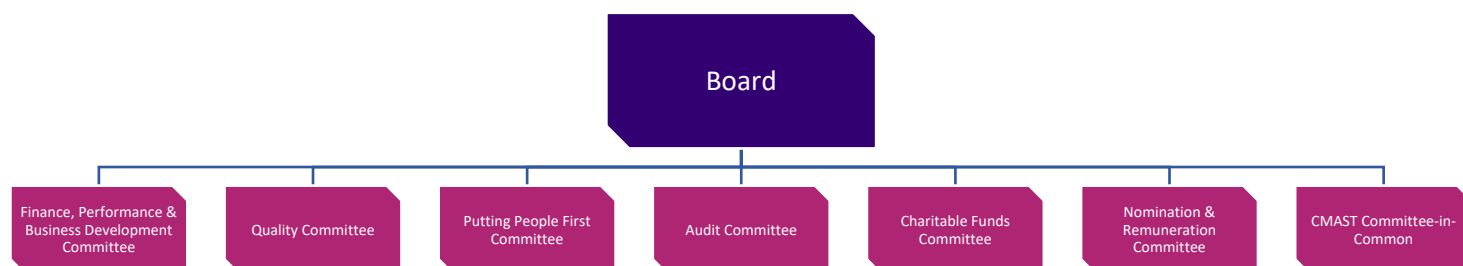


# Trust Board

8 June 2023, 11.40am

Boardroom, LWH & Virtual, via Teams



## Trust Board

Location	Boardroom, LWH & Virtual via Teams
Date	8 June 2023
Time	11.40am

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time
23/24/					
PRELIMINARY BUSINESS					
050	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	1140 (5 mins)
051	Meeting Guidance Notes	To receive the meeting attendees’ guidance notes	Written	Chair	
052	Minutes of the previous meeting on 11 May 2023	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
053	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
054	Chair’s & Chief Executive’s Announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair & CEO	
QUALITY & OPERATIONAL PERFORMANCE					
055	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	1145 (10 mins)
FINANCE & FINANCIAL PERFORMANCE					
056a	Finance Performance Review Highlight Month 1 2023/24	To note the current status of the Trust’s financial position	Written	Chief Finance Officer	1155 (20 mins)
056b	Revenue & Capital Budgets 2023/24	For approval	Written	Chief Finance Officer	
CONCLUDING BUSINESS					
057	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1215 (5 mins)
058	Chair’s Log	Identify any Chair’s Logs	Verbal	Chair	
059	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
060	Jargon Buster	For reference	Written	Chair	

Date of Next Meeting: 13 July 2023

1220 - 1230	<i>Questions raised by members of the public</i>	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair
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## 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, following 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 26<sup>th</sup> March 2013

**Board of Directors**

**Minutes of the meeting of the Board of Directors**  
**held in the Boardroom and Virtually via Teams at 09.30am on 11 May 2023**

*PRESENT*

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

*IN ATTENDANCE*

<b>Matt Connor</b>	Chief Information Officer
<b>Yana Richens</b>	Director of Midwifery (to item 028a)
<b>Jen Huyton</b>	Deputy Chief Finance Officer
<b>Gillian Walker</b>	Patient Experience Matron (item 023 only)
<b>Claire Holroyd</b>	Imaging Manager (item 023 only)
<b>Heledd Jones</b>	Head of Midwifery (to item 028a)
<b>Vicky Clarke</b>	Family Health Divisional Manager (from item 025 to item 028a)
<b>Peter Norris</b>	Public Governor
<b>Denise Richardson</b>	Member of the Public
<b>Lesley Mahmood</b>	Member of the Public
<b>Felicity Dowling</b>	Member of the Public
<b>Mark Grimshaw</b>	Trust Secretary (minutes)

*APOLOGIES:*

<b>Gloria Hyatt MBE</b>	Non-Executive Director
<b>Tracy Ellery</b>	Non-Executive Director / Vice-Chair

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



Tony Okotie - Non-Executive Director	✓	✓	A	Non-member									
Prof Louise Kenny - Non-Executive Director	A	✓	✓	A	✓		A	A	✓	✓	✓	✓	
Eva Horgan – Chief Finance Officer	✓	✓	✓	✓	✓		✓	✓	Non-member				
Marie Forshaw – Chief Nurse & Midwife	✓	A	✓	✓	Non-member								
Dianne Brown – Chief Nurse	Non-member				✓		✓	✓	✓	✓	A	✓	
Gary Price - Chief Operating Officer	✓	✓	✓	✓	✓		✓	A	✓	✓	✓	✓	
Michelle Turner - Chief People Officer	✓	A	✓	✓	✓		✓	✓	✓	✓	A	✓	
Dr Lynn Greenhalgh - Medical Director	A	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Zia Chaudhry – Non-Executive Director	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Gloria Hyatt – Non-Executive Director	✓	✓	✓	✓	A		✓	✓	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								✓	✓	✓		
Matt Connor – Chief Information Officer (non-voting)	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	

<b>23/24/</b>	
<b>019</b>	<b>Introduction, Apologies &amp; Declaration of Interest</b> The Chair welcomed everyone to the meeting.  There were no apologies or declarations of interest.
<b>020</b>	<b>Meeting guidance notes</b> The Board received the meeting attendees’ guidance notes.
<b>021</b>	<b>Minutes of the previous meeting held on 6 April 2023</b> The minutes of the Board of Directors meeting held on 6 April 2023 were agreed as a true and accurate record.
<b>022</b>	<b>Action Log and matters arising</b> Updates against actions log were noted.
<b>023</b>	<b>Patient / Staff Story</b> The Imaging Manager presented a reflection on a recent incident involving nonviolent aggression from a patient’s partner whilst they underwent an ultrasound scan. It was explained that the patient and their partner attended a 20-week screening scan with a young child. The sonographer asked the patient if the partner and child could wait in the waiting room whilst the essential measurements and checks were completed and to return to the scan room at the end to see the baby. The partner was reluctant to comply with the request and displayed open hostility and aggression to the sonographer.  The Imaging Manager explained that young children were often asked to wait in the waiting room as a sonographer carrying out a scan completed a complex examination that required a high level of

	<p>concentration and technical skills. There was also the potential for the sonographer to break bad news following the scan and the distress of this could be further exacerbated for the patient when young children were present. The Imaging Manager also acknowledged the desire for patients to share their experiences with partners and young children and that it was important to reach an appropriate balance. Actions being taken as a result of lessons learned from the incident included:</p> <ul style="list-style-type: none"> <li>• Bespoke conflict resolution training for the imaging team.</li> <li>• Benchmarking against peers and standardising practice for children attending scan appointments with parents.</li> <li>• Development of patient information leaflets to manage expectations and raise awareness prior to the appointment</li> <li>• Develop a safety net for those patients attending alone with a child</li> <li>• 'Quiet room' following bad news in progress.</li> <li>• Working with volunteers and charitable funds for resource identification.</li> </ul> <p>The Chief Executive thanked the Imaging Manager for presenting the story noting that it provided insight into the challenges experienced by the imaging team. It was remarked that the growth of private scanning facilities had helped to detach the perception of the 20-week scan from its primary purpose as a medical screening tool. There was agreement from across the Board of Directors that effective patient information leaflets would be an important part of supporting patients to understand the purpose of the scan and to have appropriate expectations of the process. It was noted that this could be further supported via the Trust's social media channels. The Board also recognised that not all patients would be able to access childcare and therefore supported the work that the imaging team was undertaking with volunteers and charitable funds to explore potential childcare arrangements.</p> <p><b>Chair's Log: For the Patient Involvement &amp; Experience Sub-Committee to receive an update from the Patient Experience Matron on the work to enhance patient information regarding baby scans and the development of a central offer for childcare/family support during and post scans.</b></p> <p>The Board thanked the Imaging Manager for her attendance and noted the update.</p> <p>Claire Holroyd, <i>Imaging Manager</i> and Gillian Walker, <i>Patient Experience Matron</i>, left the meeting</p>
024	<p><b>Chair's announcements</b></p> <p>The Chair provided the following updates:</p> <ul style="list-style-type: none"> <li>• System Working – the joint site committees involving Liverpool University Hospitals NHS Foundation Trust (LUHFT) with Clatterbridge Cancer Centre, The Walton Centre, and The Liverpool Heart &amp; Chest Hospital had been established and were going through a planning phase. The Trust continued to work closely with LUHFT through a Partnership Board. A pan Liverpool Hospitals Joint Committee has also now been established</li> <li>• Non-Executive Director Appraisals had been undertaken and the outputs would be reported to the Council of Governors on 18 May 2023</li> <li>• The Trust's Chief Executive, Kathryn Thomson had noted an intention to retire. It was noted that the Chief Executive would continue to lead the organisation for a significant period and had provided the Board with time to plan for the next steps. Thanks were noted for the service provided by the Chief Executive to date.</li> </ul>
025	<p><b>Chief Executive's report</b></p> <p>The Chief Executive presented the report which detailed local, regional, and national developments.</p> <p>The Chief Executive noted that the Children Growing Up in Liverpool (C-GULL) birth cohort study had opened on 25 April 2023. The study would trace the lives of 10,000 Liverpool families to enable researchers, clinicians, and policymakers to understand more about complex health issues. It was</p>

	<p>suggested that quarterly updates on recruitment levels be reported via the Trust's Performance Report.</p> <p><b>Action: For quarterly C-GULL recruitment numbers to be included within the Quality &amp; Operational Performance Report</b></p> <p>Non-Executive Director, Prof. Louise Kenny, commented that the funders of the study had been complimentary of the work undertaken by the Trust to support the development and delivery of C-GULL.</p> <p>The Board of Directors noted the Chief Executive update.</p> <p>Vicky Clarke, <i>Family Health Divisional Manager</i>, joined the meeting</p>
026	<p><b>Family Health Update – Maternity and Neonatal Three-Year Plan</b></p> <p>The Chief Operating Officer noted that NHS England had published a three-year delivery plan for maternity and neonatal services on 30 March 2023 following several national plans and reports, including the reports by Donna Ockenden and Dr Bill Kirkup.</p> <p>In response to the recent publication, the Trust carried out a comprehensive preliminary gap analysis assessment of its current maternity transformation programme objectives and aligned these to the recommendations of the Three-Year plan. This would be an iterative process and would be further refined.</p> <p>The Chief Finance Officer noted that when the publication was announced, it had been referenced that funding might be available to trusts to support the implementation of the recommendations. The Family Health Divisional manager noted that whilst funding had yet to be devolved, the Trust was involved in the relevant discussions. Non-Executive Director, Louise Martin, suggested that the Trust should review actions that had been taken ahead of the publication of the delivery plan to strengthen maternity services and whether these would be eligible for retrospective funding.</p> <p>Non-Executive Director, Jackie Bird, noted that the delivery plan made several references to the importance of co-production and asked, in the context of the Maternity Voices Partnership resources being limited, how the Trust intended to involve patients. The Family Health Divisional Manager acknowledged the challenge and reported that there were plans to engage with volunteers, third-sector partners and local groups. The Director of Midwifery referenced a recent focus group with patients from Mat Base and reported that the outcomes from this had been used to influence service delivery.</p> <p>The Chief Executive stated that there had been a significant amount of guidance and reports regarding maternity services published in recent years and asked if the delivery plan was supporting the collation of these documents to help avoid duplication. The Chief Nurse reported the need to ensure clarity on priorities and expectations for maternity services had been escalated to the NHS Cheshire &amp; Merseyside Integrated Care Board.</p> <p>Non-Executive Director, Louise Martin, acknowledged that the gap analysis was an iterative document but suggested that further clarity be provided on actions marked as 'complete' and yet had outstanding actions attached to them. It was also queried if the current policy of enabling Band 7 and Band 8a midwives to 'opt out' of mentoring opportunities was appropriate. The Chief People Officer agreed to review this position.</p> <p>The Board of Directors:</p> <ul style="list-style-type: none"> <li>received the report and noted the reconfiguration of the Maternity Transformation programme to align its current priorities and key objectives to the themes recommended as part of the Three-Year Plan.</li> </ul>

	<ul style="list-style-type: none"> <li>noted the current gap analysis and that work would continue to complete the action plan with progress reported via the Quality Committee.</li> </ul>
027a	<p><b>Chair's Reports from the Quality Committee</b></p> <p>The Board considered the Chair's Report from the Quality Committee meeting held on 25 April 2023.</p> <p>Non-Executive Director, Prof. Louise Kenny, who chaired the meeting, noted the following key points:</p> <ul style="list-style-type: none"> <li>Performance continued to be challenged in relation to 62-day and faster diagnosis (two-week wait) cancer targets. Industrial action was noted as a contributing factor but there were also issues identified with Hysteroscopy capacity. The Committee requested a 'deep-dive' review into pathways to better understand potential barriers to improvement – to be received in July 2023</li> <li>The Committee had received a detailed presentational update of action taken to address the poor performance and quality of care in the Gynaecology Emergency Department. Based on the findings of the review, it was noted that patient acuity predominantly aligned with the Same Day Emergency Care criteria (SDEC) and not accident and emergency. The Committee agreed with the recommended approach to review the operational model.</li> </ul> <p>The Chair queried whether the cancer pathway 'deep-dive' had sufficient pace. The Chief Operating Officer confirmed that improvement work would continue in the interim with the Quality Committee receiving assurance, or otherwise, on the progress made.</p> <p>The Board of Directors received and noted the Chair's Report from the Quality Committee meeting held on 25 April 2023.</p>
027b	<p><b>Quality &amp; Operational Performance Report</b></p> <p>The Board considered the Quality and Operational Performance Report.</p> <p>The Chief Operating Officer noted that the Maternity Assessment Unit (MAU) time to triage had significantly improved from the beginning of 2023 and patient flow through the whole maternity pathway was also in an improved position. The challenge going forward would be to sustain the level of performance. Whilst the benign gynaecology waiting list time had plateaued in recent months, the 78-week and 52-week wait positions had continued to reduce. An outpatient efficiency project (recently reported to the Quality Committee) was supporting the improvements.</p> <p>Performance against the A&amp;E 4-Hour target in the Gynaecology Emergency Department had improved during April 2023 and the Quality Committee would continue to review the efficacy and efficiency of the current patient pathways. As reported via the Committees, the Trust's cancer performance (both 62-day and two-week wait) was challenged. Several actions had been taken or were planned and these included:</p> <ul style="list-style-type: none"> <li>Working with NHS Cheshire &amp; Merseyside to amend the two-week referral pathway (resulting in more appropriate, and therefore potentially fewer, referrals)</li> <li>Introduced a revised rapid access pathway and an alternative diagnostic pathway</li> <li>Working to increase hysteroscopy capacity either through internal training or mutual aid.</li> </ul> <p>The Chief Executive noted the encouraging MAU time to triage performance and queried if the improvements were evident in other areas of the pathway e.g., time to escalate to medical review. The Head of Midwifery reported that improvements in other areas had been made and that these were tracked on a live whiteboard. Active triage had been implemented for women assessed as 'amber'.</p> <p>Non-Executive Director, Louise Martin, sought an explanation for the significant increase in Serious Incidents since January 2023. The Medical Director noted that a comparison exercise with previous years was being undertaken to identify key themes and trends – this was expected to report to the</p>

	<p>Quality Committee in June 2023. The initial view was that the increase was likely a result of including transfers from the Trust to the Royal Liverpool Hospital as serious incidents.</p> <p>The Chair remarked that the waiting list for gynaecology procedures was a significant challenge for the Cheshire and Merseyside system and asked how the Trust was contributing to reducing wait times. The Chief Operating Officer explained that the Trust was in regular communication with patients on the waiting list and that the wait for a procedure following an initial outpatient appointment was short. The utilisation of Medinet was increasing capacity for outpatient appointments. Work was being undertaken to understand patient pathways across the system and whether available resources were being deployed as efficiently as possible.</p> <p>Non-Executive Director, Jackie Bird, requested that the safe staffing element of the report include targets to provide additional context.</p> <p><b>Action: For the safe staffing section of the performance report to include staffing targets to provide additional context.</b></p> <p>It was agreed that in the context of ongoing performance challenges, it would be germane to ensure that there was a monthly Board meeting in place to closely monitor trajectories.</p> <p><b>Action: To convene monthly Board meetings to monitor performance challenges and improvement actions.</b></p> <p>The Board of Directors received and noted the Quality &amp; Operational Performance Report.</p>
027c	<p><b>Integrated Governance Assurance Report Quarter 3, 2022/23</b></p> <p>The Board received the report which provided information on oversight and assurance monitoring of the Integrated Governance and highlighted key risks to the Trust.</p> <p>Non-Executive Director, Jackie Bird, noted the need to improve awareness of VTE compliance and asked what action was being taken. The Medical Director reported that there were several workstreams to not only improve the level of compliance but to also improve the quality of assessment and overall management of the process. Jackie Bird drew attention to a number of complaints that had been received from private patients who had been treated at the Hewitt Fertility Centre. The Chief Nurse explained that there could be a lack of clarity of expectation regarding the criteria for refunds. Work was being undertaken to improve patient information and it was recognised that there were also opportunities to improve the overall private patient pathway.</p> <p>The Chair sought assurance that the impact of recent changes to the Continuity of Carer pathway was being monitored, particularly regarding vulnerable patients and families. The Director of Midwifery confirmed that the change to the pathway was focused on the intrapartum stage (antenatal and postnatal stages being unchanged) and that existing dashboards and reporting mechanisms were being utilised for monitoring. Experiences were also shared at the Midwifery Forum.</p> <p><b>Chair's Log: For the Quality Committee to assess the impact of changes to the Continuity of Carer pathway after six months of implementation.</b></p> <p>Drawing attention to the Health &amp; Safety section, Non-Executive Director, Louise Martin, noted the need to ensure that the Trust was working towards full compliance against statutory requirements and not only 'increased compliance'.</p> <p>The Board of Directors noted the report.</p> <p><i>The Head of Midwifery, Director of Midwifery, and Family Health Divisional Manager left the meeting</i></p>

	<p><b>Board Thank you</b> The following Board Thank You's were presented:</p> <ol style="list-style-type: none"> <li>1) Lee Jones - for work undertaken on staff facilities/upgrade of the conservatory – presented by Michelle Turner</li> <li>2) Susan Roberts – for stepping into a leadership role within mat base following the CQC visit - presented by Dianne Brown</li> <li>3) Dr Mo Otify – In recognition of being the first gynaecology robot proctor in the North West – presented by Gary Price</li> <li>4) Prof. Mark Turner – in recognition of his long service to the Trust and impact on the Trust's research output and status – presented by Lynn Greenhalgh</li> </ol>
028a	<p><b>Chair's Report from the Finance, Performance and Business Development Committee</b> The Board considered the Chair's Report from the FPBD Committee meeting held on 26 April 2023.</p> <p>The Committee Chair, Non-Executive Director Louise Martin, noted that the performance and financial challenges discussed at the Committee were covered elsewhere on the Board agenda. The Committee continued to receive updates regarding the Community Diagnostic Centre and the financial viability of alternative models of provision. The Committee also received an update on the third-party service provider (meaning non-commercial service arrangements with other trusts and universities etc) assurance and controls. The Trust's internal auditor (MIAA) had reported limited assurance on intra-SLA contracts in February 2023. The Committee noted the significant work undertaken to improve grip and control of the SLA process and the remaining risks and assurance gaps. The Committee was supportive of the recommended actions to close the remaining gaps in a timely manner.</p> <p>The Board of Directors received and noted the Chair's Report from the FPBD Committee meeting held on 26 April 2023.</p>
028b	<p><b>Finance Performance Review Month 12 2022/23</b> The Chief Finance Officer presented the Month 12 2022/23 finance performance report which detailed the Trust's financial position as of 31 March 2023.</p> <p>It was noted that at Month 12, the Trust reported a £2,721k deficit against a surplus plan of £528k, resulting in an adverse variance of £3,249k. The Trust successfully delivered the revised forecast outturn position agreed at Month 9 (before the additional items agreed as part of the NHS Cheshire and Merseyside plan), despite ongoing pressures and the impact of industrial action. The Trust implemented a robust financial recovery plan in-year, successfully delivering £4,881k of recovery actions.</p> <p>Delivery of the financial position had been supported by £12,253k of non-recurrent items. This supported management of the Trust's underlying deficit position in-year, however, would not be available in future years. The cash balance was £9,790k at 31 March 2023. This included Public Dividend Capital (PDC) received from NHSE, which was necessary due to the overall deficit position.</p> <p>The Chair noted that the Month 12 position had been discussed and scrutinised in detail by the FPBD Committee in April 2023.</p> <p>The Board of Directors:</p> <ul style="list-style-type: none"> <li>• Noted and received the Month 12 2022/23 Finance Performance Review</li> </ul>
028c	<p><b>Financial Plan Overview 2023/24</b> The Chief Finance Officer explained that The Trust had carried an underlying, structural financial deficit for several years which presented ongoing financial sustainability challenges (first formally declared in 2014/15). The key drivers of this deficit were the costs of delivering maternity services,</p>

	<p>investments in recent years to reduce clinical risk because of the Trust's isolated site (in the absence of capital funding available to provide a long-term solution) and limited opportunities for economies of scale due to the Trust's small size.</p> <p>In recent years the deficit had been supported by non-recurrent sources of income and non-recurrent cost savings which were now reduced or no longer available to the Trust. These sustainability issues would require a system-level response.</p> <p>The proposed financial plan for 2023/34 was a revenue deficit position of £15.5m, after a recurrent Cost Improvement Programme (CIP) of £8.3m, accompanied by a capital budget of £5.2m. This included non-recurrent system 'top-up' funding of £9.3m.</p> <p>Work was progressing to review investments made in previous years to explore whether they continued to deliver. The Trust was also developing a three-year recovery plan which would be presented to the Board and system partners in September 2023. It was likely that the Trust would require cash support during the year.</p> <p>The Chair asked the Chief Finance Officer to explain the system approach to the control total. The Chief Finance Officer explained that all Integrated Care Systems were expected to manage within their allocated resource. In the 2023/24 planning process, some organisations were planning deficits, others break even positions, and some a surplus position. The trusts planning a surplus position had been encouraged to work with the system to identify potential reallocations. The Chair noted that the FPBD Committee and the Board had tracked the development of the Trust's 2023/24 financial plan and whilst there remained an unease about planning a deficit position, the key drivers were well known and understood.</p> <p>Non-Executive Director, Zia Chaudhry, queried the impact of the financial position on staff morale. The Chief People Officer acknowledged that there would be an impact and that increasing the grip regarding the recruitment to non-clinical roles would likely reduce the ability of the organisation to move forward with pace on key projects. However, work was being undertaken to engage staff and provide as much control as possible over key decisions and ways of working. It was well-established that a focus on quality and waste elimination would produce the greatest efficiencies and front-line staff were best placed to identify such opportunities.</p> <p>Non-Executive Director, Sarah Walker, stated that it would be important to track any quality implications of the financial savings required during 2023/24 at the Quality Committee. The Chief Nurse provided assurance that there would be a clear audit trail for Quality Impact Assessments (QIAs) for decisions.</p> <p>The Board of Directors:</p> <ul style="list-style-type: none"> <li>noted the financial deficit plan of £15.5m for 2023/24</li> <li>noted the risks articulated in the report.</li> </ul>
029a	<p><b>Workforce Performance Report</b></p> <p>The Chief People Officer noted that there were encouraging signs of improving trends across several workforce metrics which demonstrated that grip and control was increasing. A review of mandatory training (those elements judged to be mandatory) was currently being undertaken, the findings from which would report to the Putting People First Committee.</p> <p>The Board noted the workforce performance report.</p>
030a	<p><b>Corporate Objectives: Objective Setting 2023/24</b></p> <p>The Chief Executive introduced the proposed corporate objectives for 2023/24 noting that they had received detailed scrutiny and review at the respective Committees. The objectives had been formed to balance ambition with pragmatism and the Chief Executive suggested that they would require a</p>



	<p>detailed review following the development of the three-year financial recovery plan (scheduled for September 2023).</p> <p>The Chair remarked that it would be important for the Board to remain cognisant of the Trust's key priorities during the year as additional challenges emerged.</p> <p>The Board of Directors:</p> <ul style="list-style-type: none"> <li>• Agreed on the 2023/24 corporate objectives</li> <li>• Agreed to undertake a detailed review of the objectives post-September 2023 to determine risks to delivery.</li> </ul>
030b	<p><b>Covid-19 Inquiry Update</b></p> <p>The Trust Secretary, as designated Covid-19 Inquiry Lead, outlined the response of the Trust to the UK Covid-19 Inquiry launched on July 21, 2022. The third module of the Inquiry, which focused on the impact of Covid-19 on healthcare systems and patients, was outlined together with the outcomes of the preliminary hearing that took place on February 28, 2023. The Trust Secretary highlighted some of the issues and themes emerging from the Inquiry, such as the authority and capacity of healthcare leaders, the impact on patients of cancelling routine care, and the effects of vaccination programs on healthcare provision.</p> <p>The Trust Secretary noted that whilst not yet received, the Trust might be required to respond to a Rule 9 request. The key steps for effective Rule 9 responses were highlighted, including having a clear understanding of the key themes and issues and ensuring that all relevant stakeholders within the Trust were informed.</p> <p>The Board of Directors noted the report.</p>
030c	<p><b>Board Assurance Framework</b></p> <p>The Board of Directors received the Board Assurance Framework.</p> <p>The Trust Secretary outlined the proposed 2022/23 quarter 4 scores for each BAF and the respective rationale for these. A proposed change to the BAF risk 2.4 score for Quarter 4 – (likelihood 4 x consequence 4) was proposed (Quarter 3 score was likelihood 4 x consequence 5). Actions to strengthen controls and assurances had been closed during the quarter which provided a greater level of control, reducing the impact of a potential cyber-attack.</p> <p>It was noted that whilst the proposed quarter 4 BAF scores aligned to the FPBD and Quality Committees had been discussed during April 2023, due to meeting schedules, a similar discussion had not taken place at the PPF Committee. At the May 2023 PPF Committee, the BAF would be discussed, and it was likely that BAF Risk 1.2 would be recommended to reduce in score level. It was agreed to review the scheduling of quarterly BAF reviews at the aligned Committees to ensure discussions took place ahead of Board.</p> <p>The Board of Directors</p> <ul style="list-style-type: none"> <li>• reviewed the BAF risks and agreed on their contents and actions.</li> <li>• Agreed on the suggested Q4 scores</li> </ul> <p><i>The following items were considered as part of the consent agenda</i></p>
031	<p><b>Emergency Planning Resilience and Response Annual Board Report</b></p> <p>This Emergency Preparedness, Resilience and Response (EPRR) Annual Report provided a summary of EPRR approach and activities for 2022/23.</p> <p>The Board of Directors noted the report.</p>



032	<p><b>Revised Risk Management Strategy for 2023/24</b></p> <p>It was noted that the Risk Management Strategy was presented to Audit Committee in March 2023 and Quality Committee in April 2023. Following feedback received, there had been performance milestones added to Section 8 of the Strategy to measure the effectiveness of the Strategy over the following 3-year period, between 2023 – 2026. This would be reviewed annually, and key achievements reported back to Quality Committee. Furthermore, there had been additions in relation to proactive and reactive risk processes (sections 4 and 5) and more descriptive roles in relation to the accountability of divisional and service managers.</p> <p>The Board of Directors approved the revised Risk Management Strategy.</p>
033	<p><b>Proposed Risk Appetite Statement for 2023/24</b></p> <p>The Board noted that the relevant risk appetite statements for Putting People First Committee, Quality Committee, and FPDB had been discussed and agreed upon at their respective committee meetings in March 2023 – April 2023.</p> <p>The Board of Directors agreed on the appetite and risk tolerance levels for 2023/24 against the key strategic aims.</p>
034	<p><b>Review of non-executive director champion roles</b></p> <p>The report provided an update on the discharging of the NED champion roles with amendments proposed where relevant.</p> <p>The Board of Directors:</p> <ul style="list-style-type: none"> <li>Noted the progress made to date in discharging the NED Champion roles</li> <li>Agreed on the proposed changes to the Trust's NED Champion roles.</li> </ul>
035	<p><b>Review of risk impacts of items discussed</b></p> <p>The Chair identified the following risk items:</p> <ul style="list-style-type: none"> <li>How the Trust manages and supports families when attending appointments</li> <li>The need for continued patient engagement in maternity services</li> <li>Performance against access targets</li> <li>The Trust's 2023/24 financial position, longer-term sustainability challenges, and the potential impact on quality and safety.</li> <li>Potential requirement of staff resources to manage Covid-19 Inquiry information</li> </ul>
036	<p><b>Chair's Log</b></p> <p>The following Chair's Logs were noted:</p> <ul style="list-style-type: none"> <li>For the Patient Involvement &amp; Experience Sub-Committee to receive an update from the Patient Experience Matron on the work to enhance patient information regarding baby scans and the development of a central offer for childcare/family support during and post scans.</li> <li>For the Quality Committee to assess the impact of changes to the Continuity of Carer pathway after six months of implementation.</li> </ul>
037	<p><b>Any other business &amp; Review of meeting</b></p> <p>The Chief Operating Officer thanked staff for their hard work and diligence during the recent Industrial Action.</p> <p><b>Review of meeting</b></p> <p>No comments noted.</p>
038	<b>Jargon Buster</b>

	Noted.
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## Action Log

Trust Board - Public  
8 June 2023

Key	Complete	On track	Risks identified but on track	Off Track
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Meeting Date	Ref	Agenda Item	Action Point	Owner	Action Deadline	RAG Open/Closed	Comments / Update
11 May 2023	23/24/027b	Quality & Operational Performance Report	To convene monthly Board meetings to monitor performance challenges and improvement actions.	Trust Secretary	June 23	Complete	
11 May 2023	23/24/027b	Quality & Operational Performance Report	For the safe staffing section of the performance report to include staffing targets to provide additional context.	CN	July 23	Complete	The additional narrative is included within the report.
11 May 2023	23/24/025	Chief Executive's report	For quarterly C-GULL recruitment numbers to be included within the Quality & Operational Performance Report	COO	July 23	On track	
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	<del>Mar 23</del> July 23	On track	MVP to be invited to July Board to coincide with wider discussion on 'how the Trust listens (to patients)'

## Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	11.05.2023	For the Quality Committee to assess the impact of changes to the Continuity of Carer pathway after six months of implementation.	Quality Committee	July 2023	Open	

		Executive Lead: Chief Nurse				
Delegated	11.05.2023	For the Patient Involvement & Experience Sub-Committee to receive an update from the Patient Experience Matron on the work to enhance patient information regarding baby scans and the development of a central offer for childcare/family support during and post scans.  Executive Lead: Deputy Director of Nursing & Midwifery	PIESC	July 2023	Open	
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	July 2023	Open	
Delegated	06.04.2023	To undertake a deep dive into the main themes for Serious Incidents and for this to also consider the impact of health inequalities.  Executive Lead: Medical Director	Quality Committee	June 2023	Open	
Delegated	06.04.2023	To monitor Cancer 62-day performance and to seek assurance on the effectiveness of improvement actions.  Executive Lead: Chief Operating Officer	Quality Committee	May 2023	Closed	Reported to the May 23 meeting
Delegated	06.04.2023	To receive the outcome of a review into the most appropriate method of measuring Caesarean Section (emergency and total) rates.  Executive Lead: Medical Director	Quality Committee	June 2023	Open	

# Trust Board

## COVER SHEET

Agenda Item (Ref)	23/24/055	Date: 08/06/2023		
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 <input type="checkbox"/>	Receive <input type="checkbox"/>	Note <input type="checkbox"/>	Take Assurance <input checked="" type="checkbox"/>
	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 1 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 <b>MUST</b> accompany the report)			
Strategy <input type="checkbox"/>	Policy <input type="checkbox"/>	Service Change <input type="checkbox"/>	Not Applicable <input checked="" type="checkbox"/>
Strategic Objective(s)			
To develop a well led, capable, motivated and entrepreneurial <b>workforce</b>	<input type="checkbox"/>	To participate in high quality research and to deliver the most <b>effective</b> Outcomes	<input checked="" type="checkbox"/>
To be ambitious and <b>efficient</b> and make the best use of available resource	<input checked="" type="checkbox"/>	To deliver the best possible <b>experience</b> for patients and staff	<input checked="" type="checkbox"/>
To deliver <b>safe</b> services	<input checked="" type="checkbox"/>		
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:	
N/A			

Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:
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#### REPORT DEVELOPMENT:

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

## **Performance Report Contents**

Section 1: LWGH Assurance Radar Charts by Trust Values

Section 2: Integrated Performance Metrics

Section 3: Safe Services

Section 4: Effective Outcomes

Section 5: Best Experience

Section 6: Workforce

KPI Lineage and Data Quality Overview

Appendix 1 – Assurance and Variation Icon Descriptions

Appendix 2 – Assurance Category Descriptions

## 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 <b>currently not changing significantly</b> . 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.	<b>Something's going on!</b> 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.	<b>Something's going on!</b> 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.	<b>Something good is happening!</b> 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.	<b>Something good is happening!</b> 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.	<b>Something's going on!</b> 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.	<b>Something's going on!</b> 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 <b>within</b> 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 <b>outside of those limits in the wrong direction</b> then you know that the target cannot be achieved.	<b>You need to change something in the system or process if you want to meet the target.</b> 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 <b>outside of those limits in the right direction</b> then you know that the target can consistently be achieved.	<b>Celebrate the achievement.</b> 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

Assurance				
Variation/Performance				
	<p><b>Excellent</b>            • 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.</p> <p><b>Celebrate and Learn</b></p>	<p><b>Good</b>            • 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.</p> <p><b>Celebrate and Understand</b></p>	<p><b>Concerning</b>            • 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.</p> <p><b>Celebrate but Take Action</b></p>	<p><b>Excellent</b>            • This metric is improving.            • Your aim is high numbers and you have some.            • There is currently no target set for this metric.</p> <p><b>Celebrate</b></p>
	<p><b>Excellent</b>            • 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.</p> <p><b>Celebrate and Learn</b></p>	<p><b>Good</b>            • 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.</p> <p><b>Celebrate and Understand</b></p>	<p><b>Concerning</b>            • 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.</p> <p><b>Celebrate but Take Action</b></p>	<p><b>Excellent</b>            • This metric is improving.            • Your aim is low numbers and you have some.            • There is currently no target set for this metric.</p> <p><b>Celebrate</b></p>
	<p><b>Good</b>            • 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.</p> <p><b>Celebrate and Understand</b></p>	<p><b>Average</b>            • 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.</p> <p><b>Investigate and Understand</b></p>	<p><b>Concerning</b>            • 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.</p> <p><b>Investigate and Take Action</b></p>	<p><b>Average</b>            • 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.</p> <p><b>Understand</b></p>
	<p><b>Concerning</b>            • 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.</p> <p><b>Investigate and Understand</b></p>	<p><b>Concerning</b>            • 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.</p> <p><b>Investigate and Take Action</b></p>	<p><b>Very Concerning</b>            • 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.</p> <p><b>Investigate and Take Action</b></p>	<p><b>Concerning</b>            • This metric is deteriorating.            • Your aim is low numbers and you have some high numbers.            • There is currently no target set for this metric.</p> <p><b>Investigate</b></p>
	<p><b>Concerning</b>            • 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.</p> <p><b>Investigate and Understand</b></p>	<p><b>Concerning</b>            • 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.</p> <p><b>Investigate and Take Action</b></p>	<p><b>Very Concerning</b>            • 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.</p> <p><b>Investigate and Take Action</b></p>	<p><b>Concerning</b>            • This metric is deteriorating.            • Your aim is high numbers and you have some low numbers.            • There is currently no target set for this metric.</p> <p><b>Investigate</b></p>
				<p><b>Unsure</b>            • 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.</p> <p><b>Investigate and Understand</b></p>
				<p><b>Unsure</b>            • 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.</p> <p><b>Investigate and Understand</b></p>
				<p><b>Unknown</b>            • 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.</p> <p><b>Watch and Learn</b></p>



# Liverpool Women's NHS Foundation Trust

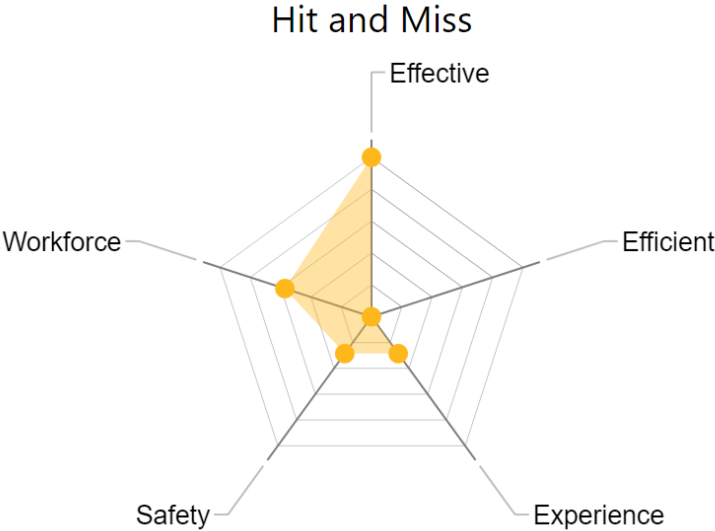
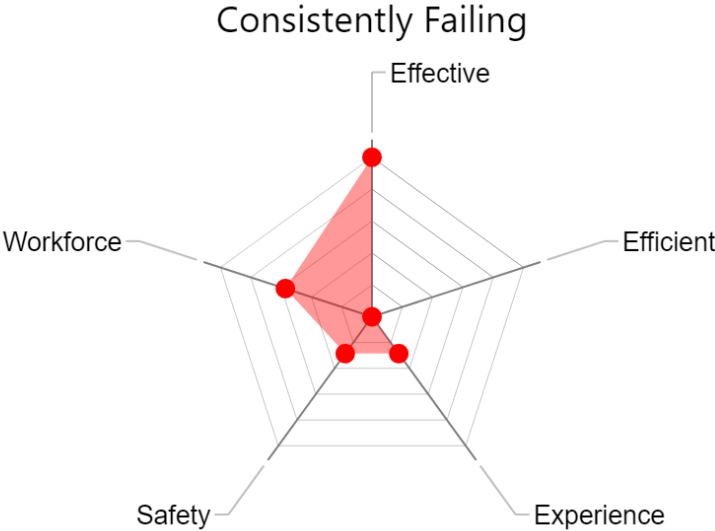
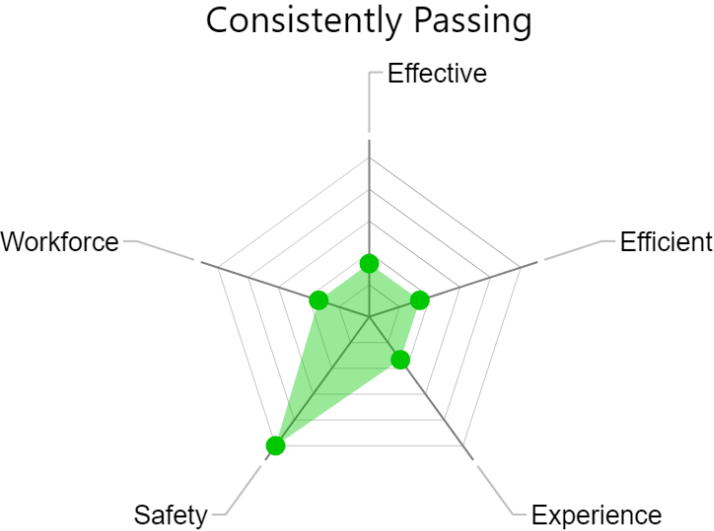
## Trust Board Performance Report June 2023

# 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	15
KPIs Hit and Miss	11
KPIs No Target	2

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





































## 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

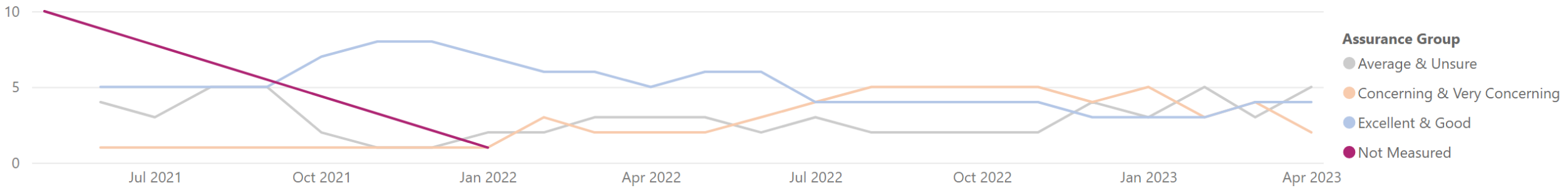
Excellent - Celebrate & Learn						Good - Celebrate & Understand						Average - Investigate & Understand					
KPI	Target < or >	Target	P	A	V	KPI	Target < or >	Target	P	A	V	KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 104 Weeks	<=	0	0			Complaints: Number Received	<=	<= 15	4			Neonatal Deaths per 1000 live Births	<=	0			
Turnover Rate	<=	<= 13%	9.88%			Financial Sustainability Risk Rating: Overall Score	<=	3	3			Cancer: 2 Week Wait	>=	>= 93%	85.09%		
						Infection Control: Clostridium Difficile	<=	0	0			Diagnostic Tests: 6 Week Wait	>=	>= 99%	91.83%		
						Infection Control: MRSA	<=	0	0			Friends & Family Test: In-patient/Daycase % positive	>=	95%	90.08%		
						MAU - Face to face Maternity Triage within 30 Mins	>=	>= 95%	99.31%			Never Events	<=	0	0		
						NHSE / NHSI Safety Alerts Outstanding	<=	0	0			Proportion of patient activity with an ethnicity code	>=	>=96%	95.71%		
												Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	>=	100%	100.00 %		
												Serious Untoward Incidents: Number of SUI's with actions outstanding	<=	0	0		
												Venous Thromboembolism (VTE)	>=	>= 95%	95.50%		

# 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						Very Concerning - Investigate & Take Action						Investigate & Understand					
KPI	Target < or >	Target	P	A ▲	V	KPI	Target < or >	Target	P	A	V	KPI	Target < or >	Target	P	A ▼	V
18 Week RTT: Incomplete Pathway > 78 Weeks	<=	0	22			Cancer: 104 Day Breaches	<=	0	8								
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	>=	>= 95%	87.88%			Cancer: 28 Day Faster Diagnosis	>=	>= 75%	47.32%								
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	>=	>=85%	14.29%			Serious Untoward Incidents: New (Rolling per year)	<=	24 /year	46								
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	>=	>=96%	85.71%			Serious Untoward Incidents: Open	<=	<5	21								
Cancer: 62 Day Screening Referrals (Percentage) Rolling 12 Months	>=	>=90%	33.33%														
Clinical Mandatory Training Compliance	>=	>= 95%	81.96%														
Friends & Family Test: A&E % positive	>=	95%	81.11%														
Friends & Family Test: Maternity % positive	>=	95%	84.33%														
Mandatory Training Compliance	>=	>= 95%	92.64%														
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	>=	>= 80%	41.54%														
Sickness Absence Rate	<=	<= 4.5%	6.34%														
18 Week RTT: Incomplete Pathway > 52 Weeks	<=	0	1586														
Overall size of Elective Waiting List	<=		17687														

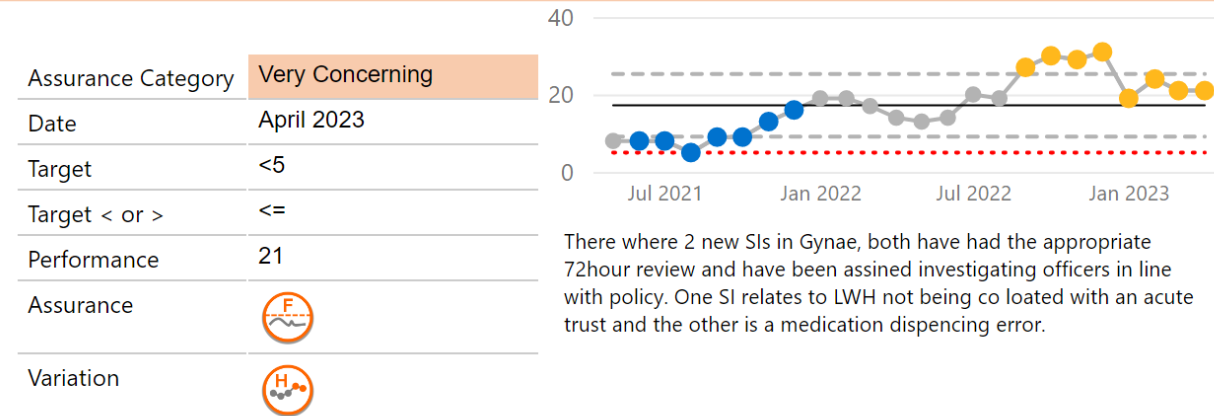
## Section 3: To deliver **Safe** Services



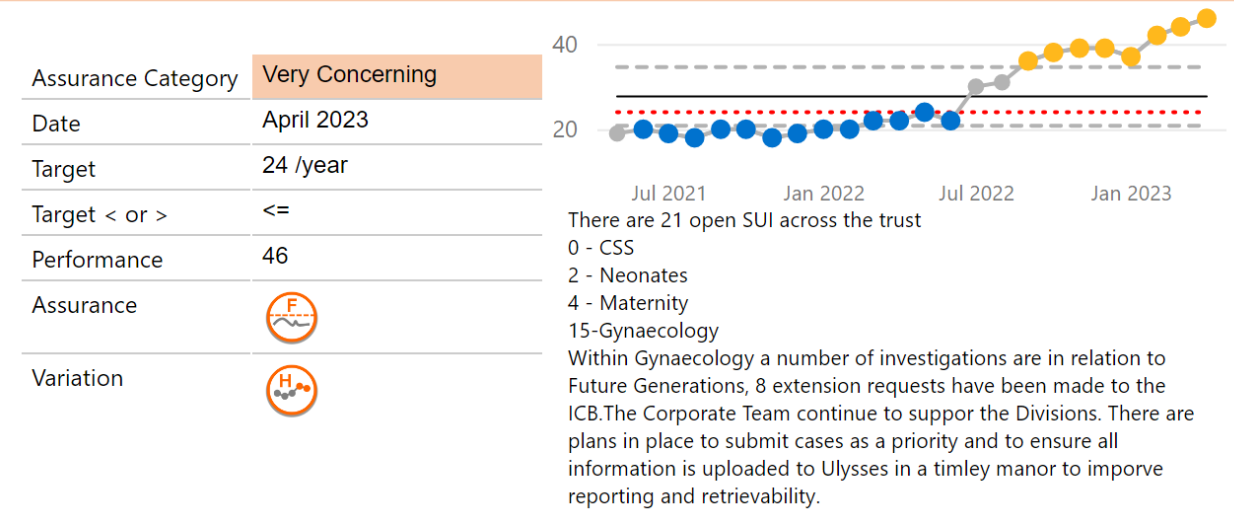
KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Infection Control: Clostridium Difficile	Good	April 2023	0	<=	0			
Infection Control: MRSA	Good	April 2023	0	<=	0			
MAU - Face to face Maternity Triage within 30 Mins	Good	April 2023	>= 95%	>=	99.31%			
NHSE / NHSI Safety Alerts Outstanding	Good	April 2023	0	<=	0			
Neonatal Deaths per 1000 live Births	Average	April 2023		<=	0			
Never Events	Average	April 2023	0	<=	0			
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	Average	April 2023	100%	>=	100.00%			
Serious Untoward Incidents: Number of SUI's with actions outstanding	Average	April 2023	0	<=	0			
Venous Thromboembolism (VTE)	Average	April 2023	>= 95%	>=	95.50%			
Serious Untoward Incidents: New (Rolling per year)	Very Concerning	April 2023	24 /year	<=	46			
Serious Untoward Incidents: Open	Very Concerning	April 2023	<5	<=	21			

# To deliver **Safe** Services - Exceptions

## Serious Untoward Incidents: Open - Chief Nurse



## Serious Untoward Incidents: New - Chief Nurse



Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	



# To deliver Safe services - Safer Staffing

April 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	90.83%	83.33%	130.00%	100.00%	*Staffing fill rates for days shift in April is reflective of RN vacancy and Sickness the bed occupancy on the inpatient ward. HDU bed occupancy allowed for movement of RN from HDU to support the ward on day shifts, 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 the inpatient ward and GED which is under review
Induction & Delivery Suites	85.90%	85.56%	87.95%	95.00%	*Safe staffing required the Maternity bleep holder to redeploy RM to maintain clinical safety and prioritise 1:1 care in labour, and an escalation of CoC Midwives as per policy. Vacant shifts are requested to be filled with bank and agency up to planned staffing numbers
Maternity & Jeffcoate	84.58%	112.50%	89.05%	100.83%	*/**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. All vacant shifts requested to be filled with bank. Additional care staff in place through temporary staffing arrangements to mitigate were fill rate of registered midwives was reduced to support ward.
MLU	85.83%	86.67%	76.67%	80.00%	*/**There were no episodes of Closure during the month, occupancy was reduced which allowed the safe delivery of Intrapartum and early postnatal care. Within Intrapartum Care clinician is Registered Midwife with Care staff supporting the running of the ward as opposed to providing direct clinical care. Vacant shifts are requested to be filled with bank
Neonates (ExTC)	100.70%	126.67%	100.35%	106.67%	*/**Fill rates are reflective of the acuity and occupancy of the NICU (Neonatal Intensive Care Unit). Safe staffing maintained and CHPPD (Care Hours Per Patient Day) are as would be expected.
Transitional Care	30.00%	83.33%	43.33%	70.00%	*/**Fill rates are reflective of the occupancy of the TC (Transitional Care). Safe staffing maintained and CHPPD (Care Hours Per Patient Day) are as would be expected.



## To deliver Safe services - Safer Staffing

### Gynaecology: April Fill Rate

**Fill rate** – April staffing fill rate is reflective of the current RN vacancy position and the increase this month of long-term sickness, alongside maternity leave. Safe staffing has been maintained due to the ability to flexibly rotate RNs across the division and also due to the low bed occupancy of 34.21% in the inpatient area, the fill rate 130.00% RN on nights is the reflection of senior RN cover rotating between GED and the inpatient area which is currently under review

**Attendance/ Absence** – sickness and absence for the month of April is at 10.88% overall, well about Trust threshold of 4.5%, with long-term sickness contributing to 60.13%

**Vacancies** – April vacancies for the inpatient area is 0.91 WTE band 5

**Red Flags** – There were no red flag incidents raised for the month of April

**Bed Occupancy** – April inpatient bed occupancy recorded as 34.21%

**CHPPD** – For the month of April the CHPPD overall was reported to be 9.1. The split between registered and unregistered care staff is 5.3hr for Registered Nurse staff and 3.9hr for Health Care Assistant.

### Neonates: April Fill Rate

**Fill-rate** – April has seen activity remain consistent in relation to acuity and occupancy. Staffing has been less challenging this month with a slight increase in sickness. Safe staffing and fill rates are reflective of acuity and occupancy. There has been a use of Bank and staff continue to provide flexibility by swapping and changing shifts and non-cot side staff working clinically. NWNODN and specialist commissioners have recognised the increase in acuity and activity.

**Attendance/Absence** – April sickness ran at 5.76%, this was up from March by 0.3%. Short term sickness sits at 35.91% with long term sickness making up 64.09%. Covid sickness was up by 0.3% which correlates to slight rise in short term sickness. Maternity leave has increased from 10 FTE to 13 FTE and turnover sits at 7.15% well below the Trust threshold.

**Vacancies** – Vacancy rate remains low, however, waiting on approval to recruit band 5, 6 and ANNP replacement posts. Funding from Neonatal Critical Care Review to support a governance lead post has been agreed.

**Red Flags** – No red Flags

**Bed Occupancy** – Unit occupancy has run at 89.5% up just over 9% on last month and acuity remains high. IC continues to run just above the 80% standard at 81.7% down 16.4% on the previous month. HD activity has increased by 6.5% to 91.4%. LD activity has increased to 93.2% from 66.9%. While TC activity has come down by 14.4% on last month's 41.5%.

**CHPPD** – Within the critical care areas the care is as expected, showing higher hours of registered nurse care and lower non-registered care. This split of 11.1hrs of registered nurses and 1.4 is what is expected considering that most of these babies need care by a nurse qualified in speciality. This will differ in TC because the numbers are reflective of the way in which non-registered care leads TC supported by registered staff and parents, hence why we see 8.1 hrs by non-registered nurse and less by registered nurses of 3.9 hrs. Care in TC is more about supporting the family. This month the care hours per patient are slightly less than last month and this is reflective of a lower IC occupancy.

## To deliver Safe services - Safer Staffing

### **Maternity: April Fill Rate**

**Fill-rate** – During April, there were 18 shifts when the actual staffing was below expected staffing levels. To optimise staffing, dynamic risk assessments were undertaken, with the Maternity escalation policy triggered to ask the remaining COC Midwives on call to work in the Unit. This was in addition to the deployment of specialist midwives, ward managers and matrons for periods of time to ensure safety. Throughout the reporting period MLU was able to remain open supporting flow through all clinical areas. Additional care staff were arranged to support clinical care delivery for postnatal women on Maternity Ward where RM shifts were unable to be filled utilising temporary staffing solutions. Maternity continued to undertake a minimum 4-hourly activity /acuity review, which allows senior midwifery staff to maintain safety by rotating staff to the areas of highest clinical need using risk based responsive decision making

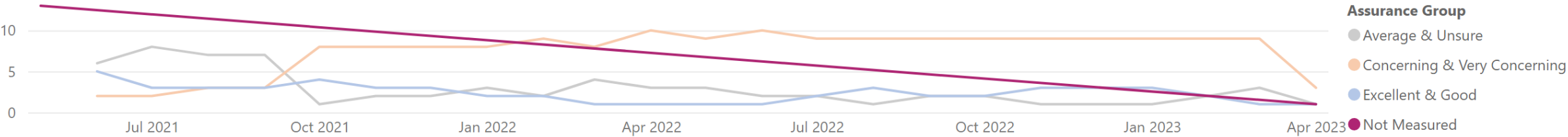
**Attendance/ Absence** – Maternity continues to report levels of sickness above the trust threshold of 4.5% which is calculated in the headroom, within its midwifery and support staff group. Maternity sickness is reported at 8.69% in month, a decrease of 2.9% from March, with short term absence accounting for 31% of this with the top reasons for short term absence being cough/cold or gastrointestinal issues. LTS is at 69%. Ward managers/matrons have individual sickness reviews and are planning return to work programmes with all LT employees to facilitate appropriate returns. Maternity leave equates to 13.52wte all of whom are within the Registered Midwives staffing group.

**Vacancies** – Vacancies at the end of Month 1 equated to 7% against current funded establishment, with Band 5 and Band 6 midwives currently undergoing recruitment processes and an expectation to reach full establishment by M6 when all new starters are in post .

**Red Flags** – During April, 30 Midwifery Red Flags were identified, which included 2 instances of 1:1 care not being provided for a short period of time during labour until staff could be redeployed- all cases reviewed by the Intrapartum Matron and presented at Maternity Risk meeting, 12 triage breaches of >30mins due to influx of attendances with all undergoing analysis to drive quality improvement as part of the MAU workstreams, 2 delays of >60mins to commence suturing and 14 delays of >4hrs for ongoing IOL (local red flag), the majority of which were reported during a 72hr period where acuity and occupancy was high in the Intrapartum areas and required additional temporary staff above the planned staffing numbers to support the surge in activity.

**CHPPD** – Since April 2021, CHPPD in Maternity has included the number of babies in the total number of patients per inpatient ward at the 23.59hrs data capture. For Intrapartum Areas, Delivery and MLU care during established labour care is required to be 1:1 with a registered midwife, with support staff utilised to assist with the functioning of the ward or help in the postnatal period once the birth care episode is completed prior to transfer to Maternity Ward. This was reported at 16.9 in April for Delivery Suite which is an increase from 14.1 in March. As CHPPD calculation combines hours provided by registered and care staff it is not the most sensitive indicator for Intrapartum Care. 1:1 Care provided by a Midwife to all women was achieved for 99.6%. The Maternity Ward is mixed antenatal and postnatal ward and therefore the fluctuation of casemix will be significant to CHPPD calculations, due to babies being inclusive in the total and classed also as patients. It is reported at 3.7 for April increasing from 3.4 for March. We will be working BirthRate Plus to implement the new Ward Based Accuity Tool with anticipated launch this summer which will provide real time evidence-based data to support staffing deployment decisions and provide assurance within this area. This was previously planned for spring, however the metrics used within the app are currently undergoing review nationally to reflect the changing needs of postnatal care provision

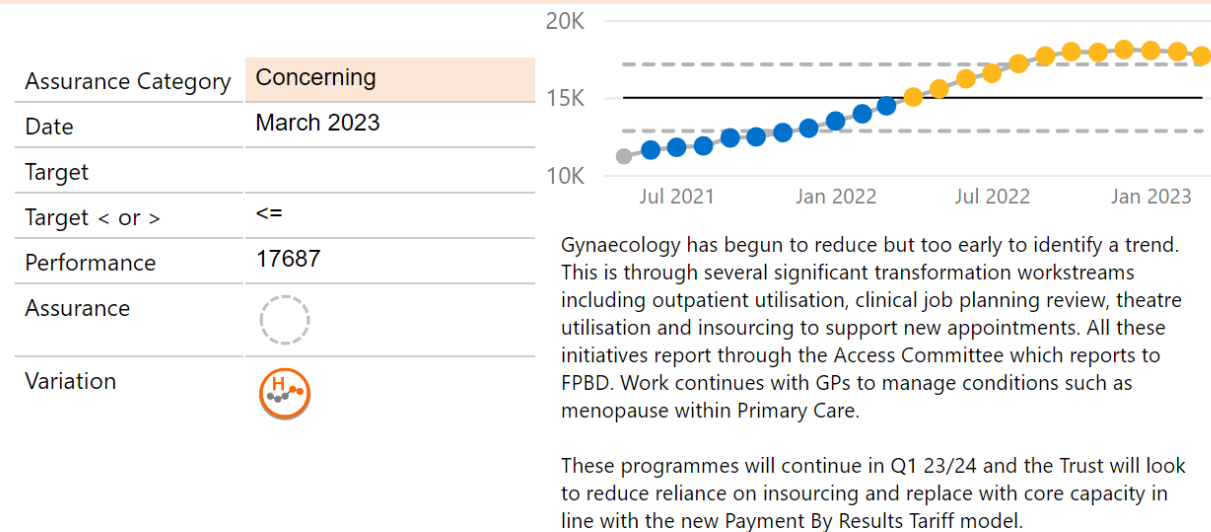
Section 4: To deliver the most **Effective** Outcomes



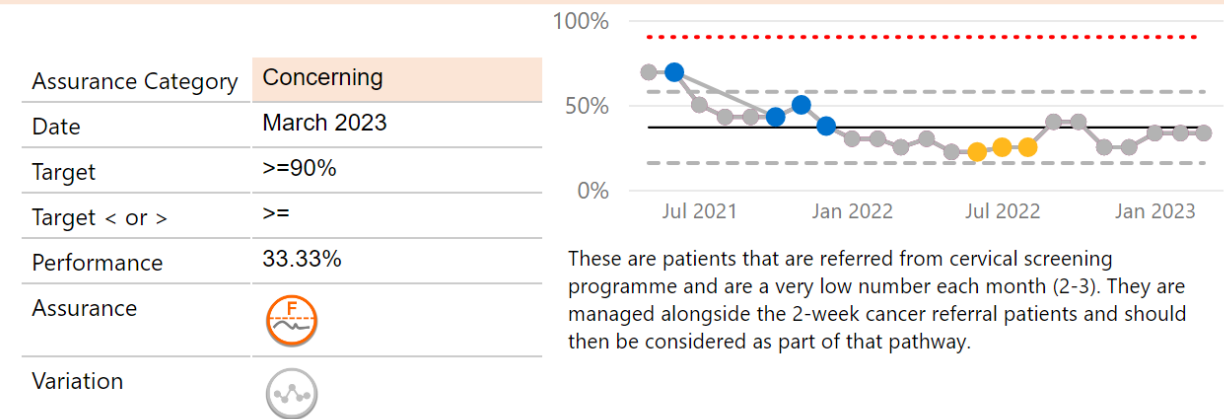
KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
18 Week RTT: Incomplete Pathway > 65 Weeks	Not Measured	April 2023	0	<=	349			.
18 Week RTT: Incomplete Pathway > 104 Weeks	Excellent	April 2023	0	<=	0			
Cancer: 2 Week Wait	Average	March 2023	>= 93%	>=	85.09%			
Diagnostic Tests: 6 Week Wait	Average	March 2023	>= 99%	>=	91.83%			
Proportion of patient activity with an ethnicity code	Average	April 2023	>=96%	>=	95.71%			
18 Week RTT: Incomplete Pathway > 52 Weeks	Concerning	April 2023	0	<=	1586			
18 Week RTT: Incomplete Pathway > 78 Weeks	Concerning	April 2023	0	<=	22			
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Concerning	April 2023	>= 95%	>=	87.88%			
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Concerning	March 2023	>=85%	>=	14.29%			
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Concerning	March 2023	>=96%	>=	85.71%			
Cancer: 62 Day Screening Referrals (Percentage) Rolling 12 Months	Concerning	March 2023	>=90%	>=	33.33%			
Overall size of Elective Waiting List	Concerning	March 2023		<=	17687			
Cancer: 104 Day Breaches	Very Concerning	March 2023	0	<=	8			
Cancer: 28 Day Faster Diagnosis	Very Concerning	March 2023	>= 75%	>=	47.32%			

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

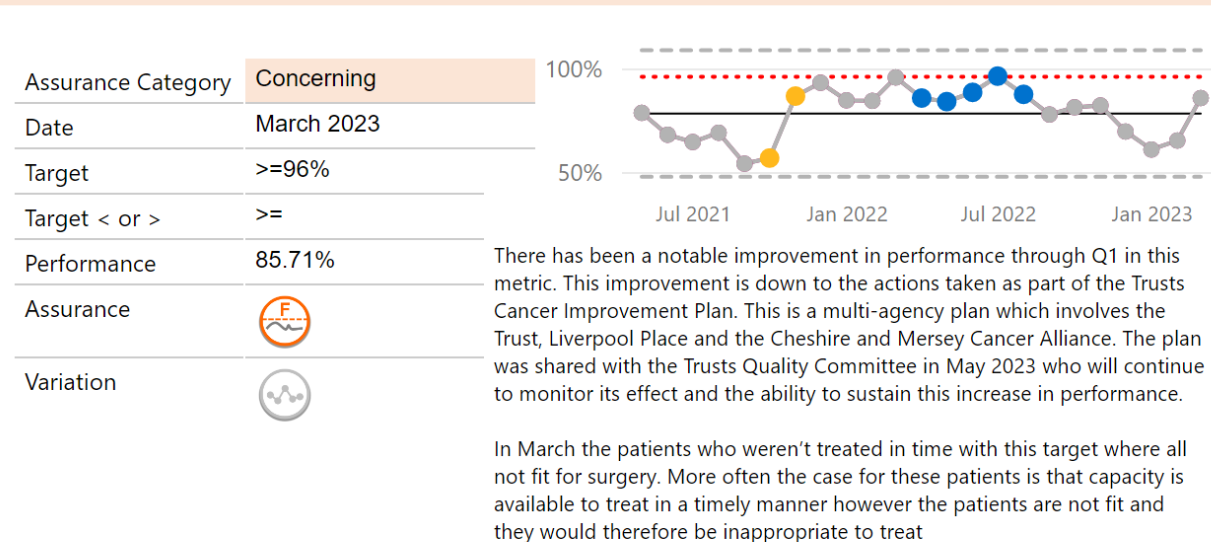
## Overall size of Elective Waiting List - Chief Operating Officer



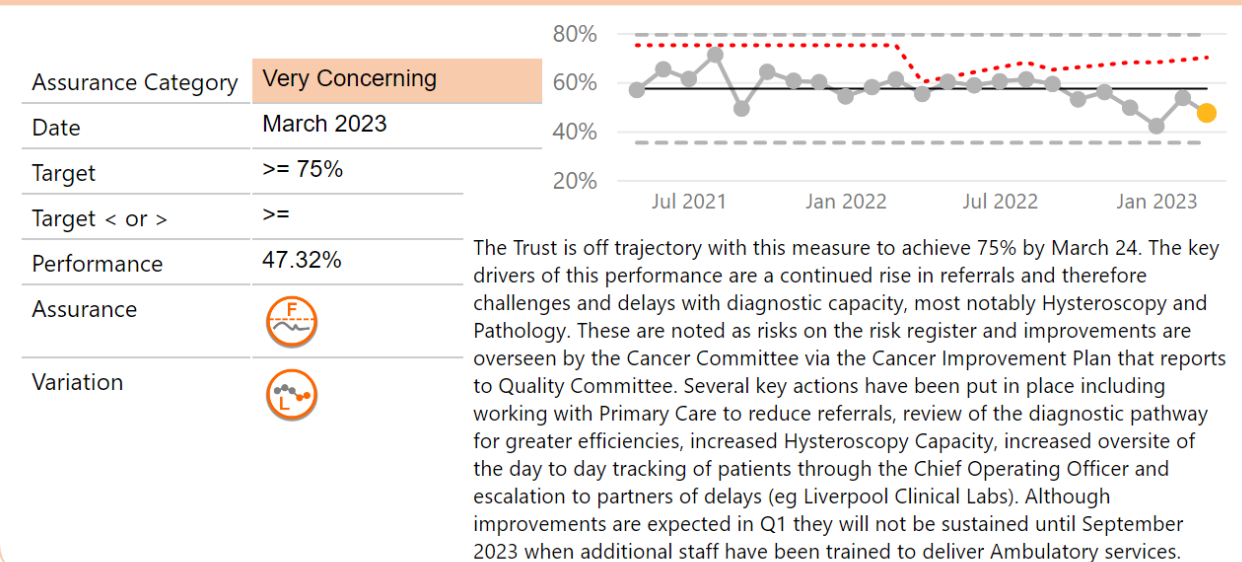
## Cancer: 62 Day Screening Referrals (Percentage) Rolling 12 Months - Chief Operating Officer



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

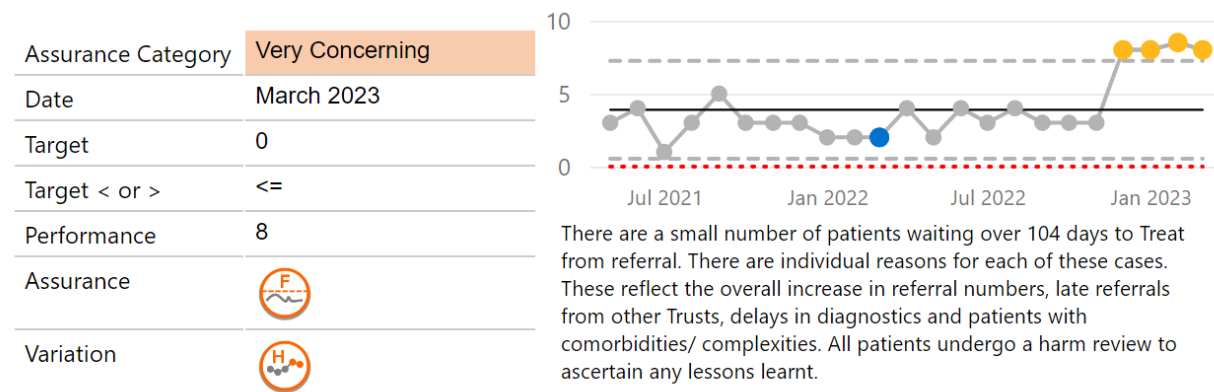


## Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

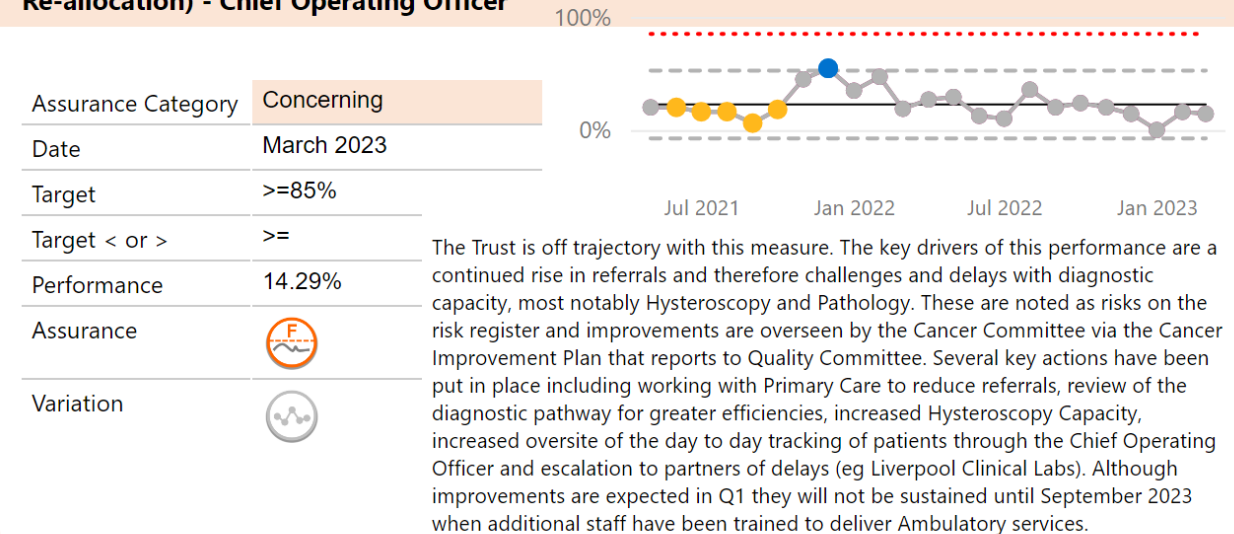


# To deliver the most **Effective** Outcomes - Exceptions

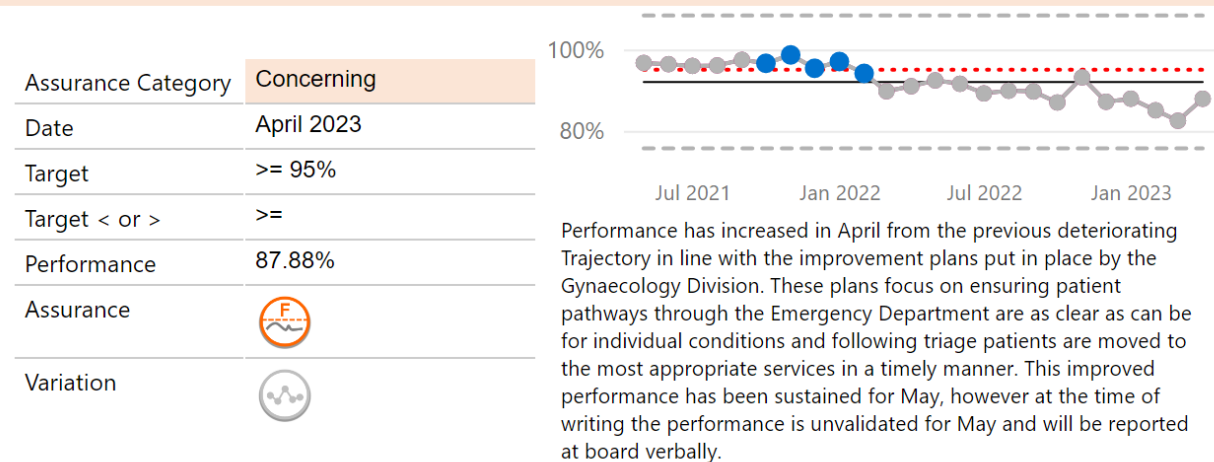
## Cancer: 104 Day Breaches - Chief Operating Officer



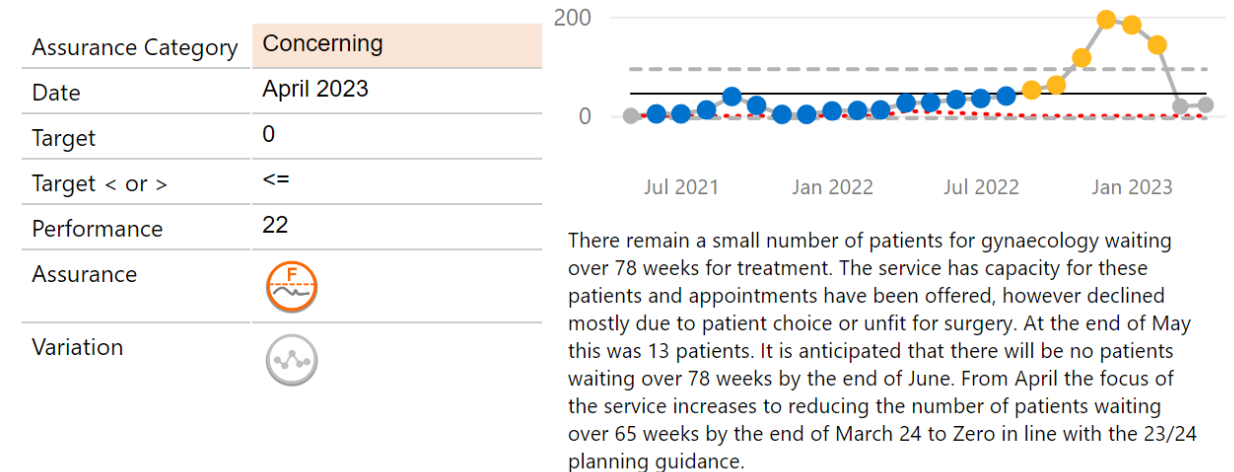
## All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation) - Chief Operating Officer



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



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





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

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

Assurance Category

Concerning

Date

April 2023

Target

0

Target < or >

<=

Performance

1586

Assurance



Variation



The number of patients waiting over 52 weeks continues to reduce in line with the national ask to ensure no patients waiting over 52 weeks for treatment by March 2025. The Trust has a regular monitoring meeting with NHSE and is currently green against our trajectory.

Additional temporary capacity has been sourced to support this improvement. The new tariff-based arrangements for 23/24 will allow better planning for more substantive additional capacity. The longest waiting patients are prioritised, and oversight is through the regular Divisional Patient Tracking List meetings.

2K

0K

Jul 2021

Jan 2022

Jul 2022

Jan 2023

Assurance Category

Date

Target

Target < or >

Performance

Assurance

Variation

Assurance Category

Date

Target

Target < or >

Performance

Assurance

Variation

Assurance Category

Date

Target

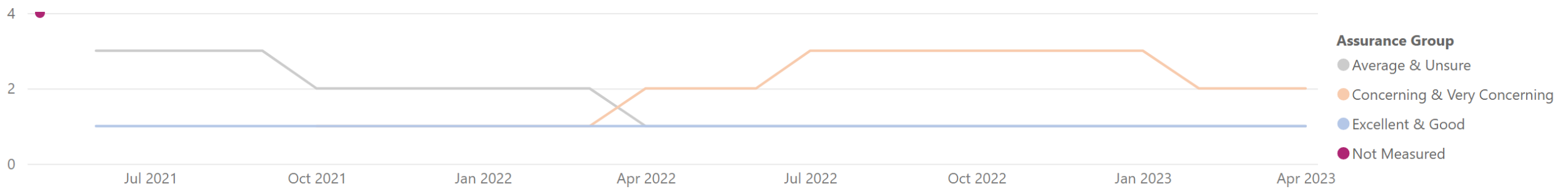
Target < or >

Performance

Assurance

Variation

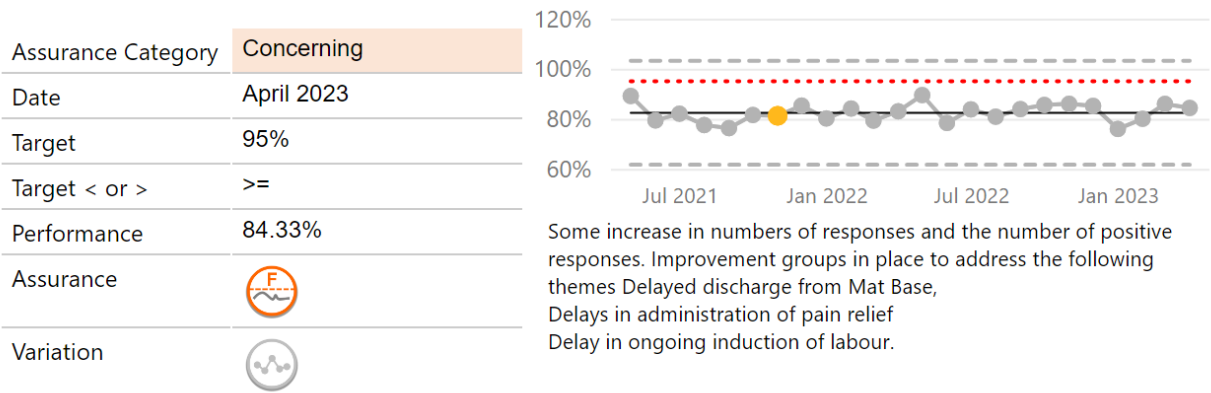
Section 5: To deliver the best possible **Experience** for patients and staff



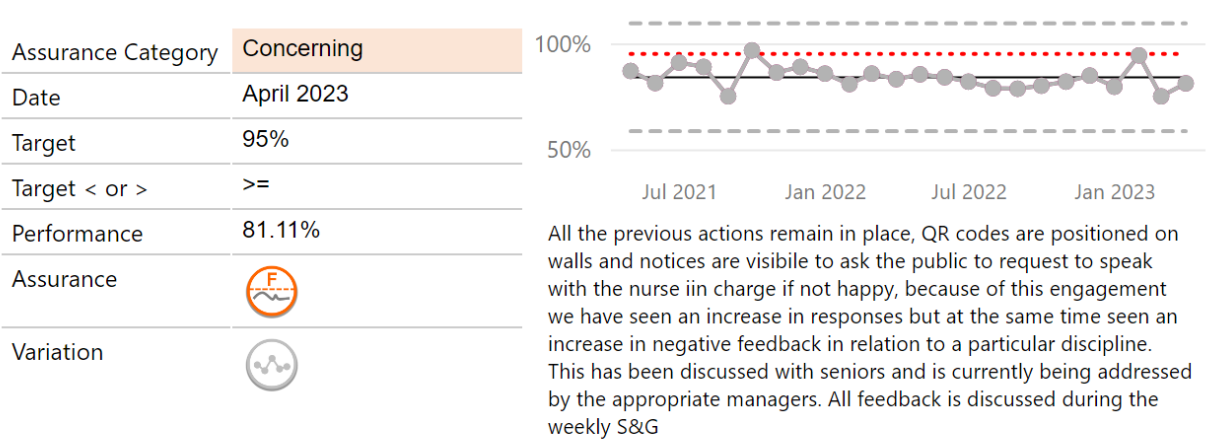
KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Complaints: Number Received	Good	April 2023	<= 15	<=	4			
Friends & Family Test: In-patient/Daycase % positive	Average	April 2023	95%	>=	90.08%			
Friends & Family Test: A&E % positive	Concerning	April 2023	95%	>=	81.11%			
Friends & Family Test: Maternity % positive	Concerning	April 2023	95%	>=	84.33%			

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

## Friends & Family Test: Maternity % positive - Chief Nurse



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

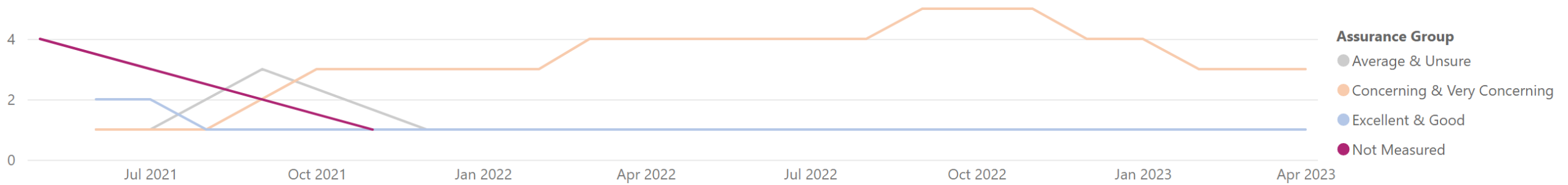


Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	





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

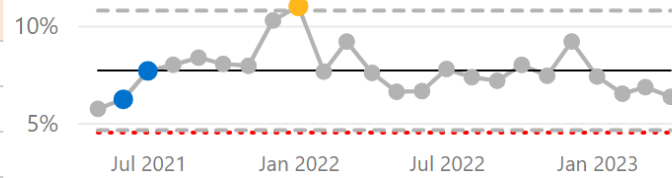


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Turnover Rate	Excellent	April 2023	<= 13%	<=	9.88%			
Clinical Mandatory Training Compliance	Concerning	April 2023	>= 95%	>=	81.96%			
Mandatory Training Compliance	Concerning	April 2023	>= 95%	>=	92.64%			
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Concerning	January 2023	>= 80%	>=	41.54%			
Sickness Absence Rate	Concerning	April 2023	<= 4.5%	<=	6.34%			

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



## Sickness - Chief People Officer

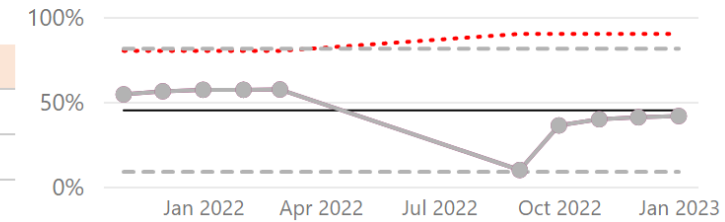
Assurance Category	Concerning
Date	April 2023
Target	$\leq 4.5\%$
Target < or >	$\leq$
Performance	6.34%
Assurance	
Variation	



Sickness fell by 0.5% in April, going down to 6.34%. This fall was reflected across the divisions, with the exception of Gynaecology, where there was an increase of 0.41%. There is still a focus on ensuring return to work meetings are conducted in a timely manner, and that all staff have an annual Wellbeing Conversation, and that these are recorded accurately. HR are working closely with local managers to ensure that both short and long term sickness are being managed appropriately.



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

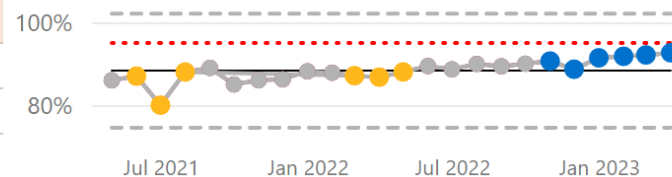
Assurance Category	Concerning
Date	January 2023
Target	$\geq 80\%$
Target < or >	$\geq$
Performance	41.54%
Assurance	
Variation	



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

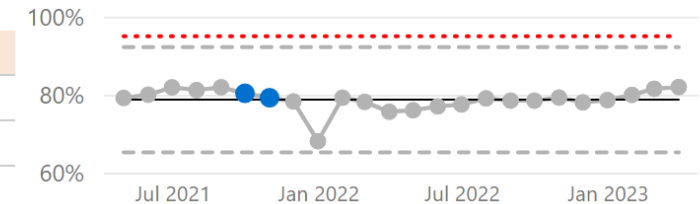
Assurance Category	Concerning
Date	April 2023
Target	$\geq 95\%$
Target < or >	$\geq$
Performance	92.64%
Assurance	
Variation	



Compliance increased by 0.53% up to 92.64%. All the main divisions are now above the target figure of 95% except for Family Health, who are at 89.11%. Again, Matrons are reviewing compliance and will be given direct / time-specific action plans to ensure compliance improves and is maintained. There continues to be a specific focus on those individuals who have competencies that expired over 12 months ago, or have never been completed.

## Clinical Mandatory Training Compliance - Chief People Officer

Assurance Category	Concerning
Date	April 2023
Target	$\geq 95\%$
Target < or >	$\geq$
Performance	81.96%
Assurance	
Variation	



Compliance increased by 0.44%, giving a Trust-wide figure of 81.96%. HRBPs continue to work closely with local managers, with weekly assurance meetings to review compliance and agreed actions. 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.

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 > 65 Weeks	Effective	5	✓ Y	✓ 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) Rolling 12 Months	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 Incidents: New	Safety	5	✓ Y		✓ Y				✓ Y	
Serious Untoward Incidents: 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				

# Trust Board

## COVER SHEET

Agenda Item (Ref)	23/24/56a		Date: 08/06/2023	
Report Title	Finance Performance Review Highlight Month 1 2023/24			
Prepared by	Jen Huyton Deputy Chief Finance Officer / Deputy Director of Strategy			
Presented by	Jenny Hannon, Chief Finance Officer			
Key Issues / Messages	To receive the Month 1 financial position.			
Action required	Approve <input type="checkbox"/>	Receive <input type="checkbox"/>	Note <input checked="" type="checkbox"/>	Take Assurance <input type="checkbox"/>
	To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it	For the intelligence of the Board / Committee without in-depth discussion required	To assure the Board / Committee that effective systems of control are in place
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – If no – please outline the reasons for deviation.			
	The Board is asked to note the Month 1 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 <b>workforce</b>	<input checked="" type="checkbox"/>	To participate in high quality research and to deliver the most <b>effective</b> Outcomes	<input checked="" type="checkbox"/>
To be ambitious and <b>efficient</b> and make the best use of available resource	<input checked="" type="checkbox"/>	To deliver the best possible <b>experience</b> for patients and staff	<input checked="" type="checkbox"/>
To deliver <b>safe</b> services	<input checked="" type="checkbox"/>		

## 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 – Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term	
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

## REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Finance, Performance and Business Development Committee	31/05/2023	Chief Finance Officer	The Committee noted the M1 position.

## EXECUTIVE SUMMARY

At Month 1 the Trust is reporting a £1,538k deficit, which is £1k favourable to plan. This position is supported by several one-off favourable items. The Trust is not required to report to NHS England at M1, therefore a highlight report has been produced only.

The cash balance in the Government Banking Service (GBS) account (£8,686k at 30 April) is above the minimum level set out in the Treasury Management policy (current policy states 15 days expenditure or c £5.9m minimum cash level).

The Trust achieved the Better Payment Practice Code target of 95% for invoices by value in M1.

## MAIN REPORT

### 1. Introduction

At Month 1, the Trust is not required to report its financial position to NHS England (NHSE). The purpose of this paper is to ensure the Board is appraised of the financial position at M1, given the challenging financial plan in place for 2023/24.

### 2. Summary I&E Position

At Month 1, the Trust is reporting an overall net position of £1,538k, which is a £1k favourable variance against the submitted plan of £1,539k:

M1 I&E Position	Budget £000s	Actual £000s	Variance £000s	RAG	R	A	G
INCOME	-11,769	-11,897	128	Green	OFF PLAN	PLAN	PLAN OR BETTER
PAY EXPENDITURE	7,539	7,782	-244	Red	OFF PLAN	PLAN	PLAN OR BETTER
NON PAY EXPENDITURE	5,769	5,652	117	Green	OFF PLAN	PLAN	PLAN OR BETTER
<b>Grand Total</b>	<b>1,539</b>	<b>1,538</b>	<b>1</b>	Yellow	OFF PLAN	PLAN	PLAN OR BETTER

However, it should be noted that this position is supported by several non-recurrent items.

#### Income

Adverse income variances due to unmet cost improvement programme (CIP) schemes (at this early stage of the year) and Community Diagnostic Centre income, have been offset by one-off favourable income items received in-month (for example profit on disposal of medical equipment which had reached the end of its useful life).

#### *Pay*

The adverse pay variance at M1 is driven by costs of industrial action, as well as increased agency and bank costs within midwifery staffing.

#### *Non-Pay*

The favourable variance in non-pay is largely driven by a reduction in clinical supplies costs in M1.

#### *Divisional Overview*

Key headlines regarding divisional performance are as follows:

- Family Health - the division has an adverse variance to last year's average costs, driven by high bank and agency costs for midwifery staffing, as well as non-recurrent consultant step down costs to support industrial action. High levels of midwifery vacancies, maternity leave, and sick leave are driving increased bank and agency costs.
- Gynaecology - overall, the division is broadly in line with last year's average costs (however the Trust needs to improve against run rate to meet the plan). The division saw favourable variances in clinical supplies offset by increased consultant step down costs in M1 in relation to industrial action.
- Clinical Support Services - theatres agency costs are reduced in-month; however, some step-down costs were seen due to industrial action.

### **3. Advanced Payment and Incentive**

The Trust is exposed to £1.2m of income risk in-year relating to API. The Trust has reported to plan in M1.

### **4. Cost Improvement Programme**

The Trust has an extremely challenging efficiency programme for 2023/24, comprising £8.336m, or 5.3% of expenditure. At present, £5.5m of schemes have been identified, equating to 3.5% of expenditure (the usual maximum level of CIP achieved based on historic delivery). There remains a target of £2.9m recurrent schemes to be identified.

CIP Schemes	£000s	%
Green	1,524	1.0%
Amber	3,006	1.9%
Red	936	0.6%
<b>Total Targets Identified</b>	<b>5,466</b>	<b>3.5%</b>
Unidentified	2,870	1.8%
<b>Total CIP</b>	<b>8,336</b>	<b>5.3%</b>

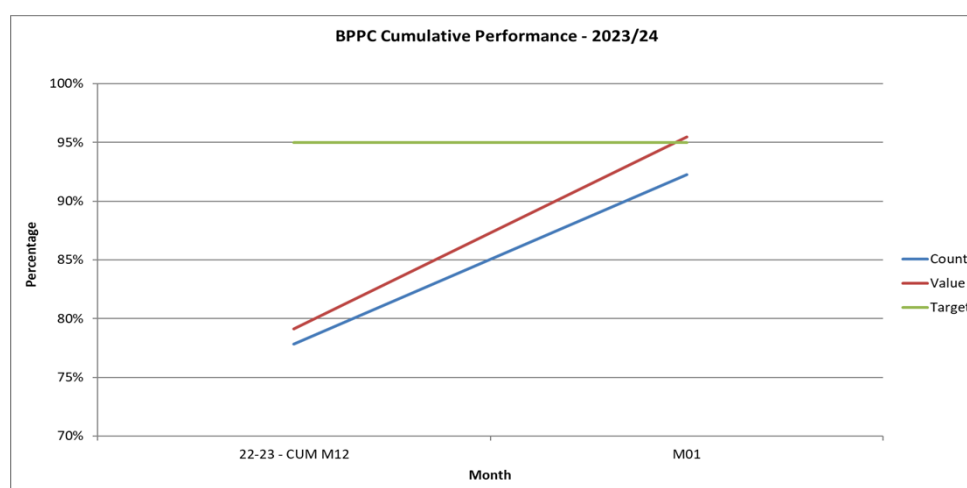
### **5. Cash and Borrowings**

The cash balance in the Government Banking Service (GBS) account (£8,686k at 30 April) is above the minimum level set out in the Treasury Management policy (current policy states 15 days expenditure or c £5.9m minimum cash level).

As the Trust has a deficit plan for 2023/24, it will require cash support during the period and is closely monitoring cash levels on a rolling 13-week basis. The Trust is liaising closely with the ICB and the national cash team to ensure cash levels are sufficient to meet operational needs. If the ICB is unable to support the Trust's cash position in this way, then an application for distressed finance will be made to the central cash team.

## 6. Better Payment Practice Code

The NHS has a target to pay at least 95% of all NHS and non-NHS trade payables within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The below shows the cumulative performance percentages by both count and value for the current and previous financial year.



## 7. Capital Expenditure

The Trust's overall capital programme for 2023/24 equates to £5.163m, comprising £5.035m CDEL allocation, £70k charity funding and £49k PDC. Prior to formal approval from the Trust Board, in May 2023 the Executive Committee have approved progression of purchase of urgent items, such as beds and ultrasound machines.

Full reporting regarding the 2023/24 capital programme will commence from M2.

## 8. BAF Risk

There are no proposed changes to the BAF score.

## 9. Conclusion & Recommendation

The Board is asked to note the Month 1 position.



## Trust Board

### COVER SHEET

Agenda Item (Ref)	23/24/56b	Date: 08/06/2023		
Report Title	Revenue and Capital Budgets 2023/24			
Prepared by	Jen Huyton, Deputy Chief Finance Officer / Deputy Director of Strategy			
Presented by	Jenny Hannon, Chief Finance Officer / Executive Director of Strategy and Partnerships			
Key Issues / Messages	Deficit plan of £15.427m after a CIP programme of £8.3m and funding existing cost pressures of £9.4m. Capital programme of £5.2m, comprising £5m business as usual capital and £0.2m from other sources.			
Action required	Approve <input checked="" type="checkbox"/>	Receive <input type="checkbox"/>	Note <input type="checkbox"/>	Take Assurance <input type="checkbox"/>
	To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it	For the intelligence of the Board / Committee without in-depth discussion required	To assure the Board / Committee that effective systems of control are in place
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – If no – please outline the reasons for deviation.			
	The Board is asked to approve the capital and revenue budgets for 2023/24.			
Supporting Executive:	Jenny Hannon, Chief Finance Officer / Executive Director of Strategy and Partnerships			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

### Strategic Objective(s)

To develop a well led, capable, motivated and entrepreneurial <b>workforce</b>	<input checked="" type="checkbox"/>	To participate in high quality research and to deliver the most <b>effective</b> Outcomes	<input checked="" type="checkbox"/>
To be ambitious and <b>efficient</b> and make the best use of available resource	<input checked="" type="checkbox"/>	To deliver the best possible <b>experience</b> for patients and staff	<input checked="" type="checkbox"/>
To deliver <b>safe</b> services	<input checked="" type="checkbox"/>		

### 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:
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5 – Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term	
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

## REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Executive Committee	24/05/23	Chief Finance Officer	Plans reviewed and approved ahead of submission to FPBD in line with overall plan submission.
Finance, Performance and Business Development Committee	31/05/23	Chief Finance Officer	The Committee recommended that the Board approve the interim budgets as set out, noting the risks and challenges.

## EXECUTIVE SUMMARY

The Trust Board accepted a deficit plan envelope of £15.427m (submitted to NHS England on 4 May 2023), noting that delivery would be extremely challenging, would mean that further investments in clinical safety could not be made during 2023/24, and further cost reduction would be required, alongside identification of £8.3m CIP.

The Trust is required to deliver an increase in activity (an average of 106% of 2019/20 adjusted baseline activity), to address the backlog and elective recovery, and the NHS has been charged with delivering on financial plans, activity and access targets, *and* quality, with equal focus.

Capital allocations remain significantly constrained, in line with 2022/23. As a result, there is a constraint on non-essential capital investment in 2023/24.

The proposed budgets are:

- An **I&E deficit plan of £15.427m** after a **CIP programme of £8.3m** and funding **the full year effect of 2022/23 items and mandatory pressures of £11.9m**, less a **reduction in pay investment of £2.5m**. This includes Aligned Payment Incentive income of £1.2m which could have either upside or downside.
- A **capital programme of £5.2m**, comprising £5m business as usual capital and £0.2m from other sources.

## MAIN REPORT

### 1. Introduction

The Trust Board accepted a deficit plan envelope of £15.427m (submitted to NHS England on 4 May 2023) on the basis of supporting system working, noting that delivery would be extremely challenging, would mean that further investments in clinical safety could not be made during 2023/24, and that further cost reduction would be required, alongside identification of £8.3m CIP.

Following an earlier March 2023 submission, the Trust has undertaken a secondary budget-setting process, to further review and scrutinise revenue budgets with a view to reviewing cost pressures, identifying further CIP, providing greater assurance for divisions regarding the basis of budgets, and identify opportunities to reduce pay investment to meet the £2.5m target.

This paper presents the revenue and capital budgets that have resulted from both sets of budget-setting processes aligned to the planning rounds.

### 2. National and Regional Picture

Nationally, there is significant pressure on NHS budgets moving into 2023/24 as the frameworks in place through the pandemic continue to be phased out. Initial expectations regarding efficiency requirements were set at 3.5% of expenditure, however this was increased for Trusts in deficit to 5%, and subsequently for all Trusts in Cheshire and Merseyside, and accompanied with the instruction that all efficiency plans must be recurrent.

Additionally, there are further expectations regarding increase in capacity to address the backlog and elective recovery. Trusts have been charged with delivering on financial plans, activity and access targets, *and* quality, with equal focus.

Cheshire and Merseyside is one of the systems which is deemed to be over-funded and have allocations in excess of its "fair share". For that reason, a "convergence factor" of 0.71% has been applied to funding and allocations for 2023/24 (a factor of 0.9% was applied in 2022/23). The ICB are in the process of developing a shared financial strategy to support development of a system-wide recovery plan and are working with providers collectively to deliver this.

### 3. Budget Setting Process

Budget setting is undertaken as part of an overall planning process incorporating budgets, capital, activity planning, workforce planning, quality improvement and other aspects in an integrated way, as shown in the diagram below.

Review of Our Strategy delivery - Trust-wide and divisional levels						
NHS Operational Plan, ICB Strategy						
Trust Board Workshop - determining priorities for 2023/24						
Planning Launch Workshop for all divisions and departments						
Refresh of Divisional 5 Year Service Transformation Plans						
Divisional Operational Plans: Objectives Operational KPIs Business Cases	Activity Plan: Capacity and Demand Modelling	Workforce Plan: Medical Job Planning Establishment Reviews	Contracts	Cost Improvement Programme	Budgets	Capital Plan

The Trust's planning round commenced in October 2022 with a review of delivery of the overarching strategy. This enabled the Board to discuss and disseminate operational priorities for 2023/24. The Trust held an initial planning workshop for all divisions and departments, also in October 2022, to set out the requirements of the planning round and agree timescales.

Divisions then refreshed their 5-year transformation plans as the starting point for plans at a divisional level, then carried out demand and capacity planning and workforce planning, both of which supported the budget setting exercise.

The initial budget setting exercise followed the standard processes, as set out below:

- Engagement with all divisions including Clinical Director, Head of Nursing/Midwifery/Allied Health Professionals, Operational Manager, and others as required.
- Rollover budgets from 2022/23 were used as the starting point, with non-recurrent items removed.
- Review of rostered establishments (and aligned budgets).
- Consultant budgets are aligned to job plans.
- All areas of expenditure are critically reviewed and challenged for efficiency ideas.
- Workforce plans are completed by relate areas.
- For additional spend (capital and revenue) that is unavoidable, business cases are required.
- Capital plans are submitted by divisions and prioritised, and self-assessed as to being critical, essential, or desirable.

This process resulted in a list of proposed cost pressures, as well as a proposed capital and initial Cost Improvement Programme plans. Trust Deputy Directors met with divisions and departments on several occasions throughout February and March to scrutinise and challenge cost pressures and proposed capital plans, prior to further scrutiny and challenge from the Executive Committee. This process resulted in the £20.4m deficit plan.

The second budget setting process, undertaken between March and May 2023, involved further, detailed, 'bottom up' budget setting work in all areas, approval and sign off of rotas, further review of budgets based on job plans, and crucially, an in-depth review of proposed cost pressures against prior business cases and agreements.

This review has focused resource in areas where:

- There were significant variances in 2022/23 indicating unfunded pressures
- Pay budgets are complex and require validation against external frameworks (e.g., Birth-rate Plus)
- There were high levels of cost pressures put forward during the 23/24 planning round (it should be noted however that all areas submitted cost pressures during the planning round).

This work is now substantially complete, and divisions have reviewed their overall budgets for 2023/24. Some areas require further work and will continue throughout the year as part of ongoing scrutiny of cost-saving opportunities, for example medical job planning consistency committees, identification of further CIP schemes, and further scrutiny of non-pay budgets and contracts for additional savings opportunities.

#### 4. Income Position

A revised financial framework, the NHS Payment Scheme (NHSPS), was introduced by the Health and Care Act 2022 to support the move to system working. From April 2023, the Trust's primary contracts will use the Aligned Payment and Incentive (API) approach; a form of blended payment with a fixed element to fund an agreed level of activity, and a variable element which will cover all elective activity on an activity-based payment basis. This does result in financial risk associated with non-delivery of agreed activity plans in 2023/24, however for Liverpool Women's Hospital this is a relatively small element of the contract (total income at risk equates to approximately £1.2m).

In addition, the baseline value proposed by the ICB for 2023/24 is £6.9m above that which would be received on a purely 'activity x tariff' basis. There is no risk against this during 2023/24, however this may present a risk in future years, and limits the Trust's ability to negotiate regarding further income.

The Trust has been set an activity delivery target of 106% of 2019/20 adjusted baseline activity; this is an average, with 108% expected by the end of the financial year. Income baselines assume this will be achieved, and divisions have worked up demand and capacity plans accordingly.

The following table shows the removal of non-recurrent income from 2022/23 contracts, as well as non-recurrent income added back in for 2023/24. Contract values are based on schedules received from commissioners.

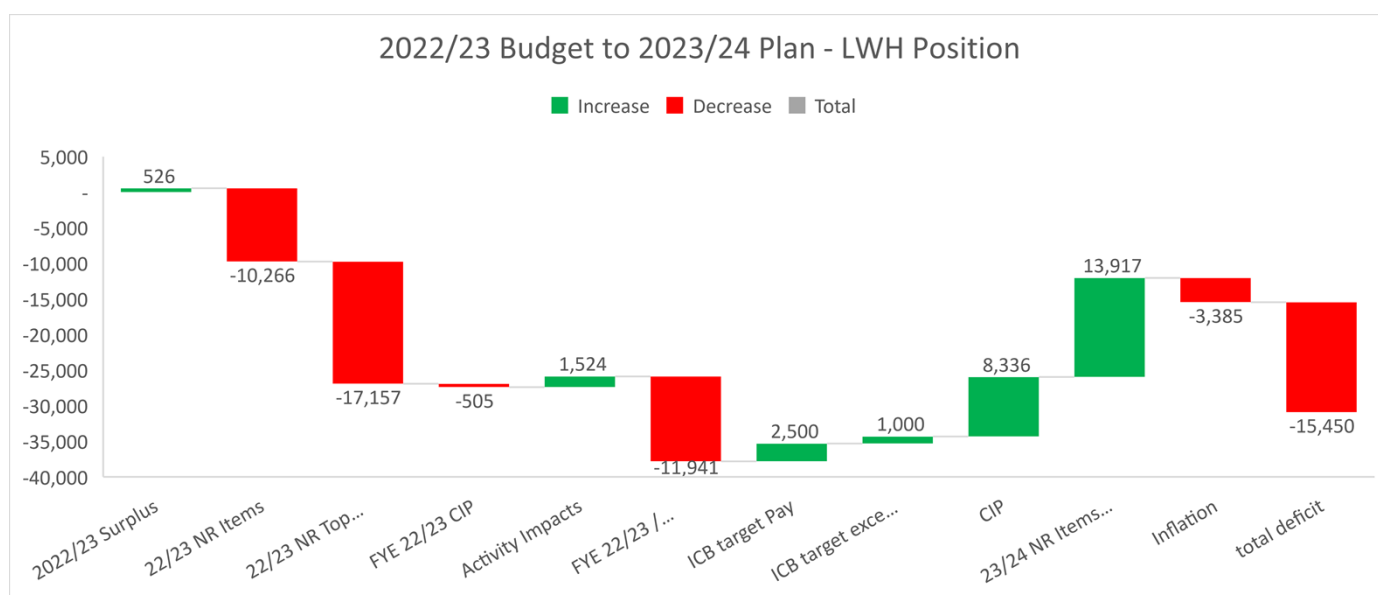
£000	2022/23 Budget	2022/23 Baseline/inflation /CIP/recurrent adjustments	Removed 2022/23 non- recurrent funding	Non-recurrent 2023/23 funding	2023/24 Plan
Cheshire and Merseyside ICB Funding	74,695	3,693			78,388
Out of area ICB Funding	1,498	- 752			746
Top up/covid/ERF/Ockenden support	21,867	-	- 21,867	12,712	12,712
CDC Funding	4,400	494			4,894
<b>Total ICB</b>	<b>102,460</b>	<b>3,435</b>	<b>- 21,867</b>	<b>12,712</b>	<b>96,740</b>
NHS England	24,957	2,136	- 137	139	27,095
Private Patients	3,837	560			4,397
Income from Trusts	3,335	- 369			2,966
Other Income from Activities	2,419	1,094			3,513
Operating Income	7,404	51			7,455
<b>Total Income</b>	<b>144,412</b>	<b>6,907</b>	<b>- 22,004</b>	<b>12,851</b>	<b>142,167</b>

## 5. Revenue Budgets

The high-level budget bridge between 2022/23 planned surplus and the 2023/24 plan is given below. As noted above, these budgets have been built on a bottom-up basis from rotas, consultant job plans, establishments for non-clinical areas, and contracts or projected spend for non-pay.

Information regarding funding of the full year effect of 2022/23 items and/or mandatory cost pressures is provided in section 6 below, however it should be noted that only pressures which are already committed (or where legally mandated) have been funded.

Note that the bridge below is against out-turn rather than budget.



The resulting budget is summarised in Appendix 1.

## 6. Full Year Effect (FYE) of 2022/23 Items and Mandatory Cost Pressures

Throughout budget setting, several unavoidable cost pressures have been identified. These relate to the full year effect of items committed in 2022/23 and/or mandatory cost pressures, and are summarised by division in the table overleaf:

Directorate	£
<b>Family Health</b>	
Med Staff	812,697
Non-Med Staff	2,095,745
Non-Pay	639,616
<b>Total</b>	<b>3,548,058</b>
<b>Gynaecology</b>	
Med Staff	750,000
Non-Med Staff	675,017
Non-Pay	1,640,000
<b>Total</b>	<b>3,065,017</b>
<b>CSS</b>	
Med Staff	-
Non-Med Staff	350,992
Non-Pay	1,603,924
<b>Total</b>	<b>1,954,916</b>
<b>Corporate</b>	
Med Staff	-
Non-Med Staff	480,501
Non-Pay	2,880,936
<b>Total</b>	<b>3,361,437</b>
<b>Total Pressures</b>	<b>11,929,428</b>

As noted in section 3 above, the Trust has undertaken a rigorous process review and scrutiny of all cost pressures put forwards, and this has resulted in several pressures not being funded within the 2023/24 plan. Some of the cost pressures not funded are already committed, for example, staff in post (particularly within corporate areas). These risks will be managed through existing grip and control measures, such as structure changes proposed following the implementation of a non-clinical vacancy freeze.

In addition to managing unfunded cost pressures, a further £2.5m prior year pay cost investment and £1.0m excess inflation was required to be removed from budgets to meet the plan. The Trust has identified options to meet this requirement and included within proposed revenue budgets shown in section 5.

It is important to note that many of these items are already committed. This means budget holders will be required to utilise opportunities which arise in-year to make changes to the way they deliver their services to achieve the budget they have been set. This will be challenging, and quality and equality impact assessments for any changes proposed will be carefully considered.

## 7. Cost Improvement Programme (CIP)

The Trust's CIP target for 2023/24 is £8.336m, which represents 5.3% of expenditure budgets following adjustment for pass through costs. The status of schemes was reviewed by departments and divisions on 24 May 2023, and is currently:

CIP Schemes	£000s	%
Green	1,524	1.0%
Amber	3,006	1.9%
Red	936	0.6%
<b>Total Targets Identified</b>	<b>5,466</b>	<b>3.5%</b>
Unidentified	2,870	1.8%
<b>Total CIP</b>	<b>8,336</b>	<b>5.3%</b>

As is shown in the table, there remains £2.9m of CIP to identify, and this is significant. However, plans and opportunities identified to date equate to 3.5% of expenditure budgets, meaning that the Trust has successfully identified a 'usual' level of CIP and met the target initially set during the planning round.

## 8. Community Diagnostic Centre (CDC)

The Trust has been operating a CDC since 2021/22, with permanent CT and MR imaging facilities constructed and brought online during 2022/23. Revenue income for 2022/23 was planned and confirmed at £4.4m, however £1.5m was clawed back in-year due to non-delivery of activity, which created an adverse financial impact for the Trust.

For 2023/24, the Trust initially applied for £4.9m of funding, to deliver imaging, cardiac and respiratory, and pathology testing. This value has been agreed and included in budgets, matched by expenditure. However, the Trust is currently working through a proposal to deliver an alternate service profile. This will likely result in a reduction in both income and expenditure budgets but should minimise the financial risk in-year.

## 9. Capital Budgets

The Trust's overall capital budget for 2023/24 is £5.163m, comprising £5.035m CDEL allocation, £70k charity funding and £49k PDC. Proposed schemes are summarised in the table below:

Category	£000s
Estates	1,180
Medical Equipment	1,771
Digital Services	2,212
	<b>5,163</b>

Initial capital requests were higher than those shown in the table, however requests have been prioritised. A number of reserve schemes are in place should savings be delivered against existing schemes, or further funding become available in year.

## 10. Cash and Working Capital

Cash support will be required during 2023/24 due to the deficit plan. The financial regime is in place to allow NHS organisations to access revenue support in the form of Public Dividend Capital (PDC) if required, however the Trust is working closely with the ICB to identify options to manage cash support requirements within the system.



## 11. Underlying Deficit and Financial Recovery 2023/24

Removal of non-recurrent sources of income during the 2023/24 planning round has revealed the scale of the Trust's underlying, structural deficit (of approximately £30m). The drivers of the deficit are well understood, have been recognised and reported on by the Trust since 2014/15. In summary, there are three key drivers:

- Maternity tariff is insufficient to cover costs exacerbated by disproportionate CNST costs and investments in maternity safety
- The Trust's isolated site has necessitated investment to improve clinical safety
- Limited opportunity for economies of scale due to organisational size.

During 2020/21 and 2021/22, both Gynaecology and Family Health had significant overspends against agreed budgets. While investment was made in the 2022/23 plan to effectively formalise many of these overspends into budgets, based on evidence and clinical need, and with increased activity and targets in place, there were still overspends in 2022/23, and additionally there is now a requirement for the Trust to 'unwind' some of this investment, resulting in a significant risk of overspends against budgets in 2023/24. The Trust has now exhausted most non-recurrent options to manage the position. To deliver the plan in 2023/24, a real-terms reduction against 2022/23 run-rate is required.

Therefore, highly stringent financial management and cost control processes will be in place during 2023/24 (with the majority already implemented). A Financial Recovery Programme to address the drivers of the deficit has been established in preparation for in-year delivery and production of the 3-year recovery plan in September (workstreams can be seen in Appendix 2) and there will be an expectation that divisions manage within the budgets agreed, managing pressures through prioritisation of resource. Mechanisms such as executive oversight are in place to further strengthen controls.

## 12. Risks

The overall deficit position for 2023/24, and the larger underlying recurrent deficit represent a risk for the Trust in terms of short-term cash management and longer-term financial sustainability.

In addition to this over-arching issue of financial sustainability, and the underpinning tension between quality and available resources, and the requirement to deliver on finance, outcomes, *and* activity, there are several other risks to the plan. These include

- **Reducing run rate** – to deliver the 2023/24 plan, the Trust will need to materially reduce its current run rate
- **API** - there is risk to income (£1.2m) if the Trust does not deliver its 106% activity target.
- **Industrial action** – future industrial action may impact the Trust's ability to deliver activity.
- **Workforce** – national and local workforce shortages in key clinical staff groups place increased reliance on bank and agency costs, and their associated financial premiums. There is also a risk that staff morale and retention may be impacted as cost control measures are implemented.
- **Agency and bank costs** - agency and bank costs have been a significant pressure in 2022/23 and the scarcity of some staff groups has an impact on hourly rates. The Trust will pursue substantive recruitment to address vacancies.
- **Lack of non-recurrent solutions** – the Trust has exhausted most non-recurrent solutions to support management of the financial position in year, which recurrent changes are implemented.
- **Cash** – due to the deficit, the Trust will require cash support. If system solutions are not identified, PDC will be utilised, at an estimated cost of £0.25m. The Trust is actively working with the ICB to identify system solutions and avoid reliance on PDC.



- **CIP delivery:** at present, there is significant risk due to the level of unidentified CIP, as well as schemes within the programme which are red or amber rated. This will be closely monitored and work to develop additional schemes will continue.
- **CNST Maternity Incentive:** if the scheme requirements are not met, an additional £1.9m of CIP schemes will need to be identified.
- **Inflation pressures:** The current economic situation and world events are likely to create ongoing volatility in cost inflation. Excess inflation has been removed from the plan on the basis that this will be managed collectively as a system, however it is already likely that inflation will be seen within energy costs.
- **Pay award –** the plan excludes impact of any agreed pay award. It is assumed this will be funded, however there is the risk of an additional pressure due to basis of calculation used by central teams, as experienced in 2022/23.

## 13. Recommendation

The Board is asked to note the process and detailed work underpinning the budget setting and planning process and the outputs of this, and approve the budgets outlined in this paper.

**Appendix 1 – Revenue Budgets 2023/24**

<b>Income &amp; Expenditure</b>		<b>2023/24</b>
		<b>Budgets</b>
		<b>£000</b>
<b>Income</b>		
Income from activities	-	134,719
Other operating income	-	7,416
<b>Total Income</b>	-	<b>142,135</b>
<b>Pay</b>		
Nursing & Midwifery Staff		37,933
Medical Staff		24,671
Healthcare Assistant & Support Staff		6,329
Professions Allied to Medicine		1,510
Professional and Technical		1,785
Scientific Staff		1,934
Non-Clinical/Other		14,483
<b>Total Pay Expenditure</b>		<b>88,643</b>
<b>Non Pay</b>		
Clinical Services & Supplies		10,030
Establishment Expenses		1,077
General Supplies & Services		3,979
Miscellaneous Services		8,098
Other Establishment Costs		23,161
Premises & Fixed Plan		10,680
Purchase of Healthcare Services		2,873
<b>Total Non-Pay Expenditure</b>		<b>59,897</b>
<b>Technical Items</b>		
Depreciation & Amortisation		6,579
Interest Payable		21
Interest receivable	-	200
PDC Dividends		2,644
<b>Total Technical Items</b>		<b>9,044</b>
<b>Total</b>		<b>15,450</b>

## Appendix 2 – Financial Recovery Workstreams

Workstream	Summary	Executive Sponsor
Maternity Tariff	Maternity tariff does not reflect requirements of the service and recent safety reviews. National influencing required with support of system.	Medical Director
CNST	Tariff increases have not met the increase in cost in this area. Discussion regarding premiums and spread of cost required.	Chief Nurse
Cost Control and Productivity	Drive to achieve efficiency and effectiveness across all areas, including our theatres and outpatient efficiency projects.	Chief Operating Officer
Review of Past Investments	Reviewing of investments since 19/20 for ongoing appropriateness, supported by robust quality and equality impact assessments.	Chief People Office
Co-location	Defining the financial benefits of co-location with adult acute services.	Medical Director
Economies of Scale	Opportunities derived through closer working with system partners.	Trust Secretary
Financial Grip and Control	Demonstrating good financial grip and control across the organisation.	Chief Finance Officer
Commercial and Digital	Making the most out of digital opportunities and commercial ventures.	Chief Information Officer

## 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](mailto: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		
<b>BAF</b>	Board Assurance Framework	the key document used to record and report an organisation's key strategic objectives, risks, controls and assurances to the board
<b>BCF</b>	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
<b>BMA</b>	British Medical Association	trade union and professional body for doctors
<b>BAME</b>	Black Asian Minority Ethnic	terminology normally used in the UK to describe people of non-white descent
<b>BoD</b>	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		
<b>CAMHS</b>	Child and Adolescent Mental Health Services	specialise in providing help and treatment for children and young people with emotional, behavioural and mental health difficulties
<b>CapEx</b>	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
<b>CBA</b>	Cost Benefit Analysis	a process for calculating and comparing the costs and benefits of a project
<b>CBT</b>	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
<b>CCG</b>	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)
<b>CDiff</b>	Clostridium difficile	a bacterial infection that most commonly affects people staying in hospital
<b>CE / CEO</b>	Chief Executive Officer	leads the day-to-day management of a foundation trust, is a board member and the accountable officer for the trust.
<b>CF</b>	Cash Flow	the money moving in and out of an organisation
<b>CFR</b>	Community First Responders	a volunteer who is trained by the ambulance service to attend emergency calls in the area where they live or work
<b>CHC</b>	Continuing Healthcare	Whereby those with long-term or complex healthcare needs qualify for social care arranged for and funded by the NHS
<b>CIP</b>	Cost Improvement Plan	an internal business planning tool outlining the Trust's efficiency strategy
<b>CMHT</b>	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 employee's 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		
<b>GMC</b>	General Medical Council	the independent regulator for doctors in the UK
<b>GDP</b>	Gross Domestic Product	the value of a country's overall output of goods and services
<b>GDPR</b>	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		
<b>HCAI</b>	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
<b>HCA</b>	Health Care Assistant	staff working within a hospital or community setting under the guidance of a qualified healthcare professional
<b>HDU</b>	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
<b>HEE</b>	Health Education England	the body responsible for the education, training and personal development of NHS staff
<b>HR</b>	Human Resources	the department which focusses on the workforce of an organisation including pay, recruitment and conduct
<b>HRA</b>	Health Research Authority	protects and promotes the interests of patients and the public in health research
<b>HSCA 2012</b>	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
<b>HSCIC</b>	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
<b>HTA</b>	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
<b>HWB / HWBB</b>	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.
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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
IOL	Induction of Labour	Term used in performance reports

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		
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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 <i>or</i> Outpatients Department	a systematic approach to improving organisational effectiveness  <i>or</i> 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'	away 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	as 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 output 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
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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