with clarity on the root causes of challenges, and a shared understanding of the pros and cons of the various options being put forward as potential solutions?

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0
Other	0

10. The committee is effectively chaired.

Strongly agree	2
Agree	2
Disagree	0
Strongly disagree	0
Unable to answer	1

11. All members of the committee are able to participate effectively.

Strongly agree	2
Agree	2
Disagree	1
Strongly disagree	0
Unable to answer	0

12. There is clarity in relation to the work of the committee and its interaction and alignment with other committees.

Strongly agree	1
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

13. Any other comments, suggestions or actions.

2
Responses

Latest Responses

"The Trust secretary's both do an excellent job in keeping us o...

13. Any other comments, suggestions or actions.

2 Responses

ID ↑	Name	Responses
1	anonymous	As PPFC does not rotate time/day of the week I am often unable to attend due to a clinical commitment I have on a Monday morning.
2	anonymous	The Trust secretary's both do an excellent job in keeping us organised.

Liverpool Women's NHS Foundation Trust

PUTTING PEOPLE FIRST COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Putting People First Committee (the Committee).
Duties:	The Committee is responsible for: a. Developing and overseeing implementation of the Trust's People Strategy (integrated workforce, wellbeing and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process b. Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee) c. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce d. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors e. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues f. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys g. Reviewing and approving partnership agreements with staff side h. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues i. Monitor and evaluate compliance with the public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics j. Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings k. Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required. l. Receiving and considering issues from other Committees when appropriate and taking any necessary action.
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of:

	• Non-Executive Director (Chair) • 2 other Non-Executive Director • *Chief People Officer • * Chief Nurse & Midwife • *Chief Operating Officer • Staff Side Chair • Medical Staff Committee representative • ~~Senior Finance Manager~~ Deputy Chief Finance Officer *or their nominated representative who will be sufficiently senior and have the authority to make decisions. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be four members including: • The Chair or at least one other Non-Executive Director • At least one from either Director of Workforce and Marketing or Director of Nursing and Midwifery • Director of Operations or their Deputy • Either Staff Side Chair or Medical Staff Committee representative • The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. **b. Officers** HR & OD Senior Team, Education Governance Chair, and a representative from the Nursing & Midwifery Board shall normally attend meetings. Members may send a nominated representative to attend meetings on their behalf when they are not available, provided they are sufficiently senior and have the authority to make decisions. Other executive directors, officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.

Frequency:	Meetings shall be held at least 10 times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Putting People First Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the subsequent Board of Directors for assurance. Approved minutes will be made available to all Board members upon request. Approved chairs reports will also be circulated to members of the Audit Committee. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Putting People First Committee.
Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; b) an Annual Report setting out the progress they have made and future developments; c) Terms of reference The following sub committees/groups will report directly to the Committee: • Equality, Diversity & Inclusion Sub-Committee • ~~Health & Wellbeing Committee~~ • Partnership Forum • Professional Forum of Nurses, Midwives & AHP's • Educational Governance Sub-Committee • Joint Local Negotiating Sub--Committee • Great Place to Work Group
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.

Reviewed by Putting People First Committee:	20 March 2023
Approved by Board of Directors:	*[April 2023]*
Review date:	March 2024
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

Liverpool Women's NHS Foundation Trust

Putting People First Committee				WORKPLAN 2023/24									
				Quarter 1			Quarter 2		Quarter 3		Quarter 4		
	BAF Link	Executive Lead / Senior Owner	⇧ to Board	17 April 2023	22 May 2023	19 June 2023	17 July 2023	18 Sept 2023	16 Oct 2023	20 Nov 2023	22 January 2024	19 Feb 2024	18 March 2024
Minutes of Previous meeting		TS			✓		✓	✓		✓	✓		✓
Actions/Matters Arising		TS			✓		✓	✓		✓	✓		✓
Chairs Report - Verbal		Chair			✓		✓	✓		✓	✓		✓
Review of risk impacts of items discussed		Chair			✓		✓	✓		✓	✓		✓
Any other business		Chair			✓		✓	✓		✓	✓		✓
Review of meeting		Chair			✓		✓	✓		✓	✓		✓
Review of BAF risks: Workforce related risks		CPO	✓		✓		✓	✓		✓	✓		✓
Workforce KPI Dashboard Report		CPO			✓		✓	✓		✓	✓		✓
Director of Workforce Report		CPO			✓		✓	✓		✓	✓		✓
Policies for Approval & Policy Audit Update		CPO			✓		✓	✓			✓		✓
To develop a well led, capable, and motivated workforce													
Staff Story		CPO			✓		✓	✓		✓	✓		✓
Service Workforce Assurance		CPO / COO / CNM / DDoW			**Medical workforce**		**Corporate**			**Family Health**	**Clinical Support Services**		**Gynaecology & Hewitt**
Talent Management & Leadership Development Review		CPO			✓								
HEE Quality Framework Annual Assessment		DoME								✓			
HENW GMC survey feedback report and action plan		DoME								✓			
Director of Medical Education Annual Report		DoME											✓
Medical Appraisal & Revalidation Annual Report		MD	✓					✓					
Medical Appraisal & Revalidation Quarterly Report		MD			**Q4**			**Q1**		**Q2**			**Q3**
Pharmacy Revalidation Annual Report		MD						✓					
Freedom to Speak Up Guardian Bi-annual Update		F2SUG			✓					✓			
Staff Listening Events Report (to Board)		CPO	✓				✓						✓
Flu Campaign		CPO	✓					✓					
Volunteer Strategy Achievements Annual Report		CPO			✓								
To be efficient and make best use of available resources													
Review of External Contracts		CPO						✓					
Disciplinary and Grievance processes annual review		CPO					✓						
Workforce Planning Return		CPO											✓
Freedom to Speak Up Guardian Annual Report including Whistleblowing		F2SUG	✓				✓						
Bi-Annual Safer Staffing Review		CNM	✓					✓ **Q4 & Q1**					✓ **Q2&Q3**
To deliver the most effective outcomes													
Equality, Diversity and Inclusion Annual Report inlcuding Equality Objectives		CPO	✓										✓
Equality, Diversity and Inclusion including WRES/WDES/Gender Pay Gap		CPO					✓				✓		
Putting People First Strategy 2019-2024 Annual Review (including Volunteer workforce)		CPO	✓										✓
Communications, Marketing and Engagement Strategy Annual Review		CPO											✓
To deliver the best possible experience for patients and our staff													
Staff Engagement and NHS Staff Survey Annual Results & Action Plan (Annual and Bi-annual Review)		Head of Culture and Staff	✓ (annual)					✓ **(bi-annual)**					✓ **(annual)**

Fair and Just Culture Update		Head of Culture and Staff					✓				✓
Guardian of Safe Working Hours (Junior Doctors) Quarterly Report		MD / G4SWH	✓ (AR)		✓ (Q4 AR)		✓ (Q1)		✓ (Q2)	✓ (Q3)	
GOVERNANCE											
Review of Risk Appetite Statement		CNM	✓								✓
Annual review of Corporate Objectives aligned to PPF & Objective setting		CPO	✓				✓ (bi-annual)				✓ (annual & OS)
PPF Terms of reference review		TS	✓								✓
PPF Committee Annual Report		CPO / TS	✓				✓ (bi-annual)				✓
PPF Business Cycle		CPO / TS									✓
Subcommittee chairs reports and Terms of reference: * Equality, Diversity and Inclusion Committee * Education Governance Committee * JLNC * Partnership Forum * Professional Forum of Nurses, Midwives & AHP's *Great Place to Work Group											

KEY CODE

Deferred due to COVID-19 implications. Staff remitted to other actions to address COVID-19 within the Trust

Item considered as planned

Item considered following deferral

Q=Quarter WP=Work plan AR=Annual Report AP=Annual Plan OS=Objective Setting

Liverpool Women's NHS Foundation Trust
Audit Committee Business Cycle 2023/24

Item	BAF Link	Exec lead	xx June 2023	20 July 2023	19 October 2023	25 January 2024	21 March 2024
MATTERS FOR APPROVAL/DECISION							
Standing Items							
Minutes of Previous meeting	N/A	TS		✓	✓	✓	✓
Actions/Matters Arising	N/A	TS		✓	✓	✓	✓
Chairs Report - Verbal	N/A	Chair		✓	✓	✓	✓
Board Assurance Framework	All	TS		✓	✓	✓	✓
Review of risk impacts of items discussed	5,2			✓	✓	✓	✓
Any other business	N/A			✓	✓	✓	✓
Review of meeting	5,2			✓	✓	✓	✓
MATTERS FOR DISCUSSION & COMMITTEE ACTION/DECISION							
Data Assurance Report	5,2	CIO					✓
Follow up of Internal and External Audit Recommendations	5,2	CFO		✓	✓	✓	✓
Register of waivers of standing orders	5,2	CFO		✓	✓	✓	
Areas of Judgement in the Annual Accounts	5,2	CFO					✓
Losses and special payments	5,2	CFO					✓
Raising staff concerns arrangements	5,2	CPO		✓			
Settlement agreements annual report	5,2	CN&M	✓				
Bribery Act compliance	5,2	TS			✓		
Review of Board, Governor and Staff register of interests	5,2	TS	✓				✓
Review of Board, Governor and staff register of gifts and hospitality	5,2	TS	✓				✓
Corporate governance manual review	5,2	TS		✓			
Review of assurances processes:	5,2	TS					
• Integrated governance	5,2				✓		
• risk management	5,2						✓
• External Inspections and Accreditations	***5,2***			✓		✓	
Counter fraud							
Counter fraud progress report	5,2	IA		✓	✓	✓	✓
Counter fraud annual report 2023/24	5,2	IA	✓				
Counter fraud work plan 2024/25	5,2	IA					✓
Internal audit							
Head of Internal Audit's opinion and annual report Draft/Final	5,2	IA	✓				✓
Internal Audit Work Plan 2024/25	5,2	IA					✓
Internal audit progress report	5,2	IA		✓	✓	✓	✓

Liverpool Women's NHS Foundation Trust
Audit Committee Business Cycle 2023/24

Review of Internal Audit Charter	5,2	IA					✓
Follow up of Internal Audit Recommendations	***5,2***	IA		✓		✓	
Annual Review of effectiveness of Internal audit	5,2	Chair		✓			
External audit							
External audit findings (ISA 260) and management letter	5,2	EA	✓				
External Audit Technical Update (formerly progress report)	5,2	EA		✓	✓	✓	✓
External Audit Plan	5,2	EA				✓	
Review of effectiveness of external audit	5,2	Chair		✓			
Financial Reporting							
Annual Governance Statement	5,2	TS	✓				
Annual report, quality report and financial accounts (to include Code of Governance compliance & Salient Features)	5,2	CFO/MD/TS	✓				
Audit Committee Annual Report	5,2	TS/CFO	✓				
Code of Governance Compliance & NED independance Dec's	5,2	TS	✓				
Other Assurance Functions							
Review of Board Committee Annual Reports	5,2	TS		✓			
Review of Divisional Governance Arrangements (rota)	5,2			✓	✓	✓	✓
Review of Chair reports of Board Committee meetings	5,2	TS		✓	✓	✓	✓
• Finance, Performance and Business Development Committee							
• Quality Committee				✓	✓	✓	✓
• Putting People First Committee				✓	✓	✓	✓
Clinical Audit Forward plan		MD					✓
Clinical Audit Annual Report & Mid Year Update	5,2	MD			✓		
ICS Governance	5,2	TS			✓		
General Governance Arrangements							
Review of Audit Committee effectiveness	5,2	TS/CFO		✓	✓		
Review of Committee terms of reference	5,2	TS					✓
Committee business cycle 2024/25	5,2	TS					✓
Private discussion with auditors (internal and external) when required		Chair		✓	✓	✓	✓

NHS
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