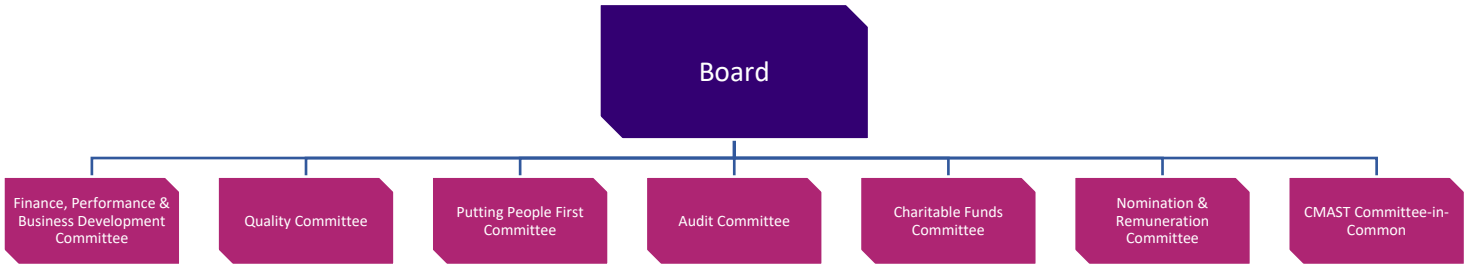
Liverpool Women's NHS Foundation Trust

Trust Board

13 July 2023, 1.30pm

Boardroom, LWH & Virtual, via Teams



Liverpool Women's
NHS Foundation Trust

Trust Board

Location	Boardroom & Virtual via Teams
Date	13 July 2023
Time	1.30pm

Item no. 23/24/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
080	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	1330 (5 mins)
081	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
082	Minutes of the previous meeting held on 8 June 2023	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
083	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
084	Staff Story	To receive staff story	Presentation	Chief Nurse	1335 (25 mins)
085	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	1400 (5 mins)
086	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	1405 (5 mins)
MATERNITY					
087	Perinatal Quality Surveillance & Safety Dashboard	For assurance	Written	Chief Nurse	1410 (5 mins)
QUALITY & OPERATIONAL PERFORMANCE					
088a	Chair's Reports from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1415 (45 mins)
088b	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	
088c	CQC Report – Trust Response	To receive	Written	Chief Nurse	
088d	Guardian of Safe Working Hours (Junior Doctors) Annual Report 2022/23	For assurance	Written	Medical Director	

PEOPLE					
089a	Chair's Report from the Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1500 (20 mins)
089b	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	
089c	Review of Culture and Staff Engagement at LWH	For assurance	Written	Chief People Officer	
BREAK – 5 mins					
Board Thank You – 5 mins					
FINANCE & FINANCIAL PERFORMANCE					
090a	Chair's Report from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1530 (20 mins)
090b	Chair's Report from the Charitable Funds Committee (inc. terms of reference and annual report)	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
090c	Finance Performance Review Month 2 2023/24	For assurance - To note the current status of the Trust's financial position	Written	Chief Finance Officer	
BOARD GOVERNANCE					
091a	Partnerships Oversight – Quarterly Update	To receive	Written	Chief Finance Officer	1550 (20 mins)
091b	Annual Evaluation of Board of Directors and Board Development Plan	To receive	Written	Trust Secretary	
091c	Governance & Performance Framework Update	To approve	Written	Trust Secretary	
091d	Board Assurance Framework	For assurance	Written	Trust Secretary	
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
092	Operational Plan 2023/24	For approval	Written	Chief Operating Officer	Consent
093	Director of Infection Prevention and Control Annual Report 2022/23	For assurance	Written	Chief Nurse & Midwife	
094	Health & Safety Annual Report 2022/23	For assurance	Written	Chief Operating Officer	
095	Research, Development & Innovation Annual Report 2022/23	For assurance	Written	Medical Director	
096	Integrated Governance Report Quarter 4 2022/23	For assurance	Written	Chief Nurse & Midwife	
097	Learning from Deaths Quarter 4 2022/23	For assurance	Written	Medical Director	

CONCLUDING BUSINESS					
098	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1610 (5 mins)
099	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
100	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
101	Jargon Buster	For reference	Written	Chair	

Date of Next Meeting: 10 August 2023

1615 - 1625	*Questions raised by members of the public*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Liverpool Women's
NHS Foundation Trust

Meeting attendees' guidance

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

Before the meeting

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

General considerations:

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

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

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

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

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

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

At the meeting

General Considerations:

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

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

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

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

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

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

Attendance

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

After the meeting

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

Standards & Obligations

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

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

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

Page 129 Handbook to the NHS Constitution 26th March 2013

Liverpool Women's
NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held in the Boardroom and Virtually via Teams at 11.40am on 8 June 2023

PRESENT

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

IN ATTENDANCE

Matt Connor	Chief Information Officer
Jen Huyton	Deputy Chief Finance Officer
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Dr Lynn Greenhalgh	Medical Director
Prof. Louise Kenny CBE	Non-Executive Director / SID

Core members	**Jun 22**	**Jul**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Apr**	**May**	**8 Jun 23**
Robert Clarke - Chair	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Kathryn Thomson - Chief Executive	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Tracy Ellery - Non-Executive Director / Vice-Chair	✓	✓	A		✓	✓	✓	✓	✓	A	✓
Louise Martin - Non-Executive Director	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
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	✓	✓	Non-member								
Dianne Brown – Chief Nurse	Non-member		✓		✓	✓	✓	✓	A	✓	✓
Gary Price - Chief Operating Officer	✓	✓	✓		✓	A	✓	✓	✓	✓	✓

Michelle Turner - Chief People Officer	✓	✓	✓		✓	✓	✓	✓	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	✓	✓	✓	✓	✓	✓
Jackie Bird – Non-Executive Director	✓	✓	✓		A	✓	✓	✓	✓	✓	✓
Jenny Hannon - Chief Finance Officer / Executive Director of Strategy & Partnerships	Non-member						✓	✓	✓		A
Matt Connor – Chief Information Officer (non-voting)	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓

23/24/	
050	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. The apologies were noted as above and there were no declarations of interest.
051	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
052	**Minutes of the previous meeting held on 11 May 2023** The minutes of the Board of Directors meeting held on 11 May 2023 were agreed as a true and accurate record.
053	**Action Log and matters arising** Updates against actions log were noted. Non-Executive Director, Louise Martin, sought an update on the action for the Putting People First Committee to undertake a review of the ward management structure to ensure that it enabled effective management relationships. The Chief Nurse reported that this was in progress and the outcome would be reported to the Committee in line with the agreed timescale.
054	**Chair's & Chief Executive's Announcements** No issues were noted.
055	**Quality & Operational Performance Report** The Board considered the Quality and Operational Performance Report. The Chief Operating Officer provided an update on urgent care performance. It was noted that there had been challenges in April and May 2023. However, there were positive signs of improvement in certain areas. The Gynaecology Emergency department had achieved 89% in April and 92% in May against the four-hour A&E, which marked a significant improvement compared to January and February 2023. The focus now was to sustain this level of performance. The Maternity Assessment Unit (MAU) time to triage was performing well, and the Division aimed to achieve 95% compliance with the 15-minute MAU triage target by July 2023. The Chief Executive acknowledged the improvements in triage time performance but emphasized the importance of

	maintaining timely clinical review after triage. It was agreed to include the reporting of time to clinical review for the MAU in future reports. Action: to include the reporting of time to clinical review for the MAU in future performance reports. The Chief Operating Officer highlighted that cancer performance was a significant area of focus for the Trust. Performance against the 62-day target had improved to 33% in April 2023. However, there was still a need to further enhance performance, and this remained significantly below the 85% target. The Chief Executive noted that while the Trust performed well in the two-week wait element, there were other steps in the patient pathway that were contributing to delays. To support enhanced visibility of these aspects, it was suggested to create a simplified cancer dashboard to illustrate the breakdown of the cancer pathway, which would be made available for the Board and relevant Committees. Action: to produce a simplified cancer dashboard to illustrate the breakdown of the various elements of cancer pathway and the Trust's performance against this. The Trust's 31-day performance was at 94% and had been sustained over recent months. A cancer improvement plan had been shared with the North West Cancer Network for feedback. The Trust was currently off trajectory for the faster diagnosis standard, but efforts were underway in collaboration with the Cancer Alliance to make improvements. Two key areas requiring improvement were increasing hysteroscopy capacity and meeting performance targets for histology work from Liverpool Clinical Laboratories. The Executive Team was reviewing the Cancer Patient Transfer List on a weekly basis to drive improvements in the faster diagnosis standard and get the Trust working towards the set trajectory. Non-Executive Director Jackie Bird inquired about the optimal patient pathway for gynaecology and the frequency of late referrals. The Chief Operating Officer acknowledged that the Trust was receiving late referrals but stated that the Trust was exploring improvements within its control, with the support of key partners. The Chief Nurse reported ongoing efforts to enhance the complaints response process to ensure it was an active discussion with patients and their families. Attention was drawn to the significant increase in serious incidents over recent months and was mostly attributed to amendments made to the "cause" group in January 2023. Recent incidents involving skin-related damage to pre-term babies had prompted the Trust to collaborate at national and international levels to explore potential changes to techniques, as most tissue viability research was based on adult skin. The Board of Directors received and noted the Quality & Operational Performance Report.
056a	Finance Performance Review Month 1 2023/24 The Chief Finance Officer presented the Month 1 2023/24 finance performance report which detailed the Trust's financial position as of 30 April 2023. At Month 1 the Trust was reporting a £1,538k deficit, which was £1k favourable to plan. However, this position was supported by several one-off favourable items. It was highlighted that the Trust had an extremely challenging efficiency programme for 2023/24, comprising £8.336m, or 5.3% of expenditure. At present, £5.5m of schemes had been identified, equating to 3.5% of expenditure (the usual maximum level of CIP achieved based on historic delivery). There remained a target of £2.9m recurrent schemes to be identified. The Trust's Financial Recovery Board had requested a month-to-month update on the impact on the Trust's run-rate. The Trust's cash balance in the Government Banking Service (GBS) account (£8,686k at 30 April 2023) was above the minimum level set out in the Treasury Management policy (current policy stated 15

	days expenditure or c £5.9m minimum cash level). It was noted that the Trust had seen recent improvements against the Better Payment Practice Code target. The Chair noted the significant savings required against pay costs and questioned how this was being managed and the level of confidence that it would be achieved over the financial year. The Chief Finance Officer reported that improvements had been seen in agency costs and that stringent vacancy control processes were in place. The Chief Executive added that work was progressing to assess demand and activity to support an assessment of the most efficient deployment of resources. It was also acknowledged that levels of sickness absence needed to reduce to support pay cost control and whilst the direction of travel was encouraging, there remained a significant opportunity to improve further. Non-Executive Director, Tracy Ellery, noted that it was encouraging to see evidence of the actions being put into place but queried if there was sufficient pace to support the Trust's need to make significant savings in-year. The Chief Finance Officer confirmed that the Trust was exploring options to access additional support and resources to increase the pace of existing measures and identify new opportunities. The Board of Directors: • Noted and received the Month 1 2023/24 Finance Performance Review
056b	Revenue and Capital Budgets 2023/24 The Chief Finance Officer reminded the Board that a deficit plan envelope of £15.427m had been accepted (submitted to NHS England on 4 May 2023). It was noted that delivery would be extremely challenging with further investments in clinical safety not being possible during 2023/24, and further cost reduction being required, alongside identification of £8.3m CIP. The drivers of the underlying deficit were outlined together with the risks of achieving the stated deficit position. It was noted that a longer-term recovery plan was in development and this would report to the Board in September 2023. The Board of Directors: • noted the process and detailed work underpinning the budget setting and planning process and the outputs of this. • Approved the budgets outlined in this paper.
035	Review of risk impacts of items discussed The Chair identified the following risk items: • Performance against access targets • The Trust's 2023/24 financial position, longer-term sustainability challenges, and the potential impact on quality and safety.
036	Chair's Log None noted.
037	Any other business & Review of meeting None noted. Review of meeting No comments noted.
038	Jargon Buster Noted.

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
13 July 2023

Key	Complete	On track	Risks identified but on track	Off Track

Meeting Date	Ref	Agenda Item	Action Point	Owner	Action Deadline	RAG Open/Closed	Comments / Update
8 June 2023	23/24/055	Quality & Operational Performance Report	To produce a simplified cancer dashboard to illustrate the breakdown of the various elements of cancer pathway and the Trust's performance against this.	COO	August 23	On track	
8 June 2023	23/24/055	Quality & Operational Performance Report	To include the reporting of time to clinical review for the MAU in future performance reports	COO	July 23	Completed	Included within Perinatal Dashboard (item 23/24/78)
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	August 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	~~Mar 23~~ July 23	Complete	MVP has contributed slides to wider discussion on 'how the Trust listens (to patients)'

Liverpool Women's
NHS Foundation Trust

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. Executive Lead: Chief Nurse	Quality Committee	July 2023	Open	
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	Closed	Received by the Quality Committee on 27 June 2023
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	

Liverpool Women's
NHS Foundation Trust

CEO Report

Trust Board
July 2023

Executive Summary:

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

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

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

Section A - *Internal*

Sir Julian Hartley visits Liverpool Women's Hospital NHS Foundation Trust

NHS Providers' chief executive Sir Julian Hartley visited Liverpool Women's Hospital NHS Foundation Trust on 16 June 2023.

The visit provided an opportunity for Trust leaders to express concern around the ongoing financial and clinical sustainability of the Trust and the women's services it delivers. Without addressing the structural shortfalls at a national and local level, this can negatively impact the delivery of critical maternity and specialist gynaecology services.

Sir Julian said after the visit...

I was inspired by the passion and expertise of staff and the board and I left reflecting on the importance of delivering the right care, in the right place, and how collaborative working can allow for a more holistic view of where that should be delivered geographically.

The full blog post can be found on the following link - Sir Julian Hartley visits Liverpool Women's Hospital NHS Foundation Trust - NHS Providers

Embracing staff feedback to embed cultural change

The Trust was used as a case study by NHS Employers for the following article - https://www.nhsemployers.org/case-studies/embracing-staff-feedback-embed-cultural-change

Section A - *Internal*

Liverpool Women's NHS Foundation Trust most improved - NHS Staff Survey

The National Guardian's Office has recently published analysis of the Freedom to Speak Up questions as outlined in the NHS Staff Survey 2022 Fear and Futility: what does the staff survey tell us about speaking up in the NHS? - National Guardian's Office .

The Trust is in the top ten most improved in terms of the Freedom to Speak Up sub-score (called the Raising Concerns sub-score in NHS Staff Survey reports). The sub-score is made up of the four questions relating to speaking up. The Trust received a letter from the National Guardian's office which formally recognises the progress we have made towards creating a truly open culture where raising concerns is actively encouraged. The National Guardian will be visiting the Trust later this year to hear from our Guardians, our leaders and our staff about our approach and ongoing work with respect to raising concerns and creating a Fair & Just culture.

https://nationalguardian.org.uk/2023/06/08/fear-and-futility/

Visit from National Maternity Safety Support Programme Team 24th July – 27th July 2023

The National Maternity Safety Support Programme Team will be visiting Liverpool Women's Hospital on 24th July – 27th July. The team is formed of senior and experienced Obstetric & Midwifery Maternity Improvement Advisors (MIAs) and the National Maternity Quality Improvement Lead. It is led by the Deputy Chief Midwifery Officer for England and the National Speciality Lead for Obstetrics.

The team predominantly facilitate the Maternity Safety Support Programme, and in addition to this, they also lead upstream work at a Regional/National Level where it's required, which consists of proactive support and advice to organisations, undertaken by a team of Obstetric & Midwifery MIAs

The diagnostic approach is undertaken using appreciative enquiry to identify areas of good practice and opportunities for improvement, which are formalised into a diagnostic report. The diagnostic approach is not prescriptive and is tailored to the needs of each unique organisation, commonly it will include the team getting to know the Maternity Service and how it is run, as well as talking with the staff, attending meetings and 1 to 1s and reviewing existing documents. This is not an inspection process but rather an approach to support continuous improvement.

The team will utilise the following six key lines of enquiry:

Mobile Breast Screening Unit

During June and July the Trust has been proud to host a Mobile Breast Screening Unit.

The service has seen over 1000 women during this period, predominantly from our immediate local community.

Thanks to partners and estates for enabling this to happen.

Section A – *Internal*

Liverpool Safeguarding Children's Partnership Section 11 compliance report 2022

Working Together to Safeguard Children (2018) places a statutory duty on organisations and professionals working with children and families to promote the welfare of children and ensure they are protected from harm. Section 11 of the Children Act 2004 addresses this and places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are safely discharged with regard to the need to safeguard and promote the welfare of children.

Compliance with this requirement is the responsibility of individual organisations, but assurance is required by the Local Multi-Agency Safeguarding Arrangements (MASAs), who have overall responsibility for performance management within the Borough.

A front line visit to LWH was conducted on 17 March 2023. Visitors representing the LSCP Scrutiny, Audit, and Review Group (SARG), met with safeguarding leads for the organisation and conducted a panel discussion with frontline practitioners from the hospital.

The purpose of the visit was to provide assurance to the Liverpool Safeguarding Children Partnership in relation to the agencies' carrying out of statutory obligations under the Children Act (2004)

Visitors were assured of compliance on all standards and no areas were identified to improve practice against the standards.

Sexual safety of NHS staff and patients

In July 2022 NHS England established a Domestic Abuse and Sexual Violence (DASV) Programme to build on robust safeguarding processes for protecting patients, improve victim support, and focus on early intervention and prevention. Work is now underway to expand its scope to support and enhance the NHS's response to domestic abuse and sexual violence associated with NHS services and/or premises, whether experienced by patients, staff or visitors. ICBs and Trusts have been asked to: 1) Appoint Domestic Abuse and Violence leads 2) Review your policies and support 3) Sign up to the DASV FutureNHS Collaboration Platform for useful resources

The safety of staff and patients is a priority for the Trust and we will be reviewing our policies and processes to ensure they are as robust as possible. Our Chief Nurse, Dianne Brown, has been identified as the Domestic Abuse and Violence Lead.

The Women's View' June / July 2023

Bringing you the latest news, updates and all things LWH

https://tinyurl.com/TWVJUNEJULY2023

Section A – *Internal*

Attending and presenting at International Stillbirth Alliance (ISA)

The ISA was founded 20 years ago in 2003 by three US based bereaved mothers. They internationally founded it as a global organisation, recognising that no country was paying sufficient attention to stillbirth, nor providing adequate support for bereaved parents and families. The Honeysuckle Team was asked to present on - Respectful and supportive bereavement care as part of the Postpartum care, diagnosis and support theme

Marie Kelleher and Caroline Batin-Robinson discussed The Honeysuckle Support group and the positive impact this can have on bereaved parents' journey. The aim of the session was to discuss support available to families dealing with the grief and loss of a baby, and to raise awareness of what strategies and interventions have proved successful to help those affected. Attending and presenting at this conference was a great opportunity to internationally showcase the work of The Honeysuckle Team at Liverpool Women's NHS Foundation Trust. This was also a great opportunity to identify the positive work of many others around the globe.

Section B - *Local*

NHS Cheshire and Merseyside Blog

Next week will see further industrial action from junior doctors across Cheshire and Merseyside (full update below).While the breadth and depth of what junior doctors do across the NHS means their absence will create challenges, we continue to respect the right of NHS staff to take action.

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

As a result of ongoing challenges with discharging patients from hospital, Cheshire and Merseyside has been placed in Tier 1 for urgent and emergency care performance – meaning we are now able to access the highest level of national support from NHS England.

An improvement plan is now in development for delivery by both NHS Cheshire and Merseyside at a system-level and Place partners at a Local Authority level.

The recently published national Primary Care Recovery Plan is also welcomed amid relentless pressure. Although the plan focuses almost entirely on GP and pharmacy services, we will be looking to implement this system-wide including via local Primary Care Networks.

We are also looking forward to celebrating the NHS's 75th birthday on July 5th and the first anniversary of NHS Cheshire and Merseyside on July 1st. Both are significant milestones which give us an opportunity to engage with staff and stakeholders and share our successes to date.

Raj Jain – Chair

https://mailchi.mp/2dd747382aec/stakeholder-brief-6131188

NHS Cheshire and Merseyside Integrated Care Board meeting

The NHS Cheshire and Merseyside Integrated Care Board met at at Runcorn Town Hall, Heath Road, Runcorn between 9am-midday on Thursday, June 29th.

https://www.cheshireandmerseyside.nhs.uk/posts/nhs-cheshire-and-merseyside-board-meeting-3/

Liverpool Health Partners Newsletter – May 2023

https://mailchi.mp/a36aa03cdae6/news-from-liverpool-health-partners-6238492?e=9bd40ca77e

Chair of NHS Cheshire and Merseyside
Raj Jain

Section B - *Local*

Five Family Hubs to be established in Liverpool

Liverpool is opening five Family Hub centres between now and 2025, providing centralised support for all families across the city.

The hubs will be based within the city's existing network of Children's Centres, with services for families with babies, children and young people up till the age of 19 (or up to 25 for young people with special educational needs and disabilities). At the heart of each Family Hub will be services that help give babies a great start to life, supporting parents through parenting classes, learning support, midwifery, health visiting, infant feeding advice and perinatal mental health support.

Over £4 million has been secured from the Government for the initiative, which will see a range of different organisations coming together in one place offering health, education and community provision.

It means that a family will only have to explain what they need help with once, rather than having to tell many different people, and professionals will work together more effectively to help residents overcome any difficulties they may be facing. The aim is to make services easier to navigate and more joined-up, ensuring families receive the right service at the right time.

Hubs will help families to access a range of help, including support for their physical and mental health, housing and debt advice, youth services, domestic abuse support, as well as services run by the community and voluntary sector. In addition, there will be an enhanced digital offer of online services. Families will be able to access a range of information about infant feeding, parenting support, perinatal mental health support, home learning and a variety of public health services for 0-19 year olds, hosted on Liverpool's Family Information and SEND Directory.

The first Family Hub network will launch later this summer, located at Clubmoor Children's Centre and serving the following wards: Norris Green, Clubmoor East, Clubmoor West, Fazakerley North, Fazakerley West, Fazakerley East, Croxteth, Croxteth Country Park, West Derby Muirhead, West Derby Deysbrook, West Derby Leyfield, Sandfield Park, Knotty Ash and Dovecot Park, Old Swan East, Old Swan West, Stoneycroft, Tuebrook Breckside Park, Tuebrook Larkhill, Old Swan East and Old Swan West.

Tuebrook, West Derby and Yew Tree Children's Centre and Fazakerley, Croxteth, Stoneycroft and Knotty Ash Children's Centres will be key connector sites within the Family Hub network. Children's Centres across the city will continue to offer services and families can access them in the usual way.

Liverpool City Council's Lead Member for Family Hubs, Councillor Angela Coleman, said: "Giving our young people the very best start in life is an absolute priority.

"Our new network of Family Hubs are designed to offer wrap-around support for parents, carers and young people, giving them easy access to health professionals who will be able to support them with any issues they are facing.

"We know that our Children's Centres already do an incredible job helping young families, and they are well established and trusted places to visit. The Family Hubs will build on their success, providing additional services that are easy to access.

"We will take the learning from our first Family Hub in Clubmoor and apply that as we roll the network out around the city between now and March 2025."

Dianne Brown, Chief Nurse at Liverpool Women's NHS Foundation Trust: "Giving babies and families the best start is essential.

"These Family Hubs will help to give local families access to a range of maternity related services and support including midwifery health visiting, infant feeding advice and perinatal mental health support.

"We look forward to working closely with our partners at Liverpool City Council to help provide these valuable services to local people and residents."

Section C - *National*

NHS England's Long Term Workforce Plan

On Friday 30 June 2023, NHS England (NHSE) published the long-awaited NHS Long Term Workforce Plan (LTWP). The publication of the LTWP and its focus on training, retention and reform. This briefing outlines the key components of the plan - https://nhsproviders.org/media/696006/long-term-workforce-plan-otdb.pdf

The government's 2023 mandate for NHS England

The following link provides a summary and analysis of the mandate to NHS England, setting out the government's objectives for 2023 onwards - **https://www.nhsconfed.org/publications/governments-2023-mandate-nhs-england?utm_campaign=1378416_Daily%20Member%20Bulletin%3A%20Tuesday%2020%20June%202023&utm_medium=email&utm_source=NHS%20Confederation&dm_i=6OI9,TJLC,23S367,3MJ1D,1**

NHS response to COVID-19: Stepping down from NHS level 3 incident – 18 May 2023

The NHS in England has decided to step down from a level 3 incident in response to COVID-19, marking a transition from the pandemic response to recovery. Despite ongoing waves of COVID-19 infections, the NHS vaccination program has significantly reduced the loss of life compared to previous waves. This decision aligns with the World Health Organization's recent announcement that COVID-19 is no longer a Public Health Emergency of International Concern. However, it is acknowledged that COVID-19 will remain a significant health issue with long-term impacts, including new waves and variants, staff absences, and the need to address the effects of long COVID.

The implications of stepping down the incident include changes to data collection and reporting. The COVID-19 Patient Notification System (CPNS) will no longer collect data on COVID-19-related deaths, which will now be recorded through the death certification process. The acute COVID-19 data collection process will be scaled down, and some data will be incorporated into existing data collection systems. The outbreak reporting process is under review, and communication structures will be adjusted, ensuring a permanent operations structure to support information dissemination and data collection during incidents or periods of heightened risk or disruption.

NHS England equality, diversity and inclusion improvement plan

On Thursday 8 June 2023, NHS England (NHSE) published its first equality, diversity and inclusion (EDI) improvement plan, developed in consultation with diverse staff, staff networks and stakeholders. This briefing from NHS Providers outlines the context of the plan and summarises the high impact actions and accountability framework.

https://nhsproviders.org/media/695905/nhse-edi-improvment-plan-next-day-briefing.pdf

Section C – *National*

Government response on the Hewitt review

On 14 June 2023 the department of health and social care has published its response to the Rt Hon Patricia Hewitt's review into integrated care systems (ICSs), alongside their response to the Health and Care Select Committee inquiry 'Integrated care systems: autonomy and accountability'. The Hewitt review was commissioned by the chancellor, Rt Hon Jeremy Hunt, in November 2022 to look at the role and powers of ICSs. The review was conducted with significant engagement with leaders from across the health and care system, and NHS Providers had a welcome and constructive dialogue with Patricia Hewitt and her team on behalf of members throughout the process.

The government's response sets out its commitment to helping ICSs develop, to streamlining the number of national level targets and to reviewing the NHS capital regime, and covers a number of themes including:
• targets and priorities for ICSs
• autonomy and support for ICSs
• ICS governance, accountability and oversight
• assessment and review of ICSs
• prevention and promoting health
• finance and funding

NHS Providers' on the day briefing summarises the response - https://nhsproviders.org/media/695923/otdb-govt-response-to-hewitt-review.pdf

Maternity Services Information Update June 2023

First provisional data from the Maternity Services Data Set to be published

NHS England has moved to a provisional and final processing submission model for the MSDS. The first provisional data submissions took place in May 2023, for April 2023 data. This first provisional data for MSDS was due to be published on 29 June 2023 in the Maternity Services Monthly Statistics publication series. A webinar explaining the changes took place on Monday 6 March 2023 and a recording is now available along with some answered questions. Links to all previous webinars are available on our maternity services events webpage.

Launch of Year Five of the CNST Maternity Incentive Scheme

NHS Resolution have launched year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), to continue to support the delivery of safer maternity care. Information about the scheme was published on 31 May 2023. To support Safety Action 2 NHS England will shortly start publishing a CNST Scorecard as part of the Maternity Services Monthly Statistics publication series. The first Scorecard was published at the end of June, in line with the publication on 29 June 2023 of MSDS Final March 2023 and Provisional April 2023 figures.

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/087***		**Date: 13/07/2023**	
Report Title	**Perinatal Quality Surveillance & Safety Dashboard**			
Prepared by	**Maternity Governance and Senior Leadership Team, Family Health Division**			
Presented by	**Dianne Brown – Chief Nurse**			
Key Issues / Messages	The Implementation of a new perinatal quality surveillance model seeks to provide consistent and methodical oversight of maternity services. The model has been developed to provide ongoing learning and insight, and to inform ongoing improvements in the delivery of perinatal services. A prerequisite of the model is to highlight trusts that require support before serious issues occur to enable proactive management and support.			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – N/A ***If no – please outline the reasons for deviation.***			
	Trust Board is asked to receive the report which gives assurance that effective systems of control are in place to monitor quality and safety in Maternity Services at LWH.			
Supporting Executive:	***Dianne Brown – Chief Nurse***			

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	**Date**	**Lead**	**Outcome**
Dashboard presented to the Quality Committee and the Trust Board at each available meeting.			

EXECUTIVE SUMMARY

This report provides an overview of quality and safety performance in maternity services at LWH to give assurance to the Trust Board and to highlight areas of concern which requires further scrutiny. The report was presented at Family Health Divisional Board on the 28th June.

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

The Family Health Division and Information Team have developed a robust and comprehensive perinatal quality surveillance dashboard, which is presented monthly at the Family Health Divisional Board meeting, following which it is cascaded by the maternity safety champions to staff via the following communication methods, e-mail, closed social media groups and clinical departmental meetings.

The Trust Board is asked to receive the report which gives assurance that effective systems of control are in place to monitor quality and safety in Maternity Services at LWH.

MAIN REPORT

Perinatal Quality Surveillance Highlight Report June 2023 (May 2023 Data)

Introduction

In December 2020, following the publication of the Ockenden Report, Trusts were mandated to develop and implement a revised perinatal quality surveillance model. NHS England set out six requirements to strengthen and optimise board oversight for maternity and neonatal safety:

1. To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge, and enquiry.

2. That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust board.

3. That all maternity Serious Incidents (SIs) are shared with Trust boards and the LMS, in addition to reporting as required to HSIB.

4. To use a locally agreed dashboard to monitor maternity and neonatal safety at board meetings.
5. Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMS) lead and regional chief midwife, formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern or need.
6. To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.

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

Provider Trusts and their Boards, supported by the senior maternity and neonatal triumvirate and the board-level perinatal safety champion at its centre, ultimately remain responsible for the quality of the services provided and for ongoing improvement to these

Maternity Clinical Dashboard (May 2023)

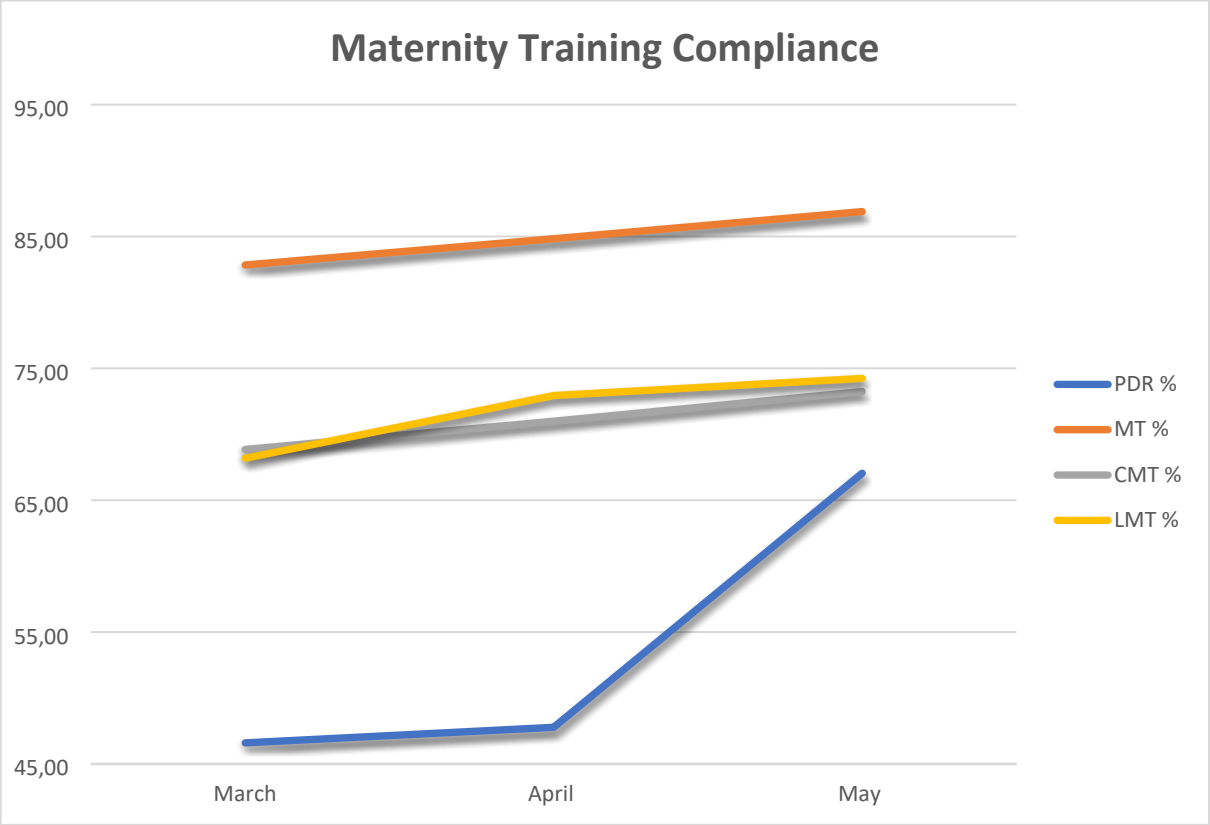
Full dashboard made available to Board members via the supporting documents folder on AdminControl

Areas of concern

Very Concerning – Investigate & Take Action.		
Metric	**Position**	**Narrative**
PDR Rate – Maternity	67.05% (Target ≥ 95%) (Last month 47.78%)	• All line managers were given a target to complete all staff PDR by 31.5 2023 (this excludes staff who are on maternity leave and on sickness absence). • HR Business Partner and HOM have meetings scheduled with all Midwifery Line managers to identify the blockers for non-completion of PDR's. • Progress monitored at the weekly Senior Midwifery Leadership Operational Group.
Concerning – Investigate and understand.		
1:1 Care in Labour	99.60% (Target 100%)	One woman did not receive 1:1 midwifery care in labour. Patient undergoing Induction of Labour progressed rapidly in labour and required transfer to Delivery Suite. 20-minute delay in allocation of a midwife to provide 1:1 midwifery care for labour, as all

		midwives were providing care to other women in established labour. No harm caused to the patient. 1:1 midwifery Care in Labour action plan and audit findings will be presented to QC and Trust Board in the Midwifery Bi-Annual Staffing Paper in August /September 2023 (as per MIS Year 5 Scheme requirements).
Newborn & Infant Physical Examination	94.81% (Target 95)	Delay in medical examination due to availability of medical staff in one case. Introduction of NIPE Midwife on twilight shift and designated NIPE examination room.
Antenatal Steroids	50% (No target)	Antenatal steroid administration has reduced owing to new clinical evidence. Plan to introduce updated patient information leaflet. Antenatal corticosteroid guideline has recently been updated.
Newborn Blood Sampling – Avoidable repeats	4.84% (≤2%)	NICU continues to be an area with a higher percentage error rate. Several initiatives have been put in place led by the NICU ward manager: 1. All new staff complete NBS training and competency form. 2. Ongoing record of NBS practitioners who have had avoidable repeats. If 3 rejections within a 3-month period, staff cease taking samples and complete a Competency Framework Booklet with sign off from the ward manager. 3. Feedback given regularly to practitioners, with evidence of sample (photographs supplied by laboratory). 4. Lessons of the Week have been circulated to Neonatal staff regarding NBS sampling and correct procedures. Most recent was March 23. 5. Regular reminders displayed on 'What You Need To Know Board in the Neonatal Unit.' 6. Currently working with Low Dependency Team Leader to address NBS rejections as higher proportion of rejections found within this area. Looking at a teaching package to address this. In Maternity the delay in receiving an order of the tenderfoot lancets, which is a national issue, resulted in an increase in error rate. Sufficient supplies of the tenderfoot lancets have not been received. The use of the NBBS competency framework for any practitioner with >3 repeats in a rolling 3-month period continues. Training for any new midwives moving into the community setting is also in place using the NBBS competency framework as the basis for this training.

Maternity Training Improvement



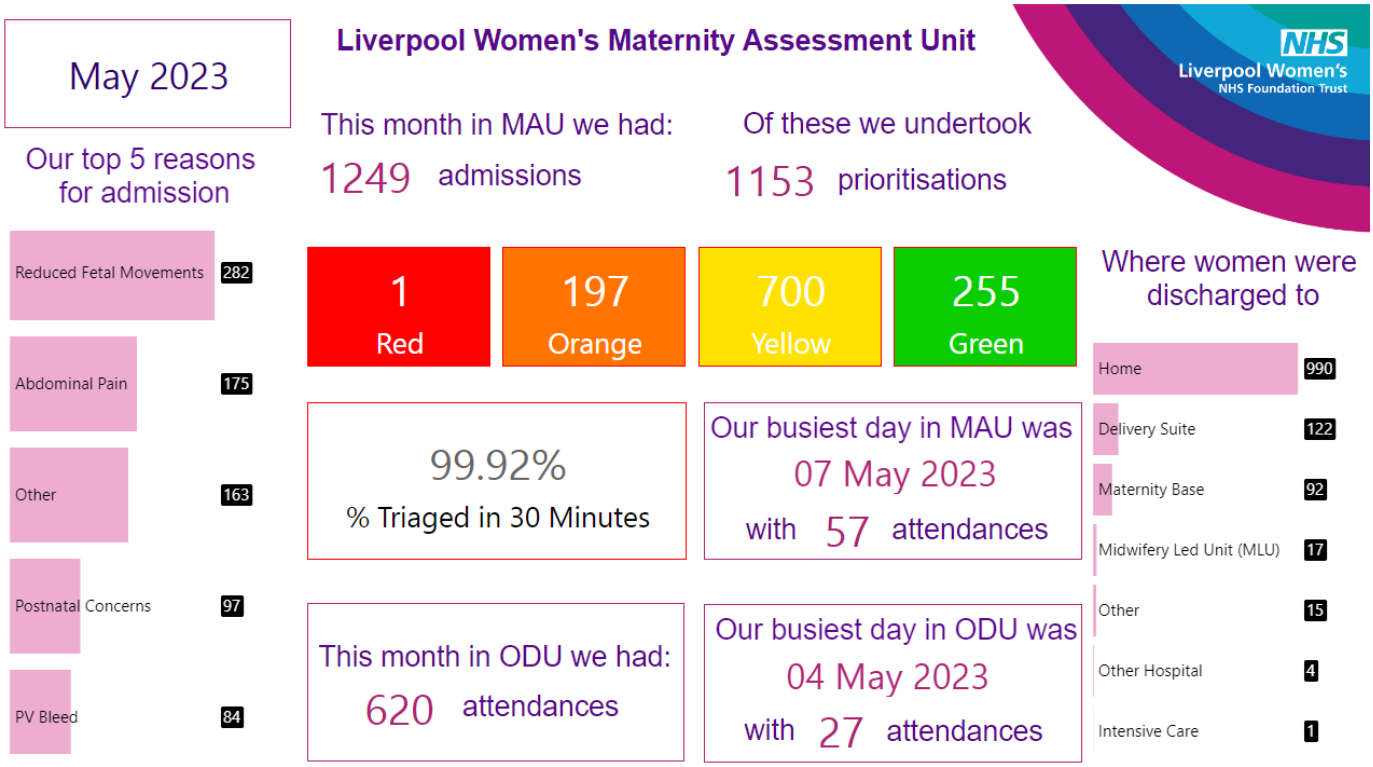
All aspects of Maternity training continue an upward trajectory towards compliance targets with weekly oversight at the Maternity Leadership meeting, focusing on ability of staff to complete eLearning during periods of low acuity.

Due to the impact of industrial action some scheduled training for MPMET, and Fetal Surveillance has been required to be stepped down over the last three months due to inability to have all staff disciplines required to be present, with additional dates planned for the summer to mitigate risks of non-compliance of Maternity Incentive Scheme which relaunched 31st May.

Subsequent Monthly reports will present the compliance for individual staff groups as defined by CNST MIS for elements of safety action 8.

Areas of improvement

Triage assessment in MAU



MAU Medical Review data

Methodology: 50 case notes reviewed over a 48hs period

Results:

- Red x 1- seen immediately and transferred to DS
- Orange x 9 of which 4 should have been yellow. Of the 5 Orange 2 seen urgently and 3 patients care to be given not clicked but were escalated to medical staff and reviewed and hence documentations reflects average wait time of 20-30 minutes.
- Yellow X 28- Average waiting time 75-90 minutes, shortest waiting time was 4 minutes and longest 103 minutes. Target met in 65%. All patients received treatment from MW(Example CTG/counselling). No discharge before medical advice.
- Green x 12. All seen in <240 Minutes with an average wait time of 110-150mins.

Results Summary

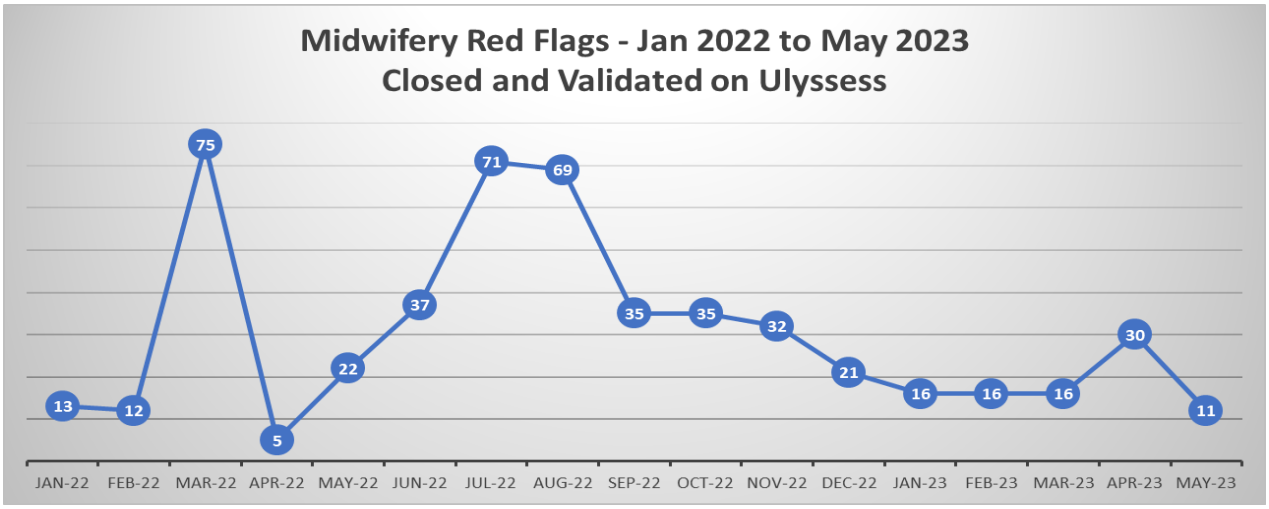
- No harm caused to patients
- Further teaching by MAU Consultant about ORANGE and yellow category
- All Orange category to be kept in Triage room
- If any medical delay 15 minutes MEWS observations to be commenced.

Recommendations

- Registrar middle grade 1300-2100 & ACP on nights
- Education and training to continue-Video, daily and weekly messages, MAU MDT
- Digital team to incorporate the check box medical review needed or not and escalation tab
- V3 guideline
- No role of a separate consultant on MAU –reduce confusion and increase continuity

Midwifery Red Flags

Midwifery Red Flag	Reported
1:1 Care in Labour not supported	**1**
>30 min Delay in Presentation to Triage	**1**
Delay >2hrs between admission and beginning of IOL process	**0**
Delay >4hrs of ongoing IOL	**9**
Delay in time critical activity	**0**
Delay of 30 Mins in providing pain relief	**0**
Missed medication during hospital admission.	**0**
Delayed recognition of and action on abnormal vital signs	**0**
Full clinical examination not carried out when presenting in Labour	**0**
TOTAL	**11**



All staff are encouraged to recognise and report midwifery red flags using the Ulysses System and the maternity managers strive to close incidents in a timely fashion. Midwifery Red flags are monitored on a 2- hourly basis by the Midwifery 104 Bleep holder, with Data and governance oversight maintained through the Divisional Maternity Governance and Risk Committee. The Head of Midwifery provides a detailed narrative of midwifery red flags within the Bi-annual Midwifery Staffing Paper. A SOP developed for the management and governance of Midwifery Red Flags was ratified in April 2023. In February a system update to Ulysses was executed enabling smarter reporting of MRF events as a cause group.

Maternity Safety Reporting

In May there were 301 clinical incidents entered, of these there were no incidents graded as moderate or above. New incidents are reviewed daily to identify incidents of concern, following this each individual incident has a more in-depth review as indicated by the level of concern. This is either by the department, an MDT or if indicated a full investigation

Perinatal Mortality – Intrauterine Deaths >24weeks.

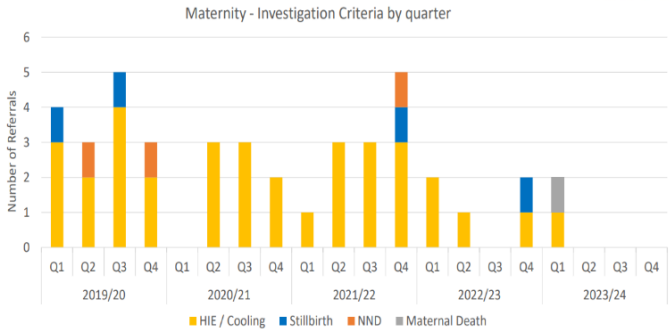
In May 2023, maternity reported one stillbirth to MBRRACE. An initial review of this case was completed and will have a full MDT review through the PMRT process. All perinatal deaths in May 2023 have been reported to MBRRACE, parental support continues to be provided by the Honeysuckle Team. Details and actions plan of every death are detailed in the Regional Quarterly Mortality Report presented by the Deputy Medical Director at Quality Committee and Trust Board.

Healthcare Safety Investigation Referrals (HSIB)

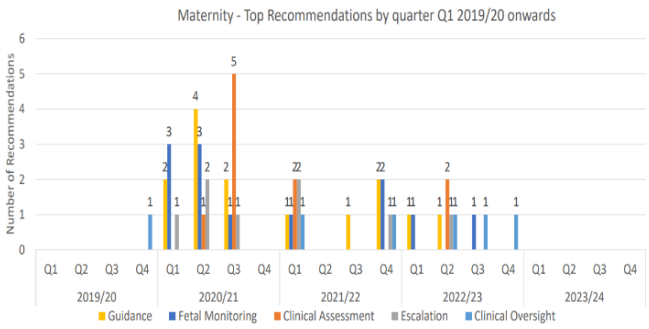
There were no cases reported to HSIB in May 2023.

On 5th May 2023, HSIB representatives presented the quarterly review of referred cases, findings and recommendations. The data presented (full report in Appendix 1) demonstrated a reduction of cases which required investigation by HSIB (Image 1) for LWH. Image 2 highlights key themes emerging from case reviews. Themes recognised, centre around guidance, fetal monitoring, clinical assessment, escalation, and clinical oversight.

Trust – investigation criteria (up to 04/05/2023)



Trust – top recommendations



A full thematic report, in relation to HSIB cases from 2021-2022 was presented to Quality Committee in November 2022. This report will be repeated in Nov 2023 when all cases referred to HSIB have been finalized and returned to the Trust.

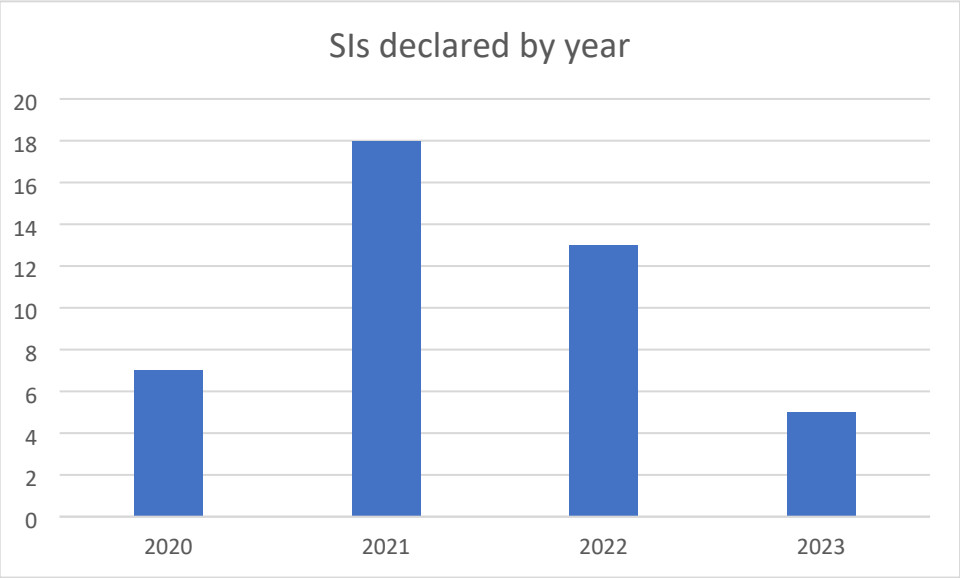
Actions taken within the Family Health Division in response to HSIB recommendations and findings:

- Business Case accepted to recruit an additional fetal Surveillance midwife (0.60wte), to support ongoing, enhanced fetal monitoring training aligned against the core competency framework.
- Revisit of Safety Huddles and handover guidance and improvement project, aligning to key national NHS Improvement project, alongside service evaluation project.
- Development of a new process and operating procedure to ensure that placentas requiring histopathological examination can be safely stored up to 24 hours post birth.
- Mandated online learning for all clinical staff of Human Factors.
- Implementation of the RCOG Teach or Treat Escalation framework, enhanced by the ratification and roll out of a Conflict of Opinion Policy.
- Revised and refreshed Maternity Escalation Policy, due for ratification at the Maternity Clinical meeting June/July 2023.
- Increased Consultant Obstetrician hours on High-Risk Intrapartum Area and MAU.
- Review of CTG Screen accessibility in Obstetric Theatres to ensure visibility to delivering clinician.

Serious Incident Reporting

There were no clinical incidents that met the SI criteria in May, therefore nil submission to StEIS.

To date, there have been five SIs reported across Maternity services since January 2023.



For each of the five cases declared this year, all followed the Duty of Candour process and were reported within the timeframes onto StEIS. Two of the completed investigations were submitted within the ICB's timeframe. Two cases required an extension, and both were agreed by Trust Executives and the ICB.

There is currently one open StEIS investigation for Maternity Services. This review is on track for its target completion date of September 2023.

Of the 5 cases declared this year, 2 related to ITU transfers and will feed into the Future Generations Work. The other three investigations do not have any common themes, one related to a missed Anti D dose, one to an incorrect VTE assessment leading to a postnatal PE. The most recent case the patient had a TACO and initial investigations are unable to identify the rational for the transfusion and the transfusion process was not followed. The full review will identify any learning.

Patients and their families are contacted at the beginning of each investigation and invited to submit any questions or concerns they wish to be included. These points are clearly identified within the investigation report and each patient or family are invited to a meeting upon completion of the investigation.

Following each investigation, the report is shared with the clinical team involved and staff are offered a debrief. Action plans form part of the overall report, and the individual actions are monitored and updated with support from the Governance Team.

There are 56 outstanding incidents related to previous SI's, 18 of which are overdue. These are monitored by the maternity governance team with escalation and oversite at the monthly Maternity Risk meeting.

Going forward the Governance team will be reviewing the process around sharing the learning from SIs. Weekly Safety and Governance meetings have been introduced across Maternity and will be utilised for disseminating learning and discussing themes and trends identified.

Maternity Incentive Scheme Year 5 (CNST): Scheme release: 31.05.2023.

NHS Resolution have published Year 5 of the Maternity incentive Scheme. As in previous years there are ten key safety actions with several evidential requirements and standards. The scheme will be Executively Led by the Chief Nurse with monthly compliance/assurance meetings planned with all safety action leads. Progress and compliance reporting will be facilitated through the Maternity Transformation Board, Quality Committee and upwards to Trust Board.

Ockenden Update.

The Ockenden report, published in 2022, outlined 15 immediate and essential actions (IEAs) of which the Trust should demonstrate compliance against. In response to the findings of a MIAA Audit, the Division are undertaking a review, check and challenge of all 15 IEAs with monitoring and assurance provided to the Family Health Divisional Board. To date the team have reviewed all 15 IEAs and their associated recommendation and progress can be noted below.

Immediate and Essential Action	Compliance with evidence to support	In Part	National Recommendation (Not for Trust Review)
Workforce Planning and Sustainability	5	3	3
Safe Staffing	8	2	0
Escalation & Accountability	5	0	0
Clinical Governance & Leadership	5	2	0
Clinical Governance Incident Investigating & Complaints	4	3	0
Learning from Maternal deaths	0	1	2
MDT Training	6	1	0
Complex Antenatal care	5	0	0
Preterm Birth	4	0	0
Labour & Birth	6	0	0
Obstetric Anaesthesia	7	0	1
Postnatal care	3	1	0
Bereavement Care	3	1	0
Neonatal Care	8	0	0
Supporting Families	3	0	0
	70	14	6

Actions to support the completion of amber rated recommendations include:

- All newly appointed band 7 & 8 midwifery posts in maternity services have been allocated a named and experienced mentor to support their transition into leadership and management roles.
- Intrapartum area shift leaders allocated to attend RCM Leadership course, which consists of situational awareness and Human Factors training. Trajectory in place for all midwifery shift leaders to attend.

- Patient information leaflet under development for women who choose birth outside a hospital setting with regards to transfer times to the consultant obstetric unit. This is being developed in partnership with NWAS and MNVP. Information now being shared with services users.
- Conflict of Opinion Policy for Maternity Services approved, ratified and available on the Trust intranet
- Delivery of External Professional Midwifery Advocate workshops and restorative clinical supervision. Positive rating from staff who attended.
- Weekly meetings to complete a full review of the National Maternity Self-Assessment Tool (94% progress) 6 actions to be confirmed on receipt of evidence (see further section within this report).
- Continue to review all essential actions rated as Green to allow for 'check and challenge' and to ensure that evidence is available in the Ockenden evidence repository.
- Human Factors training- will be a 2hr online training where all staff band 7 and above in maternity services will be required to attend.
- Progression of Governance essential actions in line with implementation of PSIRF in September 2023.
- Working with MVP to explore how service users can be involved in patient complaint process

Maternity Self-Assessment Tool – Appreciative Enquiry Workstream.

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

The Division continue to use an appreciative enquiry framework to complete this self-assessment tool. The Senior Leadership Team reviews the current position and evidence repository. Weekly meetings are being held to review the evidence for each of the 194 questions/actions. To date 188 have been reviewed, with 6 yet to be reviewed, a tracking spreadsheet is being maintained by the Lead Governance Manager to capture the rationale for ratings and record sign off. Current RAG rated position:

Red	Amber	Green	TBC
5	61	11	6

Conclusion

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

Family Health Divisional Board meeting agenda and includes review and monitoring of compliance against all Maternity KPIs that are included within the Maternity Power BI dashboard.

Recommendation

Trust Board is asked to receive the report which gives assurance that effective systems of control are in place to monitor quality and safety in Maternity Services at LWH.

Quality Committee Chair's Highlight Report to Trust Board
30 May 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• Several Sub-Committee Chair Reports escalated issues with the Neonatal Blood Fridge currently not being fit for purpose noting that the provider had advised that this would not be resolved for several months. The matter had been escalated to the Chief Operating Officer and the Medical Director to ensure efficient resolution.
• The Committee noted the following matters from the Quality Performance report:
  ○ continued poor performance against the cancer targets. The Committee received an appended Cancer Improvement Group Chair Report and Cancer Improvement Plan to demonstrate transformation work underway to support improvement.
  ○ Hysteroscopy demand and available capacity remained a key challenge. The Trust had requested mutual aid support from the region and had commenced training of consultants and specialist nurses to increase future capacity.
  ○ Issues with timely receipt of pathology results remained a key challenge. A revised escalation process had provided some improvement however the position was likely to remain pressured during Quarter 1 2023/24 whilst improvements were embedded.
  ○ positive reduction against the 18 week RTT over 52 weeks position as a result of increased activity provided by an insourced external provider. Capacity would need to be sustained during 2023/24 to continue the rate of reduction on these waiting lists.
  ○ downward trend of several metrics including, unplanned reattendance within 7 days, and patients receiving an epidural, and requested that the Committee monitor potential outliers monthly.
  ○ Noted positive yet variable performance against the cancer 2-week wait target and noted the aim to introduce a 7-day wait for first appointment target to drive more consistent attainment against the 2-week target.
• The Committee noted an increased number of complaints in relation to the Hewitt Fertility Centre, the majority of which from fee paying patients. The Gynaecology Division was responding to the complaints, reviewing causes, and updating the Refund Policy.
• The Committee raised concern in relation to compliance against LocSSIPs & NatSSIPs and requested an interim update at the next meeting. The Committee delegated a Chair Action to the Executive Committee to check and challenge progress with divisional teams.
	• The Committee noted due to the impending implementation and 'go live' of DigiCare and EPR, it had been agreed to convene an Extra-Ordinary Corporate Risk Committee to consider DigiCare risks, convened as part of the rigorous governance process.
	• The Committee commissioned a deepdive into epidural rates.
	• The Committee noted that a focussed update on DigiCare - Risk Impact on reporting as part of the EPR Go-Live would be presented to a future Committee meeting.
	• Noted work underway within Legal Services to develop a new approach to continuous analysis of claims and lesson learning within divisions. The Litigation Review would be presented to the Committee when completed.
	• Noted work in progress for an 'in-uterine transfer deepdive'
	• The Committee received its first bi-annual Equality, Diversity and Inclusion update. Progress against patient EDI objectives was in its infancy, positive steps could be demonstrated across the Trust. The Committee considered a strategic collaborative system approach to enhance capacity to deliver against this objective in line with budgetary and workforce constraints.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**

• The Committee received and noted the quality and regulatory overview of key issues and emerging concerns. (ALL)
• The Committee took the following positive assurances from the Quality Performance Report (ALL)
  ○ Positive compliance against the infection prevention and control metrics in relation to Clostridium Difficile and MRSA,
  ○ positive compliance against the VTE target
• The Committee noted continued progress towards development of a revised Quality Strategy. (ALL)
• The Committee took positive assurance from the Maternity Transformation and Improvement Update, noting considerable work to develop initiatives and improve patient care. Specifically noting: continued improvement against the time to triage target within 30 minutes; successful implementation of a revised midwifery and support staffing model; and constructive feedback from the Maternity Voices Partnership (MVP) who had conducted a 15 Steps toolkit visit. (ALL)
• The Committee took assurance from the Integrated Governance Assurance Report Quarter 4, 2022/23, noting improved triangulation. (ALL)
• The Committee received the Mortality and Learning from Deaths Report Quarter 4, 2022/23. (ALL)
• The Committee took positive assurance from the Medicines Management Assurance report for Quarter 4, 2022/23. (ALL)
• The Complaints Response Deep dive 2022/23 highlighted causes of delays and identified actions taken to address issues in relation to system and process, and cultural and behaviour. The Committee had been assured by the outcome of the review. (ALL)
	• The Committee recommended further iteration of BAF Risk 3 as part of the new 2023/24 Board Assurance Framework.
	• Approved the Patient Involvement & Experience Sub-Committee Terms of Reference.
	• The Committee received and supported the Quality Account 2022/23 ahead of submission the Audit Committee and Trust Board for approval and subsequent publication on 30 June 2023.

Summary of BAF Review Discussion (Board Committee level only)	
• The Committee reviewed the quality related BAF risks, noting two new risks aligned to the Committee on the BAF 2023/224 register: Risk 2 and Risk 3. • The Committee agreed that BAF risk 3 should be separated further into two separate risks due to significant pressures and size of the agenda.	
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Appropriate discussion dedicated to identified reports	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
29.	Review of BAF risks: Quality related risks	Assurance	36.	Integrated Governance Assurance Report Quarter 4, 2022/23	Assurance
30.	Sub-Committee Chair Reports	Assurance	37.	Mortality and Perinatal Report (Learning from Deaths) Quarter 4, 2022/23	Assurance
31.	Quality and Regulatory Update	Assurance	38.	LocSSIPs Quarterly Assurance Report Quarter 4	Assurance
32.	Quality Performance Report Month 1, 2023/24	Assurance	39.	Medicines Management Assurance Report Quarter 4	Assurance
33.	Quality Account 2022/23 Draft	Approval	40.	Equality, Diversity and Inclusion Update (bi-annual)	Information
34.	Quality Strategy Development	Information	41.	Complaint Response Deep Dive	Assurance
35.	Maternity Transformation and Improvement Update	Information			

3. 2023/24 Attendance Matrix

Core members	April	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Sarah Walker, (Chair) Non-Executive Director	**A**	✓									
Louise Kenny, Non-Executive Director	✓	✓									
Gloria Hyatt, Non-Executive Director	✓	✓									
Jackie Bird, Non-Executive Director	✓	✓									
Dianne Brown, Chief Nurse	✓	✓									
Lynn Greenhalgh, Medical Director	✓	✓									
Gary Price, Chief Operating Officer	✓	**A**									
Jenny Hannon, Chief Finance Officer	✓	✓									
Michelle Turner, Chief People Officer	✓	✓									
Nashaba Ellahi, Deputy Director of Nursing & Midwifery	**A**	✓									
Philip Bartley, Associate Director of Quality & Governance	**A**	✓									
Yana Richens, Director of Midwifery	**A**	✓									
Heledd Jones, Head of Midwifery	**A**	✓									

Quality Committee Chair's Highlight Report to Trust Board
26 June 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee received a follow-up report LocSSIPS / NatSSIPs to provide additional details in relation to performance against the category 1 caesarean section data and overall performance which had been challenged. It was noted that a category 1 caesarean section should be completed within 30 minutes of the decision to proceed to urgent caesarean section delivery. The 2023 NatSIPP guidance acknowledges that for in-time critical interventions such as category 1 caesarean sections, undertaking the full safety check-in is likely to be more harmful than beneficial. It was confirmed that a pre-operative verbal safety check is undertaken and noted that the Division would consider what digital methods could be utilised to support this process further. • The Committee was asked to sign-up to the NHS Prevention Pledge for Cheshire and Merseyside which has been adopted by most trusts in the region. The Pledge aims to improve health inequalities for both patients and staff through prevention. Commitment to the Pledge aligns to and supports established Trust strategy and objectives. The Committee was supportive of the pledge yet highlighted limited resources available to the Trust to continue to undertake additional initiatives.	• Noted the HSIB investigation into the 'Language Gap' and their recommendations to NHS England that providers should translate letters to other languages. Some available technologies exist that the Trust could utilise. • The Committee noted that the CQC had published the Trust 2023 inspection report with an overall grading of requires improvement. An action plan was being formed in response to the CQC findings and would be submitted to the Trust Board in July 2023. • The Committee noted that natural causes had been found as the cause of death by the Coroner following a recent maternal death. An internal SUI was ongoing and due for completion in July 2023. • An analysis of the reported clinical incidents in which the isolation of clinical services played a part during quarter 4 of 2022/23 was shared. The aim was to obtain a better understanding of the frequency and pattern of the impact of these risks on the patients and staff at LWH. Regular ongoing monitoring of such incidents would continue. • The Committee received a review into the most appropriate method of measuring caesarean section (emergency and total) rates as commissioned by the Trust Board. Further work was requested based on the discussion and this would report back to the Committee in due course.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**

• The Committee noted the following matters from the Quality Performance report:
  ○ Urgent Care: targets continue to be improving; with the 4-hour emergency department target showing sustained good performance and the Maternity Assessment Unit triage time also improving. It was noted that the MAU triage time will move from 30 minutes to 15 minutes in July 2023, in line with national safety indicator targets.
  ○ Gynaecology Elective recovery: targets continue a positive trajectory in line with the 2023/24 plan. Both the 65 weeks wait and the 52 weeks wait metrics continue to perform better than the anticipated trajectory. It was noted that the division was planning to step down the insourced clinical support for gynaecology elective work by the end of June 2023.
	• The Committee supported the adoption of the Cheshire and Merseyside NHS Prevention Pledge.
	• The Committee approved the Infection Prevention and Control Annual Report 2023/23 ahead of publication.
	• The Committee approved the Research, Development and Innovation Annual Report 2022/23.

- The Committee received its first staff experience story from the Children and Young Person's Specialist Nurse who commenced post in August 2022. The Committee noted the positive initiatives to ensure appropriate child centred care within health services provided by the Trust. (ALL)
- The Committee received a detailed review of the DigiCare reporting workstream, approach and activities ahead of migration to EPR. Significant assurance from the report was taken that risks had been sighted from a data management and reporting perspective (WELL LED)
- A detailed review of Serious Untoward Incidents (SUI) 2022-2023: performance of the investigatory process, health inequalities data and the themes and learning from the incidents provided assurance to the Committee that SUIs are monitored and managed, and that the Trust was aware of factors relating to health inequalities. (ALL)
- The Committee took assurance from the Integrated Safeguarding Quality Assurance Report for quarter 4, 2022/23. (ALL)
- The Committee was assured by the Health and Safety Annual Report 2023/23. (ALL)
- The Committee took positive assurance from the Maternity Transformation and Improvement Update, noting considerable work to develop initiatives and improve patient care. (ALL)

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the related BAF risks. No risks closed on the BAF for Quality Committee.
- It was noted that an additional BAF Risk 7 - Failure to meet patient waiting time targets, had been introduced at the bequest of the Quality Committee to disaggregate BAF Risk 3 at the May 2023 meeting. The risk would be owned by the Quality Committee and would also be reported to the Finance Committee due to the subject matter.
- The Committee considered BAF Risk 2 - Inability to ensure the on-going sustainability of clinical services and maintain a high standard of care at the current Crown Street site and recommended a rearticulation of the risk to ensure that safety and the drive to reduce patient harm was fully captured.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Appropriate debate dedicated to identified reports.
- Receipt of good examples of report writing

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
50.	Staff Experience Story	Information	58.	Review of Serious Untoward Incidents 2022-2023	Assurance
51.	Review of BAF risks: Quality related risks	Assurance	59.	Clinical incidents attributable to the isolation of LWH services from other specialist services, Quarter 4 2022/23	Information
52.	Sub-Committee Chair Reports	Assurance	60.	Maternity Transformation and Improvement Update	Information

53.	Quality and Regulatory Update	Assurance	**61.**	Review into the most appropriate method of measuring Caesarean Section (emergency and total) rates	Assurance
54.	Quality Performance Report Month 2, 2023/24	Assurance	**62.**	Safeguarding Quarterly Report Quarter 4, 2022/23	Assurance
55.	DigiCare Reporting Assurance Report	Assurance	**63.**	Infection Prevention and Control Annual Report 2022/23	Approval
56.	Local And National Safety Standards for Invasive Procedures – Update	Information	**64.**	Research & Development Annual Report	Approval
57.	The NHS Prevention Pledge	Approval	**65.**	Health & Safety Report Annual Report 2022/23	Approval

3. 2023/24 Attendance Matrix

Core members	April	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Sarah Walker, (Chair) Non-Executive Director	**A**	✓	✓								
Louise Kenny, Non-Executive Director	✓	✓	**A**								
Gloria Hyatt, Non-Executive Director	✓	✓	✓								
Jackie Bird, Non-Executive Director	✓	✓	**A**								
Dianne Brown, Chief Nurse	✓	✓	✓								
Lynn Greenhalgh, Medical Director	✓	✓	✓								
Gary Price, Chief Operating Officer	✓	**A**	✓								
Jenny Hannon, Chief Finance Officer	✓	✓	✓								
Michelle Turner, Chief People Officer	✓	✓	✓								
Nashaba Ellahi, Deputy Director of Nursing & Midwifery	**A**	✓	✓								
Philip Bartley, Associate Director of Quality & Governance	**A**	✓	✓								
Yana Richens, Director of Midwifery	**A**	✓	**A**								
Heledd Jones, Head of Midwifery	**A**	✓	✓								

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**23/24/088b**		**Date: 13/07/2023**	
Report Title	**Quality & Operational Performance Report**			
Prepared by	***Gary Price, Chief Operating Officer, Dr Lynn Greenhalgh, Medical Director and Dianne Brown, Chief Nurse***			
Presented by	***Gary Price, Chief Operating Officer***			
Key Issues / Messages	***For assurance – To note the latest performance measures***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – If no – please outline the reasons for deviation.			
	The Board is asked to note the assurances within the Month 2 Quality and Operational Performance Report.			
Supporting Executive:	***Gary Price, Chief Operating Officer***			

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

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

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) N/A	Comment:

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Putting People First Committee	May 23	CPO	Detailed in Chair's Report
Quality Committee	June 23	COO/CN/MD	Detailed in Chair's Report
Finance, Performance & Business Development Committee	June 23	COO	Detailed in Chair's Report

Performance Report Contents

Key Performance Indicators

Gynaecology Elective recovery continues a positive trajectory in line with the 2023/24 plan submitted to the ICB. Both the 65 weeks wait (to eliminate patients waiting over 65 weeks for treatment by March 24) and the 52 weeks wait (to eliminate patients waiting over 52 weeks for treatment by March 25) continue to achieve better than the trajectory and comparison slides for Cheshire and Mersey Trusts are included in the pack. The 6-week routine diagnostic target that supports elective recovery continues to be good with mutual aid offers for other Trusts under review.

Work is ongoing to sustain this capacity through cheaper and more permanent solutions as the demand moves from outpatient waits to Theatre waits. This work is underpinned by the Theatre and Outpatient Improvement Programmes. The Trust narrowly missed out on achieving 106% elective work versus 19/20 for months 1 and 2 and would have overachieved if it weren't for the impact of industrial action.

Cancer metrics continue to improve. The 2-week target was challenged with industrial action however has recovered in M2, the 31-day decision to treat target is good. Both the overall size of the waiting list (due to a 30% increase in referrals) and 28-day diagnostic delays are the main challenge which results in a poor 62-day performance. These are multifactorial and are improving and overseen by the Cancer Improvement Group (see Appendix 1). The Trust is meeting with NHSE and the Cheshire and Mersey Cancer Alliance end of June to review the plans.

Urgent care targets continue to be good with the 4 hr ED target showing sustained good performance and the MAU triage time following suit. The MAU triage time will move from 30 mins to 15 mins in July.

Quality Metrics

Several areas are reporting positive and an improving position.

In terms of safety, Infection and Preventions control measures of hospital acquired infections of measures of C Diff and MRSA remain at Zero. Active monitoring and oversight are led the by Infection control and prevention committee.

Several patient risk assessments, including falls risks, malnutrition screening and Venous thromboembolism demonstrate good levels of compliance. There has been a new harm metric introduced which related to hospital Acquired pressure ulcers which demonstrates the Trust ambition in relation to reducing avoidable harm and reporting in an open and transparent way.

Ongoing focus remains on the completion of complaint responses in the required timeframes and improvements have been noted.

There was one episode where a woman revieing care on the delivery suite (99.78%) did not receive 1:1 care in labour. Exceptions are detailed within the report, a harm review completed with no issues identified.

Several areas have specific and intentional actions relating to improving patient and family experience to ensure improvements are realised across the Family and Friends test, actions highlighted within the summary report. Ongoing work is progressing with ICB colleagues to ensure any Serious Incidents are closed in a timely manner as we progress toward the national implementation of PSIRF

Appendix 1: Assurance & Variation Icons Descriptions

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

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

Appendix 2: Assurance Category Descriptions

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

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report

June 2023

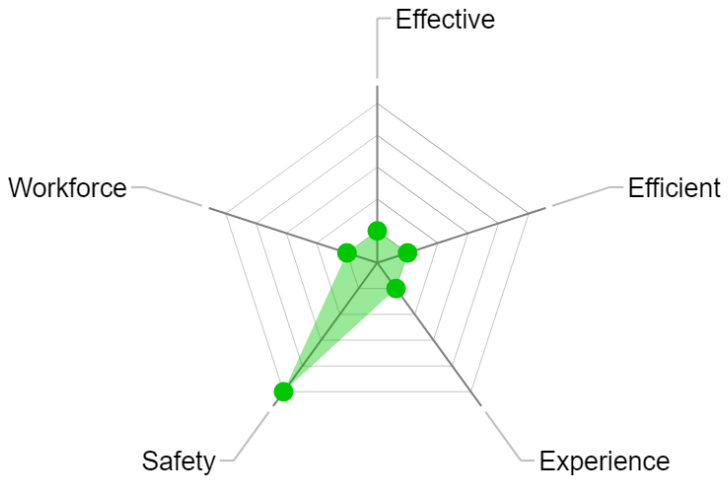
Section 1: Assurance Radar Charts by Trust Values

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'.

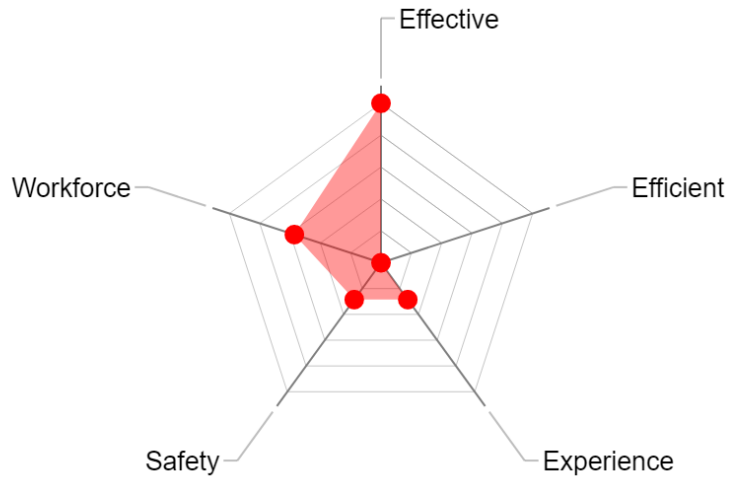
KPIs Passing Target for Six Months	9
KPIs Failing Target	15
KPIs Hit and Miss	9
KPIs No Target	2

KPIs Improving Variation	7
KPIs Concerning Variation	5
KPIs Common Cause Variation	23

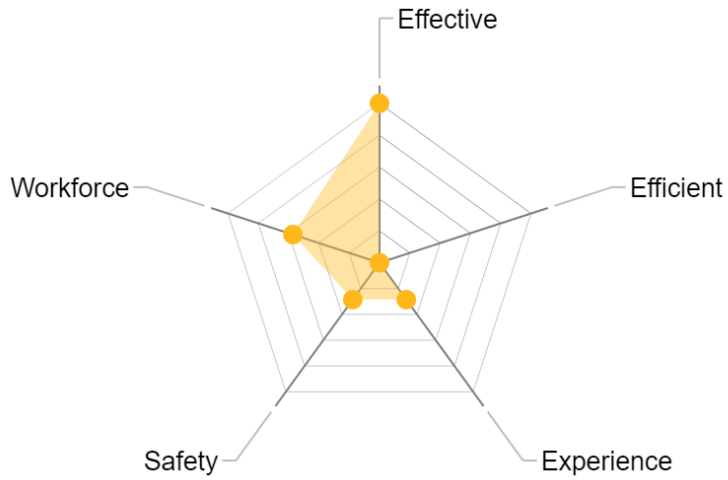
Consistently Passing



Consistently Failing



Hit and Miss



Section 2: Integrated Performance Metrics

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

Excellent - Celebrate & Learn

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 104 Weeks	<=	0	0	P	L
Never Events	<=	0	0	P	L
Serious Untoward Incidents: Number of SUI's with actions outstanding	<=	0	0	P	L
Turnover Rate	<=	<= 13%	9.20%	P	L

Good - Celebrate & Understand

KPI	Target < or >	Target	P	A	V
Complaints: Number Received	<=	<= 15	6	P	
Financial Sustainability Risk Rating: Overall Score	<=	3	3	P	
Infection Control: Clostridium Difficile	<=	0	0	P	
Infection Control: MRSA	<=	0	0	P	
MAU - Face to face Maternity Triage within 30 Mins	>=	>= 95%	99.44%	?	H
NHSE / NHSI Safety Alerts Outstanding	<=	0	0	P	
Venous Thromboembolism (VTE)	>=	>= 95%	94.79%	?	H

Average - Investigate & Understand

KPI	Target < or >	Target	P	A	V
Neonatal Deaths per 1000 live Births	<=		0		
18 Week RTT: Incomplete Pathway > 65 Weeks	<=	0	434	?	
Cancer: 2 Week Wait	>=	>= 93%	47.39%	?	
Diagnostic Tests: 6 Week Wait	>=	>= 99%	94.69%	?	
Friends & Family Test: In-patient/Daycase % positive	>=	95%	95.00%	?	
Proportion of patient activity with an ethnicity code	>=	>=96%	95.38%	?	
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	>=	100%	100.00 %	?	

Integrated Performance Metrics

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

Concerning - Investigate

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 78 Weeks	<=	0	20	F	
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	>=	>= 95%	92.68%	F	
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	>=	>=85%	33.33%	F	
Cancer: 104 Day Breaches	<=	0	2	F	
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	>=	>=96%	94.74%	F	
Cancer: 62 Day Screening Referrals (Percentage) Rolling 12 Months	>=	>=90%	33.33%	F	
Clinical Mandatory Training Compliance	>=	>= 95%	83.26%	F	
Friends & Family Test: A&E % positive	>=	95%	83.78%	F	
Friends & Family Test: Maternity % positive	>=	95%	83.96%	F	
Mandatory Training Compliance	>=	>= 95%	93.24%	F	H
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	>=	>= 80%	41.54%	F	
Sickness Absence Rate	<=	<= 4.5%	6.04%	F	
18 Week RTT: Incomplete Pathway > 52 Weeks	<=	0	1740	?	H
Overall size of Elective Waiting List	<=		17626		H

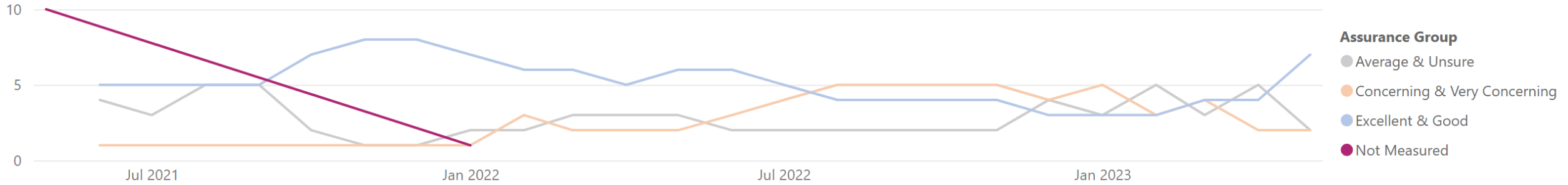
Very Concerning - Investigate & Take Action

KPI	Target < or >	Target	P	A	V
Cancer: 28 Day Faster Diagnosis	>=	>= 75%	38.73%	F	L
Serious Untoward Incindents: New (Rolling per year)	<=	24 /year	46	F	H
Serious Untoward Incindents: Open	<=	<5	18	F	H

Investigate & Understand

KPI	Target < or >	Target	P	A	V

Section 3: To deliver **Safe** Services

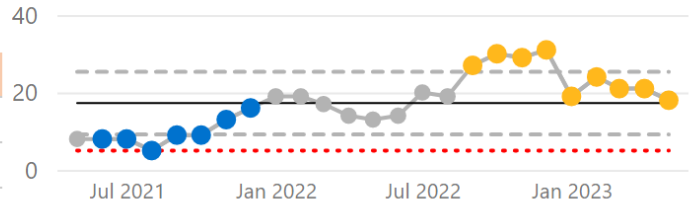


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Never Events	Excellent	May 2023	0	<=	0			
Serious Untoward Incidents: Number of SUI's with actions outstanding	Excellent	May 2023	0	<=	0			
Infection Control: Clostridium Difficile	Good	May 2023	0	<=	0			
Infection Control: MRSA	Good	May 2023	0	<=	0			
MAU - Face to face Maternity Triage within 30 Mins	Good	May 2023	>= 95%	>=	99.44%			
NHSE / NHSI Safety Alerts Outstanding	Good	May 2023	0	<=	0			
Venous Thromboembolism (VTE)	Good	May 2023	>= 95%	>=	94.79%			
Neonatal Deaths per 1000 live Births	Average	May 2023		<=	0			
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	Average	May 2023	100%	>=	100.00%			
Serious Untoward Incindents: New (Rolling per year)	Very Concerning	May 2023	24 /year	<=	46			
Serious Untoward Incindents: Open	Very Concerning	May 2023	<5	<=	18			

To deliver **Safe** Services - Exceptions

Serious Untoward Incidents: Open - Chief Nurse

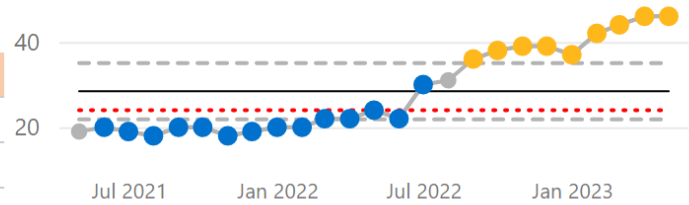
Assurance Category	Very Concerning
Date	May 2023
Target	<5
Target < or >	<=
Performance	18
Assurance	F
Variation	H



Some of the histoical SUI's for Gynae had been closed, however, new SUI's have since been declared. A piece of work is on-going to further reduce the open SUI's with support provided to the Divisional SLT to manage this work at pace. It is expected that a much improved posistion will be reported in July as we currently work with the ICB to close down SUIs in advance of PSIRF going live in September.

Serious Untoward Incidents: New - Chief Nurse

Assurance Category	Very Concerning
Date	May 2023
Target	24 /year
Target < or >	<=
Performance	46
Assurance	F
Variation	H



There were 3 SUI's reported in May, 2 of them in relation to our Isolated site location where critical care transfers were required. There has been an increase in SUI's compared to the last year which is largely due to isolated site issues (10 in total) which were not reportable to the ICB/CCG in previous years. As of September, the SUI frameowrk will cease, SUI's closed down and will be replaced by PSIRF. This will see the number of investigations decrease with a focus on trust priorities.

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

To deliver Safe services - Safer Staffing

May 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	95.97%	93.55%	150.00%	96.77%	*The RN overfill Fill Rates on nights are reflective of the senior nurse cover to rotate between the inpatient ward and GED. This is under review, due to the low bed occupancy in HDU that has allowed for staff to rotate and support the inpatient ward.
Induction & Delivery Suites	83.01%	90.32%	76.34%	85.48%	*In May the template from RM in Delivery Suite changed to 15 MW per shift due to the temporary pause of MCOC model of care and no availability of on call staff. Safe staffing required the Maternity bleep holder to redeploy RM to maintain clinical safety and prioritise 1:1 care in labour and ensure ringfenced staffing in MAU. Vacant shifts are requested to be filled with bank and agency up to planned staffing numbers
Maternity & Jeffcoate	93.55%	113.71%	84.79%	112.90%	*/**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 where fill rate of registered midwives was reduced to support ward.
MLU	87.10%	64.52%	87.90%	77.42%	*/**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 the clinician is a 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)	101.02%	111.29%	100.68%	122.58%	*/**Fill rates are reflective of the acuity and occupancy of the NICU (Neonatal Intensive Care Unit). Safe staffing maintained.
Transitional Care	48.39%	106.45%	35.48%	93.55%	*/**Fill rates are reflective of the occupancy of the TC (Transitional Care). Safe staffing maintained.

To deliver Safe services - Safer Staffing

Gynaecology: May Fill Rate

Fill rate – May staffing fill rate on days is reflective of new starters commencing with minimal vacancies. Safe staffing has been maintained due to the ability to flexibly rotate RN across the division and due to the low bed occupancy of 37.38% in the inpatient area. The fill rate 150.00% RN on nights is the reflection of senior RN cover rotating between GED and inpatient area which is currently under review.

Attendance/ Absence – sickness and absence for the month of May was reported as 4.54% an improvement from previous 10.88% in April, long-term sickness contributing to 52.46%.

Vacancies – 1 HCA Vacancy

Red Flags – There were no red flags raised for May

Bed Occupancy – Bed occupancy is at 37.38% for the month of May

CHPPD – – For the month of May the CHPPD overall was reported to be 10.3. The split between Registered and unregistered care staff is 6.1hr for Registered Nurse staff and 4.2hr for Health Care Assistant.

Neonates: May Fill Rate

Fill-rate – May has seen activity remain consistently above the 80% threshold expected. Staffing has been less challenging this month with no significant change 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 – May sickness ran at 5.24%, this was down on April by 0.5%. Short term sickness sits at 41.54% with long term sickness making up 58.46%. There was no covid sickness. Maternity leave is at 12.13 FTE and turnover sits at 8.22% well below the Trust target.

Vacancies – Vacancy rate is increasing; this is due to significant delays in approval via vacancy control process. There is concern we will miss band 5 group if there isn't quicker approval of vacancies. Currently, we have 6 band 6 vacancies, 4 have been on VCP since April 2023. Additionally, ANNP's are awaiting approval since May 2023. Funding has now been allocated for governance and education from Neonatal Critical Care Review to a total of 1.9 wte at Band 7.

Red Flags – No red Flags

Bed Occupancy – Unit occupancy has not changed this month at 89.6% (80% standard), however, acuity remains high. IC is running at 90.9% up 9.2% on last month. There has been no significant changed to HD activity, running at 91.7%. LD activity has decreased to 81.5% from 93.2%. While TC activity has increased from 27.1% to 43.5 %.

CHPPD – Within the critical care areas the care was as would be expected, showing higher hours of registered nurse care and lower non-registered care. This split of 11.5 hrs of registered nurses and 1.4 of non-registered nurse 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 6.6 hrs by non-registered nurse and less by registered nurses 2.8 hrs, the difference from last month is seen as occupancy was higher, therefore appropriate for care delivery. Care in TC is more about supporting the family.

To deliver Safe services - Safer Staffing

Maternity: May Fill Rate

Fill-rate – During May there was a temporary planned pause to the MCOC model for a period of six months, with staff in addition to their community caseload allocated inpatient shifts instead of working an on-call birth availability model. This has meant that for the Intrapartum element of care, Delivery Suite planned staffing has increased to 15 RM per shift. Additionally, there has been the requirement for deployment of specialist midwives, ward managers and matrons for periods of time to ensure safety, particularly in peaks of high activity in MAU to maintain triage time within 30mins. Triage performance was achieved at 99.2% in May. 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 target of 4.5% which is calculated in the headroom, within its midwifery and support staff group. Maternity sickness is reported at 7.79% in month, a decrease of 0.9% from April, with short term absence accounting for 24% of this with the top causes of cough/cold or gastrointestinal issues. LTS is 76%. 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 13.60wte all of whom are within the Registered Midwives staffing group.

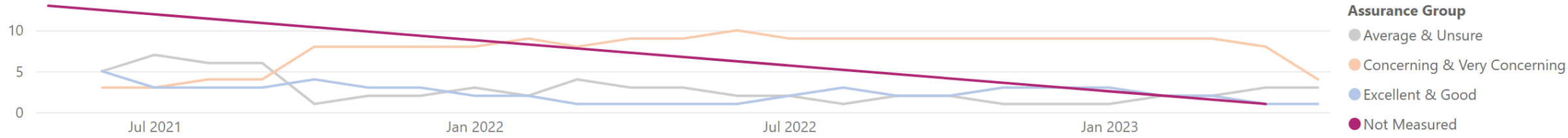
Vacancies – Several Midwives at Band 5 and 6 are currently undergoing recruitment processes and Maternity is expected to reach full establishment by M6 when all new starters are in post.

Red Flags – During May 11 Midwifery Red Flags were identified, which included 1 instance of 1:1 care not being provided for a short period of time due to rapidly progressing labour whilst caring for a PN patient. All cases reviewed by the Intrapartum Matron and presented at Maternity Risk meeting, 1 triage breach of >30mins due to influx of attendances with all undergoing analysis to drive quality improvement as part of the MAU workstreams. There were 9 delays of >4hrs for ongoing IOL (local red flag), which affected patient experience. Apologies were offered and women moved through to the next stage when safe to proceed.

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 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 16.8 in May for Delivery Suite for registered staff which is an increase from 14.1 in April. 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 is a more accurate measure and was achieved for 99.8%.

The Maternity Ward is mixed antenatal and postnatal ward and therefore the fluctuation of case mix will be significant to CHPPD calculations, due to babies being inclusive in the total and classed also as patients. It is reported at 4.0 for May increasing from 3.4 for April overall. We are working with BirthRate Plus to implement the new Ward Based Accuity Tool with anticipated launch this summer. This will provide real time evidence-based data to support staffing deployment decisions and provide assurance within this area following significant updating on a national level and based upon the changing complexity of ward-based care.

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

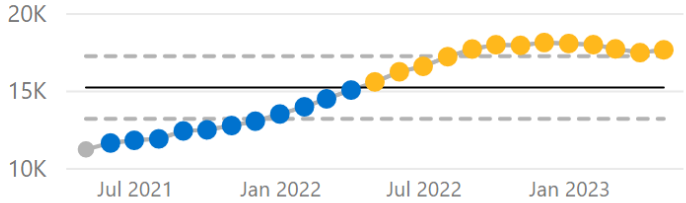


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
18 Week RTT: Incomplete Pathway > 104 Weeks	Excellent	May 2023	0	<=	0	P	L	
18 Week RTT: Incomplete Pathway > 65 Weeks	Average	May 2023	0	<=	434	?		
Cancer: 2 Week Wait	Average	April 2023	>= 93%	>=	47.39%	?		
Diagnostic Tests: 6 Week Wait	Average	May 2023	>= 99%	>=	94.69%	?		
Proportion of patient activity with an ethnicity code	Average	May 2023	>=96%	>=	95.38%	?		
18 Week RTT: Incomplete Pathway > 52 Weeks	Concerning	May 2023	0	<=	1740	?	H	
18 Week RTT: Incomplete Pathway > 78 Weeks	Concerning	May 2023	0	<=	20	F		
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Concerning	May 2023	>= 95%	>=	92.68%	F		
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Concerning	April 2023	>=85%	>=	33.33%	F		
Cancer: 104 Day Breaches	Concerning	April 2023	0	<=	2	F		
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Concerning	April 2023	>=96%	>=	94.74%	F		
Cancer: 62 Day Screening Referrals (Percentage) Rolling 12 Months	Concerning	March 2023	>=90%	>=	33.33%	F		
Overall size of Elective Waiting List	Concerning	May 2023		<=	17626		H	
Cancer: 28 Day Faster Diagnosis	Very Concerning	April 2023	>= 75%	>=	38.73%	F	L	

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

Overall size of Elective Waiting List - Chief Operating Officer

Assurance Category	Concerning
Date	May 2023
Target	
Target < or >	<=
Performance	17626
Assurance	
Variation	H

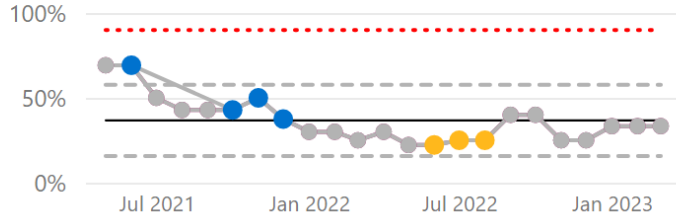


Slight increase in month due to impact of continued Industrial Action and additional activity lost to bank holidays in May. Insourcing capacity continuing to keep numbers at a stable rate as backlog is cleared

Continued insourcing to run unti lend of July and then alternative locum/agency consultant plan in place from ugust for a temporary period whilst Division develops long term capacity business case

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

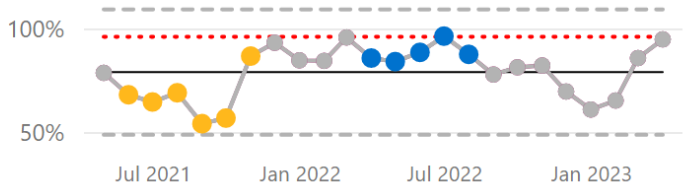
Assurance Category	Concerning
Date	March 2023
Target	>=90%
Target < or >	>=
Performance	33.33%
Assurance	F
Variation	



These are patients that are referred from cervical screening programme and are a very low number each month (2-3). They are managed alongside the 2-week cancer referral patients and should then be considered as part of that pathway.

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

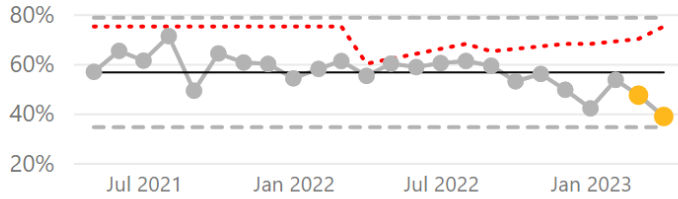
Assurance Category	Concerning
Date	April 2023
Target	>=96%
Target < or >	>=
Performance	94.74%
Assurance	F
Variation	



There has been significant improvement in performance through Q1 in this metric. This improvement is down to the actions taken as part of the Trusts Cancer Improvement Plan. This is a multi-agency plan which involves the Trust, Liverpool Place and the Cheshire and Mersey Cancer Alliance. The plan was shared with the Trusts Quality Committee in May 2023 who will continue to monitor its effect and the ability to sustain this increase in performance.

Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

Assurance Category	Very Concerning
Date	April 2023
Target	>= 75%
Target < or >	>=
Performance	38.73%
Assurance	F
Variation	L



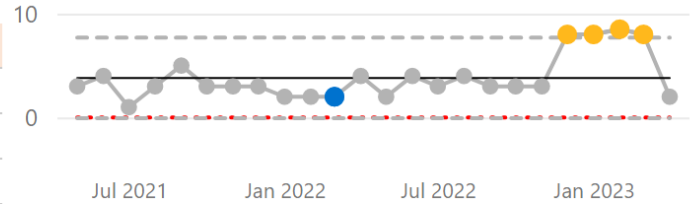
The Trust is off trajectory with this measure to achieve 75% by March 24.
The key drivers of this performance are a continued rise in referrals and therefore challenges and delays with diagnostic capacity, most notably Hysteroscopy and Pathology.

These are noted as risks on the risk register and improvements are overseen by the Cancer Committee via the Cancer Improvement Plan that reports to Quality Committee.

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

Cancer: 104 Day Breaches - Chief Operating Officer

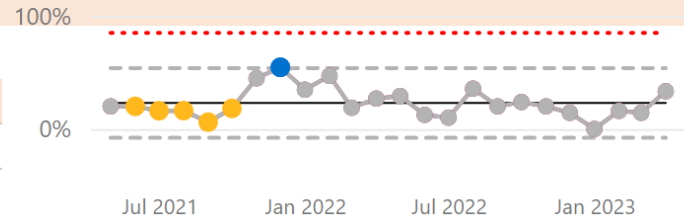
Assurance Category	Concerning
Date	April 2023
Target	0
Target < or >	<=
Performance	2
Assurance	
Variation	



There are a small number of patients waiting over 104 days to Treat from referral. There are individual reasons for each of these cases. These reflect the overall increase in referral numbers, late referrals from other Trusts, delays in diagnostics and patients with comorbidities/ complexities.
All patients undergo a harm review to ascertain any lessons learnt.

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

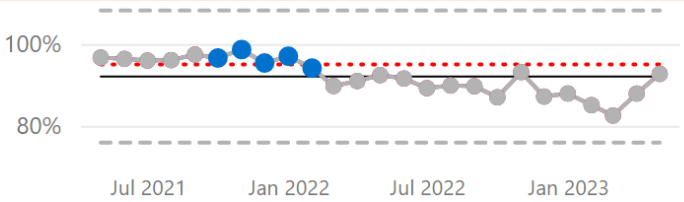
Assurance Category	Concerning
Date	April 2023
Target	>=85%
Target < or >	>=
Performance	33.33%
Assurance	
Variation	



The Trust is off trajectory with this measure. The key drivers of this performance are a continued rise in referrals and therefore challenges and delays with diagnostic capacity, most notably Hysteroscopy and Pathology. These are noted as risks on the risk register and improvements are overseen by the Cancer Committee via the Cancer Improvement Plan that reports to Quality Committee. Several key actions have been put in place including working with Primary Care

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

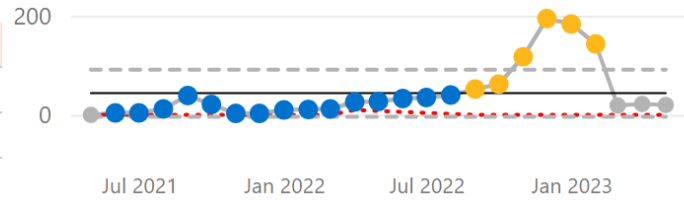
Assurance Category	Concerning
Date	May 2023
Target	>= 95%
Target < or >	>=
Performance	92.68%
Assurance	
Variation	



Performance has increased in May from the previous deteriorating Trajectory in line with the improvement plans put in place by the Gynaecology Division. These plans focus on ensuring patient pathways through the Emergency Department are as clear as can be for individual conditions and following triage patients are moved to the most appropriate services in a timely manner.

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

Assurance Category	Concerning
Date	May 2023
Target	0
Target < or >	<=
Performance	20
Assurance	
Variation	



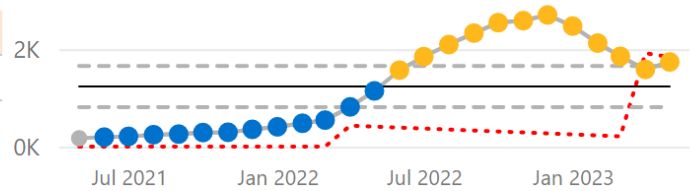
Number of 78+ weeks has remained stable for M2. Outstanding patients waiting beyond 78+ weeks for clinical reasons or by patient choice. Anticipated to clear majority of patients by end of June 2023.

Currently monitored through weekly NHSE meetings. 65+ weeks reducing steadily, currently at 413, ahead of trajectory of 799

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

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

Assurance Category	Concerning
Date	May 2023
Target	0
Target < or >	<=
Performance	1740
Assurance	
Variation	



Slight increase in May due to the impact of Industrial action. Continued use of Insourcing company for clearance of long waiters making significant impact. Insourcing to cease end of July with alternative plan for locum/agency support to commence from August

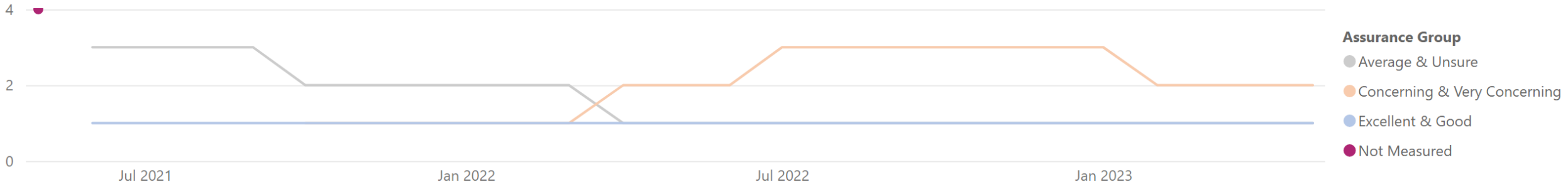
Trust currently ahead of monthly trajectory with NHSE, monitored through weekly Elective Restoration & Recovery meetings

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

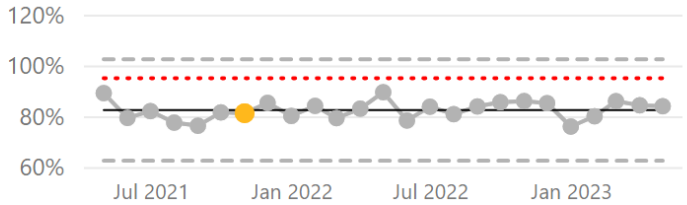


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Complaints: Number Received	Good	May 2023	<= 15	<=	6			
Friends & Family Test: In-patient/Daycase % positive	Average	May 2023	95%	>=	95.00%			
Friends & Family Test: A&E % positive	Concerning	May 2023	95%	>=	83.78%			
Friends & Family Test: Maternity % positive	Concerning	May 2023	95%	>=	83.96%			

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

Friends & Family Test: Maternity % positive - Chief Nurse

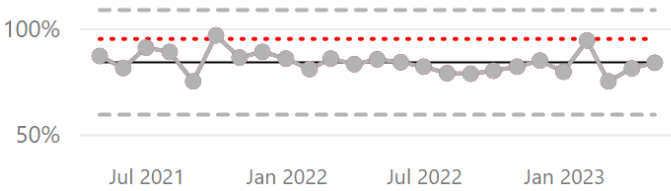
Assurance Category	Concerning
Date	May 2023
Target	95%
Target < or >	>=
Performance	83.96%
Assurance	
Variation	



Number of overall responses received remain low. Intentional rounding in place, where matrons and ward managers canvass women who are inpatients in the clinical areas, about their experience of maternity services with the aim of resolving any concerns promptly. Midwifery matrons will now be meeting on a weekly basis to review all FFT responses with the aim of addressing trends and themes and to put improvements in place.

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

Assurance Category	Concerning
Date	May 2023
Target	95%
Target < or >	>=
Performance	83.78%
Assurance	
Variation	



We have seen an increase in positive responses since previous month, previiously 81% iin April. May now showing as 84% positive feedback. Same processes in place regarding feedback, any concerns highlighted through F&F or feedback on the day to the nurse in charge are being delt with accordingly by the department manager or nurse in charge.

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

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 Incindents: New	Safety	5	Y		Y				Y	
Serious Untoward Incindents: Open	Safety	5	Y		Y					
Sickness	Workforce	5	Y		Y	Y				
Turnover	Workforce	5	Y			Y				
Venous Thromboembolism (VTE)	Safety	5	Y		Y					
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Workforce		Y	Y	Y	Y				

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/088c*		Date: 13/07/2023	
Report Title	CQC Inspection Report – Trust Response			
Prepared by	Philip Bartley – Associate Director of Quality & Governance			
Presented by	Dianne Brown - Chief Nurse			
Key Issues / Messages	The Trust has received the final report into the findings of the Care Quality Commission unannounced inspection in January 2023, and Well Led inspection of February 2023. The report highlights the steps taken to date in response of the findings and provides assurances regarding oversight and completion of required actions including next steps.			
Action required	Approve ☐	Receive ☒	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Trust Board is asked to receive the report and note the action underway to respond to the issues raised in CQC report in a timely and holistic manner.			
Supporting Executive:	***Dianne Brown - Chief Nurse***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
N/A			

EXECUTIVE SUMMARY

The Trust has undergone an inspection of its Maternity and Gynaecology core services by the Care Quality Commission (CQC) in January 2023. A full inspection of the well-led domain also took place in February 2023. The CQC published its final inspection report on 23 June 2023. The overall Trust rating had deteriorated from good to requires improvement.

- The overall rating for Gynaecology had improved from requires improvement to good.
- Maternity had deteriorated from good to requires improvement overall
- The key question 'are services safe?' for Maternity had deteriorated from good to inadequate

On 9 February 2023, a S29A Warning Notice was issued requiring the Trust to make significant improvements in relation to Regulation 12(1)(2)(a)(b). The notice stated that, "The Trust must assess and do all that is reasonably practicable to mitigate risks to the health and safety of women, birthing people." Immediate remedial actions have been taken which have demonstrated reliable and sustained improvements within the maternity assessment unit. Regular reports have been received by the Board of Directors each month thereafter detailing the actions taken and outcomes achieved.

In accordance with CQC guidance a further unannounced inspection of Maternity services should be expected within three months of receipt of the warning notice. However, a reinspection has not yet taken place and it is anticipated this could happen at any time.

The CQC report identifies nine actions the Trust must take to comply with its legal obligations and a further 14 actions the Trust should take.

This paper provides an update in response to the actions taken by the Trust in relation to the report findings. A development session is planned for September 2023 to enable the Board of Directors to consider their response to the findings of the Well Led domains and agree next steps in terms of any specific Board led actions. A further update will be provided in due course.

The report can be found on the following link - https://www.cqc.org.uk/provider/REP

MAIN REPORT

An unannounced focussed inspection of maternity services took place at the Crown Street site on 24 and 25 January 2023. This was part of the CQC's maternity services inspection programme which inspected and rated the Key Lines of Enquiry for the safe and well-led key questions. A further Unannounced inspection of Gynaecology and Termination of Pregnancy Services on 24 and 25 January 2023 inspected against all key line's enquiry, safe, effective, caring, responsive and well-led. A well-led inspection was pre-planned and took place between 21-13 February 2023.

On 9 February 2023, a S29A Warning Notice was issued requiring the Trust to make significant improvements in relation to Regulation 12(1)(2)(a)(b) stating that the Trust must assess and do all that is reasonably practicable to mitigate risks to the health and safety of women, birthing people, and babies. More specifically, concerns were in relation to.

- The Management and Assessment of Risk

- MAU triage times
- Staffing within MAU

The Trust took immediate actions in relation to the following areas.

- Medical Staffing
- Midwifery Staffing
- Leadership

A comprehensive programme of improvements has been led by the Maternity Transformation Board and these include.

- The review and refresh of the Maternity Assessment improvement task and finish group
- Additional staffing requirements modelled through operational planning and budget setting.
- Protected triage and shift leader midwife.
- Development of triage breech analysis and reporting
- Review and suspension of the Continuity of Carer model, providing specific continuity for the ante and post-natal periods only which has released staff to support other clinical areas
- Development of visible real time data, to allow oversight and immediate intervention by the clinical and leadership teams
- Enhanced clinical escalation policies
- Visit and update to the Regional Chief Midwife NHSE and ICB who have recognised the significant improvement
- Weekly, reducing to monthly updates to the CQC
- Ongoing engagement and dialogue with the LMNS re transformation support

Immediate and sustained improvements have been demonstrated and reported to the Board of Directors each month thereafter in relation to the timely access, review, and treatment of women within the Maternity Assessment Unit

The Care Quality Commission also commented within its report about the outstanding practice in the Trust and these are included below.

- There was innovative work regarding anti-racism
- The trust had developed a staff pantry in response to local economic hardship
- The trust was hosting and supporting the C-GULL – Children Growing up in Liverpool research programme
- The Non-English-Speaking Team (NEST) provided care for those women, birthing people and families booked at Liverpool Women's Hospital who did not speak English
- Supported interns, working in partnership with schools and the trust hotel services provider students with neuro diverse and physical disabilities have been provided with work experience opportunities
- The service used charitable funds to fund several initiatives to meet the basic needs of women and birthing people who were vulnerable
- The service provided robotic assisted surgery for women needing different types of urogynaecology

The Report concluded that the Trust Must Improve the following

- That we operate effective systems and processes to assess, monitor and improve the quality of services and mitigate the risks to women, birthing people, and babies.
- That we assess and do all that is reasonably practicable to mitigate risks to the health and safety of women, birthing people, and babies
- That we undertake timely and effective triage of women and birthing people
- We are assessing, documenting, and responding to ongoing risks to the safety of women, birthing people, and babies
- We Deploy sufficient, suitably qualified midwifery staff
- Maternity staff are up to date with mandatory training
- Sufficient numbers of suitably qualified, competent medical staff to deliver the service and reduce delays in medical review in maternity triage
- Operate effective systems and processes to assess, monitor and improve the quality of services and mitigate the risks to women, birthing people, and babies
- People can access the service when they need it, particularly for cancer pathways and scan services

We should ensure that.

- We roll out of the Oliver McGowan Mandatory Training on Learning Disability and Autism.
- We implement the Equality Delivery System2022 (EDS2) with defined lines of reporting.
- Staff complete relevant safeguarding checks and logs when a woman or birthing person is admitted to the service.
- Staff have access to appropriate support when dealing with safeguarding concerns.
- Staff adhere to best practise in infection prevention and control
- All equipment is in date and suitable for purpose.
- Staff answer call bells quickly to prevent risk of harm to women and birthing people.
- Staff receive an annual appraisal and complete their mandatory training
- Review systems and processes also ensuring staff follow them in relation to the safe management of medicines
- Staff are supported to raise concerns through the trust Freedom to Speak Up Guardian and action is taken on concerns raised by staff.
- We review arrangements in the gynaecology day case admissions area to ensure women's privacy and dignity is maintained
- Have sufficient medical cover available for the Bedford Unit and GED.

Response to Report Findings

An improvement plan is due to be provided to the CQC no later than 26 July 2023. The improvement plan is being operationally delivered with the oversight of the corporate governance team, overseen by the Executive team and reporting into Safety & Effectiveness Sub Committee, Quality Committee and Trust Board.

As part of the Trust approach to learning and improvement a further analysis of the report has been undertaken to ensure all elements of CQC observations and comments from the report have been collated into meaningful actions. This has included a cross divisional review, therefore, the total number of actions for Maternity is 67, and 12. All actions are now recorded in the action management system, further work is ongoing to ensure all actions completed have tangible

evidence stored within the system to support a good evidence repository. It must be noted that some actions will have longer anticipated completion dates, for example the Trust response to Gynaecology access targets, which are subject to national and local scrutiny and oversight.

Regular updates are provided to the Executive Committee against the completed action plans.

There has been no significant press interest since CQC published the report in June 2023. There is a communications handling plan in place which has been enacted.

Conclusion

There has been significant progress to address the actions identified by the Trust following the inspection by CQC, particularly in relation to the Warning Notice. This is supported by follow up 'mock inspections' of MAU and evidence provided to CQC weekly basis initially and now monthly with the approval of CQC due to the improvements made. Of the 79 actions, 63 are now closed or marked as completed. However, 34 actions require further analysis, review and robust evidence of closure. Work is progressing with divisional and governance colleagues through Divisional Boards to collate the necessary evidence and this progress will be reported through the Executive Committee every two weeks.

Next steps

- Divisional Boards will continue to oversee the required closure and completion of actions supported by the Governance in advance of the July deadline, which will include Executive review and sign off.
- Detailed improvement plans for those areas of longer-term actions, for example delivery of timely treatment within gynaecology pathways will be embedded within the responses and agreed with the CQC
- CQC action plans to be reported to and monitored by Safety & Effectiveness Sub-Committee and Quality Committee.
- Continuation of unannounced 'mock inspections' of MAU, with reporting through divisional boards and escalation when required through the relevant Executive.
- A facilitated Board reflection session will take place in September to consider the wider finding of the report and with a specific focus on the well led elements, learning and culture. A further update will be presented thereafter
- Draft action plans have been uploaded to the Supporting Documents section of Admin Control for Board members to view. However, it must be noted that these are still in development in some areas and once finalised will be reported.

Recommendation

The Trust Board is asked to receive the report and note the action underway to respond to the issues raised in CQC report in a timely and holistic manner.

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/088d***		**Date: 13/07/2023**	
Report Title	**Guardian of Safe Working Hours (Junior Doctors) Annual Report 2022/23**			
Prepared by	***Kat Pavlidi, Guardian Safe Working Hours***			
Presented by	***Kat Pavlidi, Guardian Safe Working Hours***			
Key Issues / Messages	The report presents the Guardian of Safe Working Hours (Junior Doctors) Annual Report 2022/23			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – N/A ***If no – please outline the reasons for deviation.***			
	The Board is asked to read and note this report from the Guardian of Safe Working Hours..			
Supporting Executive:	***Lynn Greenhalgh, Medical Director***			

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	**Date**	**Lead**	**Outcome**
Updates provided to the PPF Committee.			

EXECUTIVE SUMMARY

This report covers all the above for the reporting period and relates to April 1st, 2022 – March 31st, 2023.

Under the 2016 T&Cs for doctors and dentists in training, there is a requirement for the Guardian of Safe Working Hours (GoSWH) to submit a quarterly report to a sub-board committee and an annual report to the Trust Board with the following information:

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

The Board are advised:

- Rota establishment continues to fluctuate throughout the year with processes in place to mitigate the use of high-cost agency locums by using internal bank, doctors in training and ANNPs
- During this reporting period, 2022/23, the service continued to operate with a reduced number of PGD's due to a combination of maternity leave and long term sickness, as well as senior PGD's obtaining CCT.

MAIN REPORT

Introduction

The Trust received a full rotation for all doctors in training over 2022-2023. However, there is an ongoing need to cover unexpected absences such as sickness, and therefore the rotations continue to be supported by fixed term research posts and locally employed doctors who are either out-of-programme or in between training, as well as ANNPs.

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

1. Work schedules

Work schedules were released on time as mandated by the 2016 Junior Doctor Contract. These included a change in the O&G rota to include weekend Tier 1 cover from 0830-1300 on both the maternity and gynaecology wards, in response to need for support due to increased workload in both services over the weekends.

2. Rota compliance

All PGD rotas are compliant with the 2016 T&Cs.

3. Staffing levels

The number of doctors/ANNPs available at the trust are at a supposed over established rate by WTE in all specialties. However, this data is based on WTE expectations from several years prior, and an immense project is being currently done to assess the workload need which will lead to more PGDs or MAPs being required to support the service.

Despite this 'on paper' over establishment, we are seeing increasing rota gaps, owing to sickness (both short and long-term), maternity leave, doctors taking time out of programme for training/other experience, and obtaining their CCT (completion of training), in addition to increasing numbers needed for the service

that exists. This was compounded by the need to staff the MAU with junior doctors during the weekends following the January 2023 CQC inspection.

In addition, two physician associates (PAs) have been appointed as of February 2023 to help support the maternity service and primarily work within the MAU. The Trust is looking into expanding the recruitment of medical associate professions (MAPs) to help service provision.

4. Rota gaps

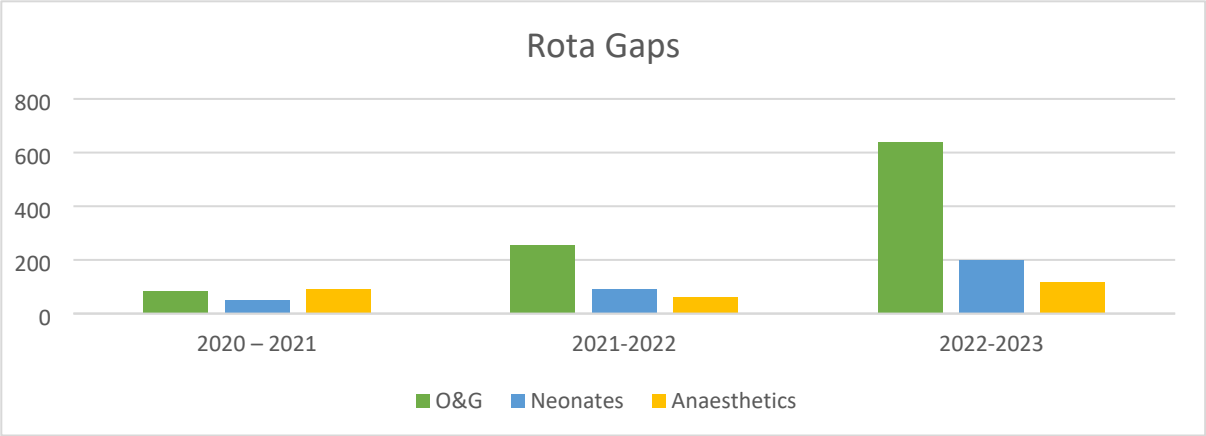
Rota gaps total per quarter

Quarter	Anaesthetics	Neonates	O&G
Q1	117	201	641
Q2	42	30	213
Q3	32	71	152
Q4	18	54	132
Total	117	201	641

Total gaps per specialty over last 3 years

Service	2020-2021	2021-2022	2022-2023	% change*
Anaesthetics	93	61	117	+92
Neonates	49	90	201	+123
O&G	82	256	641	+150

*% change relates to 2022-2023 compared to 2021-2022



The number of gaps and need for locum cover continues to increase year on year in all specialties. This is due to the overall PGD workforce not being expanded despite an increase in service need. There is an ongoing project to look into ways to improve cover, with ideas including cover by Medical Associate Professions (MAPs) to help service provision. This in theory should allow a breathing space for better training for PGDs, in turn allowing improved GMC survey outcomes.

Unfilled gaps and acting down

27.5 gaps within the O&G service went unfilled during this year. These were mainly shifts due to acute sickness and miscommunications with agency bookings (2). In addition, many of these gaps were the weekend ward cover Tier 1 shifts, which have been agreed will not be backfilled if a locum is not found.

Fourteen shifts were covered by staff acting down (mix of Tier 2/3 and consultant cover). Twelve of these were within the obstetric rota, 1 within the gynae rota and 1 within the neonatal rota. This number did not include the March Junior Doctor strike days where consultants acted down to cover the service.

Genetics

There is no requirement for locum cover as genetic doctors do not work unsocial hours.

5. Exception reports and junior doctor forum

During the reporting period of 1st April 2022-31st March 2023, the number of exception reports (ERs) are detailed below.

There were 18 exception reports made, 4 from neonatal trainees and 14 from O&G trainees. No ERs related to immediate patient safety issues, 1 related to educational, 2 to service support and 15 to extra hours worked/natural breaks.

Period	Specialty	Grade	Reason	# ERs	Outcome
Q1	O&G	Tier 1	Hours / natural breaks	4	TOIL Payment
	O&G	Tier 2/3	Hours / natural breaks	1	Payment
Q2	O&G	Tier 1	Hours / natural breaks	2	TOIL
	O&G	Tier 1	Service support	1	Unresolved
	O&G	Tier 2/3	Educational	1	Unresolved
Q3	O&G	Tier 1	Hours / natural breaks	1	TOIL
	O&G	Tier 1	Service support	1	Unresolved
	O&G	Tier 2/3	Hours / natural breaks	2	TOIL
	Neonatal	Tier 2/3	Hours / natural breaks	4	TOIL
Q4	O&G	Tier 1	Hours	1	TOIL

The two service reports relate to the Tier 1 doctor requiring covering two Tier 1 shifts due to an unfilled gap during the night. Although this is not classed as a shift requiring extra payment (as they would already be paid to be in work), this can lead to overwork and can lead to patient safety issues.

In the previous two annual reports, there was an increase in the number of exception reports which highlighted the lack of breaks. This was not reflected in the exception reports received in 2022-2023 but will continue to be monitored.

Exception reporting is encouraged regularly by the GoSWH, but a trend is noted where doctors do not submit them. This is a national trend noted, with likely reasons being:

- A fear that doctors would be perceived as being inefficient
- Extra time ends up being useful due to training opportunities gained
- A feeling that nothing will get done about the problem
- A fear that doctors would be perceived as unprofessional
- Finishing or starting early on some days so extra time worked 'balances' out

The GoSWH has met with each batch of doctors within each specialty to explain the process of exception reporting and encourage/increase the level of exception reports which will be monitored.

As previously reported, regular junior doctor forums were previously poorly attended; this was seen to be a trend across the region. However, the Trust has seen recently an increase in the number of attendees and become a useful platform for the doctors to raise any concerns, giving the Trust the opportunity to address these issues. These forum meetings are now better organised, with a full agenda published prior to each meeting, and minutes taken. PGDs are able to attend these meetings either face to face or via Teams, with the meetings recorded so they can watch it at a time suited to them.

6. Fines

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

7. Fatigue and Facilities Charter

A site for a new Junior Doctors Mess has been found as of the beginning of 2022 and was expected to be available by June of 2023; however there have been further delays which the GoSWH will be looking into.

Other relevant data

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

Actions taken to resolve issues

1. Staffing

A medical workforce task team has been set up as of 2022 to address the ongoing rota gaps as well as the ongoing service needs of the Trust. Owing to advances in medicine, as well as the need for increased senior support (e.g. based on the Ockenden report and CQC inspections), the service required to keep patients safe and well managed is ever increasing. Staffing with PGDs has not kept up with this service need, and the ongoing workforce project will aim to mitigate these issues to allow for better and safer care for patients.

2. Rota gaps

Doctors previously training at LWH have been asked to be part of the bank of locums, in addition to current trainees. This has been especially seen with gaps required to be filled within the O&G service on the Maternity Assessment Unit (MAU) over the weekends as part of the CQC inspection from January 2023. These shifts will be included within the rotas from August 2023 onwards with changes made to allow any new rotas to be compliant with the T&Cs 2016.

The O&G and Anaesthetic service continue to recruit to 'Clinical Fellow' and 'Research fellow' (locally employed, Trust grade doctor) and FY3 roles throughout the year.

3. Exception reporting

The GoSWH continues to work with Educational Supervisors on how to address exception reports, including specific timescales, in line with the T&Cs 2016. This will ensure all exceptions are responded to, resolved in good time, and escalated where necessary.

The Guardian is continuing to engage with junior doctors at their Induction sessions and scheduled JD fora and continues to promote the use of the exception reporting system.

Qualitative narrative highlighting areas of good practice or persistent concern

All services continue to cover locum shifts within the junior doctor and ANNP workforce to reduce the need for agency staff.

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

The GoSWH is concerned about the increasing number of rota gaps and locum shifts outside of the normal rotas. Covered mostly in advance of the shift occurring, these increasing number of shifts going out for locum is leading to physical and mental exhaustion. This is a major risk as PGDs will continue to present with burnout, leaving their training posts as well as leaving the NHS, a theme seen across the whole of the UK.

The Board is asked to understand that covering rota gaps as a locum are in addition to hours worked of compliant rotas. Therefore any extra sessions carried out are with prior agreement with the junior doctor, although this inevitably leads to an increase in the overall hours worked. The Board are asked to understand that the GoSWH is concerned about this issue, as it could be deemed unsafe practice in the long term with too many doctors working too many hours. There is a balance required, however, to cover gaps to ensure safe provision of care to patients and our rota coordinators work hard to reduce these risks and avoid fewer trainees taking on too many shifts.

Summary

The Board are advised:

- the number of gaps across all services has increased compared to the previous reported year (2021-2022).
- should the rota establishment fluctuate throughout the year there are robust processes in place to mitigate the use of high cost agency locums wherever possible by using internal bank, doctors in training and ANNPs, however this is increasing levels of physical and mental exhaustion amongst junior doctors.

This report advises the Board that doctors in training are safely rostered and enabled to work hours that are safe and in compliance with their contract, but that the number of gaps is of very high risk and is a continuing to be a concerning trend.

Recommendations:

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

Appendices

As indicated in the text above.

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

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The GP ST2 Trainee noted that there had been issues experienced particularly by male GP trainees not from the UK into the placement programme at the Trust and suggested a dedicated supervisor for cultural and pastoral support. The Committee considered the importance of culturally competent trainers and leaders. • Received the Q4 2022/23 and the Annual Report from the Guardian of Safe Working Hours. The Committee noted that doctors in training had been safely rostered and enabled to work hours that are safe and in compliance with their contract during 2022/23, but the number of rota gaps across all services had increased compared to the previous reported year (2021-2022). Risk was identified that the number of rota gaps was a concerning trend and likely to become increasingly problematic into 2023/24. Alternative workforce options to fill rota gaps would continue to be considered due to limited availability of a junior doctor workforce. The Committee took partial assurance noting that the risk had been identified within the BAF. • The Mandatory Training and PDR compliance continued to be a matter of concern. PDR rates was currently at the lowest rate compared to the past 12 months. Mandatory training compliance was significantly away from the target within the Maternity and Medical workforce. The Committee recommended an enhanced performance management process to drive forward improvements and a review of utilisation of the pay progression policy and withholding incidents will be implemented. Further consideration of additional penalty actions to be taken.	• Noted the Let's Talk Survey and Big Conversation events held during April 2023. A detailed report would be prepared for a future meeting. • The Committee noted that the RCOG had undertaken a project to provide Guidance on medical staffing workforce for providers. • Additional time requested to review the Maternity Red Flag Deep Dive ahead of Committee consideration.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• Received a positive staff story from a GP ST2 Trainee about her experience on placement at the Trust. As a GP she felt it valuable to develop skills and learning within women's health to support patients in a community setting. She commented that there had been a 50/50 split of placement time within Obstetrics and Gynaecology however noted it would be beneficial to have more time dedicated within Gynaecology due to the skills required to support patients within a GP setting. She noted that there could be better utilisation of patient pathways and improved direct access routes for GPs to the Trust for advice. (WELL LED) • The Committee took assurance from the Medical Workforce Assurance Report noting that the Trust continued to work towards its corporate objective of 24/7 resident consultant cover, support newly appointed consultants, consider other non-medical roles to support the medical workload, and continued to train the post graduate doctor workforce. The Committee noted that progress towards 24/7 consultant working was being progressed however timescales to be reviewed in light of financial constraints. (ALL) • Took positive assurance from the Workforce Performance Report noting positive upward trends in mandatory training compliance and sickness rates. (ALL)	• The Committee approved the Terms of Reference of the Professional Forum of Nurses, Midwives & AHPs; Great Place to Work Group; and the Medical Workforce Review Sub-Committee.

• Received the Annual Report from the Director of Medical Education and took assurance that training and education had been maintained across the Trust despite significant challenges related to high rates of sickness, the ongoing impacts of covid and more recently the impact of industrial action particularly within nursing and Junior Medical staff. Assurance was gained via feedback from HEENW and monitoring learner feedback across the Trust. It was noted that innovative training approaches should be supported by collaborative working with HEIs and HEENW. (ALL) • Noted the Medical Appraisal and Revalidation report covering Quarter 4, 2022/23. (ALL) • Received a positive position update against the Midwifery Preceptorship Programme, noting a retention rate for all cohorts at the Trust currently at 98%. The Committee noted that the Preceptorship Team would continue to implement the Midwifery Preceptorship programme and work towards the Gold Standard against the National Midwifery Preceptorship Framework. (WELL LED) • The Committee received the Freedom to Speak Up (FTSU) Guardian Update noting progress against the Freedom to Speak Up Strategy. It was noted that Mersey Internal Audit Agency had undertaken an audit on FTSU at the Trust. Positive increase of response rate to the temperature check survey was noted and feedback used to influence communication of key messages moving forward. Specific concerns related to confidentiality and outcomes, the team was preparing guidance in the form of "Frequently Asked Questions" to address these concerns prior to the next survey in October 2023. (WELL LED) • Received the Volunteers Annual Report 2022/23 and commended the Voluntary Service Team for their valuable contribution to the Trust. (WELL LED)	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the PPF aligned BAF risks, noting the outturn position for 2022/23 for BAF risk 1.1 and 1.2.
- The Committee received the BAF for 2023/24 and approved the proposal to close BAF risk 1.1 and 1.2 and replace with a single BAF risk 1: Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities.
- The Committee discussed BAF Risk 1 and supported the proposed risk score of 16, and target score of 12. The Committee would recommend to the Trust Board in July 2023.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Robust discussion
- The Committee commented on the quality of narrative provided within the reports submitted.

2. Summary Agenda

No.	Agenda Item	Purpose	Rating	No.	Agenda Item	Purpose	Rating
06.	Board Assurance Framework (BAF): Workforce related risks	Assurance		14.	Maternity Red Flag Deep Dive	Assurance	Report deferred
07.	Staff Story	Information		15.	Midwifery Preceptorship: Feedback	Information	
08.	Workforce Assurance Report: Medical Workforce	Assurance		16.	Mandatory Training Audit Progress Report	Information	
09.	Chief People Officer Report	Information		17.	Big Conversation Initial Themes	Information	
10.	Workforce KPI Dashboard Report	Assurance		18.	Freedom to Speak Up Guardian Bi-Annual Update	Information	

11.	Director of Medical Education Annual Report	Information		**19.**	Volunteer Service Annual Report 2022/23	Assurance	
12.	Guardian of Safe Working Hours (Junior Doctors) Quarterly Report Quarter 4 2022/23 & Annual Report 2022/23	Assurance		**20.**	Sub Committee Chair Reports & Terms of Reference	Approval	
13.	Medical Appraisal & Revalidation Quarterly Report	Information					

3. 2023 / 24 Attendance Matrix

Core members	May	Jun	Oct	Nov	Jan	Mar
Gloria Hyatt, Chair, Non-Executive Director	✓					
Louise Martin, Non-Executive Director	✓					
Zia Chaudhry, Non-Executive Director	A					
Michelle Turner, Chief People Officer	✓					
Dianne Brown, Chief Nurse	A					
Gary Price, Chief Operations Officer	✓					
Jen Huyton, Deputy Chief Finance Officer	A					
Liz Collins, Staff Side Chair	✓					
Dyan Dickins, MSC Chair	A					

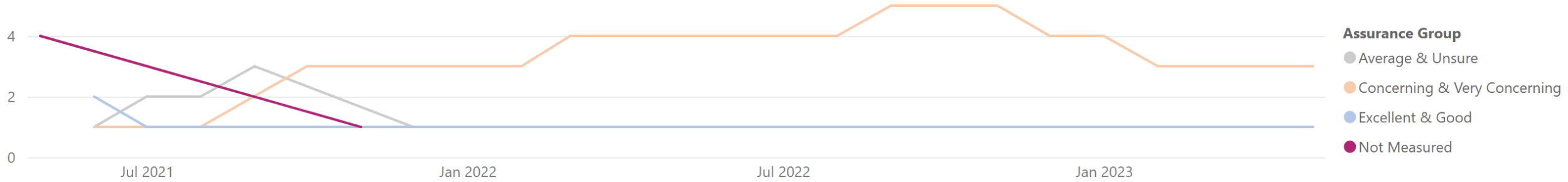
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) Non-Member (NM) *Non-quorate meetings highlighted in greyscale*

Liverpool Women's
NHS Foundation Trust

Trust Board

Workforce Performance Report
June 2023

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

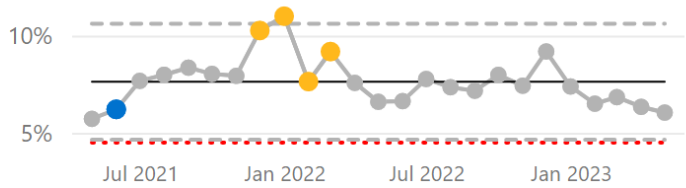


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Turnover Rate	Excellent	May 2023	<= 13%	<=	9.20%	P	L	
Clinical Mandatory Training Compliance	Concerning	May 2023	>= 95%	>=	83.26%	F		
Mandatory Training Compliance	Concerning	May 2023	>= 95%	>=	93.24%	F	H	
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Concerning	January 2023	>= 80%	>=	41.54%	F		
Sickness Absence Rate	Concerning	May 2023	<= 4.5%	<=	6.04%	F		

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

Sickness - Chief People Officer

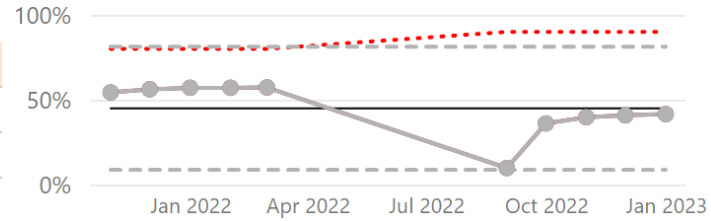
Assurance Category	Concerning
Date	May 2023
Target	<= 4.5%
Target < or >	<=
Performance	6.04%
Assurance	F
Variation	



Sickness fell by 0.30% in May, going down to 6.04%. At a divisional level, it fell in the Family Health and the Gynaecology, but increased in both Clinical Support Services and Corporate divisions. Sickness absence is reviewed on a weekly basis by divisional management teams with a particular scrutiny of return to work meetings which are seeing an increase in compliance. All divisions are now producing monthly infographics to visualise for staff the levels and impact of sickness absence.

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

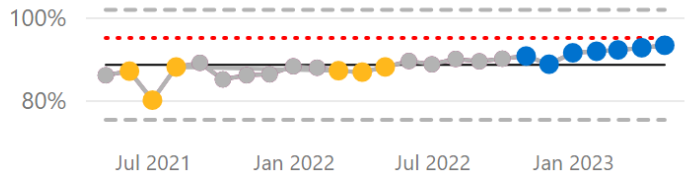
Assurance Category	Concerning
Date	January 2023
Target	>= 80%
Target < or >	>=
Performance	41.54%
Assurance	F
Variation	



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

Mandatory Training Compliance - Chief People Officer

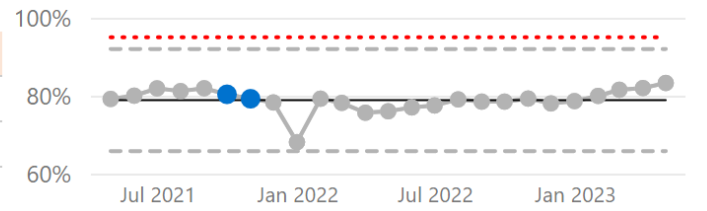
Assurance Category	Concerning
Date	May 2023
Target	>= 95%
Target < or >	>=
Performance	93.24%
Assurance	F
Variation	H



Compliance increased by 0.60% up to 93.24%, which is now just 1.76% below the Trust's target figure of 95%. All the main divisions are now above the target figure except for Family Health, who increased to 90.01% this month. Compliance continues to be reviewed on a weekly basis by divisional management teams, with 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	May 2023
Target	>= 95%
Target < or >	>=
Performance	83.26%
Assurance	F
Variation	



Compliance increased by 1.30%, giving a Trust-wide figure of 83.26%. While there were increases in Clinical Support Services and Family Health, there were smaller decreases in Corporate and Gynae Divisions. The main concern remains Family Health where compliance is at 77.63%. Compliance continues to be reviewed on a weekly basis by divisional management teams, with a specific focus on those individuals who have competencies that expired over 12 months ago, or have never been completed.

COVER SHEET				
Agenda Item (Ref)	*23/24/089c*		Date: 13/07/2023	
Report Title	Review of Culture and Staff Engagement at LWH			
Prepared by	Rachel London, Deputy Director of Workforce			
Presented by	Rachel London, Deputy Director of Workforce			
Key Issues / Messages	***This paper provides an overview of the key themes and associated actions from the Big Conversation undertaken in April 2023, as well as relevant data from the sources outlined above, to provide the Board with a temperature check of levels of staff engagement, and assurance that this remains a priority area of focus for the organisation.***			
Action required	Approve ☐	Receive ☒	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): NA			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to note the contents of the paper and the ongoing commitment to Big Conversations as an important tool of staff engagement at LWH.			
Supporting Executive:	Michelle Turner, Chief People Officer			

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

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

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* BAF RISK 1	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: 1704	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
NA			

EXECUTIVE SUMMARY

In April 2023 Trust Board received an update on the key themes and trends emerging from the 2022 Staff Survey. The national annual staff survey is supplemented by local surveys, bi-annual Big Conversations and local communication and involvement mechanisms; all essential tools to gauge levels of staff motivation and engagement.

This paper provides an overview of the key themes and associated actions from the Big Conversation undertaken in April 2023, as well as relevant data from the sources outlined above, to provide the Board with a temperature check of levels of staff engagement, and assurance that this remains a priority area of focus for the organisation.

MAIN REPORT

1. Introduction

LWH has been on a journey in respect of a gradual improvement in staff engagement, notably we were recognised as the joint most improved Trust within the 2022 Staff Survey.

The Big Conversation has proved an important tool to practically gather staff feedback but also to demonstrate a commitment from the Board to building relationships with specific areas and being able to support them to deliver improvements over time. The challenge for any engagement initiatives is sustaining them and ensuring that Divisions take action on the feedback received as part of the Big Conversation. To date, the structures put in place appear to be delivering positive results in respect of staff feeling listened to and involved.

2. Factors Driving Engagement

Engagement is intrinsically linked with both productivity and discretionary effort, as well as with staff retention. The *NHS Long Term Workforce Plan* highlights the need to make the NHS 'People Promise' a reality for staff, recognising the differing needs of the workforce in terms of generational difference and career stage. Existing activities pertaining to staff engagement and retention are already broadly aligned to these recommendations and will be developed further with a specific focus on Nursing and Midwifery Retention.

3. Channels of two- way communication to improve engagement

Existing Trust wide processes and forums established over the last 24 months continue to function well but require constant monitoring and reinforcing to ensure that they continue to be active and relevant.

- **Twice-yearly Big Conversations**
- **Great place to Work Group (LWH Staff Forum) –** this group involves staff representative from every team who can feedback from colleagues, receive information and feedback on trust proposals.
- **Staff Networks** (Race, Disability and Pride) are becoming more active and sharing valuable feedback about staff experiences within these protected groups.
- **Three key messages** – the most important messages from the annual staff survey are agreed between the head of culture and staff experience, deputy director of workforce and the staff side chair and shared with all staff in a visible, easy to read way. Survey data is also shared with directorates in an easy-to-understand format.
- **People Pulse** LWH will take part in a national survey which runs in the 3 quarters (the national Staff Survey running in the other). Divisions will be provided with breakdowns

At **Divisional Level**, the Trust wide mechanisms should be embedded and supplemented with additional forums. For example, within Maternity there are a number of tools used

- Midwifery forum once per month open to all staff with themed topics,
- Regular listening sessions with the Head of Midwifery
- Department meetings now happen regularly for each department.
- External PMA undertook listening sessions with the Continuity of Care midwives.

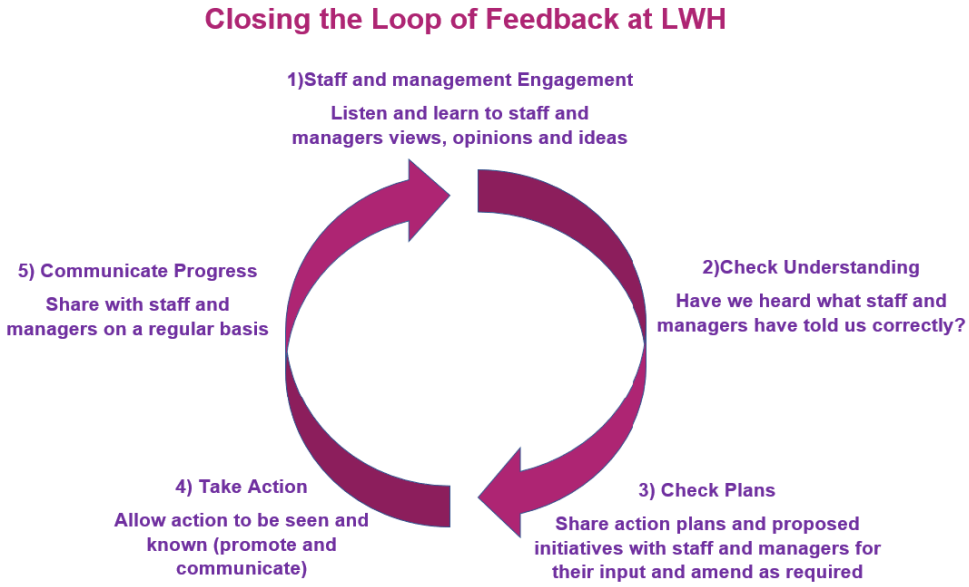
4. Feedback from the Big Conversation

The third LWH Big Conversation took place on 18th and 19th of April. A range of Executive and Non-Executive Directors visited every department in the Trust, as well as Aintree, Knutsford and Community Midwifery and asked two key questions

What is brilliant about your team / department?
What would you like to see change, to make things even better?

Departments were advised in advance of the visits and whilst some requested visits on alternative days, the momentum and impact of condensing most visits into a 24-hour period is concluded to be more effective.

Following the Big Conversation, Divisions have been provided with their local feedback to enable them to carry out feedback and communications based on the theme of *You Said, Together We Will* and ensuring the feedback loop is closed.



General Themes raised in the Big Conversation April 2023

Cross Divisionally, there were some common themes raised, both positive and negative, however encouraging to see positive messages regarding line management and leadership as this is critical for staff engagement.

✓ **Staff felt confident to speak up**
✓ **Wellbeing Conversations taking place**
✓ **PDR helpful (preceptorship midwives)**
✓ **Positive feedback for Leadership Programme**
✓ **Team working**
✓ **Team meetings happening**
✓ **Staff Support Team / Staff Psychologist**
✓ **Good induction and onboarding processes**
✓ **In general positive feedback about flexible working options and ability to swap shifts**

X Lack of IT equipment
X Pay (wider NHS issue)
X Speed of decision making
X Access to rest and recreation facilities
X Quality of PDR (though some positive comments)
X Need 1-1s with line manager (clinical areas)
X Being moved around due to staffing
X Need rotas further in advance and need rest periods between days and nights
X Need more food choices at night, bread and milk should be provided to staff

In terms of **general actions** to address these themes, the following are ongoing

- Great Place to Work Group and the Charity have worked together to revamp the conservatory and outdoor space
- Review of Line Management Structures within maternity to improve access to manager, PDR and 1-1s.
- E-PDR launched for all staff in June 2023.
- Review of e-roster metrics for publication at Board level
- A pilot of staff breakfast items across all clinical areas is ongoing

In relation to specific feedback and Divisional Actions, please see below:

Area	Issue	Feedback
Imaging	Lack of rest facility for on call radiographers who are called out multiple times at night	Resident on call room has been identified and is awaiting furnishing
Imaging	Access to Work Equipment	HR working with the DAWN (Disability network) on project to improve awareness of reasonable adjustments and the Access to Work procurement process.
Imaging	Vacancies within Sonography	Recent successful recruitment, changes to process to allow direct entry sonographers.
Gynaecology	Band 2 HCAS undertaking Band 3 HCA work	A review has been undertaken and changes to bands are being implemented.

Gynaecology Admin	Feel there is a lack of thanks and appreciation from managers such as excellence awards or team of the month More recognition for the service as it is all about 'mothers and babies'	Managers to review current reward and recognition schemes.
Maternity Base	Workload, pressure to discharge	A number of changes to process have been implemented through the Matbase Improvement Group.
Maternity General	Concerns about delayed induction of labour	MLU redesign and estate piece of work ongoing
Maternity General	Need breaks, need sleep pod	Sleep pod being implemented
Maternity General	Need more career opportunities and development for Band 6s	'Postceptorship' programme in development
MAU	Universal positive feedback about ward manager and matron	NA
Gynaecology Ward	Need involvement in TOG meeting to ensure appropriate staffing levels Ward manager making **positive** changes	Gynaecology leadership team to action

Divisional Plans to improve Engagement

Each Division has a Divisional People Plan to identify and drive forward divisional priorities within the people agenda. Elements relating to staff engagement are summarised below:

Gynaecology

- Completion of Exit interviews and analysis of data reviewing hotspots or issues.
  Completion of stay conversations with staff.
- Improve wellbeing offers within the department.
- Identify wellbeing/engagement champions in departments to support improvements
- Continue to work with L & OD with regards to any interventions or development work to improve morale and engagement.

Clinical Support

- Effective onboarding and induction for all new starters and internal appointment
- Ensuring STAY conversations take place where appropriate and exit interviews offered to all leavers
- Quality PDR's take place to aid retention to ensure development needs are met
- Development of roles to aid retention

Family Health

- Reduce the reliance on temporary staffing solutions including bank staff
- Retention activity for those with 3-5 years of career service
- Engage in annual talent mapping process; developing a succession plan for critical and hard to fill roles
- Develop a succession plan for the services management team B7 and above (in line with PDR window)

- Engage in ongoing / consistent / standardized two-way communication channels for colleagues via Weekly 3 key messages (Trust/Divisional) Regular PMA two-way feedback, Monthly HR drop-in sessions (HR Advisor), Monthly workforce dashboards, stay Interviews (link to retention strategy)

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

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

- Over 100 staff have completed a Management and Leadership Programme
- All managers offered a coach or mentor
- Launch of Staff Support service giving access to on site psychological support and introduction of wellbeing coaches
- Investment in new roles – such as Advanced Practitioners and Physicians Associates, Deputy Ward Manager roles, and Out of Hours Site Managers
- New ways of working in clinical areas such as discharge coordinators
- Flexible working opportunities increasing – all areas of maternity can make unlimited requests
- Improvements to mandatory training reporting, data and validation
- Manager checklist to help onboarding of new starters
- More support from volunteers in clinical areas
- Preceptorship programme to support and retain our newly qualified midwives
- Menopause Club and Wellbeing Days in clinical areas
- Departmental Staff Apps to improve communication in Neonatal
- Growth of the Great Place to Work Group where staff can share good practice and make suggestions about improving staff experiences
- Growth of the REACH and DAWN staff networks for staff from racially minoritised groups or who have disabilities
- Award of 34th place in Inclusive Companies Award
- Banding increases for Health Care Support Workers and roll out of the Care Certificate and career development pathways
- Improvements to staff facilities including staff rooms and rest areas.
- New policies to give staff more time off and support for fertility treatment and in the event of baby loss

6. Summary and next steps

Following the loss of the dedicated post focusing on Staff Experience, responsibilities have been divided between the HR team who remain committed to an ongoing improvement in staff engagement working closely with Divisional colleagues to achieve this. The programme of activities continues with the next Big Conversation taking place in September 2023.

Our Engagement Plans for 2023/24

- ✓ Big Conversation 18th April – 1st May. Executive Director, NED and Senior leader walk about
- ✓ April's Let's Talk Survey – temperature check
- ● Continue to close loop of feedback and checking understanding with staff
- ✓ 3 Key Messages
- ✓ Great Place to Work Group
- ✓ Staff Inclusion Networks – Pride@LWH, REACH and DAWN
- ● July Let's Talk Survey – temperature check
- ● Big Conversation – September 2023 to check how actions are landing and any new emerging themes
- ● National Staff Survey – October 2023
- ● January Let's Talk Survey – temperature check

7. Recommendations

The Board is asked to note the contents of the paper and the ongoing commitment to Big Conversations as an important tool of staff engagement at LWH.

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
31 May 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• The Committee noted the following matters from the operational performance report:
  ○ enhanced cancer performance management to address the the cancer targets.
  ○ increasing demand for Hysteroscopy and noted that the Trust had requested mutual aid support from the region. The Trust had also commenced a training programme for internal consultants and specialist nurses to improve capacity.
• The Committee was informed that for Month 1 2023/24, the Trust was reporting an overall net position of £1,538k deficit, which was a £1k favourable variance against the submitted plan of £1,539k. It was noted that final budgets would be issued from Month 2.
• Delivery against the planned CIP target for 2023/24 of £8.336m, of which there remained £2.9m of unidentified CIP.
• The Committee received a business case to access capital funding in order to develop and expand existing ambulatory capacity. The Committee approved the submission of the case to CMAST with the caveat that commissioners agree to fund all activity articulated above the current funded baseline.
	• The Committee received the Revenue and Capital Budget for 2023/24. The key risks to the Trust in terms of short-term cash management and longer-term financial sustainability were highlighted and discussed by the Committee. The Committee noted that the Drivers of Deficit programme of work had commenced, with each workstream overseen by an executive sponsor, to identify savings to support the revenue and capital budget in both the short and long term.
	• The Committee took assurance from the progress within the programme activities underway for digiCare EPR Programme noting the key risks to project delivery. The Committee noted continued flexibility of the programme team to deliver training and to manage significant training DNA rates. It was noted that an extraordinary Corporate Risk Committee meeting date had been scheduled to consider the risks in relation to EPR as part of robust governance arrangements.
	• The Committee received a verbal update on the Crown Street Community Diagnostic Centre (CDC). It was noted that an options appraisal report had been prepared to be considered by the Executive Committee that afternoon, and a subsequent report including a preferred option would be submitted to the next FPBD Committee meeting.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• The Committee noted positive improvement against the Better Payment Practice Code (BPPC) target as the team achieved 95% for invoices by value in Month 1. (WELL LED) • Noted that the Quality Impact Assessment process was being utilised as part of the vacancy control process when considering the option to withhold recruitment to vacant posts. (ALL) • Received the unaudited draft annual accounts 2022/23 and agreed that they were consistent with the monthly financial reporting to the Committee. (WELL LED) • The Committee received the annual Skills Development Network Accreditation update noting the achievements to date as the Finance Team, Procurement Team, and Digital Services Team continue to develop their teams against the scheme. (WELL LED)	• The Committee remitted a Chair action to the Putting People First Committee to undertake a deep dive into actions taken to address persistent high levels of sickness absence in midwifery. • The Committee recommended the Annual Estates and Facilities Compliance Report, subject to identified additions and amendments, to the Board of Directors. • The Committee recommended the revised FPBD Committee reporting structure subject to minor amendments to the Board of Directors.

Summary of BAF Review Discussion (Board Committee level only)

- The Committee received the BAF 2023/24 register, noting three risks aligned to the Committee: Risk 4, Risk 5, and Risk 6.
- The Committee agreed that BAF Risk 6 should be reviewed due to the current risk score and the target risk score being the same. It was agreed to review the narrative and scores ahead of the next meeting.
- Noted a review of action taken within the BAF risk narrative.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- All matters on the meeting agenda discussed fully; with active participation by and constructive challenge from all attendees in relation to the proposed actions and recommendations in each of the papers presented to the committee.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
27.	Review of BAF risks: FPBD related risks	Assurance	34.	Community Diagnostic Centre 2023/24	Information
28.	Operational Performance Report Month 1 2023/24	Assurance	35.	Crown Street Enhancements Programme Update	Approval
29.	Finance Performance Report Month 1, 2023/24	Information	36.	Skills Development Network Accreditation (annual)	Information
30.	Revenue and Capital Budget Approval 2023/24	Approval	37.	Annual Estates and Facilities Compliance Report	Assurance
31.	Operational Plan 2023/24: Narrative Summary	Information	38.	Delivery Net Zero NHS and Trust Green Plans – *report deferred*	Assurance
32.	Review of unaudited draft Annual Accounts 2022/23 (prior Audit)	Information	39.	FPBD Committee Reporting Structure	Approval
33.	Digital Services Update	Assurance	40.	Sub-Committee Chairs Reports	Assurance

3. 2023 / 24 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Louise Martin, Non-Executive Director (Chair)	✓	✓									
Tracy Ellery, Non-Executive Director	✓	✓									
Sarah Walker, Non-Executive Director	A	✓									
Jenny Hannon, Chief Finance Officer	✓	✓									
Kathryn Thomson, Chief Executive	✓	✓									
Gary Price, Chief Operations Officer	✓	A									
Dianne Brown, Chief Nurse	✓	✓									
Matt Connor, Chief Information Officer	✓	✓									

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

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
28 June 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• The Committee noted the following key matters from the operational performance report:
  ○ Increasing demand pressures on Theatre Waits. Theatre and Outpatient Improvement Programmes were underway to focus on improvement. It was noted that elective work had been impacted by industrial action.
  ○ Cancer Metrics: the overall size of the waiting list (due to a 30% increase in referrals) and 28-day diagnostic delays continue to be the main challenge resulting in a poor 62-day performance. The Trust is meeting with NHSE and the Cheshire and Mersey Cancer Alliance end of June 2023 to review the plans. The 2-week target had been challenged with industrial action however had recovered in Month 2 and the 31-day decision to treat target was good.
• The Committee noted the following key matters from the Finance performance report for Month 2 2023/24:
  ○ Whilst the Trust is reporting an overall net position of £3,078k deficit, which was a £2k favourable variance against the submitted plan, this position is supported by £1.7m of non-recurrent items. The Committee expressed concern with regards to the non-recurrent amount and the anticipated run rate and requested escalation action taken by the Executive Team to be shared with the Committee.
  ○ Cash Balance: is below the minimum level set out in the Treasury Management Policy, however the average balance through the month was within the range. The Trust will require cash support in June 2023.
  ○ CIP fallen short of the YTD target by £293k. At present the Trust is forecasting to deliver to plan, however £2.9m of the £8.3m target currently remains unidentified.
• The Committee received an options paper for the operations of the Crown Street Community Diagnostic Centre (CDC) in 2023/24 and further updated financial information was tabled at the meeting. Sensitivity analysis had been undertaken, costs of overheads included, and decommissioning options provided. Each Committee member was invited to provide an opinion against the options provided. A majority of the Committee supported the recommendation to proceed with an option to pursue a 5-day model, worked over weekends 8am – 8pm with a top-up enabling weekend provision for 5 months (only). Whilst this option still does not fully contribute the expected levels of income required to fulfil standard service
	• The Committee received an update regarding development of the Cheshire and Merseyside (C&M) Finance Strategy and 3-year recovery plans. The Trust's developing Finance Strategy would be aligned to the C&M plans. The Committee noted the development of a recovery plan, alongside a requirement for increased reporting to the ICB.

development finance criteria (i.e., makes a full contribution to Trust overheads), it does provide a positive financial contribution in 2023/24 to the overall Trust overheads that have already been accounted for. The Committee supported the overarching principles of collaborative system working but expressed its' disappointment at the current imbalance of risk sharing which requires individual Trusts to retain all risks associated with performance (activity, staffing and costs). The Committee noted that this revised Option 4 proposal would require re-visiting by the Trust Board once the additional top-up funding for 5 months of weekend provision expires. The report and committee comments would be shared with the Trust Board for formal agreement in July 2023.	
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• Urgent Care: targets continue to be improving; with the 4-hour emergency department target showing sustained good performance and the MAU triage time also improving. It was noted that the MAU triage time will move from 30 minutes to 15 minutes in July 2023, in line with national safety indicator targets. • Gynaecology Elective recovery: targets continue a positive trajectory in line with the 2023/24 plan. Both the 65 weeks wait and the 52 weeks wait metrics continue to perform better than the anticipated trajectory. It was noted that the division was planning to step down the insourced clinical support for gynaecology elective work by the end of June 2023. • The Committee took assurance from the progress within the programme activities underway for DigiCare Electronic Patient Record (EPR) Programme noting readiness, cutover plans and key risks to project delivery. The Committee was assured by the governance and preparedness of the Digital Team to go-live with EPR in July 2023. (ALL) • Received a presentational estates and facilities update which detailed progress against creating a mechanical and electrical services (M&E) and Fabric Asset Register and creating comprehensive planned preventative maintenance (PPM) schedules. (ALL) • The Committee noted the Post Implementation Review of the Crown Street Community Diagnostic Centre (CDC) from implementation to completion and lessons learnt. (WELL LED) • Received the Trust self-assessment against the Healthcare Financial Management Agency (HFMA) Sustainability Checklist. This had been audited by Mersey Internal Audit Agency (MIAA) as required. Progress against the actions within the checklist would be monitored by the Financial Recovery Board. (WELL LED) • The Committee received and had been assured by the Security Management Annual Report 2022/23. (ALL) • Received a presentational update against the NHS and Trust Green Plan. Development through year 1 and plans for year 2 noted. (WELL LED)	• The Committee considered the request to renew the Digital Maternity contract and requested additional narrative on the purpose and benefits of renewing the contract. The paper would be updated and submitted to the Trust Board for discussion and approval in July 2023. • A Committee majority support to proceed with the revised Option 4 of the Crown Street Community Diagnostic Centre proposal for the first five months of 2023/24. Updated paper and Committee feedback to be shared with the Trust Board in July 2023. • The Committee approved the Digital Hospital Sub-Committee Terms of Reference and the Access Sub-Committee Terms of Reference.
Summary of BAF Review Discussion	

2

(Board Committee level only)
• The Committee reviewed the related BAF risks. No risks closed on the BAF for FPBD Committee. • The Committee noted the review undertaken of BAF Risk 6 subsequent to Committee comments in May 2023 and approved the change of the risk score. • It was noted that an additional BAF Risk 7 - Failure to meet patient waiting time targets, had been introduced by the Quality Committee to disaggregate BAF Risk 3. The risk would be owned by the Quality Committee and reported to the Finance Committee due to the subject matter.
Comments on Effectiveness of the Meeting / Application of QI Methodology
• All matters on the meeting agenda discussed fully; with a range of topics covered and debate not focussed solely on 'finances', indicating a positive approach to consider full scope of reports.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
49.	Review of BAF risks: FPBD related risks	Assurance	**56.**	Post Implementation Review of the Community Diagnostic Centre 2022/23	Information
50.	Operational Performance Report Month 2, 2023/24	Assurance	**57.**	Crown Street Community Diagnostic Centre Options Paper	Information
51.	Finance Performance Report Month 2, 2023/24	Information	**58.**	HFMA Sustainability Checklist Update	Information
52.	C&M Finance Strategy	Information	**59.**	Security Management Annual Report	Information
53.	Digital Services Update	Assurance	**60.**	Delivery Net Zero NHS and Trust Green Plans	Assurance
54.	Digital Maternity Contract Review	Approval	**61.**	Sub-Committee Chairs Reports	Approval
55.	External asset survey on the estate	Information			

3. 2023 / 24 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Louise Martin, Non-Executive Director (Chair)	✓	✓	✓								
Tracy Ellery, Non-Executive Director	✓	✓	✓								
Sarah Walker, Non-Executive Director	A	✓	A								
Jenny Hannon, Chief Finance Officer	✓	✓	✓								
Kathryn Thomson, Chief Executive	✓	✓	A								
Gary Price, Chief Operations Officer	✓	A	✓								
Dianne Brown, Chief Nurse	✓	✓	✓								
Matt Connor, Chief Information Officer	✓	✓	✓								

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

Charitable Funds Committee Chair's Highlight Report to Trust Board
22 June 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee noted that overall fund balances had fallen during 2022/23 in comparison to 2021/22, principally due to a fall in the market value of investments, although there had been some recovery towards the end of the year. The impact of the economic downturn and rising prices during the year has had a significant impact on the charitable sector. • The Committee noted that fundraising expenses had been higher during 2022/23 which was due to investment in higher profile events, for example Strictly 2022. • The Committee deferred a subsequent funding application for expenditure for equipment (Mona Lisa Laser) due to insufficient information provided. Additional detail in relation to the Mona Lisa Laser application was requested, particularly clarification of any ongoing revenue costs, and sight of the business case.	• Received a presentational update of investment performance noting movement from UK equity to Overseas equity as a key trend across the industry. It was proposed that an Overall Equities asset be established to include both UK Equities and Overseas Equities to widen the range available to invest. • The Committee noted the Charity total income for 2022/23 at £374k in year. The final accounts would be subject to independent examination and would be presented in full to the next Committee meeting. • Noted the plan to develop a legacy strategy. A legacy stream alongside other fundraising performance would be included within the quarterly charity financial reports. • Received the draft Charitable Funds Strategy 2023-2027. The Committee provided feedback on the narrative to offer additional clarity ahead of submission to the Board of Trustees.
Positive Assurances to Provide	**Decisions Made**
• Completed Fundraising Projects: Conservatory and Garden project had been completed and officially opened on 19 May 2023 by the Deputy Lieutenant for Merseyside. Ongoing fundraising for the Bereavement suite and the Neonatal flats refurbishment were noted. • Investment restrictions include no direct investment in tobacco, armaments, or oil and gas stocks. Clarification as to restrictions in relation to manufacturing of formula milk was requested. • The Committee had been assured by the Costs and Assumptions Review noting the revised process for accepting, approving, and monitoring fundraising projects and related expenditure. The revised process would ensure full engagement of relevant departments, divisional sign-off of projects, named leads and Committee oversight throughout. • The Committee received the benchmarking review of financial service support costs in comparison with local NHS Charities, with information taken from published 2021/22 accounts. The Committee agreed that the amount recharged to the Charity for financial service support was reasonable. • Positive assurance taken from the impact review of Charitable Fund Applications actioned during 2022/23. It was recommended that the team utilise the post implementation review templates for future reporting.	• The Committee approved the appointment of Dame Lorna Muirhead as Patron of the Charity. • Charitable Funds Strategy 2023-2027 to be submitted to the Board of Trustees for approval (post the next Committee meeting). • The Committee recommended approval to the Board of Directors the: Committee Annual report, Terms of Reference and Business Cycle for 2023/24, recognising a change to the timetable of meetings in year. • Fundraising Staffing report remitted to the Executive Team to consider.

• Received a position update against the recently published HFMA report "Streamlining NHS Charitable Funds." The Committee noted ongoing work to meet with fundholders and review the activity and purpose of existing funds.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Commented on the rescheduling of meeting dates to accommodate reporting requirements from the team.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
06.	Investment Position Update	Information	**11.**	Process of Legacy Donations	Information
07.	Quarterly charity and finance integrated report	Information	**12.**	Draft Liverpool Women's Charity Strategy 2023 - 2027	Information
08.	Costs and Assumptions Review	Assurance	**13.**	HFMA Briefing – 'Streamlining Charitable Funds'	Information
09.	Financial Services Support Costs: Annual Benchmarking Review	Information	**14.**	Committee Annual Report, including Terms of Reference and Workplan 2023/24	Approval
10.	CF Applications Impact Annual review	Information	**15.**	Fundraising Staffing	Approval

3. 2023/24 Attendance Matrix

Core members	June 2023	October 2023	January 2024
Zia Chaudhry (Chair), Non-Executive Director	✓		
Louise Martin, Non-Executive Director	✓		
Jackie Bird, Non-Executive Director	A		
Jenny Hannon, Chief Finance Officer	A		
Jennifer Huyton, Deputy Chief Finance Officer	✓		
Dianne Brown, Chief Nurse	✓		
Matt Connor, Chief Information Officer	A		
Claire Deegan, Head of Financial Services	✓		
Kate Davis, Head of Fundraising	✓		

Liverpool Women's
NHS Foundation Trust

Charitable Funds Committee

Annual Report 2022/23

Background

This report covers the period April 2022 to March 2023. There were three meetings held during this period. The September 2022 Committee was cancelled as this was the date of the State Funeral of Her Majesty Queen Elizabeth II. The meeting was rescheduled and took place early October 2022 therefore all matters could be approved within a timely manner. Subsequently only three of the four planned meetings took place.

The Committee has been established to exercise the Foundation Trust's functions as sole corporate trustee of the Liverpool Women's Charity (registered charity number 1048294). The Trust Board is regarded as having responsibility for exercising the functions of the Trustee. The Trust Board delegates these functions to the Committee, within any limits set out in these terms of reference and the sections of the standing financial instructions pertaining to charitable funds.

In discharging these duties, the Committee is responsible for:

Compliance

a. Manage the affairs of the Liverpool Women's Charity in accordance with appropriate legislation and ensure statutory compliance with the Charity Commission regulations.
b. Ensure systems and processes are in place to receive, account for, deploy and invest charitable funds in accordance with charity law.
c. Scrutinise requests for use of charitable funds to ensure that any such use is in accordance with the aims and purposes of any charitable fund or donation and are clinically and ethically appropriate. Committee members will bear in mind due diligence to Charity Commission and Trust guidance regarding the ethical use of funds and acceptance of donations.

Budget, Income & Expenditure

d. Review and approve an Annual Business plan and budget
e. Receive and approve periodic income and expenditure statements, ensuring that performance is in line with the Charity's budget and plan.
f. Receive and consider the Annual Accounts including the Annual Report from the auditors, before submission to the Board of Directors for approval.

Fundraising

g. Ensure a fundraising strategy is prepared and monitored which complies with Charity Commission guidance and legislation and which includes appropriate communication and marketing plans;
h. ensure systems and processes are in place to receive, account for, deploy and invest funds raised in accordance with charity law;
i. ensure systems, processes and communication are in place around fundraising, staff engagement and funding commitments;
j. ensure a cohesive policy around external media and communication;
k. encourage a culture of fundraising and raise the profile of the Charity within the Trust and with external partner organisations
l. ensure effective communication regarding 'whistleblowing' relating to fundraising, donations or subsequent use of funds.

Investment Management

m. Consider and agree an investment strategy for the safe and secure investment of funds not immediately required for use, taking into account any appropriate ethical considerations.
n. Appoint and review external investment advisors and operational fund managers.
o. Review the performance of investments on a regular basis (utilising comparator information) with the external investment advisors to ensure the optimum return from surplus funds.

This remit is achieved through the Committee being appropriately constituted and complying with the duties delegated by the Board of Directors through its terms of reference.

Constitution

The Charitable Funds Committee is accountable to the Board of Directors. Membership during the year comprised:

- Non-executive Director Chair
- Two other Non-executive Directors
- Chief Finance Officer (or nominated deputy)
- Chief People Officer
- Chief Nurse & Midwife
- Financial Accountant
- Head of Fundraising

Meetings were also attended by other executives and senior management staff as appropriate.

The Committee's constitution allows for members to participate by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference. Due to the Covid-19 pandemic meetings had been held virtually during 2021/22. This practice continued into 2022/23, and all meetings were held virtually utilising Microsoft Teams.

The Terms of Reference requires that all members of the committee attend a minimum of 75% of the meetings held. The table at appendix 1 lists the names of the members

of the Committee and the meetings they attended during 2022/23 together with the names of senior management who were invited to attend during the year. The majority of members attended 75% or more of the meetings during 2022/23.

Key achievements / activity

The key items discussed and reviewed by the Committee during 2022/23 were as follows:

- Regular investment updates have been received from the Charity's Fund Manager. Assurance has been provided on the delivery of fund performance despite the market volatility brought about by the pandemic and war in Ukraine.
- Ethical implications of investments made on behalf of the Charity considered and positive direct disinvestment from the oil and gas industry during 2022/23.
- Regular reports have been received on the financial performance of the charity
- Review of the Charitable Funds Annual Report and Accounts and recommendation for approval by the Trust Board.
- Development of the Fundraising Strategy and convening a Fundraising Away Day and a Board development session to take forward.
- Key successful fundraising appeals and events, for example, the Bereavement Suite and Mona Lisa Laser appeals and the introduction of the Strictly event and Challenge events.
- The establishment of charity related risks introduced to the Trust corporate risk process. The risks were reviewed by the Committee on a regular basis.
- The Committee received the annual benchmarking review of the provision of financial services to the Charity. Assurance was received by the Committee on value for money.
- Approved application requests for expenditure of charitable funds as required.
- The Committee received the annual Impact Assessment review against the application of charitable funding across the Trust for staff and patients. The positive benefits demonstrated upon patient and staff wellbeing and improved areas of hospital estate was acknowledged.
- Review of fundraising team expenditure received

Chair Log
The Committee had utilised the Chairs Log during 2022/23 and had received zero chair actions and delegated a total of 2 chair actions to the Trust Board/Committees during 2022/23 to seek additional assurances.

Areas for Development

For the second time, an effectiveness survey was circulated to members of the Committee seeking feedback on the activity of the Committee during 2022/23. On the whole, the responses received were positive – the full results can be seen in Appendix 2. There were mixed results on the following questions:

- Qu 3 - I am confident that the committee effectively monitors and scrutinises progress against the aligned strategies: *The strategy/objectives of the charity were being refreshed so as a member for a short time I cannot confirm this.*

- Qu 8. Written reports received enable the Committee to hold informed discussions on key issues with clarity on the root causes of challenges, and a shared understanding of the pros and cons of the various options being put forward as potential solutions? *There have been instances when the reports submitted are long and the key points are not clearly highlighted in a summary. Alignment with Trust templates for some areas would be beneficial. Occasionally problems have been highlighted or solutions suggested before there has been discussion by the Charity team with others in the Trust i.e. IT or Finance.*

The following narrative observations were provided on the survey:

- *The Committee meeting dates need to be revised to ensure that they do not clash with busy times for the Finance team such as Annual Accounts or the quality of reporting suffers. When the Charitable Accounts and Annual Report come to the Committee they must be accompanied by the Investigating Accountant's Report/ Letter to give better assurance. Dialling in to the meeting to give this assurance and discuss the process would be an improvement too. The Autumn meeting needs to be timed to accommodate this. The Charity Fundraiser must be at the Committee meetings. The dates must take account of the post holder's booked leave but once meeting dates have been agreed attendance is expected which has not always been the case this year. The strategy needs agreeing to give a framework against which the Committee can set a work plan and measure progress.*

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in March 2022 and were approved by the Board in April 2022.

Other than housekeeping amendments e.g. updating of job titles, the membership has been revised to add the Chief Information Officer and remove the Chief People Officer. No other amendments are suggested.

The draft Terms of Reference is included at Appendix 3.

Proposed Amendments to the Committee Business Cycle

Each of the Committees established by the Board of Directors has an annual business cycle which is subject to review each year. The business cycle forms the 'core' agenda for Committee meetings throughout the year with scheduled business ensuring that the Committee discharges its responsibilities as set out in the Terms of Reference.

The Charitable Funds Committee last reviewed its annual business cycle in March 2022 and is therefore scheduled to complete a further review in order to set the business cycle for 2023/24.

All members of the Committee had the opportunity to participate in the annual review and propose any amendments to the business cycle and terms of reference during February 2023 by completing the committee effectiveness survey. The Committee

members who responded did not make any suggested amendments to the business cycle or terms of reference.

In addition to the survey, discussions had been held between the Committee Chair, Chief Finance Officer and Trust Secretary to consider means to enhance Committee effectiveness.

A significant review of the workplan had been conducted ahead of 2022/23 and all matters of business had been considered as planned during the cycle of meetings held in 2022/23. No further additions were recommended to be introduced to the business cycle in-year.

During 2022/23, the responsibility of the fundraising team was remitted away from the Chief People Officer into the Chief Finance Officer portfolio. As such any reports on the business cycle against the Chief People Officer as the responsible owner have been transferred to the Chief Finance Officer.

The following additional amendment for the workplan has been made:

- Charity Accounts – timetabling of the draft Charity Accounts moved into Quarter 2, to be finalised in Quarter 3 to align with Trust's own accounts and audit workplan

It is likely that key areas of attention during 2023/24 will be as follows:

- To ensure that the Fundraising Strategy is developed and approved to take forward the future direction of the Charity
- To continue to monitor the level of interdebtedness between the Trust and Charity and explore how to reduce this to zero
- To ensure that fundraising costs do not exceed income a cost and assumption review had been commissioned to provide assurance in 2023/24
- To ensure that there is robust project management in place for the delivery of charitable funded schemes
- To ensure that Charitable Fund activity and spend was aligned with the priorities of the Trust.

The draft Business Cycle is included at Appendix 4.

Conclusion

In the final analysis, it is concluded that the Charitable Funds Committee has achieved its objectives for the Financial Year 2022/23.

Tracy Ellery CHAIR
Charitable Funds Committee
March 2023

Appendix 1

Charitable Funds Committee, Attendance at Committee: April 2022 – March 2023

Core members	**June 2022**	**October 2022**	**February 2023**
Tracy Ellery, Non-Executive Director (Chair)	✓	✓	✓
Louise Martin, Non-Executive Director	✓	✓	✓
Jackie Bird, Non-Executive Director	✓	✓	✓
Michelle Turner, Chief People Officer	A	A	✓
Eva Horgan, Chief Finance Officer (until end Dec 2022)	✓	✓	NM
Jenny Hannon, Chief Finance Officer (as of Jan 2023)	NM	NM	✓
Marie Forshaw, Chief Nurse (until end Aug 2022)	A	NM	NM
Dianne Brown, Chief Nurse (as of 01 Sept 2022)	NM	A	✓
Kate Davis, Head of Fundraising	✓	✓	A
Chris Gough, Financial Accountant	✓	A	NM
Josh Ingman, Assistant Financial Accountant (represent Financial Accountant)	NM	✓	NM
Claire Deegan (represent Financial Accountant)	✓	A	✓

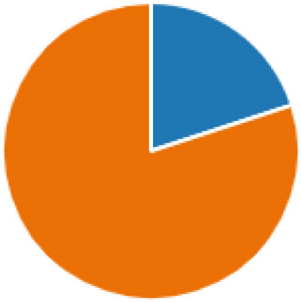
Invited attendees	Job Title	June 2022	October 2022	February 2023
Zia Chaudhry	Non-Executive			✓
David Dodgson	Financial Controller		A	
Mark Grimshaw	Trust Secretary	✓	✓	A
Nadia Alsafaar	Fundraising Manager		✓	
Tony Okotie	Non-Executive	✓		
Tom Holbrook	Investment Director, Investec Management Services		✓	✓
Andrew Maxwell	Investment Director, Investec			✓
Louise Hope	Assistant Trust Secretary	✓		
Hattie Ella Brignal	Fundraising Assistant	✓		
Linda Haigh	Interim Deputy Chief Finance Officer		✓	
Matt Connor	Chief Information Officer			✓

Charitable Funds Committee Effectiveness Review 2022/23

5	05:39	Active
Responses	Average time to complete	Status

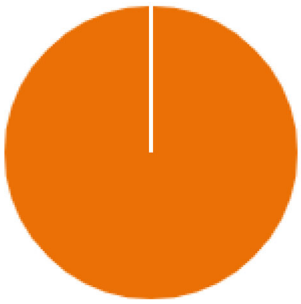
1. I understand the duties of the committee.

Strongly agree	1
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0



2. I believe the committee receives sufficient assurance to conclude upon its areas of responsibility.

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0

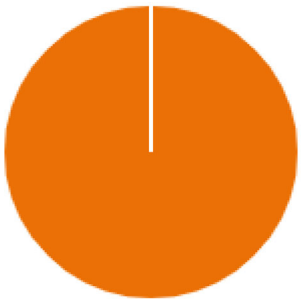


3. I am confident that the committee effectively monitors and scrutinises progress against the aligned strategies.

Strongly agree	0
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	2

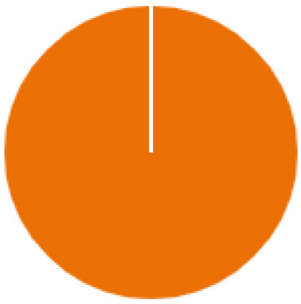
4. I am content that the committee is delivering the right level of assurance to the Board / Committee.

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0



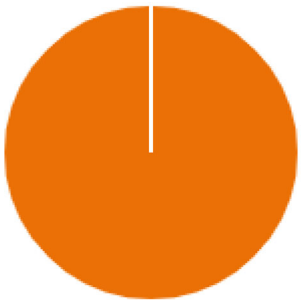
5. I believe that the committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management.

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0



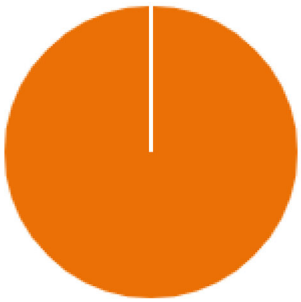
6. I feel that the committee has the right balance of experience, attendance, knowledge and skills to fulfil its role.

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0



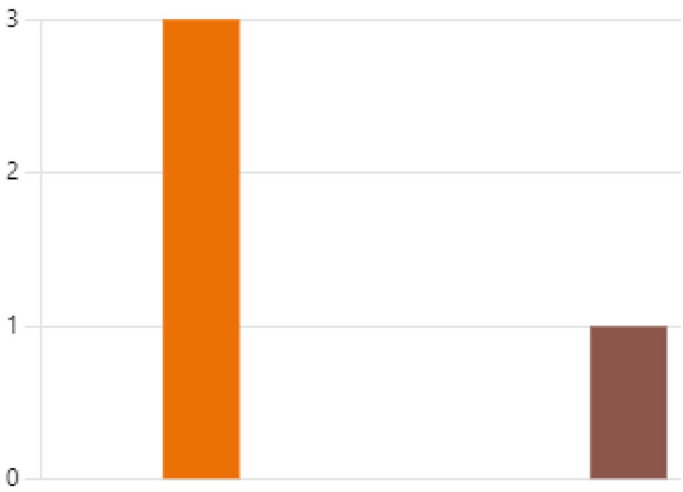
7. The committee has structured its agenda and work plan to cover its key responsibilities.

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0



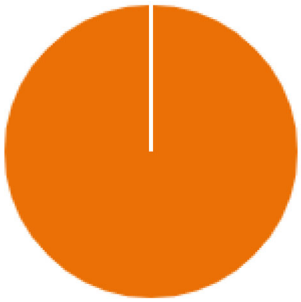
8. Written reports received enable the Committee to hold informed discussions on key issues with clarity on the root causes of challenges, and a shared understanding of the pros and cons of the various options being put forward as potential solutions?

Strongly agree	0
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0
Other	1



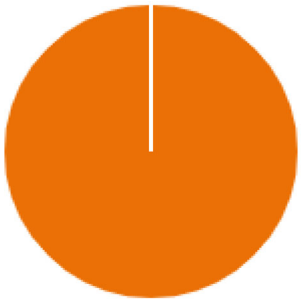
9. The committee is effectively chaired.

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0



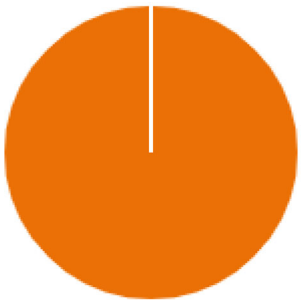
10. All members of the committee are able to participate effectively.

Strongly agree	0
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0



11. There is clarity in relation to the work of the committee and its interaction and alignment with other committees.

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0



12. Any other comments, suggestions or actions.

3

Responses

Latest Responses

"*The Committee meeting dates need to be revised to ensure t...*

8. Written reports received enable the Committee to hold informed discussions on key issues with clarity on the root causes of challenges, and a shared understanding of the

4 Responses

ID ↑	Name	Responses
1	anonymous	["Agree"]
2	anonymous	["Agree"]
3	anonymous	["Agree"]
4	anonymous	["There have been instances when the reports submitted are long and the key points are not clearly highlighted in a summary. Alignment with Trust templates for some areas would be beneficial. Occasionally problems have been highlighted or solutions suggested before there has been discussion by the Charity team with others in the Trust i.e IT or Finance."]

12. Any other comments, suggestions or actions.

3 Responses

ID ↑	Name	Responses
1	anonymous	only attended one
2	anonymous	Question 3, the strategy/objectives of the charity were being refreshed so as a member for a short time I cannot confirm this.
3	anonymous	The Committee meeting dates need to be revised to ensure that they do not clash with busy times for the Finance team such as Annual Accounts or the quality of reporting suffers. When the Charitable Accounts and Annual Report come to the Committee they must be accompanied by the Investigating Accountant's Report/ Letter to give better assurance. Dialling in to the meeting to give this assurance and discuss the process would be an improvement too. The Autumn meeting needs to be timed to accommodate this. The Charity Fundraiser must be at the Committee meetings. The dates must take account of the post holder's booked leave but once meeting dates have been agreed attendance is expected which has not always been the case this year. The strategy needs agreeing to give a framework against which the Committee can set a work plan and measure progress.

NHS
Liverpool Women's
NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee has been established to exercise the Foundation Trust's functions as sole corporate trustee of the Liverpool Women's Charity (registered charity number 1048294). The Trust Board is regarded as having responsibility for exercising the functions of the Trustee. The Trust Board delegates these functions to the Committee, within any limits set out in these terms of reference and the sections of the standing financial instructions pertaining to charitable funds.
Duties:	The Committee's responsibilities fall broadly into the following areas: **Compliance** a. Manage the affairs of the Liverpool Women's Charity in accordance with appropriate legislation and ensure statutory compliance with the Charity Commission regulations. b. Ensure systems and processes are in place to receive, account for, deploy and invest charitable funds in accordance with charity law. c. Scrutinise requests for use of charitable funds to ensure that any such use is in accordance with the aims and purposes of any charitable fund or donation and are clinically and ethically appropriate. Committee members will bear in mind due diligence to Charity Commission and Trust guidance regarding the ethical use of funds and acceptance of donations. **Budget, Income & Expenditure** d. Review and approve an Annual Business plan and budget e. Receive and approve periodic income and expenditure statements, ensuring that performance is in line with the Charity's budget and plan. f. Receive and consider the Annual Accounts including the Annual Report from the auditors, before submission to the Board of Directors for approval. **Fundraising** g. Ensure a fundraising strategy is prepared and monitored which complies with Charity Commission guidance and legislation and which includes appropriate communication and marketing plans; h. ensure systems and processes are in place to receive, account for, deploy and invest funds raised in accordance with charity law; i. ensure systems, processes and communication are in place around fundraising, staff engagement and funding commitments;

	j. ensure a cohesive policy around external media and communication; k. encourage a culture of fundraising and raise the profile of the Charity within the Trust and with external partner organisations l. ensure effective communication regarding 'whistleblowing' relating to fundraising, donations or subsequent use of funds. **Investment Management** m. Consider and agree an investment strategy for the safe and secure investment of funds not immediately required for use, taking into account any appropriate ethical considerations. n. Appoint and review external investment advisors and operational fund managers. o. Review the performance of investments on a regular basis (utilising comparator information) with the external investment advisors to ensure the optimum return from surplus funds.
Membership:	The Committee membership shall consist of the following: • Non-executive Director Chair • Two other Non-executive Directors • Chief Finance Officer (or nominated deputy) • ~~Chief People Officer~~ • Chief Nurse ~~& Midwife~~ • Financial Accountant • Head of Fundraising • Chief Information Officer Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be three members which must include one Executive Director and one Non-Executive Director. The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. **b. Officers** The non-executive Chairman shall normally attend meetings. Other Board members shall also have right of attendance subject to invitation by the Chairman of the Committee. The Fundraiser to attend as required at request of the Committee.

	Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held on a quarterly basis. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. This includes seeking the advice of specialists from within and outside the NHS as appropriate.
Accountability and reporting arrangements:	The minutes of the Charitable Funds Committee shall be formally recorded and a Chair's Report will be submitted to the subsequent Board of Directors for assurance. Approved minutes will be made available to all Board members upon request.
Reporting Committees/Groups	The Charitable Funds Committee has no reporting committees / groups.
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by: Charitable Funds Committee:	May 2023
Approved by: Board of Directors	[*June 2023*]
Review date:	March 2024
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

Charitable Funds Committee	BAF Link	WORKPLAN 2023/24				
				Quarter 1	Quarter 3	Quarter 4
Standing Items		Exec / Senior Owner	⇧ to Board	June 2023	October 2023	January 2024
Minutes of Previous meeting		Trust Secretary		✓	✓	✓
Actions/Matters Arising		Trust Secretary		✓	✓	✓
Chairs Report - Verbal		Chair		✓	✓	✓
Review of risk impacts of items discussed		Chair		✓	✓	✓
Any other business		Chair		✓	✓	✓
Review of meeting		Chair		✓	✓	✓
Review of risks: CFC related risks		Chief Finance Officer		✓	✓	✓
MATTERS FOR DISCUSSION & COMMITTEE						
Charitable Funds Strategy Review		Chief Finance Officer		✓	✓	
Quarterly Charity and Finance Integrated Report		Chief Finance Officer		✓	✓	✓
Approval of Annual Report and Accounts (include independent investigating accountant report/letter with final report)		Chief Finance Officer	✓ (Dec)	~~✓(Draft)~~	✓	
Revenue & Capital Budget for 2023/24		Chief Finance Officer				✓
CF Applications Impact Annual review		Chief Finance Officer		✓		
Review of expenditure - fundraising costs versus other		Chief Finance Officer			✓	
Financial Services Support Costs: Annual Benchmarking Review		Chief Finance Officer		✓		
Investment Report		Investec		✓	✓	✓
Annual review of investments		Chief Finance Officer				✓
~~Fundraising Update~~				~~✓~~	~~✓~~	~~✓~~
Authorisation of funding applications expenditure (as required)		Chief Finance Officer		✓	✓	
Review of Fund Signatories'		Chief Finance Officer			✓	
MATTERS FOR APPROVAL / DECISION						
CFC Terms of Reference		Trust Secretary	✓			✓
CFC Effectiveness Review Annual Report		Trust Secretary	✓			✓
CFC Business Cycle		Trust Secretary				✓

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**23/24/090c**		**Date: 13/07/2023**	
Report Title	**Finance Performance Review Month 2 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	***To receive the Month 2 financial position.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☒**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – If no – please outline the reasons for deviation.			
	The Trust Board is asked to note the Month 2 Financial Position.			
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 ***workforce***	☒		To participate in high quality research and to deliver the most ***effective*** Outcomes	☒			
To be ambitious and ***efficient*** and make the best use of available resource	☒		To deliver the best possible ***experience*** for patients and staff	☒			
To deliver ***safe*** services	☒						

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 5 – Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Finance, Performance and Business Development Committee	28/06/23	Jenny Hannon, Chief Finance Officer	The Committee noted the report.

EXECUTIVE SUMMARY

The Trust has a challenging financial plan for 2023/24 of £15.5m deficit. At Month 2 the Trust is reporting a £3,078k deficit which represents a £2k favourable variance to plan. This position is supported by £1,667k of non-recurrent items. The forecast outturn is £15,427k deficit, which is in line with the submitted plan.

CIP has fallen short of the YTD target by £293k, however at present the Trust is forecasting to deliver to plan. £2.9m of the £8.3m (5.3%) target currently remains unidentified with targeted work underway to address this.

The cash balance was £4,750k at the end of Month 2.

MAIN REPORT

1. Summary Financial Position

	Plan	Actual	Variance	RAG	*R*	*A*	*G*
Surplus/(Deficit) YTD	-£3.1m	-£3.1m	£0.0m		*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast	-£15.5m	-£15.5m	£0.0m		*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0		*4*	*3*	*2+*
Cash	£6.0m	£4.8m	-£1.3m		*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£0.7m	£0.4m	-£0.3m		*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£0.7m	£0.4m	-£0.3m		*>10% off plan*	*Plan*	*Plan or better*
Aligned Payment and Incentive	106%	105%	-1%		*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£0.2m	£1.7m	£1.5m		*>£0*		*<=£0*
Capital Spend YTD	£0.7m	£0.7m	£0.0m				

At Month 2 the Trust is reporting a £3,078k deficit, which represents a £2k favourable variance to plan year to date (YTD). This is supported by £1,667k of non-recurrent items. The forecast outturn is £15,450k deficit, which is in line with the submitted plan.

2. Underlying Position

As noted above, the YTD position is supported by £1.7m of non-recurrent items. The adjusted position in Month 2 (following removal of key non-recurrent items) is a deficit of £4.7m.

The key drivers of the underlying YTD position are:

- CIP and requirement to reduce pay investment (£650k)

- Nursing, midwifery, and support staff pressures (£700k) across maternity, gynae, and theatres (some of which relates to costs of industrial action)
- Medical staffing (£180k); driven by Family Health (some of which relates to industrial action)
- Estates (£100k); energy and soft FM costs
- Admin and clerical (£100k); cost pressures in corporate areas.

A fast pace of change and improvement to underlying run rate is required to enable delivery of the financial plan and the Trust has in replace rapid recovery actions to address this.

3. Divisional Summary Overview

Family Health
The Family Health Division has an adverse variance of £592k YTD, the majority of which relates to Maternity. This is largely driven by pay pressures in medical staffing and midwifery, and agency staffing (caused by sickness, vacancies, and maternity leave).

Gynaecology:
The Gynaecology Division has an adverse variance to plan of £309k YTD, driven primarily by nursing and support staff pay pressures (relating to sickness and pay costs driven by additional activity), and Aligned Payment and Incentive (API) income underperformance (see below for further details).

Clinical Support Services
CSS are £261k adverse to plan YTD, driven by Imaging pay (£121k) in relation to staffing pressures, and theatres pay (£125k), driven by nursing, ODP and support staff costs partially mitigated by a vacancy factor in medical staffing.

The Community Diagnostic Centre position is £28k adverse YTD, driven by income underperformance.

4. Aligned Payment and Incentive (API)

Overall, at Month 2, the Trust has delivered 105% of its adjusted 19/20 baseline, compared to 102% in the same period last year. The average activity target for 2023/24 is 106%, however this assumes activity will phase up throughout the year. Despite this, there is some income underperformance compared to plan. This is driven by the impact of industrial action as well as changing case mix, a shift in activity type from day case to outpatient procedure.

5. Cost Improvement Programme

The Trust has a cost improvement programme target of £8.3m. This equates to 5.3% of expenditure. £2.9m of this target remains unidentified however targeted work is under way to identify this on a recurrent basis.

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

At Month 2, there is an adverse variance of £293k against the £734k target. This is driven by under delivery against non-pay and income schemes.

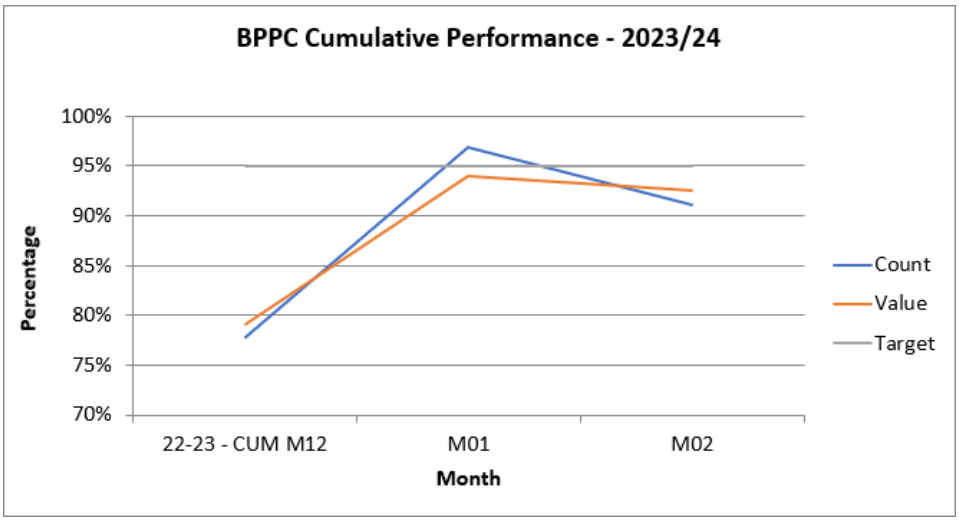
6. Cash and Borrowings

Total cash on 31 May was £4.812m. The end of each month is the lowest point for cash holding as commissioner block payments are received on the next working day. The average daily balance across May was £12m.

As the Trust has a deficit plan for 2023/24, it will require cash support throughout the year 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.

7. 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.



8. Capital Expenditure

The Trust's overall capital programme for 2023/24 equates to £5,154k. The capital plan remains under regular review to ensure timeliness of spend and efficient pricing.

Year to date, spend has exceeded plan, at £743k (£42k over plan). The main area of the total spend (£370k) is the Electronic Patient Record (EPR) project which is due to be operational by July. Estates have commenced their programme of works for the year, and urgent medical spend on ultrasound machines and other medical equipment equates to £167k year to date.

9. Agency

At Month 2, the Trust has a favourable variance of £239k against plan. Actual costs of £151k are predominantly driven by maternity (sickness and vacancy) and theatres (vacancy). Enhanced controls have been implemented regarding agency spend.

10. BAF Risk

There are no proposed changes to the BAF score of 16, however the risk narrative has been updated in month and is reported as part of the BAF update on this agenda.

11. Conclusion & Recommendation

The Board is asked to note the Month 2 position.

Appendices

Appendix 1 – Board Finance Pack, M2

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M2

YEAR ENDING 31 MARCH 2024

Liverpool Women's NHS Foundation Trust

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M2
YEAR ENDING 31 MARCH 2024

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	(1,684)
(b) PDC + Interest Payable + Loans Repaid	1,056
CSC Ratio = (a) / (b)	**(1.60)**
NHSI CSC SCORE	**4**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25	
LIQUIDITY	
(a) Cash for Liquidity Purposes	(17,383)
(b) Expenditure	24,959
(c) Daily Expenditure	68
Liquidity Ratio = (a) / (c)	**(254.2)**
NHSI LIQUIDITY SCORE	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)	
I&E MARGIN	
Deficit (Adjusted for donations and asset disposals)	3,072
Total Income	(23,175)
I&E Margin	**-13.3%**
NHSI I&E MARGIN SCORE	**4**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)	
I&E MARGIN VARIANCE FROM PLAN	
I&E Margin (Actual)	-13.30%
I&E Margin (Plan)	-13.10%
I&E Variance Margin	**-0.20%**
NHSI I&E MARGIN VARIANCE SCORE	**2**
Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%	
Note: NHSI assume the score of the I&E Margin variance from Plan is a 1 for the whole year	
AGENCY SPEND	
YTD Providers Cap	139
YTD Agency Expenditure	151
	8%
NHSI AGENCY SPEND SCORE	**2**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%	
Overall Use of Resources Risk Rating	**3**

Note: scoring a 4 on any of the metrics will lead to a financial override score of 3.
The overall ratio is determined using weighted average of each score and then rounding down

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2
INCOME & EXPENDITURE: M2
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	Month 2 Budget	Month 2 Actual	Month 2 Variance	YTD Budget	YTD Actual	YTD Variance	YEAR Budget	YEAR Forecast	YEAR Variance
Income									
Clinical Income	(11,177)	(10,870)	(306)	(22,344)	(21,994)	(350)	(134,750)	(134,750)	0
Non-Clinical Income	(591)	(584)	(7)	(1,193)	(1,180)	(13)	(7,416)	(7,416)	0
Total Income	**(11,768)**	**(11,455)**	**(313)**	**(23,537)**	**(23,175)**	**(362)**	**(142,166)**	**(142,166)**	**0**
Expenditure									
Pay Costs	7,539	8,349	(810)	15,077	16,134	(1,057)	88,336	88,336	0
Non-Pay Costs	3,178	2,231	947	6,430	5,222	1,208	38,628	38,628	0
CNST	1,814	1,641	173	3,601	3,602	(2)	21,603	21,603	0
Total Expenditure	**12,530**	**12,221**	**309**	**25,108**	**24,959**	**149**	**148,567**	**148,567**	**0**
EBITDA	**762**	**766**	**(4)**	**1,571**	**1,784**	**(214)**	**6,401**	**6,401**	**0**
Technical Items									
Depreciation	575	647	(72)	1,097	1,122	(26)	6,583	6,583	0
Interest Payable	2	2	0	4	3	1	21	21	0
Interest Receivable	(32)	(44)	12	(32)	(100)	68	(200)	(200)	0
PDC Dividend	235	221	14	441	441	0	2,645	2,645	0
Profit/Loss on Disposal or Transfer Absorption	0	(50)	50	0	(172)	172	0	0	0
Total Technical Items	**779**	**775**	**5**	**1,510**	**1,294**	**215**	**9,049**	**9,049**	**0**
(Surplus) / Deficit	**1,542**	**1,541**	**1**	**3,080**	**3,078**	**2**	**15,450**	**15,450**	**0**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2a
WTE: M2
YEAR ENDING 31 MARCH 2024

TYPE	DESCRIPTION	M12	M1	M2	Movement M1-M2
SUBSTANTIVE	ADMINISTRATIVE AND CLERICAL	287.67	286.00	283.01	(2.99)
	CHAIRMAN AND NON-EXECUTIVES	8.00	8.00	8.00	0.00
	EXECUTIVE BOARD AND SENIOR MANAGERS	65.92	69.32	70.32	1.00
	HEALTHCARE ASSISTANTS AND OTHER SUPPORT STAFF	198.71	199.98	208.70	8.72
	MEDICAL AND DENTAL	185.09	188.10	188.87	0.77
	NURSING, MIDWIFERY AND HEALTH VISITING	723.46	728.61	729.02	0.41
	P.A.M.S.	28.49	28.88	28.40	(0.48)
	PROFESSIONAL AND TECHNICAL	44.70	49.95	50.87	0.92
	SCIENTIFIC AND PROFESSIONAL	39.09	38.62	38.62	0.00
SUBSTANTIVE TOTAL		1,581.13	1,597.46	1,605.81	8.35
BANK	ADMINISTRATIVE AND CLERICAL	6.55	6.06	5.65	(0.41)
	MIDWIVES	26.64	21.53	24.66	3.13
	NURSING STAFF	39.97	29.28	35.49	6.21
	SUPPORT STAFF	31.18	27.20	25.68	(1.52)
	SCIENTIFIC AND PROFESSIONAL	0.32	0.91	1.00	0.09
	P.A.M.S.	0.42	0.95	1.31	0.36
	MEDICAL AND DENTAL	2.80	2.80	2.80	0.00
TOTAL BANK		107.88	88.73	96.59	7.86
AGENCY	ADMINISTRATIVE AND CLERICAL	1.00	-	-	0.00
	P.A.M.S.	4.04	1.21	3.54	2.33
	MEDICAL AND DENTAL	0.10	-	-	0.00
	NURSING STAFF	1.04	0.34	0.31	(0.03)
	MIDWIVES	7.19	10.33	2.03	(8.30)
	OTHER	-	1.73	-	(1.73)
AGENCY TOTAL		13.37	13.61	5.88	(7.73)
TRUST TOTAL		1,702.38	1,699.80	1,708.28	8.48

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
EXPENDITURE: M2
YEAR ENDING 31 MARCH 2024

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR Actual	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	504	509	(5)	935	1,002	(67)	5,411	5,411	0
Medical	2,096	2,351	(255)	4,184	4,374	(190)	25,105	25,105	0
Nursing & Midwifery	3,264	3,511	(247)	6,328	6,789	(461)	37,912	37,912	0
Healthcare Assistants	585	636	(51)	1,094	1,214	(120)	6,565	6,565	0
Other Clinical	(26)	488	(514)	690	1,014	(324)	2,330	2,330	0
Admin Support	793	809	(15)	1,524	1,588	(64)	9,164	9,164	0
Agency & Locum	322	45	277	322	151	171	1,848	1,848	0
Total Pay Costs	**7,539**	**8,349**	**(810)**	**15,077**	**16,131**	**(1,054)**	**88,336**	**88,336**	**0**
Non Pay Costs									
Clinical Suppplies	912	1,013	(101)	1,669	1,716	(47)	10,031	10,031	0
Non-Clinical Supplies	572	276	296	1,595	936	659	9,233	9,233	0
CNST	1,814	1,641	173	3,601	3,602	(2)	21,603	21,603	0
Premises & IT Costs	760	343	417	1,751	1,209	542	10,467	10,467	0
Service Contracts	934	598	336	1,415	1,364	51	8,897	8,897	0
Total Non-Pay Costs	**4,992**	**3,872**	**1,120**	**10,030**	**8,827**	**1,203**	**60,231**	**60,231**	**0**
Total Expenditure	**12,530**	**12,221**	**309**	**25,108**	**24,959**	**149**	**148,567**	**148,567**	**0**

Note that the values above exclude hosted services and Technical Items.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M2
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	MONTH 2 Budget	MONTH 2 Actual	MONTH 2 Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR Actual	YEAR Variance
Maternity									
Income	(3,898)	(3,951)	53	(8,005)	(8,062)	58	(48,328)	(48,328)	0
Expenditure	2,577	2,735	(157)	4,814	5,397	(583)	28,856	28,856	0
Total Maternity	**(1,321)**	**(1,216)**	**(105)**	**(3,190)**	**(2,665)**	**(525)**	**(19,472)**	**(19,472)**	**0**
Neonatal									
Income	(1,895)	(1,828)	(67)	(3,678)	(3,653)	(25)	(22,067)	(22,067)	0
Expenditure	1,627	1,557	71	2,941	2,982	(42)	17,643	17,643	0
Total Neonatal	**(268)**	**(271)**	**3**	**(737)**	**(670)**	**(67)**	**(4,424)**	**(4,424)**	**0**
Division of Family Health - Total	**(1,589)**	**(1,487)**	**(102)**	**(3,928)**	**(3,336)**	**(592)**	**(23,896)**	**(23,896)**	**0**
Gynaecology									
Income	(2,179)	(2,108)	(72)	(4,360)	(4,264)	(96)	(26,208)	(26,208)	0
Expenditure	1,366	1,713	(347)	2,863	3,025	(162)	17,123	17,123	0
Total Gynaecology	**(813)**	**(394)**	**(419)**	**(1,497)**	**(1,238)**	**(258)**	**(9,085)**	**(9,085)**	**0**
Hewitt Centre									
Income	(885)	(813)	(72)	(1,686)	(1,735)	50	(10,365)	(10,365)	0
Expenditure	856	790	67	1,588	1,688	(100)	9,527	9,527	0
Total Hewitt Centre	**(29)**	**(23)**	**(6)**	**(98)**	**(47)**	**(51)**	**(838)**	**(838)**	**0**
Division of Gynaecology - Total	**(842)**	**(418)**	**(425)**	**(1,595)**	**(1,285)**	**(309)**	**(9,923)**	**(9,923)**	**0**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	1,099	1,230	(131)	2,118	2,229	(112)	12,285	12,285	0
Total Theatres	**1,099**	**1,230**	**(131)**	**2,118**	**2,229**	**(112)**	**12,285**	**12,285**	**0**
Genetics									
Income	2	(5)	7	(7)	(11)	4	(42)	(42)	0
Expenditure	148	159	(11)	321	316	5	1,928	1,928	0
Total Genetics	**150**	**154**	**(4)**	**314**	**305**	**9**	**1,886**	**1,886**	**0**
Other Clinical Support									
Income	(518)	(496)	(21)	(1,284)	(1,135)	(149)	(9,272)	(9,272)	0
Expenditure	1,030	1,026	5	1,911	1,921	(9)	12,231	12,231	0
Total Clinical Support	**513**	**529**	**(17)**	**628**	**786**	**(158)**	**2,959**	**2,959**	**0**
Division of Clinical Support - Total	**1,761**	**1,913**	**(152)**	**3,060**	**3,320**	**(261)**	**17,130**	**17,130**	**0**
Corporate & Trust Technical Items									
Income	(2,394)	(2,426)	32	(4,518)	(4,586)	68	(25,884)	(25,884)	0
Expenditure	4,606	3,959	647	10,061	8,965	1,096	58,024	58,024	0
Total Corporate	**2,211**	**1,533**	**679**	**5,543**	**4,379**	**1,164**	**32,139**	**32,139**	**0**
(Surplus) / Deficit	**1,542**	**1,541**	**1**	**3,080**	**3,078**	**2**	**15,450**	**15,450**	**0**
Of which is hosted;									
Income	0	(172)	172	0	(272)	272	0	(272)	272
Expenditure	0	172	(172)	0	272	(272)	0	272	(272)
Total Corporate	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
CIP: M2
YEAR ENDING 31 MARCH 2024

		M2 £'000			YTD £'000		
TYPE	Scheme	Target	Actual	Variance	Target	Actual	Variance
Income	Income Private Patient	9	0	(9)	18	0	(18)
Income	Income non-patient care	20	17	(3)	39	33	(6)
Income	Other income	83	60	(23)	167	66	(101)
Total Income		**112**	**77**	**(35)**	**225**	**99**	**(125)**
Pay	Service re-design	18	8	(10)	36	17	(19)
Pay	E-Rostering	2	0	(2)	4	0	(4)
Pay	Establishment reviews	0	0	0	0	0	0
Pay	Digital transformation	0	0	0	0	0	0
Pay	Corporate services transformation	(4)	0	4	(7)	0	7
Pay	Other Pay	2	0	(2)	3	0	(3)
Total Pay		**18**	**8**	**(10)**	**36**	**17**	**(19)**
Non-Pay	Service re-design	183	161	(22)	366	322	(44)
Non-Pay	Medicines optimisation	14	0	(14)	27	0	(27)
Non-Pay	Procurement - medical devices and consumables	14	0	(14)	27	0	(27)
Non-Pay	Digital transformation	10	0	(10)	20	0	(20)
Non-Pay	Pathology & imaging networks	0	0	(0)	1	0	(1)
Non-Pay	Procurement - non-clinical	4	0	(4)	8	0	(8)
Non-Pay	Other	11	1	(10)	22	2	(20)
Non-Pay	Unidentified	1	0	(1)	1	0	(1)
Total Non-Pay		**237**	**162**	**(75)**	**474**	**325**	**(149)**
Total		**367**	**248**	**(119)**	**734**	**441**	**(293)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
BALANCE SHEET: M2
YEAR ENDING 31 MARCH 2024

BALANCE SHEET	YEAR TO DATE		
£'000	Opening	M2 Actual	Movement
Non Current Assets	105,732	105,389	(343)
Current Assets			
Cash	9,790	4,812	(4,978)
Debtors	9,647	11,129	1,482
Inventories	839	837	(2)
Total Current Assets	**20,276**	**16,778**	**(3,498)**
Liabilities			
Creditors due < 1 year - Capital Payables	(2,002)	(1,710)	292
Creditors due < 1 year - Trade Payables	(26,830)	(18,576)	8,254
Creditors due < 1 year - Deferred Income	(4,492)	(12,301)	(7,809)
Creditors due > 1 year - Deferred Income	(1,530)	(1,527)	3
Loans	(918)	(913)	5
Loans - IFRS16 leases	(50)	(50)	0
Provisions	(628)	(612)	16
Total Liabilities	**(36,450)**	**(35,689)**	**761**
TOTAL ASSETS EMPLOYED	**89,558**	**86,478**	**(3,080)**
Taxpayers Equity			
PDC	79,115	79,115	0
Revaluation Reserve	11,996	11,995	(1)
Retained Earnings	(1,553)	(4,631)	(3,078)
TOTAL TAXPAYERS EQUITY	**89,558**	**86,479**	**(3,079)**

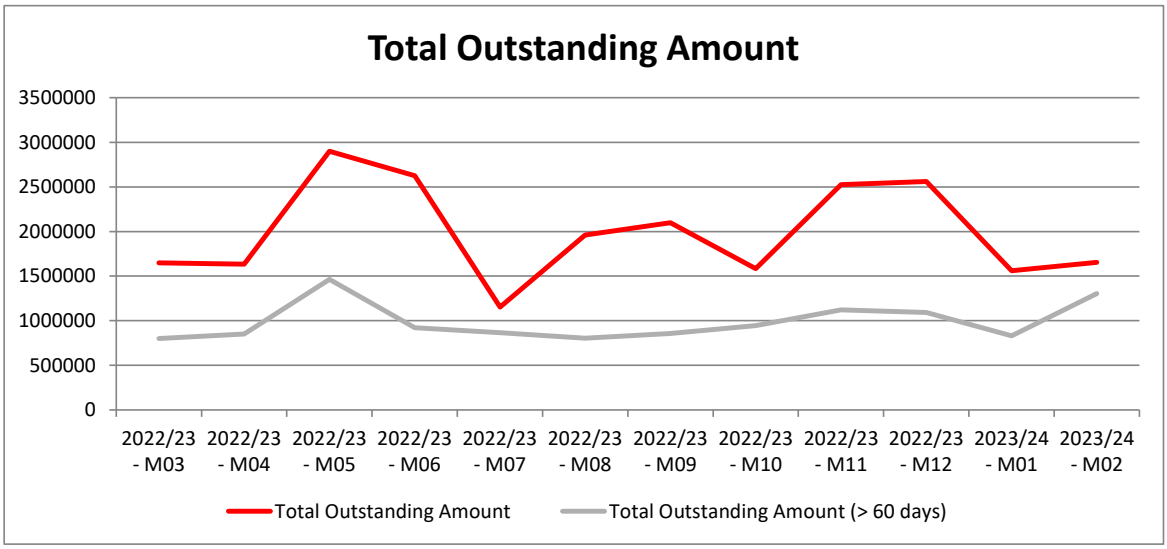
CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	(2,906)
Depreciation and amortisation	1,122
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	(2,383)
Net cash generated from / (used in) operations	**(4,167)**
Interest received	100
Purchase of property, plant and equipment and intangible assets	(1,034)
Proceeds from sales of property, plant and equipment and intangible assets	125
Net cash generated from/(used in) investing activities	**(809)**
PDC Capital Programme Funding - received	0
Loans from Department of Health - repaid	0
Interest paid	(2)
PDC dividend (paid)/refunded	0
Net cash generated from/(used in) financing activities	**(2)**
Increase/(decrease) in cash and cash equivalents	**(4,978)**
Cash and cash equivalents at start of period	9,790
Cash and cash equivalents at end of period	**4,812**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding
Loans from Department of Health - Capital (ITFF) - 2.0% Interest Rate	5,500	(4,587)	913
Loans from Department of Health - Capital (Neonatal) - 2.54% Interest Rate	14,572	(14,572)	0
Loans from Department of Health - Revenue - 1.50% Interest Rate	14,612	(14,612)	0
Total	**34,684**	**(33,771)**	**913**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CAPITAL EXPENDITURE: M2
YEAR ENDING 31 MARCH 2024

		YTD			YEAR		
Area	Capital Scheme	PLAN	ACTUAL	VARIANCE	PLAN	FOT	VARIANCE
Digital	EPR frontline digitisation	188	151	37	560	560	0
Digital	IT/digital investment	90	370	(280)	706	706	0
Digital	IT/digital investment	150	0	150	280	280	0
Digital	Community diagnostic equipment	100	0	100	153	153	0
Digital	Community diagnostic IT	100	0	100	100	100	0
Digital	PACS - image sharing - CAMRIN programme	0	0	0	49	49	0
Estates	Building works/refurbishment - Maternity	25	11	14	950	950	0
Estates	Building works/refurbishment - Neonatal	0	0	0	180	180	0
Estates	Building works/refurbishment - Gynaecology	8	0	8	300	300	0
Estates	Estates programme	0	44	(44)	560	560	0
Estates	Charity funded bereavement suite works	0	0	0	70	70	0
Medical Equipment	Medical equipment - Clinical Support - Fluoroscopy	0	0	0	262	262	0
Medical Equipment	Medical equipment - Clinical Support - Theatres	0	0	0	107	107	0
Medical Equipment	Medical equipment - All other clinical areas	40	167	(127)	738	738	0
Medical Equipment	Medical equipment - leased blood gas analysers	0	0	0	139	139	0
TOTAL CAPITAL		**701**	**743**	**(42)**	**5,154**	**5,154**	**0**

Note 1: The Capital Expenditure is shown on an "Accruals" basis based on the date of receipt of the capital item by the Trust. This figure differs to the capital expenditure figures shown in the cashflow statement which are on a "Cash" basis.

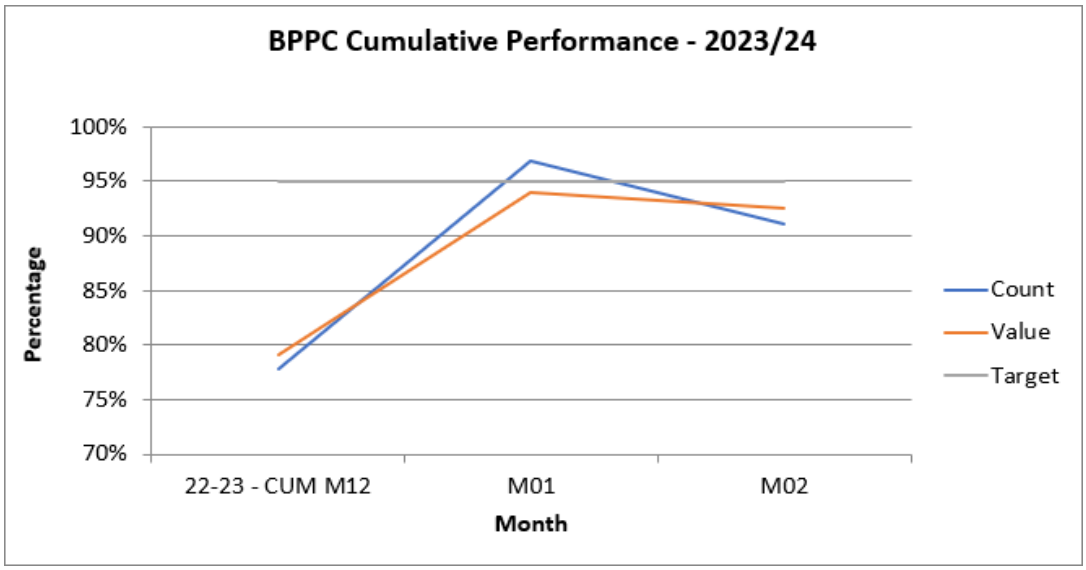


The underlying aged debtors is shown in the graph above. The level of debtor within the sales ledger has fallen significantly since the end of March, from £2.6m to £1.7m.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 10
BETTER PAYMENT PRACTICE CODE (BPPC) - CUMULATIVE PERFORMANCE FOR M2
YEAR ENDING 31 MARCH 2024

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.

2023/24



BPPC Data Summary	M01	M02
Count	97%	91%
Value	94%	93%
Target	95%	95%

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **11**
AGENCY USAGE: M2
YEAR ENDING 31 MARCH 2024

Division	Directorate	YTD £000's Plan	Actual	Variance
Family Health	Maternity	0	64	(64)
Gynaecology	Gynaecology	0	7	(7)
Gynaecology	HFC	0	4	(4)
CSS	Theatres	0	34	(34)
CSS	CDC	24	15	9
CSS	Imaging	0	23	(23)
Corporate	Finance	0	5	(5)
All	All	366	0	366
Total		**390**	**151**	**239**

Note that the agency premium budget is held centrally (with the exception of CDC ring-fenced funding).
The Trust is reporting performance against plan in the absence of the 2023/24 provider cap.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/91a*		**Date: 13/07/2023**	
Report Title	**Partnerships Oversight – Quarterly Update**			
Prepared by	*Helen Chainey, Strategic Projects Manager* *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	*To note the current position with the Trust's partnerships with other NHS organisations.* *To provide detail on the development of a Liverpool Trusts Joint Committee and its intended purpose and seek approval for the terms of reference.*			
Action required	**Approve ☐**	**Receive ☒**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to: 1. *Note the content in the report* 2. *Agree the process set out in this paper for monitoring, evaluation, and review of partnership arrangements* 3. *Discuss the progress made within each of the partnerships and consider whether this is sufficient in the context of operational pressures during the last period* 4. *Discuss whether there are material gaps in the Trust's partnership portfolio.* 5. *Consider and approve the terms of reference for the Liverpool Trusts Joint Committee.*			
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 ***workforce***	☒	To participate in high quality research and to deliver the most ***effective*** Outcomes	☒
To be ambitious and ***efficient*** and make the best use of available resource	☒	To deliver the best possible ***experience*** for patients and staff	☒
To deliver ***safe*** services	☒		

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 6 – The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Executive Team	21/6/23	CFO	The Executive Team requested that future iterations of the report provide updates on non-NHS partnerships as well as NHS partnerships

EXECUTIVE SUMMARY

This report provides an update to the Board on the Trust's partnerships with NHS bodies, noting that building effective partnerships is critical for NHS organisations operating in the emerging health and care landscape. Whilst the report focuses on the Trust's provider partnerships, it also details the Trust's involvement within the Liverpool Place and wider system joint committees and workstreams. It outlines key highlights with respect to the current state and planned development of the Trust's partnerships, as well as proposed arrangements for monitoring, evaluation, and review of effectiveness.

Since the last update, the has been some progress across a range of partnerships, however it has been challenging for teams to dedicate sufficient time and resource to the development of partnerships during the last period, given competing pressures, such as the development of the Trust's financial recovery programme, management of industrial action, Care Quality Commission inspection and planning for 2023/24.

The Board is asked to:

1. Note the content within the report
2. Approve the process set out in this paper for monitoring, evaluation, and review of partnership arrangements
3. Discuss the progress made within each of the partnerships and consider whether this is sufficient in the context of operational pressures during the last period
4. Discuss whether there are material gaps in the Trust's partnership portfolio
5. Consider and approve the terms of reference for the Liverpool Trusts Joint Committee

MAIN REPORT

1. Introduction and Background

This paper provides an update regarding partnership development and management, following on from the final update provided to the Finance, Performance and Business Development (FPBD) Committee in February 2023.The Trust Board agreed that going forward, partnerships would be managed through the Executive Committee, with a quarterly review, supplemented with general updates and decisions through normal Committee meetings as required. Following the quarterly meetings outputs would be reported to the Trust Board as appropriate to provide assurance.

The update provided to FPBD in February 2023 noted that the Trust had further developed its existing partnership working with Alder Hey Hospital for Children NHS FT and Liverpool University Hospitals NHS FT and had established a new Partnership Board to oversee the development of the Community Diagnostic Centre at Crown Street. The report also noted partnership work with system and Place colleagues to develop strategy and plans, and to support the Liverpool Clinical Services Review.

This paper outlines key highlights with respect to the current state and planned development of the Trust's partnerships, as well as proposed arrangements for monitoring, evaluation, and review of effectiveness.

To support delivery of the Liverpool Care Services Review (received and approved at the Integrated Care Board meeting on 26 January 2023) a Liverpool Trusts Joint Committee (LTJC) has been set up, with terms of reference under development since May 2023. Following a meeting of the LTJC on 16 June 2023, the attached terms of reference (appendix 1) are now being recommended for approval by the Boards of member organisations. This report will provide detail on the development of the LTJC and its intended purpose.

2. NHS Provider Partnerships Update

As a provider of tertiary services, the Trust has partnership arrangements with many provider organisations in Cheshire and Merseyside, as well as multiple Trusts outside of the region.

This section of this report summarises new developments within provider relationships.

Liverpool University Hospitals NHS FT (LUHFT)

Since the last report to the FPBD Committee, two new members of the LUHFT senior leadership team have joined the LWH/LUHFT Partnership Board: the new Executive Director of Strategy and Partnerships and the new Managing Director of the Royal Liverpool site. LWH's Medical Director remains the Chair of the Partnership Board and has begun establishing relationships both new members.

Over the last review period, the Partnership Board has focused on:

- Strengthening the understanding of shared risks through the continued refinement of a shared risk register between both organisations
- Refreshing the Terms of Reference (ToR) of the Partnership Board in terms of governance and reporting arrangements to reflect the introduction of the Cheshire and Merseyside Integrated Care Board (C&M ICB) Women's Services Committee as the overseeing body.

- Formalising a data-sharing agreement between the two organisations to enable joint working and provide activity data and information.
- Review and discussion of serious incidents occurring due to the Trust's isolation from adult acute services.

Alder Hey Children's Hospital NHS FT (AH)

A. Partnership Board

The first informal meeting of the Partnership Board with AH was held between the two organisations in January 2023, where it was agreed that there would be a focus on the following three areas of work:

- Services already in place (such as paediatric gynaecology and transition into adult services, fertility preservation for cancer patients, some areas of joint working with genetics, and some diagnostic services)
- Services/areas of work currently under development (such as the Genomics Unit, Starting Well research theme and fetal spinal surgery)
- New strategic programmes of work that we want to undertake (such as immunisation, education and training, innovation, and population health).

Since this meeting work has been underway to develop a shared mission statement, a ToR, and agree initial priorities for the Board.

B. Liverpool Neonatal Partnership

The Trust has long-established links with AH within its Neonatal service, and in 2018 formally established the Liverpool Neonatal Partnership, which is focused on creating a single service across the two sites which provide neonatal care, to ensure the safest service possible is provided for babies. Building work for the new neonatal unit was due to commence in Autumn 2022 however due to increased building costs and issues identified with the enabling groundworks, this had to be delayed. Contracts are currently due to be signed by the end of this month with building work commencing the following month now that the aforementioned issues have been resolved.

Mersey Care NHS FT (MC)

The Trust has been working with Mersey Care to develop plans for a potential Urgent Treatment Centre (UTC) on the Crown Street site since 2019. Colleagues from Mersey Care visited the Crown Street site in May 2023 to discuss progression of the UTC project.

The Trust will continue to work closely with Mersey Care as this project develops, with particular reference to gaining a clear understanding of the city-wide plan for urgent care delivery. Updates are provided to the Crown Street Enhancements Programme Board as well as FPBD.

Crown Street Community Diagnostic Centre Partnership Board

The Trust established a new Crown Street Community Diagnostic Centre Partnership Board in January 2023 to provide oversight of delivery and strategic direction, and to provide a vehicle for shared decision making, featuring representation from:

- Liverpool Women's Hospital

- Liverpool University Hospitals
- Liverpool Heart and Chest Hospital
- Clatterbridge Cancer Centre
- Cheshire and Merseyside Regional CDC Programme
- Cheshire and Merseyside Radiology Imaging Network (CAMRIN)

During the review period, the Board have met regularly and agreed a ToR. A Chair's report is produced and submitted to the LWH/LUHFT Partnership Board. The most recent Chair's report noted that the CDC would be working with partner Trusts to agree forecast activity levels in line with the business case.

3. Liverpool Place

In the last update to the FPBD Committee, the recommendations regarding closer partnership working between acute and specialist provider organisations in Liverpool developed as part of the Liverpool Clinical Services Review were noted.

The review's recommendations included:

- Establishing a series of site-based joint committees.
- A new sub-committee of the ICB is established to take forward the Trust's Future Generations Programme, re-set as a system priority – Women's Services committee
- Exploration of opportunities for efficiency within corporate services.

Over the recent months, the Liverpool Trusts Joint Committee (LTJC) has been established with membership comprising of the Chair and Chief Executive from each of the seven Liverpool Trusts (see section 5 for further detail).

The Women's Services Committee has now met twice. The ToR are due to be finalised and approved at the next meeting outlining the scope of the committee. The interview process to appoint a Programme Director is underway with appointment expected imminently, and work continues to appoint an Independent Clinical Advisor.

Local Maternity and Neonatal System (LMNS)

It was previously agreed that the LMNS would move to being hosted by C&M ICB beginning July 2023 when the staff would be transferred under TUPE arrangements. There have been several meetings between respective corporate teams regarding their individual elements of the transfer, and teams are working to 1 July transfer date at present.

Cheshire and Merseyside Integrated Care Partnership (ICP)

Cheshire and Merseyside Acute and Specialist Trust (CMAST) provider collaborative

The Trust continues to engage with the CMAST workstreams, working together to lead on system-wide programmes and workforce development, including harnessing clinical and professional leadership resources.

In the medium and longer term CMAST will develop an overview of existing services, locations and pathways to ensure they are patient-centred, productive, streamlined and of high quality which Liverpool Women's will play a key role in, particularly via the Women's Services Review workstream of the ICB.

4. Liverpool Trusts Joint Committee (LTJC)

As members of the Board will be aware, Cheshire and Merseyside Integrated Care System (ICS) were asked in 2022 by NHS England to commission an independent review to:

a) identify and provide recommendations to realise opportunities for greater collaboration between acute and specialised trusts to optimise the model of acute care in Liverpool and beyond; and

b) considered alignment and interdependencies with One Liverpool, the city's health and wellbeing strategy, and the wider Cheshire and Merseyside system.

This outcome of this work was the Liverpool Care Services Review which the Cheshire and Merseyside Integrated Care Board (ICB) received and approved at its Board meeting on 26 January 2023. A copy of this Review is available on the ICS's website by clicking here (from page 144), although separate papers for information would have been taken to each of the member NHS provider's Boards.

In order to ensure the delivery of six of the recommendations of the Review, a Liverpool Trusts Joint Committee (LTJC) has been set up, with terms of reference under development since May 2023. Following a meeting of the LTJC on 16 June 2023, the attached terms of reference are now being recommended for approval by the Boards of member organisations.

LTJC TERMS OF REFERENCE

The LTJC is responsible for leading and overseeing the development and implementation of the Liverpool Acute (Provider) Strategy and the six Review recommendations that fall into the scope of the LTJC (see section 3 of the attached terms of reference).

The membership of the LTJC comprises of the following NHS provider trusts across Liverpool, who are each represented on the LTJC by the Chair and Chief Executive:

a) Alder Hey Children's NHS Foundation Trust (AHCH);

b) The Clatterbridge Cancer Centre NHS Foundation Trust (CCC);

c) Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH);

d) Liverpool Women's NHS Foundation Trust (LWFT);

e) Liverpool University Hospitals NHS Foundation Trust (LUHFT);

f) Mersey Care NHS Foundation Trust (MCFT);

g) The Walton Centre NHS Foundation Trust.

Appendix 1 of these terms of references also provides a useful organogram outlining the governance arrangements to oversee all of the Review's recommendations, and not solely the six overseen by the LTJC.

NEXT STEPS

Members will note that the Appendix 2 (Template Delegation) of the terms of reference has yet to be completed. The company secretaries of the member NHS provider trusts will be working together over the next few months to address this, with any recommendations going to both the LTJC and member NHS provider trust Boards for approval where necessary.

In future a summary set of minutes will also be produced on behalf of the LTJC that will allow member NHS provider trusts to share them with their Public Boards and Council of Governors.

5. Partnership Monitoring, Evaluation, and Review

A record of key partnerships has been created. Prior to the next review by the Executive Committee and Board, the register will be further developed to include a summary of the aims and intended benefits of each partnership (from a Liverpool Women's Hospital perspective), as well as any key risks. Partnerships will then be regularly reviewed against their recorded aims and intended benefits, on a rolling annual basis, with a view to providing assurance to the Executive Committee and the Trust Board regarding benefits realisation, value for money, risk, and overall effectiveness. This will provide information to inform decisions regarding the Trust's partnerships portfolio, including participation in existing partnerships, and requirements to develop new partnerships. 'Lessons learned' from review of individual partnerships may be implemented across the portfolio, as well as shared with partner organisations.

It is proposed that the following partnerships are reviewed as part of the next update to this Committee:

- ACHD Partnership Board
- Liverpool University Hospitals and Liverpool Women's Partnership Board
- Mersey Care

6. Conclusion and Recommendations

The Trust has a portfolio of partnerships in place which support delivery of its services. There has been some progress across a range of partnerships in the last period, as highlighted in this report, however it has been challenging for teams to dedicate sufficient time and resource to the development of partnerships during the last period, given competing pressures, such as the development of the Trust's financial recovery programme, management of industrial action, Care Quality Commission inspection and planning for 2023/24.

The Board is asked to:

1. Note the content within the report
2. Approve the process set out in this paper for monitoring, evaluation, and review of partnership arrangements
3. Discuss the progress made within each of the partnerships and consider whether this is sufficient in the context of operational pressures during the last period
4. Discuss whether there are material gaps in the Trust's partnership portfolio
5. Consider and approve the terms of reference for the Liverpool Trusts Joint Committee

Liverpool Trusts Joint Committee

Terms of Reference

Version	DRAFT 1.5
Implementation Date	16/06/2023
Review Date	December 2023
Approved By	Trust boards
Approval Date	[ ]

REVISIONS		
Date	**Reason for Change**	**Author**
2 May 2023	Version 1.0 – first draft	HD
2 May 2023	Version 1.1 – second draft	HD
3 May 2023	Version 1.2 – third draft (to align with Sub-Committee TORs)	HD
3 May 2023	Version 1.3 – fourth draft	HD
12 June 2023	Version 1.4 – fifth draft – feedback from LTJC member trusts	DS
16 June 2023	Version 1.5 – comments from LTJC meeting/Approved	DS

1	Name	**Liverpool Trusts Joint Committee (LTJC)**
2	General	Capitalised terms have the meaning set out below: "**2006 Act**" means the National Health Service Act 2006 (as amended); "**Chair**" means the chair of the LTJC; "**C&M MHLDC**" means the Cheshire and Merseyside Mental Health, Learning Disability & Community Collaborative; "**CMAST**" means the Cheshire and Merseyside Acute and Specialist Trusts Collaborative; "**Delegation**" means the terms of any delegation to the LTJC including any associated delegation agreement as agreed by the relevant board(s) and appended to these Terms of Reference at Appendix 2 and "Delegated" shall be construed accordingly;

		"**ICB**" means the NHS Cheshire and Merseyside Integrated Care Board, including any individual, organisation or committee to which its powers or responsibilities are delegated; "**LCSR**" means the Liverpool Clinical Services Review "**LCSR Recommendations**" means the six recommendations from the Liverpool Clinical Services Review which come within the scope of the LTJC, as set out in paragraph 4; "**LTJC**" means the Liverpool Trusts Joint Committee; "**LTJC Sub-Committees**" means the three sub-committees of the LTJC, being • LUHFT and TWCFT (Aintree site) • CCC and LUHFT (Royal Liverpool site) • LHCH and LUHFT (Broadgreen site) "**Member**" refers to a member of the LTJC listed in paragraph 7; "**Purpose**" the purpose of the LTJC as set out in paragraph 3; "**Trusts**" are Alder Hey Children's NHS Foundation Trust (**AHFT**); Liverpool Heart and Chest NHS Foundation Trust (**LHCH**); Liverpool University Hospital NHS Foundation Trust (**LUHFT**); Liverpool Women's NHS Foundation Trust (**LWFT**); Mersey Care NHS Foundation Trust (**MCFT**); The Clatterbridge Cancer Centre NHS Foundation Trust (**CCC)**; and The Walton Centre NHS Foundation Trust (**TWCFT**); and "**Work Plan**" means the rolling plan of work to be carried out by the LTJC over a 12-month period (or such longer period as may be agreed by the Trusts). For the avoidance of doubt the Work Plan does not form part of these Terms of Reference. All references to legislation are to that legislation as updated from time to time.
3	Purpose	The Liverpool Clinical Services Review was commissioned in 2022 to realise opportunities for greater collaboration between acute and specialist trusts, to optimise acute care clinical pathways in Liverpool and beyond. A diagram setting out the various governance groups and organisations involved in overseeing and implementing the recommendations from the LCSR is set out at Appendix 1. Through delivering its Work Plan (via the LTJC Sub-Committees), the LTJC will be responsible for leading and overseeing the development and implementation of the Liverpool Acute (Provider) Strategy and the six LCSR Recommendations within the scope of LTJC.

		The six LCSR Recommendations within the scope of the LTJC are as follows: • R3 - Improving outcomes and access to emergency care using existing co-adjacencies • R5 - Providing timely access to high-quality elective care through existing estates/assets • R7 - Combining expertise in clinical support services to provide consistent services (Liverpool) • R9 - Attracting and retaining talent in Health and Social Care within Liverpool City Region • R11 - Integrating digital systems to improve care delivery • R12 - Making best use of resources to secure financial sustainability for all organisations in Liverpool. Should the LTJC identify further opportunities to improve clinical services in Liverpool through collaboration, these additional workstreams will be agreed to and overseen by the LTJC as part of the Work Plan. The following principles will inform the work of the LTJC in delivering the Work Plan: • Ensure that proposals are underpinned by demand and capacity analysis • Ensure that clinicians are at the forefront of the development of the envisaged approach on each site, with appropriate clinical leadership from each organisation to oversee the work and facilitate involvement from the clinical community • Ensure engagement with partners in the urgent care pathway, including General Practice, community and mental health providers, North West Ambulance Service NHS Trust, to incorporate pre- and post-hospital elements of the pathway • Ensure engagement with wider system partners who may be impacted or have the potential to mitigate the impact of any proposed pathway changes including the ICB, neighbouring Place systems, CMAST, NHS Commissioning: Specialist Services, and the C&M MHLDC • Ensure that programmes of work are resourced to deliver, securing a dedicated team from relevant Trusts to support the LTJC to develop and implement the operating model for each site, undertaking design work and modelling for operational and proposed service transformation.

		• Ensure that the Work Plan complies with statutory duties and best practice standards in delivering service change • Ensure that any need for patients, public and stakeholders' involvement are identified as a core part of the Work Plan and form part of a planned engagement approach with patients, public and stakeholders • Ensure no detriment to patients within a wider geography to Liverpool.
4	Scope	The LTJC shall identify the projects and areas it will work on to achieve its Purpose in its Work Plan. The LTJC may add and remove projects and areas from the Work Plan from time to time provided that they are linked to the LTJC's Purpose. The LTJC shall hold to account the LTJC Sub-Committees which shall be responsible for delivering elements of the Work Plan and associated priorities through delegations from the LTJC and reporting back to the LTJC, as set out in their respective terms of reference.
5	Status and legal basis	The LTJC is established by the Trusts as a joint committee pursuant to sections 65Z5 and 65Z6 of the 2006 Act in respect of those functions within its scope which are formally delegated by the Trusts to the LTJC in accordance with paragraph 6 below. The Trusts have the power to arrange for any of their functions to be exercised by the other or jointly with each other under section 65Z5 of the 2006 Act. Where the Trusts have arranged for functions to be exercised jointly, they have the power to form a joint committee for this purpose under section 65Z6 of the 2006 Act, and to establish and maintain a pooled fund. The Trusts must have regard to the guidance published by NHS England in March 2023 (and any subsequent/replacement guidance) about the exercise of these powers.
6	Decision-Making	• Decision-making by each Trust Chief Executive Member of the LTJC The Chief Executive of each Trust sits on the LTJC. Where a Chief Executive has delegated authority from their Trust to take decisions, they are able to take decisions on behalf of their Trust while sitting on the LTJC. Other members of the LTJC cannot require a Chief Executive to exercise their delegated authority in a particular way. The Trusts will work towards having consistency in the levels of delegated authority held by each of the Chief Executives when sitting on the LTJC. Where the Chief Executive does not have delegated authority from their Trust to

		take a decision which the Trusts wish to take in the LTJC (outside of the formal delegations to the LTJC) then that decision will need to be referred back to the relevant Trust board for determination unless it has been delegated to the LTJC as outlined below. • Decision-making by the LTJC as a joint committee The Trusts may formally delegate decision-making to the LTJC in relation to particular projects or workstreams within the Work Plan. Such delegations will be in accordance with the guidance given by NHS England. Delegations will be appended to these Terms of Reference and must be delivered in accordance with these Terms of Reference and the Delegation. If there is any conflict between these Terms of Reference and a Delegation, the Delegation will prevail. Where functions of the Trusts have been delegated, the LTJC acts as a joint committee of the relevant Trusts. The LTJC shall make decisions by consensus of all Members, with the Chair and Chief Executive Members from each Trust seeking to make consensus decisions on behalf of their own Trust. If consensus cannot be reached between all Members, the matter will be referred to the Trust boards for further consideration.
7	Accountability	The LTJC is accountable to each Trust board.
8	Reporting arrangements	The Members from each Trust shall be responsible for ensuring that appropriate reporting is made to their Trust board and their Trust's Council of Governors and that feedback from their Trust is fed through to the LTJC. The LTJC shall submit a summary of the minutes from the LTJC Chair to each Trust board meeting in public. The LTJC shall ensure that the work of the LTJC Sub-Committees is reflected in its own minutes. The LTJC shall provide regular reports on its work to the ICB. The LTJC shall provide an annual report to the Trusts and the ICB.
9	Membership	The Members of the LTJC are: • Chair of AHFT • Chief Executive of AHFT • Chair of LHCH • Chief Executive of LHCH • Chair of LWFT • Chief Executive of LWFT • Chair of LUHFT • Chief Executive of LUHFT • Chair of MCFT • Chief Executive of MCFT • Chair of CCC • Chief Executive of CCC

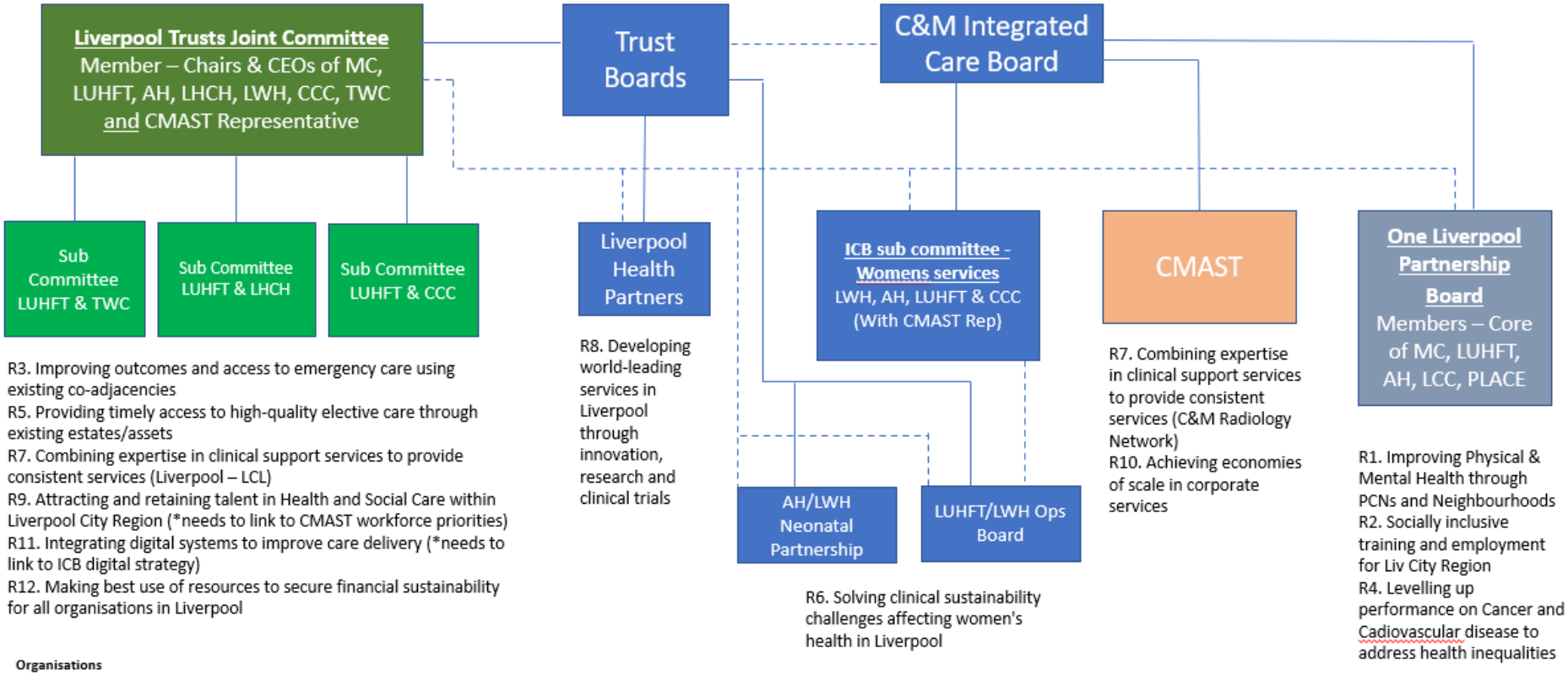
		• Chair of TWCFT • Chief Executive of TWCFT Decisions are taken by the Members as set out in paragraph 6 above.
10	Attendees	The Chair of the LTJC may invite such attendees to LTJC meetings to provide information or be involved in discussion as the Chair considers appropriate. The following shall be invited to attend every meeting of the LTJC: • Representative from CMAST A representative from C&M MH&CC may also where appropriate to the agenda be invited to attend meetings of the LTJC. The Trusts agree to make any of their officers who are involved in delivery of the Work Plan available to attend the LTJC as requested.
11	Deputies	With the permission of the Chair, Members may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf and count in the quorum. The decision of the Chair regarding authorisation of nominated deputies is final. Should permission not be granted, the Chair will provide details of the rationale to the respective organisation. Such nominations should usually be received five working days before the date of the meetings and should always include a short explanation as to why the nomination of a deputy is necessary. The nominated deputy must ensure that they understand the extent to which they are able to take decisions on behalf of their Trust.
12	Chair	The first Chair of LTJC (the "**Chair**") shall be the Chair of LUHFT who will remain in this position unless otherwise agreed by a majority of the remaining Members. Meetings of the LTJC will be run by the Chair. The decision of the Chair on any point regarding the conduct of the LTJC shall be final. The first Deputy Chair of LTJC shall be the Chair of LWFT who will remain in this position unless otherwise agreed by a majority of the remaining Members. If the Chair is not in attendance, then reference to Chair in these Terms of Reference shall be to the Deputy Chair.
13	Quoracy	As a minimum, one Member from each Trust, or their authorised deputy, must be in attendance for the LTJC to be quorate. If any Member of the LTJC has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that

		individual shall no longer count towards the quorum. Members may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting provided all Members are able to hear and speak to one another.
14	Frequency of Meetings	The LTJC will meet at least monthly in private. Additional meetings may take place as required by giving not less than 14 calendar days' notice in writing to all Members. The Chair may call an additional meeting at any time by giving not less than 14 calendar days' notice in writing to Members. Three of the Members may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all Members specifying the matters to be considered at the meeting. In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.
15	Declaration of Interests	If any of the Members has an interest, financial or otherwise, in any matter and is due to be present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the NHS England guidance on managing conflicts of interest in the NHS as applicable from time to time. The Chair of the meeting will determine how a conflict of interest should be managed. The Chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.
16	Support to the LTJC	The Lead Officer for the LTJC is the Director of Corporate Affairs of LUHFT and is responsible for managing LTJC agendas and all governance arrangements for the Work Plan.

		The LTJC will be provided support by LUHFT. This will include: • Seeking agenda items from Members two weeks in advance of each meeting; development and agreement of the agenda with the Chair in consultation with the Lead Officer; • Sending out agendas and supporting papers to Members at least five working days before the meeting. • Liaising with attendees invited to LTJC meetings under paragraph 10 • Drafting minutes including an updated version of the Work Plan for approval by the Chair within five working days of any LTJC meeting. • Distributing approved minutes (including updated Work Plan) to all attendees following within 10 working days of Chair's approval. • Maintaining an on-going list of actions, specifying which Members are responsible, due dates and keeping track of these actions. • Publicising LTJC meetings, minutes and associated documents as appropriate • Providing such other support as the Chair requests, for example advice on the handling of conflicts of interest.
17	Authority	The LTJC is authorised to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires within its remit, from any officer of a Trust. The Trusts shall ensure that their officers co-operate fully and promptly with any such request made by the LTJC. The LTJC is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations provided it ensures that full funding is available to meet the associated costs. The LTJC is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary provided it ensures that full funding is available to meet the associated costs. The LTJC is authorised to create sub-committees or working groups as are

		necessary to achieve its Purpose. The LTJC is accountable for the work of any such group. The LTJC may delegate decision-making to the LTJC Sub-Committees in relation to particular projects or workstreams. Such delegations will be in accordance with the guidance given by NHS England and will be appended to the relevant Sub-Committee Terms of Reference.
18	Conduct of the LTJC	Members must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity. Members of the LTJC will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct. The LTJC shall undertake an annual self-assessment of its own performance against the Work Plan and these Terms of Reference. This self-assessment shall form the basis of the annual report from the LTJC to the Trusts and the ICB Board.
19	Amendments	These Terms of Reference may only be amended by resolution of each of the Trust boards. Any amendments shall only take effect upon all Trust boards agreeing the change to the Terms of Reference or on such date as all Trust boards agree, whichever is the later.
20	Review date	These Terms of Reference will be reviewed at least annually and earlier if required. Any proposed amendments to the Terms of Reference will be required to be approved by all Trust boards.

APPENDIX 1 – LIVERPOOL CLINICAL SERVICES REVIEW GOVERNANCE ORGANOGRAM



APPENDIX 2 – TEMPLATE DELEGATION

[To be determined]

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/091b*		Date: 13/07/2023	
Report Title	Annual Evaluation of Board of Directors and Board Development Plan			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***This report provides an evaluation of the Board during 2022/23 and presents the progress made against the Board Development Plan 2022/23.***			
Action required	Approve ☐	Receive ☒	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – N *If no – please outline the reasons for deviation.*			
	The Board is asked to: • ***Note the Board evaluation for 2022/23*** • ***Note progress made against the Board Development Plan for 2022/23, noting potential areas for attention in 2023/24.***			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
N/A			

EXECUTIVE SUMMARY

This paper summarises the evaluation process and Board development work undertaken in 2022/23.

The Board is asked to:

- Note the Board evaluation for 2022/23
- Note progress made against the Board Development Plan for 2022/23, noting potential areas for attention in 2023/24.

MAIN REPORT

BOARD EVALUATION

The 2022/23 annual Board evaluation process has comprised five components:

i) Regular Evaluation of Board Meetings and dynamics

The Board routinely undertakes an informal evaluation of the Board at the end of every Board meeting and a summary of the feedback from Directors is recorded in the minutes of the meeting. Throughout the year the quality of papers and contribution from members and officer has been good with noted improvements from previous years. There has been a recognised need to ensure that papers presented to the Board can provide a clear commentary from other forums and to ensure they provide a balanced perspective with financial, quality and workforce issues reflected.

The Board welcomed the opportunity to return to face-to-face meetings for the entirety of 2022/23 following the restrictions that had been in place due to the coronavirus pandemic.

By the end of March 2023, all essential Board items had been reviewed with an additional section of the Board being added during the year to focus on issues pertaining to maternity services. In addition to a patient story being received, during the year the Board also received updates from Divisions and particular service areas to provide an opportunity for deeper oversight and understanding.

The Board has been required and will be required to maintain strong oversight on financial and operational performance, 2022/23 being highly challenging and the coming year anticipated to be more so. The impact of financial pressures on quality, outcomes, and patient experiences and the balance required in decision making will require particular attention. Equality, Diversity and Inclusion improvements continue to be pursued alongside driving cultural change as high priorities. As the leading tertiary women's health Trust Maternity safety and performance is front and centre of Board thinking and actions from recent CQC inspections are all areas for Board scrutiny.

The coming year will see powerful issues converging, the long highlighted clinical sustainability and isolated site issues, the long-term viability of small Trusts and the long understood underlying financial position these will bring increased external scrutiny but also opportunity to work more collaboratively and sustainably. The year saw the prospect of advancing the long-term strategic goal of co-location change as the system took a more direct role.

In summary the Board has continued to develop through the year with strong relationships between the Directors maintained and new relationships built. Non-Executive Directors continue to display a wide range of skills, knowledge and abilities and the balance of these will again be enhanced with specific Board and team development activity.

ii) Evaluation of Board Assurance Committees

Each Committee has completed its annual evaluation with all concluding that all had met their key objectives for 2022/23. The committee effectiveness reviews included a desktop review and survey. All Terms of Reference have been reviewed and an assurance report provided to the Board of Directors.

iii) Individual Performance Reviews and Personal Development Planning

There is an established process in place for individual performance review and objective setting for each Director on at least an annual basis.

All Directors participate in an annual appraisal process which includes evaluation of their performance against objectives agreed at the beginning of each year. The Chair appraises all Non-Executive Directors, and the Senior Independent Director appraises the Chair, taking into account the views of other Board members, members of the Council of Governors and external stakeholders (e.g., Chair's from system partners) as part of this process. The outcomes from appraisals of the Chair and Non-Executive Directors are reported to the Council of Governors. The Chief Executive appraises Executive Directors, and the Chair appraises the Chief Executive. A report on outcomes of these appraisals is presented to the Nomination and Remuneration Committee of the Board of Directors.

Throughout 2022/23 the Chair has maintained regular one-to-one discussions with each Non-Executive Director as has the Chief Executive with each member of the Executive Team. The Executive Team have continued to be present on site throughout the week with a formal Executive Team meeting every Wednesday. In addition, the Chair held at least monthly MS Teams calls with the NEDs to keep them fully informed of Trust performance and developments, Integrated Care System and national developments, risks and priorities. NEDs' walkabouts were reintroduced, and there are plans to involve Governors in walkabouts in 2023/24.

iv) Well Led, Board composition and succession planning

NHS England (then NHS Improvement) published its Well-Led Framework in June 2017. The Framework provides a means for trusts to undertake developmental reviews to assess their arrangements for effective leadership and governance. The Framework is based on eight Key Lines of Enquiry (KLOE), consistent with those used by the Care Quality Commission for inspection purposes, and outcomes of periodic reviews inform the content of Board-owned development plans to enhance practice, as appropriate, across the range of KLOE subject areas.

The Trust last commissioned an external review in 2021 (commencing in January 2021, final report received in July 2021) by Grant Thornton. Grant Thornton was appointed following a tender exercise and were fully independent from the Trust.
The independent review confirmed that there were no material governance concerns and several areas of good practice were noted, particularly:

- The Trust is focussed on quality and sustainability and this features in meetings throughout the levels of the organisation
- The data and information available to Divisions is of good quality and used to guide operational performance conversations at Divisional meetings and performance reviews, providing a 'golden thread' between Divisions and the Board
- The Trust has many examples of how it has worked extensively with its partners on the delivery of its services

Some areas for further work and opportunities for improvement were also highlighted, which the Board of Directors acknowledged, and these were the subject of an action plan. Examples included:

- Ensuring that best practice is shared between the respective Divisions to work towards a maturity level parity.
- The need to ensure that a documented Quality Improvement Methodology is in place
- Learning from serious incidents is an area that requires strengthening.

There is an expectation that trusts will, in addition to an independent external validation being undertaken every three years, undertake annual development review activities, with the scope determined by the Board of Directors. In September 2022, the Trust reviewed its current well-led action plan alongside several published documents that related or impacted NHS provider governance to help to ensure that the Trust's well-led aims are aligned with these. This included the update of the Code of Governance NHS England guidance documents on good governance and collaboration; and an addendum on the role of foundation trust councils of governors.

As expected, there is a significant focus on 'system' within the documents and therefore the updated well-led action plan focused upon areas of improvement to support the Trust's approach to being a 'good partner' as the Integrated Care System matured and developed.

A process is underway to reflect on the most recent CQC report and key themes around 'well-led' will be identified and included within an updated well-led action plan which will report to the Board in September 2023.

A detailed succession plan was received by the Nomination & Remuneration Committee in October 2021 and it is suggested that this process is repeated in 2023. The skill mix and composition of the Non-Executive cohort is reviewed annually by the Council of Governors.

v) 2022/23 Board Development Plan

The 2022/23 Board Development Plan is attached at Appendix 1 and summarises the development work undertaken by the Board of Directors during the last 12 months.

All Board directors participated in the 2022/23 Board Development Plan with dedicated time scheduled throughout the year. In addition to the collective programme, individual Board members have throughout the year participated in numerous online webinars and reviewed briefing papers and guidance issued by NHSE, NHS Providers, HFMA, Cheshire and Merseyside ICS, NHS Confederation, alongside the regular communications and leadership webinars. Topic areas included system development, collaborative working, health inequalities, risk appetite, estates strategy, finance strategy and operational planning. This engagement has provided significant personal development and has supported Board members in keeping abreast of key developments, issues, challenges and policy direction along with the Trust's response. The 2023/24 Board development plan will continue to build on these themes and comments are sought ahead of this being presented in September 2023 for review and approval.

Individual professional development programmes supplement this collective programme and are agreed between each executive team member and the Chief Executive (Chair for the Chief Executive) and between each NED and the Chair. The Trust regularly accesses the development programmes provided by NHSE, NHS Providers, MIAA, AQuA and other bodies to support the development of Directors as well as clinical leaders and senior managers.

A joint training session between Non-Executive Directors and the Council of Governors in September 2022 provided an opportunity to reflect on roles and responsibilities and ways of working. This was a successful session and something that the Trust will look to replicate for NEDs and Executives during 2023/24.

RECOMMENDATION
The Board is asked to:

- Note the Board evaluation for 2022/23
- Note progress made against the Board Development Plan for 2022/23, noting potential areas for attention in 2023/24.

Liverpool Women's
NHS Foundation Trust

Board Development Programme

October 2022 – October 2023

Strategic Aim	Topic	Link	Intended Outcome	Lead Director	Date										
					Oct 22	*Nov 22*	*Dec 22*	*Jan 23*	*Feb 23*	*Mar 23*	*Apr 23*	*May 23*	*Jun 23*	*7 Jul 22*	*1 Sept 22*
To develop a well led, capable, motivated and entrepreneurial workforce.	Fair & Just Culture Book Clubs	Trust Strategic aim / NED PDRs	For Board members to participate in Fair & Just Culture 'Book Clubs'	CPO	Throughout the year										
	Effective Board Dynamics		To follow up session held in August 2022	Chair / CPO						✓					
	Anti-racism – an introduction	Trust strategic aim	To understand the Trust's approach and develop Board members awareness. To also identify effective approaches for the Trust to take forward.	CPO						✓					
	CQC Preparation		To outline the work undertaken by the Trust to develop a state of 'readiness' for inspection and to outline the role of the Board and support available for preparation.	CN	✓			✓	✓						
To be ambitious and efficient and make best use of available resources.	Electronic Patient Record	Key strategic aim	To provide the Board with a common understanding of the current issues, progress made to date and future requirements	CIO	✓										
	Integrated Care System	Key strategic aim	To receive update on developments with the ICS and consider actions that the Trust may need to take	CEO / Chair	✓										
	Information Governance	Statutory requirement	To outline the Board's responsibilities for Information Governance	CIO									✓		
	Cyber Security	BAF risk	To outlines the Board's responsibilities for cyber security and to reflect on the efficacy of the Trust's current controls in light of a highly rated BAF risk.	CIO						✓					
	Finance and Operational Planning	BAF Risk	To understand and contribute to the Trust's approach for 2023/24 considering the significant level of risk	CFO						✓					
To deliver safe services.	Future Generations	Trust strategic aim	To receive update on progress against the Expression of Interest and any potential future actions.	CFO											
	Safeguarding	Statutory requirement	To outline the Board's responsibilities for Safeguarding	CN&M						✓					
	Health & Safety	Statutory requirement	To outline the Board's H&S responsibilities.	CN&M									✓		
To participate in high quality research to deliver the most effective outcomes	Strategic Objectives / Risk Appetite and BAF		To discuss the strategic objectives for 22-23, the Trust's risk appetite and the implications for the BAF.	CN&M / TS						✓					
	Leading on Women's Health Strategy	Key strategic aim	To include aspects such as; Role in PLACE, Liverpool 'Pound', Anchor Institution, 'Thought Leader', Corporate Social Responsibility, addressing inequalities.	CEO				✓							
	Quality Improvement		To consider purpose of the session										✓		
To deliver the best possible experience for patients and staff.	How do we listen?	Link to BAF risk. Identification as key strategic priority	To understand the Trust's mechanisms for engaging with current and potential service users and the wider community. To explore whether there are further opportunities to make improvements.	CN&M										✓	
	Trust Psychologist & Staff Health & Wellbeing Update	Trust strategic aim	To understand the Trust's approach to staff health and wellbeing	CPO				✓							

	Trust Strategy	Well-Led Review	Update on devivery to date and future steps.	CFO	✓										
	Digital Inclusion	Trust Strategy	We are planning some work with Microsoft and hope to be a lead Trust for digital inclusion with the tools that are available for our staff and patients to benefit from.	CIO						✓					

Colour Code:

Board Skills Training

Developmental Discussion / Strategy Development

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/091c*		Date: 13/07/2023	
Report Title	Governance and Performance Framework 2023/24			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***The report outlines the updates made to the Trust's Governance & Performance Framework since its adoption in July 2021.***			
Action required	Approve ☒	Receive ☐	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – N *If no – please outline the reasons for deviation.*			
	The Board is asked to approve the updated Governance and Performance Framework and the adoption of the processes and templates included within the document.			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☐

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
The updated framework has been discussed at the Trust Management Group, Executive Team and aspects at the Finance, Performance & Business Development Committee			

EXECUTIVE SUMMARY

The Governance and Performance Framework is a comprehensive resource that outlines the Trust's approach to governance and performance management. It consists of three sections, covering corporate governance processes, performance management, and standardized meeting procedures. Since its implementation in July 2021, the framework has driven positive changes, such as streamlined reporting structures, improved performance reports, and enhanced templates. However, the healthcare landscape has evolved, prompting necessary updates to the framework. Proposed changes include refining the Finance, Performance and Business Development Committee structure and simplifying the Performance Management Framework and meeting templates. Future work involves auditing Divisional Boards, developing best practice templates, and continuing training initiatives.

The Board is asked to approve the updated Governance and Performance Framework and the adoption of the processes and templates included within the document.

MAIN REPORT

INTRODUCTION

The Governance and Performance framework brings together a range of current and new practice to support the Trust's governance journey. The document should operate as a 'One stop shop' for staff and external stakeholders to understand the Trust's approach to governance and performance management.

The Framework incorporates three sections:

- Section 1 describes the Trust's Corporate Governance processes, the context within which the Trust operates and how it identifies and manages risk.

- Section 2 describes how the Trust will utilise improved information management to drive better performance and introduce a tiered performance management process to ensure a rigorous, supportive and consistent approach to performance management is achieved at all levels of the organisation.

- Section 3 outlines a standardised approach to Trust meeting and provides templates to be used across the organisation.

The framework has been in place since July 2021 and this report provides a reflection on the progress made to date, identifies proposed updates / amendments, and outlines further work planned in the spirit of continuous improvement.

REFLECTION ON PROGRESS MADE TO DATE

The draft Governance and Performance Framework (as viewed by the Board in December 2021) has been used to drive changes in governance structures, performance management process and administrative processes. The below are examples of the improvements made to date:

- Streamlined reporting structure into the Quality Committee which has helped to strengthen the underpinning assurance processes. This remains an area of continued focus going into 2023/24.
- Updated Performance Report now embedded at all levels of the organisation
- Earned autonomy model of performance management is well embedded and understood with increased oversight of divisions put into place by the Executive Team when necessary

- Updated templates started to become embedded throughout the organisation, most successfully with the use of the new Chair's Report template that has strengthened the flow of assurance through the governance structure.
- Training on report writing and meeting administration has continued on a rolling basis

UPDATES MADE TO THE FRAMEWORK

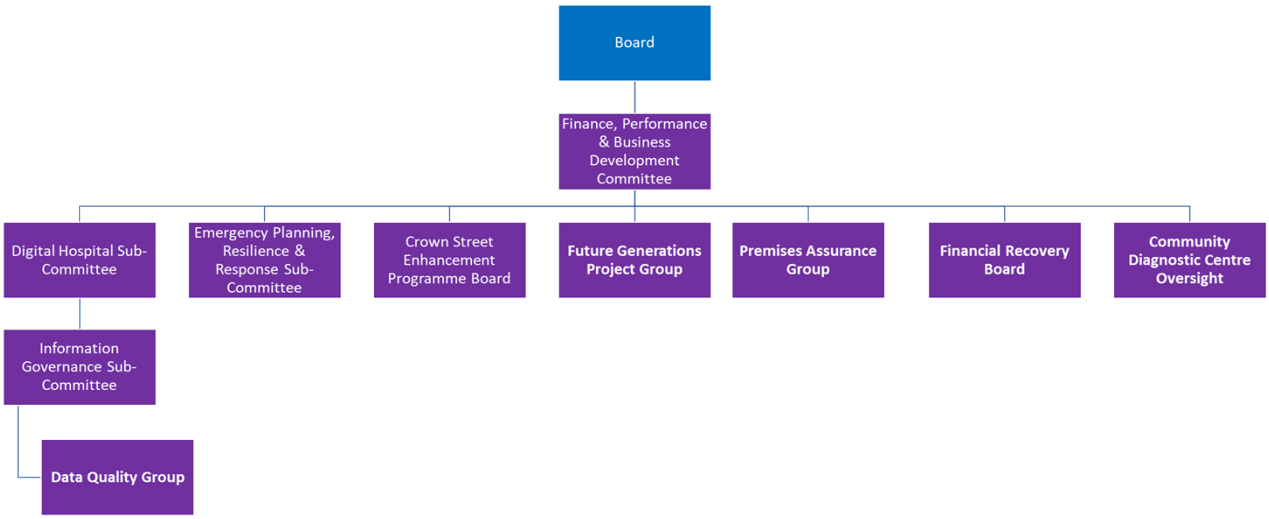
The framework has been in place since 2021 and the healthcare landscape has shifted significantly since that point. There have therefore been several 'housekeeping' amendments made to ensure that there are the requisite references to the Integrated Care Board and NHS England. Other 'housekeeping' amendments include –

- Board level responsibilities updated
- Corporate Calendar updated
- Board & Committee Structure & membership updated
- Risk Appetite statement updated

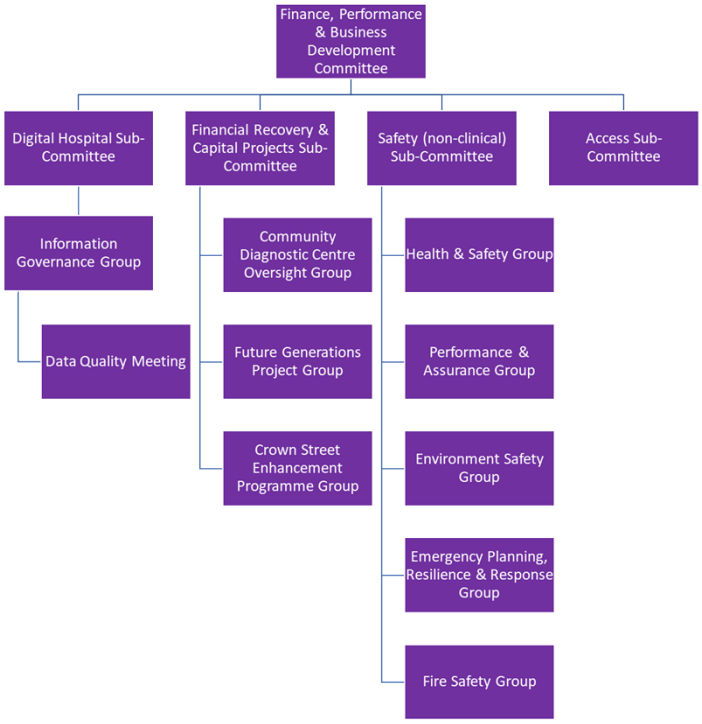
Changes to the underpinning Finance, Performance and Business Development Committee (FPBD) structure

Some observed issues with current structure:

- Number of operational level meetings reporting directly into FPBD – these have grown over the last couple of years
- The reporting of non-clinical safety matters is separated into different meetings – the health and safety group reports into Quality Committee (via Corporate Risk sub-committee) whilst other matters report into FPBD via distinct routes
- The Financial Recovery Board remains an 'ad hoc' meeting in status – financial recovery and performance being an issue that requires even greater focus and attention.



Proposed amendments:



Suggested benefits:

- Streamlined reporting and assurance to FPBD
- Permanent space for Executive Led scrutiny on financial performance and recovery
- Safety (non-clinical) sub-committee – benefits
    - enable the Trust to have increased visibility on all matters pertaining to safety
    - heightened control over key risks
    - standardise approach Trust-wide
    - link Trust security and operational risks to its EPRR strategy (preparation and response)
    - Centralise the Trust workplans across subgroups below to prioritise the highest risk and oversee appropriate mitigation plans
    - Support and develop appropriate work, based on risk and resources
    - Provide additional assurance for the management of Trust security and risk

Changes to the Performance Management Framework (section 2)

With reflections and lessons taken since the implementation of the Performance Management Framework it is proposed that action is taken to simplify the structures and processes. This includes removing the specific criteria and risk levels for earned autonomy with this being replaced by three levels and space for Executive judgement. Diagrams for the framework and the relationship with the assurance framework have also been streamlined and simplified.

Changes to meeting templates and guidance (section 3)

It is proposed to make some significant changes to report template used for Board and Committee meetings. The new template has removed the tick box approach and provides greater space for narrative in order to encourage completion. Recognising the need for the Trust to reflect system priorities in its decision-making, sections have been added that prompt content regarding links to system aims; Trust

strategy; ED&I; quality, financial and workforce implications; and links to the Board Assurance Framework (BAF) and Corporate Risk Register (CRR)

The meeting guidance notes have also been refreshed in order to streamline the content (from >3 pages to 1.5 pages).

FUTURE WORK PLANNED

Despite progress having been made in embedding the Governance & Performance Framework, work will need to continue to drive further improvements and support the Trust in its journey to a 'good' well-led rating.

- Auditing of Divisional Boards to ensure that their governance and performance management processes are operating effectively and in line with the framework (supported by the Audit Committee)
- Best practice templates for Committees and the Board to be developed to support report authors to ensure content is reflecting Trust and system priorities and demonstrating balance between financial, quality and workforce elements.
- Training on report writing and meeting administration to continue on a rolling basis.

RECOMMENDATION

The Board is asked to approve the updated Governance and Performance Framework and the adoption of the processes and templates included within the document.

Liverpool Women's
NHS Foundation Trust

Governance and Performance Framework 2023/24

Supporting high-quality governance standards for our colleagues and their teams

Overview

What is the Governance & Performance framework?

This framework outlines the structure, accountabilities and processes by which governance (including the onward assurance to the Board of Directors) and performance management is achieved at the Liverpool Women's NHS Foundation Trust.

It is relevant to governance across the activities of the Foundation Trust but it is particularly applicable to two of the Key Lines of Enquiry in the Well-Led Framework:

- Are there clear responsibilities, roles and systems of accountability to support good governance and management (KLOE 4)?
- Are there clear and effective processes for managing risks, issues and performance (KLOE 5)?

What is the purpose of the framework?

This framework is intended to document and provide a clear explanation of the governance, performance management and delivery mechanisms within the Trust. It is based on best practice guidance and examples, from within and without the NHS Foundation Trust sector, in corporate and integrated governance.

It reflects the Trust's arrangements and systems to use information and intelligence, at strategic and operational levels, to improve services and manage risks to delivery. Further, it details the arrangements that the Board has put in place so that it may be assured with regard to performance and achievement of the Trust's Strategic Objectives and when it needs to take action to drive further improvements.

Fundamentally, the purpose of this framework is to explain and document the governance and performance management processes that the Board and Executive have put in place to facilitate and to gain assurance that the Trust is 'well-led', operating efficiently, achieving its objectives and delivering the best possible care for its patients.

How to get the most out of this Framework (and how it is structured)?

This document will provide a comprehensive overview of governance and performance management structures and mechanisms in the Trust and the contents page will allow navigation through the relevant sections. It is structured in three sections:
- corporate governance;
- performance and accountability framework;
- effective meeting practice

Contents

Executive Summary

Governance in this context is the system by which the Trust is directed and controlled. The Board of Directors is responsible for overseeing the governance of the Trust. This includes setting the Trust's Strategic Objectives and providing the leadership to put those Objectives into effect. The Assurance Framework enables the Board of Directors to supervise the management of the Trust. It is to be distinguished from the day-to-day operational management of the Trust by full-time executives.

Governance is primarily conducted and orchestrated through the leadership and functions of the Board. It is however the business and concern of everyone in the organisation. For the Board to undertake its duties effectively, (and for the Trust to provide the best services to patients) it requires the structure, people and process of governance to be integrated into the fabric of the organisation and, that any "Ward to Board" risks and issues are well-articulated and escalated via an easily navigated path. A key job of the Board is to seek assurance that risks to its strategic objectives are known and that there are clear plans in place to mitigate, eliminate or manage those risks. The Board is the key place where all the aspects of governance (clinical, financial, workforce, staffing, information, research etc.) come together.

To deliver effective governance requires some core competency skills across the organisation. This document aims to improve our understanding of governance in the Trust and has focused on the associated structures, systems and processes.

Using the building blocks of the Well-Led Framework for the NHS and best practice in corporate and integrated governance, this document explains how the Trust uses available information and intelligence to plan at strategic and operational levels to improve services and manage risks to delivery, assurance is provided with regard to performance, how it identifies when to take action to effect change and how the Board of Directors exercises its accountability to those who deliver and use its services.

The hope is that this document will provide a useful reference guide for those people, internally and externally, who have an interest in the governance of the Trust.

For staff and leaders in the Trust it should provide information to facilitate the escalation of risks and enhance understanding of where and what reports should be made and why the flow of information from Ward to Board, and vice versa, is so important if the Trust is to achieve its potential and if we are to provide the best possible care to our patients in an efficient, reliable, and sustainable way.

Through being clear and transparent about our structures and the ways in which the Board will oversee performance, gather information, obtain assurance and make decisions the aim is to strengthen the governance of the Trust as a core component of our aim to become an 'Outstanding' Trust.

Introduction

This Guide describes the way in which the organisation effectively “governs” its business in order to achieve its objectives. The system of governance is a series of dependent relationships that link the structure, people and processes by which governance is delivered.

- The Board of Directors leads the Corporate Governance oversight within the organisation, providing both internal and external assurance about our work. It achieves that by oversight of the Trust’s management and operational processes. **Section 1** of this document describes the Trust’s Corporate Governance processes, the context within which the Trust operates and how it identifies and manages risk.

- It is important that the Trust has a clear Performance Management Framework which sets out the overarching principles and approach to delivering a high performing organisation. This framework aims to ensure that the Trust successfully delivers national standards for performance and contractual targets agreed with commissioners. **Section 2** of this document describes how the Trust will utilise improved information management to drive better performance and introduce a tiered performance management process to ensure a rigorous, supportive and consistent approach to performance management is achieved at all levels of the organisation.

- To support the Trust’s Governance and Performance Frameworks, it is vital to ensure that meetings are: effective (carry out actions); timely; attended by the right people; and recorded. **Section 3** of this document outlines a standardized approach to Trust meeting and provides templates to be used across the organisation.

Section 1 – Corporate Governance

This section outlines the corporate oversight of the organisation by describing:

- The way in which the organisation takes into account external stakeholders and regulatory context
- The Governance Road Map: an overview of the improvement plan to strengthen and embed robust and sustainable corporate and clinical governance systems
- The overall vision and strategy of the Trust
- The way in which the Board receives and uses information in order to make decisions and gain assurance through its committee structure
- The role of the Council of Governors and its relationship with the Membership and Board of Directors
- The approach to risk management and related processes within the Trust

Regulatory Framework

Proportionate, risk-based regulation plays an important role in building public confidence in the NHS.

Two main regulators hold NHS Foundation Trusts to account for the quality of care they deliver and how they are run.

- The **Care Quality Commission** is the independent regulator of health and social care services, they register, inspect and monitor providers of health services including NHS Foundation Trusts, and enforce action where necessary
- **NHS England** is responsible for overseeing providers of NHS funded care acting as both an economic regulator and supporting providers to meet standards set by the CQC.

The NHS oversight framework for 2022/23 replaces the NHS system oversight framework for 2021/22, which described NHS England and NHS Improvement's approach to oversight of integrated care boards (ICBs) and trusts.

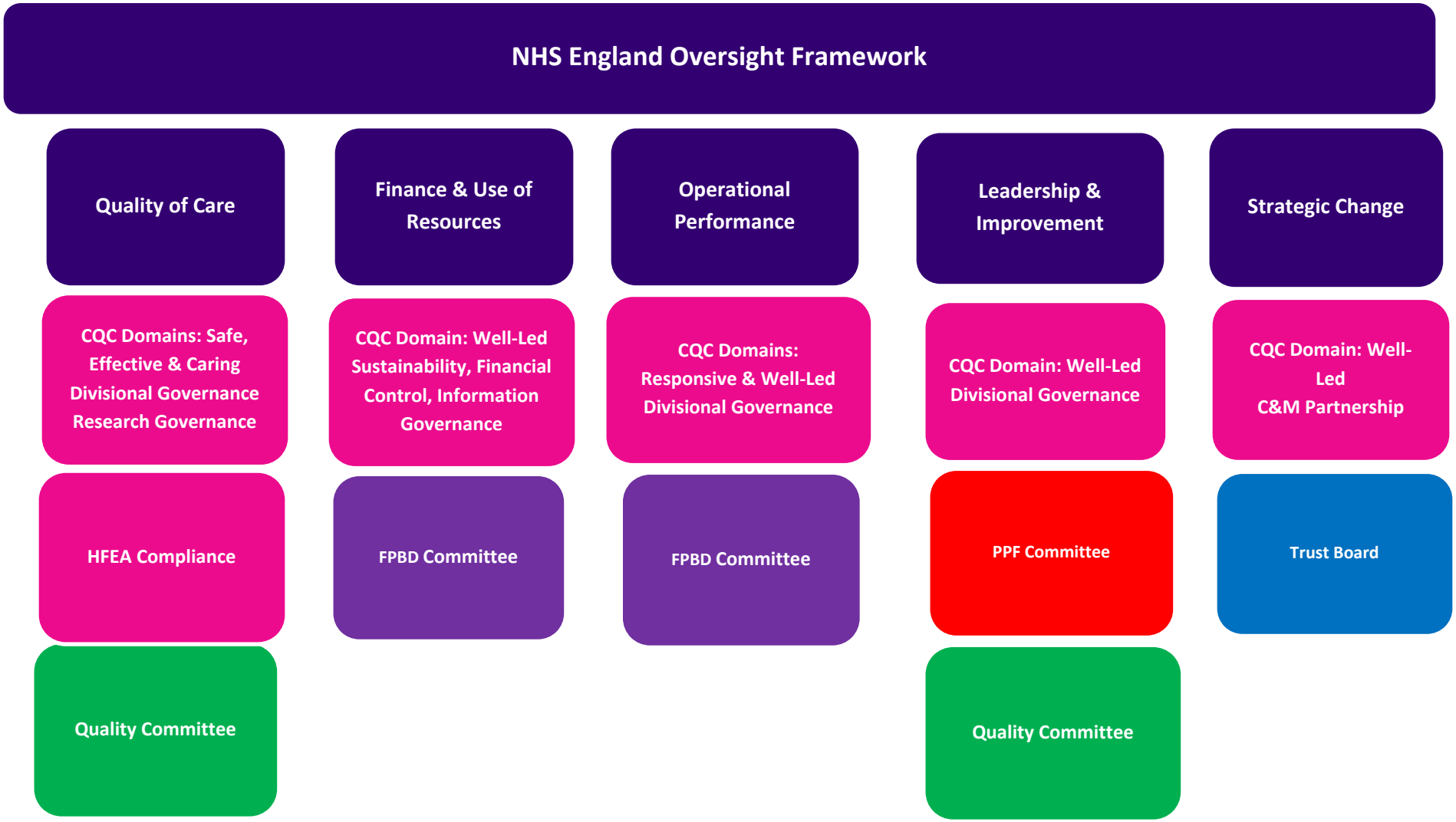
This framework outlines NHS England's approach to NHS oversight for 2022/23 and is aligned with the ambitions set out in the NHS Long Term Plan and the 2022/23 NHS operational planning and contracting guidance. It also reflects the significant changes enabled by the Health and Care Act 2022 including the formal establishment of integrated care boards and the merging of NHS Improvement (comprising of Monitor and the NHS Trust Development Authority) into NHS England.

The framework describes how the oversight of NHS trusts, foundation trusts and integrated care boards will operate. This supports the ambition for system-led delivery of integrated care in line with the direction of travel set out in the NHS Long Term Plan, Integrating care: next steps to building strong and effective integrated care systems across England and the government's white paper on integration – Joining up care for people, places and populations.

The Trust is also subject to regulation from the **Human Fertilisation & Embryology Authority** (HFEA). This is a Government regulator responsible for making sure fertility clinics and research centres comply with the law.

Good governance of the organisation ensures that the Board can give an account to stakeholders of its strategic and operational management of the organisation. Our improvement programme, strategic objectives and performance measures are therefore aligned to this framework and this is illustrated on the next page.

How the regulatory framework 'maps' onto our Board Committee Structure



Integrated Care Board and Provider Collaboratives

Integrated Care Boards (ICBs) are statutory NHS organisations responsible for developing a plan in collaboration with NHS trusts/foundation trusts and other system partners for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the defined area.

ICBs were established in July 2022 as part of the Health and Care Act 2022. They replaced clinical commissioning groups (CCGs) and some of the direct commissioning functions of NHS England.

Each ICB is responsible for a defined geographical area, known as an integrated care system (ICS). ICSs are partnerships of NHS bodies and local authorities, working with other relevant local organisations, that come together to plan and deliver joined up health and care services to improve the lives of people in their area.

What does this mean for the Trust?

NHS providers are increasingly being expected to look beyond their organisational priorities to focus on system-wide objectives and improving outcomes and reducing inequalities for the communities they serve. While the legal functions and duties of NHS trusts and foundation trusts remain largely unchanged under the recent reforms, they are also expected to participate in multiple collaborative forums, including membership of the ICB and forming collaboratives with other providers. NHS trusts and foundation trusts are also now bound by a new duty to collaborate with local partners and a shared duty to promote the triple aim*.

Liverpool Women's NHS Foundation Trust is part of the NHS Cheshire & Merseyside ICB and is also a member of the Cheshire & Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative. As part of this membership, the Trust has formed a committee-in-common** and signed a Joint Working Agreement. The committee-in-common reports to the Board.

**The triple aim is a legal duty on NHS bodies which requires them to consider the effects of their decisions on:*

- *the health and wellbeing of the people of England (including inequalities in that health and wellbeing)*
- *the quality of services provided or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services)*
- *the sustainable and efficient use of resources by both themselves and other relevant bodies.*

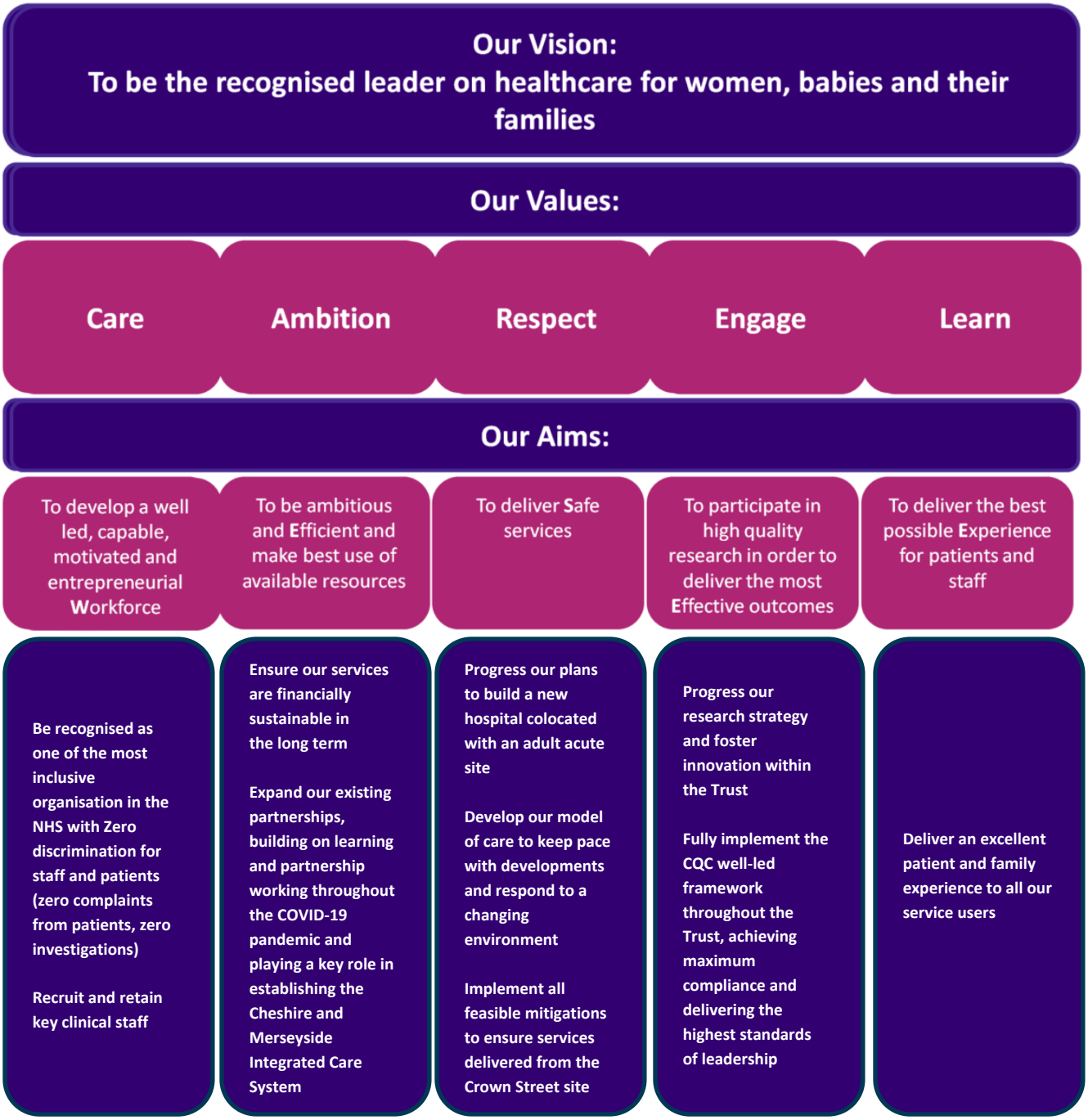
*** A Committee in Common (CiC) in the NHS is a joint committee that is made up of representatives from two or more NHS organizations, usually NHS Trusts or NHS Foundation Trusts. The purpose of a CiC is to provide a forum for collaboration and decision-making between the participating organizations on matters of mutual interest or concern.*

CiCs are typically established to oversee joint initiatives, share resources, or coordinate services between NHS organizations. CiCs are an important mechanism for promoting collaboration and partnership working between NHS organizations. By working together in this way, NHS organizations can achieve economies of scale, share knowledge and expertise, and provide better services to patients.

Our Vision and Strategic Objectives

One of the hallmarks of a well led organisation is a compelling organisational vision that puts quality of care and the safety of its patients central to all of its activities, having been agreed in consultation with stakeholders, patients and staff. The Trust's vision and strategic objectives are explicitly stated and are detailed below.

The Vision and Objectives are the framework against which the Board is able to measure organisational success and to effectively scrutinise performance and to hold management to account through the Board Assurance Framework (BAF). The BAF therefore enables the Board to monitor and drive overall improvement.

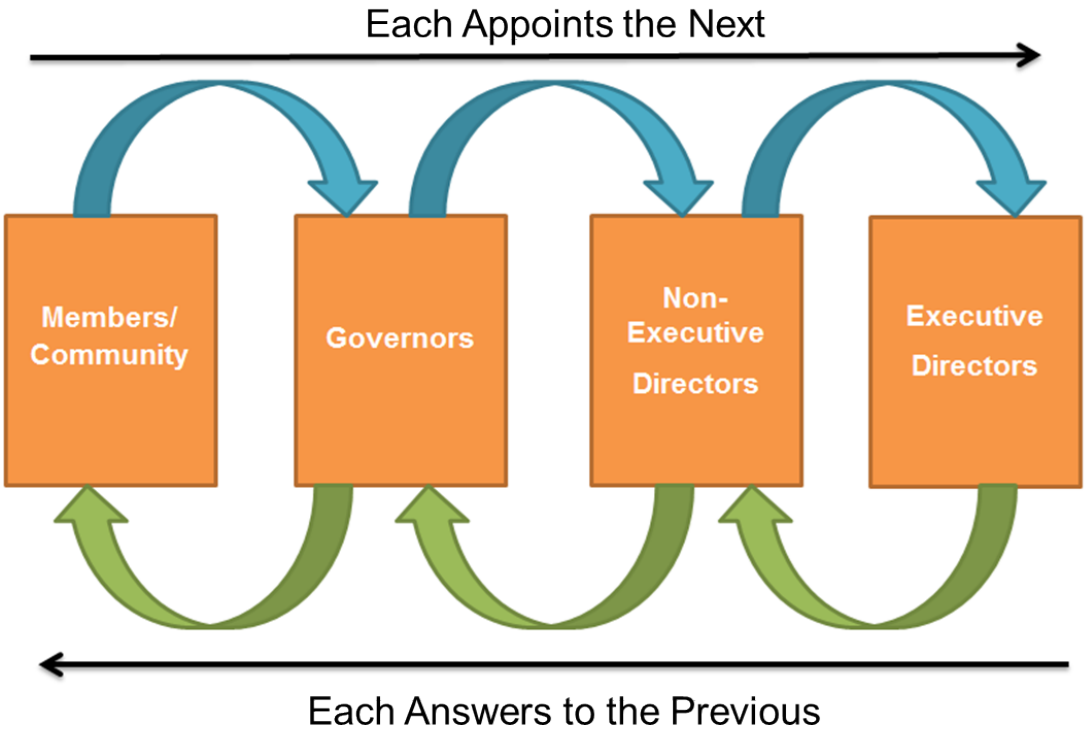


Foundation Trust Governance Structure

Accountability from the Trust flows outwards to national healthcare regulators as well as to the public who access services locally. The Council of Governors, collectively, is the body that connects the Trust with its patients, staff and wider stakeholders in the community that it serves. It comprises governors who are elected by the public and staff members. It also includes stakeholder governors who are appointed by organisations who have an important relationship with the Trust.

Governors have key statutory duties to hold the non-executives, individually and collectively, to account for the performance of the Board of Directors and to represent the interests of the Members and the public. Governors therefore need to understand how the Board of Directors uses information and intelligence to understand and be assured that the Trust provides high quality sustainable services. This depends on a good flow of information between the Board of Directors and Council of Governors in order to support effective and informed dialogue and debate.

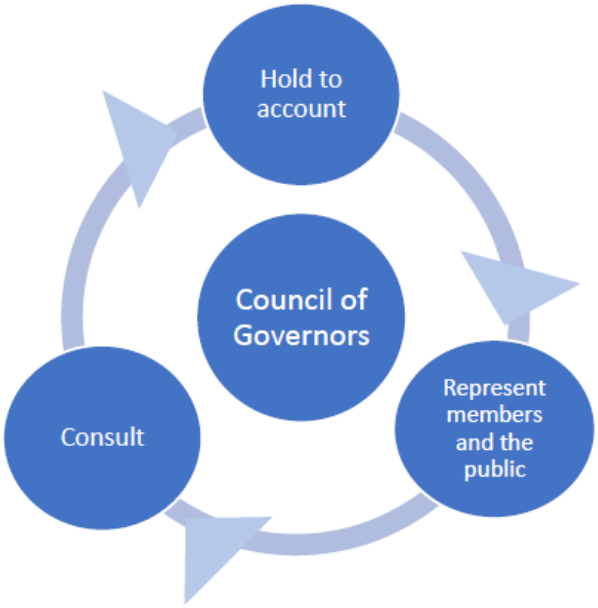
The interaction between the Council of Governors and the Board of Directors is therefore a key relationship in the governance of foundation trusts and the Trust Chairman leads both the Council of Governors and the Board of Directors.



Council of Governors

The Council of Governors' duties, to hold the non-executives to account for the performance of the board of directors and to represent the interests of Trust members and the public, are inextricably connected. As representatives of members and the public, governors need to communicate to the communities they serve about the activities and performance of the Trust. Equally they must feed-back views to the Board of Directors, so that these may be taken in to account when setting the Trust's strategies and plans.

- Appoint/remove Chair/NEDs
- Approve CEO appointment
- Appoint external auditors
- Receive annual report and accounts
- Require directors to attend their meetings to obtain information about performance of the Trust's functions and the directors' performance of their duties
- Approve board decisions on significant transactions, mergers, acquisitions, dissolutions etc.



- Share information about the Trust's strategy and forward plans with members
- Seek their feedback and report back to the Council of Governors and Board of Directors

- Consider and make suggestions on the Trust's strategy and forward plans ensuring the interests of members and the public have been taken into account
- Ensure collective views of members, public and stakeholders are put forward and represented

Members (we have a Membership of just under 10,000 staff and public)

Public, Staff and Partners

Partners appoint and Members elect representatives to sit on the Council of Governors

Views of members are fed to the Trust through the Governors

Governors consult with and inform members about the Trust's strategy and activities

Council of Governors

Chaired by Trust Chair, the Council consists of 27 governors elected by the members (staff and public) and 8 governors appointed by the Trust's key partner organisations

The Council appoints the Chair and Non-Executives to sit on the Board of Directors

It must approve appointment of Chief Executive

Council holds the NEDs to account for the performance of the Board in delivering its duties, ensuring interests of members and public are served

Approves significant transactions, mergers, acquisitions, dissolutions etc

Board works with the governors to ensure strategy and forward plan has regard to their views

Board of Directors

Includes Chair, Chief Executive, Non - Executive Directors and Executive Directors

The Board of Directors is responsible for all aspects of the operation and performance of the trust, and for its effective governance. The Board of Directors is collectively responsible for taking actions which legally bind the trust.

Corporate Assurance

In addition to setting the strategic direction of the organisation, the Board must identify and manage any likely risks and threats to achieving its strategic objectives.

The Board must ensure that there are robust systems of accountability that enable it to monitor and manage performance (operational, financial and quality) and the impact on patients and staff and achievement of the Trust's strategy and vision.

This is managed through delegated responsibility to Board committees and relevant Board members. Foundation Trusts are required by statute to have two Board committees - an Audit Committee and a Nominations & Remuneration Committee. The number and remit of other Board committees is determined by the Board, based on strategic priorities and operational requirements relating to quality, finance, performance and workforce.

By delegating responsibilities for seeking assurance in specified areas to Board Committees, the Board can ensure that there is adequate focus in these areas whilst freeing itself to give appropriate attention to matters of strategy, long-term sustainability and system working.

This section sets out the assurance map of the organisation and describes how information is received by each of the four main assurance committees of the Board, and then onward to the Board itself.

There are summaries for each board committee describing the responsibilities and reporting arrangements.

Board Level Responsibilities for Assurance

All Board members share corporate responsibility for formulating strategy, ensuring accountability and shaping culture. They also share responsibility for ensuring that the Board operates as effectively as possible. However, there are also distinct roles for different members of the Board, reflecting their organisational responsibilities and aligned to each of the Board Committees and sub-committees. Each executive Board member is responsible for leading implementation of strategy in their functional areas and takes principal responsibility for providing accurate, timely and clear information to the Board.

The Chief Executive is designated as the Accounting Officer for the Foundation Trust in accordance with the National Health Service Act 2006 and NHS Foundation Trust Accounting Officer Memorandum. This means that the Chief Executive has overall responsibility to Parliament for the organisation and management of the Trust, ensuring that it operates in accordance with statutory duties, making efficient and effective use of the Trust's resources, in a way which ensures the proper stewardship of public money and assets

Quality Committee	Finance, Performance & Business Development Committee	Trust Board	Putting People First Committee	Audit Committee	Charitable Funds Committee
Sarah Walker **Non-Executive Director**	**Louise Martin** **Non-Executive Director**	**Robert Clarke** **Chair**	**Gloria Hyatt** **Non-Executive Director**	**Tracy Ellery** **Non-Executive Director**	**Zia Chaudhry** **Non-Executive Director**
Lynn Greenhalgh – Medical Director Dianne Brown – Chief Nurse	Jenny Hannon – Chief Finance Officer Gary Price – Chief Operating Officer	Kathryn Thomson – Chief Executive	Michelle Turner – Chief People Officer	Jenny Hannon – Chief Finance Officer	Jenny Hannon – Chief Finance Officer

Corporate Calendar

Trust Board of Directors
Formal meetings – Feb, Apr, May, July, Sept, Nov & Dec – Week 2 (unless otherwise agreed or by exception)
Workshops on other months

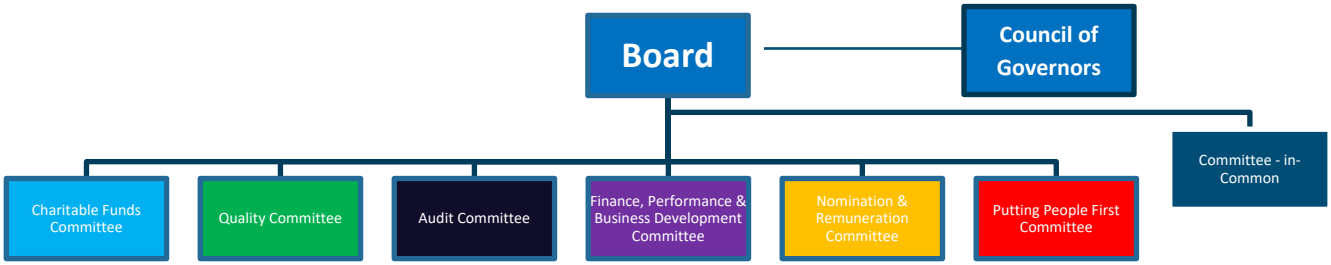
Quality Committee	FPBD Committee	PPF Committee	Audit Committee	CF Committee
Monthly Week 4	Monthly Week 4	Bi-monthly Week 3	Quarterly Week 3	Quarterly Week 2

Sub-Committees

Executive Team / Divisional Performance Review
Executive Team meets weekly
Divisional Performance Reviews are monthly (alternating between holistic WESEE meetings and focused meetings)

Divisional Boards
Meet Monthly

Board of Directors: Committee Structure



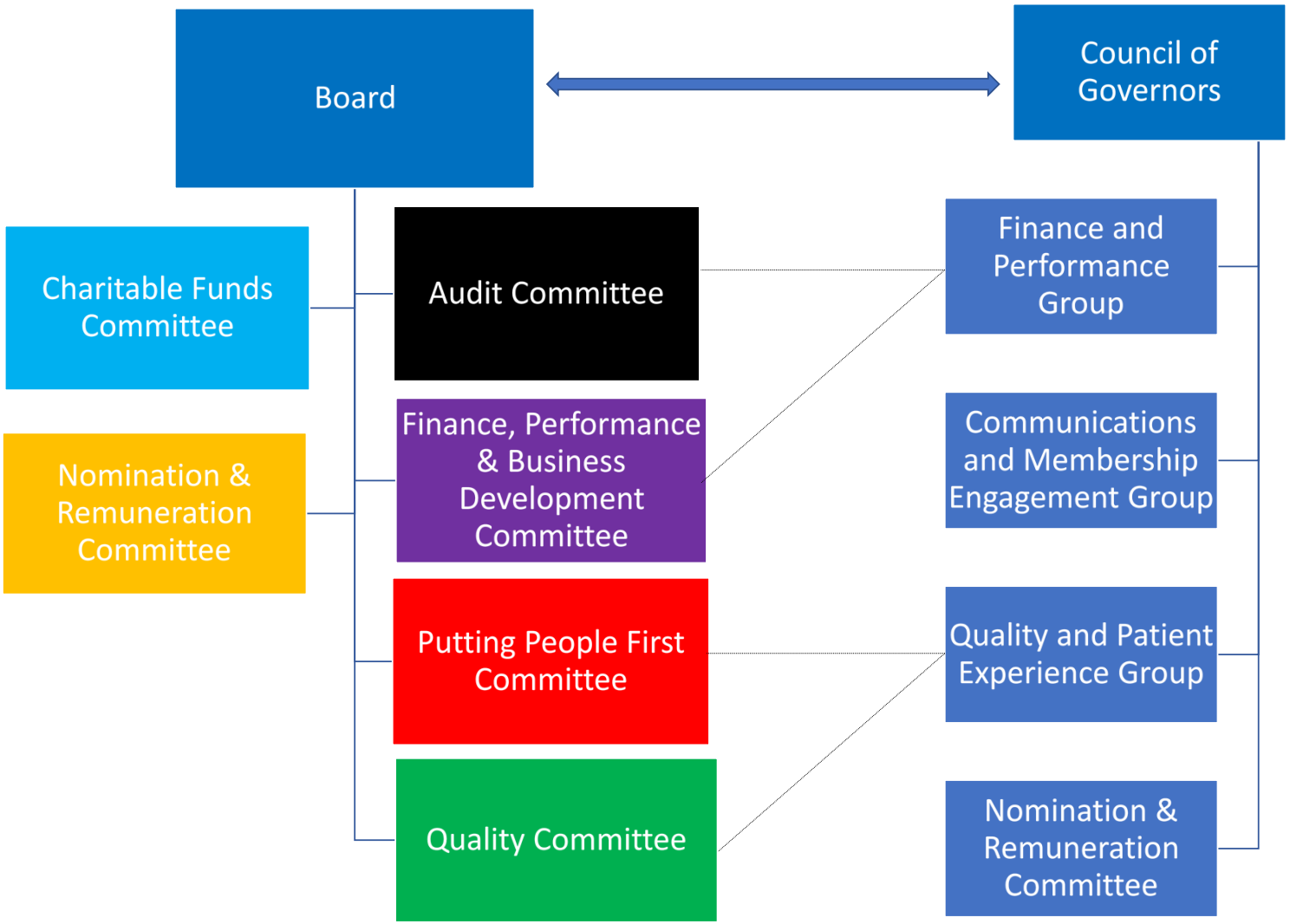
Board of Directors: Committee Membership

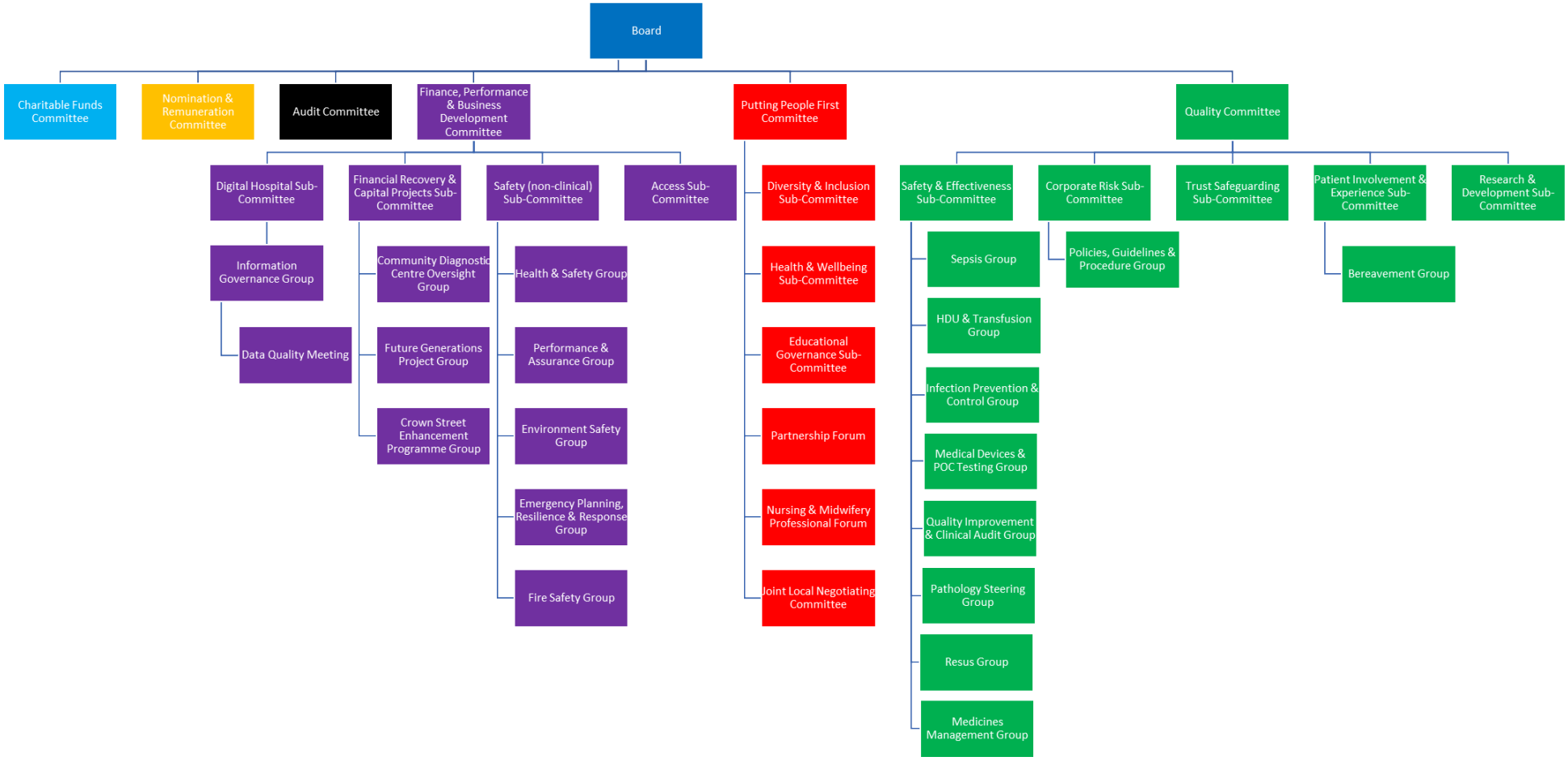
Board Committee	NED Membership
Audit Committee *Membership requirement is not less than 3 Non-Executive Directors*	Chair: Tracy Ellery NED: Jackie Bird NED: Zia Chaudhry Accountable exec: Chief Finance Officer
Finance Performance and Business Development Committee *Membership includes NED Chair and two additional NEDs*	Chair: Louise Martin NED: Tracy Ellery NED: Sarah Walker Accountable exec: Chief Finance Officer
Quality Committee *Membership includes NED Chair and three additional NEDs*	Chair: Sarah Walker NED: Jackie Bird NED: Gloria Hyatt NED: Louise Kenny Accountable exec: Chief Nurse & Medical Director
Putting People First Committee *Membership includes NED Chair and two additional NEDs*	Chair: Gloria Hyatt NED: Louise Martin NED: Zia Chaudhry

	Accountable exec: Chief People Officer
Charitable Funds Committee *Membership includes NED Chair and one additional NED* *Additional NED for succession/continuity/ development*	Chair: Zia Chaudhry NED: Louise Martin NED: Jackie Bird Accountable exec: Chief Finance Officer
Board Remuneration and Nomination Committee *Membership includes Chair and all NED's*	Chair: Robert Clarke NED: Sarah Walker Jackie Bird Tracy Ellery Gloria Hyatt Louise Martin Zia Chaudhry Louise Kenny

Assurance Structure

Council of Governor and Board Assurance Integration




Board
Charitable Funds Committee
Nomination & Remuneration Committee
Audit Committee
Finance, Performance & Business Development Committee
Putting People First Committee
Quality Committee
Digital Hospital Sub-Committee
Financial Recovery & Capital Projects Sub-Committee
Safety (non-clinical) Sub-Committee
Access Sub-Committee
Diversity & Inclusion Sub-Committee
Safety & Effectiveness Sub-Committee
Corporate Risk Sub-Committee
Trust Safeguarding Sub-Committee
Patient Involvement & Experience Sub-Committee
Research & Development Sub-Committee
Information Governance Group
Data Quality Meeting
Community Diagnostic Centre Oversight Group
Future Generations Project Group
Crown Street Enhancement Programme Group
Health & Safety Group
Performance & Assurance Group
Environment Safety Group
Emergency Planning, Resilience & Response Group
Fire Safety Group
Health & Wellbeing Sub-Committee
Educational Governance Sub-Committee
Partnership Forum
Nursing & Midwifery Professional Forum
Joint Local Negotiating Committee
Sepsis Group
HDU & Transfusion Group
Infection Prevention & Control Group
Medical Devices & POC Testing Group
Quality Improvement & Clinical Audit Group
Pathology Steering Group
Resus Group
Medicines Management Group
Policies, Guidelines & Procedure Group
Bereavement Group

Escalation, Assurance & Triangulation

The purpose of escalation is to effectively share information. It also ensures that the necessary help and support is provided to resolve issues. It is also important for senior staff and the Board to be appropriately briefed on what is happening in our front-line services.

Frameworks and structures exist to support us all. They are there to help us make the right decisions, whilst sharing information appropriately across the Trust. The Trust's meeting structure has been set-up to support the flow of information with routes and methods of escalation being embedded within the structure.

Looking at the key structures within this document will allow you to visualise how information is shared and managed throughout our Trust. It will enable you to see how it applies within your own area. The Board has a crucial role in ensuring the Trust provides safe, effective care and fulfils its statutory and regulatory obligations. To do so it needs to have in place effective internal and external sources of assurance which includes anything that negatively impacts on quality of care and identification of early warning triggers in relation to workforce, finance, and clinical services.

The value of assurance, based on robust evidence, can be further enhanced through 'triangulation'. This involves collecting and evaluating evidence relating to a similar subject or activity from several different sources, ideally more than two (known as triangulation) and considering them together rather than separately.

Triangulation enhances our ability to confirm the accuracy and completeness of what is being presented. The examples below demonstrate how triangulation can be used and illustrate its value:

Triangulation – use

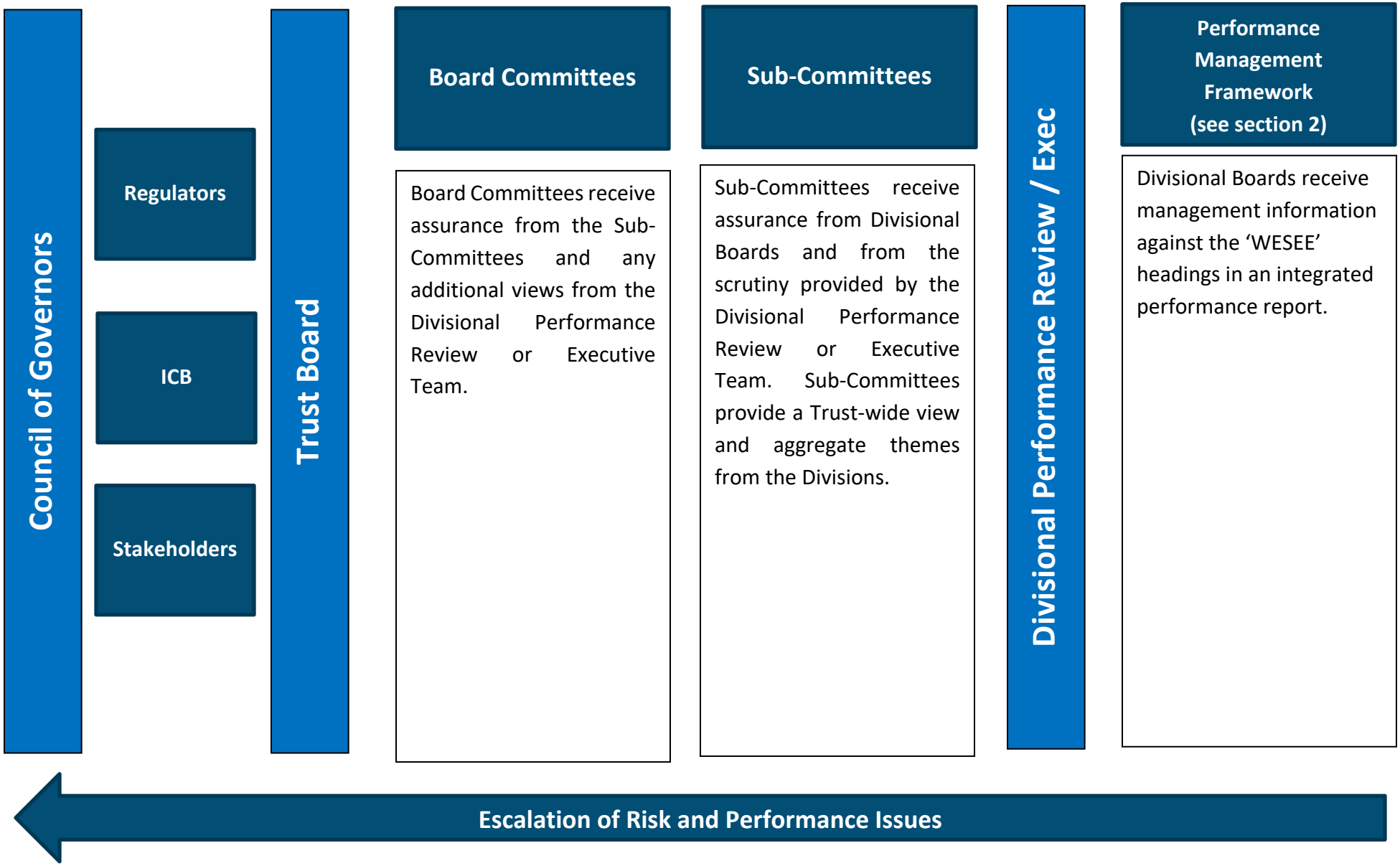
- visiting front line staff to determine whether data in performance reports is accurate and capturing all concerns
- considering findings from internal reviews and visits alongside papers presented at the meetings to corroborate findings
- reviewing qualitative information such as comments from service user and carer feedback and staff surveys alongside data in performance reports
- identifying potential risk areas through consideration of a range of different data simultaneously (e.g. workforce data on staff turnover, financial data on targets, quality indicators, etc)
- identifying common themes from patient safety incidents, case note reviews, audits and patient feedback

Triangulation – value

- indicators or metrics of quality performance are valid and reliable
- concerns about findings can be escalated
- there are detailed, credible and evidence-based findings underpinning action plans which can be delivered

- there is confidence in how Board/committee/group members work together and challenge evidence and action plans and resolve concerns
- the Board/committee/group avoids bias and undue influence
- ‘peers’ would be likely to reach a similar judgment based on the same information, in the same context

Flow of Information - Overview



Quality Committee

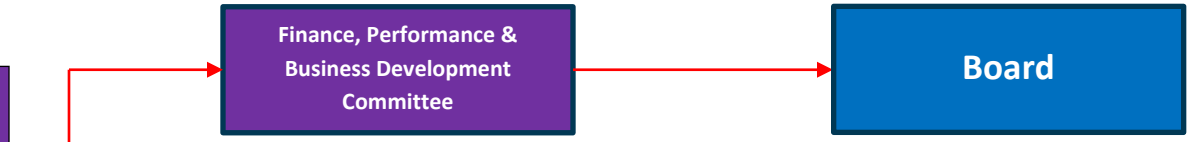
Key Sources of Assurance	
Divisional Performance Review	Provides assurance on the actions being taken on specific quality issues that have been escalated from the Divisional Board Meetings.
Patient Involvement & Experience Sub-Committee	Provides assurance against progress on the Trust's Patient Experience Strategy and an aggregated position escalated from the Divisional Boards regarding the 'Experience' domain.
Safety & Effectiveness Sub-Committee	Provides assurance regarding an aggregated position escalated from the Divisional Boards regarding the 'Effectiveness' domain and any issues requiring escalation from the supporting Groups reporting into the Sub-Committee.
	Provides assurance regarding an aggregated position escalated from the Divisional Boards regarding the 'Safety' domain and any issues requiring escalation from the supporting Groups reporting into the Sub-Committee.
Corporate Risk Sub-Committee	Provides assurance regarding the robustness of the Trust's risk management processes.
Hospital Safeguarding Sub-Committee	Provides assurance regarding the robustness of the Trust's safeguarding processes.
R&D Sub-Committee	Provides assurance on the Trust's R&D agenda.
Other sources	- Internal audit reports in relation to clinical quality and patient safety - CQC and other regulatory inspections - In-patient and other care related surveys

Assurances are provided to the Trust Board on the following key matters:

- Development and implementation of the Trust's Clinical & Quality Strategy
- Data and trends in patient safety, experience and outcomes, including undertaking necessary "deep dives"
- Appropriateness of the actions taken by management to address the significant concerns or adverse findings highlighted by external bodies in relation to clinical quality
- Development and implementation of action plans arising from both in-patient and other care related surveys with recommendations to the Board as appropriate
- Impact of Quality Impact Assessments of Cost Improvement Programmes on quality, patient safety and wider health and safety requirements
- Effectiveness of the clinical systems in maintaining compliance with the Care Quality Commission (CQC's) Essential Standards of Safety and Quality
- Systems and processes in place in relation to Infection Control and the progress against identified risks to reducing hospital acquired infections
- Appropriateness of the actions taken by management to address the adverse events (including serious incidents), complaints, claims and litigations
- Appropriateness of the actions taken by management to implement internal audit report recommendations relating to quality and patient safety
- Appropriateness of the Trust process for learning lessons and embedding actions.
- Advise the Board of key strategic risks relating to quality and patient safety and consider plans for mitigation as appropriate

Finance, Performance & Business Development Committee

Key Sources of Assurance	
Divisional Performance Review	Provides assurance on the actions being taken on specific finance / performance issues that have been escalated from the Divisional Board Meetings.
Divisional Boards	Provides assurance regarding an aggregated position escalated from the Divisional Boards regarding the 'Efficient' domain.
Digital Hospital Sub-Committee	Provides assurance regarding progress against the Trust's Digital Strategy
Financial Recovery & Capital Projects Sub-Committee	Provides assurance regarding financial performance, recovery actions and capex delivery
Safety (non-clinical) sub-committee	Provides assurance on aspects of non-clinical safety e.g. estates, health & safety
Access Sub-Committee	Provides assurance on processes to ensure effective waiting time performance
Other sources	- Internal audit reports in relation to finance and Performance - CQC and other regulatory inspections - Findings of other significant assurance functions, internal and external to the Trust

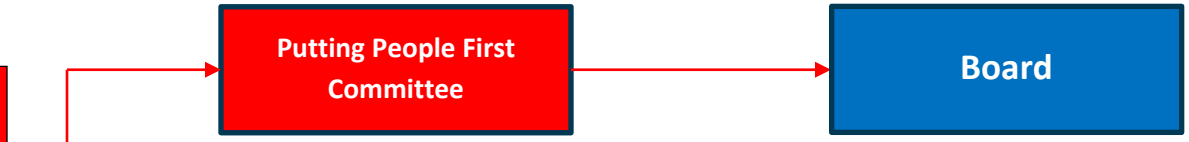


Assurances are provided to the Trust Board on the following key matters:

- Development and implementation of the Foundation Trust's financial and performance strategy to ensure delivery of financial and performance targets
- Delivery of the Trust's cost improvement and transformation programmes and the development of efficiency and productivity processes
- Investment and borrowing strategy and compliance with Trust's policies and procedures in respect of limits, approved counterparties and types of investment
- Performance against financial and operational performance KPIs by undertaking necessary "deep dives"
- Appropriateness of the investment appraisal of business cases and wider business development opportunities
- Appropriateness of the contracting and planning mechanisms in place with commissioners of healthcare and any financial or operational risks arising from those contracts are identified and mitigated as appropriate
- Scrutiny over rolling capital programme and its delivery
- Appropriateness of the actions taken by management to implement internal audit report recommendations relating to finance and performance
- Advise the Board of key strategic risks relating to financial and operational performance and consider plans for mitigation as appropriate
- Best use of Trust's resources

Putting People First Committee

Key Sources of Assurance	
Divisional Performance Review	Provides assurance on the actions being taken on specific people issues that have been escalated from the Divisional Board Meetings.
Divisional Boards	Provides assurance regarding an aggregated position escalated from the Divisional Boards regarding the 'Workforce' domain.
Diversity & Inclusion Sub-Committee	Provides assurance against progress on the Trust's Diversity & Inclusion aims and objectives.
Health & Wellbeing Sub-Committee	Provides assurance against progress on the Trust's Health & Wellbeing aims and objectives.
Educational Governance Sub-Committee	Provides assurance on the Trust's performance as a provider of education.
Other sources	- Internal audit reports in relation to finance and Performance - CQC and other regulatory inspections - Findings of other significant assurance functions, internal and external to the Trust



Assurances are provided to the Trust Board on the following key matters:

- Trust's strategy and plans on workforce issues including the efficient deployment of staffing to meet service requirements
- Trust's strategy and plans for workforce education, learning and development, and that individual training and development approaches are fit for purpose
- Effective oversight and management of the significant issues/risks in relation to the workforce planning
- Effectiveness of the workforce enablers that are put in place to drive high performance and quality improvement
- Performance indicators relevant to the remit of the committee
- Trust's compliance with the Public Sector Equality Duty
- Organisational Development including leadership capability, workforce planning, cost management, regulation of the workforce and their health and wellbeing
- Effectiveness of the action plans that support improvement in staff experience and services to patients
- Effective oversight and management of key strategic risks relating to workforce and employment practice and appropriateness of the actions taken by management to address these risks

Audit Committee

Key Sources of Assurance	
Board Committees	Provide assurance that their governance processes are being undertaken effectively.
Internal Audit	Via progress and follow up reports. Also provide assurance on anti-fraud activity
External Audit	Provide assurance regarding the Trust's financial and quality processes
Over-arching systems of integrated governance, risk management and internal control	

Assurances are provided to the Trust Board on the following key matters:

- Effectiveness of the Trust's systems of integrated governance, risk management and internal control, that support the achievement of the corporate objectives.
- Effectiveness of the internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Trust Board.
- Independence and objectivity of the external audit activity and the effectiveness of the audit process.
- Findings of other significant assurance functions, both internal and external to the Trust, and the implications to the governance of the organisation.
- Reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- Integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.
- Freedom to Speak Up arrangements
- Standing Orders (SOs) and Standing Financial Instructions (SFIs)

Charitable Funds Committee

Key Sources of Assurance	
Fund Management	Provide assurance that the fund manager is maximizing the return on the Trust's charitable investments.
Fundraising Team	Provide assurance on; the fundraising strategy and systems and processes for deploying funds and communicating with staff and other stakeholders
Finance Team	Receive assurance on the income and expenditure statements and the annual accounts.

Assurances are provided to the Trust Board on the following key matters:

Compliance

- That the affairs of the Liverpool Women's Charity are managed in accordance with appropriate legislation and ensure statutory compliance with the Charity Commission regulations.
- Systems and processes are in place to receive, account for, deploy and invest charitable funds in accordance with charity law.

Budget, Income & Expenditure

- That an Annual Business plan and budget has been reviewed and approved
- Periodic income and expenditure statements are received, ensuring that performance is in line with the Charity's budget and plan.

Fundraising

- That a fundraising strategy is prepared and monitored which complies with Charity Commission guidance and legislation and which includes appropriate communication and marketing plans;
- That systems and processes are in place to receive, account for, deploy and invest funds raised in accordance with charity law;
- That systems, processes and communication are in place around fundraising, staff engagement and funding commitments;
- That there is a cohesive policy around external media and communication;
- That a culture of fundraising is encouraged
- That there is effective communication regarding 'whistleblowing' relating to fundraising, donations or subsequent use of funds.

Investment Management

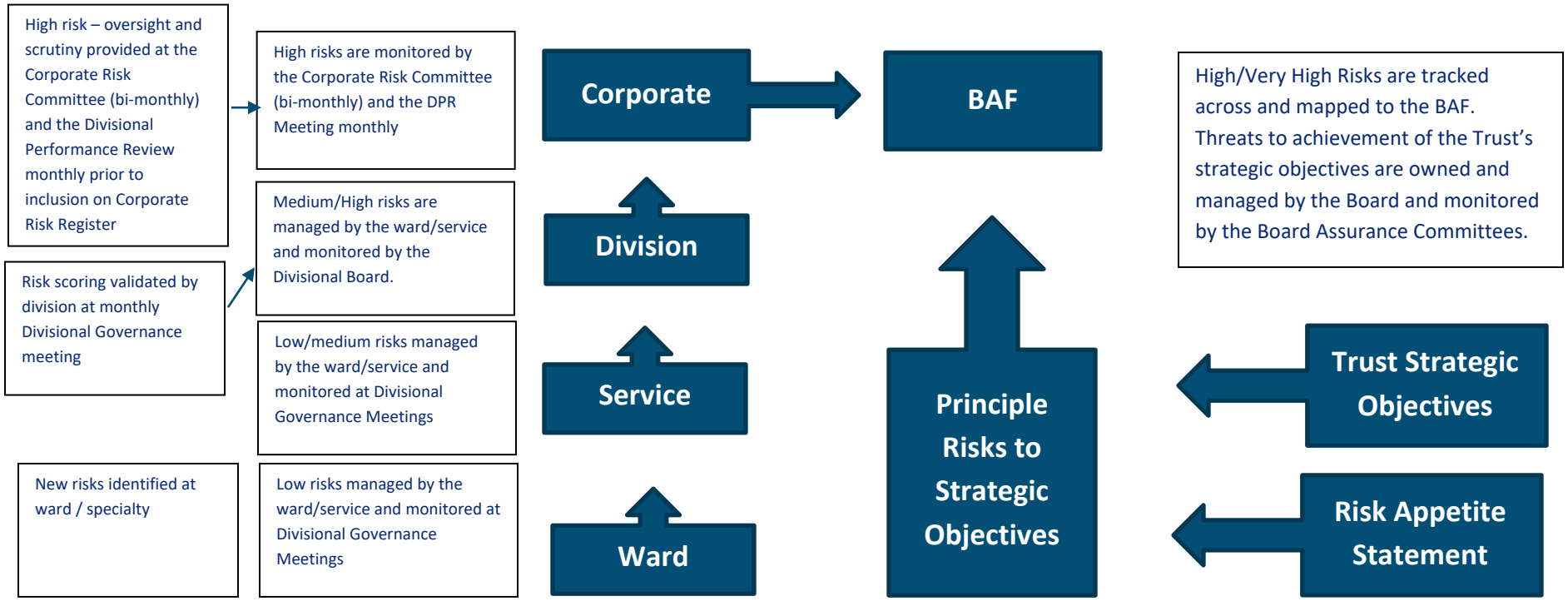
- An investment strategy is in place for the safe and secure investment of funds not immediately required for use, taking into account any appropriate ethical considerations.

Risk Management: Overview

The Board is responsible for ensuring that the Trust has appropriate processes for risk identification and risk management in place to deliver its strategic plans and comply with the registration and licensing requirements of key regulators. This includes systematically assessing and managing risks at all levels from ward to Board.

Risk Management is the process of identifying, assessing, analysing and managing all potential risks. Decisions made within the Trust should take into account potential risks that could directly or indirectly affect patient care.

Board Assurance Framework: This is a document that sets out strategic objectives, identified threats to achievement of each strategic objective along with controls in place and assurances available on their operation. One of the sources of information for the BAF is the Corporate Risk Register. The BAF provides an overall 'heat map' summary of areas of pressure and threat affecting the Trust.



Risk Appetite

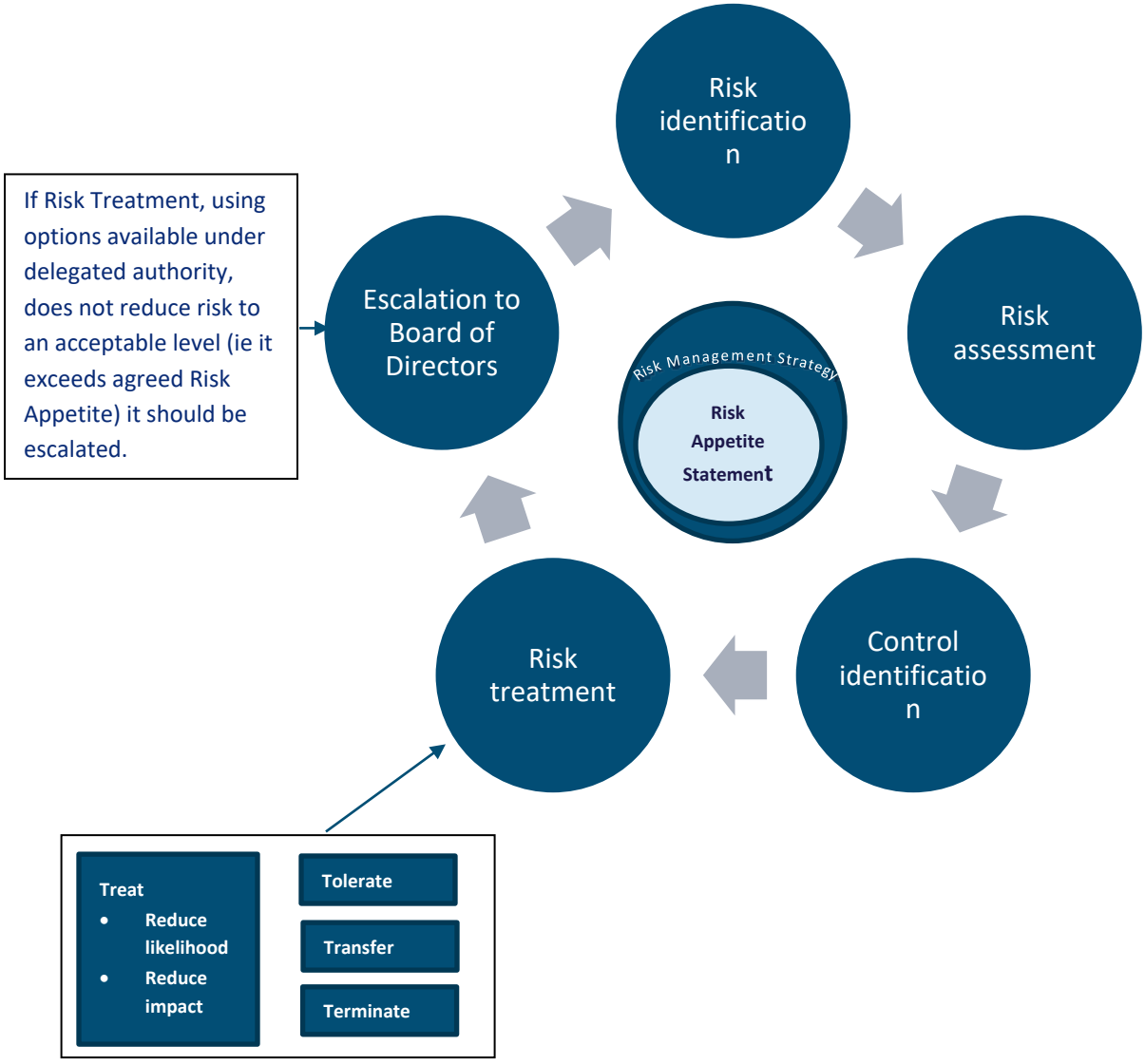
Risk appetite refers to the amount of risk that the Board is prepared to accept, tolerate, or be exposed to in pursuit of its strategic objectives. The higher the appetite, the greater the autonomy that is granted to the risk owner before the threshold is crossed for escalating issues to the Board; the lower the appetite the greater the control that the Board will wish to exercise over its management.

Appetite Level	Description:
None	**Avoid**: The avoidance of risk and uncertainty is a Key Organisational objective
Low	**Minimal**: The preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Moderate	**Cautious**: The preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
High	**Open**: Being willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and value for money).
Significant	**Seek**: Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Also described as **Mature**: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

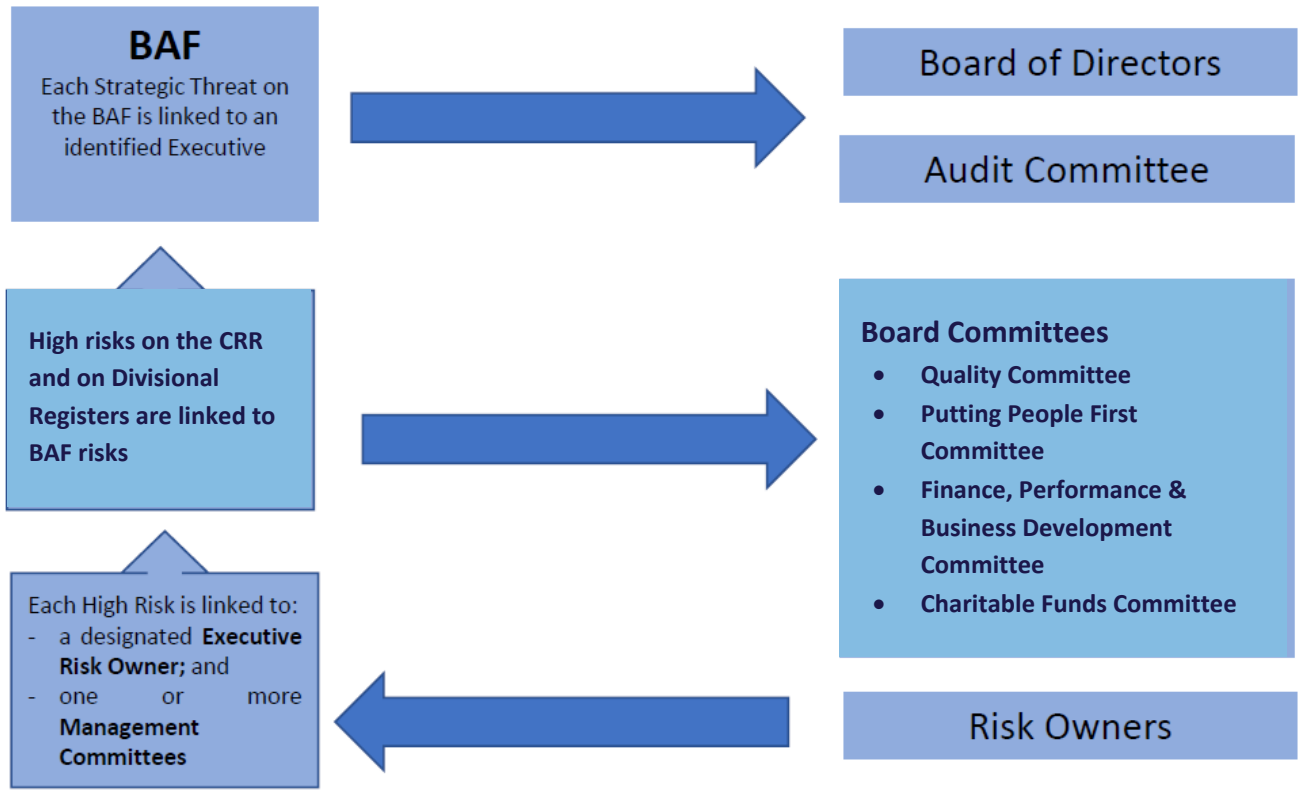
To develop a well-led, capable and motivated workforce is a **Moderate** risk appetite Liverpool Women's NHS Foundation Trust has a moderate appetite for risk to this objective. The Trust operates in a complex environment in which it faces challenging financial conditions and changing demographics alongside intense political and regulatory scrutiny. However, the continued delivery of high-quality healthcare services and service sustainability requires some moderate risk to be accepted where this is likely to result in better healthcare services for patients. Support for moderate risk in service redesign that requires innovation, creativity, and clinical research to improve patient outcomes are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.
To be ambitious and efficient and make the best use of available resources is a **Moderate** risk appetite Liverpool Women's NHS Foundation Trust has a moderate appetite for risk to this objective. This is in respect to meeting our statutory financial duties of maintaining expenditure within the allocated resource limits and adherence to departmental and internal expenditure and financial controls. This includes the demonstration of value for money in our spending decisions, while ensuring quality and safety is maintained.
To deliver safe services is a **Low** risk appetite Our risk appetite for safety is low. Our fundamental strategic aim describes our commitment to patient and staff safety. When and wherever possible we will apply strict safety protocols for all of clinical and non-clinical activity. We will not compromise the safety of our patients, we will report, record and investigate our incidents and we will ensure that we continue to learn lessons to improve the safety and quality of our services.
To participate in high quality research and to deliver the most effective outcomes is a **High-risk** appetite Liverpool Women's NHS Foundation Trust supports High risk against this objective. A level of service redesign to improve patient outcomes that requires innovation, creativity, and clinical research are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.
To deliver the best possible experience for patients and staff is a **Low** risk appetite Liverpool Women's NHS Foundation Trust has a low risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality and sustainability of the Trust and its patients, may affect the experience of our patients, the reputation of the Trust or the reputation of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Senior Management Team.

Risk Appetite: Application

The Board's agreed risk appetite statement should become embedded into the Trust's risk management and other reporting and decision-making processes.



Risk Management – Role of Board Committees

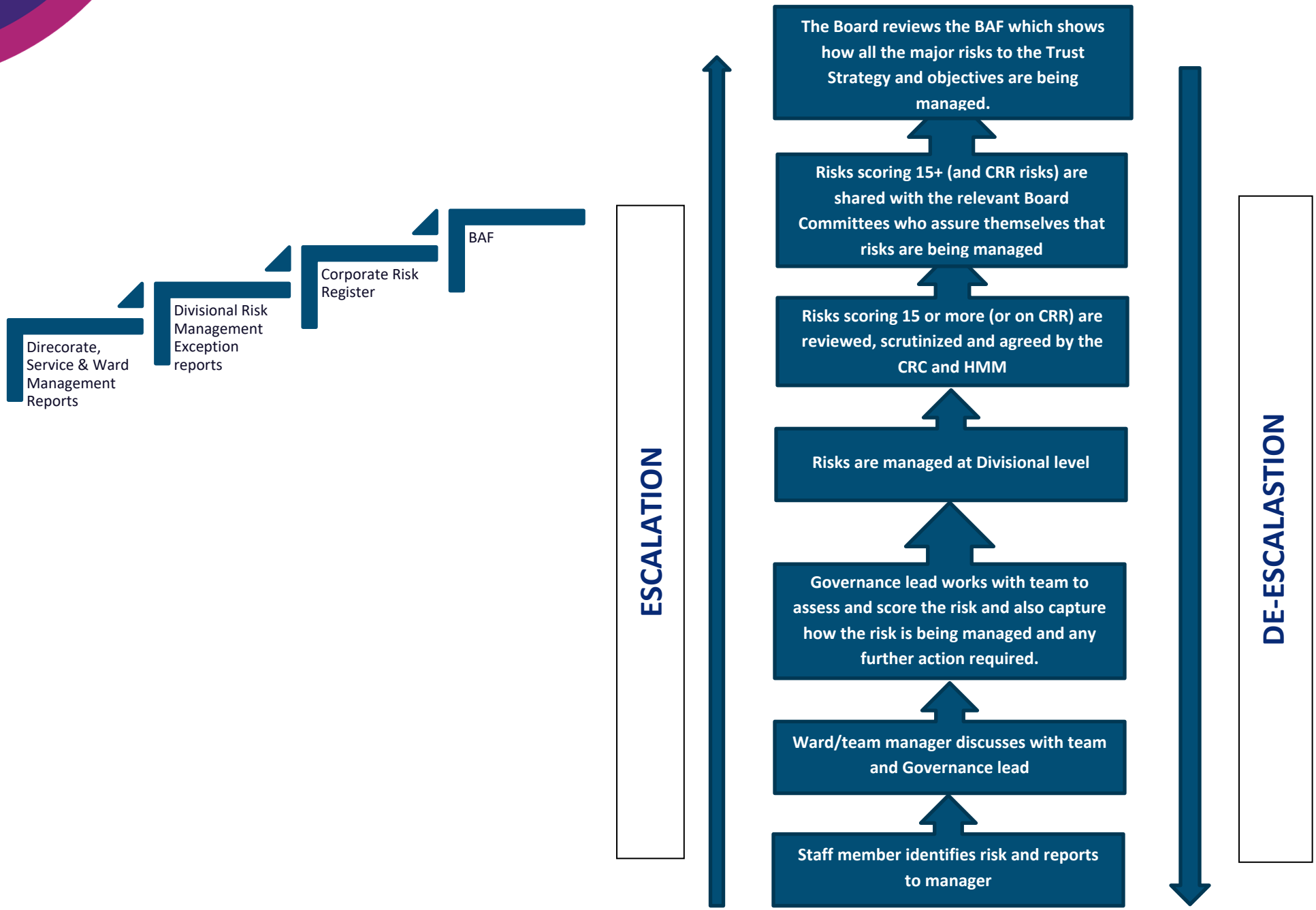


The **Board** is collectively responsible for setting strategy and ensuring good stewardship and direction.

The **Audit Committee** provides advice to the Board of Directors on the operation of the Trust's governance processes, risk management and internal control systems within the Trust.

Having reviewed the evidence provided by the risk owners, the **assurance committee** provides assurance to the Board of Directors that the high level risks within their remit are being mitigated effectively and that the BAF entry reflects the most recent information about strategic threats and relevant controls.

Risk owners provide assurances to the assurance committee overseeing the risks that are within their remit that processes and controls are effective. Performance information and action plans will provide evidence that mitigating actions are effective in reducing risk to acceptable levels.


Direcorate, Service & Ward Management Reports
Divisional Risk Management Exception reports
Corporate Risk Register
BAF
ESCALATION
The Board reviews the BAF which shows how all the major risks to the Trust Strategy and objectives are being managed.
Risks scoring 15+ (and CRR risks) are shared with the relevant Board Committees who assure themselves that risks are being managed
Risks scoring 15 or more (or on CRR) are reviewed, scrutinized and agreed by the CRC and HMM
Risks are managed at Divisional level
Governance lead works with team to assess and score the risk and also capture how the risk is being managed and any further action required.
Ward/team manager discusses with team and Governance lead
Staff member identifies risk and reports to manager
DE-ESCALASTION

Section 2 – Performance Management Framework

Introduction

It is the Trust's intention to implement a clear Performance Management Framework which sets out the overarching principles and approach to delivering a high performing organisation. This framework aims to ensure that the Trust successfully delivers national standards for performance and contractual targets agreed with commissioners.

This framework document describes how the Trust will utilise improved information management to drive better performance and introduce a tiered performance management process to ensure a rigorous, supportive and consistent approach to performance management is achieved at all levels of the organisation.

Definition

Performance management is about establishing a formal, regular and rigorous system of data collection and usage to indicate trends and measure the performance of services. Performance management should be used to help identify areas of best practice, to focus on continuous improvement and delivering improved outcomes, to take action to improve patient care and to ensure that the activities of services are in line with the overall organisational strategy and priorities.

Purpose

The primary purpose of the Performance Management Framework is to give the Trust the support structure with which to make systematic, continuous improvements to performance enabling achievement of its objectives. Its secondary purpose is to enable the Trust to be publicly accountable for its performance and to allow any other person or organisation with an interest in its services to see and understand how we will work to improve. The Performance Management Framework is part of the Trust's wider governance framework (as described in section 1) which aims to protect the interests of all stakeholders.

The framework should also be a useful engagement tool to demonstrate ownership of performance at every level of the organisation, not just the top. If everyone performs to the best of their ability at all times then the organisation will see the benefit. Performance management should be at the heart of what we do to enable continuous improvement in delivering quality, efficient and patient-focused services through a cycle of Plan-Do-Review. The Trust's Quality Improvement Strategy provides further detail on this element.

Performance measurement, monitoring and management should always be directly linked to achieving Trust objectives and the strategy to ensure that we plan and deliver effectively and for continuous improvement to be an embedded way of working. Our behaviours should reflect planning to improve and progress and not to accept failure as the only alternative. This means getting the organisational planning stage right so we know which indicators are crucial in order to measure our performance.

Reporting levels

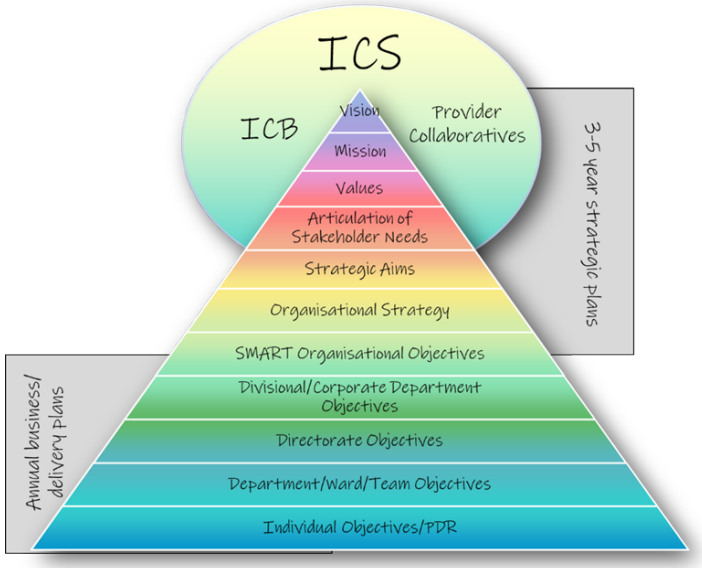
The main strands of performance reporting within the Trust are:

- National and local performance reporting e.g. to the ICB, regulators and commissioners
- Board performance reporting
- Board Committee performance reporting
- Operational performance reporting

The remit of the Trust Board is to:

- Set the right level of ambition and communicate those goals widely
- Understand which services are performing well and which require improvement
- Create an environment of appropriate challenge and holding to account
- Understand current and future challenges and plan for those

In line with this, operational performance management must be embedded to generate alignment of all Divisions across the Trust, so that all are working together to achieve the organisational objectives. In order to facilitate this, structures exist within the Trust that support reporting to the Board, and the comprehensive detail required for management of performance at the operational level. Reporting structures have been designed to accommodate differing needs of managers at all tiers of the organisation, and the information flow across these levels mirrors the Trust's management and governance structure. This is illustrated below:



A key aspect of this approach is that operational performance measures are identified at as low a common denominator as possible. Measures made at a team level are summarised to create a service level that can then be further summated, if appropriate, to a Divisional level. Divisional level performance measures are then summated to give a Trust-wide picture of performance.

Board Reporting

The Trust's Integrated Performance Report provides a summary of the business-critical indicators for the Trust. It is issued to the Trust Board monthly highlighting key areas of success or concern and actions being taken to address the issues.

Performance is also visually displayed in the form of tables and charts which show historic performance and trends.

Board Committee and Sub-Committee Reporting

The Board's Committees and sub-committees will receive a breakdown of the Integrated Performance Report aligned to their respective areas of focus. Like the Integrated Performance Report, this will highlight key areas of success or concern and actions being taken to address the issues.

Operational Reporting

The Divisional Performance Reporting is at a high level for monitoring operational performance, finance, quality and workforce. Following a similar format to the Board report, it contains performance, workforce, finance and quality targets disaggregated to Divisional level. Its purpose is to provide an insight into the contribution of individual Divisions to performance of the business-critical indicators, as well as furnishing the Divisions with performance data more specific to their area of activity.

Planning Priorities

Each year through the Annual Planning round, the Board will agree a set of planning priorities, these will inform the objectives and priorities of Divisions. Progress against these priorities will be monitored bi-monthly through Divisional performance review meetings.

Key Performance Indicators

The set of Key Performance Indicators (KPIs) which comprises the Performance Management Framework will be reviewed and set each year to take account of changes in local, contractual and regulatory requirements. This is to ensure that the KPI list is flexible and will adapt to local, contractual and regulatory needs as they arise. KPIs will be drawn from a variety of sources and will cover a wide range of themes.

Where national guidance exists, the metric will be constructed according to this guidance to allow for benchmarking. Where this has not yet been available, the metrics will be defined locally in discussion with senior managers and clinicians as required.

Throughout all levels of reporting, it will be key to demonstrate how the Trust's approach to quality improvement has been utilised to support areas of underperformance.

To support this, the Trust should use benchmarking to understand and evaluate its position in relation to best practice and to identify areas and means of performance improvement. Using a systematic and continuous process benchmarking can help us to measure ourselves against others that are performing well. We can use benchmarking to identify best practice performance levels, determine the drivers of high performance, quantify gaps between other organisations performance and best practice and build foundations for performance improvement.

Divisional Boards

Divisional Boards are accountable for delivering performance targets within their respective divisions. The Divisional Boards are led by the Divisional Managers who with the Clinical Director and Lead nurse form the Divisional Senior Leadership team.

The following illustrates a suggested scope structure and information flow for a Divisional Board to ensure the relevant aspects of the Performance Management Framework can be accommodated. Divisional Boards will also undergo a process of 'board development' to support them in their newly reconfigured state. This programme of development is not within the scope of this strategy.

Divisional Board (Monthly)			
Performance Data	*Reporting Groups and Reports*	*On-going Action Plans*	*Process*
Integrated Performance Report	Divisional Governance Meeting (DGM) (feeds in quality, safety and experience and lesson learning)	Action plans relating to key risks and performance issues	Reviewing formal minutes and actions
Divisional Risk Register	Other feeder groups	Action plans relating to service developments	Reviewing forward work programme (aligned to risks and areas of underperformance)
QI projects / CIP	Specialty meetings		Review of sub groups form and function (annual).
Horizon Scanning (opportunities and risks / PESTLE)	Feedback from Trust Management Group (Quarterly)		
Workforce Plans			

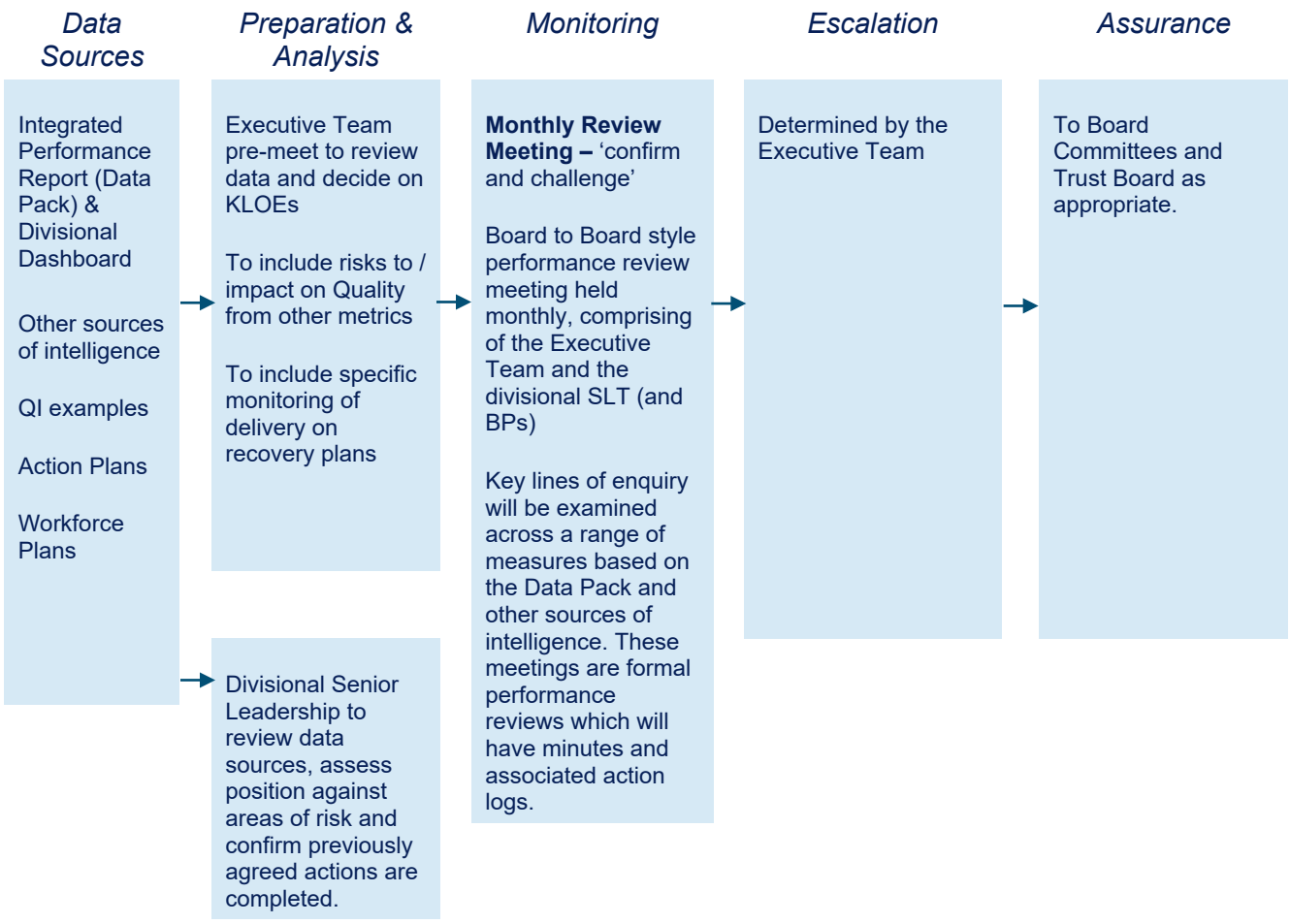
Performance Review Meeting

The objective of the Divisional Performance Reviews is to review the performance of each Division in relation to an agreed suite of KPIs, ensuring compliance and continual improvement. The reviews will also provide a forum for Divisions to discuss issues and challenges facing services with Executive Directors and agree solutions in partnership and also to share and celebrate success and good practice.

There will be a clear and consistent schedule of Divisional Performance Reviews agreed at the start of each new financial year. The meetings will be a 'Board to Board' style session, with the Divisional Senior Leadership Team (SLT) being held to account by the Executive Team. The meetings will maintain action logs. Actions will be linked back to the Division's priorities as laid out in business plans and will link to the delivery of the Trust's objectives and strategy.

As above, set prioritised indicators, specific to each Division's core business, will be agreed and clinical groups and divisions will be held accountable for delivery of these key metrics.

Consistent data sources will be used for the meeting, adopting a CQC style 'data pack' approach, so that the focus of the meeting will be on performance issues and agreeing appropriate remedial actions. The data pack will be used to identify key lines of enquiry and key areas of risk. The diagram below illustrates the Performance Review Meeting process:



Performance Review process – key steps:

- On a monthly basis, data will be received by the Performance Team who will validate and publish performance against plan via the Integrated Performance Report (IPR) and Divisional Dashboards.
- The IPR is shared monthly with Divisions and the Trust Board of Directors
- Each division holds a monthly Divisional Board meeting in which performance will be analysed and discussed, with consideration given to longer term trends and the efficacy of corrective or mitigating actions.
- Updated narrative explanation to accompany the respective KPIs to be written and used in onward reporting to Divisional Performance Reviews and into the Assurance Framework.
- The Executive Team will decide what further action is required.
- Levels of intervention will be on an earned autonomy basis which will take into account a) the overall level of performance of a division b) how acute and impactful a specific performance concern is.
    - Levels of autonomy – to be agreed by the Executive Team with clarity provided to the Division on the rationale and with a clear exit strategy (to the next level of autonomy)
        - High – Division attends bi-monthly Divisional Performance Review – WESEE meeting
        - Medium – In addition to the above, the Division attends the bi-monthly Divisional Performance Review – FOCUSED meeting
        - Low – In addition to the above, the Division may be required to attend fortnightly or weekly oversight meetings with the Executive Team or a smaller group of Executives on areas of acute performance challenges.

Role of the Divisional Performance Review – WESEE meeting

All Divisions will be required to attend this meeting. Divisions should present a holistic review of their performance with updates against all aspects of the Trust's WESEE framework. Updates from this meeting will be escalated as necessary into the assurance framework. If a performance challenge is noted, further information will be requested to be presented at the next meeting, next Divisional Performance Review – FOCUSED meeting or oversight meeting – depending on the level of risk and potential impact.

Role of the Divisional Performance Review – FOCUSED meeting

On the months between the Divisional Review Meeting - WESEE cycle, a Divisional Performance Review – FOCUSED meeting will be held (attended by the Executive Directors and the Trust Secretary). The Divisional Performance Review – FOCUSED meeting will review issues that require further monitoring and receive performance 'deep dive' reports when requested. Information from the Divisional Performance Review – FOCUSED meeting can report directly into the Board Committees for assurance.

Role of the Executive Oversight meetings

If an issue requires close monitoring above a monthly meeting, Divisions may be asked to attend either a weekly or fortnightly oversight meeting with Executives. This will most likely be on a specific area of performance but may also cover aspects such as approach to governance, leadership challenges etc.

Trust Management Group

This meeting will be held on a quarterly basis with the primary purpose of providing a forum for the Executive Team to brief Divisional SLTs and Deputy Directors on key strategic issues. The forum will also provide an opportunity for Divisional SLTs to hold the corporate services to account for the level of support delivered. Corporate services include:

- Finance
- Human Resources
- Communications & Fundraising
- Estates
- Digital services
- Corporate Governance

Minutes of this meeting will be reported to the Executive Team with key messages reported back to the Divisional Boards.

Senior Management Team Meeting

This meeting will be responsible for receiving and scrutinizing business cases and CIP performance across the organisation.

Performance Management – Accountabilities

Ownership of performance lies with everyone working for and with the Trust with overall accountability and leadership for performance with the CEO and the Executive Team. The underlying principle that performance is everyone's responsibility relies heavily on effective appraisals enabling every employee to be the best they can be, understanding what performance means for them and their role. Objective setting, not just at individual level, is required and those objectives will provide the context for how performance will be measured, whether a KPI or local measure or how an individual contributes to team/ward objectives. Competency frameworks provide an assessment process to ensure all staff have the skills, knowledge, experience, and behaviours to deliver performance aligned with Trust values.

Divisional Performance responsibility

Ultimate accountability and responsibility for Divisional performance is held by the Divisional Manager. The Divisional Senior Leadership Team (Divisional Manager, Clinical Director and Lead Nurse / midwife) provide the supporting resources to deliver objectives and activity at each level. The relationship between the Divisional Senior Leadership Team provides the leadership that enables performance to be managed. The Divisional Managers lead on performance enabling delivery and resources to align to divisional objectives and priorities identified during the planning process.

The Divisional Dashboard provides an overview of Divisional performance using Trust priority deliverable KPIs and local indicators around service delivery as a collective dashboard for performance management. Divisional Performance Reviews will use the Divisional Dashboard for exception reporting and to provide assurance on performance in all domain areas.

Chief Executive Officer

The Chief Executive Officer is responsible for the management of the organisation including ensuring that financial and quality of service responsibilities are achieved within available resources and identifying opportunities for improvement and ensuring those opportunities are taken.

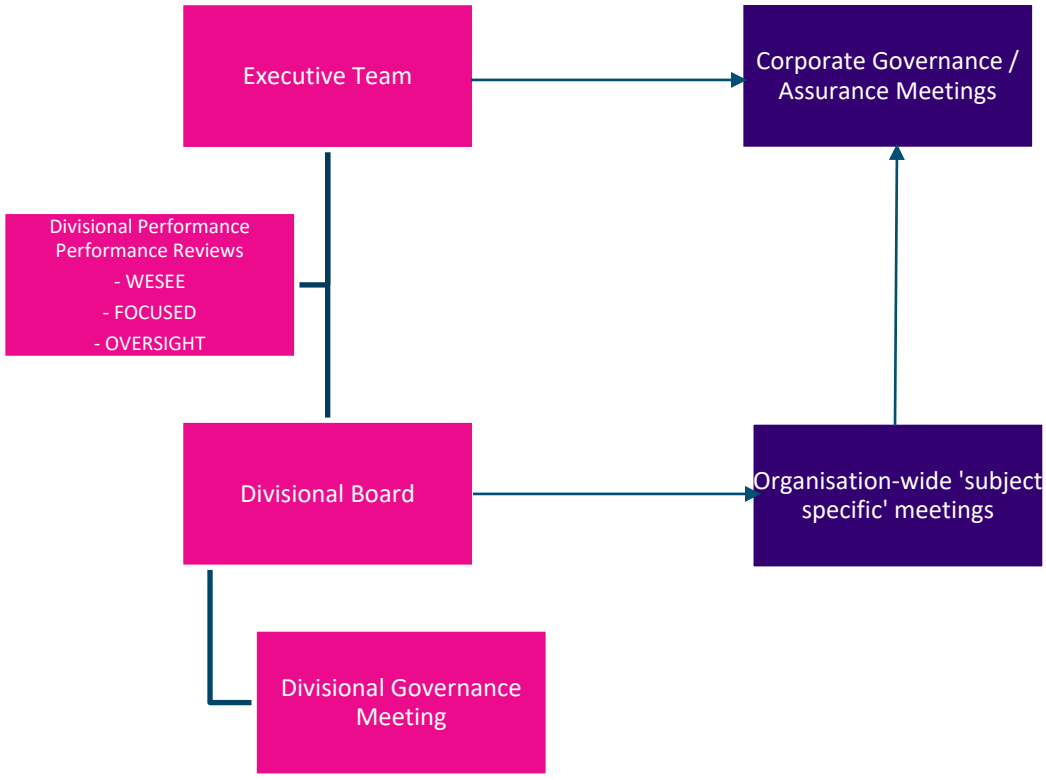
Executive Team

The Chief Operating Officer is the Executive lead for performance, supported by the Chief Nurse and Medical Director in relation to clinical matters and quality. The Chief Operating Officer is the named Executive Director with responsibility for establishing and managing the Performance Management Framework.

The Information Services Department under the management of the Chief Information Officer has responsibility for providing the data and management information both within the Trust and to appropriate external parties.

The Executive Team will review the performance of the Divisions at the monthly Hospital Management Board and bi-monthly Divisional Performance Review Meetings.

Performance Management Framework - Escalation



Section 3 – Effective Meeting Practice

Introduction

We need to ensure that our meetings are:

- effective (carry out actions);
- timely;
- attended by the right people; and
- recorded.

Paperwork that supports meetings, whether it's an action log, reports, action notes or full minutes are often requested for review by external bodies such as the CQC, and the external auditors.

A suite of supporting templates has been produced to provide help and support for all meetings that take place in our meeting structure (within the Assurance and Performance Management Framework).

It covers the 'architecture' or framework for meetings; the agreed standards of practice and provides the templates to be used.

Also covered are the behaviours expected of members in meetings. This outlines how members and those attending should always act in accordance with the Trust's values and seek to create a safe space to challenge and feel comfortable to be challenged with the aim of achieving the right outcome for our service users and patients.

Whilst this framework has been written for all meetings in the formal meeting structure, staff involved in local meetings (for example team meetings) should apply the good practice set out in the framework and use those templates that are applicable to ensure risks, decisions and actions are appropriately evidenced, recorded and progressed.

Roles and Responsibilities

The Role of the Chair

The role and contribution of the chair is pivotal in ensuring that boards/committees/groups/task and finish groups are effective in their operation. Key points are summarised as follows:

- To agree the committee/group cycle of business with the executive / senior lead and the administrative secretary in advance of the forthcoming financial year ensuring this aligns with the terms of reference.
- The chair will review and confirm the agenda with the executive / senior lead and the administrative secretary in advance of the meeting to ensure all items are relevant to the duties of the committee and aligned against the cycle of business.

- The chair will sign off the minutes within the agreed timeframe to enable draft minutes to be circulated to committee/meeting members.
- The chair is responsible for leading members in establishing effective decision-making processes and act as the guardian of due process.
- The chair is responsible for ensuring that constructive relationships based on candour, trust and mutual respect exist between members.
- 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.

Virtual / Hybrid Meetings

The Chair's role in leading a virtual / hybrid meeting is ultimately the same as your role during a face to face meeting. However, the techniques needed to keep everyone engaged, allow a good debate and determine the view of the meeting on each item of business may be different to those which you use for a face to face meeting. The points below can assist with the smooth running of the meeting:

Access arrangements

- Make sure you have been given the correct dial in details and any access codes or PINs.
- Check if you are the leader or host for the call and if you require any additional log in details in that capacity.

Know the technology

- Make sure you know how to use the technology and ask for assistance before the meeting if you are not familiar with the app being used.
- Make sure you have enough devices/screens to run the meeting and read the papers.
- Make the best use of the technology – for example you may be able to see who is speaking, who is not on mute and so on. There may be a messaging facility so that participants can alert you to the fact that they wish to speak, or that you can use to ask someone to mute their

microphone. Be aware that these messages may be visible to all participants in the meeting. If you need to message someone privately, then a text message is probably the quickest way.

Meeting management

- You may prefer that someone else hosts and controls the call so that you don't have to deal with that aspect of the technology as well. This could be done by the meeting administrator. You will both need to be clear before the meeting who is going to have that responsibility.
- 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. For longer meetings it will be necessary to have an agreed break and it is suggested you should not run for more than 2 hours continually without one. This might be for 30 minutes (for example) or the meeting could be split into two parts.
- Be clear about which agenda item you are on at any one time.
- Invite questions at an appropriate time after any presentation. You may need to remind participants to mute and unmute their microphones. Ask participants to indicate to you if they wish to speak on the particular item and remind them of the need for clarity and brevity.
- 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.
- 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.
- It will be particularly important to keep the discussion focussed and not to let people become distracted with unimportant peripheral points. You will need to control this firmly but diplomatically.
- It will be important to curtail the length of the meeting so that people remain engaged. Having a timed agenda can assist with this. If the business has not been finished within a reasonable timeframe and you feel participants are no longer concentrating it may be better to reconvene the meeting after a short break or at another time and date. For this reason, it will be key when planning the agenda to ensure the most urgent and important items are dealt with first, leaving those which are less so to the end of the meeting.

Technical problems

- If the call is disrupted by technical issues, such as poor audio or video quality due to a lack of good internet connectivity it may be necessary to call for a short adjournment of the meeting

and change to a telephone conference instead. The virtual meeting app should provide suitable numbers for dialling in as well.

- If there is background noise, you may be able to privately message the person whose microphone is not on mute or you can make a general request for people to recheck that they are on mute. You may also be able to use the system to mute their line remotely. It is important for everyone to be able to hear each other.

Good practice indicates that the use of a standardised question set is utilised throughout the meeting such as:

Following each agenda item:

- What key decisions were made or what key outcomes were agreed?
- Is there anything that requires escalating?
- Were any new risks identified that require capturing on the risk register and was the risk rating accurate?
- Level of assurance provided by the report/item.

At the end of the meeting:

- Was the quality of the paper(s) sufficient to allow members to discharge their duties and the expectations of each paper?
- What worked well?
- Was there sufficient time on the agenda to discuss the items?

The Role of the Executive / Senior Lead

The role of the executive / senior lead is to ensure that relevant and appropriate information is provided to the committee / group to enable them to provide assurance to the Board or parent meeting. Specific responsibilities include:

- To agree the cycle of business with the chair and the administrative secretary in advance of the forthcoming financial year.
- To agree the agenda with the chair/secretary in advance of the meeting to ensure that all items are relevant to the duties of the committee / group and aligned against the cycle of business.
- To reinforce with operational teams/individuals the requirement to ensure papers are submitted to the secretary within the agreed deadline dates.
- To sign off the final set of papers prior to circulation to committee / group members.
- Agreeing the final wording of the assurance report prior to submission to the chair of the committee / group and/or the Board, ensuring they reflect the key issues discussed.
- Agree the final minutes prior to submission to the committee / group chair for final approval.

The Role of the Administrative Secretary

The role of the secretary is to provide administrative support to the meetings and ensure they are managed effectively. Key responsibilities of a secretary include:

- To arrange dates (for the coming year), times and venues for meetings and circulate to all members.
- To develop and maintain the cycle of business in conjunction with the chair and executive / senior lead.
- To draft the agenda, collate papers and circulate them within the required timeframe.
- To reinforce with report authors with regard to the submission of papers according to the agreed deadline dates.
- Work with the chair to identify actions during the meeting and record them on the action tracker.
- To transcribe the minutes and actions from the meeting. Minutes should be drawn up within five working days of the meeting and approved by the chair and the executive / senior lead for the committee meetings. The minutes and action tracker should then be circulated to members.
- To manage the action and chair's log tracker and follow up on outstanding actions/actions arising from the chair's log.

The Role of Meeting Attendees

The meeting members play a major role during the discussion and decision-making process. It is their role to ensure they have received sufficient information to inform their decision-making.

The Corporate Governance Team

The role of the Corporate Governance Team is to provide senior level support to the Board and its Committees to ensure that meetings are managed effectively and appropriately; to be the key contact point for those reporting in. They are responsible for complete, objective record keeping which identifies items requiring follow-up and actions taken. This record evidences the discussions held and the outcomes arising from those discussions in a professional way that can be audited. (NB. all minutes, not just those of the Board and its Committees are externally assessed and can also be released under Freedom of Information). They are also responsible for ensuring the Committees remain consistent with their terms of reference and do not operate ultra vires.

The Corporate Governance Team also provides administrative advice regarding the functioning of the Trust's meetings and must be informed if a meeting within either the performance or assurance framework is cancelled. The establishment of a committee / sub-committee / group must be discussed with the Corporate Governance Team.

Meeting Guidance notes

The Trust's Meeting Guidance notes should be appended to every meeting pack and serve as a reminder of the expected meeting processes and behaviours. These can be found at Appendix 11.

Meeting Logistics

It is important that the necessary arrangements are made for the smooth running of meetings. The following are some high-level issues to consider:

- The secretary should ensure that room bookings are made in sufficient time. A schedule of meeting dates for the coming year must be produced for each meeting for the whole year and circulated to members.
- As much as is practicable, give consideration to accessibility issues such as the following:
    - Visibility – Consider those with impaired sight
        - Clear signage (identifying location and directions); well-lit meeting space and adjacent areas; projection screen visible from all seating (if using projection).
        - Adjustments might also be required to the meeting pack, presentations etc.
    - Acoustics – Consider those with hearing impairment
        - Public address (PA) system; roving microphone; limit unnecessary background music; seating available near presenter for lip reading; availability of assistive listening devices. Is there well-lit space for an interpreter if needed?
    - Mobility – Consider those who may be in a wheelchair or have other mobility impairments
        - Accessible parking near venue; proximity to bus stop; ramp and/or elevator access; accessible bathrooms; barrier-free pathways; wide doorways and aisles to accommodate wheelchairs/scooters; no loose cables across walking areas.
    - Technology – Consider those who may need to use adaptive devices
        - Electrical outlets in accessible seating areas to accommodate devices, laptops, etc.; extra space or work surface
    - Overall, it might be helpful (particularly for meetings with external attendees) to ask whether an individual require any reasonable adjustments to attend the meeting
- Agendas and papers must be circulated to members in good time to allow them time to prepare for the meeting. Papers should be sent out ideally five working days before a meeting, although for weekly meetings local arrangements will be determined by the Chair of those meetings. Corporate Governance meetings, namely the Board of Directors and its sub-committees; and the Council of Governors and its sub-committees, will circulate agendas and papers seven days prior to the meeting taking place.

Virtual Meetings

The Covid-19 pandemic created a multitude of challenges and the on-set of lockdown and social distancing meant that a different approach was required to the day-to-day management of the organisation. Part of this included how meetings were conducted and initially there was no choice other than to utilize virtual technology. This method brought about a number of advantages whilst also highlighting several limitations. As the Trust has moved into a recovery phase and out of social distancing measures, the Trust has largely not returned to 'normal' and virtual meetings are now something that we retain as business as usual. The following section outlines the advantages and limitations of virtual meetings, provides some thoughts on when best to apply a particular meeting methodology and how to also manage the challenges of 'hybrid' meetings (attendees both in a physical meeting and using technology).

Advantages to Virtual Meetings

- **Everyone has a chance to participate in the meeting,** wherever they may be. Whether someone is working from home or at a different venue, or even stuck in traffic, they can still

attend the meeting. With this, important announcements and crucial information are not

missed.

- **Virtual meetings save time.** Virtual meetings are also more flexible, so there is less concern for reschedules or delays. Meetings online also do not require traveling, therefore, you can start immediately. The time you save can be used for other important tasks and productivity can be increased.
- **Virtual Meetings are environmentally friendly**. Because traveling is more infrequent, and online meetings do not require paperwork, virtual meetings are better for the environment.
- **They can increase the efficiency of a meeting.** Face-to-face meetings can often result in discussions moving off into tangents and lose focus on the business at hand. Virtual meetings create a sense of discipline and enable business and transactions to be progressed with minimal interruptions and digressions.

Limitations to Virtual Meetings

- **Whilst virtual meetings can improve efficiency, they can limit debate and spontaneity**. It can be difficult to hold natural debates and conversations via virtual meetings in comparison to face-to-face meetings.
- **Group size.** Whereas virtual meetings can work well for small groups, they are usually difficult to manage with large gatherings.
- **Reduced flexibility**. In a virtual meeting, it can be difficult and clunky to break into small groups or employ other interactive discussion techniques.
- **No social interaction**. The interpersonal chemistry and synergy that develops in face-to-face meetings can be somewhat reduced in a virtual meeting. It can be more difficult to build trust and team cohesion when people can't see or hear one another.
- **People can be easily distracted**. Most likely, as people participate in the virtual meeting in their own home, they can also do other things and try to multitask. This can lead to divided attention and poor concentration towards the meeting.
- **Unique challenges**. It can be difficult to identify who is speaking, establish a speaker's lineup and ensure equality and fairness.

When to apply virtual meetings

As can be seen, there are advantages and disadvantages to virtual meetings. The appropriate application of technology to a meeting can depend on the outcomes required and the specific context.

- Virtual meetings can be useful for small team meetings with specific and focused actions. If wider debate or challenge on an issue is important, consider whether a virtual meeting may limit this.
- Virtual meetings can be useful for MDT meetings across sites as travel time is reduced.
- If a specific issue requires a quick resolution and it is difficult to arrange a face-to-face meeting, a virtual meeting can be helpful.
- If you need to carry out group work, consider whether a virtual meeting is appropriate and whether other mechanisms could be utilized.

Hybrid Meetings

Hybrid meetings (some attendees in the room and some using technology) can be especially challenging. Communication inequality is inherent to the hybrid format, in a way that can't really happen with in-person meetings. It might be better therefore to follow a principle of "one remote, all remote", where all participants call into a video conference from a separate laptop, in a separate quiet place, so that there's a level playing field. However, it is increasingly likely that a hybrid approach will become increasingly common. The following are key tips for maximizing the success of a hybrid meeting:

- make sure that the meeting has a clearly-stated purpose, and that everyone who's invited has something specific to contribute (and knows what that is). This makes it less likely that your remote participants will disengage because the meeting doesn't seem relevant to them.
- Structure the meeting for maximum participation, including participation by the remote individuals.
- Use the best technology you can, maximising human-to-human interaction. Video is preferable to audio only.
- The Chair can play an important part in holding a successful hybrid meeting by carefully involving remote participants. For example, by asking them to speak first in any go-around.

Tips for successful Virtual Meetings

- The choice of the right communication channel is vital - if the technology does not work well the meeting will be harder to run, will likely last for longer than is optimal and will be less effective. An audio call or telephone conference will be less risky but a video conference is more engaging if you can get it to work well.
- Virtual meetings need to be well structured and avoid unnecessary complexity – It is entirely possible to hold an effective meeting by virtual means. However, it should be structured more simply than a face to face meeting and should recognise the constraints of technology.
- Preparation is **key**
- The Chair will need additional techniques to run an orderly meeting, allowing adequate debate and obtaining the sense of the meeting – see 'Role of Chair' above.
- "Ground rules" for participants should be circulated to all those joining the meeting in good time beforehand – see 'Meeting Practice Notes' – appendix 11
- Clear instructions on accessing the meeting system or app are essential – Not all participants will be familiar with the technology. Give everyone clear instructions in advance about how to access and use the meeting app and offer individual practice calls if necessary.
- Good meeting practices are even more necessary for virtual meetings than for face to face
- Don't all talk at once
- Agree some protocols about how and when people can speak – turn taking when people cannot see each other is really important. The administrator cannot necessarily capture everything is everyone is talking at once. This takes strong chairing.
- If there is a chat function on the application you are using – use with caution - it is a useful way to emphasis a point. If you do use the chat function on Teams for example make sure that you

are clear as to which point you are commenting. This will help the other participants at the time and the clerk afterwards.

- Be present – the Chair needs to ensure that there is active listening and if people are not on camera that they are not multitasking beyond taking their own notes.
- Be careful about quorum – people can drop out of the meeting easily.
- Ensure that papers are particularly clear on what they are asking of the meeting.

Meeting Documentation

Style Guide

Documentation must follow a standard format (which will be set out in the Trust's style guide - https://drive.google.com/file/d/1lw_aMuLATcf_Jv60UESpc9kxzq31xVUN/view). Documents must be written in predominantly Arial size 11 font and have page numbers in the footer. You can set your version of Word to default to Arial 11 through the font drop down box using the "set as default" button. The Trust logo must also be applied in accordance with the style guide. Further information can be obtained from the Trust's Communications Team.

Nomenclature

To provide clarity on the type of meeting, it is important to maintain consistency regarding the descriptors attached to particular bodies. Within the Assurance Framework, the following descriptors will be applied:

- Level 1: Trust Board
- Level 2: Committee (Chaired by a Non-Executive Director)
- Level 3: Sub-Committee (Chaired by an Executive Director or nominated representative)
- Level 4: Group (established meeting that reports to a Sub-Committee)
- Level 5: Task and Finish Group (time limited meeting that reports to a Group or Sub-Committee)

For the Performance Management Framework, the following descriptors will be applied:

- Level 1: Divisional Board
- Level 2: Divisional Committee e.g. governance
- Level 3: Reporting Group
- Level 4: Task and finish groups (time limited)

Front Sheet

The Front Sheet will include the following information:

- Title of the meeting
- Date and time of the meeting
- Location of the meeting
- Meeting structure diagram (illustrating where the meeting reports into and what meetings report into it)

An example can be found as appendix 1.

Agenda

The agenda is the notice to members of the items that are to be discussed at the meeting. Individual agendas are built from the meetings's work schedule, action logs and any other items notified to the administrator in the period between meetings. For the Board and Board Committees, it also important that the BAF is reviewed and used to drive the agenda content i.e. by ensuring that gaps in controls and assurances receive explanations via reports.

All agendas must, as a minimum, include the following standing items: apologies; declaration of any conflicts of interest in any agenda items to be discussed; minutes of the last meeting; the action log; and a concluding item considering everything that has been discussed at the meeting and whether there is anything to escalate to the 'parent' committee / meeting.

The number of items on an agenda shouldn't be so big that they can't all be reasonably discussed in the time allotted for the meeting. Shorter agendas will ensure that all items are properly considered with well thought out conclusions.

The agenda is:

- drafted by the administrator of the meeting in sufficient time to allow it to be agreed by the chair of the meeting and circulated to paper authors
- required to show the date, time and venue for the meeting
- circulated to document authors in sufficient time (who may or may not be members of the committee / meeting) indicating which papers they are required to write
- sent out as part of the final meeting paperwork.

Please see appendix 2.

Minutes

Minutes are an official summary record of what happened at the meeting. It is important that the right type of record is made of the meeting and the chair of the meeting is accountable for deciding what the style of minute is made and ensuring they provide an accurate record.

Minute numbers should be expressed in a clear format that allows the reader to move between the minute document, the action log, and any other supporting paperwork that is linked to that minute. This should show the year and corresponding item number e.g. 2020/21/001.

Some minutes are internal facing, some are public facing but the quality of minutes should always be of the highest standard as they may be called on as evidence for external inspections, audits, fact finds, inquests, Freedom of Information requests etc. Their importance should not be underestimated.

Minutes of meetings are not line-for-line reporting, but they must:

- be written by the person administering the meeting within five working days of the meeting taking place, unless the meeting is weekly then it is within two working days
- be written in the past tense (it is a record of what happened at a meeting that took place in the past)
- use professional, formal language
- include a brief outline of the context of the item / discussion so the reader understands something about the item that was discussed
- the important points of discussion
- record any risks / benefits highlighted and what was being done in relation to these
- capture any challenge to the proposals / decisions and the responses to the challenge
- record any actions agreed ensuring they include who is responsible for the action and when it must be completed by
- be checked by the chair of the meeting
- be circulated to members of the committee as part of the meeting paperwork for the next meeting.

It is the responsibility of the chair to check the minutes before they are presented at the next meeting. It is during the course of the next meeting that they are checked for accuracy.

A minute template can be found at appendix 3.

Action notes template

Action notes are far less detailed than minutes. They do not capture any discussion but record only the agreed actions. These can be used for those meetings where it is not necessary to make a formal record of the discussion / challenge. It will be for the chair of the meeting to decide if formal minutes or action notes are required.

Action notes are a record of the meeting. Any actions agreed at the meeting will need to be transferred to and managed through the 'Action Log' to ensure that actions can be effectively managed, especially those with distant future dates are not lost sight of.

An action note template can be found at appendix 4.

Action log

Action logs are an important tool and source of evidence for committees and meetings, and those being assured of the work of the committee/meeting. Actions are captured in the minutes of the meeting; however, the action log is in a different format to the minute. The log also provides a mechanism for ensuring the committee / meeting doesn't lose sight of those actions with completion dates set in the future.

Actions in the log may need to be brought to the attention of people who don't normally attend the meeting. The administrative support for the meeting is usually the person who will circulate the log to members and if necessary, to others outside of the meeting who are named as action leads.

It is also the administrative support person who will capture comments from action leads between meetings and prepare the most up to date log so it can be reviewed at the next meeting. The cumulative action log should be a standing item at each meeting, so it is reviewed regularly by the committee / meeting.

As good practice, where a particular minute has a number of actions these should be split up and each given a separate log number so each separate action can be tracked individually (this is particularly important if they have different completion dates and different leads) e.g. 2020/21/001(a) and 2020/21/001 (b).

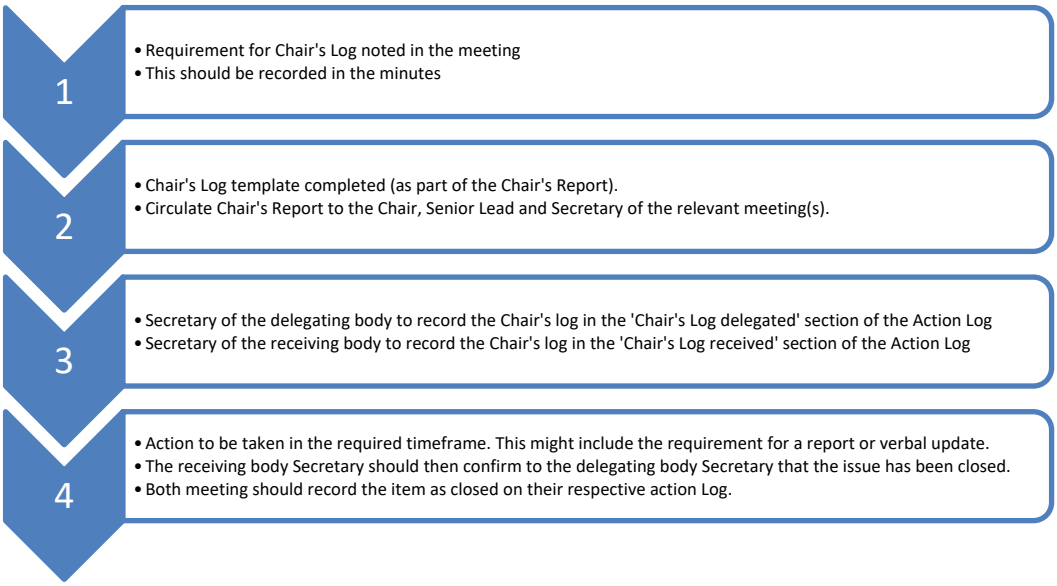
Action Logs will also incorporate 'Chair's Logs'.

All committees and Groups will use the Chair's Log to:

- Escalate risk over the threshold delegated to the committee (in accordance with the Risk Management Policy threshold and the Trust's Scheme of Reservation and Delegation or identified through other issues presented at the committee)
- Escalate decisions outside the delegated authority of the committee
- Communicate gaps in assurance to be addressed by other forums.
- Commission tasks for other committees
- Integrate issues which cross the terms of reference of different committees

The chair and the secretary for the committee/group will be responsible for ensuring the chair's log is populated at the end of each meeting. The chair of the committee/secretary who receives the chair's log will ensure that action is taken as required by the chair's log and will report back to the originating committee on action taken.

Process:



An action log template can be found at appendix 5.

Terms of reference

'Terms of Reference' is the name of the document that formally establishes a committee / sub-committee / group. Every Committee / sub-committee / group in the Trust's meeting structure must have this document in place. The Terms of Reference:

- clearly set out information about the Committee / sub-committee / group including: membership and anyone in attendance; its position in the meeting structure; which committee it reports to and any subordinate committee that reports into it; its duties and its powers of decision making; and the minimum number of members required at the meeting to be quorate
- must be agreed by the committee itself and then ratified by the committee which acts as 'parent' in the meeting structure
- must be reviewed on an annual basis (at the least) by the committee to ensure the information still reflects what it was set up to do
- must be ratified by the 'parent' committee if there any changes or revisions.

A Terms of Reference template can be found at appendix 6.

Annual work plan

All meetings must have a work schedule in place. Once the Terms of Reference have been agreed a work schedule should be drawn up. This is a document which assists with the development of future agendas. It:

- plots the duties set out in the Terms of Reference across the meetings that will take place over a period of time (usually a year)
- shows both standing items that must be taken at each meeting and those that occur at particular points in the period
- should be agreed by the committee each year or if there are any significant changes to the committee's duties during the period.
- maintains a record of items that were not scheduled but were received to assist with the end of year review.
- for the Board and the Board Committees, the work plan should be reviewed quarterly against the Board Assurance Framework to ensure that the assurances being received are helping to close out gaps in controls and assurances.

A template annual work plan can be found at appendix 7.

Reports

Requirements for reports

The primary reason for the use of formal reports is to ensure that the meeting is fully informed of the circumstances relating to the subject in question. Having the complete picture will enable the meeting to take informed decisions on the basis of the information presented. For this reason, written reports should always be used in preference to verbal briefings. The availability of reports prior to meetings allows subjects to be considered prior to decisions being made. There is an inherent risk that verbal briefings will not cover all the salient points and this can lead to ill-informed decisions being taken.

The use of reports enables the Trust to demonstrate its commitment to observe the principles of good governance and provides evidence of openness and transparency in decision making. Reports also result in a robust governance audit trail which provides the Trust with the ability to evidence decision-taking and demonstrate compliance with the requirements of external authorities e.g. NHS Improvement or the Care Quality Commission (CQC).

In view of the above, formal reports are the means by which items are presented to the meetings within the Trust's assurance and performance frameworks and any papers submitted to these meetings for consideration must be accompanied by an appropriate covering report.

Content of reports

There are many different types of report and content will vary dependent on the subject matter and purpose of the report. However, in general, reports will be used to give an account of something, to address a particular issue or to propose solutions for a specific problem. Whatever the nature or purpose of the report, there are a number of standard headings which will always need to be included. Use of these headings should lead to the production of a logical report covering all key aspects of the subject matter. A standard report template is available and must be used (see below). If you do not have a copy, it is available from the corporate governance team. Individual report headings are covered in more detail later in this guide.

It is imperative that, regardless of the subject matter, reports are used to provide assurance to the group considering the report. This assurance may be positive or negative, depending on the prevailing circumstances, but all reports should include an appropriate assurance statement.

Report authors should be aware of their target audience when preparing reports and be mindful that different groups will require different levels of details. In some cases, the approval process will necessitate the consideration of matters at Executive Team, Committee and Board level. Use of the same report at each of these levels would not be appropriate as each group will be interested in a differing level of detail and content to inform their decision-making.

The Trust observes a principle of 'no surprises' in the conduct of business at formal meetings. Authors should note that the preparation of reports does not eliminate the need for engagement with key stakeholders on the subject matter covered in reports. Prior engagement and involvement will help to engender support for proposals, promote understanding amongst key stakeholders and will reduce the risk of avoidable delays in the decision-making process.

Preparation

Authors should ensure that they have sufficient time to write their reports having taken into account the relevant deadline for submission. Prior to writing reports, authors should ask themselves (and answer!) the following questions:

- Why am I writing this report?
- What is the report intended to achieve?
- What is the desired outcome of the report?
- Do I have all the relevant information to write the report?
- Do I need to consult with others in preparing the report?
- What is my audience?

Having answered the above questions, authors can commence writing their reports but should bear in mind the following – 'Content is King'. You may produce an attractive, colourful report in the correct style and format which will be meaningless unless the content is correct.

Report template

The Trust has adopted a single report template for the submission of reports to all Trust forums. A single template encourages adoption of a corporate style and will result in consistency of presentation. The template incorporates a header page which, in addition to standard entries such as subject and author, enables references to elements such as strategic objectives, Equality Impact Assessments and the Board Assurance Framework. These references facilitate the identification and retrieval of documentary evidence to demonstrate compliance with a range of internal and external assessments. It is important that these are given full consideration by the author and if unsure, contact should be made with the corporate governance team.

With the implementation of the Integrated Care Board and the Health and Social Care Act 2022, report templates now include a section to reference to the impact on system working and collaboration.

There is an increasing understanding of the interrelatedness of financial, quality, performance and workforce issues. Authors are encouraged by the report template to outline these considerations if not already covered in the report content.

The standard template must be used for the production of reports to all Trust forums. An example can be found at appendix 9. Pointers and reminders are included for the sections of the report template.

Assurance / escalation process and report to 'parent' committee / meeting

The Chair's Report is a high-level report designed go to the 'parent' Committee / meeting. In providing the report the Chair will be acting on behalf of the group, though the content of which will probably have been discussed at the meeting.

The Chair's Report is not intended to simply be a summarised version of the minutes, but rather identify issues that require escalation, report key risks and provide a view on the strength of the assurances received.

A template can be found at appendix 8.

Particular issues for action will be noted as 'Chair's Logs' (further detail provided under the Action Log section).

Committee effectiveness

All committees / sub-committees /groups must take time to consider if they are still effective and what, if any, changes need to be made to the way they operate or to their duties. Any changes made will need to be reflected in the Terms of Reference which will then need to be agreed by the committee and approved by the 'parent' committee.

All those listed on the Terms of Reference (members and regular attendees) must be offered the opportunity to review the effectiveness of the committee. The review must be carried out on an annual basis. A survey should be circulated to core members and regular attendees for feedback.

This will be set out in the Terms of Reference. The outcome should be reported to the committee itself so it can evaluate the results, consider comments and ideas and take action to address any weaknesses found. The outcome should also be reported to the 'parent' committee via the assurance / escalation process.

A committee effectiveness survey template can be found at appendix 10.

Committee Annual Report

Board committees are required to provide an annual report summarising their work over the course of the year.

A committee annual report template can be found at appendix 11.

Business Case Template

This can be found at appendix 12.

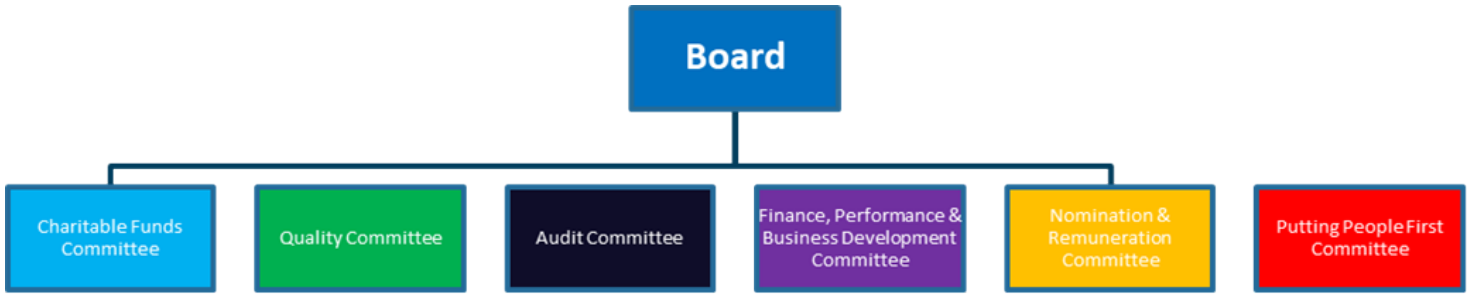
Liverpool Women's
NHS Foundation Trust

Name of Meeting

Date of Meeting

Location of Meeting

Reporting Structure e.g. Trust Board



Liverpool Women's
NHS Foundation Trust

Appendix 2

Name of Meeting

Location	
Date	
Time	

AGENDA					
Item no. 20/21/	**Title of item**	**Objectives/desired outcome**	**Process**	**Item presenter**	**Time**
PRELIMINARY BUSINESS					
	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	xx:xx (xx mins)
	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
	Minutes of (title of meeting) held on (date of minutes)	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	
Headings to be used as appropriate					
CONCLUDING BUSINESS					
	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	
	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
Finish Time: xx					

Date of Next Meeting:

Appendix 3

Liverpool Women's NHS Foundation Trust

Name of Meeting

Minutes of the [Meeting]
held [location] at [time] on [date]

PRESENT
Name of Core Member Job Title

IN ATTENDANCE
Name of attendee Job Title

APOLOGIES:
Name Job Title

Core members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Present (✓) **Apologies (A)** **Representative (R)** **Non attendance (NA)**												

20/21/	
Item number	**Title** Body of the minute **Action:** *Note action, owner and timeframe* **Resolved:** *The Committee/ Sub-Committee/Group agreed/recommended/noted etc. If more than one resolution, utilise bullet points.*

Appendix 4

Liverpool Women's
NHS Foundation Trust

Name of Meeting

Action Notes of the [Meeting]
held [location] at [time] on [date]

PRESENT
Name of Core Member Job Title

IN ATTENDANCE
Name of attendee Job Title

APOLOGIES:
Name Job Title

Core members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Present (✓) **Apologies (A)** **Representative (R)** **Non attendance (NA)**												

20/21/	Summary of item	Action(s)	Assigned to	Timeframe
Item number	*Only one or two sentences*			

Appendix 5

Action Log

Name of Meeting
Date of Meeting

Key	Complete	On track	Risks identified but on track	Off Track

Meeting Date	Agenda Item	Action Point	Owner	Action Deadline	RAG Open/Closed	Comments / Update

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update

Appendix 6

[INSERT NAME OF COMMITTEE/SUBCOMMITTEE/GROUP] TERMS OF REFERENCE

Constitution:	The [Committee/Subcommittee/Group] is established by the [name of establishing Committee] and will be known as the [Committee/ Subcommittee/Group]. Include a summary of the purpose of the meeting.
Duties:	The [Committee/Subcommittee/Group] is responsible for:
Membership:	The [Committee/Subcommittee/Group] membership will be appointed by the [name of establishing Committee] and will consist of: • • • • Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum The [name of establishing Committee] will appoint a member of the [Committee/Subcommittee/Group] as Chair of the Committee/Subcommittee/Group and another member to be Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent.
Quorum:	A quorum shall be [xxxx] members including: • • • •

	•
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. **b. Officers** The [state titles of relevant officers] shall normally attend meetings. Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held [X] times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The [Committee/Subcommittee/Group] is authorised by the [name of establishing Committee] to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the [Committee/Subcommittee/Group.]
Accountability and reporting arrangements:	The [Committee/Subcommittee/Group] will be accountable to the [name of establishing Committee]. The minutes of [Committee/Subcommittee/Group] will be formally recorded and submitted to the [name of establishing Committee]. The Chair of the [Committee/Subcommittee/Group shall draw to the attention of the [name of establishing Committee] any issues that require disclosure to it, or require executive action. The Committee will report to the [name of establishing Committee] annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the [Committee/Subcommittee/Group].

Reporting Committees/Groups	The sub-committees/groups listed below are required to submit the following information to the [Committee/Subcommittee/Group]: a) Chairs Report [and/or] minutes of meetings; and b) an Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • • •
Monitoring effectiveness:	The [Committee/Subcommittee/Group] will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the [Committee/Subcommittee/Group].
Reviewed by [Committee/ Subcommittee/Group]:	DD/MM/YY
Approved by [name of establishing Committee]:	DD/MM/YY
Review date:	MM/YY
Document owner:	[Name & title] Email: Tel:

Appendix 7

COMMITTEE NAME Work Plan 2020/21		MEETING DATE 2020/21							
		Quarter 1		Quarter 2		Quarter 3		Quarter 4	
		Meeting date	Meeting date	Meeting date	Meeting date	Meeting date	Meeting date	Meeting date	Meeting date
Report Deadline									
	Member lead								
MATTERS FOR DISCUSSION & ACTION/DECISION									
To develop a well led, capable, and motivated workforce									
To be ambitious and efficient and make best use of available resources									
To deliver safe services									
To participate in high quality research and to deliver the most effective outcomes									
To deliver the best possible experience for patients and our staff									
MATTERS FOR APPROVAL / DECISION									

Liverpool Women's
NHS Foundation Trust

Appendix 8

Name of Meeting

KEY INFORMATION

Agenda Item (Ref)	***Secretary to complete***	**Date of meeting:** Click here to enter a date.		
Report Title				
Prepared by	***Name and Job Title***			
Presented by	***Name and Job Title***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
Recommendation:				
Supporting Executive(s):	***Name and Job Title***			

Committee or meeting report considered at:	Date	Lead	Outcome

EXECUTIVE SUMMARY

Outline:

Recommendation:

Appendix 9

MAIN REPORT

Information: The Rationale & Evidence for the Recommendations

Type over highlighted prompts – CONTENT FOR TEXT BOXES MUST BE COMPLETED OR A STATEMENT PROVIDED THAT IT IS NOT RELEVANT / REQUIRED FOR THE REPORT:

Introduction - Provide context, background and purpose.

Trust Strategy & System Impact

Outline how the report links to / supports elements of the Trust's strategy **and** the 'triple aim'* / other NHS Cheshire and Merseyside system priorities

*a legal duty on NHS bodies which requires them to consider the effects of their decisions on:

- the health and wellbeing of the people of England (including inequalities in that health and wellbeing)
- the quality of services provided or arranged by both the Trust and other relevant bodies (including inequalities in benefits from those services)
- the sustainable and efficient use of resources by both the Trust and other relevant bodies.

Trust Strategy Link

ICB Strategy Link

Main body - What are the key findings and how were they reached?

Use information that is meaningful and relevant – graphs and tables do not require describing. The use of graphs, tables, graphics and RAG ratings focus the reader's attention.

Try to ensure that the report is forward looking / trend based wherever appropriate – not 'snapshot' or two data point reporting. The use of revised trajectories alongside existing can be useful to show the expected impact of actions.

It is better to be exception based in order to direct the reader to the key issues to focus on those areas requiring greater attention.

Your analysis can be enhanced by using benchmarking or comparator information where possible / appropriate.

Many Body - Solutions:

Try to be action orientated – not just reporting performance. This is where you can provide effective assurance to the Board / Committee / Sub-Committee.

Outline the accountability arrangements for the proposed actions and how they are SMART.

Appendix 9

Information: Additional considerations

Equality, Diversity & Inclusion Implications

Outline how the report may impact positively or negatively, equality, diversity and/or inclusion.

If the report is introducing a new (or updated) strategy, policy or service change, and Equality Impact Assessment must be included as an appendix.

Quality, Financial or Workforce implications

Outline how the report may have quality, financial or workforce implications not already included in the main body of the report.

Link to the Board Assurance Framework and/or Corporate Risk Register

Outline how the report either a) strengthens an existing control or source assurance b) creates a new control or source of assurance and / or c) identifies a new gap in control or assurance.

Specify which BAF risk(s) the comment(s) relate to.

Link to the BAF

Link to the CRR

Recommendation

Type over these prompts:

Be clear on what you are asking the Board / Committee / Sub-Committee. Who will take ownership for delivery?

SUPPORTING DOCUMENTS

*List appendices here – **PLEASE DO NOT EMBED DOCUMENTS***

Either include the additional documents as appendices or send through to Secretary with clear labels.

Liverpool Women's
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Appendix 10

[Name of Meeting] Chair's Highlight Report to [Name of Meeting]

Date

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
Positive Assurances to Provide *Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED*	**Decisions Made**
Summary of BAF Review Discussion *(Board & Committee level only)*	
Comments on Effectiveness of the Meeting / Application of QI Methodology	

Appendix 10

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.					
2.					
3.					
4.					
5.					
6.					

3. [Fiscal Year] Attendance Matrix

Core members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

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

Appendix 11

Meeting Guidance Notes for an NHS Foundation Trust

Meetings are an essential part of any NHS Foundation Trust's decision-making process. To ensure that these meetings are productive and efficient, it is crucial to follow proper etiquette and behaviors before, during, and after the meeting. Here are some guidance notes to keep in mind:

Before the Meeting:

- Review the agenda: Before attending the meeting, make sure to review the agenda to understand the purpose of the meeting, the topics that will be discussed, and what is expected of you.
- Come prepared: Bring any necessary documents or materials to the meeting, such as reports, data, or notes.
- Ensure your apologies are sent if you are unable to attend and *arrange for a suitable deputy to attend in your absence - members are expected to attend at least 75% of all meetings held each year.

  **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.*

- Be punctual: Arrive on time, or better yet, a few minutes early, to ensure that you are ready to start the meeting promptly.
- Check the technology: If the meeting is a hybrid one, meaning some participants are attending in person and others are attending remotely, make sure to check the technology beforehand. Ensure that the meeting room has adequate audio-visual equipment, such as microphones and cameras, to allow remote participants to participate fully.
- Communicate with remote participants: If you are attending the meeting remotely, make sure to communicate any special requirements or needs to the meeting organizer in advance. This will help them to accommodate you better during the meeting.
- Test the connection: Make sure to test your internet connection and any required software or applications beforehand to avoid technical issues during the meeting.

During the Meeting:

- Listen actively: Listen attentively to what others are saying and avoid interrupting or talking over others. This will help you to fully understand the issues being discussed and contribute to meaningful discussions.
- Be respectful: Respect others' opinions and perspectives, even if you disagree with them. Avoid using derogatory language, and be courteous and professional at all times.
- Stay focused: Stay focused on the agenda and avoid going off-topic. This will help the meeting to stay on track and achieve its objectives.
- Pay attention to the camera: If you are attending the meeting remotely, make sure to look at the camera instead of the screen when speaking. This will help to create a more engaging experience for in-person participants.
- Mute when not speaking: If you are attending the meeting remotely, make sure to mute your microphone when not speaking to avoid background noise.
- Encourage participation: Encourage participation from both in-person and remote participants. Ask remote participants for their opinions and actively engage them in the discussion.

Appendix 11

Standards and Obligations

These points outline key behaviours and processes to be followed during our meetings.

- Minutes should note when there is no consensus, including who agreed and disagreed.
- Members must be open and declare any conflicts of interest to the committee chair, who should be notified if any conflicts of interest are perceived. If concerns are not adequately addressed, members may consider whistleblowing or contacting the Senior Independent Director for high-level concerns.
- At the end of the meeting, a standing item should identify new risks to the organization and document them in the relevant risk register with appropriate scores. These steps ensure transparency, accountability, and effective risk management within the NHS Foundation Trust.

After the Meeting:

- Follow up: Follow up on any action items assigned to you during the meeting promptly.
- Share the recording: If the meeting was recorded, share the recording with all participants, both in-person and remote. This will allow everyone to review the discussion and follow-up on any action items.
- Provide feedback: If you have any feedback or suggestions on how the meeting could be improved, share them with the appropriate person.
- Evaluate the technology: Evaluate the technology used during the meeting and identify any areas for improvement. This will help to ensure that future hybrid meetings are even more effective.
- Thank participants: Thank the chairperson and other participants for their time and contributions.

In conclusion, following proper etiquette and behaviors before, during, and after the meeting, as well as specific considerations for hybrid meetings, will help to ensure that our meetings are productive, efficient, and respectful. Remember to come prepared, listen actively, stay focused, follow up promptly, and provide feedback.

Liverpool Women's NHS Foundation Trust

Committee Effectiveness Survey

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer	Comments/ actions
I understand the duties of the committee.						
I believe the committee receives sufficient assurance to conclude upon the its areas of responsibility						
I am confident that the committee effectively monitors and scrutinises progress against the aligned strategies.						
I am content that the committee is delivering the right level of assurance to the Board / Committee.						

Liverpool Women's NHS Foundation Trust

Committee Effectiveness Survey

I believe that the committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management.						
I feel that the committee has the right balance of experience, attendance, knowledge and skills to fulfil its role.						
The committee has structured its agenda and work plan to cover its key responsibilities.						
The committee is effectively chaired.						
All members of the committee are able to participate effectively.						
There is clarity in relation to the work of the committee and its interaction and alignment with other committees.						

Liverpool Women's
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Liverpool Women's NHS Foundation Trust

[Name of Committee] Annual Report 2020/21

Committee Name

The Committee is responsible for …….

It completes these duties by undertaking the following:

INSERT DUTIES FROM COMMITTEE/GROUP TERMS OF REFERENCE.

This remit is achieved through the Committee being appropriately constituted, and by the Committee being effective in ensuring internal accountability and the delivery of assurance services.

This report outlines how the Committee has complied with the duties delegated by the **[PARENT COMMITTEE]** through the terms of reference.

Constitution

The **[Committee Name]** is accountable to the Board of Directors/ Division etc.

Membership during the year comprised;

- **Insert membership from Terms of Reference**
- Person A
- Person B
- Person C

Section to include:

- **Attendance other than members**
- **No. of meetings held during the year in accordance with terms of reference**
- **Terms of reference reviewed**
- **Format of meetings held, face:face/virtual**
- **Quorum achieved for % of meetings**

Key Achievements

Section to include significant achievements demonstrating that the committee had achieved its key duties.
Information drawn from agenda items considered over the course of the year.

Conclusion

In evaluating its achievements it is concluded that the **[Committee Name]** has achieved its objectives for the Financial Year **2020/21**.

Work planned for [2021/22]

- **Include forward planning**
- **New additions to the workplan for the following year**
- **Continuation of monitoring of any key issues / projects**

NAME - Chair
[Committee Name]
[DATE]

APPENDIX 1: COMMITTEE ATTENDANCE Committee Name **Attendance at Committee: 2020/21**

MEMBERS	JOB TITLE	April 2020	May 2020	June 2020	July 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	%
NAME 1		✓	✓	✓	AP	✓	✓	✓	MTG NOT HELD	✓	✓	AP	**80**
NAME 2		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	**100**
NAME 3		Non member				✓	✓	✓		✓	✓	✓	**100**
NAME 4		✓		✓		AP	✓	✓		AP	✓	AP	**50**
Represent quorum if needed													
REP NAME 1					✓							✓	
Invited Attendance													
		✓		✓	✓	✓	✓	✓	MTG NOT HELD	✓	✓	✓	
								✓		✓			
			✓										

The quorum shall be [INSERT QUORUM DETAILS FROM TERMS OF REFERENCE].

Appendix 13

Business Case Template

1. Background

   - *what's the business case about, brief intro*

2. Case for change

   - *what's the reasons for a change/for the business case*

3. Risk Management

   - *should link case for change with risks trying to mitigate*

4. Options appraisal

   - *what solutions have been explored and what is the preferred option and why*

5. Benefits realisation - what benefits will be realised by the change of the business case & how it ties into *the Trust's vision, aims and values*

6. Financial impact

   - *are there any costs/savings and how will they be funded.*

7. Timetable for delivery

8. Conclusion/Recommendation

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/091d***		**Date: 13/07/2023**	
Report Title	**Board Assurance Framework**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***The report outlines any updates relating to the Board Assurance Framework and any key areas for consideration for the Board.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y ***If no – please outline the reasons for deviation.***			
	The Board requested to • ***review the BAF risks and agree on their contents and actions.*** • ***Agree the suggested Q1 scores***			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

BAF discussed at the PPF, FPBD and Quality Committees since the previous version was presented to Board in May 2023.

EXECUTIVE SUMMARY

The Board Assurance Framework (BAF) is a monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives and to ensure it has appropriate oversight of the Trust's risk profile and risk management arrangements.

The BAF has been significantly updated for 2023/24 to clarify the Trust's most significant strategic risks. This has resulted in predecessor BAF risks that were reported throughout 2022/23 being either replaced or merged into the new BAF risks for 2023/24. The new BAF risks have been scrutinised and discussed at the Board's committees.

MAIN REPORT

Introduction

The following report provides an update to Board members on the latest review of the BAF items.

The report is intended to allow the members of the Board to review any proposed changes or additions and agree them moving forward. The report is also an opportunity for the Board to make informed judgements as to the level of assurance that they can take and to identify any further action required to improve the management of the identified risks.

Process for reviewing BAF areas during the meeting

As the Board works through the agenda, members are requested to consider the BAF areas contained in Appendix 1 and the associated interdependent 15 and above risks / CRR risks. Keeping these risks in mind should support consideration of whether any assurances provided through the reports received could contribute to mitigation (or escalation) of the BAF risks. These can be noted when the BAF itself is discussed.

In addition, members should consider whether because of the review of assurances and/or identification of risks, whether there is a need to commission additional assurance to be reported to future Board and / or Committee meetings. In particular, the Board needs to ask itself whether it is attaining adequate assurance against its highest scoring risks i.e., are these areas of risk driving the Board and Committee agendas. Any information that has been discussed in the meeting that needs to be shared with other corporate governance meetings should be included in the Chair's Log.

Changes to BAF

As was noted in May 2023, an updated BAF for 2023/24 has been produced and this includes a reduced number of BAF risks to help provide greater clarity on the key strategic risks facing the Trust. The risk areas covered are as follows:

- Clinical sustainability (to be aligned to the Quality Committee)
- Financial sustainability (to be aligned to FPBD)
- Workforce (to be aligned to the PPF Committee)
- Patient Experience (to be aligned to the Quality Committee)
- Being an effective partner (to be aligned to FPBD)
- Digital (to be aligned to FPBD)

Following consideration of its aligned BAF risks, the Quality Committee also suggested that a separate BAF risk be created in relation to patient waiting times. This was discussed and agreed at the June 2023 Committee meeting.

The following provides an outline of each BAF risk, the proposed scoring for Quarter 1 2023/24 and any comments made by the Board's Committees during recent meetings:

1 – Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities

Proposed Q1 Score – Likelihood 4 x Consequence 4 = 16

The Liverpool Women's NHS Foundation Trust is facing acute and chronic staffing challenges in various areas, which have been exacerbated by factors such as low morale, high sickness absence rates, and maternity staffing issues. The Trust is also dealing with an increase in turnover, challenges associated with specialist obstetric anaesthesia recruitment and theatre staffing, insufficient numbers of doctors in training, a national shortage of nurses and midwives, and the clinical risk associated with an isolated site. Additionally, the recent pandemic and the associated recovery of elective activity are impacting the Trust's operations. Over recent months, the Trust has also been managing the impact of industrial action. For these reasons, staffing relating risks on Trust's previous BAF iterations have been scored highly with Risk 1.2 Failure to recruit & maintain a highly skilled & engaged workforce – scored as a '20'. The Trust recently received the outcome from the 2022 Staff Survey, and this started to show areas of improvement in several areas. The Trust's sickness and mandatory training rate has also shown signs of improvement in the last quarter of 2022/23. It is for this reason, that the opening score for this risk as part of the 2023/24 BAF is suggested to be set at '16'.

This is further strengthened by the level of assurance that can be provided that the Trust is making progress in terms of the diversity and inclusivity of its workforce. For example, during 2022/23, for the second year running the Trust benchmarked within the top 50 inclusive places to work (improving from 2021/22). Recognising that that Trust could make continued progress on the mechanisms that it has in place to hear the views and voices of its diverse staffing groups and ensure that these voices have an impact on service improvement and development, this risk was scored at a '12'.

Now that these elements have been combined into a single BAF risk, it is felt germane that an appropriate score for Q1 of 2023/24 would be '16' with a view that there is the scope that this can be reduced to '12' during the year.

2 – Inability to ensure the on-going sustainability of clinical services and maintain a high standard of care at the current Crown Street site.

Proposed Q1 risk score is 20 – Likelihood 4 x Consequence 5

The Trust's services being located on an isolated site away from an acute centre, remains the most significant risk to the organisation and to patient safety. Good progress is being made on mitigating measures to make the Crown Street site safer with several significant capital projects either completed, underway or planned. It should be acknowledged that the impact of this risk cannot be fully mitigated whilst the Trust operates on an isolated site, and that following the implementation of the actions outlined below, the Trust does not believe that any further mitigation is possible. This view was recently confirmed by an independent review undertaken by the Northern England Clinical Senate, in February 2022.

The Trust can demonstrate evidence of being open and responsive to change in service development and delivery, but further work can be done to strengthen the approach to horizon scanning and longer term, strategic planning at a Divisional level.

At its June 2023 meeting, the Quality Committee suggested that elements relating to safety and the ability of the Trust to minimise harm should be reflected more prominently in this risk – this will be taken forward to the July 2023 meeting for consideration.

3 – Failure to deliver an excellent patient and family experience to all our service users

Proposed Q1 risk score is 20 – Likelihood 3 x Consequence 4

To improve further, it is imperative that the organisation ensures that it can listen to patient voices and the local community and ensure that services are responsive and can cater to differing needs. The evidence for how effective the organisation is undertaking this can be strengthened from the current position.

The Ockenden Final Report made several comments about the importance of trusts listening effectively to the patient voice and strengthening the Trust's approach to this will be a significant area of priority during 2023/24. Considering the importance of this and the fact that available controls / assurances remain limited in this area, the target score for 2023/24 has been set at '12' to reflect the current reality.

Following the operational pressures faced as a result of the COVID pandemic, a large number of patients had their treatment and appointments delayed as a result of changes to clinical capacity. This has led to an increasing number of patients waiting beyond 52 weeks to receive their treatment. Continued rises in referrals from Primary Care and an increasing backlog of patients to be seen has led to delays in care and deterioration of Trust performance in relation to national Referral to Treatment (RTT) standards.

4 – Inadequate digital strategy and sub-optimal clinical records systems increase the risk of major IT system failures due to cyber-attacks, compromising patient safety and Trust operations

The proposed Q1 risk score is 20 – Likelihood 4 x Consequence 5

The Trust's Digital Services department places cyber security management at the core of operational activities, ensuring it maintains its Cyber Essentials standard. Various controls are implemented that are considered effective and this reduces the likelihood of a cyber-attack impact. However, if a cyber-attack was successful the impact would likely be catastrophic to Trust services, likely rendering digital systems that clinical services are increasingly dependent on, unavailable for a period of time. The Digital Services department continues to strengthen controls through process refinement and the introduction of security technologies.

The lack of an EPR (and as a corollary, having in place a disparate number of systems), remains a significant risk to the organisation because information is spread across disparate systems leading to information being incomplete, hard to find in a timely manner and a potential for inaccuracies due to manual transfer of information. However, there is evidence of pro-active mitigating controls and progress being made in the procurement and subsequent implementation of an integrated Meditech EPR system.

Based on this, the impact is considered catastrophic (5). Due to recent world events, the environment risk or likelihood for a cyber-attack has increased from possible (3) to likely (4) due to increased cyber threats from Russia. The NHS has reflected the increased threat through guidance issued to all NHS providers and arm's length bodies during March 2022. The current situation with multiple clinical systems would also justify this risk rating.

5 – Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term

The proposed Q1 risk score is 16 – Likelihood 4 x Consequence 4

The Trust has a well-defined and evidence-backed case that it is not financially sustainable while remaining on an isolated site. This situation is worsening each year due to prior capital investment, ongoing revenue investment, and other pressures. The Trust is facing a significant financial challenge in 2023/24 and is at risk of not being able to deliver its financial plan. The likelihood of this risk has been assessed as 'likely' rather than 'almost certain'. The Trust has put together a plan to recover its financial position from the 2022/23 financial year, and this is continuing for 2023/24 and beyond to try to move the organization to a more sustainable financial footing.

6 – The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative

The initial proposed Q1 risk score was 8 – Likelihood 2 x Consequence 4

Following a request from the May 2023 Committee, the scoring of this risk has been reviewed. With further consideration, and with calibration of the other BAF risks, it is proposed to change the current risk score from likelihood 2 x consequence 4 to likelihood 3 x consequence 3. This is to reflect that the consequence score had potentially been over-estimated (particularly when comparing to other BAF risk areas and being mindful of the risk appetite). The likelihood had also been potentially underscored considering the nascent and developing state of the Trust's partnerships and the shifting healthcare landscape. There is confidence that the Trust is well-placed to strengthen and develop its partnerships and therefore a target score of likelihood 2 x consequence 3 (6) has been suggested.

7 - Failure to meet patient waiting time targets

This BAF risk is new following a request from the May 2023 Committee meeting. The proposed Q1 score is 16 (l4 x c4) as whilst the Trust is making improvements in waiting times and has controls to mitigate harm, delays remain and the Trust is limited in the action it can take to reduce these with pace. The target has been set at '12' and it is felt that this is a reasonable target to aim for by year-end.

Key changes to BAF format

- In document links to support navigation from dashboard to individual BAF risks
- Reduced number of BAF risks overall with the aim of increasing clarity on the Trust's strategic risks
- Risk descriptor included – aligning with Risk Management Strategy
- Risk Tolerance Statement included
- Assurances now rated and an assessment made on their level
- Links to corporate and high-level divisional risks made clearer and more explicit (responding to CQC comment).
- Appendix 1 demonstrates how Liverpool-based trusts score their aligned BAF risks.

Closed Risks or Strategic Threats

The following 2022/23 BAF risks have been closed and replaced with those highlighted above.

1.1 Failure to be recognised as one of the most inclusive organisations in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations) - *key assurances and controls for this area have been transposed into the 'sustainable workforce' risk.*

1.2 Failure to recruit & maintain a highly skilled & engaged workforce - *key assurances and controls for this area be transposed into the 'sustainable workforce' risk.*

2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site - *key assurances and controls for this area have been transposed into the 'effective partnerships' risk as the future of this issue will be taken forward as an ICB sub-committee.*

2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment – *multiple clinical system element of the risk has been carried over to the 'digital' risk and not included in the clinical sustainability risk.*

2.3: Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system - *the issues have carried forward into the 'clinical sustainability' risk*

2.4: Major and sustained failure of essential IT systems due to a cyber-attack – *this has been carried over to the 'digital' risk*

3.1: Failure to deliver an excellent patient and family experience to all our service users - *the issues have been carried forward into the 'patient experience' risk*

4.1: Failure to ensure our services are financially sustainable in the long term - *the issues have carried forward into the 'financial sustainability' risk*

4.2: Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS - the issues have carried forward into the '*partnerships*' risk

4.3: Failure to deliver the agreed 2022/23 financial plan - *the issues have carried forward into the 'financial sustainability' risk*

5.1: Failure to progress our research strategy and foster innovation within the Trust - *the issues have carried forward into the 'clinical sustainability' risk*

5.2: Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership - *the issues will carry forward as part of the Corporate Risk Register. The impact of the expected CQC report will also need to be factored into this.*

Recommendation

The Board requested to

- review the BAF risks and agree on their contents and actions.
- Agree the suggested Q1 scores

NHS
Liverpool Women's
NHS Foundation Trust

Board Assurance Framework 2023/24

Trust Board

July 2023

Board Assurance Framework Key

Risk Rating Matrix (Likelihood x Consequence)					
Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

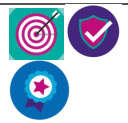
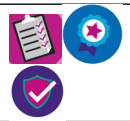
Director Lead	
CEO	Chief Executive
CPO	Chief People Officer
COO	Chief Operating Officer
CFO	Chief Finance Officer
CIO	Chief Information Officer
CN	Chief Nurse
MD	Medical Director

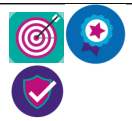
Key to lead Committee Assurance Ratings	
	Green = Positive assurance: the Committee / Board is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity - no gaps in assurance or control AND current exposure risk rating = target OR - gaps in control and assurance are being addressed
	Amber = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy
	Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each BAF Risk and also to identify any further action required to improve the management of those risks.

Board Assurance Framework: Legend	
Strategic Aim	The 2021/25 strategic aim that the BAF risk has been aligned to.
BAF Risk:	The title of the strategic risk that threatens the achievement of the aligned strategic priority
Rationale for Current Risk Score:	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk.
Controls:	The measures in place to reduce the risk likelihood or risk consequence and assist secure delivery of the strategic priority.
Assurances:	The measures in place to provide confirmation that the controls are working effectively in supporting the mitigation of the risk. Level 1 – Operational oversight Level 2 - Board / Committee oversight Level 3 – external (independent) oversight
Gaps in Controls / Assurance:	Areas that require attention to ensure that systems and processes are in place to mitigate the BAF risk Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the BAF risk.
Required Action:	Actions required to close the gap in control/ assurance
Lead:	The person responsible for completing the required action.
Implemented By:	Deadline for completing the required action.
Progress:	A RAG rated assessment of how much progress has been made on the completion of the required action.

Board Assurance Framework Dashboard 2023/2024

BAF Risk	Strategic Aim(s)	Committee	Lead	May 2023	Q2	Q3	Q4	Q2Q Movement	2023/24 Target
1 – Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities		PPF Committee	Chief People Officer	16 (I4 x c4)				N/A	12 (I3 x c4)
2 – Inability to ensure the on-going sustainability of clinical services and maintain a high standard of care at the current Crown Street site.		Quality Committee	Chief Operating Officer / Medical Director	20 (I4 x c5)				N/A	15 (I3 x c5)
3 – Failure to deliver an excellent patient and family experience to all our service users		Quality Committee	Chief Nurse	12 (I3 x c4)				N/A	8 (I2 x c4)
4 – Inadequate digital strategy and sub-optimal clinical records systems increase the risk of major IT system failures due to cyber-attacks, compromising patient safety and Trust operations		FPBD Committee	Chief Information Officer	20 (I4 x c5)				N/A	15 (I3 x c5)
5 – Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term		FPBD Committee	Chief Finance Officer	16 (I4 x c4)				N/A	12 (I3 x c4)
6 – The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative		FPBD Committee	Medical Director / Chief Finance Officer	9 (I3 x c3)				N/A	6 (I2 x c3)

7 - Failure to meet patient waiting time targets		Quality Committee	Chief Operating Officer	16 (I4 x c4)				N/A	12 (I3 x c4)

BAF HEAT MAP

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic				BAF 2 BAF 4	
4 Major			BAF 3	BAF 5 BAF 7 BAF 1	
3 Moderate			BAF 6		
2 Minor					
1 Negligible					

BAF Risk 1 – *Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Insufficient numbers of administrative and clinical staff, challenges in creating a diverse workforce, and ineffective staff engagement strategies may result in a lack of capability to deliver safe care, effective outcomes, and organisational objectives.	The Trust may struggle to provide safe and effective care, achieve organisational objectives, and engage effectively with patients and staff due to the staffing challenges.	If the Trust is unable to address these staffing challenges, it may result in negative outcomes for patients and staff, including reduced trust in the quality of care provided, a negative impact on staff morale, and potential legal and regulatory consequences for failing to create a diverse workforce that is representative of the community it serves. Additionally, it may negatively impact the Trust's reputation and lead to reduced patient confidence.

	We will be an outstanding employer	✓		**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience	✓		**To be ambitious and efficient and make the best use of available resources**	
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Putting People First Committee**	**Lead Director:**	**Chief People Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**				**3**	**March 2024**	Our risk appetite for workforce **is moderate.** Liverpool Women's NHS Foundation Trust has a moderate appetite for risk to this objective. The Trust operates in a complex environment in which it faces challenging financial conditions and changing demographics alongside intense political and regulatory scrutiny. However, the continued delivery of high-quality healthcare services and service sustainability requires some moderate risk to be accepted where this is likely to result in better healthcare services for patients. Support for moderate risk in service redesign that requires innovation, creativity, and clinical research to improve patient outcomes are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.
Consequence	**4**				**4**		
Risk Level	**16**				**12**		

Rationale for risk score and quarterly update – *May 2023*

The Liverpool Women's NHS Foundation Trust is facing acute and chronic staffing challenges in various areas, which have been exacerbated by factors such as low morale, high sickness absence rates, and maternity staffing issues. The Trust is also dealing with an increase in turnover, challenges associated with specialist obstetric anaesthesia recruitment and theatre staffing, insufficient numbers of doctors in training, a national shortage of nurses and midwives, and the clinical risk associated with an isolated site. Additionally, the recent pandemic and the associated recovery of elective activity are impacting the Trust's operations. Over recent months, the Trust has also been managing the impact of industrial action. For these reasons, staffing relating risks on Trust's previous BAF iterations have been scored highly with Risk 1.2 Failure to recruit & maintain a highly skilled & engaged workforce – scored as a '20'. The Trust recently received the outcome from the 2022 Staff Survey, and this started to show areas of improvement in several areas. The Trust's sickness and mandatory training rate has also shown signs of improvement in the last quarter of 2022/23. It is for this reason, that the opening score for this risk as part of the 2023/24 BAF is suggested to be set at '16'.

This is further strengthened by the level of assurance that can be provided that the Trust is making progress in terms of the diversity and inclusivity of its workforce. For example, during 2022/23, for the second year running the Trust benchmarked within the top 50 inclusive places to work (improving from 2021/22). Recognising that that Trust could make continued progress on the mechanisms that it has in place to hear the views and voices of its diverse staffing groups and ensure that these voices have an impact on service improvement and development, this risk was scored at a '12'.

Now that these elements have been combined into a single BAF risk, it is felt germane that an appropriate score for Q1 of 2023/24 would be '16' with a view that there is the scope that this can be reduced to '12' during the year.

Key Controls and Assurance Framework

Key Controls:

- Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff.
- LWH 'People Promise' to launched in 2022 – bringing together key strands of people strategy including behavioural framework
- Behavioural framework developed in partnership with staff in 2021
- Great Place to Work Group Launched as a cross section of staff committed to improving staff experience and a source of two way communication
- Consultant revalidation process.
- Reward and recognition processes linked to values.
- Pay progression linked to mandatory training compliance
- Targeted OD intervention for areas in need to support.
- New Leadership Programme and Talent Management framework in place.
- Programme of health and wellbeing initiatives including launch of LWH Staff Support Service, recruitment of LWH Psychologist and Wellbeing Coaches
- All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities.
- Workforce planning processes in place to deliver safe staffing.
- Shared decision making with JLNC and Partnership Forum.
- Putting People First Strategy
- Guardian of Safe Working.
- PDR training programme in place and PDR window for band 7 and above in N&M commenced in 2021
- Two Freedom to Speak Up Guardians (including representation from a diverse and clinical background)
- Whistle Blowing Policy
- Regular Local Staff Surveys
- Quarterly Trust wide listening events - Big Conversation
- Divisional oversight of Mandatory training
- Mandatory training quarterly validation
- Annually agreed funding contract with HEE
- Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer.
- Effective electronic rota management system for AFC staff implemented with doctors implemented by early 2022
- Director of medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN
- Guardian of Safe Working Hours appointed in 2016 under new Junior Doctor Contract.
- Acting down policy and process in place to cover junior doctor gaps
- National Revalidation process ensuring competent staff.
- Shared decision making and review of risk with JLNC.
- Succession Planning and Talent Programmes
- NHSE/I leadership programme to reduce sickness
- Shared appointments with other providers
- Secured operating time at the LUH
- Increased consultant recruitment with incentives Neonatal Partnership
- Maternity introduction of ACP Midwives
- Work underway to ensure that the number of staff without a Covid-19 vaccine is minimised
- Flexible working programme
- Bi-annual safe staffing reports
- Birth rate Plus Report
- NHSP utilisation for bank staff
- Preceptorship for nursing and midwifery staff
- Strategic Medical Workforce group established for short- and medium-term workforce planning
- Industrial action working group
- Monitoring of applications for employment within the Trust throughout the recruitment & selection process over a 12-month period via TRAC reporting
- Links with community leaders established to improve under-representation
- Annual review of all employee relation casework to determine if staff are reporting any form of discrimination and to ensure that process is
- fairly/consistently applied across all staff groups (benchmark against local and national data, where possible)
- All HR policies have up to date equality impact assessments at the point of review, in line with the policy schedule
- HR policies reviewed in line with fair and just culture
- WDES and WRES action plan delivery in line with timescales presented from NHS England
- Demographic tracking for training access
- Establishment of staff inclusion Networks and work in collaboration with local Trusts to promote staff networks and LGBTQ Network to be launched in 2022.
- Reciprocal Mentorship Scheme developed
- Extension of e-learning package to design and deliver specific EDI training and education to all LWH staff
- Education and celebration of the key EDI events: Black History Month, Disability History Month, LGBT+ History Month and key faith observance days/festival
- Utilising widening participation programmes and alternative ways to advertise and promote our job opportunities to attract local population to work at LWH.
- Staff from diverse backgrounds having career conversations with manager
- Updated EIA process and new policy
- Establishment and Declaration and Embedding of LWH as an Anti-Racist Organisation

		Assurance Level	Assurance Rating	Overall Assurance Rating
Key Assurances:	The EIA process is overseen by the ED&I sub-committee	**2**		
	Quality of appraisal audit (November 2022)	**2**		
	Mandatory training audit (November 2022)	**2**		
	WRES and WDES submissions	**2**		
	PPF Strategy and action plan – monitored by PPF Committee	**2**		
	Policy schedule is currently on track with EIA's being requested as required	**2**		
	Policy review process reported to PPF	**2**		
	Staff Communications	**1**		
	Review of appraisal process – PPF and feedback from staff inclusion	**2**		
	EDI Lead and monitoring through the ED&I Action Plan networks	**1**		
	Monthly KPI's for controls.	**2**		
	Great Place to work minutes to PPF	**2**		
	Divisional Board and Divisional Performance Reviews	**2**		
	Chair's Reports to PPF Committee	**2**		

Gaps in Control / Assurance:

To ensure that there are robust processes in place to target advertising, work shadowing opportunities, pre-application training and offering career advice (Action 1.1 / 1)

To simplify the EIA process (Action 1.1 / 2)

To further widen opportunities for the local community to join the LWH workforce (Action 1.1 / 3)

To continue to develop more diverse recruitment and selection processes (Action 1.1 / 4)

Enhance availability and quality of training across all protected characteristics including disability and inter-sectionality (Action 1.1 / 5)

Establishment and Declaration and Embedding of LWH as an Anti-Racist Organisation (Action 1.1 / 6)

Development of ED&I Strategy (Action 1.1 / 7)

	Report form Guardian of Safe Working	**2**				Need to ensure that career conversations are being undertaken for all staff, particularly racially minoritized staff with a focus on their development and talent management Need to create template for patient story capture and response at Divisional level and process to ensure consistent approach is sustainable over time (Action 1.1 / 4). To provide assurance regarding Patient Information Leaflet audit to PIEG on an annual basis (Action 1.1 / 5) Local ownership of FFT results to enable improvements to be created and implemented at a local level (Action 1.1 / 6) Work being undertaken to review the pathway for trans patients going through fertility prior to the commencement of hormone therapy. Quality of appraisals requires further improvement and monitoring (Action 1.2 / 1) Further evidence required that robust plans are being reviewed regularly at Divisional Board level (Action 1.2 / 2) Mandatory Training Compliance is currently not at required levels (Action 1.2/3) Further utilisation of the rota management system. E-Rostering System not fully utilised (Action 1.2 / 3) Requirement for assurance that workforce plans are reviewing regularly at Divisional Board level (Action 1.2 / 4) Requirement to respond effectively to Ockenden recommendations regarding staffing (Action 1.2 / 5) Clinical risks associated with isolated site impact upon recruitment & retention of specialist medical staff (Action 1.2 / 6)
	Bi-annual Speak Up Guardian Reports.	**2**				
	Annual Report whistle blowing report to PPF and Audit Committee	**2**				
	Quarterly internal staff survey (Let's Talk)	**1**				
	Reports and feedback from Big Conversation into the Board and Divisional Boards	**2**				
	Assurance that MT competencies are assigned correctly via sign off from practice educators and Heads of Nursing	**2**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)					
Ref:	**Action required**	**Lead**	**Due Date**	**Quarterly Progress Update**	**RAG**
1.1 / 1	Robust targeting of job adverts – engagement in health and careers fairs with local community groups for example Pakistani Centre, Al Ghazali Centre	Head of Culture, Inclusion, Wellbeing and Engagement	February 2023 (ongoing)	Wellbeing Coach and Assistant Psychologist vacancies will be targeted via universities with specific focus on racially minoritised communities. Review piece with Patient Experience to identify and prioritise communities within which to target entry level roles. HCA and admin roles- specific careers event in Toxteth (small numbers of roles). Advertisement of key roles via Inclusive Companies jobs page in place. Supported internships for BAME individuals from the local area to commence in January 2023.	
1.1 / 3	Establishment of mentoring scheme for 14/15 year olds in the L8 area to encourage them into the midwifery pathway	Head of Culture, Inclusion, Wellbeing and Engagement	February 2023	See 1.1/1	
1.1 / 4	Exploration and implementation of more diverse recruitment and selection processes including diverse interview panels and alternative recruitment methods Diverse interview panels have commenced but are yet to be consistently applied to all senior roles. Employees with protected characteristics have been invited to take part in national training to participate in recruitment processes in other NHS Trusts.(COMPLETED)	Head of Culture, Inclusion, Wellbeing and Engagement	January 2023	Targeted recruitment days in partnership with local authority to take place from early 2023 onwards.	
1.1 / 9	Enhance availability and quality of training across all protected characteristics including disability and inter-sectionality	Head of Culture, Inclusion, Wellbeing and Engagement	December 2022	Enhanced training for senior leaders developed, additional baseline training in development, additional training around neurodiversity etc required.	
1.1 / 11	Development of ED&I Strategy	Head of Culture, Inclusion, Wellbeing and Engagement	January 2023	This will be included as a major strand of a revised PPF Strategy – to be developed in January 2023	
1.1 / 5	To create template for patient story capture and response at Divisional level and process to ensure consistent approach is sustainable over time	Head of Audit, Effectiveness and Patient Experience	December 2022	Patient Experience Matron is developing a process for the effective sharing of lessons from patient stories through to the Divisions	
1.1 / 6	To provide assurance regarding Patient Information Leaflet audit to PIEG on an annual basis	Head of Audit, Effectiveness and Patient Experience	January 2023	Audit currently being undertaken to review the accessibility of PILs in terms of language.	
1.1 / 7	Local ownership of FFT results to enable improvements to be created and implemented at a local level	Head of Audit, Effectiveness and Patient Experience	January 2023	The results are reporting through to Divisions but further work required before this can be moved to an embedded control	
1.2 / 2	To receive assurance that Divisional Boards are effectively reviewing and updating workforce plans	Deputy Director of Workforce	February 2023	Workforce plans for medical and non-medical staff to be presented as part of the annual planning process. Quarterly reporting of ED&I elements of ESR is being undertaken.	

1.2 / 3	E-rostering system for doctors - Allocate is implemented for O&G and work commenced for other specialties	Deputy Director of Workforce	November 2022	Roll out of the e-rostering system Allocate for Neonatal and Anaesthetics is ongoing. Project resource has been identified to progress and this work will be completed by Autumn 22 – *evidence required to move this into controls.*	
1.2 / 4	To provide evidence that robust workforce plans are being reviewed regularly at Divisional Board	Deputy Director of Workforce	April 23	Workforce planning is a regular item at each Divisional Board – the evidence of this is reported through to DPRs. More evidence required that this 'robust' and can demonstrate maturity. Will be assessed as part of Divisional Governance maturity assessment – propose that deadline is amended accordingly.	
1.2 / 5	Respond to Ockenden recommendations relating staffing	Deputy Director of Workforce	September 2022	See Maternity Staffing report on February 23 Board agenda for more detail. Funding to fulfil Ockenden staffing requirements not yet fully secured – negotiations continue as part of budget setting.	
1.2 / 6	To ensure that staffing issues are included and noted as a key risk in discussions regarding the single site risk.	CPO	On-going		

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2491		
4 Major		2660	2087, 1704	2467	
3 Moderate				2641, 2549	2645
2 Minor					
1 Negligible					

Return to Dashboard

Ref	Description	Risk Rate Score
	Corporate Risks	
2641	Condition: There is a significant risk to the dietetic service and delivery of patient care at LWH	12
2660	In November Occupational Health alerted the Trust via Infection Prevention Committee that there were clinical staff in the organisation who were not compliant with screening / evidence of immunity/ up to date vaccination for a) EPP procedures and b) HEP B	8
2087	Condition: Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high level MAU cover.	12
2491	Noncompliance with mandated level of fit mask testers qualification, accreditation and competency.	15
1704	Effective management systems are not in place or sufficient to ensure all employees complete and keep up to date with their mandatory training requirements.	12
2549	Condition: Staff shortages in the Ultrasound Team within the Imaging Department due to Vacancies and 5 staff members leaving in May & June 22	12
2645	NWAS INDUSTRIAL ACTION FOR 21 AND 28 DECEMBER 2022 Condition: National ambulance and NHS trade unions recently announced two days of strike action. GMB, Unite, and Unison members will take part in industrial action on the 21 December, with GMB also taking a further 24 hours of action on the 28 December. Specifically, as follows: _GMB - 21 and 28 December 00.01 to 23.59 _Unite - 21 December 00.01 to 23.59 _Unison - PES staff only 21 December 12:00 - 00.00	15
	High Scoring (15+) Divisional Risks	
2467	Condition: Inability to recruit specialised allied health professions in a timely manner for blood bank	16

BAF Risk 2 – *Inability to ensure the on-going sustainability of clinical services and maintain a high standard of care at the current Crown Street site.*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Insufficient understanding of the evolving healthcare needs of the local population and failure to adequately consider the needs of underrepresented groups or communities when developing clinical service strategies. Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system.	Clinical service strategies may not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities. Additionally, the location, size, layout, and accessibility of current services may not provide for sustainable integrated care or safe and high-quality service provision. Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system.	Suboptimal patient outcomes, increased health inequalities, and lack of sustainability of clinical services. Inefficient delivery of care, compromised patient safety, and reduced patient experience. Failure to optimize the facilities available to the Trust and ensure their safety could result in adverse events, increased risk to patient safety, and potential reputational harm for the Trust.

	**We will be an outstanding employer**			**Our services will be the safest in the country**	✓
	**Every patient will have an outstanding experience**	✓		**To be ambitious and efficient and make the best use of available resources**	✓
	**To participate in high quality research in order to deliver the most effective outcomes**				

Responsibility for Risk			
Committee:	**Quality Committee**	**Lead Director:**	**Chief Operating Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**				**3**	**March 2024**	Our risk appetite for safety is **low.** Our fundamental strategic aim describes our commitment to patient and staff safety. When and wherever possible we will apply strict safety protocols for all clinical and non-clinical activity. We will not compromise the safety of our patients, we will report, record, and investigate our incidents and we will ensure that we continue to learn lessons to improve the safety and quality of our services.
Consequence	**5**				**5**		
Risk Level	**20**				**15**		

Rationale for risk score and quarterly update – *May 2023*

The Trust's services being located on an isolated site away from an acute centre, remains the most significant risk to the organisation and to patient safety. Good progress is being made on mitigating measures to make the Crown Street site safer with several significant capital projects either completed, underway or planned. It should be acknowledged that the impact of this risk cannot be fully mitigated whilst the Trust operates on an isolated site, and that following the implementation of the actions outlined below, the Trust does not believe that any further mitigation is possible. This view was recently confirmed by an independent review undertaken by the Northern England Clinical Senate, in February 2022.

The Trust can demonstrate evidence of being open and responsive to change in service development and delivery, but further work can be done to strengthen the approach to horizon scanning and longer term, strategic planning at a Divisional level.

Key Controls and Assurance Framework

Key Controls:

- Programme for a partnership in relation to Neonates with AHCH has been established.
- £15m capital investment in neonatal estate to address infection risk
- Transfer arrangements well established for neonates
- Transfer arrangements for adults
- Formal partnership and board established with Liverpool Universities Hospitals with respect to:
  - Diagnostics
- Agreed funding for all mitigations on site are included in operational planning
- A telemedicine pilot has been implemented to provide additional support for pregnant women on ITU at the Royal Liverpool Hospital.
- SOP implemented for paediatric resus provision
- Liverpool Clinical Services Review (LCSR) established
- Divisional Operational Plans complete

	○ Medical and surgical expertise ○ Intensive care facilities ○ Theatre access at Liverpool Universities Hospitals for women with Gynae cancers ○ Provision of maternity expertise at LUHFT sites ○ Provision of Gynaecology expertise at LUHFT sites ○ Placenta accreta service, including specialist imaging and supervision of review from Sheffield Teaching Hospitals NHS FT • Blood product provision by motorised vehicle from nearby facility, with revised protocols in place to prioritise transport of blood products. • Investments in additional staffing inc. towards 24/7 cover - Maternity • Investments in additional staffing inc. towards 24/7 cover - Anaesthetics joint anaesthetic appointments with LUHFT • Investments in additional staffing inc. towards 24/7 cover – Gynaecology, including additional investment in ANP roles within GED • Investments in additional staffing inc. towards 24/7 cover - Neonates • Enhanced resuscitation training provision - Paediatric • LWH appointed at C&M Maternal Medicine Centre • Enhanced resuscitation training provision - Adult • Crown Street Enhancements Programme Board established to oversee: ○ Construction work required to accommodate new FMU, colposcopy suite, CT & MR Imaging suites (ongoing) ○ Implementation of Robotic Assisted Surgery (complete) ○ Implementation of 24/7 transfusion laboratory on site (ongoing) ○ Decant into and new ways of working within FMU (complete) ○ Decant into and new ways of working within colposcopy (ongoing) • Community Diagnostic Centre established at Crown Street, to include the following diagnostics with access for LWH patients: ○ Imaging – CT, MR, X-ray, ultrasound ○ Physiological – ECHO, ECG, BP monitoring, Spiro, FeNO, Sleep studies Mannitol ○ Phlebotomy ○ Pathology	• Use of telemedicine to facilitate consultations both at Crown Street and other site • Historic controls still in place include: ○ Use of cell salvage & ROTEM ○ Innovative use of bedside clotting analysis and fibrinogen concentrates ○ Early order of blood products (high wastage) ○ Out of hours transfusion lab provided off-site by LCL ○ Outreach midwife post ○ AN & Gynae outpatient service at Aintree Hospital ○ Gynaecology Tier 2 rota providing cover for LWH and Liverpool Place ○ Expanded role of anaesthetists to cover HDU patients and provide pain service ○ Additional pain service provided by Walton Centre, with psychologist input ○ Upskilling of HDU staff ○ Joint clinics ○ SLAs in place for clinical support services from LUHFT ○ Ambulance transfer of patients for urgent imaging or other diagnostics not currently provided on site ○ Planned pre-op diagnostics provided off-site by LUHFT ○ Appointment of resus officers, upgrading of resus trolleys and provision of automated defibrillator trolleys ○ Existing informal links with partner organisations ○ ANP roles ○ Transfer of patients for urgent imaging and critical care ○ Theatre slots at LUHFT with access to colorectal surgeons ○ Purchase of sentinel node biopsy and 3D laparoscopic kit ○ ACHD Partnership • Progress being made in relation to building relationships with LUFT - Task and finish groups established, reporting into the Partnership Board with LUHFT setting out arrangements for partnership working across all four LWH and LUHFT sites • Operational ‘Plans on a page’ for Divisions – incorporates horizon scanning section • Operational planning process • Availability of data on service trends and demographics • Workforce plans

		Assurance Level	Assurance Rating	Overall Assurance Rating		
Key Assurances:	Divisional Board meetings	1			**Gaps in Control / Assurance:**	Ability of clinical staff to engage with the system development due to time and financial impact (Actions 2.2 / 1, 2.2 / 3, 2.2 / 4) To improve horizon scanning processes to constantly review and update plans on a page (Action 2.2 / 7) To understand commissioning priorities emerging from developing ICS (Action 2.2 / 7) To ensure that Divisions are fully utilising data to understand changing service demands (Action 2.2 / 8) To ensure that workforce plans are informed by trends and data led intelligence. (Action 2.2 / 9) Transfers are often subject to delay due to the Trust being considered a ‘place of safety’. Transfer of adults requires accompanying clinical staff, which can lead to staffing pressures on the ward. (Action 2.3/2) Onsite and partnership mitigations cannot fully address the clinical risk - this can only be achieved through co-location. Arrangements not formally agreed and underpinned by detailed SLA. (Action 2.3/3)
	Operational plans and budgets	2				
	Neonatal partnership updates provided to the Board	2				
	IPC Reports	1				
	Transfers out monitored by Partnership Transfers out monitored at HDU Group	1				
	Serious incidents, should they occur are tracked and reported through the governance framework,	1				
	Partnership activity to report through to Board on a quarterly basis	2				
	Staff Staffing levels reports to board	2				
	Training compliance rates reported to PPF Committee	2				
	LWH working as part of NW Maternal Medicine Network	3				
	Crown Street Enhancements Programme progress	2				
	Community Diagnostic Centre Oversight Group reviews progress on a fortnightly basis. Progress also reported to and monitored by regional CDC Programme Board.	2				
	Mobile CT and respiratory testing operational.	1				
	Partnership Board meetings and involvement in wider Estates Strategy Safety and Effectiveness Senate – received update in January 2022	2				

	Mapping of requirements from and interdependencies with LUHFT across all Trust specialties	**2**				Lack of 24/7 transfusion laboratory on site leads to delay in patients receiving transfusion. (Action 2.3/4, 2.3/5) Emerging clinical standard leading to potential loss of services and increase in difficulty in relation to recruitment of consultants. Twilight cover to be in place from April 2022 (Maternity) and January 2022 (Neonates). There remains an on-going challenge in relation to Anaesthetics recruitment. (Action 2.3/6) Financial and workforce constraints for delivery of additional facilities on site. (Action 2.3 / 1) Construction works not yet complete to accommodate new FMU, colposcopy suite, CT & MR Imaging suites – due to complete December 2022 (Action 2.3/8) 24/7 transfusion laboratory not yet established – aim for completion September 2022 (Action 2.3/4) Colposcopy decant not yet complete – aim for completion June 2022 (Action 2.3/9) Full CDC Services not yet implemented (Action 2.3 / 10) Signed SLA with LUHFT required (Action 2.3 /3)
	Single Site risk report – provided to July 2022 Board	**2**				
	Engagement from appropriate Executives in designated working groups	**2**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
2/1	To ensure that Divisions are fully utilising data to understand changing service demands	Deputy COO	September 2023	5 year transformational plans include section on horizon scanning to support future planning – further evidence required that data is being utilised as effectively as possible to support this. Updated performance reports will support this. Suggest that deadline is amended to reflect the need to assess the maturity of this process.	
2/2	To ensure that workforce plans are informed by trends and data led intelligence.	Deputy COO	April 2023	Workforce planning has taken place alongside operational planning processes for 2023/24 – suggest to move to controls.	
2/3	Detailed agreements to form part of SLA with LUHFT, clearly explaining routes of access and expectations of both organisations.	Deputy Chief Finance Officer	September 2023	SLA management improving – will be taken forward as part of the LWH/LUHFT Partnership Board. Process to be agreed.	
2/4	Project to establish 24/7 transfusion laboratory on site at Crown Street	Head of AHPs	March 2023	Staffing continues to be an issue that requires resolution	
2/5	Implement remote issue of blood products to minimise delay in transfusion	Head of AHPs	TBC (pending information from Liverpool Clinical Laboratories regarding training)	Additional IT issues encountered	
2/6	Continue to recruit to secure 24/7 Anaesthetics cover	Clinical Directors	January 2023	Resource pressures continue to restrict progress in this area	
2/7	Complete construction of MR imaging suite	Associate Director of Strategy	February 2023	Complete	
2/8	Deliver CDC project plan to establish CDC services: -Imaging – CT, MR, X-ray, ultrasound -Physiological – ECHO, ECG, BP monitoring, Spiro, FeNO, Sleep studies -Phlebotomy	Deputy Chief Operating Officer	September 2023	CDC delivery model continues to be developed with commissioners	

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2316, 2232, 2598, 2323, 2599, 2604	2178	
4 Major		2660	2088, 2087, 2329, 1635, 1966, 2085	2684, 2572, 2321, 2430	
3 Moderate		2469	2488, 2296, 2086	2641	2395
2 Minor			2084		2606
1 Negligible					

Linked Corporate and High Scoring Divisional Risks Heat Map

Ref	Description	Risk Rate Score
	Corporate Risks	
2641	Condition: There is a significant risk to the dietetic service and delivery of patient care at LWH	12
2660	In November Occupational Health alerted the Trust via Infection Prevention Committee that there were clinical staff in the organisation who were not compliant with screening / evidence of immunity/ up to date vaccination for a) EPP procedures and b) HEP B	8
2087	Condition: Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high level MAU cover.	12
2469	Condition: Allocation of resources to carry out water safety checks and maintenance has failed to achieve required targets despite prioritising this work and reducing resources for other tasks - see risk 2274.	6
2329	Condition: There is a risk to the Trust is not meeting it requirements for the safe and proper management of medicines	12
1966	Condition: Risk of safety incidents occuring when undertaking invasive procedures.	12
2085	Condition: Uncertainty around access to dedicated diagnostic capacity and physiological measurement needed to support needs of a changing patient demographics and an increase in complex multiple co-morbidities, and meeting the pre-operative assessment standards of the Association of Anaesthetists of GB & Ireland (AAGBI) and the Royal College of Anaesthetists (RCoA), to asses patients' clinical risk and plan for additional requirements for their safety and provide an optimal experience.	12
2232	Condition: There is a risk that due to a number of causes the Trust is unable to meet the safety requirements related to Blood Transfusion	15
2488	Condition: Failure to meet clinical demand for red blood cells	9
2296	Condition: The LWH laboratory autoview analyser (the machine used to process Blood Group and Save samples on site) will no longer be supported as of 1st march 2020. This machine cannot continue to be used after this date.	9
2086	Condition: Uncertainty about provision of adequate on-site Blood bank stocking all major blood products necessary to support the needs of the Maternity service.	9
2321	Condition: Due to the Trust not being located next to or with acute services, it is unable to meet the National Recommendations for Maternal Medicine.	12
1635	Risk of delays to treatment due to significant problems with the junior doctor rotas-vacancies and maternity leave.	12
2084	Condition: Uncertainty of adequacy of 24/7 access to specialist input to support changing patient profiles and needs, new guidance and the Chief Medical Officer's recommendation of the specialist multidisciplinary team approach to treatment planning and co-ordination, including pre-operative, surgical and up to level 3 post-operative care for improved patient safety and improved outcomes.	6
2088	Condition: Lack of on-site specialist staff and services	12

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2323	Condition: The Trust is currently non-compliant with standards 2,5,6 of the seven-day service standards	15
2395	Condition: Ambulatory gynaecology demand is exceeding current capacity	15
2606	Failure to comply with national infection trajectory specifically in relation to E. coli bacteraemia	10
High Scoring (15+) Divisional Risks		
2178	Condition: Lack of a robust system to ensure that ultrasound scanning performed by non-Sonographer practitioners is monitored and reviewed/audited and appropriate subsequent action taken.	20
2598	Condition: Risk relating to the Trusts Emergency Response	15
2599	Condition: Risk relating to the Trusts Internal Security (Premises)	15
2572	Condition - there is a lack of strategic leadership and robust procedures to ensure the safety of people and assets within the Crown Street and Knutsford sites.	16
2604	Condition: Risk relating to Trust Security Systems	15
2430	Condition: Network outlier for pre-term mortality - rate is higher than the national average	16
2316	Condition: Risk of women needing to access emergency care with pregnancy complications and not being able to be triaged in the MAU within 30 minutes of presenting at the department as per BSOTS. Impact on the safety of patients (physical and psychological);	15
2684	T5, T8, Compact fluorescent lamps are becoming obsolete from October 2023 to February 2024. Stocks of lamps will become depleted and then non-existent.	16

BAF Risk 3 – *Failure to deliver an excellent patient and family experience to all our service users*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Inadequate systems and processes in place to listen to patient voices and our local communities, including lack of patient and community engagement mechanisms. Failure to act on the feedback provided by patients, carers, and the local communities. Inadequate systems and processes for timely patient care and inability to effectively engage with patient groups with protected characteristics.	Inability to adequately listen to patient voices and our local communities, and failure to act on the feedback provided by patients, carers, and the local communities. Inability to effectively engage with our patient groups to understand further the needs of individuals with protected characteristics and respond proactively to identified needs.	Decreased patient satisfaction, lack of trust in the Trust's ability to provide effective care, and negative impact on the Trust's reputation. Failure to effectively engage with patient groups with protected characteristics may result in poor patient experience and reduced access to appropriate care, as well as potential legal or regulatory issues. Overall, the risk is the inability of the Trust to provide patient-centred care that meets the needs of the local population, including those with protected characteristics, leading to decreased patient outcomes, decreased patient satisfaction, and potential legal or regulatory issues.

	We will be an outstanding employer			**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience	✓		**To be ambitious and efficient and make the best use of available resources**	
	To participate in high quality research in order to deliver the most effective outcomes	✓			

Responsibility for Risk			
Committee:	**Quality Committee**	**Lead Director:**	**Chief Nurse**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**3**				**2**	**March 2024**	Our risk appetite for experience is **low.** Liverpool Women's NHS Foundation Trust has a low-risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality and sustainability of the Trust and its patients, may affect the experience of our patients, the reputation of the Trust or the reputation of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Senior Management Team. Despite retaining this a 'low' risk appetite the Quality Committee agreed that the Trust would need to be more ambitious in its attempts to better understand the views of patients and local communities.
Consequence	**4**				**4**		
Risk Level	**12**				**8**		

Rationale for risk score and quarterly update
To improve further, it is imperative that the organisation ensures that it can listen to patient voices and the local community and ensure that services are responsive and can cater to differing needs. The evidence for how effective the organisation is undertaking this can be strengthened from the current position. The Ockenden Final Report made several comments about the importance of trusts listening effectively to the patient voice and strengthening the Trust's approach to this will be a significant area of priority during 2023/24. Considering the importance of this and the fact that available controls / assurances remain limited in this area, the target score for 2023/24 has been set at '12' to reflect the current reality.

Key Controls and Assurance Framework		
Key Controls:	• Women, Babies, and their Families Strategy 2021 - 2026 • PALs and Complaints data • Patient Stories to Board	• Women, Babies and their Families experience Strategy 2021 - 2026 • KPI for displeased Friends and Family and Bi-Monthly reports from the Divisions at the Patient Involvement and Experience Sub Committee.

	• Friends and Family Test • National Patient Surveys • Healthwatch feedback • Social media feedback • Membership feedback • Patient Experience Matron in place to build relationships with local community leaders and mechanisms for hearing feedback on the Trust's services • Bespoke Patient Surveys • Patient experience review reports produced by the Divisions and reported to PIESC • BBAS – Ward Accreditation Scheme • PLACE assessment • MVP • Care Opinion • Patient Experience Walkabouts • Matron Walkabouts • Non-Executive Director Quality Walkabouts • Managing Concerns and Complaints Policy • Annual Quality Schedule returns to the ICB (WELL-LED-01CARING-01) • Bi-monthly update on status of patient leaflet at the Patient Involvement and Experience Sub Committee				• KPI for Complaint responses • KPI for Complaint action plans • K041 national return • Patient information leaflets are accessible for all protected groups. Patient leaflets are on the website that can translate this information into various languages/ fonts and read aloud versions. • Utilisation of the Health Inequalities data within power BI to lead work between the Patient Experience Team and the EDI Manager to target areas of disparity. • Engagement with local groups lead by the Patient Experience Matron to listen to the concerns and required adjustments and improvements desired. These include the Whitechapel Homeless (Liverpool), Rotunda (deprived areas and different ethnic minorities), Irish Community and Travellers, Deaf Society, Chinese Community, North Liverpool, Storrington Avenue, Norris Green (deprived areas), Women's Health and Social Care Groups (WHISK), Women's Muslim Association, Brain charity, Chinese community and other groups that show Health Inequalities are forming part of the Trust Schedule of Involvement Events. • FFT Data now included EDI monitoring to allow experience reviews to be compared between groups with and without a protected characteristic • Enhanced communication and patient experience for people with disabilities coming for care at the Trust as part of Reasonable Adjustment activities • Barriers removed to access/health inequalities to maternity services for all with specific focus to migrant and asylum-seeking women as part of the NEST work. • Role created in patient experience team to improve engagement with the local community groups • Regular Divisional reporting on protected characteristics for staff and their experience		
		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**		
Key Assurances:	Annual audit of patient leaflets to ensure accessibility and usability	**1**			**Gaps in Control / Assurance:**	Need to create template for patient story capture and response at Divisional level and process to ensure consistent approach is sustainable over time (Action 1.1 / 4). Completed To provide assurance regarding Patient Information Leaflet audit to PIEG on an annual basis (Action 1.1 / 5) This is on the agenda at every meeting and an annual audit is undertaken Local ownership of FFT results to enable improvements to be created and implemented at a local level (Action 1.1 / 6) This is done and reported through each PIESC meeting Work being undertaken to review the pathway for trans patients going through fertility prior to the commencement of hormone therapy. External MVP involvement in reviewing complaints processes- MVP chair on the PIESC distribution list with all of the complaints information on. All information should be reviewed by the Divisional Board prior to coming to PIESC Evidence how the divisions are using this data to influence their service design and improvements – Outpatient Transformation is a good example of this Recent patient/women's stories to Trust Board have highlighted that the Heads of Service have not always been aware of the story that was being shared, at Trust Board, that reflected on the care provided within their division. This has resulted in a lack of opportunity for senior presence at the Trust Board meeting to answer any questions and identify actions that have been put into place in relation to the patient/women's experience within their Care Group, this also shows lack of assurance patient stories are shared at local divisional level – The new SOP has been approved for this No set policy/process for Experience based co design policy to listen to patient voices when service changes are needed. New SOP has been approved for this QI projects need to be developed from patient voices and experience based co-design
	Personalised Maternity Care Budgets/ Maternity Early Adopter and Pioneer site – LMS Cheshire and Mersey	**1**				
	Patients with learning difficulties, mental health or autism spectrum are allowed relatives to stay with them throughout their stay. Pro-active admissions for these groups with preadmission and discharge planning	**1**				
	Admission procedures and assessments e.g. MUST /VTE/ FALLS / risk assessment Maternity	**1**				
	Pre-operative assessments	**1**				
	Development of a Supporting Patients with Additional Needs Strategy Barriers identified and measures put in place to remove e.g. Presence of representatives from MRANG in the antenatal clinic to support asylum seekers	**1**				
	Patient Involvement & Experience Sub-Committee review the progress against the Women's, Babies and Families Experience Strategy. This is undertaken in June of each year and any concerns are escalated to the Quality Committee via the Chairs report.	**2**				
	Patient Involvement & Experience Sub-Committee review PALs and Complaint data quarterly via the Themes and Trend report, and any concerns raised are escalated to the Quality Committee via the Chairs report.	**2**				
	The Trust Board Meeting has a patient/women's story to Board most months throughout the year	**2**				
	Patient Involvement & Experience Sub-Committee review the Friends and Family themes and trends quarterly. Friends and Family also form part of the Trust Performance report that each Division must review. More recently a new KPI regarding displeased comments has been added. This has given each area the opportunity to review displeased comments and act on them. This also enables the areas to display the 'you said we did' data out in the areas. The Patient Involvement and Experience Sub Committee has a standing agenda item for the relevant Divisions to discuss the key findings from the Friends and Family and show what improvements have been made as a result.	**2**				

	Patient Involvement & Experience Sub-Committee review the results of the National Maternity Survey, National Inpatient Survey and the National Cancer Survey Annually. All surveys are also reviewed by the Trust Quality Committee.	**2**				MVP review needed of complaints actions and themes for improvement presented at PIESC – MVP on the distribution list for all PIESC papers No formal process in place to monitor the completion of complaint/ PALS+ action plans on the Ulysses system. –Emails go out each week to the Divisions with outstanding actions Poor performance against Trust KPI for displeased FFT responses and you said we did in the areas and updating power bi No documented processes for all feedback received i.e., National Surveys, FFT – Yes this is complete and SOP has been approved. PLACE assessments feedback Gaps in effective delivery of Access Policy including training of staff associated with RTT pathway management Gaps in Standard Operating Procedures for management of patient pathways Timescales for delivery of key elective recovery programme actions 3.1/10 – Work to reconfigure the MLU estate to maximise efficiencies for IoL.
	Patient Involvement & Experience Sub-Committee have both Healthwatch Sefton and Healthwatch Liverpool on the group as active participants.	**2**				
	Patient Involvement & Experience Sub-Committee review as part of the quarterly themes and trends reports as working with the Communications team all social media comments are sent through to PEX to review and action.	**2**				
	Reports on community engagement and relationships via the Patient Involvement and Experience Sub-Committee and attends CoG Comms and Engagement Group to share experiences	**2**				
	Patient Involvement & Experience Sub-Committee listen to the Patient Experience Strategy updates from each Division via the Patient Experience review paper and any patient experience intelligence that they have.	**2**				
	Safety and Effectiveness Sub Committee review the BBAS quarterly and any issues are escalated to the Quality Committee via the chairs report. Patient Experience Matron forms part of the accreditation team	**2**				
	Patient Involvement & Experience Sub-Committee review the outcomes form the PLACE assessment, this is also on the Quality Committee	**3**				
	Patient Experience Matron attends the MVP meetings and MVP chair is part of the circulation list for PIESC	**2**				
	Patient Involvement & Experience Sub-Committee review the Friends and Family themes and trends quarterly	**2**				
	Matrons' operation group reviews the feedback gained and issues escalated on the chairs report to the Nursing and Professional forum	**1**				
	Complaints annual report is approved by Quality Committee and the Quarterly themes and trends report is discussed at Patient Involvement and Experience Sub Committee. The Integrated Governance report included Patient Experience data and is reviewed at Quality Committee.	**2**				
	The Quality schedule is reviewed by the ICB and this covers an annual submission for Well Led 01 and Caring 01. The reports are also discussed at the CQPG.	**2**				
	External to NHSE digital to monitor the complaints activity	**3**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
3/1	To create template for patient story capture and response at Divisional level and process to ensure consistent approach is sustainable over time	Head of Audit, Effectiveness and Patient Experience	December 2022	Patient Experience Matron is developing a process for the effective sharing of lessons from patient stories through to the Divisions	
3/2	To provide assurance regarding Patient Information Leaflet audit to PIEG on an annual basis	Head of Audit, Effectiveness and Patient Experience	January 2023	Audit undertaken last year and scheduled for Q4	
3/3	Local ownership of FFT results to enable improvements to be created and implemented at a local level	Head of Audit, Effectiveness and Patient Experience	January 2023	The results are reporting through to Divisions but further work required before this can be moved to an embedded control	
3/4	MVP to conduct a review of complaints process	Head of Audit, effectiveness, and Patient Experience	~~October 2022~~ March 23	MVP chair linked in with the Deputy Head of Experience and the Patient Experience Matron. MVP chair also is now part of the Patient Involvement and Experience Distribution list and will attend meetings when available as works just 3 days per month. Suggested to amend deadline as new MVP Chair only in post from late 2022.MVP chair is on the distribution list of the Patient Involvement and Experience Sub Committee.	
3/5	Divisional Boards to review Patient Experience Data prior to being reviewed by the Patient Involvement and Experience Sub Committee	Divisional Management Teams	Feb 23		
3/6	To develop a SOP for Experience based co design to listen to patient voices when service changes are needed.	Head of Audit, effectiveness, and Patient Experience	Feb 23	The SOP has been developed and approved.	
3/7	QI projects need to be developed from patient voices and experience-based co-design.	Quality Manager	Feb 23	Patient Experience Team have met with the QI manager and Ulysess is to be updated to included Patient Experience QI prior the Patient Experience projects being registered.	
3/8	Improvement of compliance against Trust KPI relating to displeased comments in FFT and to ensure that Power BI is updated so the 'You said we did data' can be extracted	Divisional Management Teams	Feb 2023		
3/9	To develop a SOP to document the process for when feedback is received and what needs to be completed in the Divisions.	Head of Audit, Effectiveness and Patient Experience	Feb 2023	The SOP has been developed and approved.	
3/10	Continue to provide updates to the Board regarding the Elective Recovery Plan through Divisional Performance Reviews and to FPBD on a monthly basis through the Integrated Performance Report	Deputy COO	On-going		

3/11	Work to reconfigure the MLU estate to maximise efficiencies for IoL.	FH Div Manager	January 2023	

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2316 2667		
4 Major			2087	2485 2418	
3 Moderate			2649		
2 Minor			2084		
1 Negligible					

Linked Corporate and High Scoring Divisional Risks Heat Map

Ref	Description	Risk Rate Score
Corporate Risks		
2087	Condition: Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	12
2649	Condition: There is little evidence to support Audim audits are being undertaken as required in line with National Standards of Healthcare Cleanliness (2021)	9
2084	Condition: Uncertainty of adequacy of 24/7 access to specialist input to support changing patient profiles and needs, new guidance and the Chief Medical Officer's recommendation of the specialist multidisciplinary team approach to treatment planning and co-ordination, including pre-operative, surgical and up to level 3 post-operative care for improved patient safety and improved outcomes.	6
High Scoring (15+) Divisional Risks		
2418	Condition: Lack of support and appropriate care for patients presenting with mental health conditions	16
2485	Condition: Limited access to MRI scan (currently 5-6 weeks wait) needed for cancer patient pre-treatment (both surgical and radiotherapy treatment). MRI requested and undertaken at CCC as per pathway, as expertise in reporting is there and feeds into specialist MDT. Of note MRI added into clinical pathway as part of BGCS stratification for surgery during the first wave of COVID pandemic - this is considered best practice.	16
2316	Condition: Risk of women needing to access emergency care with pregnancy complications and not being able to be triaged in the MAU within 30 minutes of presenting at the department as per BSOTS. Impact on the safety of patients (physical and psychological);	15
2667	Risk: Delay in access to timely radiography out of hours	15

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BAF Risk 4 – *Inadequate digital strategy and sub-optimal clinical records systems increase the risk of major IT system failures due to cyber-attacks, compromising patient safety and Trust operations*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Sub-optimal clinical records system, including both paper and electronic systems. Inability to embed aims and objectives in the Trust's digital strategy.	Major and sustained failure of essential IT systems due to a cyber-attack, leading to the inability to access patient records, deliver care, and support administrative functions. Sub-optimal clinical records systems, including difficulty in accessing or locating information, duplication of effort, and potential errors or omissions in patient care. Failure to embed aims and objectives in the Trust's digital strategy may lead to ineffective use of technology and missed opportunities to improve patient outcomes and experiences.	Patient safety compromised due to inability to access critical clinical information in a timely and accurate manner. Disruption to Trust operations and reduced capacity to deliver care. Reputational harm to the Trust, as well as potential regulatory or legal issues. Failure to embed aims and objectives in the Trust's digital strategy may result in missed opportunities to improve efficiency, quality, and safety of patient care. Overall, the risk is the inability of the Trust to effectively manage and utilize digital systems, including clinical records, leading to potential patient safety issues, operational disruption, and reputational harm.

	We will be an outstanding employer			**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience			**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Finance, Performance & Business Development Committee**	**Lead Director:**	**Chief Information Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**				**3**	**March 2024**	Our risk appetite for safety is **low.** Our fundamental strategic aim describes our commitment to patient and staff safety. When and wherever possible we will apply strict safety protocols for all clinical and non-clinical activity. We will not compromise the safety of our patients, we will report, record, and investigate our incidents and we will ensure that we continue to learn lessons to improve the safety and quality of our services.
Consequence	**5**				**5**		
Risk Level	**20**				**15**		

Rationale for risk score and quarterly update

The Trust's Digital Services department places cyber security management at the core of operational activities, ensuring it maintains its Cyber Essentials standard. Various controls are implemented that are considered effective and this reduces the likelihood of a cyber-attack impact. However, if a cyber-attack was successful the impact would likely be catastrophic to Trust services, likely rendering digital systems that clinical services are increasingly dependent on, unavailable for a period of time. The Digital Services department continue to strengthen controls through process refinement and the introduction of security technologies.

The lack of an EPR (and as a corollary, having in place a disparate number of systems), remains a significant risk to the organisation because information is spread across disparate systems leading to information being incomplete, hard to find in a timely manner and a potential for inaccuracies due to manual transfer of information. However, there is evidence of pro-active mitigating controls and progress being made in the procurement and subsequent implementation of an integrated Meditech EPR system.

Based on this, the impact is considered catastrophic (5). Due to recent world events, the environment risk or likelihood for a cyber-attack has increased from possible (3) to likely (4) due to increased cyber threats from Russia. The NHS has reflected the increased threat through guidance issued to all NHS providers and arm's length bodies during March 2022. The current situation with multiple clinical systems would also justify this risk rating.

Key Controls and Assurance Framework

Key Controls:

- Approved Digital Generations Strategy
- Approved Meditech Expanse Business Case
- Maintenance of present system
- Development of individual / service solutions e.g. PENs (Gynaecology) and Staff training
- Incident reporting
- Tactical solutions including the implementation of K2 Athena system
- Exchange/LHCRE enables for patent information sharing
- Virtual Desktop technology to aid staff working flexibly.
- Additional network resilience for LUHFT supplied systems (K2/PENS/CRIS) to reduce risk of unplanned systems downtime
- PACS upgrade removes a separate login for that system, reducing multiple systems issues.
- Task and Finish group established to ensure that clinical investigation undertaken at external trusts have been actioned accordingly.
- Appropriate task and finish groups established as required by Safety and Effectiveness sub-committee
- Digital clinical leadership business case developed
- Optimisations to K2 system and refinements implemented
- Ongoing review of systems and mitigations quarterly
- Microsoft Windows security and critical patches applied to all Trust servers on all servers\laptops and desktop devices on a monthly basis.
- Network switches and firewalls have firmware updates as and when required installed. Wifi network firmware patches applied for Controllers and Access points.
- Mobile end devices patched as and when released by the vendor.
- Externally managed network service provider to ensure network is a securely managed with underpinning contract.
- Robust CareCert process to enact advice from NHS Digital regarding imminent threats.
- Network perimeter controls (Firewall) to protect against unauthorised external intrusion.
- Robust Information Governance training on information security and cyber security good practice.
- Regular staff educational communications on types of cyber threats and advice on secure working of Trust IT systems.
- Additional cybersecurity communications in relation to Covid phishing/ scams, advising diligence.
- Enhanced VPN solution including increased capacity to secure home working connections into the Trust.
- Review and updating of information security policies and home working IG guidance to support staff who are remote working.
- Malware protection identifies and removes known cyber threats and viruses within the Trust's network and at the network boundaries.
- Cyber Security Monitoring System identifies suspicious network and potential cyber threat behaviour.
- National CareCert alerts inform of known and imminent cyberthreats and vulnerabilities
- Mobile device management – providing enhanced security for mobile devices
- Cyber Security Strategy

		Assurance Level	Assurance Rating	Overall Assurance Rating		
Key Assurances:	Quarterly risk assessments completed	**1**			**Gaps in Control / Assurance:**	Multiple Clinical Systems issues remain (Action 2.2 / 2) Ability of clinical staff to engage with the system development due to time and financial impact (Actions 2.2 / 1, 2.2 / 3, 2.2 / 4) ICS wide Shared Care Record programme not fully implemented/ active programme of work) Lack of Cyber Security strategy (Action 2.4 / 1) Lack of Network Access Controls within the physical network (Action 2.4 / 2) Effective USB port control (Action 2.4/ 3) Lack of visibility of medical devices (Action 2.4 / 4)
	FPBD Committee overview and scrutiny	**2**				
	Digital Hospital Committee oversight	**2**				
	Approved EPR Business case which define clear direction and preferred solution.	**2**				
	EPR programme board chaired by MD	**2**				
	Independent lessons learnt Positive review	**3**				
	MIAA Critical Application Audit (rolling programme across trust systems)	**3**				
	Effective Staff communications on Digicare	**1**				
	Cyber Essentials Plus Standards/KPIs	**3**				
	IMT Risk Management Meeting	**2**				
	Medical Devices Committee	**2**				
	MIAA Cyber Controls Review	**3**				
	Cyber Essentials Plus Accreditation	**3**				
	Cyber Penetration Test	**3**				
	NHS Care Cert Compliance	**3**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
4/1	Issue appropriate communication to all staff in relation to digital development by multiple means and forms	CIO	January 2023	Dedicated communications support identified for DigiCare launch and support	
4/2	Procure and implement Network Access Control (NAC) solution	CIO	March 2023	Procured. Planning session with supplier scheduled 1st week of November. Implementation plan to follow with revised fully implemented date March 2023	
4/3	Purchase and implement software for USB port control	CIO	March 2023	Procured and solution is installed. Due to the invasive nature of the system, it is currently configured for monitoring mode. Assessment of the data collected to follow with port control policies to be implemented by March 2023	

4/4	Improve grip, control and governance on medical devices	CIO	March 2023	Digital attendance at Medical Devices Committee. Asset inventory of medical devices under review. Funding for Digital solution to protect medical devices submitted to ICS in October.	

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2604		
4 Major				2655, 2531	1960
3 Moderate			2603		2386
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
2603	Condition - Current Intranet in poor condition and no longer fit for purpose.	9
High Scoring (15+) Divisional Risks		
1960	Condition: Risk of incomplete patient records	20
2655	Condition - No robust system in place for tracking of instrumentation if we suffer a breakdown of tracking system prior to replacement system being installed.	16
2531	Risk Title: Inadequate IT Helpdesk Provision	16
2604	Condition: Risk relating to Trust Security Systems	15
2386	Condition: Risk of personal and sensitive information being compromised or being misused	15

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BAF Risk 5 – *Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Insufficient funding, or failure to secure funding, from external sources. Inadequate cost control and/or cost reduction measures. Inadequate financial management and controls, including lack of effective financial planning and forecasting.	Risk that the Trust will not have sufficient cash resources in the 2023/24 financial year, resulting in inability to pay suppliers, staff, or meet other financial obligations. Risk that the Trust will not deliver agreed plan in the 2023/24 financial year, including inability to meet operational targets or clinical quality standards. The Trust is not financially sustainable in the long term, potentially leading to intervention from external regulators and the Trust no longer being a going concern.	The Trust fails to meet its financial plan and is unable to secure sufficient resource to safely deliver its clinical services, resulting in negative outcomes for patients and staff, reduced trust in the quality of care provided.

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	Every patient will have an outstanding experience			**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Finance, Performance & Business Development Committee**	**Lead Director:**	**Chief Finance Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**				**3**	**March 2024**	Our risk appetite for efficient is **moderate** This is in respect to meeting our statutory financial duties of maintaining expenditure within the allocated resource limits and adherence to departmental and internal expenditure and financial controls. This includes the demonstration of value for money in our spending decisions, while ensuring quality and safety is maintained.
Consequence	**4**				**4**		
Risk Level	**16**				**12**		

Rationale for risk score and quarterly update

The Trust has a well-defined and evidence-backed case that it is not financially sustainable due to the size of the organisation and particular mix of services, while remaining on an isolated site. This situation is exacerbated each year due to prior capital investment, ongoing revenue investment, and other pressures. The Trust is facing a significant financial challenge in 2023/24 and is at risk of not being able to deliver its financial plan. The likelihood of this risk has been assessed as 'likely' rather than 'almost certain'. The Trust is producing a long-term financial recovery plan to try to move the organisation to a more sustainable financial footing.

Key Controls and Assurance Framework

Key Controls:

- 5 Year financial model produced giving early indication of issues
- Multiple iterations of the Future Generations business case have demonstrated that the Trust's long-term financial viability will be improved if the preferred option of co-location with an adult acute site is funded
- Early and continuing dialogue with NHSE/I and Cheshire and Merseyside ICS
- Engagement in place with Cheshire and Mersey Partnership to review system solutions
- Clinical Engagement and support for proposals
- Reduction in CNST Premium and achievement of Maternity Incentive Scheme.
- Reduction in corporate overheads costs.
- Agreed financial plan for 2023/24 with NHSE and C&M
- Finance Recovery Board in place with multiple workstreams to address the identified drivers of the deficit, each supported by Executive Sponsors.
- Working within ICS/system to ensure issues understood and Trust secures required amount of available funding.
- Agency and Premium Pay: There are several workstreams underway to reduce this spend. These include ensuring all approvals for usage are made by senior leaders, recruitment campaigns for permanent staff, a programme to support retention, management of sickness, removal of incentive payments and review of premium pay rates.
- Deferral of Investment: Investments in 2023/24 were limited to only those contractually committed or mandated.
- Income: A detailed look at all aspects of income has been undertaken and has already yielded some successes, e.g. updating arrangements and ensuring all billing is undertaken for service provided.

	• Rapid transformation workstreams identified. • Collaboration and efficiency at scale is developing across Liverpool and C&M, underpinned by findings of Liverpool Clinical Services Review. • Internal audit reports • CIP process in place, including QIA and EIA process • Monthly reporting and monitoring of position including taking corrective action where required. • Sign off of budgets by budget holders and managers, and holding to account against those budgets • Divisional performance reviews				• Non-Pay, Procurement and Contracts: Contracts have been looked at to ensure the Trust is not paying for any goods or services that are not required, and that prices charged are reasonable. Enhanced spending controls are in place with additional monitoring and oversight. • Balance Sheet and Non-Recurrent Items: A full review of the balance sheet to ensure, for example, that accruals, provisions and deferred income has been appropriately released.
		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**	
	Future Generations Clinical Strategy and Business Plan (BoD Nov 15, PCBC 2016/17, case and LTFM refreshed in 2021/22)	**2**			
	Submission of Cheshire and Mersey STP capital bid Summer 2018 ranked no1 of schemes	**2**			
	Active participation in C&M planning processes	**2**			
	Northern Clinical Senate Report supporting preferred option both in 2017 and 2022.	**3**			
	Process in place regarding CNST MIS. Prior achievement of MIS. Engagement with NHS Resolution and learning from claims and incidents.	**2**			
	Direct engagement with NHS Resolution.	**2**			
	Focus on benchmarking and efficiencies, including joint working where possible.	**2**			
	FPBD and Board (monthly reports)	**2**			
	Recovery plan with agreed actions in place; monitored through Financial Recovery Board, Executive Team and Finance, Performance and Business Development Committee and reported to Board.	**2**			
	FPBD Committee receives monthly reports, chair's reports from the Financial Recovery Board and specific recovery centred reports.	**2**			
	Internal Audit- high assurance for all finance related internal audit reports in 2020/21 and 2021/22.	**3**			
	External Audit – no amends to accounts and largely low rated recommendations in ISA260.	**3**			
	Mitigations being worked up in case of identified risks materialising	**2**			
	Agency use monitored weekly at Executive Team meetings and via regular meetings with the Divisions	**2**			
	Quality impact assessments are underway to prevent deleterious effects of deferrals	**2**			

Further Actions (Additional Assurance or to reduce likelihood / consequences)					
Ref:	**Action required**	**Lead**	**Due Date**	**Quarterly Progress Update**	**RAG**
5/1	Refresh LTFM	CFO	August 2023		
5/2	Complete Trust 3-year recovery plan	CFO	September 2023		
5/3	Contribute to ICB recovery plan	CFO	September 2023		
5/4	Deliver outcomes from Financial Recovery Board workstreams	CFO	March 2024		
5/5	Identify full CIP programme	CFO/COO	April 2023		
5/6	Monitoring and management of existing CIP programmes	CFO/COO	Ongoing		
5/7	Delivery of activity and income targets	COO	Ongoing		
5/8	Careful monitoring of cashflow forecast and close working with ICB to manage cash in year	CFO	Monthly		
5/9	Negotiation of CDC contract for 2024/25 and beyond	COO	February 2024		

5/10	Active participation in the Women's Services ICB Sub-Committee	MD	Ongoing		
5/11	Progression of estates workstream with LUHFT	CFO	July 2023		

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic					
4 Major			1635		
3 Moderate			2301		
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
2301	Condition: There is both an operational and a financial risk related to the position in relation to contracts and SLAs for services provided to and by the Trust.	12
1635	Risk of delays to treatment due to significant problems with the junior doctor rotas- vacancies and maternity leave. This is placing severe strain on the ability to fulfil the on-call rota as well as covering in hours duties. There is an increased reliance on locums, causing financial pressures. The risk include potential gaps in the rota which may put patients at risk, regular locum use which may result in potential compromise to the quality of the service provided and risk to the training provision of junior doctors if they are being moved around to fulfil the basic rota.	12
High Scoring (15+) Divisional Risks		

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BAF Risk 6 – *The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Conflicting priorities and objectives among clinical services providers in the Integrated Care System (ICS), including differing views on clinical strategy, resource allocation, and accountability. Ineffective governance structures or processes that do not facilitate effective decision-making or resource allocation.	The Trust may struggle to engage effectively with provider, commissioner, and other partners across the system. The Trust may also struggle to maintain those partnership relationships required to safely deliver its services from an isolated site.	If the Trust is unable to engage effectively with system partners, this could result in limitations in the Trust's ability to influence system plans and decision-making, including during contract negotiation with commissioners and agreement regarding capital funding to deliver the Future Generations Programme. Additionally, if the Trust is unable to maintain partnership relationships with providers, it may have a negative impact on the Trust's ability to deliver safe care, resulting in negative outcomes for patients and staff, reduced trust in the quality of care provided.

	We will be an outstanding employer			**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience			**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes	✓			

Responsibility for Risk			
Committee:	**Finance, Performance & Business Development Committee**	**Lead Director(s):**	**Chief Finance Officer & Medical Director**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**3**				**2**	**March 2024**	Our risk appetite for effective is **high.** A level of service redesign to improve patient outcomes that requires innovation, creativity, and clinical research are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.
Consequence	**3**				**3**		
Risk Level	**9**				**6**		

Rationale for risk score and quarterly update

The Trust has well defined partnerships and relationships with a number of key stakeholders. These have been strengthened and added to during the Covid-19 pandemic response. The regulatory and system landscape remains uncertain, and the Board will be looking for additional clarity on future arrangements (and the Trust's assured role in this) in order to mitigate this risk and work towards the target score and improve the overall assurance rating on the controls.

Key Controls and Assurance Framework		
Key Controls:	• Robust engagement with ICS discussions and developments through CEO and Chair • Evidence of cash support for the Trust's 2022/23 position • Chair of the Maternity Gold Command for Cheshire and Merseyside • C&M Maternal Medicine Centre • Liverpool Trusts Joint Committee • Neonatal partnership in place with Alder Hey, with developing partnership board arrangements • Partnership Board in place with LUHFT and involvement in wider Estates Plan • Crown Street Community Diagnostic Centre Partnership • Positive and developing relationship with Merseycare NHS FT	**Future Generations Specific** • Clinical Sustainability in Women's Services ICB Sub-Committee, chaired by ICB Chair • Future Generations Strategy in place • Continuing dialogue with regulators • Continuing partnership with Liverpool University Hospitals • Future Generations Programme re-set as a system priority through Liverpool Clinical Services Review

	• Signed up to CMAST Joint Working Agreement and Committee in Common • Participation in CMAST networks and workstreams • LMNS Hosting Arrangement • Liverpool Clinical Services Review • Finance Directors Group • Health care partnership are using existing memorandum of understanding in relation to staff movement between local hospital at time of staffing need. • LWH have provided assistance to LUFT by taking over LWH non obstetric Ultrasound scanning activity • LWH identified as Gynaecology Oncology Hub for Cheshire and Mersey. • Theatre sessions provided at LWH for other Trusts such as Colorectal for LUFT • Provision of mutual aid to NWAST by supporting staff testing on LWH site for them • Provision of Mutual aid to NWAST for staff Covid-19 vaccinations					
		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**		
Key Assurances:	Quarterly Partnership Reporting to Board	**2**			**Gaps in Control / Assurance:**	Governance arrangements are developing (Action 4.2 / 1)
	LNP Assurance meeting with NEDs	**2**				There is limited capital available to deliver the Trust's Future Generations Strategy. To progress delivery, it is likely that capital funding will need to be identified within the local system. This will require alignment across all system partners regarding priorities for capital funding, and at present there are competing priorities.
	Future Generations Strategy has been included within refreshed overall corporate strategy and is a key supporting strategy within Trust strategic framework. The ICB is now leading the programme of work to address the clinical sustainability challenges related to the isolated site.	**2**				Some partnership arrangements are not yet underpinned by formal governance arrangements and/or service level agreements.
	The majority of dialogue with regulators will be led by the ICB in future. Chair and CEO will maintain ongoing dialogue with relevant key stakeholders at both national and regional level, as appropriate. Trust Communications Team has established good links with respective teams at Place and the ICB and will support any future communication and engagement activities regarding the programme.	**2**				
	Partnership with Liverpool University Hospitals in place and strengthening. Shared dashboard and risk register under development. Shared review of relevant SIs	**2**				
	Active engagement with commissioners ongoing via newly established sub-committee of ICB	**2**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)					
Ref:	**Action required**	**Lead**	**Due Date**	**Quarterly Progress Update**	**RAG**
6/1	Continue to provide updates to the Board regarding the development of the ICS, highlighting when decision points are likely	CEO	On-going		
6/2	Underpin all partnership arrangements with formal governance and service level agreement where appropriate	CFO	Dec-23		

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic					
4 Major					
3 Moderate					
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
High Scoring (15+) Divisional Risks		

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BAF Risk 7 – *Failure to meet patient waiting time targets*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Inadequate capacity planning and management, inefficient referral and triage processes, resource constraints, operational inefficiencies, and external factors contribute to the risk of patient waiting times at Liverpool Women's NHS Foundation Trust.	The event occurs when the demand for services exceeds the Trust's capacity to deliver timely care, leading to prolonged waiting times for patients. This can manifest in various ways, such as delayed appointments, extended waiting lists, or increased waiting times for diagnostic tests or treatments.	Prolonged waiting times at Liverpool Women's NHS Foundation Trust can result in patient dissatisfaction, negative feedback, and loss of confidence in the Trust's services. Delays in accessing care can compromise patient outcomes, leading to increased pain, discomfort, and complications. Breaches of regulatory targets and standards, such as NHS maximum waiting time targets, may trigger regulatory scrutiny and financial penalties. The Trust may incur additional costs and resource utilization to address the backlog, impacting its budget and sustainability. Persistent waiting time issues can also damage the Trust's public perception and relationships with stakeholders.

	We will be an outstanding employer			**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience	✓		**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Quality Committee**	**Lead Director:**	**Chief Operating Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**				**3**	**March 2024**	Our risk appetite for experience is **low.** Liverpool Women's NHS Foundation Trust has a low-risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality and sustainability of the Trust and its patients, may affect the experience of our patients, the reputation of the Trust or the reputation of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Senior Management Team. Despite retaining this a 'low' risk appetite the Quality Committee agreed that the Trust would need to be more ambitious in its attempts to better understand the views of patients and local communities.
Consequence	**4**				**4**		
Risk Level	**16**				**12**		

Rationale for risk score and quarterly update
Following the operational pressures faced as a result of the COVID pandemic, a large number of patients had their treatment and appointments delayed as a result of changes to clinical capacity. This has led to an increasing number of patients waiting beyond 52 weeks to receive their treatment. Continued rises in referrals from Primary Care and an increasing backlog of patients to be seen has led to delays in care and deterioration of Trust performance in relation to national Referral to Treatment (RTT) standards.

Key Controls and Assurance Framework		
Key Controls:	• Fortnightly Access Board meetings with Divisional Operational Teams and Information present monitoring key performance • Daily monitoring of performance through Power BI dashboards – daily and weekly updates on key performance metrics • Weekly Patient Tracking List (PTL) meetings with Divisional Operational teams and Patient Access	• Theatre Utilisation Group • Text reminder service to reduce DNA's and ensure patients still require appointments – facility in place if they wish to change or cancel appointments • Patient Initiated Follow-Ups – to minimise numbers of patients who no longer require follow up to release capacity

	• Elective Recovery Programme in place with workstreams to improve performance and reduce waits • External validation programme of work reviewing all admitted and non-admitted pathways to ensure RTT guidance being applied correctly • Review of Medical & Nursing job plans to ensure capacity in place to treat patients in a timely manner • Cancer Committee – meets bi-monthly to review Cancer performance and track actions to improve performance				• Locum Consultant in place for Gynaecology to increase clinical capacity • Sub-specialisation of Gynaecology and sub-specialty recovery plans in place to monitor actions/risks at a sub specialty level and establish performance trajectories to deliver improvements • Controls in place to monitor length of stay for women in induction of labour - Daily safety huddles - IoL metrics included on Executive and SLT live dashboards • C&M weekly maternity escalation cell	
		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**		
	Access Board reporting	**2**				
	Escalation through to FPBD and Board	**2**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
7/1	Continue to provide updates to the Board regarding the Elective Recovery Plan through Divisional Performance Reviews and to FPBD on a monthly basis through the Integrated Performance Report	Deputy COO	On-going		
7/2	Access Policy review and delivery of SOP's via Waiting List Management audit action plan	Patient Access Lead	September 2023		
7/3	Work to reconfigure the MLU estate to maximise efficiencies for IoL.	FH Div Manager	September 2023		

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2316, 2667		
4 Major			2087	2485	
3 Moderate			2649		
2 Minor			2084		
1 Negligible					

Return to Dashboard

Ref	Description	Risk Rate Score
Corporate Risks		
2087	Condition: Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	12
2649	Condition: There is little evidence to support Audim audits are being undertaken as required in line with National Standards of Healthcare Cleanliness (2021)	9
2084	Condition: Uncertainty of adequacy of 24/7 access to specialist input to support changing patient profiles and needs, new guidance and the Chief Medical Officer's recommendation of the specialist multidisciplinary team approach to treatment planning and co-ordination, including pre-operative, surgical and up to level 3 post-operative care for improved patient safety and improved outcomes.	6
High Scoring (15+) Divisional Risks		
2485	Condition: Limited access to MRI scan (currently 5-6 weeks wait) needed for cancer patient pre-treatment (both surgical and radiotherapy treatment). MRI requested and undertaken at CCC as per pathway, as expertise in reporting is there and feeds into specialist MDT. Of note MRI added into clinical pathway as part of BGCS stratification for surgery during the first wave of COVID pandemic - this is considered best practice.	16
2316	Condition: Risk of women needing to access emergency care with pregnancy complications and not being able to be triaged in the MAU within 30 minutes of presenting at the department as per BSOTS. Impact on the safety of patients (physical and psychological);	15
2667	Risk: Delay in access to timely radiography out of hours	15

Appendix 1 – System BAF risk mapping

	LWH BAF 1				LWH BAF 2				LWH BAF 3				LWH BAF 4				LWH BAF 5				LWH BAF 6			
	Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities				Inability to ensure the on-going sustainability of clinical services and maintain a high standard of care at the current Crown Street site.				Failure to deliver an excellent patient and family experience to all our service users				Inadequate digital strategy and sub-optimal clinical records systems increase the risk of major IT system failures due to cyber-attacks, compromising patient safety and Trust operations				Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term				The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative			
	Target				Target				Target				Target				Target				Target			
	Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
LWH BAF	20				20				12				20				20				8			
LUHFT BAF	tbc				tbc				tbc				tbc				tbc				tbc			
WC BAF	5 (12)				2 (9)				1 (12)				11 (15)				3 (9)							
	8 (9)				4 (9)				6 (12)				12 (6)				7 (9)							
	9 (12)				10 (12)																			
LHCH BAF	4 (12)				2 (12)				1 (6)				11 (12)				3 (12)				9 (4)			
	5 (12)				8 (12)												7 (12)				10 (9)			
	6 (12)																							
AHH BAF	2.1 (15)				1.1 (9)								4.2 (16)				3.4 (16)				3.2 (12)			
	2.2 (9)				1.2 (15)																3.5 (16)			
	2.3 (15)				1.3 (12)																3.6 (9)			
CCC BAF	10 (12)				1 (15)								13 (12)				3 (16)				6 (12)			
	11 (16)				2 (12)								14 (12)											
MC BAF	p.8 (15)				s.8 (16)				s.5 (12)				r.12 (8)				p.7 (16)				f.7 (8)			
	p.5 (12)				r.11 (12)				s.9 (12)								r.9 (15)				f.5 (12)			
									p.9 (12)								r.13 (15)							
ICB BAF	TBC				TBC				TBC				TBC				TBC				TBC			

LUHFT BAF Risks Summary	
1	If we do not enhance the systems and processes employed to deliver planned care at elective activity plans level, we will not reduce patient delays, negative impact on health outcomes, negative impact on finances, and potential increase in demand for social care
2	If we do not introduce innovative solutions to address the safety concerns within Urgent & Emergency Care, we may not see improvements in the delivery of safe care and the health and safety of staff.
3	If we do not embed the plans to achieve improvements in the fundamentals of nursing care (falls, pressure ulcers, nutrition and hydration), we may not achieve a reduction in length of patient stay and positive health outcomes for patients.
4	If corporate and quality governance arrangements do not meet the requirements of the Well-Led Framework, the Trusts assurance and escalation processes may not be fit for purpose, impacting on the provision of high quality, sustainable, harm free care.
5	If we do not support the wellbeing and resilience of our people, then our ability to recruit and to provide safe staffing levels in order to provide safe, caring and effective care may be compromised
6	If we do not address Equality Diversity & Inclusion (EDI) inequalities affecting our workforce, we may fail to improve the experience of staff from diverse background and fail to recruit, promote and retain diverse talent.
7	If we are unable to embed agreed leadership behaviours throughout the organisation, we may fail to strengthen our current leadership capability, which will have a negative impact on our ability to recruit and retain the best people.
8	If we do not deliver the agreed financial plan this may result in a detrimental impact on medium/long term sustainability and effective system collaboration.
9	If we are unable to develop cyber secure and compatible patient information systems due to resourcing and lead time limitations, this may result in detrimental impact on service continuity and consistency.
10	If we are unable to build and sustain effective partnerships with other health, care, voluntary sector and other key organisations, this may impact adversely on our ability to deliver the Trust strategy and the Liverpool Clinical Services Review
11	If we are unable to fulfil our responsibilities as an anchor organisation to the wider community, this may result in missed opportunities to support the Liverpool system and its people to improve health outcomes and address health inequalities.
12	If we do not deliver agreed milestones in line with the Research Strategy to become a clinically research active organisation, this may reduce the patient access to clinical research and reduce opportunities to improve patient care and treatment options.

WC BAF Risks Summary	
1	Impact on patient outcomes and experience
2	Inability to develop further regional care pathways
3	Inability to deliver financial plan for year
4	Inability to deliver the operational plan
5	Inability to attract, retain and develop sufficient numbers of qualified staff
6	Inability to improve equitable access to services
7	Inability to secure capital funding to maintain the estate to support patient needs
8	Inability to develop a national training offer
9	Inability to develop and attract world class staff
10	Inability to grow an innovative culture
11	Inability to prevent Cyber Crime
12	Inability to deliver the Digital Aspirant plan and associated benefits

LHCH BAF Risks Summary	
1	Failure to maintain safety and quality and avoid harm would result in poorer patient & family experience
2	Inability to recover operational services in line with 22/23 planning guidance could result in poorer patient outcomes, inability to address the backlog of patients waiting and deliver financial consequences to the Trust
3	Inability to achieve the five year capital programme within a challenging and uncertain operating environment and deliver an Estates Strategy that supports the provision of outstanding services
4	A deterioration in the physical and mental wellbeing of our workforce would hinder our ability to provide the best possible care, experience and outcomes for patients
5	If delivery of people development programmes continues to be constrained, workforce morale and quality of care may suffer
6	Challenges in retaining and recruiting a high quality, diverse and inclusive workforce would affect our ability to deliver world class care
7	Failure to deliver financial plans and changes in the funding regime could impact sustainability for the Trust and system partners
8	Inability to drive the Research and Innovation agenda to exploit future opportunities
9	Failure to be recognized as an Anchor Institution, demonstrating social value, sustainable green strategy and contribution to population health may increase costs in the longer term and disappoint public, staff and regulatory expectations
10	The priorities of the ICS are developing and may present tensions for our strategic plans and collaborations and divert leadership capacity
11	Failure to ensure strong digital transformation and IT service resilience could erode LHCH's position as a world-class provider of specialist care delivering services for patient needs

Alder Hey BAF Risks Summary	
1.1	Inability to deliver safe and high-quality services
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care
1.3	Building and infrastructure defects that could affect quality and provision of services
1.4	Access to Children and Young People's Mental Health
2.1	Workforce Sustainability and Development

Clatterbridge Cancer Centre BAF Risks Summary	
1	Quality governance
2	Demand exceeds capacity
3	Insufficient funding
4	Board governance
5	Environmental sustainability

Merseycare BAF Risks Summary	
s.5	Failure to achieve continuous improvement and learning against the STEEEP and CQC domains will result in the Trust not archiving clinical excellence.
s.8	There is a risk of unstable pressure on our services due to rising levels of need within our communities resulting in an exacerbating workforce; affordability challenges and an Inability to shift resource whilst managing high levels of demand and acuity.
s.9	There is a risk that Trust won't be able to address unwarranted variation in access and waiting times across services due to the COVID backlog limiting the ability of staff to shift their attention upstream.
p.8	There is a risk of reduced workforce availability, retention, and wellbeing due to staffing constraints leading to a failure to innovate our workforce models and address wellbeing and culture.
p.5	Failure to create a workforce that is representative of the communities that we serve and does not take a just and learning approach to reduce the gap in outcomes and experience of BAME staff and patients, resulting in continuing inequalities.

2.2	**Employee Wellbeing**		**6**	**Strategic influence within ICS**		**p.7**	**If the Trust continues to see an overspend in senior medical staffing and medication, there is a risk that the Trust's control total will not be achieved.**
2.3	**Workforce Equality, Diversity & Inclusion**		**7**	**Research portfolio**		**p.9**	**There is a risk of poor patient experience and culturally inappropriate services due to our preventative model of care note being adequately co-produced with patients.**
3.1	**Failure to fully realise the Trust's Vision for the Park**		**8**	**Research resourcing**		**r.11**	**There is a risk to the modernisation of our inpatient and community estates across an enlarged footprint due to capital constraints limiting investment to support the new models of care.**
3.2	**Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships**		**9**	**Leadership capacity and capability**		**r.12**	**There is a risk that the Trust will not be able to meet its strategic ambitions around digitally enabled care due to our current platforms not being strong enough to support the use of intelligence to predict and prevent the need for acute care.**
3.4	**Financial Environment**		**10**	**Skilled and diverse workforce**		**r.9**	**The CIP target associated with Mersey Care is not delivered recurrently, there is a risk the Trusts control total will not be achieved. Risk Score 15 over 5 years**
3.5	**ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment**		**11**	**Staffing levels**		**r.13**	**There is a risk of less autonomy in the new financial system due to the need for all NHS organisations to support national financial recovery after COVID19, resulting in less flexibility for the Trust to make strategic investments.**
3.6	**Risk of partnership failures due to robustness of partnership governance**		**12**	**Staff health and wellbeing**		**f.7**	**There is a risk to Integrated care reforms due to the Trust not working effectively in partnership at Cheshire and Merseyside and Place levels with other organisations, resulting in effective collaboration being hampered and misalignment with Mersey Care's own strategy.**
4.1	**Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People**		**13**	**Development and adoption of digitisation**		**f.4**	**Failure to maximise on our intellectual assets, through research and development, reduces our ability to reinvest in the delivery of our clinical strategy to improve the experience and outcomes for service users.**
4.2	**Digital Strategic Development & Delivery**		**14**	**Cyber security**		**f.5**	**Failure to realise the opportunities from the acquisition of North West Boroughs and in so doing miss the opportunity to create an at-scale provider of outstanding integrated physical and mental health services for the community.**
			15	**Subsidiaries companies and Joint Venture**			

Appendix 2 – Corporate Risks and High Scoring Divisional Risks

Ref	Description	Severity	Likelihood	Risk Rate Score	Directorate	Review Date	Next Review Date	BAF Link(s)
Corporate Risk Register								
2641	Condition: There is a significant risk to the dietetic service and delivery of patient care at LWH	3 Moderate	4 Likely	12	Clinical Support Service	16/05/2023	15/06/2023	1 & 2
2660	In November Occupational Health alerted the Trust via Infection Prevention Committee that there were clinical staff in the organisation who were not compliant with screening / evidence of immunity/ up to date vaccination for a) EPP procedures and b) HEP B	4 Major	2 Unlikely	8	Human Resources	12/05/2023	11/06/2023	1 & 2
2087	Condition: Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	4 Major	3 Possible	12	Maternity	17/05/2023	15/08/2023	1, 2 & 3
2469	Condition: Allocation of resources to carry out water safety checks and maintenance has failed to achieve required targets despite prioritising this work and reducing resources for other tasks - see risk 2274.	3 Moderate	2 Unlikely	6	Facilities & Estates	21/05/2023	21/05/2023	2
2301	Condition: There is both an operational and a financial risk related to the position in relation to contracts and SLAs for services provided to and by the Trust.	4 Major	3 Possible	12	Financial Services	15/05/2023	13/08/2023	5
2649	Condition: There is little evidence to support Audim audits are being undertaken as required in line with National Standards of Healthcare Cleanliness (2021)	3 Moderate	3 Possible	9	Governance IPC	14/04/2023	14/05/2023	3
2329	Condition: There is a risk to the Trust is not meeting it requirements for the safe and proper management of medicines	4 Major	3 Possible	12	Pharmacy	20/04/2023	20/05/2023	2
1966	Condition: Risk of safety incidents occurring when undertaking invasive procedures.	4 Major	3 Possible	12	Governance	19/05/2023	20/06/2023	2
2085	Condition: Uncertainty around access to dedicated diagnostic capacity and physiological measurement needed to support needs of a changing patient demographics and an increase in complex multiple co-morbidities, and meeting the pre-operative assessment standards of the Association of Anaesthetists of GB & Ireland (AAGBI) and the Royal College of Anaesthetists (RCoA), to asses patients' clinical risk and plan for additional requirements for their safety and provide an optimal experience.	4 Major	3 Possible	12	Theatres & Anaesthesia	18/05/2023	16/08/2023	2
2232	Condition: There is a risk that due to a number of causes the Trust is unable to meet the safety requirements related to Blood Transfusion	5 Catastrophic	3 Possible	15	Pathology	13/04/2023	13/07/2023	2
2491	Noncompliance with mandated level of fit mask testers qualification, accreditation and competency.	5 Catastrophic	3 Possible	15	Governance	22/04/2023	21/06/2023	1
2488	Condition: Failure to meet clinical demand for red blood cells	3 Moderate	3 Possible	9	Clinical Support Service	01/05/2023	18/06/2023	2
2296	Condition: The LWH laboratory autoview analyser (the machine used to process Blood Group and Save samples on site) will no longer be supported as of 1st march 2020. This machine cannot continue to be used after this date.	3 Moderate	3 Possible	12	Pathology	13/04/2023	12/10/2023	2
2603	Condition - Current Intranet in poor condition and no longer fit for purpose.	3 Moderate	3 Possible	9	Human Resources	15/05/2023	13/08/2023	4
1704	Effective management systems are not in place or sufficient to ensure all employees complete and keep up to date with their mandatory training requirements.	4 Major	3 Possible	12	Human Resources	10/03/2023	08/06/2023	1
2549	Condition: Staff shortages in the Ultrasound Team within the Imaging Department due to Vacancies and 5 staff members leaving in May & June 22	3 Moderate	4 Likely	12	Clinical Support Service	17/10/2023	21/05/2023	1

2645	NWAS INDUSTRIAL ACTION FOR 21 AND 28 DECEMBER 2022 Condition: National ambulance and NHS trade unions recently announced two days of strike action. GMB, Unite, and Unison members will take part in industrial action on the 21 December, with GMB also taking a further 24 hours of action on the 28 December. Specifically, as follows: _GMB - 21 and 28 December 00.01 to 23.59 _Unite - 21 December 00.01 to 23.59 _Unison - PES staff only 21 December 12:00 - 00.00	3 Moderate	5 Almost Certain	15	Governance	11/05/2023	10/06/2023	1
2086	Condition: Uncertainty about provision of adequate on-site Blood bank stocking all major blood products necessary to support the needs of the Maternity service.	3 Moderate	3 Possible	9	Maternity	17/01/2023	18/07/2023	2
2321	Condition: Due to the Trust not being located next to or with acute services, it is unable to meet the National Recommendations for Maternal Medicine.	4 Major	3 Possible	12	Maternity	17/05/2023	16/07/2023	2
1635	Risk of delays to treatment due to significant problems with the junior doctor rotas- vacancies and maternity leave. This is placing severe strain on the ability to fulfil the on-call rota as well as covering in hours duties. There is an increased reliance on locums, causing financial pressures. The risk include potential gaps in the rota which may put patients at risk, regular locum use which may result in potential compromise to the quality of the service provided and risk to the training provision of junior doctors if they are being moved around to fulfil the basic rota.	4 Major	3 Possible	12	Human Resources	05/05/2023	03/08/2023	1, 2 & 5
2084	Condition: Uncertainty of adequacy of 24/7 access to specialist input to support changing patient profiles and needs, new guidance and the Chief Medical Officer's recommendation of the specialist multidisciplinary team approach to treatment planning and co-ordination, including pre-operative, surgical and up to level 3 post-operative care for improved patient safety and improved outcomes.	2 Minor	3 Possible	6	Gynaecology	15/03/2023	13/06/2023	1, 2 & 3
2088	Condition: Lack of on-site specialist staff and services	4 Major	3 Possible	12	Neonatal	10/05/2023	09/06/2023	1 & 2
2323	Condition: The Trust is currently non-compliant with standards 2,5,6 of the seven-day service standards	5 Catastrophic	3 Possible	15	Governance	18/04/2023	17/10/2023	2
2395	Condition: Ambulatory gynaecology demand is exceeding current capacity	3 Moderate	5 Almost Certain	15	Gynaecology	23/03/2023	22/05/2023	2
2606	Failure to comply with national infection trajectory specifically in relation to E. coli bacteraemia	2 Minor	5 Almost Certain	10	Governance	23/08/2022	23/08/2023	2
2607	There is a risk of disruption to services as a result of industrial action from a number of trade unions in relation to matters relating to pay and conditions of service. The RCN are the first union who have undertaken a ballot for industrial action which closed on 2nd November 2022, 97% of members voted in favour (167 nurses). Industrial action is expected to begin before the end of this year and the RCN's mandate to organise strikes runs until early May 2023, six months after members finished voting. Ballots for other unions are due to take place on the following dates -GMB 24th October - 29th November -Unite 26th October-30th November -Unison 26th October- 25th November -CSP 7th November- 12th December -RCM 11th November- 9th December -BMA- Early January There an indication that unions may take the decision to co-ordinate strike action which would heighten the potential disruption to services at LWH. Exemptions and derogations are to be agreed at a local level, if these are in line with previous years, maternity and neonatal services would be exempted, some activity across gynaecology and fertility will be stood down. We are working in partnership at a system level to agree a shared approach to managing industrial action, as well as ongoing liaison with our staff side colleagues. Additional Risk Update 28/04/2023	5 Catastrophic	5 Almost Certain	25	Human Resources	12/05/2023	19/05/2023	1

	Confirmed RCN strike action planned between 20:00 30.04.2023 and 01.05.2023 23:59, Gynaecology and Neonatal Services enacting Business Continuity Plans due to staffing and the potential for the Trust to declare a Major Incident to NHS England. Additional Risk Update 5/5/23 RCN action took place on 30th April and 1st May. Trusts had been informed that no derogations would be agreed on a national level. On 30th April a safety critical mitigation was agreed for the Neonatal Unit and staff were called back in to work to maintain patient safety. The National Pay Award has now been agreed by the NHS Staff Council. The RCN and Unite unions did not agree the pay deal . The RCN will ballot its members for further industrial action later this month. Unite has said the council's vote will not affect action it has planned. In respect of Junior Doctors, the BMA undertook industrial action from 11th to 15th April. Services were maintained due to consultants acting down and support from advanced nursing staff. The BMA will ballot NHS Consultants in England for strike action from the 15th May							
High Scoring Divisional Risks								
1960	Condition: Risk of incomplete patient records	4 Major	5 Almost Certain	20	Imaging	20/03/2023	/ /	4
2178	Condition: Lack of a robust system to ensure that ultrasound scanning performed by non-Sonographer practitioners is monitored and reviewed/audited and appropriate subsequent action taken.	5 Catastrophic	4 Likely	20	Imaging	03/05/2023	03/06/2023	2
2467	Condition: Inability to recruit specialised allied health professions in a timely manner for blood bank	4 Major	4 Likely	16	Facilities & Estates	05/04/2023	04/07/2023	1
2655	Condition - No robust system in place for tracking of instrumentation if we suffer a breakdown of tracking system prior to replacement system being installed.	4 Major	4 Likely	16	Clinical Support Service	02/05/2023	01/06/2023	4
2598	Condition: Risk relating to the Trusts Emergency Response	5 Catastrophic	3 Possible	15	Facilities & Estates	23/03/2023	21/06/2023	2
2599	Condition: Risk relating to the Trusts Internal Security (Premises)	5 Catastrophic	3 Possible	15	Facilities & Estates	20/02/2023	21/06/2023	2
2418	Condition: Lack of support and appropriate care for patients presenting with mental health conditions	4 Major	4 Likely	16	Governance	07/04/2023	14/09/2022	2 & 3
2531	Risk Title: Inadequate IT Helpdesk Provision	4 Major	4 Likely	16	Digital Services (IM & T)	25/04/2023	25/05/2023	4
2572	Condition - there is a lack of strategic leadership and robust procedures to ensure the safety of people and assets within the Crown Street and Knutsford sites.	4 Major	4 Likely	16	Facilities & Estates	10/05/2023	10/06/2023	2
2604	Condition: Risk relating to Trust Security Systems	5 Catastrophic	3 Possible	15	Facilities & Estates	10/05/2023	09/06/2023	2 & 4
2386	Risk Title: Data Loss Prevention Condition: Risk of personal and sensitive information being compromised or being misused	3 Moderate	5 Almost Certain	15	Digital Services (IM & T)	27/04/2023	26/07/2023	4
2430	Condition: Network outlier for pre-term mortality - rate is higher than the national average	4 Major	4 Likely	16	Neonatal	12/03/2023	10/09/2023	2
2485	Condition: Limited access to MRI scan (currently 5-6 weeks wait) needed for cancer patient pre-treatment (both surgical and radiotherapy treatment). MRI requested and undertaken at CCC as per pathway, as expertise in reporting is there and feeds into specialist MDT. Of note MRI added into clinical pathway as part of BGCS stratification for surgery during the first wave of COVID pandemic - this is considered best practice.	4 Major	4 Likely	16	Gynaecology	10/11/2022	10/11/2023	3

2316	Condition: Risk of women needing to access emergency care with pregnancy complications and not being able to be triaged in the MAU within 30 minutes of presenting at the department as per BSOTS. Impact on the safety of patients (physical and psychological);	5 Catastrophic	3 Possible	15	Maternity	08/05/2023	08/06/2023	2 & 3
2667	Risk: Delay in access to timely radiography out of hours	5 Catastrophic	3 Possible	15	Neonatal	10/05/2023	09/06/2023	3
2684	T5, T8, Compact fluorescent lamps are becoming obsolete from October 2023 to February 2024. Stocks of lamps will become depleted and then non-existent.	4 Major	4 Likely	16	Facilities and Estates	10/05/2023	10/08/2023	2

Changes to Risk Summary (Quarterly)

8 additional risks captured from the Corporate Risk Register (1635 onwards)

5 additional extreme risks captured from the Divisional Risk Registers (2430 onwards)

Appendix 3 - Risk Descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long- term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on many patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day)	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days)	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff
			Low staff morale Poor staff attendance for mandatory/key training	Loss of key staff Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10– 25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met

Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?
The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/092*		Date: 13/07/2023	
Report Title	2023/24 Operational Plan Narrative Summary			
Prepared by	***Joe Downie, Deputy Chief Operating Officer***			
Presented by	Gary Price, Chief Operating Officer			
Key Issues / Messages	*This paper summarises the 2023/24 Operational Plan Narrative and includes the Divisional Plans on a Page. Progress against these will be monitored via committees throughout the year and formal updates will be given to Trust Board as in previous years.*			
Action required	Approve ☐	Receive ☒	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
Supporting Executive:	Gary Price, Chief Operating Officer			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

EXECUTIVE SUMMARY

This document is the summary narrative for the 2023/24 Operational Plan. The document highlights the key deliverables for 2023/24 and challenges for our services in support of our Trust Strategy. Included in the document as Appendixes are the Divisional Plans on a Page which are aiming to continue to deliver on our 5 year clinical transformation plans.

Progress against these plans will be monitored via committees and progress will be formally reported to the Trust Board as in previous years.

1. Background

There is no national requirement for operational plan narrative in 2023/24 plan submissions, however it should be seen as good practice to have a document that summarises the ambition and intent for our services for 2023/24.

This document demonstrates the key areas of focus for 2023/24 in what will be a challenging year. It summarises the Financial, Quality and Operational challenges and ambition with reference to the key areas of Workforce requirements and developments. Key in 2023/24 will be the further development of our partnerships. Implementation of DigiCare will be a key ambition of the year ahead.

In addition to the narrative the Divisional Plan on a Page summaries are included as Appendices.

2. Recommendations

The Board is asked to note this plan narrative. The Trust Governance processes monitor performance against these plans with the Divisional Performance Reviews monitoring overall monthly progress. Updates and assurance against the plans will be further monitored via committees and reported to Trust Board.

Operational Plan 2023/24

1. Our Vision, Values and Aims

Our vision at Liverpool Women's is to be the recognised leader in healthcare for women, babies, and their families. We want to be the provider that sets the standards that others follow, and champions women's and family health in Liverpool, the North West region and across the country. Our vision is underpinned by a shared set of values based around the needs of our people. We encourage these behaviours in all our staff, partners, and volunteers to make sure our values are delivered in the same way, every day, to every person we care for.

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

We have a set of five strategic aims which underpin all our strategies and plans, and through working with patients, staff, governors, and our partners we have developed a series of ambitions to push those aims one step further, helping us create the mind-set we need to achieve our vision and be outstanding in everything we do.

2. Our Strategy

Launched in April 2021, Liverpool Women's overarching strategy, 'Our Strategy', sets out the path the Trust will follow to achieve its aims and ambitions over a 5-year period. Our Strategy's central focus is on three of our Trust aims; 'The ***best people***, giving the ***safest care***, providing ***outstanding experiences***', however the remaining aims of Efficiency and Effectiveness also play a key role. The strategy sets out 10 strategic objectives, which are delivered through and underpinned by a cohesive set of enabling strategies and plans:

Strategic Priorities for 2023/24

We engaged fully with system partners during 2022/23 to develop the Cheshire and Merseyside Integrated Care Partnership Interim Strategy and associated Joint Forward Plan, and there is good alignment with Our Strategy. We will be doing more in 2023/24 to refresh our underpinning strategies and shape our plans to build even closer alignment; for example, supporting development of a C&M Women's Health Strategy.

In 2023/24 we will continue to deliver on our strategic objectives to ensure we have the ***best people***, giving the ***safest care,*** providing ***outstanding experiences.*** We will work closely with the Cheshire and Merseyside Integrated Care Board to agree and implement a long-term solution to deliver clinically safe and sustainable women's services in Liverpool for the long-term future, and we will work with our system partners to improve efficiency and deliver integrated care for women, babies and their families.

3. Our Workforce

It remains our focus to improve staff experience, retention, and sustainable workforce supply through a systematic focus on all elements of the NHS People Promise. 2024 will see the launch of our new 5-year people strategy and throughout 2023 we will engage with a range of stakeholders across the organisation to ensure the strategy reflects the priorities and challenges of an ever-changing NHS and the ambitions of the newly published NHS Long Term Workforce Plan. In the context of future structural change as part of the Liverpool Clinical Services Review, we continue to focus on creating a supportive and developmental culture for our staff whilst working within the system to align system, processes and ways of working to enable our staff to be as agile as possible into the future.

Our key workforce ambitions are listed below and our detailed in our people plan

We are compassionate and inclusive

We are recognised and rewarded

We each have a voice that counts

We are safe and healthy

We are always learning

We work flexibly

We are a team

In 23/24 we will continue to roll out our Actively Anti-Racist programme of work. This is part of our wider inclusion ambition and our declaration of intent to proactively address racial inequity in our organisation.

4. Improving Quality of Care

In 2023/24 our Key areas of focus to improve Quality of Care will be

- A re-fresh and relaunch of our approach to QI trust wide – linked to BBAS, incidents, SI's etc
- Offer role-appropriate training in quality improvement across the trust
- Roll out of LFPSE (Learning from Patient Safety Events) & Education of the changes to incident reporting.
- Implementation & roll out of PSIRF(Patient Safety Incident Response Framework) – Replaces SI framework
- To improve the culture of incident reporting changing the perceptions of blame to opportunities for learning, being able to demonstrate that we are an organisation that learns and change has been embedded and sustained
- Promote a positive health and safety culture across the Trust in line with the requirements of a robust health and safety management system
- Review our approach to learning from claims and litigation
- Development of a refreshed Quality Strategy , which will include specific focus on patient experience and engagement , outcomes , health inequalities , and safety

5. 23/24 Operational Planning Guidance

Priorities for 2023/24 remain like those outlined in 2022/23 Operational Planning Guidance with a key focus on performance recovery.

The table below outlines National NHS objectives for 23/24.

National NHS objectives 2023/24

	Area	Objective
Recovering our core services and improving productivity	Urgent and emergency care*	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

Below are key areas of focus in relation to Operational Performance for Liverpool Womens through 23/24;

Urgent and Emergency Care

- Improve A&E Waiting Times

Cheshire & Merseyside Integrated Care System (ICS) target of 90% for LWH of the 4 hour wait time target.

Elective Care

- Reduce 65+ weeks to Zero by March 2024

LWH have made good progress on reducing long waits through Q4 2022/23 and this will continue into Q1 23/24.

Cancer

- Continue to reduce number of patients waiting over 62 days
- Meet the Faster Diagnosis Standard of 75% by March 2024

Significant demand through 22/23 has created a significant challenge for LWH in regard to numbers of patients on Cancer PTL. A significant programme of transformation and improvement work will be taking place throughout 23/24 to improve Cancer Standards

Diagnostics

- Increase percentage of patients requiring a diagnostic within 6 weeks to 95% by March 2025

LWH currently achieving between 90-95% for this measure and aim is to achieve this by March 2024

Maternity & Neonatal Services

Delivery of Maternity Triage standards

Delivery of 3 Year Single Delivery Plan for Maternity & Neonatal services

6. Digital Services Operating Plan 23/24

The Digital Services department will continue to implement the key objectives within the **Digital.Generations** strategy. The main focus of delivery is the implementation of the **digiCare Programme** which will see the go-live of MEDITECH Expanse EPR from July 23. This will mark a momentous milestone within the digital capabilities at Liverpool Women's Hospital, replacing the legacy Patient Administration System known as MEDITECH Magic with a modern fully featured EPR.

From the start of the 23/24 financial year significant activities to support the programme will be underway centred on testing, training, cutover planning and underpinned by robust communication and organisational change activities. Several supporting workstreams are being led by teams within Digital Services including Information Technology who are ensuring the 'end user computing' experience is optimal for a successful go-live, and this is aligned to the Digital Fundamentals theme within the digital strategy.

Post July the Digital Services department will move to an 'adoption and optimisation' phase which will continue throughout 23/24. This phase will place emphasis on ensuring that digiCare is fully exploited to support safe use, effective adoption, and good data quality capture. The programme will enhance functionality, configuration and integration utilising regular staff engagement and feedback.

Whilst the digiCare Programme will consume most of the departments focus and resources, the department will continue to ensure that:

- Business As Usual support activities across all digital functions are maintained.
- Support the Trust with department digital development and quality improvement
- Deliver local CIP and act as an enabler through digital solutions to support CIP delivery across the Trust
- Optimisation and integration of other Trust digital systems such as K2 Digital Maternity continues.
- Further exploit and embed the use of data across the Trust through Power BI dashboard developments supporting operational performance and direct patient care.
- Meet the national data security protection toolkit (DSPT) and cyber security requirements.
- Contribute to ICS wide digital initiatives and programmes of work.
- Enhance the Trusts digital maturity capabilities aligned the national What Good Looks Like framework.

7. Research and Development

Liverpool Women's NHS Foundation Trust has a long history of supporting high quality research. By combining research with excellence in clinical practice and teaching over many years, the Trust has become one of the world's leading authorities in the healthcare of women, babies and their families. In order for this position to be maintained and enhanced, a refreshed strategy for research was recently adopted, thus providing a clear understanding of our current situation and our priorities over the next five years. The strategy will strengthen the place of research at the

centre of the Trust's purpose, combining it with its clinical and educational activities. Ultimately, it will result in research being one of the drivers for improvement in clinical standards and outcomes for women, babies and families locally, nationally and internationally. During 2023/24 the Trust will focus on the following key priorities:

- ***Synergise working relationships with the Harris Centre***: continue to build on the strengths of existing effective working relationships for organisational mutual benefit in order to facilitate the delivery of high quality and impactful research - in particular prioritising the set up and delivery of the Children Growing up in Liverpool (C-GULL) birth cohort study.
- ***Professional development of research delivery staff***: ensure alignment with local and national training programmes to develop the skills, capability and knowledge within our team of substantive research staff
- ***Clear leadership for nurses, midwives and allied health professional research***: development of a framework and addressing barriers to progress
- ***Development opportunities for nurses, midwives and allied health professionals***: in collaboration with clinical practice, establishing research opportunities for the workforce – whoever they are, wherever they work
- ***Continued support for existing cohort of researchers***: recognise where individuals are placed in terms of their research experience and expertise, and continue to provide the appropriate support and guidance.
- ***Continue to deliver high quality research within existing resources***: ensure we enhance our reputation and build on existing good practice by increasing the research portfolio to enable opportunity for more patients and service users to benefit from an improved experience and treatment outcomes.

Maternity Divisional Operational Plan on a Page 2023/2024

This plan outlines year 1 of the 5 year Divisional Transformation Plans in order to support delivery of the Trusts Vision, Aims and Ambitions

NHS
Liverpool Women's
NHS Foundation Trust

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

Activity and Finance:

Activity
Antenatal 8,270
Deliveries 7,851
Postnatal 7,241

Expenditure
Mat Pay £23.583
Mat Non–Pay £1,951
Mat Total £25,534

Income
Commissioner £47,595
Non Commissioner £1,448

CIP Identified:
800K Identified

Further development of Capacity & Demand planning in Maternity services

Continued development of SLA review

Impact of Ockenden 2 and financial support to deliver essential requirements

Fetal Medicine commissioning and continued development as a regional/national service

Funding framework for Maternity services

CNST delivery – contribution & claims through NHS Resolution

Quality, Safety and Patient Experience

Delivery of Maternity 3 Year plan
Embed the Ockenden 2 recommendations
Deliver CNST year 5
Lead in the NW on Maternal Medicine Networks
Deliver regional PAS service
Lead on Fetal Medicine Unit and further development as a tertiary and quaternary lead service to Cheshire & Merseyside, Isle of man and North Wales
Ensure implementation of and ongoing monitoring of maternity Survey
Deliver on QI projects and embed QI methodology
Harnessing digital technology to ensure delivery of safe and effective care and positive patient experience
Develop a maternity service that meets outstanding outcome for CQC inspection

Workforce, Diversity and Leadership

Delivery of RCOG guidelines for consultant workforce
Delivery and refresh of Birthrate Plus for midwifery workforce
Continue to work with senior team to improve sickness and PDR compliance
Continued development of training trajectory for all areas of training
Continue the culture programme within maternity
Continued development of preceptorship and posteptorship programme

Digital Enablers

Optimisation of K2 and BadgerNet
Implementation of Meditech Expanse
Clinically focussed, concise real time performance monitoring
Use of telemedicine to provide care across the region remotely
Ensure staff have correct kit to use new clinical systems and digital processes

Estates Strategy

Large scale development and modernisation
Priorities are Maternity Base, Midwifery Lead Unit and Bereavement and Honeysuckle suite
Fetal Medicine Unit
Undertake a review of capacity and demand to ensure estate is fit for future (antenatal services, maternity base and theatre provision
Equipment Replacement programme

Key Performance Indicators

Delivering Services Closer to People's Homes – St Chad's development
Improve referrals time to fetal medicine centre|
Improve DNA rates for new and follow up maternity appointments
Improve response times to Triage phone calls
Reduce LOS
Increase early discharge rates by 15%
Increase births within MLU by 10%

Partnerships

LMNS /ICB
North West Maternal Medicine Network
Cheshire & Merseyside Maternal Medicine Network
Liverpool Neonatal Partnership and the NWNODN
Countess of Chester -Fetal Medicine Unit
Research programme with The University of Liverpool's Division of Reproductive and Development Medicine
Liverpool University Hospitals NHS Foundation Trust –ICU Telemedicine Partnership Board
Cross Divisional working CSS to improve scan waiting times and Theatre Utilisation
Cross Divisional working Gynae to enhance patient access centre services
Pan trust working with specialist Trust partners – Hybrid Mail

Risks to Delivery

Finance challenges

External funding

Workforce challenges

Sickness and absence rates

Industrial Action

Horizon Scanning

LMNS
Collaborative working Specialist Trusts

C&M ICB
Recruitment and retention of all staff groups

Neonatal Divisional Operational Plan on a Page 2023/2024

This plan outlines year 1 of the 5 year Divisional Transformation Plans in order to support delivery of the Trusts Vision, Aims and Ambitions

NHS
Liverpool Women's
NHS Foundation Trust

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

Activity and Finance:

Activity
ITU 3,219
HDU 3,257
SCBU 5,880
TC 2,580

Expenditure
Neo Pay £13,883
Neo Non–Pay £1,484
Neo Total £15,367

Income
Commissioner £19,047
Non Commissioner £2,072

CIP Identified:
800K

Funding frameworks for Neonatal services

Quality, Safety and Patient Experience

Deliver on QI projects and embed QI methodology
Nursing KPI's developed and unit accreditation to commence.
New point of care testing equipment under review –BGA
New risk and governance meetings embedded
MatNeoSip – continue to develop
Delivery of the Liverpool Neonatal Partnership

Workforce, Diversity and Leadership

Talent pool for all grades to encourage all staff to develop
Proactive recruitment Nurses, ANNP and Consultants
Further development of ANNP team.
Development of the AHP team inline with GIRFT
Retention and development of Team

Digital Enablers

Improve the Wi-Fi connectivity
More use of the telemedicine system
System interfaces – K2, BadgerNet
Delivery of remote clinics.
Implementation of Meditech Expanse
Clinically focussed, concise real time performance monitoring
Use of telemedicine to provide care across the region remotely

Estates Strategy

Refurbishment of Office accommodation within the NICU
Identification and refurbishment of Neonatal Clinical office space
Refurbishment of the parent flats.
Development of Neonatal unit

Key Performance Indicators

Improve DNA rates new – Neonates
Improve DNA rates follow up Neonates
BCG delivery
NNAP data
Vermont Oxford Benchmarking

Partnerships

Liverpool Neonatal Partnership
Research Partnerships – C-Gull
Educational Partnerships JMU, Liverpool University School of Medicine
Neonatal network/ODN

Risks to Delivery

Finance challenges

External funding

Workforce challenges

Sickness and absence rates

Industrial Action

Horizon Scanning

Further development of the Liverpool Neonatal Partnership.

Working with APH

Funding for BCG service

Recruitment and retention of all staff groups

Clinical Support Services Divisional Operational Plan on a Page 2023/2024

This plan outlines year 2 of the 5 year Divisional Transformation Plans in order to support delivery of the Trusts Vision, Aims and Ambitions

NHS
Liverpool Women's
NHS Foundation Trust

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

Activity and Finance:

Provisional CSS figures based on NHSE budget submission. £'s are not yet confirmed and signed off by Execs for 23.24.

Expenditure budgets:
Pay : £1,452k
Non – Pay : £1,199k
Total : £2,651k

Activity targets (excluding CDC):
Commissioner : £3,649k
Non-Commissioner : £346k
Total : £3,895k

CIP Identified:
Target: £1,200k
Income: £71k
Expenditure: £272k
Total : £343k

Quality, Safety and Patient Experience

The Division will ensure quality, safety, and patient experience is at the centre of our clinical decision making. Priorities for 2023/24 include:

All service areas to complete at least one QI project (registered with the Governance team) and will link more effectively with PALs and FFT for patient feedback across all departments.

To enhance quality of services at Crown Street by progressing the 24|7 Transfusion lab.

Implement service requirements in line with the national Clinical Genetics service specification and build links with LUFT to create clinical pathways for rare disease patients.

Strengthen the divisional governance structure by implementing recommendations of the self-assessment.

Implement the clinical and quality strategy actions plans for each service.

Developing and sustaining a culture of safety, learning, and support in accordance with the Three-Year Delivery Plan for Maternity and Neonatal Services (NHSE, 2023).

Review of dietetics service and SLA in line with National Standards for Food and Drink.

Review capacity for Emergency Gynaecology procedures and Cancer Pre-op Cancer Pathways.

Workforce, Diversity and Leadership

The Division will continue to deliver the Trust people strategy and develop a fair and just culture in all areas of the Trust. In 2023/24 this will be supported by:

Explore rotational posts key clinical areas.

Encourage leadership and management responsibilities and develop staff across all layers of the division to enrol in leadership development opportunities.

Continue to implement actions identified at the Imaging and Anaesthetic away days.

Grow the medical workforce in Anaesthetics and embed the specialty and specialist roles.

Implement a workforce model for the CT & MRI service.

Review of establishment and skill-mix for all services in response to the latest demand and capacity modelling, with particular focus on imaging, pre-op and theatres.

Rollout of new Health and Care Professional Council (HCPC) standards of conduct.

Digital Enablers

Support the implementation of DigiCare

All departments to have a dedicated page on the staff intranet.

Electronic Resus training booking system to be created and implemented.

To create new process for monitoring pathology activity to support contract management.

To expand KPI monitoring and waiting list oversight for imaging, anaesthetics and pre-op departments.

To explore innovative digital pre-op solutions for improved triage and to support capacity and demand.

Estates Strategy

Develop the 24|7 LCL Transfusion lab.

Joint working with Gynaecology to identify space for the pre-op department in the ambulatory redesign.

Establish a location for residential x-ray on-call.

Key Performance Indicators

Reduce 52-week waits in year and restore the diagnostic waiting times to pre-pandemic, achieving the national target of 95% DM01 for Imaging by March 2024.

To achieve 85% capped utilisation in theatres.

Benchmark DNA rates, increase PIFU and clinical utilisation.

Increase and sustain mandatory training and appraisal compliance to achieve the Trust target of 95% and 90% respectively.

Clinical governance KPIs: LOCSSIPs, SUIs, Never Events, complaints, incidents and FFT.

90% To Take Home (TTO) dispensing within 2-hours and 75% outpatient dispensing within 30-minutes.

Partnerships

Liverpool University Hospitals NHS Foundation Trust
Liverpool Heart and Chest NHS Foundation Trust
Alder Hey Children's Hospital NHS Foundation Trust
The Walton Centre NHS Foundation Trust
Clatterbridge Cancer Centre
Liverpool Clinical Laboratories
NHS Blood and Transplant
NW Genomic Medicine Service Alliance & NW Genomic Laboratory Hub
CAMRIN
C&M Pathology Network
Wirral University Teaching Hospitals NHS Foundation Trust
Gynaecology and Family Heath divisions.
Cheshire and Merseyside Integrated Care Board.

Risks to Delivery

Challenging financial environment and the impact on recruitment and retention.

Regional funding uncertainty regarding the CDC and the dependency on regional Trust SLAs.

Workforce recruitment gaps due to regional demand for qualified staff.

Clinical retention risk due to limited specialties available.

Uncertainty of Genetics funding and service specification requirements.

Delivery of quality and service improvement projects.

SLAs, contract management and dependency on external providers.

Horizon Scanning

Joint working across the region to create a sustainable working model for the CDC as new CDCs are onboarded across C&M.
Lead on the Perinatal Pelvic Health Service project across C&M.
Genomics Service Specification soft launch in Q1.
Consider the future implementation of dispensing within the Pharmacy department and the wider hospital.

Gynaecology: Operational Plan on a Page 2023-4

This plan outlines year 1 of the 5 year Divisional Transformation Plans in order to support delivery of the Trust's Vision, Aims and Ambitions

NHS
Liverpool Women's
NHS Foundation Trust

Activity and Finance

In 2023/24 we will:

Continued improvement of elective and cancer waiting times.

Working towards the delivery of the divisions activity plan (106% of 19/20 activity)

5% CIP delivery.

We will focus on the delivery of "Model Hospital" data with the aim of being within the top quartile for the divisions relevant areas.

We will review the financial opportunity for the Hewitt Centre

Expand the ambulatory estate to meet future demand.

Service Line Reporting review

We will explore new areas for growth including bidding for additional NHS activity.

Quality, Safety and Patient Experience

The Trust will improve quality safety and patient experience by implementing our quality strategy. IPC will continue to be at the centre of our clinical decision making

Review and enhance the Robotic Gynaecology service
Deliver on multiple key QI projects by directorate in 2022/24
Maintain accreditation for Fertility services and deliver BSGE accreditation
CQC action plan
Improve Gynaecology Cancer services in C&M by reviewing the Optimal Gynae Cancer Pathway
Ensure all wards and key areas maintain their current ward accreditation
Invite patients representatives to appropriate divisional forums
Review out of hours service provision

Workforce, Diversity and Leadership

Health and Wellbeing will be an objective in every manager's PDR.
Develop a robust succession plan for aspiring leaders and clinical staff
Critical nursing roles – robust succession planning
Promote the services and achievements from within the Division
Further integration of Hewitt into the Divisional structure.
Establish closer working cross divisionally
Closer divisional relationships with EDI and OD colleagues

Enablers

Digital Programme (Digicare and Ideas)
Estates Review (consolidation of estate where possible)
Robust data to make informed decisions

Risks to Delivery

Recruitment and retention of staff
Operating within the agreed financial envelope
Staff unable to provide WLI activity
Increased referrals – 2ww
Scanning competencies / capacity
Insufficient junior medical cover.
Industrial action
Implementation of Digicare

Key Performance Indicators

We will eliminate 65 week waits in year with a plan to reduce the current number of patients waiting longer than 52 weeks by 50%, by March 2024

We will improve compliance against the Diagnostic 6 week target, with an ambition to achieve 95% compliance by March 2024, supported by the development of the CDC

We will return to pre pandemic levels for the number of patients waiting more than 62 days for Cancer treatment, working with our partners in the system

We will improve compliance against the 75% faster diagnostic target, with an ambition to achieve 70% by March 2024, aiming to achieve the 75% target by March 2025.

We will aim to improve all HR KPI's as part of a "Well Led" division.

We will deliver the divisional CIP target

Continued full focus on quality/Patient safety KPIs

Partnerships

Our key partnerships for 2023/24 are listed below. Collaboration will be vital to develop our services

Health Education England to support Recruitment and Retention of key roles
Liverpool University Hospitals
The Cheshire and Mersey Cancer Alliance
WHAM
Cancer Alliance

Estates Strategy

Ambulatory Expansion Programme
Equipment Replacement programme
GED and EPAU relocation
Outpatient Transformation Programme

Horizon Scanning

Recruitment and retention of all staff groups
Review of Directory of Services (DoS)
Work towards 5 year Gynaecology and Hewitt Divisional strategy

Hewitt Fertility Centre : Operational Plan on a Page 2023-24

This plan outlines year 2 of the 5 year Divisional Transformation Plans in order to support delivery of the Trust's Vision, Aims and Ambitions

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

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Activity and Finance

In 2023/24 we will:

Focus on the financial opportunity for the Hewitt Centre including:

Close monitoring of contracts and SLAs to ensure timely invoicing and follow up of non-payment.

Review of all contracts to ensure appropriate KPIs are agreed and are being achieved.

To carry out financial modelling of all additional/add-on services offered to patients to ensure charges cover base costs.

To benchmark all prices against equivalent providers and to continue with regular review.

To achieve all planned CIP targets:

We will focus on maximising capacity and improving activity by reviewing private and NHS pathways and ensuring they are efficient, streamlined and cost-controlled.

We will explore new areas for growth including bidding for additional NHS activity.

Quality, Safety and Patient Experience

The Trust will improve quality safety and patient experience by implementing our quality strategy. IPC will continue to be at the centre of our clinical decision making

Maintain accreditation for Fertility services (HFEA)
maintaining UKAS accreditation for diagnostic semen analysis
Deliver on multiple key QI projects in 2023/24
Ensure HFC wards and key areas start the BBAS ward accreditation process.
Patient involvement for feedback for digital programs
Patient representative on HFC management meetings
TMMR equipment

Workforce, Diversity and Leadership

We will continue to deliver our people strategy and develop our fair and just culture in all areas of the Trust. In 2023/2 this will be supported by:

Critical fertility specialist nursing roles – for nursing leaders to complete a comprehensive TNA and implement robust succession planning.
BBAS ward accreditation to be achieved.
Ongoing review of 12-day working and development of business case to ensure the appropriate number of scientists to cover 7 day working.
Closer divisional relationships with EDI and the development of an EDI forward plan for HFC.
Health and Wellbeing will be an objective in every manager's PDR.
Creating an innovative operational service manager role to encompass patient engagement, comms and EDI.
Further development of transgender patient pathway, working with local LGBTQ+ groups

Key Performance Indicators

We will continue to improve pregnancy outcomes against national standards.

We will improve compliance against the Diagnostic 6 week target, with an ambition to achieve 95% compliance by March 2024.

We will aim to improve all HR KPI's as part of a "Well Led" division.

We will deliver the divisional CIP target.

Digital Enablers

Digital transformation programme.
Launch of IDEAS patient portal.
Operationalise business case for e-consent.
Business case for SMARTS (digital data analytics portal).
Digicare go-live
Enhanced Social Media Usage
Increase virtual consultations (Attend Anywhere)

Risks

Operating within the agreed financial envelope
Scientific workforce - working patterns, staff numbers, recruitment and retention issues and capacity
Nurse Staffing- Capacity and Capability of a specific skill set, recruitment and retention.
Sonography recruitment/ competencies / capacity
Incomplete and untimely reporting of live patient data to new HFEA data registry (PRISM) via third-party IDEAS fertility database

Partnerships

Our key partnerships for 2023/24 are listed below. Collaboration will be vital to develop our services
HFEA
Health Education England to support Recruitment and Retention of key roles and training of ANPs.
WHAM
Lloyds pharmacy
Wrightington, Wigan and Leigh NHS Foundation Trust
CMagic

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/093*	Date: 13/07/2023		
Report Title	Director of Infection Prevention & Control – Annual Report 2022/23			
Prepared by	*Dr Tim Neal, Director of Infection Prevention and Control (DIPC)*			
Presented by	*Dr Tim Neal, (DIPC)*			
Key Issues / Messages	The report provides the performance related to Infection Prevention & Control and exception reporting during 2022-23 The Trust's objective was met in respect of MRSA bacteraemia and *Clostridioides difficile* infection The Trust exceeded the nationally set trajectory in respect of Gram-negative bacteraemia			
Action required	Approve ☒	Receive ☐	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is requested to approve the report and agree its publication			
Supporting Executive:	Dianne Brown, Chief Nurse			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☐

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
IPC Group	02/06/23	Dianne Brown	Approved
Safety & Effectiveness Group	12/05/23	Chris Dewhurst	Approved
Quality Committee	26/06/23	Dianne Brown	Approved

Liverpool Women's
NHS Foundation Trust

Infection Prevention & Control Annual Report 2022 - 2023

Dr Tim Neal, Director of Infection Prevention & Control

Contents Page

TABLE OF ABBREVIATIONS

ANTT	Aseptic Non Touch Technique
CPE	Carbapenamase-Producing Enterobacteriales
CQC	Care Quality Commission
DIPC	Director of Infection Prevention and Control
HCA	Health Care Act
HCAI	Health Care Associated Infection
HII	High Impact Intervention
ICB	Integrated Care Board
IPC	Infection Prevention & Control
IPCG	Infection Prevention and Control Group
IPCN	Infection Prevention and Control Nurse
IPCT	Infection Prevention & Control Team
IPS	Infection Prevention Society
KPI	Key Performance Indicator
LWFT	Liverpool Women's NHS Foundation Trust
MMG	Medicines Management Group
MRSA & MSSA	Meticillin Resistant (Sensitive) Staphylococcus Aureus
NICERS	New Infection Control environmental reporting system
NICM	National Infection Control Manual
NLMS	National Learning Management System
NUMIS	Nursing & Midwifery Information System
OLM	Oracle Learning Management System
SI	Serious Incident
SEC	Safety and Effectiveness Committee
SWSG	Strategic Water Safety Group
SSI	Surgical Site Infection
TNA	Training Needs Analysis
UKHSA	UK Health Security Agency (previously Public Health England)

1 Summary of Key Achievements and Main Findings

1.1 Key Achievements 2022 - 2023

The Trust was compliant with the prescribed C.*difficile* and MRSA bacteraemia targets

Table 1: Trust Attributable Infections

Organism	Target/Trajectory	April 2021 - March 2022	April 2022 - March 2023
Clostridioides difficile infection	0	0	0
Staphylococcus aureus Sepsis			
MRSA	0	0	0
MSSA	Adult = 0 (local target) No target for NICU	1	1
Gram-negative Sepsis			
E.coli sepsis	5	4	9
Klebsiella spp	1	0	2
Pseudomonas aeruginosa	0	0	0

1.2 Main Findings

The IPCT has supported the Trust in the aftermath of the global Covid-19 pandemic along the Government's 'Living with Covid' strategy. The Trust has met it's key IPC metrics (*C.difficile* infection & MRSA bacteraemia) but exceeded *E.coli* and *Klebsiella spp.* trajectories.

1.2.1 Education

The IPCT has maintained current induction and mandatory training.

1.2.2 Guidelines

A Quality Improvement project was undertaken to reduce the total amount of IPC SOP's from 27 to 18, a new SOP was created – 'Common Infectious Agents in Hospital Patients'.
The IPC Team reviewed the national IPC Manual (released January 2023) and incorporated this into Trust policies.

1.2.3 Infection Prevention and Control Audits and Clinical Practice Audits

55 (100%) Infection Prevention and Control Audits were completed in accordance with trust plan.
600 (86 %) clinical practice ward audits (including 5 moments for hand hygiene and local environment audits) have been completed in accordance with the Trust plan.

1.2.4 MRSA

50 adult patients were identified in the Trust with MRSA, 43 (86%) were identified by pre-emptive screening, three neonates were identified with MRSA colonisation.

1.2.5 C. difficile

There have been no Trust acquired *C.difficile* infections in 2022-23 (Target = zero)

1.2.6 Bacteraemia

There have been no MRSA bacteraemias in 2022-23

There was 1 neonatal MSSA bacteremia in 2022-23, (1 Trust Attributable)

10 neonates had significant Gram-negative sepsis (5 congenital) and 6 neonates had significant Gram-positive infections (4 congenital).

There were 13 *E. coli* bacteraemias in 2022-23 (9 Trust attributable).

There were 3 *Klebsiella spp* bacteraemias in 2022-23 (2 Trust Attributable)

There were no *Pseudomonas aeruginosa* bacteremias in 2022-23

1.2.7 Surgical Site Infection Surveillance

Given the static nature of the wound infection rate over several years, and the favourable Trust position when benchmarked against other organisations in the national GIRFT survey, a decision was taken to reduce continuous prospective wound surveillance as SSI rates for Maternity and Gynaecology divisions remained between 2-3%, being lower than the 5% Trust target.

2 Infection Prevention & Control Team Members

Miss K Boyd
Infection Prevention & Control Analyst (part time 0.80 WTE - 30 hours/week Infection Prevention and Control Analyst, 0.20 WTE - 7.5 hours/week Policy Officer for the Governance team)
Dr T J Neal
Consultant Microbiologist – Infection Prevention & Control Doctor and Director of Infection Prevention and Control (DIPC) (2 sessions / week worked on LWFT site)
Mrs Anne-Marie Roberts
Infection Prevention and Control Practitioner (1 WTE – 37.5 hours)
Mrs Eleanor Walker
Infection Prevention and Control Neonatal Nurse (0.40 WTE – 15 hours)
Ms Jenny McLaughlin
Infection Prevention and Control Nurse (0.80 WTE – 30 hours)

The IPCT is represented at the following Trust Groups and Committees:

Huddle	Daily
Covid-19 Oversight Meeting	Weekly
Covid-19 Command meetings	Weekly
Safety and Effectiveness Committee	Monthly
Infection Prevention & Control	Quarterly
Water Safety Group	Quarterly
Strategic Water Safety Group	Quarterly
Medicines Management	Monthly
PLACE	Ad-hoc
Building Planning	Ad-hoc
Health and Safety Committee	Quarterly
Nursing and Midwifery Forum	Monthly
Maternity Quality Meeting	Monthly
Education Governance Meeting	Quarterly
Cleaning National Standards	Ad Hoc
Matrons Group	Quarterly
Cleaning / AUDIM audits	Weekly
Medical Devices Meeting	Monthly

The Team is managed by the Deputy Director of Nursing and Midwifery.

There are no Trust costs associated with the Infection Prevention and Control doctor and DIPC.

3 Role of the Infection Prevention & Control Team

The following roles are undertaken by the IPC team: -

- Education
- Surveillance of hospital infection
    - Surgical Site data collection
    - National bacteraemia data reporting
    - PHE data reporting
- Investigation and control of outbreaks
- Development, implementation and monitoring of Infection Prevention and Control policies
- Audit
- Assessment of new items of equipment
- Assessment and input into service development and buildings / estate works
- Patient care/ incident reviews

Infection Prevention and Control advice is available from the Infection Prevention & Control team and 'on-call' via the DIPC or duty Microbiologist at Liverpool University Hospitals NHS Foundation Trust

4 Infection Prevention and Control Group

The IPC Group meets quarterly and is chaired by the Chief Nurse. The group receives regular reports on Infection Prevention and Control activities from clinical and non-clinical divisions/departments.

Reports received include those from:

- Estates and Operational Services
- Health and Safety
- Occupational Health
- Decontamination
- Divisions/departments
- Link Group
- Water Safety group
- Infection Prevention and Control team members

The Terms of Reference of the IPCG are included as **Appendix A**

The IPCT report quarterly to IPCG and the DIPC reports quarterly to SEC which also receive a ‘Chair’s Report’ from the IPCG meetings. The Quality Committee receives minutes from SEC. The Trust Board also receives an annual presentation and report from the DIPC.

Trust IPC issues, processes and surveillance data are relayed to the public via Infection Prevention and Control posters, patient information leaflets, the Trust website (copy of this report) a notice board in the main reception, which is updated monthly, and departmental notice boards in ward areas.

Throughout the year many changes in practice have been initiated, facilitated, supported or mandated through the work of the IPCT and IPCG. Some of these are on a large scale, such as input of the IPCT into large capital projects undertaken by the Trust (see section 8.2) however many appear smaller and take place in the clinical areas as a consequence of audit, observations and recommendations. These interventions equally contribute to the provision of clean and safe care in the organisation. The IPCT examined its effectiveness throughout the year. The following detail some of the changes facilitated throughout the year.

5 External Bodies

5.1 Health Care Act & Care Quality Commission

The Health Care Act (HCA) was published in October 2006 and most recently revised in December 2022. This code of practice sets out the criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean environment where the risk of HCAI is kept as low as possible.

The Health Care Act action plan is a standing item on the IPCG agenda.

5.2 Integrated Care Board (ICB) Assurance Framework

Assurance data is reported monthly to the ICB and Quarterly at IPCG, it incorporates performance data, exception reporting, audit data and screening compliance.

5.3 Mandatory Surveillance

The Trust submits data on MRSA, MSSA, *E.coli, Klebsiella spp*. and *Pseudomonas aeruginosa* bacteraemia and *Clostridioides difficile* infections by the 15th day of each month to the UKHSA via an online Health Care Associated Infection Data Capture System. HCAI data is also submitted each month for the Trust Quality Report and Corporate Information.

6 Education

6.1 Mandatory training and Induction:

Mandatory training in Infection Prevention and Control is a requirement for all Trust staff including clinical, non-clinical staff and contractors. The IPCT review the training package annually and ensure that it reflects best practice, national recommendations and issues identified as non-compliant in the previous year. All staff receive training in Infection Prevention and Control every three years via electronic learning. The electronic package is incorporated into the NLMS and linked to OLM.

Training continues to be provided by the IPCT for medical staff which includes consultants, trainees and ad-hoc mandatory training for corporate services. Four formal teaching sessions have been delivered by the DIPC throughout 2022-23

The IPCT has provided four IPC training sessions in 2022-23

Although the majority of mandatory training is delivered by the IPC team a number of Link Staff also provide training including hand hygiene within their areas.

In 2022-23 the IPCT introduced a monthly ‘Bug-Bulletin’ as a mechanism of communicating relevant and topical IPC issues to staff.

The DIPC contributes monthly to the Trust 'Safety Check-In' programme highlighting issues of importance to IPC and impacting patient safety.

6.2 Link Staff

The IPC link staff meeting was held once this year at the end of the Professional Development day. The programme is organised to reflect current initiatives, implementation of new guidance and reinforcement of any non-compliance relating to IPC. The number of attendees was 10, Link Staff meetings and Professional Development days are included in the TNA provision for Link Staff and will be twice yearly moving forward.

6.3 ANTT Training

Sixteen ANTT training sessions were provided in 2022-23 by the Infection prevention and control team. Each department has ANTT assessors who have been trained to assess ANTT in clinical practice. ANTT was added to the core clinical competencies and ANTT e-learning training and assessment in clinical practice. Results of ANTT training and assessment can now be viewed on Power BI. ANTT training and assessment was streamlined for all clinical staff to yearly training and assessment. In 2022 ANTT assessment was added to the Clinical Corporate mandatory training days.

6.4 Guidelines/Policies

The below Policies SOP have been reviewed in line with the Trust policy process, one document has been created to amalgamate 8 other SOP's.

- PPE quick reference SOP
- Aseptic Non-Touch technique SOP
- Use and Disposal of Sharps SOP
- Seasonal and Pandemic Influenza SOP
- Management of Known Suspected or at Risk Creutzfeldt Jacob Disease SOP
- Prevention of Wound Infections SOP
- Personal Protective Equipment SOP
- Peripheral Cannula and Ongoing Care SOP
- Management of Inpatients with Vial Infection rashes SOP
- Linen SOP
- Isolation and Barrier Nursing SOP
- Effective Hand Hygiene SOP
- Communal Refrigerator in healthcare Settings SOP
- MRSA Policy
- Management of Diarrhoea caused by Clostridioides difficile Policy
- Common Infectious agents in hospital patients
- Use of Portable Electric Fans
- Infection Prevention and Control Policy

A new 'National Infection Control Manual' was published by NHS England in January 2023. It is expected that this document is incorporated into (or replaces) local policies. The IPCT have reviewed the NICM and will reflect the contents of this in Trust policies as they are updated.

7 Audits

7.1 ICNA Trust audit programme

The IPCT continue to use the updated IPS audit tools. The audit programme for the year is established and agreed by the IPCG.

From 1st April 2022 the IP&C clinical practice and hand hygiene audits were redesigned and incorporated into the Liverpool Women's Nursing & Midwifery audit system. Local IPC hand hygiene and Environment audits are completed monthly. Matrons complete monthly audits of clinical areas and IPC KPI's are audited within the monthly KPI audit. IPCT assist in undertaking the overarching BBAS audits.
Results from this new audit system feed into Power BI and will be included in divisional reports.

300 Hand Hygiene audits (85%) have been carried out by ward department staff and have been reviewed by the IPCT with audit range 73-100%. 300 (86%) local IPC environment audits have been carried out by ward department staff with scores range from 60-100%.

The Infection Prevention and Control environmental audits are carried out a minimum of twice a year in each clinical area unannounced by the IPC team. A total of 55 Infection Prevention and Control audits in 23 clinical areas have been undertaken.
2022-2023 IPC audit scores range from 62- 100%
In all instances deficiencies identified through the audit programme generate an action plan which is monitored via Divisional reports to IPCG.

7.2 Mattress audits

Mattress audits are completed in all areas in the Trust. The audit examines cleanliness and mattress integrity.
49 mattress audits were completed by departments during 2022-2023 (652–individual mattresses audited) with scores ranging from 60-100%. Results are available on Power BI and reported through the Divisional report to IPCG. Local areas have ownership for replacement and condemning of any mattress not fit for purpose. There is a system in place for the provision and storage of replacement mattresses across the Trust.

8 Antimicrobial Stewardship

The organisation reports on antimicrobial issues via the Trust Medicines Management Group (chaired by the Deputy Chief Pharmacist). The DIPC is a member of the MMG and there are named pharmacists who lead on antimicrobial issues.

Point prevalence audits on antimicrobial usage are undertaken quarterly across the maternity & gynaecology divisions based on NICE guideline NG15. The audit includes:

NICE recommendation 1.1.24 - *When prescribing antimicrobials, prescribers should follow local (where available) or national guidelines on the most appropriate dose and route of administration*.

NICE Recommendation 1.1.26 - *When prescribing any antimicrobial, undertake a clinical assessment and document the clinical diagnosis (including symptoms) in the patient's record and clinical management plan.*

NICE guideline 1.1.24 - *When prescribing antimicrobials, prescribers should follow local (where available) or national guidelines of prescribing the shortest effective course*

Results

Indication documented on electronic prescribing system: 100%
Duration documented on electronic prescribing system: 100%

Results are distributed via Combined infection meeting, Medicines Management and Maternity Clinical meetings. Education for prescribers is disseminated via antimicrobial prescribing talk and Trust induction. Midwifery and nursing feedback is disseminated via the individual area matrons.

The Trust antimicrobial formulary is updated regularly, in conjunction with the DIPC, and taking account of microbial epidemiology. Adherence to formulary recommendations is audited quarterly

88% of antimicrobials prescribed are in line with formulary recommendations

9 Infection Prevention and Control and the Environment

9.1 Water Safety

The Trust has a local Water Safety Group which meets quarterly to assure compliance with the Trust Water Safety Plan (planned preventative maintenance, flushing compliance, rectification of system defects and surveillance). In addition to reporting to the Trust IPC Group the WSG reports to a regional strategic WSG chaired by the DIPC and attended by the Independent Authorising Engineer (water).

The average weekly water flushing compliance for 2022-23 was 93%.

Water sampling (surveillance) is undertaken in accordance with the timetable outlined in the water safety plan. Positive results are managed in accordance with national guidance.

9.2 Building Projects & Design Developments

The team remain reliant on the Estates department and the Divisions alerting and involving the team in impending projects via the Infection Prevention and Control group meetings.

2022-23 projects requiring IPC Team involvement included:

- Imaging / Colposcopy department – major refurbishment to move bone density room and colposcopy rooms and incorporate CT scanner / MRI Scanner
- Ongoing refurbishments following the Aintree Obstetric / Gynaecology Outpatient Department merge.

10 Surveillance of Infection

Hospital infection (or possible infection) is monitored in the majority of the hospital by 'Alert Organism Surveillance' this involves scrutiny of laboratory reports for organisms associated with a cross infection risk e.g., MRSA, *Clostridioides difficile* etc.

On the Neonatal Unit, which houses most of the long-stay patients, surveillance is undertaken by both ‘Alert Organism’ and by prospective routine weekly surveillance of designated samples. The IPCT examines results of these samples and action points are in place for the unit based on these results.

Surveillance of bacteraemias (blood stream infections) for both national mandatory and in house schemes is also undertaken. National mandatory reporting of blood stream infections includes *Klebsiella* and *Pseudomonas* in addition to *E.coli* and *S.aureus.*

10.1 Clostridioides difficile

Mandatory reporting of this disease commenced in January 2004 and includes all patients over 2 years old. Historically the number of cases at LWFT has been low. The prescribed trajectory for this disease for the Trust in 2022-23 was zero.

During the period April 2022 – Mar 2023 there were no patients identified with *C.difficile* infection in the Trust. The last reported positive *C.difficile* patient in LWH was in 2017-18

10.2 Bacteraemia Surveillance

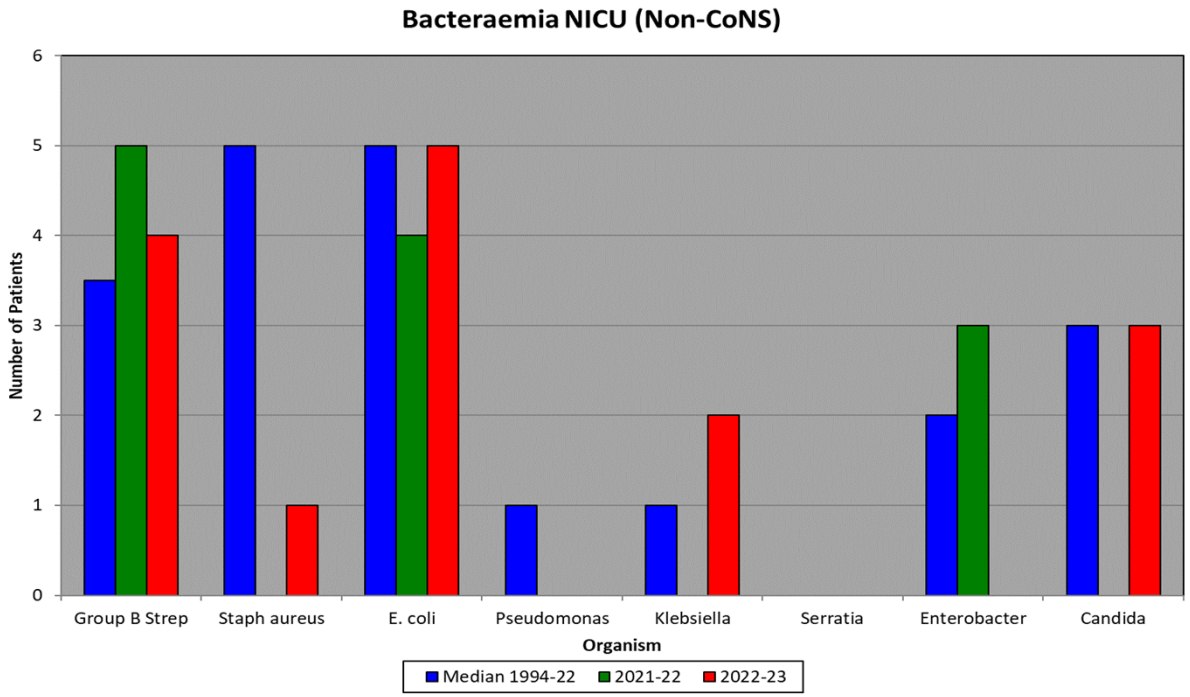
10.2.1 Neonatal Bacteraemia

As always, the commonest organism responsible for Neonatal sepsis was the common skin organism, coagulase-negative staphylococcus (CoNS). In the period April 2022 – March 2022 10 babies (13 in 2021-22 and 10 in 2020-21) had infections with Gram-negative organisms, 5 of these infections (3 *E. coli*, 1 *Haemophilus influenzae* and 1 *Acinetobacter sp*) occurred in the first 5 days of life and were congenitally acquired. The remaining 5; (2 *E. coli,* 2 *Klebsiella spp* and 1 *Acinetobacter sp.*) occurred after 5 days of life.

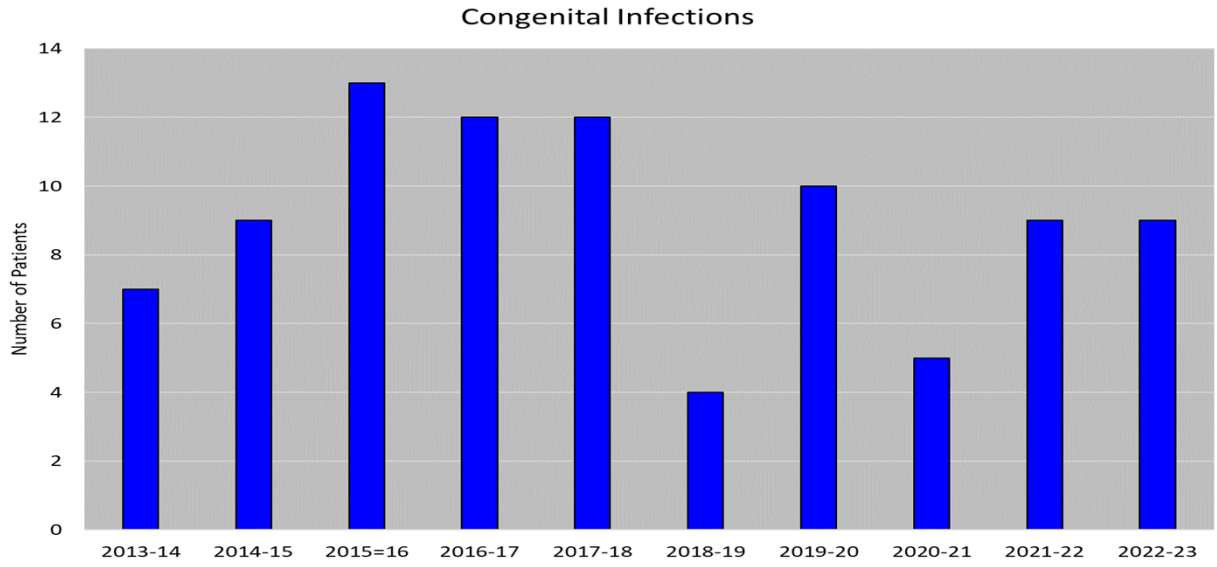
There were 6 episodes of infection with significant Gram-positive pathogens (7 in 2021-22 and 5 in 2020-21); 4 of these infections (3 Group B Streptococcus, and 1 *Listeria.*monocytogenes) were congenitally acquired and 2 (1 Group B Streptococcus and 1 *Staphylococcus aureus*) occurred after day 5.

All non-coagulase-negative Staphylococcal sepsis on the unit is subject to a review to determine the focus of infection, precipitating causes and the appropriateness of care.

The bar chart below describes the pattern of ‘definite-pathogen’ Neonatal bacteraemia in the current year in comparison to last year and the median value for each organism for preceding years. There is considerable variability in the figures from year to year (probably reflecting the complexity of pathogen host relationship in this group). Of note no Pseudomonas sepsis has been reported since 2017-18.



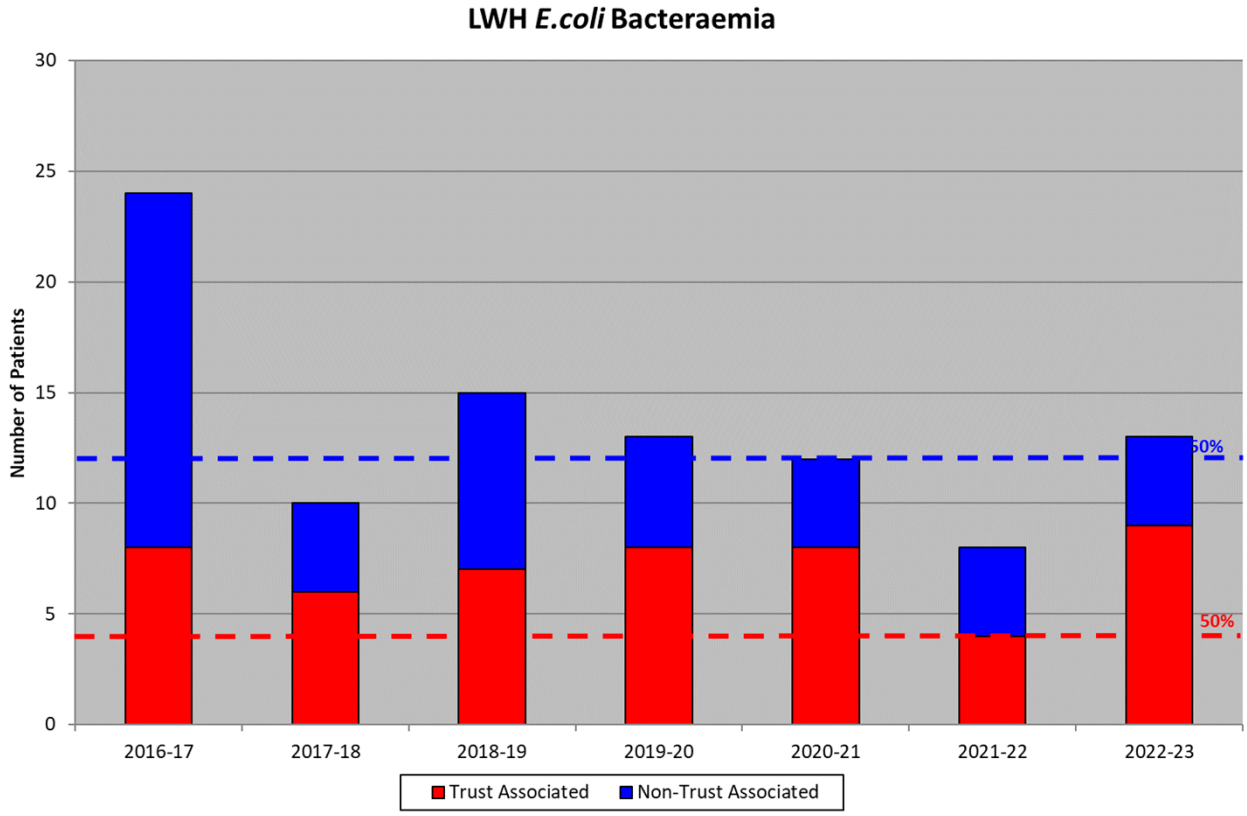
The IPCT have been monitoring the number of Neonatal infections classified as 'congenital' i.e., presenting in the first 5 days of life. 9 babies this year had congenital infection.



10.2.2 Adult Bacteraemia Surveillance

There have been no MRSA bacteraemias in adult patients in the period April 2022 to March 2023.

There is a national ambition to reduce Gram-negative bacteraemia (particularly *E.* coli) by 50%. Although this is not a specific Trust target the IPCT have been working with regional groups facilitated by the ICB to reduce *E. coli* sepsis. In 2022-23 the Trust reported 13 *E. coli* bacteraemias (9 Trust associated) compared to 8 in 2021-22 and 13 in 2020-21. Both the total number of *E. coli* bacteraemias and those categorised as Trust associated (defined by time from admission) have increased this year.



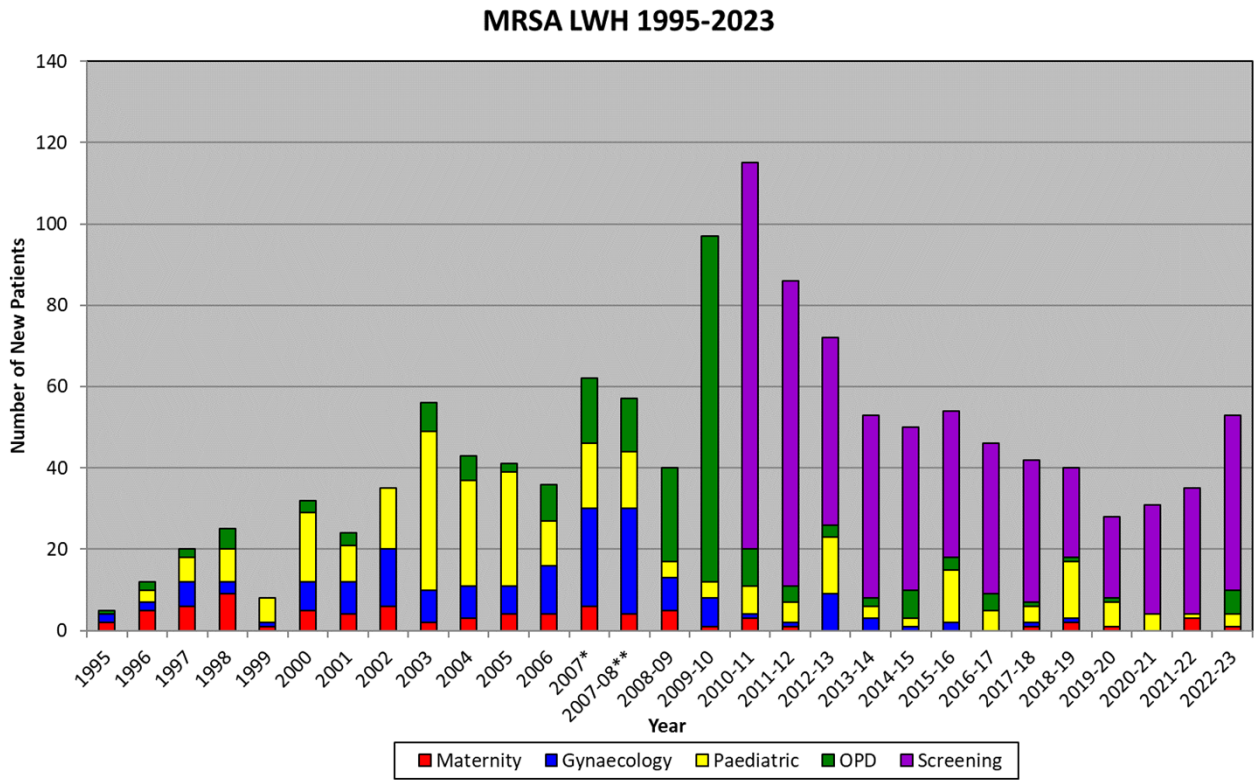
The Trust recognised the increase in cases and requested a 'Deep Dive' review of the 4 initial cases from the neonatal unit. That review did not identify any additional themes other than extreme prematurity. All adult cases were reviewed by a multidisciplinary team of clinicians, the reviews did not identify any preventable elements.

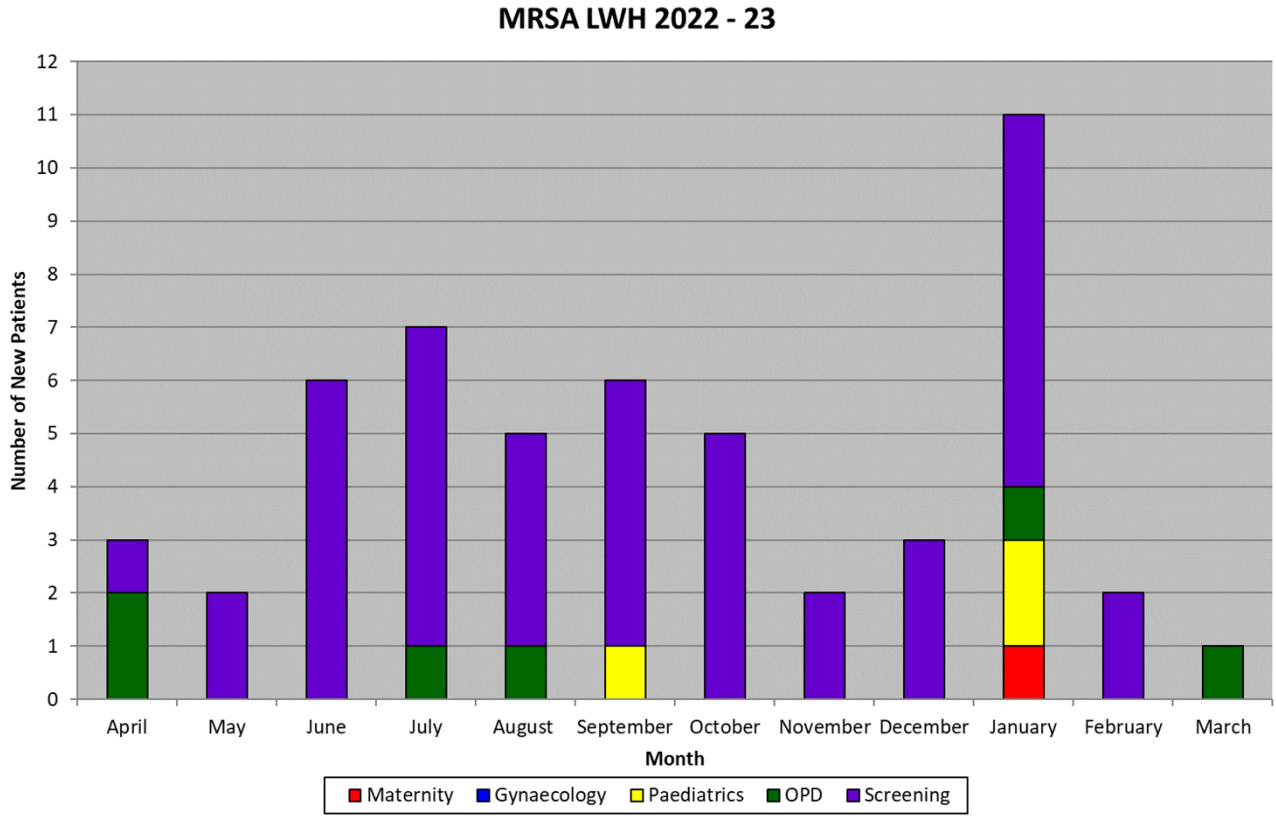
In addition to the mandatory surveillance the IPCT has been collecting clinical data on bacteraemic adults in the Trust; 27 patients were identified with positive blood cultures from 437 cultures submitted (6.2%). 13 (48% of positives, 2.9% of total) of these were contaminated with skin organisms.

10.3 Alert Organism Surveillance

10.3.1 MRSA

The total number of patients identified carrying MRSA in the Trust during the year 2022-23 was 53, representing a steady increase in numbers since 2019. Forty three of the 50 adult patients were identified by routine screening either on, or prior to, admission. Three unlinked patients (2 maternity and 1 gynaecology) had MRSA identified in wounds. The charts below show the number of new patients identified with MRSA and the annual totals for the period 1995 – 2023.





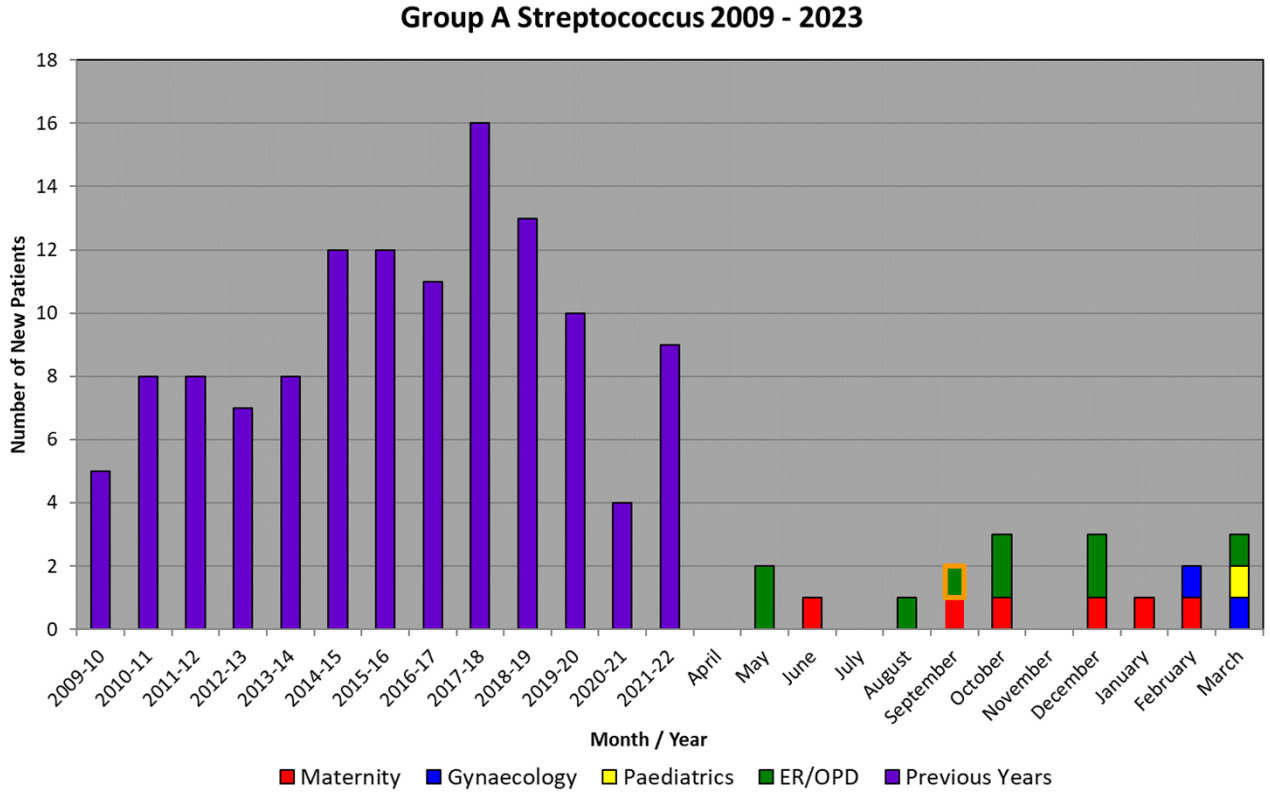
As outlined in previous Annual Reports the Government had established targets for screening such that all elective admissions and all eligible emergency admissions to hospital should be screened for carriage of MRSA.

In the period April 2022 to March 2023, 4315 adult patients were screened for MRSA carriage: 46 (1%) were positive.

During the period of this report 3 neonates was identified with MRSA no links were established between these cases.

10.3.2 Group A Streptococcus

In the period April 2022 to March 2023, 18 patients were identified with Group A streptococcus as detailed below. This is an increase on the number reported in 2021-22 and is consistent with a significant rise in Group A Streptococcal infections and Scarlet Fever recognised in the community. All patients with Group A Streptococcal infection are reviewed. One patient presenting to ER in September had Group A streptococcal sepsis (iGAS), review of this case identified good care and no preventable factors. The majority of other patients had genital tract infection.



10.3.3 Carbapenemase Producing Enterobacteriales

The Trust had no new cases of CPE in 2022-23. There were two patients known to be CPE positive admitted to the Trust in 2022-23.

10.3.4 Covid-19

2022-23 saw continued Covid-19 activity however the success of the vaccination programme and changes in the virus lessened the clinical impact of the disease. Nationally, and locally, there were small peaks in prevalence in July, October and December 2022.

In 2022-23 the Trust managed 75 patients with Covid-19 infection. There were no hospital acquired cases.

Guidance on testing patients has changed throughout the pandemic and in July 2022 was reduced to symptomatic patients only. The IPCT have worked with the Trust to implement new guidance on testing and infection control precautions as the pandemic has progressed.

10.4 Routine Neonatal Surveillance

Nearly all infection on the Neonatal unit is, by definition, hospital acquired although a small proportion is maternally derived. Routine weekly colonization surveillance has continued this year on the Neonatal unit. Results are shown in Appendix B

As colonisation is a precursor to invasive infection the purpose of this form of surveillance is to give an early warning of the presence of resistant or aggressive organisms and to ensure current empirical antimicrobial therapy remains appropriate. Action points are embedded in the Neonatal unit and IPC policies linked to thresholds of colonisation numbers to limit spread of resistant or difficult to treat organisms.

As well as resistant or aggressive organisms focus has remained on both *Pseudomonas aeruginosa*. and *Staphylococcus aureus* as potential serious pathogens. The median number of babies colonized with *Pseudomonas* each week was 0, and with *S.aureus* was 2 (both metrics decreased from last year).

10.5 Surgical Site Surveillance

Potential Surgical Site Infections are discussed at monthly review meetings where any themes are highlighted and fed back to Divisions through 'Lessons of the week' information.

Given the static nature of the wound infection rate over several years, and the favourable Trust position when benchmarked against other organisations in the national GIRFT survey, a decision was taken to reduce continuous prospective wound surveillance

Wound infections are discussed at monthly review meetings where any themes are highlighted and fed back to Divisions through 'Lessons of the week' information.

From coding data the Trust SSI rates for the period 01.04.2023 – 31.03.23 is 3.5%, lower than the 5% Trust threshold.

11 Health & Wellbeing

The Trust Health & Wellbeing Department report monthly to the IPCG including vaccination updates. Staff have historically been screened for TB, Hepatitis B and Rubella immunity. Guidance on Measles, Chicken pox, HIV and Hepatitis C have been incorporated for all 'new starters' and a catchup exercise is in place for staff already employed. The IPCG supports the Health & Wellbeing team in ensuring that workers in designated areas have appropriate vaccinations and immunity.

12 Infection Control Team Work Plan

12.1 Infection Control Team Work Plan 2022-23

Work Plan	Completion Date	Comments
Covid-19 Planning		Section 9.3.4
• Advise and support management and care of patients with Covid-19	Ongoing	Completed
• Work within Trust structures to support the Trust reset plan and 'Living with covid' guidance	Ongoing	Completed
• Maintain and update the Board assurance framework related to Covid-19	Ongoing	Completed
Training		
• Continue all Trust mandatory & induction training	Ongoing	Section 6
• Review and continue to support IPC Link staff role and professional development	Ongoing	
• Link staff to be given allocated time and working alongside managers across the areas		
Audit		
• Continue to audit in line with the IPS Audit programme	Ongoing	Section 7
Reporting		
• Continue to support the new Trust wide audit programme	Complete	Section 7.1
• Investigate robust way of pulling CPE data	Complete	Section 9.3.3
Engage		
• Continue active engagement with Link staff, managers, and matrons	Complete	Section 6
• Encourage Link staff to accompany IPC Team on IPC environmental audits for professional development	Ongoing	
Surveillance		Section 9
• Continue 'Alert Organism' surveillance focused on resistant pathogens	Ongoing	
• Continue to monitor cases mandatorily reportable infections	Ongoing	
• Implement actions identified through RCA of bacteremia's and C.difficile infections	Ongoing	
• Work with the CCG and Trust Sepsis lead to deliver their target reduction in Gram-negative sepsis.	Ongoing	

Health Act & NICE • Review compliance and evidence • Review and ensure Trust maintains its compliance with current NICE guidance relating to infection, infection control, sepsis and antimicrobial stewardship.	Ongoing Ongoing	Section 5.1

11.2 Infection Control Team Work Plan 2023-24

Work Plan	Completion Date	Comments
Training • Provide Trust mandatory & induction training • Review and continue to support IPC / ANTT Link staff role and professional development •		
Audit • Continue to audit in line with the IPS Audit programme • Support BBAS accreditation audits • Support CQC mock assessments		
Reporting • Continue to support and monitor the nursing & midwifery local audit programme		
Engage • Continue active engagement with Link staff, managers, and matrons • ~~Encourage~~ Provide opportunities for Link staff to accompany IPC Team on IPC environmental and BBAS audits for professional development		

Surveillance • Continue 'Alert Organism' surveillance focused on resistant pathogens • Continue to monitor cases mandatorily reportable infections • Implement actions identified through RCA of bacteremia's and *C.difficile* infections • Work with the CCG and Trust Sepsis lead to deliver their target reduction in Gram-negative sepsis. • Work with Pharmacy Lead / clinical divisions to deliver the CQUIN03 target for 2023/23 of prompt IV to oral switch Support and expand on the collaboration with pharmacy to support the AMR agenda		
Health Act & NICE • Review compliance and evidence in IP&C Board assurance framework • Review and ensure Trust maintains its compliance with current NICE guidance relating to infection, infection control, sepsis and antimicrobial stewardship.		

13 Appendices

13.1 Appendix A – Terms of Reference - Infection Prevention and Control Group Terms

INFECTION PREVENTION AND CONTROL GROUP TERMS OF REFERENCE

Constitution:	The Group is established by the Effectiveness and Safety Committee and will be known as the Infection Prevention and Control group.
Duties:	The Group is responsible for: providing assurance to the Trust Board in relation to those systems and processes it monitors and ensure compliance with external agency's standards e.g.: CQC etc. 1. Agree and disseminate the systems and processes for effective Infection Prevention and Control. 2. Develop the strategic direction of Infection Prevention and Control, ensuring that the team is resourced sufficiently to achieve improvement in performance. 3. Review and approve the work of the Infection Prevention & Control team members in line with Trust objectives through the IPCC team work plan. 4. Review and endorse all policies relating to Infection Prevention & Control and evaluate their implementation. 5. Receive and review regular reports of infection incidents or outbreaks and ensure that reports are forwarded to appropriate external authorities. 6. Ensure that lessons identified from incidents, outbreaks, or reports from external organisations are actioned by relevant Divisions in the organisation. 7. Implement a regular reporting timetable including comprehensive Division reports and reports from support services at regular intervals. 8. Ensure that effective Infection Prevention and Control is being delivered in Divisions and monitor evidence of prevention and control practice. 9. Promote and facilitate the education of staff of all grades in hand hygiene Infection Prevention & Control and related topics Receive, discuss and endorse the annual Infection Prevention &

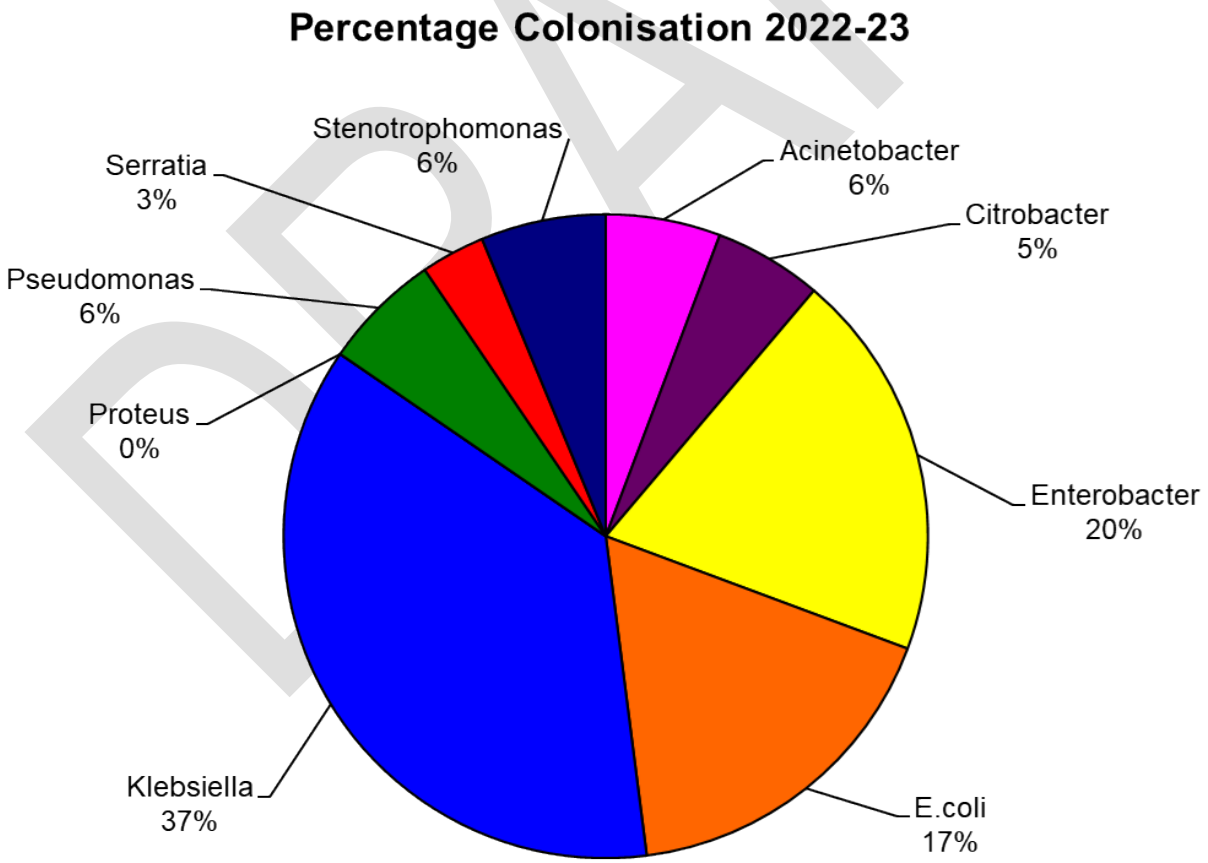
	Control report produced by the Infection Prevention & Control team prior to submission to the Effectiveness and Safety Committee and Trust Chief Executive.
Membership:	The Group membership will be appointed by the [Safety and Effectiveness Committee] and will consist of: • The Chair – Director of Nursing, Midwifery or Representative of CEO • Director of Infection Prevention and Control • Infection Prevention & Control practitioner • Trust Decontamination Lead • Representative of UKHSA • Estates or Patient Facilities Manager • Health and Safety Advisor • Occupational Health Nurse • Deputy Director of Nursing and Midwifery • Head of Nursing Gynaecology Division • Head of Midwifery Maternity • Head of Nursing Neonates • Head of Nursing Clinical Support Division • Antibiotic Pharmacist • Representative from Clinical Commissioning Group • Safety Lead from Family Health Division • Safety Lead from Gynaecology Division • Safety Lead from Clinical Support Division Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum
Quorum:	A quorum shall be 6 members including: Chair (or approved Deputy) IPCN or DIPC Representative from each Division Representative from Facilities Department
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. **b. Officers** Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies

	may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held [4] times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Group is authorised by the Effectiveness and Safety Committee to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Group.
Accountability and reporting arrangements:	The Group will be accountable to the Effectiveness and Safety Committee The minutes of Group will be formally recorded and submitted to the Effectiveness and Safety Senate. The Chair of the Group shall draw to the attention of the Effectiveness and Safety Committee any issues that require disclosure to it or require executive action. The Group will report to the Effectiveness and Safety Committee annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Group.
Reporting Committees/Groups	The sub-committees/groups listed below are required to submit the following information to the Infection Prevention and Control Group: a) Chairs Report [and/or] minutes of meetings; and b) an Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • Local Water Safety Group • Link Staff Meeting / Professional Development Day
Monitoring effectiveness:	The Group will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Effectiveness and Safety Committee.
Reviewed by Infection prevention and Control Group:	29/04/2022
Approved by Effectiveness and Safety Committee:	IPC group
Review date:	April 2023

Document owner:	Dianne Brown, Chief Nurse Email: dianne.brown@lwh.nhs.uk Tel: 01517024010

13.2 Appendix B - Neonatal Colonisation Surveillance

Organism	2012-13	2013/14	2014/15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Acinetobacter	3	3	6	3	3	3	3	3	3	3	6
Citrobacter	6	4	3	4	7	4	6	3	4	6	5
Enterobacter	21	17	14	17	22	19	18	23	20	19	20
E.coli	20	30	27	21	22	28	23	20	26	18	17
Klebsiella	32	34	39	41	35	31	34	39	33	31	37
Proteus	3	1	1	1	1	1	0	2	1	1	0
Pseudomonas	11	5	4	3	3	4	6	3	5	7	6
Serratia	2	2	1	3	2	5	3	2	3	6	3
Stenotrophomonas	2	4	4	7	5	5	7	5	5	9	6



Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/094*		Date: 13/07/2023	
Report Title	Health and Safety Annual Report 2022/23			
Prepared by	Tracy Bryning, Health and Safety Manager			
Presented by	Gary Price, Chief Operating Officer			
Key Issues / Messages	Annual report to the Board for compliance and assurance.			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is asked to support the continuing development and promotion of a positive health and safety management system and culture and note the annual report for 2022/23.			
Supporting Executive:	Gary Price, Chief Operating Officer			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Health and Safety Group	27/04/23	A Hawksey	Accepted and approved
Quality Committee	26/06/23	A Hawksey	Accepted and approved

Liverpool Women's
NHS Foundation Trust

Health and Safety Annual Report 2022/2023

Tracy Bryning
Health and Safety Manager

22nd April 2023

Executive Summary

This report gives an overview of compliance and governance assurance regarding the health and safety arrangements, activities, performance, and improvements for Liverpool Women's NHS Foundation Trust (LWH) for the financial year 2022/2023.

The Health and Safety Team has grown through this financial year with the Patient Safety Manager being promoted to Head of Risk and Safety; a newly created band 3 administration post recruited to in May 2022 has proven to be of great value; a temporary band 5 Fit Mask Tester Coordinator joined the team in January 2023 and a highly qualified and experienced, part time band 7 Fire Safety Advisor joined the team in March 2023 in a job sharing arrangement (SLA) with Alder Hey Children's NHS Foundation Trust.

As in the previous reporting year, the Trust faced ongoing challenges considering the covid-19 pandemic, frequently responding to changing guidance and collaborations between the HSE, PHE, DHSC and TUC.

Actions have been taken to improve the Trust's fit mask testing resilience to align with the Department of Health and Social Care's (DHSC) mandated resilience principles for fit mask testing, provision and EPRR Standard 12. The challenge remains in releasing staff from clinical duties to complete testing, despite the Fit Mask Tester being placed in clinical areas and offering early and late appointment times. Whilst the Trust is not yet fully compliant considerable progress has been made in stabilising face fit mask testing facilities, supplies and engagement across the divisions.

Managers are responsible for the regular review, monitoring and updating of workplace risk assessments. Due to many pressures on staff in the past year, there remains a gap in managers completing annual workplace health and safety audits. This will be addressed by the introduction of the Ulysses Risk and Safety Management module in May 2023. The module will act as a repository for all workplace risk assessments and health and safety workplace audits and will reflect compliance across the Trust. There is a clear gap in managers knowledge of their health and safety duty and responsibilities which will be addressed by introducing additional inhouse training, workshops and access to a formal qualification in Managing for Safety.

There is an extensive work plan for health and safety; Section 10 reflects some of the higher priority plans for future improvements and activities, demonstrating the Trust's commitment to effective health and safety management and continuing improvements in health and safety performance.

There remains scope for improvement, particularly in relation to compliance with the overall organisation's safety management system, knowledge of duty and responsibilities, risk assessment/risk management, audit and communication.

Report

Key Objectives and Current Situation

1.1 Risk Assessments & Audits

i. Mandatory annual health and safety workplace assessments remain behind schedule.

ii. The deployment of the Ulysses Risk and Safety Management Module was delayed due to the covid-19 situation. This project was made a priority action for 2022/23. We were fortunate to be able to second a Band 6 Project Manager for a short period at the start of 2023, solely to work on developing and customising the module.

The benefits of this module include:

- Ulysses is fully supported by both I.T. and the Governance Risk Team
- All staff are familiar with its functionality
- There are no limits to user licences
- Training is fully supported
- It is fully customisable, and we could benefit from other users' development of the module and vice versa
- It can manage any of our risk assessments; staff will be able to use their existing log in detail to complete annual departmental audits and actions, risk assessments, etc.
- The module links to relevant incidents, risk register entries or risk assessments and provides an overall compliance dashboard
- Easy to interrogate from a reporting perspective and matches corporate reporting for incidents, risks, safeguarding, legal, alerts and complaints
- Reports will be available through Power Bi

iii. A fire risk assessment tool will also be created within the module early in the first quarter of 2023/24.

1.2 Fit Mask Testing

i. **Overview**

The Trust is required to meet its statutory health and safety duty and infection prevention and control duty, to meet the FFP3 Resilience Principles and fulfil the criteria required of EPRR Standard 12 – *duty to maintain plans/infection control: in line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.*

Staff undertaking aerosol generating procedures on patients with a confirmed or suspected respiratory infection should be face fit mask tested in line with current national practice.

The resilience principles for fit mask testing requires staff to be retested at two yearly intervals or when there is a significant change their face shape and to be successfully tested and have access to a minimum of two mask types, preferably three. There has also been a mandated requirement to be able to report on fit testing activity across the organisation. The Health and Safety Manager was invited to represent the Trust at the DHSC's national stakeholder group.

To facilitate fit mask testing, the Trust has been able to access support provided by the DHSC and has benefited from having an accredited fit mask tester on site 37.5 hours per week since January 2022. The placement ended in March 2023.

In January 2023, the Trust recruited a 25-hour bank Fit Mask Tester Coordinator who has been trained as an accredited Face Fit Mask Tester. The post holder has been able to streamline associated administration processes and work closer with managers and staff across the divisions, prioritising Anaesthesia and Theatres, NICU, HDU and midwives working on the Delivery Suite. Although these areas are prioritised, all clinical staff who request to be fit tested are given an appointment. Face fit mask tester is also applicable to Estates Technicians.

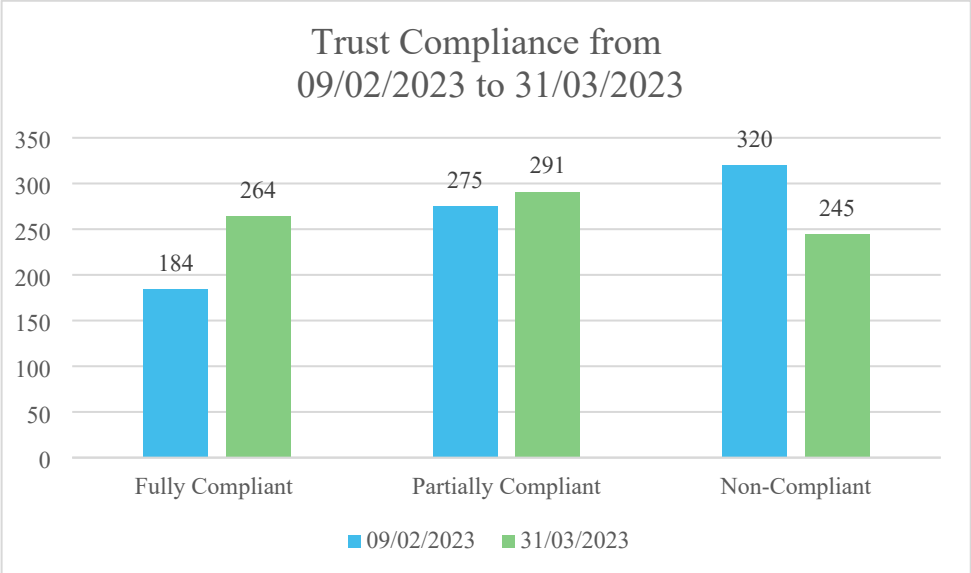
With infection guidance regularly changing for who needs to wear an FFP3 respirator and when, the fit testing registers of staff are very fluid and need robust management processes.

Table 1 ***fit testing figures at end of March 2023:***

Department or area	Total staff testing required	Total tests completed	Passed on 2 masks	Passed on 1 mask	Staff untested
Anaesthetics	44	19	6	7	31
Maternity	234	205	85	40	107
Gynaecology	155	203	67	69	19
NICU	213	183	50	83	80
Imaging	26	44	19	6	1
Theatres	86	98	16	66	4
Physio		4	2	0	
Medical Staffing	79	36	14	8	57
Junior Doctors	60	42	12	18	30
Total	**897**	**834**	**271**	**297**	**329**

The table below demonstrates the increased compliance across the Trust following the work undertaken reviewing the registers, streamlining administration processes, and offering additional testing appointments over more flexible hours:

Chart 1 ***shows fit testing figures at close of March 2023:***



ii. **Divisional Face Fit Tester Training/Resilience**

Relying upon clinical staff members to carry out face fit mask testing has nationally proven to be ineffective and high risk especially due to reliance on clinical staff who may leave, recruitment and retention issues, existing pressures on staff and staffing, lack of a coordinated provision, risk of not complying with statutory legal duty and FFP3 resilience principles.

Eight staff from across the divisions have completed accredited training as fit mask testers using the qualitative method of testing and four staff completed training as fit mask testers using the quantitative method of testing, with the Gynaecology Division being under-represented. Divisions have been provided with new fit mask testing kits to use and maintain within their own areas.

Testers have failed to maintain their face fit mask testing knowledge and competencies not taking opportunity to shadow the Fit Mask Tester Co-Ordinator and complete tests under supervision. Very few have completed face fit mask tests within their division or area of work. The Trust Fit Test Co-Ordinator will continue to offer supported sessions with the divisional testers to ensure that they retain their competency.

Until the end of March 2023, Fit Mask Tester training was funded via the DHSC and NHS Supplies, this has now ceased and becomes the responsibility of the Trust from 1st April 2023.

iii. **Recording of Mask Types for Individuals**

Much work has been completed to allow staffs assigned mask types to be recorded within the Skills section of E-Roster, however, is not yet made available. There is a helpful reporting facility that will allow for a quick look up of, for example, how many staff are using a particular mask type as their first or second choice. The Fit Test Co-Ordinator is expediting this piece of work and will feed back to the Health and Safety Committee in April 2023.

ESR will also shortly reflect mask types successfully face fit tested to individuals as a non-competency. Recording the staff member against the fourteen permitted UK mask types allows for NHS Supplies to monitor usage and maintain national stock levels. The ESR system will then be able to produce reports for areas to know who is tested, fully or partially compliant and when their next test is due.

iv. **Transparent Face Masks**

In August 2022, the Trust created suitable and sufficient pathways to bring the use of transparent face masks into use. Staff can now access transparent face masks to help them communicate with people with certain conditions like hearing loss.

Besides benefitting those who are affected by hearing loss, the masks help those who rely on facial expressions to support communication. For example, people with learning disabilities, autism or dementia, or foreign language speakers and their interpreters.

The masks are see-through and have an anti-fogging barrier to ensure the face and mouth are always visible to help doctors, nurses, midwives and AHPs communicate better with their patients. There are three approved mask types available, including an FFP3 type for use in clinical settings, designed for protection against droplet or splash to the wearer when in close proximity to an infected individual.

Clear face masks cannot be used where care is being provided in close quarters, in poorly ventilated spaces and with patients who may have a high-risk respiratory condition or where status is unknown.

v. **Other Issues**

- A designated fit testing hub has been established on the Jeffcoate Corridor.
- It is a requirement to have the PortaCount machine recalibrated annually, meaning that it is not available for up to ten days. An application has been made for a second machine in the new financial year's capital bids.

vi. **Summary of Actions**

a. Divisions have been informed that they must facilitate fit testing with the designated Fit Tester as uptake has been lower than expected in some departments leading to breaches in the requirement to retest staff at a two-yearly interval, exposing people and the organisation to risks that could otherwise be managed through compliance.

b. Expedite the recruitment of a substantive Fit Mask Tester Co-ordinator who has achieved accreditation, to be in post by July 2023.

1.3 PPE

i. The established central PPE storeroom continues to ensure safe levels of stock are maintained with a robust internal requisition and distribution process established.
ii. The Government is extending the central, free provision of PPE to the health and care sector, by up to one year to March 2024 or until stocks are depleted. At current rate of

usage, three mask types will need to be re-procured during 2023/24 and, therefore, will be charged for.

1.4 COSHH

i. **Alcumus Sypol COSHH Management Software**

The Trust has utilised the October 2021 the organisation has maintained 100% compliance utilising the Alcumus Sypol COSHH management software, for completing COSHH risk assessments.

The Health and Safety Manager, who is Co-ordinator for the Alcumus Sypol System, is monitoring usage of the system and has established meaningful compliance reports for system users and managers.

1.5 DSE

i. The Health and Safety (Display Screen Equipment) Regulations apply to workers who use DSE daily, for continuous periods of an hour or more. We describe these workers as 'DSE users'. The regulations do not apply to workers who use DSE infrequently or only use it for a short time.

ii. As an employer, we must protect our staff from the health risks of working with display screen equipment (DSE), such as PCs, laptops, tablets and smartphones.

iii. Annual DSE (display screen equipment) risk assessments are required to be undertaken for all DSE users across the organisation and for those who are homeworking, on an annual basis or when there is a significant change in software, hardware or a person's individual circumstances, as is a requirement of the Display Screen Regulations 1992 (amended 2002).

iv. The individualised risk assessments are shortly to added to the health and safety audit schedule. This will enable the Trust to produce reliable evidence of compliance via the Ulysses system.

1.6 Fire Safety

i. In March 2023, the Trust were successful in recruiting a permanent, part time Fire Safety Advisor in collaboration with Alder Hey Children's NHS Foundation Trust, ending this provision previously provided through an SLA with Liverpool University Hospitals NHS Foundation Trust. A comprehensive live workplan has been developed to ensure that the Trust works towards improved compliance with the Regularly Reform (Fire Safety) Order 2005 and meeting its statutory duty.

ii. There is an under reporting of fire related incidents and near misses with only 2 near miss incidents being reported in this financial year. The Fire Safety Advisor and Governance Managers are to encourage incident reporting and improvement is expected in the next quarter.

iii. In March 2023, Leviathan who act as the Trust's Authorised Engineer for Fire conducted an annual report of our fire safety arrangements. Their final report is expected shortly from which the fire safety action plan will be updated. The Chief Operating Officer has identified finance in anticipation of Estates maintenance works that may be identified from the audit

2. Health and Safety Training

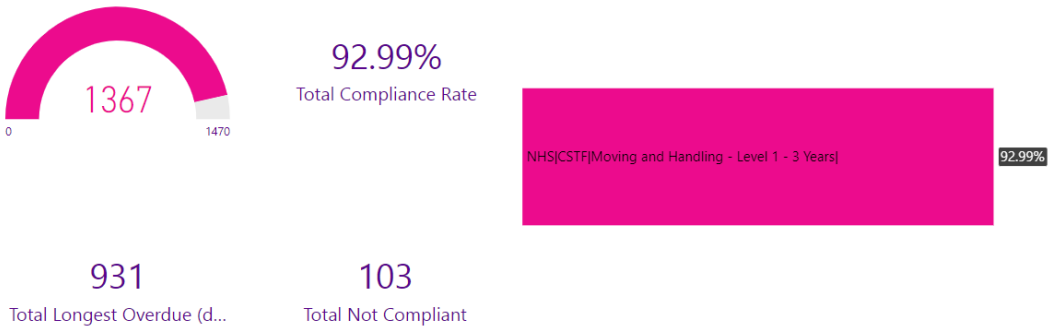
i. Manual Handling (People and Inanimate Objects)

The Manual Handling Operations Regulations (1992) sets out a hierarchy of measures to reduce the risks of manual handling in the workplace, so far as are reasonably practicable. These measures include access to specialist advice, access to suitable and sufficient training programs, provision of people and inanimate object handling equipment to reduce the risks and adequate risk assessments.

LWH has maintained a service level agreement (SLA) with Liverpool University Hospitals Foundation Trust (LUHFT) to provide update training for our manual handling cascade trainers and delivery of training for newly nominated manual handling cascade trainers. The SLA includes provision of ad hoc guidance and advice from LUHFTs Manual Handling Advisor.

An e-learning package for Moving and Handling Level 1 certificate is now accessible to all staff to support safe moving and handling practices.

Table 2 *shows current compliance with Moving and Handling Training*



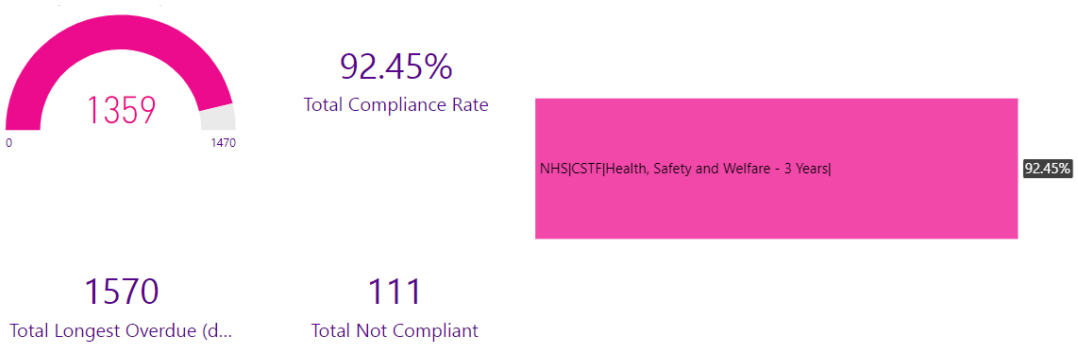
ii. First Aid

First Aid training continues to be provided externally via the Health and Safety Training Manager.

iii Health, Safety & Welfare Mandatory Training

Health and Safety legislation requires employers to provide adequate health and safety training and employers have a general duty to provide information, instruction and training and to provide a safe place of work, under Section 2 of the Health and Safety at Work Act (1974).

Table 3 *shows current compliance with Health and Safety Training*



Overall, across the organisation there have been operational and staffing issues in releasing clinical staff to complete mandatory training subjects. There have been notable improvements in the latter end of the reporting year; managers and governance staff are committed to improving compliance. Mandatory training compliance is reviewed and escalated through the quarterly Health and Safety Group.

iv **Executive Health & Safety Training**

As part of the Health and Safety Regulations and the Care Quality Commission Well Led Domain, a training session has been designed for executives and non-executive directors which is offered on an annual basis to ensure that the board members remain up to date with their legal responsibilities under the Health and Safety at Work Act.

vi **Training Needs Analysis 2023/24**

The Health and Safety Training Needs Analysis has been completed and submitted for 2023/24 and includes provision for the delivery of the following health and safety related training in addition to mandatory health and safety training requirements:

- DSE (Display Screen Equipment) Assessor Training
- Health and Safety Awareness Training for Managers, Supervisors, Team Leaders
- First Aider Training and Update Training
- Manual Handling Cascade Trainers Training – new and refresher training
- Fire Warden Training
- Ladder Safety Training
- IOSH Qualification for band 7 and above

vii Failure of staff to attend a health and safety funded training place without contact or acceptable mitigation will result in a cross charge being made to the service area.

2. <u>Policies & Standard Operating Procedures</u>

i. Health and safety related policies and standard operating procedures are reviewed and updated in line with any significant changes in practice, law or Trust policy and procedures.

3. Health & Safety Management System

Employers have a duty to consult with their employees, or their representatives, on health and safety matters. Communication is key to an effective health and safety system and industry best practice is to apply a reflective and collaborative learning stance to health and safety incident investigation. It is good practice for large organisations to establish and maintain a Health and Safety Committee, where the Committee should provide a link between staff doing the work and the people directing it.

The Health and Safety Group, as it has been known since April 2021, continues to meet on a quarterly basis with the caveat to be able to call an extraordinary meeting.

The health and safety profile continues to improve across the Trust:

- Regular place on the Safety Check in meetings
- Creating a list of health and safety related questions for interview candidates of all levels and grades
- Regular articles and toolbox talks through the staff weekly Digest
- Items shared through the Executive and In the Loop messaging
- A number of other initiatives are currently being explored including reintroducing the requirement for all band 7's and above to complete an IOSH Managing for Safety qualification.
- Development of the new Trust intranet to provide access to information, advice and guidance along with toolbox talks and risk assessment guidance

4. Reported Non-Clinical Health and Safety Incidents

In the reporting period 2022/23 there were ninety-seven non-clinical health and safety related incidents reported, which sees an increase in reported incidents of eleven incidents from the 2022/23 period.

Table 4 – *Non-Clinical Health & Safety Incidents by Cause*

	MATERNITY (FAMILY)	NICU	GYNAECOLOGY & HEWITT	CORPORATE FUNCTIONS	CLINICAL SUPPORT SERVICES	**TOTAL**
STAFF INCIDENTS						
COLLISION	1					1
COSHH (INCLUDING SPLASH)	2			2	5	9

ILL HEALTH	1		1			2
INJURY	5	1	5	2	6	19
MOVING & HANDLING	1					1
NEEDLESTICK INJURIES	12	1	10	1	2	26
SLIPS, TRIPS, FALLS	4		1	1	4	10
TOTAL STAFF INCIDENTS	26	2	17	6	17	68
ORGANISATIONAL INCIDENTS						
EQUIPMENT	1			2		3
ENVIRONMENT	4	9		7	1	21
TOTAL ORGANISATION	5	9	0	9	1	24
PATIENT/VISITOR INCIDENTS						
SLIPS, TRIPS, FALLS	3	1				4
INJURY		1				1
TOTAL PATIENT INCIDENTS	3	2	0	0	0	5
Overall Total	34	13	17	15	18	97

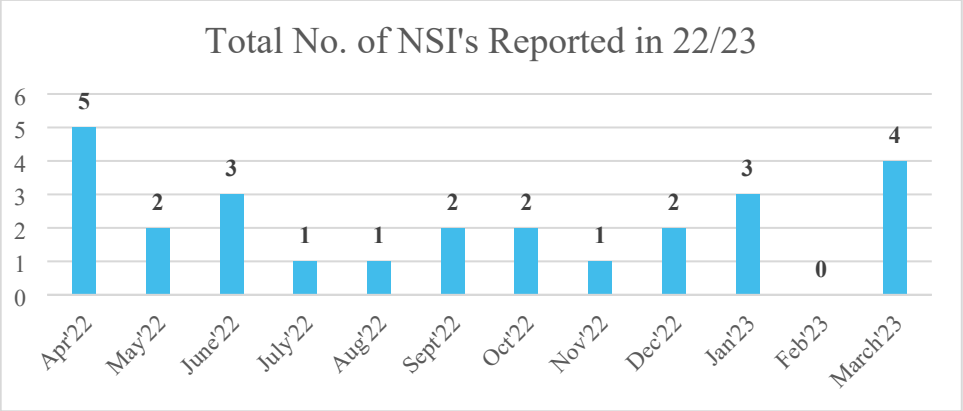
The three primary causes of incidents are categorised as needlestick incidents, environmental and injury. The following section reflects the findings of some of the primary causes.

6.1 Needlestick Injuries

Inoculation incidents may be subdivided into two categories. Those resulting from percutaneous exposure which occurs as a result of a needlestick or a medical sharp contaminated with blood or bodily fluid; and those resulting from mucocutaneous exposure which occur when bodily fluids come in to contact with open wounds or mucous membranes such as the mouth and eyes. There are more than twenty pathogens that can be transmitted following a needlestick (NSI) or sharps injury. The most common are Hepatitis B, Hepatitis C and HIV and, therefore, are a significant occupational hazard to healthcare professionals.

The total number of needlestick injury incidents formally reported via the Ulysses reporting system in 2022/23 was twenty-six which is three less than the previous year.

Table 5 – *Needlestick Incidents 2022/23*



From a Ulysses extract, sixteen of these incidents involved percutaneous exposure to needles, one from a suture needle, one from scalpels/blades, one from a broken pipette, one from a vial of oxytocin and two from toothed forceps.

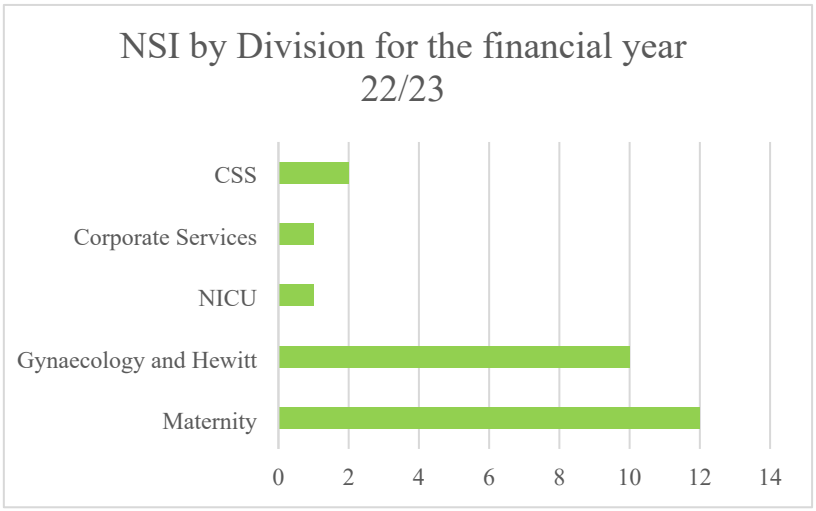
The the other four incidents related to a sharps bin not being closed when full, a member of staff catching their finger in the shars bin, a fragmin needle being found in a black bin bag, and in another incident a member of OCS was scratched emptying a black bin.

Safety needles were directly involved in two of the incidents, whilst two student members of the team were injured.

A quarterly summary of needlestick injuries including cause, equipment failure, poor disposal methods, staff on staff injury and where good practice can be improved is shared with all clinical Heads, Infection Control Team and the Medical Director. It is expected that services respond to the report by sharing the lessons learned, areas for improvement or where there is a gap in training.

The majority of needlstick injuries were sustained by nursing staff, eight in total. Seven doctors and seven midwives, The four other include the students

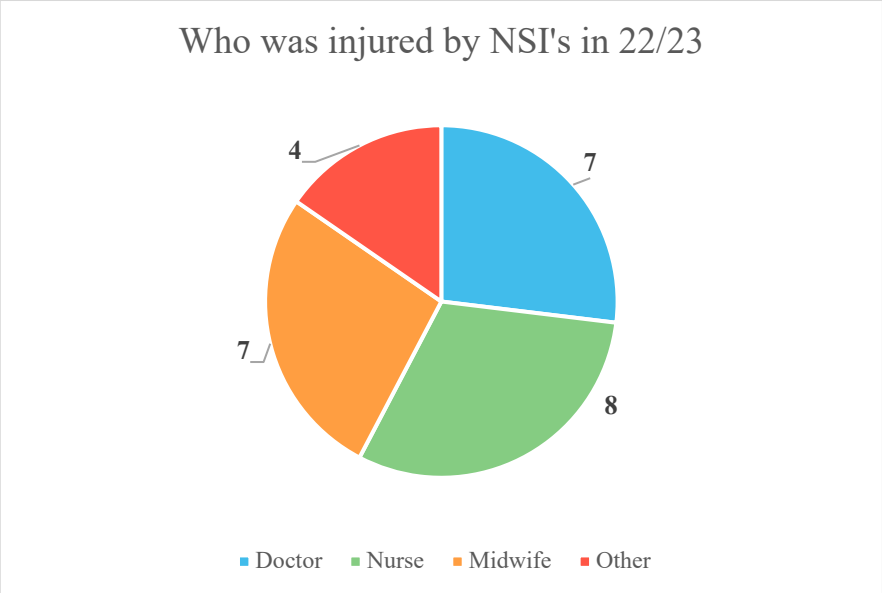
Table 6 – *Needlestick Incidents by Service 2022/23*



The Neonatal Unit were the highest reporter of sharp incidents in the previous financial year, due to the use of CFM needles. The reporting has reduced with no incidents of injuries from CFM needles being reported this year. The unit have successfully piloted CFM pads, and these have now fully replaced the use of the open-ended CFM needles.

Maternity was the highest reporter of incidents in the financial year 2022/23, they reported three of the equipment sharps incidents (Pipette and toothed forceps) and two incidents relating to students.

Table 7 – *Staff Reporting a Needlestick Injury in 2022/23*



All incidents were of a low risk nature and the Sharps Injury and BBV Policy was followed in each case with exception that in several incidences staff were delayed in contacting Occupational Health or the Emergency Department due to staffing pressures and their not being released from duty. This is contrary to policy as staff must be released from duty and managers must manage the situation. PEP, a short-term antiretroviral treatment to reduce the likelihood of HIV infection, should be initiated as soon as possible after exposure, preferably within 24 hours and under 72 hours.

The use of the Sharpsmart disposal system still offers good value. Ongoing audits are conducted at factory level where the containers are opened, photographed, and checked for non-compliant contents. The onsite audits look at usage and whether the documentation is correct and complete.

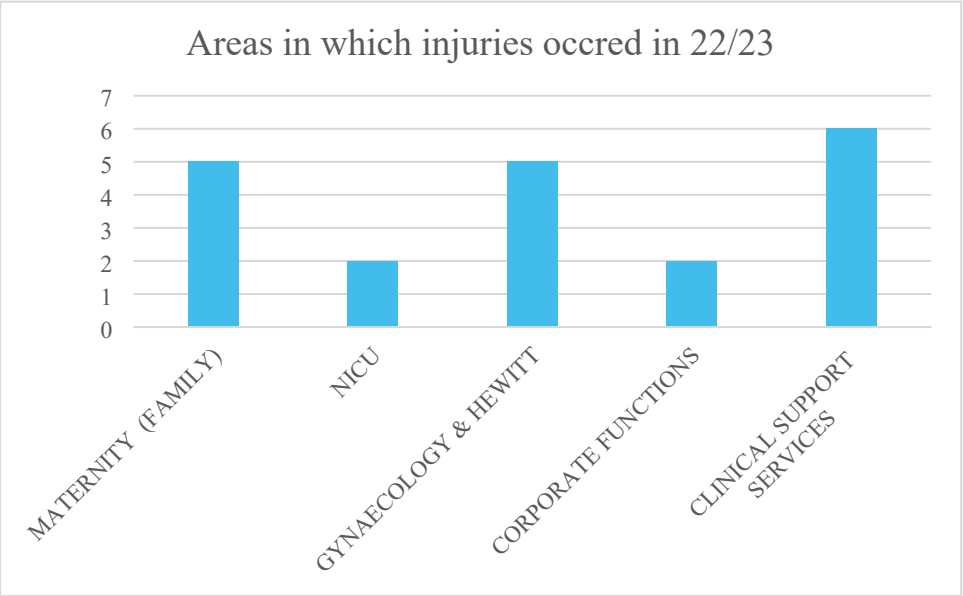
Ongoing training continues to be delivered by the auditor whenever any 'bad practices' are observed or evidenced.

No issues have been raised over any safety aspects of the system.

6.2 Personal Injury

There was a total of 20 personal injuries in this reporting period. From the details of the incidents there were no themes or trends identified.

Table 8 – *Injury Incidents by Division*



There were no further themes identified and all incidents of personal injury were dealt with appropriately, within protocols and first aid was applied, where necessary.

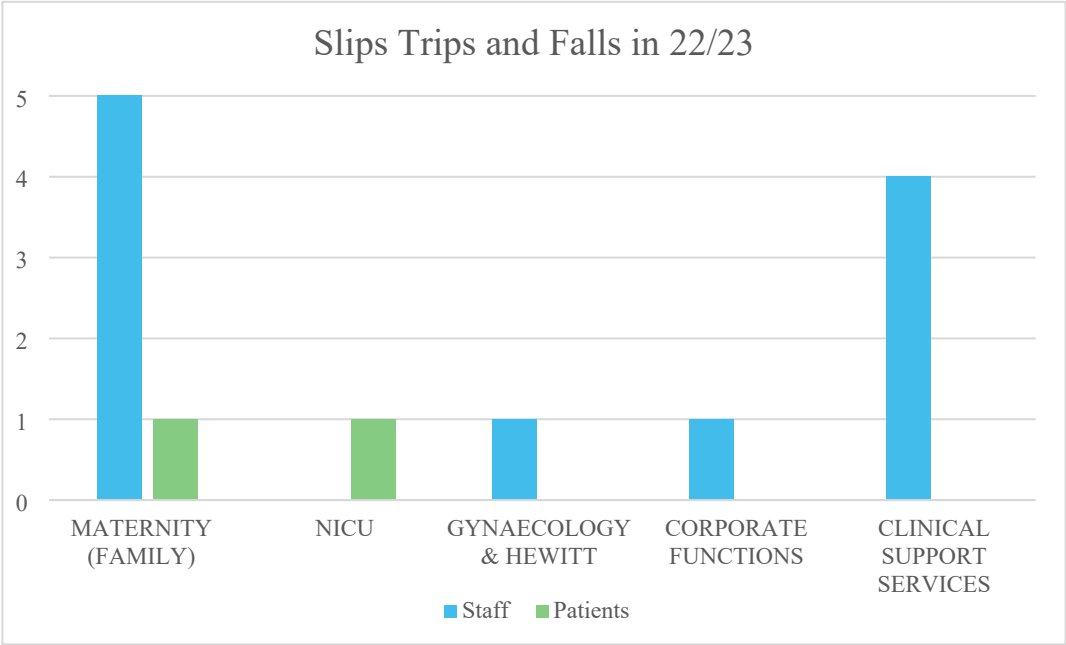
6.3 Slips, Trips & Falls

There was a total of fourteen slips, trips and falls incidents reported during 2022/23 a decrease of three incidents from the previous reporting period 2021/22. The majority of slip, trips and falls incidents were reported by Maternity Services (eight). There were two RIDDOR reportable incidents.

Two incidents involved visitors; one incident involved a sibling slipping on water that she had spilled. In the second incident a patient slipped on a grape in the waiting room and fell to her knees.

There were several reports of staff tripping on poorly placed equipment. All staff have been reminded to be vigilant to slip, trip and falls hazards and the need to deal with these immediately. The importance of using wet floor warning signs has also been reiterated, including appropriate placement and removing the signs to a safe storage area once the hazard has been removed.

Table 9 – *Slips, Trips, Falls incidents by Division*



6 RIDDORS (Reporting of Injuries, Diseases and Dangerous Occurrences)

The Trust is required to submit RIDDOR reportable incidents to the HSE within prescribed timescales. Persistent late reporting exposes the Trust to potential prosecution for non-compliance with the regulations.

In this reporting year there were four RIDDOR reports made to the HSE which was a decrease of five from the previous annual report.

Cause	Cause Group	Reportable Injury/Occurrence or Over 7 Day Absence
Trip	Injury	Over 7-day absence – soft tissue injuries
MSK injury	Injury	Over 7-day absence – soft tissue injuries
MSK Injury	Injury	Over 7-day absence – soft tissue injuries
Fracture	Injury	Over 7-day absence – specified injury

Staff members received appropriate care and support in all incidents. Investigations were completed, where required and appropriate communications made with all staff to prevent similar occurrences in the future, such as guidance for preventing slips, trips and falls.

8. Legal Claims

The Health and Safety Manager provided investigation reports in response to two employer liability claims in relation to a staff member tripping when a lift failed to align with the floor and a contracted staff member suffering a needlestick injury when emptying a domestic waste bin. Appropriate actions and process were followed in both cases at the time of the incidents.

9. Health & Safety Executive (HSE) Priority Objectives 2023/24

The prevention of death, injury, and ill health to those at work and those affected by work activities:

- Lead and engage with others to improve workplace health and safety
- Provide an effective regulatory framework
- Secure effective management and control of risk, reduce the likelihood of low-frequency, high-impact catastrophic incidents

10. Health and Safety Work Plan for 2023/24

The following table reflects priorities from the Health and Safety workplan for the new financial year 2023/24

Action or Project	Responsible Persons	Target Date
Create workplan to ensure robust fire safety arrangements including improvement in site housekeeping and firefighting first aid measures, training in line with legislation, rolling programme of risk assessments and fire drills, best practice on all LWH sites	H&S Manager/Fire Safety Advisor	30th April 2023
Ensure that Fit Testing arrangements are suitable and sufficient to improve compliance and managers are engaged	Head of Risk & Safety/H&S Manager	On going
To continue to modernise health and safety and fire workplace audits and risk assessments by further developing electronic solutions through the roll out of the Ulysses Risk Management Module	H&S Manager/Governance Support Officers	On going
Relaunch Sypol system, support users training, develop reporting tools from within the system	H&S Manager	May 2023
Report RIDDORs to the HSE/Report KPI through Performance, Power Bi	H&S Manager	On going
Establish Health and Safety Advocates/RES Group across all divisions	Head of Risk & Safety/H&S Manager	July 2023
Continue to collaborate with the Governance Team &		

COO to establish a robust safety management system, as per HSG65	H&S Manager	On going
Timely review, audit and development of health and safety policies and SOPs and introduce Policy on a Page as an appendix	H&S Manager	On going
Complete ladder training for all ladder users, and managers	H&S Manager	July 2023
Develop robust, informative, and user-friendly intranet for health & safety, fire, and fit testing	H&S Manager	July 2023
To keep the Trust up to date with changes in health and safety legislation and significant HSE projects	H&S Manager	On going

11. Recommendations

The Health and Safety Group and Corporate Risk Sub Committee are requested to consider and accept the following recommendations:

- Support the continuous review of the Trust's Health and Safety Management System arrangements
- Support the continuing development and promotion of a positive health and safety management system and culture
- Encourage managers and staff to commit to attendance of health and safety related training and the fit mask testing programme
- Promote health and safety duty and responsibilities across the Trust.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/095*		Date: 13/07/2023	
Report Title	RD&I Annual Report 2022/23			
Prepared by	***Louise Hardman, Head of RD&I***			
Presented by	***Lynn Greenhalgh, Medical Director***			
Key Issues / Messages	***Note the contents of the annual report***			
Action required	Approve ☒	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	Note the contents of the annual report			
Supporting Executive:	***Lynn Greenhalgh, Medical Director***			

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

Strategy ☒ Policy ☐ Service Change ☐ Not Applicable ☐

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 5.1 Failure to progress our research strategy and foster innovation within the Trust	Comment: Provide assurance of progress against research strategy
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
RD&I Committee	19/05/2023	Lynn Greenhalgh	Approved
Quality Committee	26/06/2023	Lynn Greenhalgh	Approved

EXECUTIVE SUMMARY

Welcome to Liverpool Women's NHS Foundation Trust's Research, Development & Innovation (RD&I) Annual Report for 2022/23. This provides an opportunity to demonstrate our commitment to continuous, evidence-based research and celebrate our achievements.

Key Themes

The national strategy for research in the NHS remains focused on the clinical and economic imperatives for Trusts to continue to improve their performance in initiating and delivering research. This will accelerate the benefits of research for patients and develop the UK's competitive advantage in the life sciences.

Locally, research activity benefits the Trust's clinical capabilities and deliverables, which means that the Trust can implement evidence-based interventions in a timely manner, thus improving the quality of health care for our patients and enhancing patient choice. Research fosters personal development and attracts high calibre staff. As a result, more of our nursing and midwifery staff than ever before are benefiting professionally from their participation in delivering research. As well as the work of individuals, engagement with Cochrane reviews, NICE, and Clinical Research Networks (CRNs) has positioned the Trust as a national leader in its clinical work-streams.

Summary Report

Key findings from the report can be summarised as follows:

Performance

- A total of 1,431 individuals were recruited to participate in research.
- The Trust conducted 121 clinical research studies across all speciality areas, with a further 22 studies in set up at the year end, including 4 industry studies
- Approximately 163 clinical staff contributed directly to research
- Individuals affiliated to the Trust contributed to 159 research publications during the year
- The 2023/24 North West Coast (NWC) CRN baseline funding allocation to the Trust has been matched with the 2022/23 allocation
- Excellent performance at research leadership in all medical speciality areas

Innovation

- Further programme of work to assess the performance of the new parenteral nutrition product that comprises a specific amino acid formulation concentration.
- In association with Robinson Healthcare, the development of a speculum to assist in the diagnosis of urogenital atrophy for use in both primary and secondary care.
- Development of a tactile sensory array 'intelligent mattress' to deliver moving stroking touch to preterm babies in the NICU at velocities and forces that research has shown are optimal

Strategy

- The launch of the Research, Development & Innovation Strategy 2023-28 following extensive internal and external consultation
- Development and implementation of the Nursing, Midwife and Allied Health Professional talent pipeline plan
- Continued collaborations with Liverpool Health Partners and Health Education Institutions

Conclusions

Research continues to demonstrate favourable outcomes to the Trust, its staff and its patients. The governance arrangements for research within the Trust are operating well. Good management of research performance has produced measurable results which must be maintained in order to maximise the benefit of external support. The opportunities for strengthening RD&I across the Trust need to be evaluated.

Recommendations

The Board is asked to note the Trust's RD&I Annual Report for 2022/23.

Abbreviations

AHP	Allied Health Professionals
BAME	Black, Asian, and minority ethnic
CCG	Clinical Commissioning Group
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
CRN	Clinical Research Network
DfID	Department for International Development
HEI	Higher Education Institutes
HFC	Hewitt Fertility Centre
HLO	High Level Objective
HTA	Health Technology Assessment
LCR	Liverpool City Region
LHP	Liverpool Health Partners
LMICs	Low and middle income countries
MRC	Medical Research Council
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NWC CRN	North West Coast Clinical Research Network
PCT	Patent Cooperation Treaty
PDA	Patent ductus Arteriosus
PMDD	Premenstrual dysphoric disorder
PPH	Post-partum haemorrhage
PTSD	Post-traumatic stress disorder
SPARK	Single Point of Access for Research and Knowledge
SPs	Strategic principles
UoL	University of Liverpool
WHO	World Health Organisation

EXECUTIVE SUMMARY

1. RD&I Strategy

The Trust's vision is to be the recognised leader in healthcare for women, babies and their families. To achieve this vision, the Trust aims to foster a research culture, to support its existing strengths and to explore new directions in its research efforts. Therefore, a Research and Innovation Strategy was produced and approved by the Trust Board in March 2018. The following eight Strategic Principles (SPs) were devised:

(SP1) Research activities will become an integral part of the Trust's clinical activities

(SP2) All of the Trust's clinical staff will contribute to the research agenda and relevant non-clinical staff will support research activity

(SP3) The Trust will support and build upon its present research strengths

(SP4) New areas of research that the Trust supports will link to the healthcare challenges of our local population of women and their newborn babies

(SP5) A contribution to research internationally will be supported, particularly when social and economic disadvantage is linked to poor outcomes

(SP6) The Trust will continue to underpin high quality research by training researchers and managing research infrastructures

(SP7) The Trust will work with local, national and international research partners to achieve its vision and aims

(SP8) Innovation will be encouraged and receive corporate support

The strategy document described the ways in which these eight Strategic Principles were to be pursued in a five-year cycle between 2018 and 2023. Progress against each of these strategic principles has been presented on a regular basis to the Effectiveness Senate, Quality Committee, and also documented within R&D Annual Reports.

A post implementation review of the strategy was undertaken in order to summarise performance against these strategic principles during the first three years of the five-year strategy and reported upon in the 2020/21 R&D Annual Report.

The following dashboard summarises the implementation of the Strategic Principles over the full five years, highlighting successful delivery of the aims and objectives. Further detail can be found within previous R&D Annual Reports.

Principle		Progress	Status with respect 2023 target
SP1	Research activities will become an integral part of the Trust's clinical activities	Research activity demonstrated within all Trust clinical areas, some at saturation point	
SP2	Trust's clinical staff will contribute to the research agenda and relevant non-clinical staff will support research activity	Excellent support from the relevant clinical and non-clinical staff in support research activity within their respective areas	
SP3	The Trust will support and build upon its present research strengths	Obstetrics, maternity, perinatal mental health, gynaecology and neonates continue to demonstrate research strengths	
SP4	New areas of research that the Trust supports will link to the healthcare challenges of our local population of women and their newborn babies	Reproductive medicine research activity growing; work undertaken to link research with Liverpool Health Partner themes; development of the C-GULL cohort research project	
SP5	A contribution to research internationally will be supported, particularly when social and economic disadvantage is linked to poor outcomes	Obstetrics, gynaecology and neonates continue to provide international research leadership	
SP6	The Trust will continue to underpin high quality research by training researchers and managing research infrastructures	Non-medical staff have been supported in the development of own research projects; a number of NMAHP collaborative groups established; business case to provide additional support approved	
SP7	The Trust will work with local, national and international research partners to achieve its vision and aims	Relationships with CRN, LHP, SPARK, HEIs, funding bodies, international partners is strong	
SP8	Innovation will be encouraged and receive corporate support	Regular innovative ideas identified, collaborative work undertaken with relevant partners in order to consolidate further progress	

For the Trust's position to be maintained and enhanced, it was recognised that a refreshed strategy would need to be adopted by the Trust. The strategy would need to strengthen the place of research at the centre of its clinical and educational activities. Ultimately this would result in being one of the drivers for improvement in clinical standards and outcomes for women, babies and families locally, nationally and internationally. Therefore, a new strategy has been developed though an extensive consultation exercise, involving our staff, our service users, our governors and our external partner organisations. This approach has enabled us to gain a clear understanding of our current situation and our priorities over the next five years. The Trust has recognised the healthcare challenges of its own population, which are strongly associated with social and economic disadvantage. It has also recognised the great strengths that it has in its present research portfolio; the value of co-operation between medical and non-medical professionals, clinical specialities, disciplines and institutions.

The strategy comprises a series of principles and aims which are aligned to five overarching components: People, Potential, Project, Partners and Place. It assesses where we are now outlines where we want to be through the development of priorities for each component and details how they are doing to be achieved. The five themes can be summarised as follows:

PEOPLE	POTENTIAL	PROJECT	PARTNERS	PLACE
• Provide equitable support for research amongst all staff • Professional development of research delivery staff • Continued support for existing cohort of researchers • Clear leadership for nurses, midwives and allied health professional research • Development opportunities for nurses, midwives and allied health professionals • Ensuring that research is a core component of everyone's role	• Develop an innovation service in collaboration with external partners • Unlock hidden potential of all staff • Create sustainable growth in research and innovation through investment • Promote the implementation of research findings into practice	• Patients and service users in all clinical areas will have access to research relevant to their situation • Increase research activity according to population health needs • Support local, national, international leaders in the development of women and child's health research	• Increase the number of staff from across the multi-disciplinary workforce who hold a substantive University contract • Continue to develop collaborations with external partners and stakeholders • Synergise working relationships with the Harris Centre	• Continue to deliver high quality research within existing resources • Streamline RD&I processes to free up capacity for nurturing project development • Patient and public involvement in research design and conduct • Making research and innovation visible • All departments proactively support research and innovation

The RD&I Strategy 2023-2028 was officially launch at the Trust's Research Showcase event on 27th March 2023.

1. Research Activity at Liverpool Women's NHS Foundation Trust during 2022/23

Our commitment to conducting clinical research demonstrates our dedication to improving the quality of care we offer and to making our contribution to wider health improvements. Our healthcare providers stay up to date with new and innovative treatment options and are able to offer the latest medical treatments and techniques to our patients.

This section summaries the research performance of the Trust, the content of which is detailed in section 2. Further detail in respect of the types of projects that are active within each clinical area can be found in Appendix 1.

1.1 Research Activity Summary for 2022/23

As reported in the Trust's Quality Report for 2022/23 we have continued our efforts to contribute to quality National Institute for Health Research (NIHR) studies and to maintain our numbers of participants recruited to NIHR studies (recruitment accruals). We have also continued to focus our efforts on collaborative research with academic partners to ensure the research we conduct is not only of high quality, but is translational, providing clinical benefit for our patients in a timely manner.

The Trust is continually striving to improve the quality of its services and patient experience. Research is recognised by the organisation as being pivotal to this ambition.

The Trust worked with the Department of Health and Social Care (DHSC), NHS England, the NIHR Clinical Research Network (CRN) and all delivery partners across the sector to restore a diverse and balanced portfolio of studies which were impacted due to the pandemic. During 2022/23 the Research Reset programme was implemented – a cross-sector collaboration which aimed to build back a thriving, sustainable and diverse R&D portfolio within the NHS and to give as many studies as possible the chance of completing and yielding results, generating the evidence needed to improve care and sustain our health and care system.

The number of patients receiving relevant health services provided or sub-contracted by LWH in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee was 1,431 of which, 1,016 were recruited into NIHR portfolio studies.

The Trust was involved in conducting 121 clinical research studies across our speciality areas of maternity, neonates, gynaecology oncology, general gynaecology, reproductive medicine, anaesthetics and genetics during 2022/23. At the end of 2022/23 a further 22 studies were in set up, including 4 industry studies.

There were approximately 163 clinical staff contributing to research approved by a research ethics committee at the Trust during 2022/23. These staff contributed to research covering a broad spectrum of translational research from basic research at the laboratory bench, through early and late clinical trials, to health systems research about healthcare delivery in the community.

Some members of staff were either funded directly by research income, or the individuals were named on grant applications. Many other members of staff contributed to research within their general job plans. These were named on delegation logs for study activity, for such tasks as the administration of trial medication and performing other interventions including surgery, radiology;

collation of questionnaires; dispensing of trial medication; collection and processing of research tissue and blood samples.

Specific examples of the co-operation of clinical staff in helping with research delivery have been:

- An antenatal study investigating the best way to care for women with babies who appear to be bigger than expected and whether labour should be started a little earlier for these women.
- A clinical trial comparing carboprost and oxytocin to determine which is most effective in the first line treatment of post-partum haemorrhage.
- A Hewitt Fertility Centre collaboration with ExamenLab Ltd, Belfast investigating the impact of the quality of sperm on fertilisation, embryo quality, pregnancy and miscarriage.
- Co-operation from obstetric, maternity and theatre staff in the delivery of a research study investigating the physiological and pathological effect of different agents, novel substances and biomarkers on myometrial contractility.
- A trial investigating whether infants born at 30+0 to 32+6 weeks gestation who are given full milk feeds initiated in the first 24 hours after birth reduces the length of hospital stay in comparison to IV fluids with gradual milk feeding.
- An ectopic pregnancy diagnosis study undertaken in the emergency room the aim of which is to develop a metabolomics profile analysis in biofluids to detect an ectopic pregnancy in symptomatic women in early pregnancy.
- A feasibility study establishing the best way to take a sample to sequence a baby's genome.

Our research has contributed to the evidence-base for healthcare practice and delivery, and in the last year, individuals affiliated to the Trust contributed to 159 research publications, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

1.2 Contribution to National Institute for Health Research

The Trust does not provide funding for research projects. Trust research is funded by the NIHR, grants (eg MRC, HTA and charitable organisations), and industry. All income received is accounted for by the salary costs of the growing research delivery team, research costs and consumables. End of year financial reports are provided to the various funders in order to reconcile funds received against expenditure.

The Trust's annual business planning in collaboration with the North West Coast (NWC) Clinical Research Network (CRN) took place in March 2023. The CRN provides a large proportion of the funding that supports the research function at the Trust. The Trust was informed that the 2023/24 baseline funding allocation would be matched with the 2022/23 allocation.

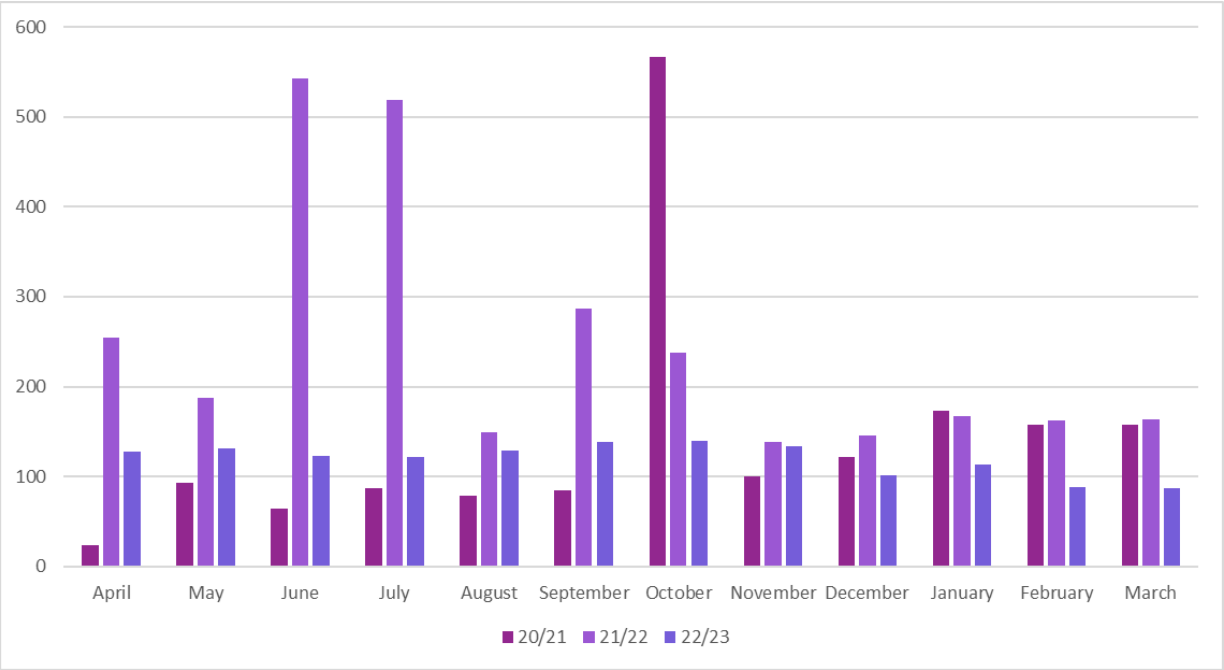
As a government funded initiative, the NIHR CRN has produced a number of high-level objectives against which Trusts are measured. These objectives allow the CRN to track progress and improvements. The RD&I department report performance against these objectives on a regular basis to the RDI Sub-Committee of the Quality Committee.

Current and historic performance strengthens the Trust's reputation as a high performing research institution. The following sections illustrate the Trust's 2022/23 performance in comparison with the objective metrics set by the Department of Health that apply to this organisation.

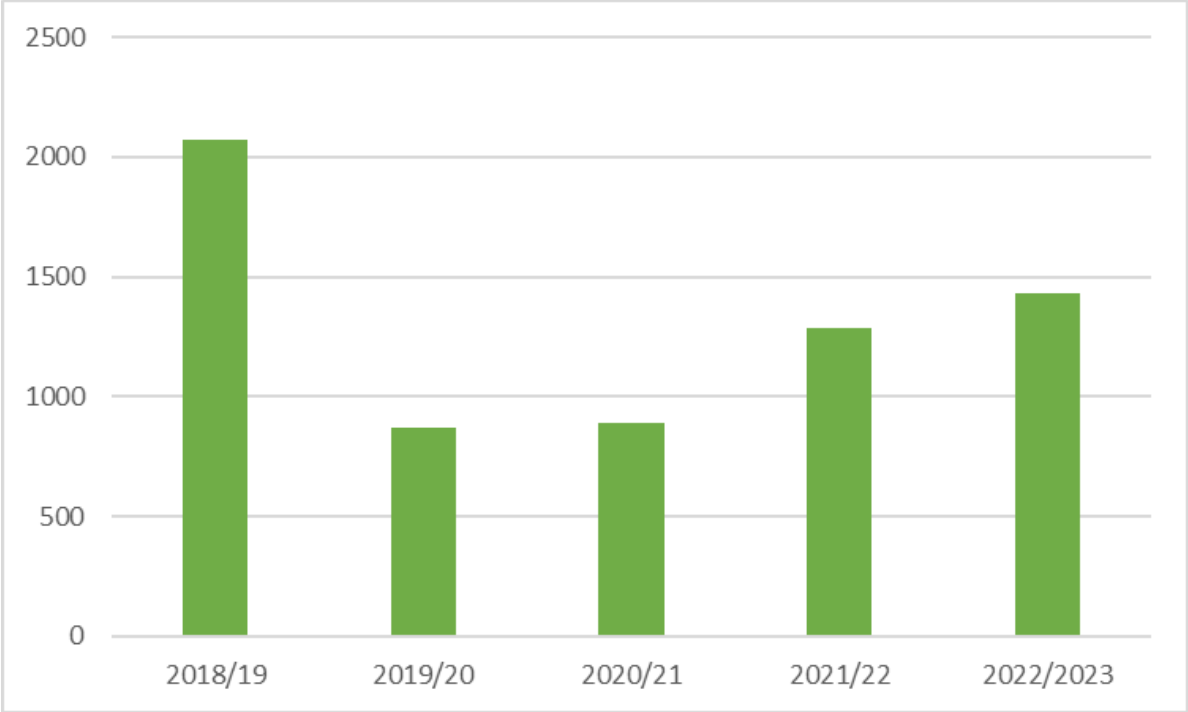
The impact of COVID-19 recovery on the majority of research studies during 2022/23, has been acknowledged by the NIHR and will be taken into account when reviewing the Trust's overall performance for the year.

1.3 Number of participants recruited to NIHR research studies

Although during 2022/23 the effects of COVID-19 continued to impact upon the Trust's usual research activity, contribution to COVID related research studies and the proactive efforts to restart non-COVID research resulted in regaining a position comparable with 2019/20. The figure below demonstrates the Trust's overall performance of recruitment of participants to NIHR portfolio research studies during 2022/23, in comparison with 2020/21 and 2021/22.



The following graph shows a comparison with NIHR portfolio research activity from 2018/19 through to 2022/23 which demonstrates continuing good performance in the number of individuals recruited to NIHR portfolio research during 2022/23. The reduction in the overall recruitment number during the last three years can be attributed to the closure of a large interventional trial and the impact of COVID-19. However, during 2021/22 and 2022/23 the commencement of a gradual recovery to pre-pandemic levels can be seen.



If there is a national NIHR portfolio study that the Trust is not recruiting to, which meets our clinical areas of expertise, the Trust can be assured that the feasibility, questions of local leadership, equipoise will have been explored and we are confident there is good reason for not being a participating site. However, we remain vigilant in managing our portfolio, continually exploring feasibility of new studies and anticipating and preparing for replacement studies where studies are due to close following completion of recruitment.

1.4 Research Reset

Since summer 2020, the Department of Health and Social Care (DHSC), NHS England, NHS R&D Departments, the NIHR Clinical Research Network (CRN) and all delivery partners across the sector have been working to restore a diverse and balanced portfolio of studies which were impacted due to the pandemic. The Managed Recovery process was implemented in Spring 2021 and has had success with the studies included in the process. However, this has not had the effect of clearing the path for other studies paused or delayed in the early stages of the pandemic to return to the levels of recruitment that would normally be expected.

Work commenced during 2022/23 to revitalise NHS research portfolio through the Research Reset programme – a cross-sector collaboration taking action to build back a thriving, sustainable and diverse R&D portfolio within the NHS which remains open to new studies. The objective in implementing Research Reset was to give as many studies as possible the chance of completing and yielding results, generating the evidence needed to improve care and sustain our health and care system. However, amendments or closure of studies that are not viable in the current context could occur.

Availability of both R&D and research delivery staff, including those supported through the NIHR CRN and the wider NHS, was a major factor in the practicability of studies. Pressures on NHS R&D Departments remain high as they support large portfolios of studies and follow-up activities. The aim of Research Reset was to make delivery of the portfolio sustainable within the resource and capability currently available.

Research sponsors and funders were requested to take firm action and close studies in the following categories if they were no longer viable:

- Close studies in set-up which have passed their planned opening date by more than 90 days
- Close recruitment to studies that have not recruited any participants in the last 6 months (unless in line with expected recruitment)
- Close recruitment to studies that have met their recruitment target in England and move into follow up

In addition, Sponsors were asked to regularly review their portfolios in collaboration with Funders, Chief Investigators, CROs and CTUs to provide an intended action to address the following groups of studies:

- Studies which, from a data perspective, appear to be recruiting at a lower rate than expected
- Studies the NIHR CRN has lost contact with, or appear to be behind key milestones

This is a challenging moment, but this reset is needed to put the NHS R&D system back on course, preserving a world-leading, vibrant and flourishing R&D system in the NHS that gives as many people as possible the opportunity to participate in and benefit from research. It is only by taking this action that the potential benefits for patients will be fully realised.

Unfortunately, a number of national clinical research studies for which the Trust acted as a participating site were closed to recruitment. However, there were no Trust sponsored, hosted or led studies that were required to close.

1.5 Performance in Initiating and Delivering Clinical Research

Trusts holding NIHR contracts are required to provide and publish, on a quarterly basis, outcomes with regard to performance in initiating and delivering clinical research trials, including commercial trials. The DHSC use this reporting mechanism to assess the performance of Trusts. Consequences for unsatisfactory performance may result in a proportion of a Trust's Research Capability Funding (RCF) allocation being withheld.

All NHS providers are required to submit information in two specific areas:

- Initiating clinical research
- Delivering commercial contract clinical research to time and target.

The Trust's performance during 2022/23, released by the NIHR Central Commissioning Facility, has been reported as meeting both requirements.

The collection of NHS provider data on initiating and delivering clinical research, is a separate exercise from the ongoing collection of performance data by the NWC CRN against the NIHR HLOs. The overall aim of both exercises is to increase the number of patients participating in research and enhance the nation's attractiveness as a host for research.

2. Performance at Research Leadership

2.1 Maternity

- A new collaborative world-leading programme of research focused on improving the health and wellbeing of children and their families within the Liverpool City Region (LCR) has been awarded funding from the Wellcome Trust. The 'Children Growing-up in Liverpool (C-GULL)' research study is led by Professor Louise Kenny. The data resource will be used to better understand and improve the lives of LCR children and their families. This is the first newly established longitudinal birth cohort to be funded in the UK for almost 20 years.

  Currently, Liverpool ranks badly in terms of the highest rates of child mortality and conditions such as asthma, type 2 diabetes, epilepsy and risk factors for poor health such as obesity, poor nutrition and low levels of physical activity. To help develop a better understanding of these issues, researchers will collect information from 10,000 babies and their families, starting in pregnancy and over the first years of life, allowing changes in their health and development to be monitored and recorded over time. The information gathered will provide important evidence for policy, practice and research that will ultimately help improve child health and development in the area.

  Due to COVID-19 the launch of C-GULL was delayed. However, by the end of 2022/23 all approvals were in place for the commencement of recruitment in April 2023. The programme will bring together citizens, researchers and clinicians across the Liverpool City Region and wider to make one of the largest family studies in the UK.

- COPE: The Carboprost or Oxytocin Postpartum haemorrhage Effectiveness study. The grant award of approximately £1.8 million in response to a commissioned call by the NIHR HTA, supports a trial which aims to recruit 3,948 women in up to 40 UK hospitals. The study will randomize women following the doctor's decision to give treatment to stop the bleeding caused by PPH. Professor Weeks is the trial lead, with trial management provided by a team from the Clinical Trials Research Centre (CTRC) at the University of Liverpool. Despite the difficulties facing the team during the pandemic, efforts to set up the trial across the UK commenced in the latter half of 2020/21. The trial is currently recruiting well nationally.

- Dr Andy Sharp was successful in securing a grant award of approximately £250,000 funded by the NIHR Research for Patient Benefit programme. PLANES: Placental Growth Factor Led Management of the Small for Gestational Age Fetus, is a feasibility study which aims to establish whether the management and care given to pregnant women who are carrying a small baby can be improved by the use of a blood test (sFlt-1/PlGF ratio). The test could reveal whether the mother's placenta is working as well as it should. The research is recruiting well, with the Manchester site coming on board during 2022/23.

- During 2019/20, the Trust was awarded approximately £341,765 by the NIHR Health Technology Assessment programme. The funding will support delivery of the FERN – Intervention or Expectant Management for Early Onset Selective Fetal Growth Restriction in Monochorionic Twin Pregnancy research study. The clinical research study opened to recruitment in April 2022.

- Dr Kayleigh Sheen was successful in being awarded £268,000 in response to a commissioned call by the National Institute for Health Research RfPB and will support a 2 year study aiming to evaluate whether the Fear of Childbirth Questionnaire is an accurate measure for fear of childbirth, and if routine use of the questionnaire in maternity care is feasible and acceptable for women and midwives.

- Dr Andy Sharp holds the post of CRN NWC Specialty Lead for Reproductive Health and Childbirth. Dr Sharp is also the system lead for Obstetrics and Gynaecology at the University of Liverpool.

- In March 2022, Professor Andrew Weeks was appointed an NIHR Senior Investigator for the period 2022-2026.

- Dr Angharad Care and Dr Laura Goodfellow both hold the position of Clinical Lecturer at the University of Liverpool. These appointments are excellent examples of how both the Trust and the University have supported the career advancement of talented individuals.

- Dr Emma McGoldrick was successful in securing funding as part of the NIHR Research Scholars Programme. The programme is an initiative to develop early career health and care researchers, equipping tomorrow's clinical research leaders with the skills, knowledge and experience needed to become Principal and Chief Investigators of the future.

2.2 Gynaecology

- Professor Hapangama and her team continue to deliver ground breaking endometrial research supported by specific grant funding awards. She secured grant funding of £197,039 from the Wellbeing of Women, to support ExPeDITe: Ectopic Pregnancy DIagnosis sTudy. The research study aims to develop metabolomic profile analysis in biofluids to detect an ectopic pregnancy in symptomatic women in early pregnancy. If successful, the results of the research could help to improve the way an ectopic pregnancy is diagnosed and reduce the health risks and stress to women.

  They have also been successful in securing a number of other research grants such as:

  - MRC DiMen PhD studentship: 'Handbrake on hysterectomy' - *Developing a personalised and fertility sparing pharmacological therapy for uterine fibroid-induced symptoms*
  - Society of Reproductive Investigators, USA Bayer PLC, Discovery Grant: *Developing a novel, physiomimetic 3D in vitro model as a holistic solution against adenomyosis*
  - Wellcome Trust Bridging Grant: *Metabolomics and cytokine profile analysis in biofluids to develop a non-invasive diagnostic test for ectopic pregnancy*
  - Sand pit Grant, Institute of Life Course and Medicine, University of Liverpool: *Developing a novel, physiomimetic 3D in vitro model and a vascular reporter model as a holistic solution against uterine fibroids*
  - Department of Women's & Children's Health, University of Liverpool, Pump-priming: *Developing a novel, physiomimetic 3D in vitro model and a vascular reporter model as a holistic solution against uterine fibroids*
  - University of Liverpool, Shared Research Facilities Voucher Scheme: *What transcriptional abnormalities do lesions such as adenomyosis, endometriosis and fibroids inflict on the eutopic endometrium?*
  - University of Liverpool, Shared Research Facilities Voucher Scheme: *Vibrational spectroscopic analysis of serum to diagnose and stratify women with deeply infiltrating endometriosis*
  - British Society of Gynaecological Endoscopists: *Biospecimens for the Evaluation of Endometriosis Associated Pain (BEEAP) Study*

- Professor Hapangama together with Drs John Kirwan, Sian Taylor, Purushothaman Natarajan and Lucy Dobson have designed a research study to see whether it is possible to develop an acceptable and easy to collect biomarker-based screening test, to identify those with an increased risk of endometrial cancer among women presenting with abnormal post/peri-menopausal bleeding. If successful it could mean many women could have an early test, at their convenience, to rule out endometrial cancer without needing to be referred to hospital, waiting for a scan, or having more invasive tests.

- Dr Nicola Tempest holds the position of NIHR Academic Clinical Lecturer at the University of Liverpool. Dr Tempest was also awarded the prestigious annual Laxmi Baxi Foundation award for the best abstract at the Society for Reproductive Investigation, Brisbane, 2023 for her work on "*spatial transcriptomics identifies distinct region and cell-type specific endometrial abnormalities in women with recurrent implantation failure*".

- Dr Paula Briggs has collaborated with the pharmaceutical company Bayer by acting as the UK Chief Investigator for the OASIS 4 clinical trial – investigating whether elinzanetant, a non-hormonal therapy, can reduce the effect of hot flushes following hormonal therapy treatment for breast cancer. As a result of the hard work by the research team, the Trust was also able to both screen and randomise the first UK participant to the trial.

2.3 Neonates

- Dr Elaine Neary is enrolled with the NIHR Research Scholars Programme which supports her research project "Using Novel Echocardiographic Techniques to Facilitate Identification of Preterm Neonates at Risk of Developing Significant Chronic Pulmonary Hypertension".

- Dr Nim Subhedar is enrolled within the NIHR Clinician Researcher Programme. The programme provides funding of £10,000 a year with the aim of supporting established clinicians interested in pursuing and leading their own clinical research.

- Research led by Professor Colin Morgan has led to the development of an idea for a new parenteral nutrition product that comprises a specific amino acid formulation concentration. A programme of further work to examine the changes in gene expression present in arginine supplemented infants <30 weeks' gestation between day 3 and day 10 of postoperatively has commenced. The changes in gene expression will be compared with those seen between day 3 and day 10 in unsupplemented preterm and term infants.

- Professor Mark Turner is the CEO of Conect4children-Stichting, a Dutch non-profit foundation that provides a pan-European paediatric clinical research network to clinicians and industry. This is a spin off from his work as scientific leader of CONECT 4 Children, an academic consortium that worked with a consortium of 10 large pharmaceutical companies on a €140 million, 6 year project that integrated research activity in 20 countries. He also is also Co-Director (Europe) of the International Neonatal Consortium which has developed global standards for research about medicines in neonates and is using real world data from 300,000 babies to develop a disease progression model for chronic lung disease of prematurity and reference ranges for laboratory values in neonates.

- A regular monthly research meeting offers peer support in the design of research projects and discuss potential recruitment challenges for those studies that are active on the unit. All members of staff who are or who wish to be research champions are encouraged to attend and participate. It is hoped that in the future the meeting will expand to accommodate parent involvement in research design.

2.4 Genetics

- Dr Jenny Higgs holds the post of CRN NWC Specialty Lead for Genetics.

- BaMSS – Baby and Mum Samples Study, a feasibility research project that aims to answer the question "what is the best way to take a sample to sequence a baby's genome?", organised by Genomics England will inform further research where thousands of babies will have their genome sequenced when they're born. This could help doctors find out if they have a particular genetic condition, and if they need any treatments when they're young. The research midwifery team at the Trust were key contributors in helping to adapt the study protocol to align with clinical

pathways. The Trust has been successful in being selected as a collaborating site for the main programme, opening in Spring 2024.

- The overall genetics research portfolio is continuing to grow, particularly in respect to rare disease studies. Although the numbers of patients participating in such research studies are small, the time and effort involved in identifying individuals who meet the research study criteria is considerable. Our committed genetics research team have compiled a catalogue of approximately 30 genetic research studies open at the Trust. The catalogue has greatly helped in identifying the type of study each patient would be eligible to take part.

2.5 Hewitt Fertility Centre

Joint Hewitt Fertility Centre and RD&I monthly meetings are continuing to take place and have been instrumental in continuing to drive forward the HFC research agenda.

- Mr Andrew Drakeley has been successful in securing funding for the STOP-OHSS (Shaping and Trialling Outpatient Protocols for Ovarian Hyper-Stimulation Syndrome): A feasibility study and randomised controlled trial, with internal pilot, to assess the clinical and cost-effectiveness of earlier active management of OHSS. Dr Drakeley is a co-applicant in this NIHR HTA funded project. The trial opened to recruitment in August 2022.

- Mr Andrew Drakeley has also been successful in securing funding for the LOCI Trial: Letrozole or Clomifene, with or without metformin, for ovulation induction in women with polycystic ovary syndrome. Dr Drakeley is a co-applicant in this NIHR HTA funded project. The trial is currently active and has recruited a total of 36 participants to date.

- A collaborative research project between the Trust and ExamenLab Ltd, Belfast commenced recruitment in January 2021. The aim of the research is to study the associations between sperm quality and the impact that this has on fertility diagnosis, fertility treatment, embryo quality, pregnancy and miscarriage. It is hoped that findings can be used to improve infertility treatment or current therapies. The project is recruiting well and is on track to achieve its target.

- Andrew Drakeley has been appointed to the role of Honorary Clinical Associate Professor at the University of Liverpool.

- 2022/23 marked the arrival and installation of the TMRW Life Sciences Cryo Robot Select (CFS). It is the first fertility clinic in the UK to receive the world's first automated platform for the safe management and care of frozen eggs and embryos. The CRS digitally tracks and monitors frozen eggs and embryos eliminating most potential points of failure and reducing the manual steps to a fraction of the current systems used world-wide. The CRS, developed and manufactured in the UK, has now been installed for validation studies at the Centre ahead of clinical use in the near future

2.6 University of Liverpool

- ***Harris Wellbeing of Women Research Centre***

  The Harris-Wellbeing of Women Research Centre has now secured small research centre status at the University of Liverpool and as part of this has expanded its remit to include the delivery of

women's health research in areas such as growth restriction (A Sharp), twin pregnancy (A Sharp, A Khalil), infection (K Navaratnam), population health (L Kenny) and global health (D Lissauer). A revised Centre strategy is being developed in collaboration with key partners under the interim leadership of Professor Mark Turner.

The Trust will be working to synergise working relationships with the Centre continuing to build on the strengths of existing effective collaborations for organisational mutual benefit in order to facilitate the delivery of high quality and impactful research.

- ***Perinatal Mental Health***

Pauline Slade, Professor of Clinical Psychology at the University of Liverpool continues to lead on a number of ground-breaking psychological research projects, namely:

- *Perinatal Access to Resources and Support: a Feasibility Study with External Pilot (PeARS):* The study, funded by CLAHRC, aimed to check the feasibility of a simple intervention based on three evidence based components to improve uptake of perinatal support for women in neighbourhoods with high deprivation. Outputs to date include five presentations and two papers.

- *Fear of Childbirth: Developing an evidence-based, usable and acceptable tool for UK maternity services (FOCUS*): The project, funded by Liverpool CCG aimed to develop a clear definition of the fear of childbirth construct; evaluate the utility and acceptability of existing measures for fear of childbirth with a UK sample; and, determine and implement where necessary, any requirement for modifications to current measures for fear of childbirth, for use with a UK sample. Outputs to date include three presentations and five papers. Following a successful bid, the team was award further funding from the NIHR Research for Patient Benefit programme.

- *Programme for the prevention of posttraumatic stress disorder in midwifery (POPPY):* The project, funded by Health Education North West, developed and evaluated the feasibility of an educational and supportive package for midwives, aimed at reducing the probability that work-related events are perceived as traumatic, that posttraumatic stress responses develop, and to ensure that access to psychological input for those with clinical PTSD is facilitated. Outputs to date include sixteen presentations and three papers. Following request by the World Health Organisation a case study was submitted and subsequently published in July 2021 – "Programme for Prevention of PTSD in Midwifery (POPPY) World Health Organisation Collaborating Centre - Evidence Based Public Health Nursing, Midwifery and Allied Health Professions into Practice".

- *Psychological health and relationship Experiences After vaginal Childbirth: The effects of experiencing perineal cuts or tears (PEACH):* The aim of this study, funded by the University of Liverpool, was to explore the effects of different degrees of perineal trauma on women's experiences of childbirth, perineal pain and their psychological and emotional health in the first nine months after they had given birth. Outputs to date include one presentation and two papers. A further two papers are currently being prepared.

- *Preventing Post Traumatic Stress Disorder: the Stress and Wellbeing after Childbirth Study (STRAWB2)":* This definitive trial, funded by the NIHR Research for Patient Benefit programme (£348,363), compared self-help material with usual care for women screened to be at risk of developing Post-Traumatic Stress Disorder (PTSD) after childbirth. The trial successfully recruited to time and target and within budget. Outputs to date include seven presentations and one paper.

- *Post-traumatic stress disorder following childbirth*: A systematic review of clinical effectiveness of psychological interventions, and metasynthesis of barriers and facilitators to uptake of care. Outputs to date include one paper.

- *Coping with the Uncertainties of Childbirth (CUBS):* The feasibility and acceptability of a single-session of Acceptance and Commitment Therapy (ACT) intervention to support women self-reporting fear of childbirth in a first pregnancy. The study has recently been completed and a paper has been published. A follow on study has been developed, and has received ethical and governance permissions to commence recruitment.

- *INDIGO* – the study funded by the Welling of Women and in collaboration with Professor Andrew Weeks sought to better understand the trauma-based experiences that obstetricians and gynaecologists face, and the contributing factors that these experiences have on burnout. The results of the study have been published and are currently being adapted into joint RCOG / RCM guidelines led by Professors Weeks and Slade.

2.7 International Research

- The Centre for Women's Health Research (based at Liverpool Women's Hospital) hosts the **Cochrane Pregnancy and Childbirth Cochrane Centre**. The Cochrane Centre is an independent, international not-for-profit organisation, dedicated to making healthcare readily available worldwide. Pregnancy and Childbirth is one of the many Cochrane Review Groups and was the first group to be formed. It produces and disseminates systematic reviews of healthcare interventions and promotes the search for evidence in the form of clinical trials and other studies of interventions. Cochrane produces high quality systematic reviews which are published monthly as part of the Cochrane Library. Sub-sets of Cochrane reviews published in the Cochrane Library are also published in the WHO Reproductive Health Library. The Group have also produced a Cochrane Pocketbook which allows doctors, midwives, students and parents to quickly access the best evidence for the care of pregnant women.

- The **Sanyu Research Unit** which was established in 2012, is directed by Professor Andrew Weeks and has a specific remit to improve maternal and newborn health by developing and evaluating innovative, cost-effective technologies and approaches that can be adapted in both high and low resource settings. Due to its co-location at the Trust, it is in the ideal situation to undertake maternal health research here in the UK. This important proof of concept research can be translated into either research studies in Low and Middle Income Countries (LMICs) to provide appropriate context to the clinical setting or translated directly into clinical practice. Some of the activities on-going within Sanyu during 2022/23 are:

  - *MOLI Study* (funded jointly by MRC/Wellcome/DfID: £1,160,007). This mixed methodology trial consists of a cohort study followed by an open label randomized trial comparing oral

misoprostol alone with oral misoprostol followed by oxytocin in women induced for hypertension of pregnancy. Recruitment within three public hospitals in Nagpur, India, commenced in January 2020 and completed in July 2022. A total of 1033 women were recruited (520 in the RCT and 513 in the cohort study). The results of the MOLI study and sub-studies have been presented at various conferences and will be presented at a hybrid dissemination meeting to be held in Liverpool in April 2023.

- *Q-MOLI - MOLI Sub-Study (1)* A qualitative study exploring patients' and health care professionals' expectations and experiences of labour induction with misoprostol and oxytocin for hypertension in pregnancy in India. The findings of the study were presented at the RCOG World Congress in June 2022, the All India Congress of Obstetrics and Gynaecology in January 2023, and will be presented at the MOLI study results dissemination meeting to be held in Liverpool in April 2023

- *Q-MOLI – MOLI Sub Study (2)* A situational analysis was conducted to assess current IOL resources, policies, and practices in India. The project aimed to enhance our understanding of factors that may pose barriers to implementing safe and effective IOL regimens. It consisted of three research streams: a document review of guidelines on IOL; key stakeholder interviews to gather information and opinions about current policies and practices on IOL in India; and site assessments and provider interviews at public and private facilities in Nagpur district and five nearby rural districts. The findings of the study were presented at the All India Congress of Obstetrics and Gynaecology in January 2023, and will also be presented at the MOLI study results dissemination meeting to be held in Liverpool in April 2023 and at the RCOG World Congress in June 2023.

- *Participant Generated Experience and Satisfaction (PaGES) Index - MOLI Sub Study (3).* A combined qualitative and quantitative tool has been developed in which participants record and rank their own 'comments' to identify what they consider most important about their experience and priorities. Data was collected from all recruits, both before and after birth. The findings of this study will be presented at the MOLI study dissemination meeting to be held in Liverpool in April 2023, and at the RCOG World Congress in June 2023. The PaGES abstract will be published in the BJOG, in the top 500 scoring abstracts, and is currently undergoing revision for publication in BMC Research Methods.

- *Baby Saver Tray* (funded by Sir Halley Stewart Trust: £14,000 and Canada Grand Challenges $100,000 CAD). Infant mortality and morbidity in LMICs is a major health problem. Evidence based practice suggests that keeping the mother and baby as close as possible during the immediate post-partum period, which includes delaying cord clamping, will bring benefits for both mother and baby. The Baby Saver Tray (BST) follows on from Professor Weeks' earlier development work on the BASICS trolley at the Trust. A feasibility study to test the device was conducted between August 2020 and February 2021 in Uganda. A number of deliverables were attained, including satisfaction from the women, their attendants and the providers of resuscitation. Recommendations / changes to the design have been taken on board, a local manufacturing unit is being developed in Uganda for mass production. Additional trays are also being produced in Wales for use in Ukraine during the war and for further research in Uganda.

- *The Babygel Study* (funded by European and Developing Countries Clinical Trials Partnership (EDCTP), €5.9m/£5.2m). The principal objective of this study is to determine whether the provision of alcohol-based hand rub (ABHR) to pregnant women for postnatal household use is effective for the prevention of severe illness or death during the first 3 months of life. Over 60 months, pregnant women will be recruited from homes within 72 study villages in Mbale region, Eastern Uganda Uganda in a cluster randomised trial. To date 4,845 women have been enrolled, the programme of work is due to complete in January 2025. Alongside this cluster trial are 3 PhDs (University of Bergen), health economics assessments (University of Exeter) and 3 masters students (Busitema University).

- *Immediate Postnatal Woman's Assessment (ImPoWA) Tool* – As the global provision of post-natal care is poor, the study will look to optimisation of immediate maternal post-natal care in healthcare facilities through the development and validation of a maternal self-assessment tool for post-natal Ugandan women. Beyond development of the tool, the study aims to evaluate the acceptability and usability of self-monitoring in the immediate postnatal period.

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- Dr Carol Kingdon, Reader in Medical Sociology at the University of Central Lancashire is research active within the area of Midwifery and Maternal Child Health. She has contributed to a global series on optimising caesarean section use published in The Lancet. This research has also informed the new World Health Organisation Guideline recommendations on non-clinical interventions to reduce unnecessary caesarean sections.

- Professor Mark Turner is the CEO of Conect4children-Stichting, a Dutch non-profit foundation that provides a pan-European paediatric clinical research network to clinicians and industry. This is a spin off from his work as scientific leader of CONECT 4 Children, an academic consortium that worked with a consortium of 10 large pharmaceutical companies on a €140 million, 6 year project to develop a sustainable pan-European research network that integrated research activity in 20 countries, 24 European Reference Networks, 25 clinical specialties, and liaised with networks in 6 other high income countries. He also is also Co-Director (Europe) of the International Neonatal Consortium which has developed global standards for research about medicines in neonates and is using real world data from 300,000 babies to develop a disease progression model for chronic lung disease of prematurity and reference ranges for laboratory values in neonates. As President of the European Society for Developmental, Perinatal, and Paediatric Pharmacology, he also hosted Liverpool 2022 meeting of the society. This work showcases the city's leadership in the development of medicines including the pregnant and lactating women, and for neonates.

3. Innovation

Searching for and applying innovative approaches to delivering healthcare must be an integral part of the way the NHS does business. Doing this consistently and comprehensively will dramatically improve the quality of care and services for patients.

During 2022/23 the Trust has continued to benefit from outsourced expert support from the 2Bio Impact Science team. 2Bio's service model is based on identifying problems and solutions; developing, testing and implementing the solutions and then supporting their adoption and

dissemination. In addition, discussions have been held with local Trusts in order to establish collaborative ways of working for the future.

Projects

- Research led by Professor Colin Morgan has led to the development of an idea for a new parenteral nutrition product that comprises a specific amino acid formulation concentration. The research team, together with the R&D Department and a team of expert patent attorneys worked to further protect the IP by formally submitting an international patent allowed the team to publish the preliminary data without other parties using the information for commercial gain whilst additional scientific analysis is undertaken. A programme of further work to examine the changes in gene expression present in arginine supplemented infants <30 weeks' gestation between day 3 and day 10 of postoperatively has commenced. The changes in gene expression will be compared with those seen between day 3 and day 10 in unsupplemented preterm and term infants.

- Dr Paula Briggs in association with Robinson Healthcare, has developed a speculum to assist in the diagnosis of urogenital atrophy for use in both primary and secondary care. The validation of this objective method of diagnosing urogenital atrophy and assessing response to treatment will facilitate ongoing research in relation to this condition.

- The Trust has entered into preliminary discussions in respect of a collaboration with Liverpool John Moores University. An 'intelligent mattress' has been developed that will deliver the c-tactile afferents preferred forces and velocities of gentle massaging touch that a preterm would have experienced in-utero. A programme of research will be designed aiming to address the question of how to maximise preterm infants' neurodevelopmental outcomes. The hypothesis is that this 'Mattress' device promotes experiences that are conducive to normal development. An application for grant funding to support this programme of work is in development.

4. Summary of Local and National Partnerships

4.1 Health Education Institutions

Although the Trust has a long history of significant collaborations with the University of Liverpool, concerted efforts have been made to develop existing partnerships with other HEIs.

Discussion between researchers at LWH and **Liverpool John Moores University** have continued with the aim of igniting new collaborations/joint working, identifying combined research strengths, exploring important research questions and strengthening existing networks. Some of the early indications of success have been:

- Proposal to develop a tactile sensory array 'intelligent mattress' to deliver moving stroking touch to preterm babies in the NICU at velocities and forces that research has shown is optimal for c-tactile afferents.

- A research study looking at the role of physical activity on metabolic health during pregnancy, specifically trying to understand the role of obesity and health status during pregnancy and whether these are related to habitual physical activity levels.

- Dr Kayleigh Sheen, in collaboration with colleagues at the Trust and the University of Liverpool, has been successful in securing a NIHR Research for Patient Benefit grant to the value of £267,680. The grant will fund a research study the aim of which is to provide an accurate way to identity women who experience fear of childbirth (FOC) during pregnancy in routine maternity care.

Following the appointment of Dr Julie Abayomi as Associate Head of Applied Health & Social Care at **Edge Hill University**, the Trust has been able to further strengthen its research partnership with the institution, for example:

- Dr Abayomi in collaboration with Hazel Billson, Maternal & Women's Health Dietitian (LWH) and Dr Andy Sharp (LWH/UoL) will undertake a study examining dietary intake and weight changes of women with a multiple pregnancy. Funding of £12,158 has been successfully obtained from the British Dietetic Association.

- The University continues to funded for two PhD studentships; one to research the dietary intake and weight change & physical activity of BAME pregnant women, then comparing observational data to pregnancy outcome data; and the other to evaluate the Mamafit programme with regard to diet, physical activity & perinatal mental health in pregnant/postnatal women. Both studies are recruiting well and are expected to complete in Summer 2023.

- Dr Abayomi together with Dr Katerina Bambang has been successfully in their bid for funding for a new PhD studentship to research the dietary intake of women attending the multiple miscarriage clinic. The project will be developed during 2023/24.

During 2021/22, Professor Dame Tina Lavender was appointment to the role of Professor of Maternal and Newborn Health, Department of International Public health at the **Liverpool School of Tropical Medicine**. Professor Lavender had previously been appointed as an NIHR Senior Investigator and therefore the Trust now has the privilege of being appointed as the affiliated Trust. This new working partnership has already demonstrated early success, namely:

- Research Capability Funds, linked to Prof Dame Tina Lavender's Senior Investigator award, has afforded an opportunity for a midwife, Sarah Farrell to be seconded to the Centre for Childbirth, Women's and Newborn Health to conduct a study, titled 'Maternity care experiences of women from minority ethnic groups'. Sarah, who is being mentored by Prof Tina Lavender and Dr Tracey Mills, is currently in the recruiting to her research study and is expected to complete in Summer 2023.

- Due to the success of the pilot secondment, Sian Rogers has been able to secure a second developmental placement within Prof Lavender's team. Her focus will on bereavement care for women from ethnic minority backgrounds.

4.2 Postgraduate Research

During 2022/23, the Trust hosted a number of postgraduate students, which can summarised as follows:

Speciality	Degree	University	Student initials	Supervisor
Maternity	MD	UoL	JG	Sharp
Maternity	MD	UoL	SB	Sharp
Maternity	PhD	UoL	SL	Sharp
Neonates	PhD	UoL	SG	Turner
Maternity	PhD	UoL	KL	Weeks
Maternity	PhD	UoL	TD	Weeks
Maternity	PhD	UoL	TP	Weeks
Maternity	PhD	UoL	TK	Wallace
Gynaecology	MD	UoL	PB	Hapangama
Gynaecology	MD	UoL	PN	Hapangama
Gynaecology	PhD	UoL	MA	Hapangama
Gynaecology	MD	UoL	LD	Hapangama
Gynaecology	PhD	UoL	HA	Hapangama/Tempest
Gynaecology	MD	UoL	LN	Hapangama/Tempest
Gynaecology	MD	UoL	PD	Hapangama
Gynaecology	MD	UoL	DC	Hapangama
Gynaecology	Post PhD	UoL	NT	Hapangama
Gynaecology	Post PhD	UoL	CH	Hapangama
Gynaecology	PhD	UoL	AM	Hapangama
Gynaecology	PhD	UoL	DR	Hapangama
Gynaecology	PhD	UoL	FA	Hapangama
Gynaecology	PhD	UoL	JW	Hapangama
Gynaecology	PhD	UoL	SP	Hapangama
Gynaecology	Post-doc	UoL	SJ	Hapangama
Gynaecology	MRes	UoL	CCT	Hapangama
Gynaecology	MRes	UoL	LM	Hapangama
Gynaecology	MRes	UoL	FB	Hapangama/Maclean
Gynaecology	MRes	UoL	KS	Hapangama/Tempest
Neonates	PhD	EHU	DM	Morgan

Speciality	Degree	University	Student initials	Supervisor
Maternity	PhD	LJMU	JW	Fowler
Maternity	PhD	LJMU	CL	TBC

In addition, the Trust supported 18 individuals from across the multi-disciplinary workforce with Master studies via the Apprenticeship Levy.

4.3 Liverpool Health Partners (LHP)

The overarching aim of Liverpool Health Partners is to bring together leading organisations within the City region in order to develop world-leading research which:

- addresses the needs of the local population
- plays to region's strengths and fulfils its research potential
- establishes an optimal collaborative framework through which LHP partners can work with one another and with other relevant stakeholders to shape and deliver the strategies for LHP's programmes.

During 2022/23, LHP purpose was revisited by its partners and is currently undergoing an organisational transformation. The revised purpose will deliver increased leverage of Liverpool's research and innovation achievements, greater relationship building with commercial partners and industry to attract inward investment and become self-financing, and the ability to develop a larger national and international presence.

In order to achieve the revised purpose, the partners unanimously agreed and recognised the importance of a Joint Research Office for Liverpool and a single point of access for researchers, the life sciences industry and research sponsors. The partners committed to retain and enhance the SPARK joint research office offer which underpins the delivery of the future strategic objectives and purpose of LHP.

The partners commissioned a review of the remit, processes and stakeholder experience of SPARK to shape a joint research office for Liverpool that is sustainable, fit for purpose and capable of underpinning the revised LHP purpose. The Trusts Head of RD&I was a member of the working group that provided a recommendation report to the LHP Board following a series of stakeholder engagement, data mapping and benchmarking exercises.

4.4 Provision of Mutual Aid

Following recommendation by the NWC CRN, the RD&I Department was been approached by a number of organisations to provide help and support. The following examples of mutual aid were provided during 2022/23:

- Research Governance support for Alder Hey until appropriate management arrangements were in place

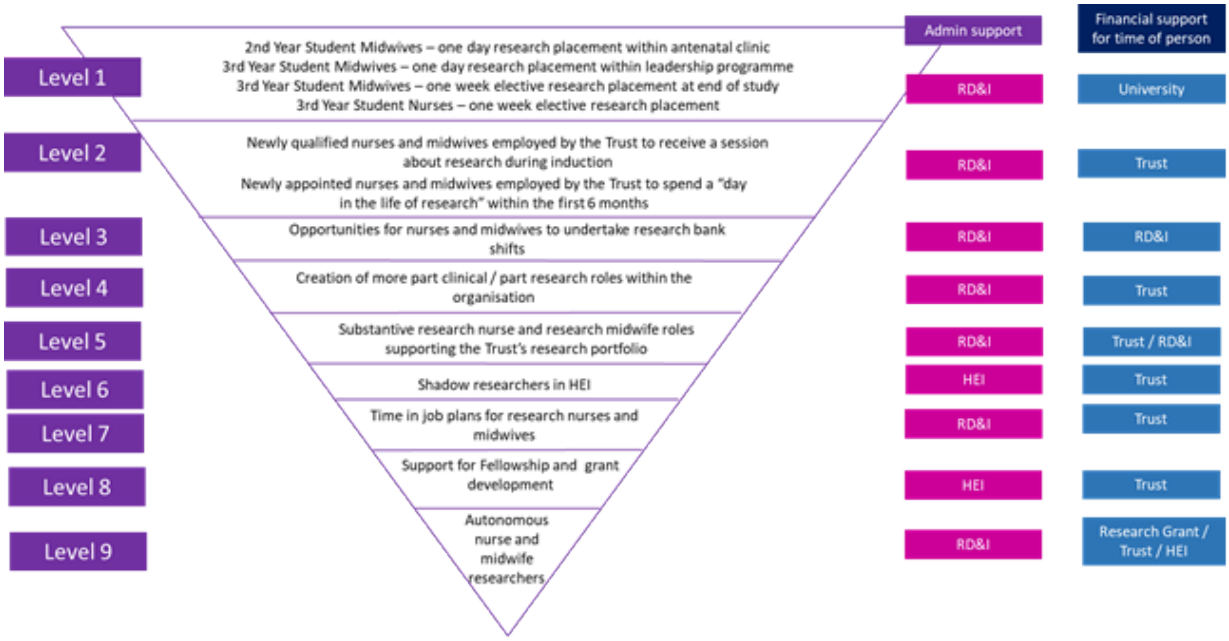
- Mentorship for newly appointed R&D Manager at Arrow Park

- Research Governance support for Liverpool Heart and Chest until appropriate management arrangements were in place

5. Development of the Nurse, Midwife and Allied Health Professional Research Workforce

It is recognised that healthcare institutions that embrace research can demonstrate better clinical outcomes and therefore it is important that nurses, midwives and allied health professional's are included in efforts to foster a research culture.

One of the remits of the RD&I Sub-Committee has been the development of the "Talent Pipeline Plan on a Page".



Its aim is to proactively nurture and support nurses and midwives from when they are students through their formative career years in order to give some individuals the opportunity and desire to become autonomous researchers. This aspirational plan was ratified by the RD&I Sub-Committee and a business case was developed and approved during 2022/23.

During 2022/23 efforts to realise the delivery of this plan have commenced. Some of the early positive developments can be highlighted as follows:

- Following suspension during the COVID-19 pandemic, the RD&I department has re-commenced hosting research placements for student midwives and nurses. All third year midwives will complete at least one day with research midwives in practice, ie a day within their leadership week and taking advantage of elective placements in research. As considerable positive informal feedback has been received to date, it is planned to undertake a more formal pre/post evaluation reflection in order to document the comments. By sensitising these students to research within their training, it will thus help develop potential researchers of the future.

- Jane Wilson, Consultant Midwife has embarked on a PhD with LJMU, supported by Dr Gillian Fowler. The aim is to develop a pilot study comparing healing and pain outcomes at 7 days postnatally when the Hegenberger speculum is used, compared with traditional care.

- Claire Lyon, Community Midwife has also embarked on a PhD with LJMU. Her aim is to develop a develop and validate a tool for health professionals for use in the assessment of perineal wound healing in women who have sustained either a first or second degree tear or had an episiotomy.

- Diane McCarter, Advanced Neonatal Nurse Practitioner is also undertaking a PhD in conjunction with Edge Hill University and undertaking a programme of work involving the use of the bioelectrical impedance device in assessing body composition in neonates.

- Following the success of her development placement at LSTM, Sarah Farrell, Research Midwife has been awarded a Clinical Phd Fellowship.

- Sian Rogers, Research Midwife has been awarded a 4Louis bursary to support her MSc studies. 4Louis is a charity working across the UK to support anyone affected by miscarriage, stillbirth and the death of a baby or child. As well as supporting families directly, 4Louis supports LWH and other Trusts by providing tools, equipment and training to professionals who care for families. Sian will be exploring midwives' experiences of caring for women undergoing pregnancy following a stillbirth or neonatal death. In February 2023, Sian was appointment to a developmental placement within LSTM. Her focus will on bereavement care for women from ethnic minority backgrounds. She has also been successful in securing a RCM Small Research Award, which includes the opportunity to sit on the RCM research prioritisation steering group and contribute to a briefing paper.

- Amy Mahdi, Research Midwife has been awarded a place on the third cohort of the NIHR early career researcher development pathway. The aims of the programme include: understanding the drivers, policy context and value of research in the NHS; ensuring the development of the knowledge, intellectual abilities, and methodologies to do and lead research; understanding how to engage and influence others to ensure the wider impact of research; understanding the factors/dimensions that create and enable leadership in research; developing aspirational goals and an initial 3-year career plan to achieve leadership potential.

- Mollie McGrane, Clinical Embryologist has been successful in being awarded a Health Education England/NIHR Predoctoral Integrated Clinical and Practitioner Academic Fellowship. The programme provides research training awards for health and social care professionals, excluding doctors and dentists, who wish to develop careers that combine research and research leadership with continued practice and professional development.

- Charlotte Stanley and Emily Rice have recently become the Trust's first accredited clinical research practitioners, allowing them to be recognised as a registered health professional amongst both colleagues and patients.

- Yana Richens, Director of Midwifery and Diane McCarter, Advanced Neonatal Nurse Practitioner have both been awarded places on the NIHR Senior Research Leader Programme

2023-2026. Places on the programme were competitively reviewed, with only 15 awarded nationally. Their acceptance on the programme is a testimony to their experience and skill as a research leader, and the work that they continue to do to promote and improve research excellence in nursing and midwifery.

- Brenda Broken, Midwifery Support Worker was awarded Employee of the Month in January 2023 for her invaluable and enthusiastic contribution in helping the midwifery research team recruit to the Baby and Mum Samples Study (BaMSS).

- Tamanda Timvere, Clinical Andrologist was awarded the Jean Purdy prize at the Society for Reproduction and Fertility conference in Belfast 2023 for her presentation: "Can the introduction of automation in therapeutic sperm preparation improve embryologists semen analysis performance?".

6. Other Achievements

Other notable achievements attained during 2022/23 can be highlighted as follows:

- The Liverpool School of Tropical Medicine and partners, of which the Trust was one, were awarded the COVID-19 Research and Innovation Award at the North West Coast Research and Innovation Awards 2022. The collaborative group worked tirelessly recruiting the highest participant number in the UK to Oxford/AstraZeneca's novel COVID-19 vaccine trial. Within nine months the vaccine received approval - directly benefiting millions of UK patients and within a year 4 billion people globally were vaccinated, helping bring the world out of the COVID-19 pandemic. The City-wide response truly demonstrated a willingness to pool and manage collective resources for the benefit of all.
- Winners of Dedicated to Excellence 2023:

    - *Outstanding Contribution to Family Health: Professor Colin Morgan, Neonatal Consultant,* for his commitment to recognising and nurturing talent across multiple professional groups and inspiring the pursuit of excellence in education, training and research.

    - *Excellence in Innovation & Research: Success is in the sperm - Tamanda Timvere, Olivia Sandys, Bethany Muller, Marta Starosta,* for implementing new technology, reducing the need for invasive procedures to aid insemination, testing new methods to assess sperm 'stress' before treatment, and sparking research into new methods of sperm freezing.

- On 27th March 2023 the Trust was delighted to host a Research Showcase event, celebrating the pioneering and innovative research taking place across the Trust. The event welcomed presentations from across our multi-disciplinary workforce including senior researchers, post-graduates, PhD students and early career researchers representing the wealth of talent we have at LWFT. A diverse range of research topics were explored in a series of short presentations, with the event also highlighting some exciting new research proposals. It provided a fantastic networking opportunity to engage and raise awareness of the cutting-edge research being delivered across the Trust in collaboration with our academic and industry partners. The programme also included the launch of the new RD&I Strategy. The following prizes were awarded:

- Established Researcher: Best Presentation: Joanna Gent
- Established Research: Runner-up: Kate Naveratnum
- Early Career Researcher: Best Presentation: Sian Rogers
- Early Career Researcher: Runner-up: Mollie McGrane
- Best Poster: Amber Adamson & Marta Starosta

7. Opportunities for Strengthening RD&I Across the Trust

There is scope to strengthen research, development and innovation within each Division by instituting RD&I leads within each clinical area. Regular review of divisional reports by the R&D Sub-Committee and the Quality Committee will ensure oversight of progress within each area.

In order to increase capacity and strengthen the support for the delivery of research across the Trust, continued and increased collaboration with the Harris–Wellbeing Research Centre / Centre for Women's Health Research should be encouraged. A number of activities can be successfully and conveniently supported, all to the Trust's benefit, for example:

- Management and coordination of RD&I studies and evaluations led by the Trust, ensuring adherence to research governance and quality assurance requirements
- Management of RD&I data within the Trust and beyond, particularly building upon the work of CIPHA (Combined Intelligence for Population Health Action)

The Trust needs to develop a comprehensive approach to innovation. Effective innovation will need to combine expertise in commercial processes, market assessment, intellectual property, patents etc and integrate with three essential components:

- Identification of clinical needs
- Effect product development
- Deployment of products into clinical practice

At present the Trust provides support for product development by buying in expertise for commercial processes, intellectual property etc, and so there is a need to upgrade this approach, for example:

- Undertaking scoping opportunities within the organisation, with a realistic assessment of likelihood of clinical impact and commercial success
- Identifying the Trust's appetite for novelty, investment, and risk
- Specifying the Trust's preferences for in-house expertise, outsourcing, and collaboration – and then identifying and deploying the resources to meet these requirements

8. Report Conclusions

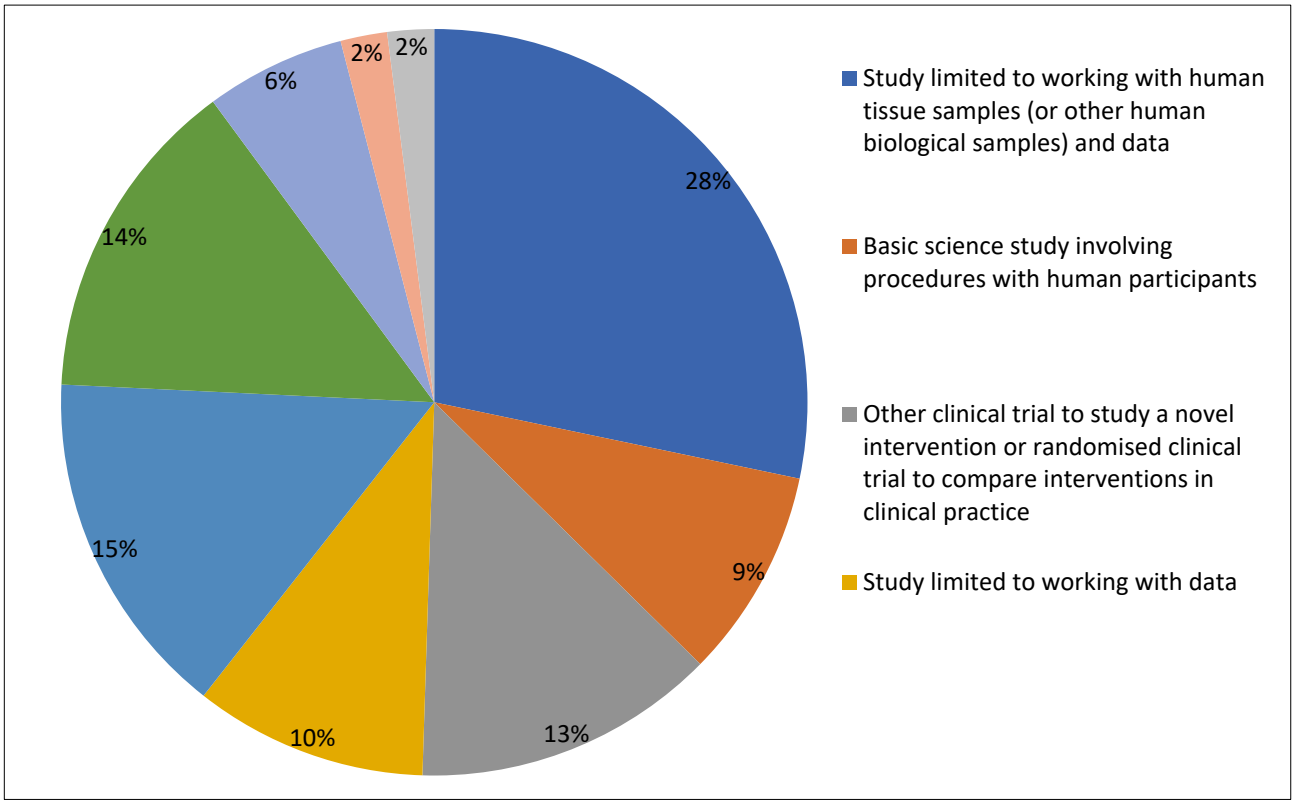
Research continues to demonstrate favourable outcomes to the Trust, its staff and its patients. The governance arrangements for research within the Trust are operating well. Good management of research performance has produced measurable results which must be maintained in order to maximise the benefit of external support. Positive improvements continue to be made in accordance with the overarching Trust research strategy.

External partnerships can be demonstrated as being very helpful in driving forward the Trust's own research agenda. In particular, partnerships with Higher Education Institutes continues to be an effective way to host high quality, high impact research. Therefore, efforts should be made to maintain and increase such collaborations.

Although the implementation of the City-wide joint research service has been at times challenging, by actively engaging and driving forward discussions and decisions, the changes have enabled and strengthened the Trust's ability to deliver and lead research. As evidenced by the City-wide response to the COVID-19 pandemic, lessons can be learned, and experience built upon to improve collaboration and achieve the Trust's own research aims.

APPENDIX 1 – Additional Information

Tables 1 & 2 – Projects active at LWH by study type



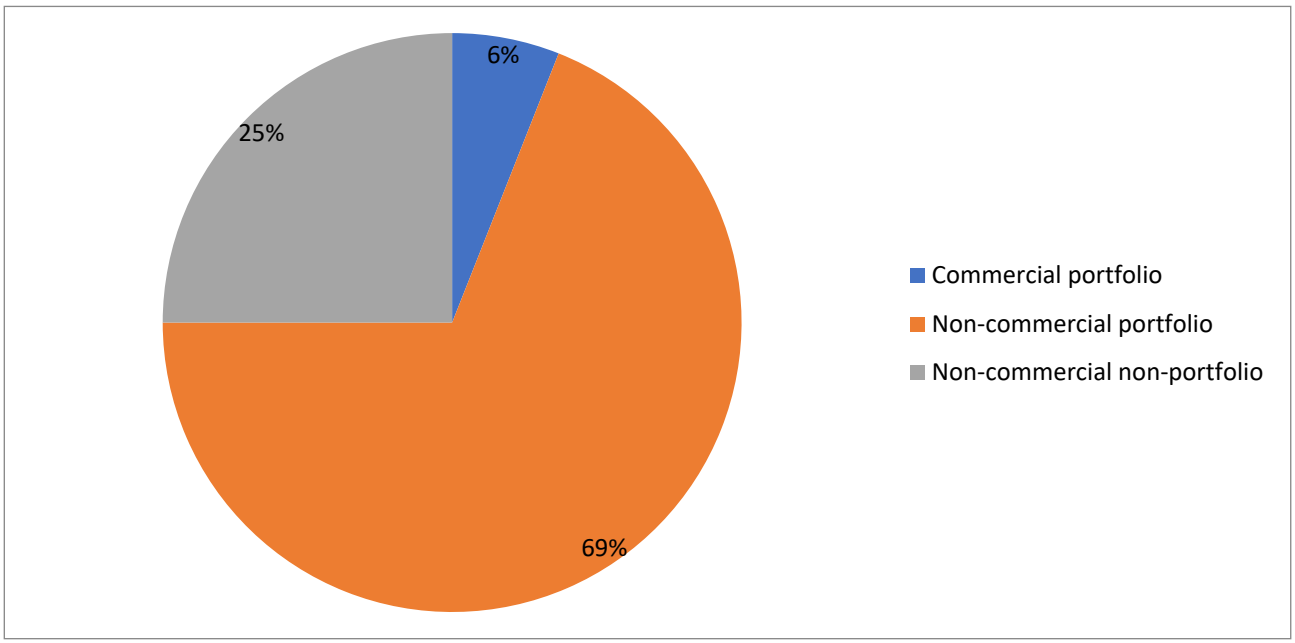
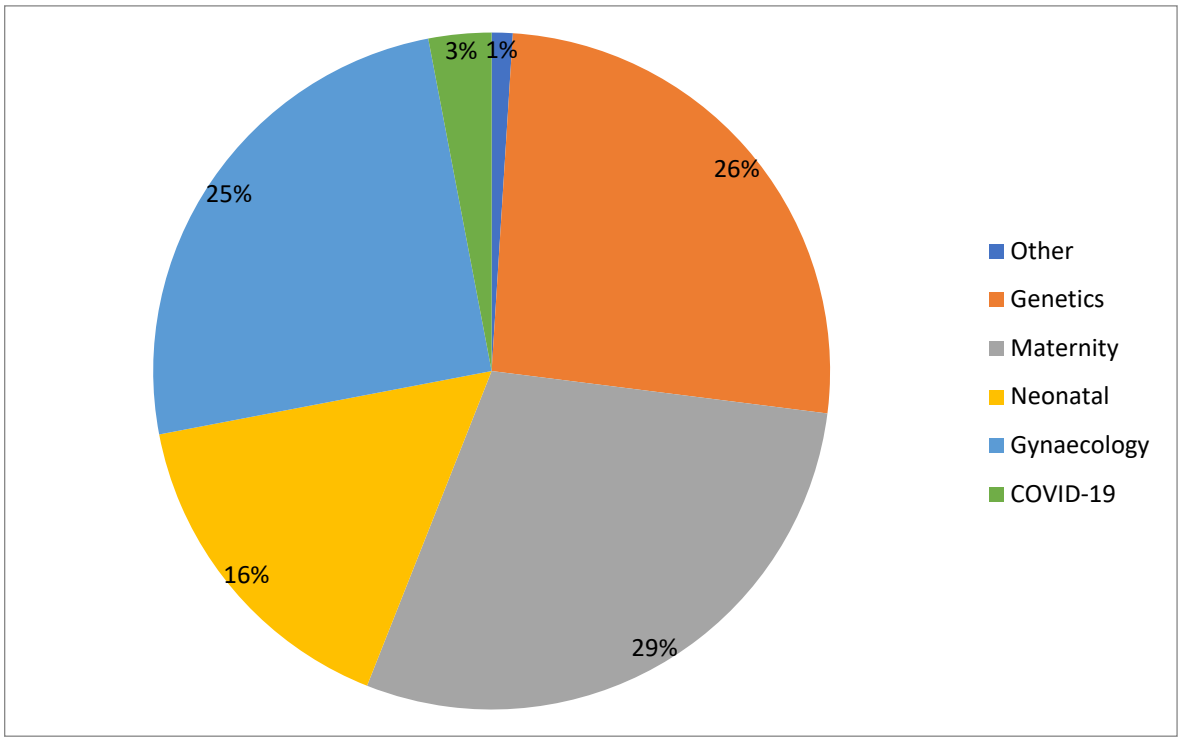


Table 3 – Studies by speciality at LWH



Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/096***		**Date: 13/07/2023**	
Report Title	**Integrated Governance Assurance Report Quarter 4 2022/23**			
Prepared by	***Allan Hawksey Head of Risk and Safety***			
Presented by	***Phil Bartley, Associate Director of Governance and Quality***			
Key Issues / Messages	This report provides information of oversight and assurance monitoring of Integrated Governance and highlights key risks to the Trust.			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	It is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place and the positive progress in managing risk has been made with Senior Management having oversight of such risks.			
Supporting Executive:	***Dianne Brown Chief Nurse***			

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

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

EXECUTIVE SUMMARY

The following Integrated Governance Assurance report covers Quarter 4 of 2022/23. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of Integrated Governance across the Trust.

This report continues to be revised to ensure it captures the key risks and achievements for the Trust, clearly identifying areas for improvement and documenting plans in place to address such issues. The report now includes Serious Incident reporting.

Main points reflected within the main body of the report from the Corporate Team are:

- Incident reporting within the Ulysses system continues to increase across all Divisions reflecting staff awareness of what constitutes an incident supported by ongoing training within the system from the Corporate Team. **There have been no Serious Incidents declared as a result of potential / perceived incident under reporting and an overall increase of 450 incidents in 22/23 compared to 21/22. There were 345 more patient safety incidents reported in 22/23 compared to 21/22. No harm incidents increased by 772 in 22/23, low / minor increased by 444 in 22/23, moderate decreased by 16 in 22/23, severe increased by 1 in 22/23 and deaths related to patient safety incidents increased by 1 in 22/23**
- A key area of risk for Q4 related to a significant number of PACS and CRIS imaging incidents not reported or being closed in a timely manner. There had been a significant number of historical incidents reported by the Imaging Department which had been impacted by the sickness of a member of the team who usually undertook compliance audits. **The usual audit process has since been resumed, PACS and CRIS imaging incidents have reduced, in part, due to real time audits having been recommenced and directed support / education from the Imaging Team to resolve areas of non / poor compliance.**
- The number of medication incidents reported through 22/23 has increased. Members of the Medicines Safety Group (MSG) continue to encourage the reporting of medication incidents so The Trust can learn from these incidents and prevent patient harm. **There were 487 patient safety incidents relating to Medication across 22/23 – 117 in Q1, 98 in Q2, 121 in Q3 and 151 in Q4. All incidents were graded as low / minor harm or less except for 3 incidents detailed within the report (from page 7 onwards).**
- There were 23 non-clinical health and safety related incidents reported, one less incident from the previous quarter**. All incidents were appropriately managed, and all processes were followed.**
- Complaints in Q4 22/23 saw an increase of 1 complaint compared to the previous quarter, and an increase of 4 compared to the same quarter in 21/22. Gynaecology Services division, which incorporates Gynaecology and the Hewitt Fertility Centre services, accounted for 50% of the received volume. The Trust are continuing to see a sustained increase in the number of complaints received relating to the Hewitt Fertility Centre when comparing previous levels. **These continue to be almost exclusively from fee paying patients where they are requesting part or full reimbursement of the costs incurred due to their dissatisfaction with the services provided. Discussions are continuing with the Gynaecology Divisional team and Patient Experience team to try and understand the reasons for the increase and how they can be managed, including how we can speed up the responses in relation to these requests. A refund policy has been developed and is awaiting formal approval, the aim is for this to be formally approved by June 2023.**
- Clinical Audit DNACPR findings good documentation in hospital notes regarding the decision of DNACPR. **There was good discussion with the family in all cases which was documented. Staff are recognising the dying phase appropriately. All patients and relatives had the opportunity to be involved in discussions relating to their end-of-life care plan. There was evidence of an individualised plan of end-of-life care in**

50% cases, which is an improvement from the previous 2021 audit. There is an ongoing action plan in place to ensure that there is evidence of an individualised plan of end-of-life care in the other 50 % of cases whereby a plan has been agreed to ensure 100 % compliance.

- The functions of the Quality Improvement Team and the Clinical Audit and Effectiveness were merged from 1 April to form the Continuous Improvement Team. Initial engagement with representatives from AQUA has confirmed the need to address Trust culture in relation to quality improvement and learning and work towards a shared culture and vision of continuous improvement. **Further meetings will take place in Q1 to refine roles, responsibilities, and timescales.**
- To date in this financial year, the Trust has agreed settlements totalling £557051. **The previous financial year's settlements totalled £1609988. Damages settlements in 2021/22 totalled £42551491.36**
- Divisional FFT "you said, we did" reports are now a standing item on the Patient Involvement and Experience Subcommittee. **This enables greater visibility and promotion of the improvements being implemented from the FFT and allows this learning to be shared across the various divisions who attend this meeting.**
- There were 14 serious incidents declared to the Integrated Care Board (ICB) during Q4 (an increase of 6 from Q3) – there were 2 reported in January 7 in February and 5 in March. 3 of these cases were subsequently de-escalated with the ICB. All cases had had Executive oversight and sign off. **Some cases related to the Isolated Site Risk (critical care transfer), and some incidents that did not form part of a theme, pattern, or trend. All Serious Incidents had full duty of candour completed and an investigating officer appointed by the Divisions at the point of declaration to the ICB. This enabled investigations to be expedited as quickly as possible to ensure any immediate learning identified could be implemented and shared across the Divisions.**
- As of 31 March 2023, there were 15 out of 25 action plans that had actions overdue. **These were subsequently escalated to all Heads, Divisional Managers and Safety Leads to action and all Divisions agreed to have a plan in place to resolve overdue actions which will be monitored via Divisional Governance meetings in addition to the Safety and Effective Sub Committee.**
- In Q4 there was 1 tribunal claim submitted to HR with an expected date July 2023
- There remains ongoing work across all Divisions via their integrated governance reports, with a particular focus on Maternity and Gynaecology to be able to demonstrate:

  Key areas of risk affecting patient safety and quality of services
  Divisional plans to manage and mitigate those risks
  Evidence of embedded learning Divisionally and cross Divisionally
  Audit of embedded learning within 6 months of learning being identified (As per Ockenden within Maternity but that expectation is across all Divisions) and how assurance is gained, 6 months, 12 months and beyond that learning is embedded, practice and culture has changed and there is clear tangible evidence of improved patient safety outcomes

This report does not reflect the associated risks in relation to the Trust's Future Generations Strategy. Work is on-going between governance, patient experience, finance & transformation & strategy which may support further additions to this paper throughout 2023/24 and beyond in relation to this piece of work.

The Committee are requested to note the contents of the paper and take assurance that there are sufficient governance processes in place consisting of divisional and corporate oversight to mitigate and manage risk and to take assurance that feedback provided by the Committee following the Q3 report has been acted upon and the additional information requested has been incorporated into the Q4 report.

MAIN REPORT

INTRODUCTION

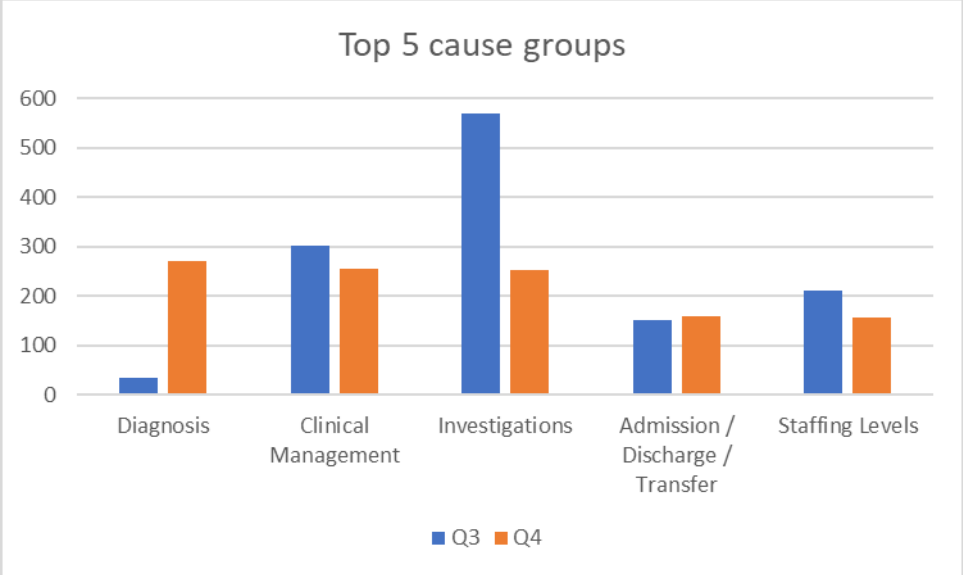
This integrated governance report is a quarterly integrated review of quality governance and the standard of care at Liverpool Women's Hospital. The intention of the report is to complement the monthly quality governance dashboards and performance reports by providing a longer term, thematic analysis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

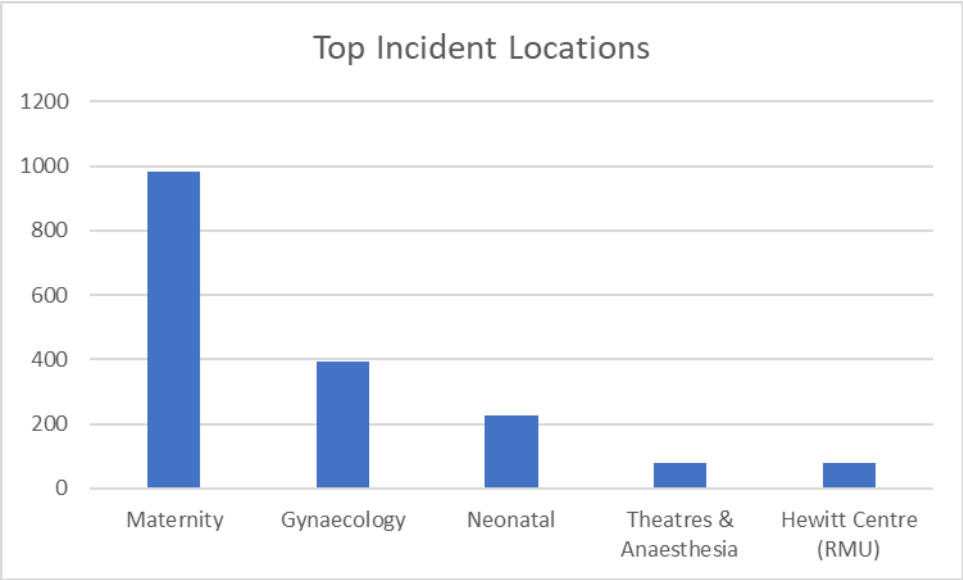
KEY THEMES AND AREAS OF RISK ACROSS THE TRUST

1. Incidents

HEADLINE - A key area of risk for Q4 was within the diagnosis cause group (271) relating to diagnosis delay / failure to (260), diagnosis missed (5), diagnosis wrong (3) and undiagnosed breach (3) with 182 in Gynaecology and 59 in Maternity. These related to PACS and CRIS imaging incidents

- 2004 reported in total
- Decrease of 19 incidents compared to 2023 incidents in Quarter 3 22/23





Total number of incidents reported across Q2 for 2022/23 compared across 2021/22.

2021-22	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total	557	636	498	510	468	835	597	718	577	686	657	657	**7396**
Quarterly	**1691(>279)**			**1813 (>122)**			**1892 (>79)**			**2000 (>108)**			**(>2626)**
2022-23	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**total**
Total	641	693	500	700	658	627	849	665	509	616	653	735	**7846**
Quarterly	**1834 (<166)**			**1985 (>151)**			**2023 (>38)**			**2004 (<19)**			**(>450)**

Patient Safety Incidents

1915 total PSI for Q4 (Trust wide)

Family health (1181)	Gynae (Inc HFC) (504)	CSS (184)
Investigations (194))	Diagnosis (202)	Investigations (29)
Clinical Management (193)	Communication (46)	Medication (19)
Admission / Discharge / Transfer (122)	Clinical Management (41)	Staffing Levels (19)
Staffing Levels (116)	Appointments (37)	Clinical Management (18)
Medication (111)	Admission / discharge / transfer (29)	Communication (17)

Analysis of the key themes

- Diagnosis – 271 incidents of which 260 related to PACS and CRIS incidents
- Clinical Management – 254 incidents of which 35 related to Delay Over 4 Hours During Ongoing Induction Of Labour and 22 related to Failure To Follow Clinical Guidelines
- Investigations – 252 of which 119 related to Inadequately Labelled Samples
- Admission / discharge / transfer – 160 of which 36 related to Term Baby admitted to the Neonatal Unit
- Staffing levels – 156 of which 47 related to Staff Problem = Levels and 39 to a Staffing Problem.

Comparison to 21/22

- There were 345 more patient safety incidents reported in 22/23 compared to 21/22
- No harm incidents increased by 772 in 22/23, low / minor increased by 444 in 22/23, moderate decreased by 16 in 22/23, severe increased by 1 in 22/23 and deaths related to patient safety incidents increased by 1 in 22/23

Improvements and actions

Trust Wide – A key area of risk for Q4 related to a significant number of PACS and CRIS imaging incidents whereby imaging reports and images were not being fully completed and closed. There had been a significant number of historical incidents reported by the Imaging Department which had been impacted by the sickness of a member of the team who usually undertook compliance audits. **The usual audit process has since been resumed, PACS and CRIS imaging incidents have reduced, in part, due to real time audits having been recommenced and directed support / education from the Imaging Team to resolve areas of non / poor compliance.**

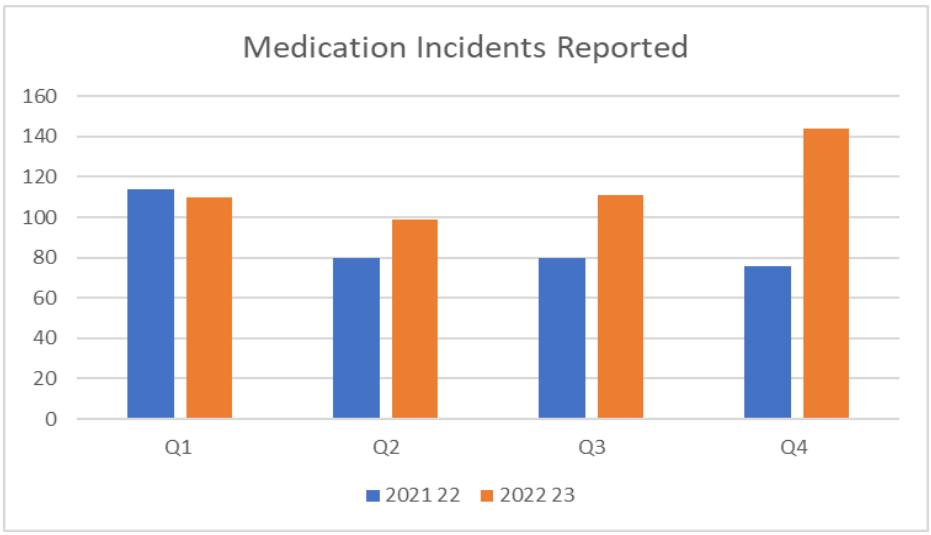
2. Medicines Safety

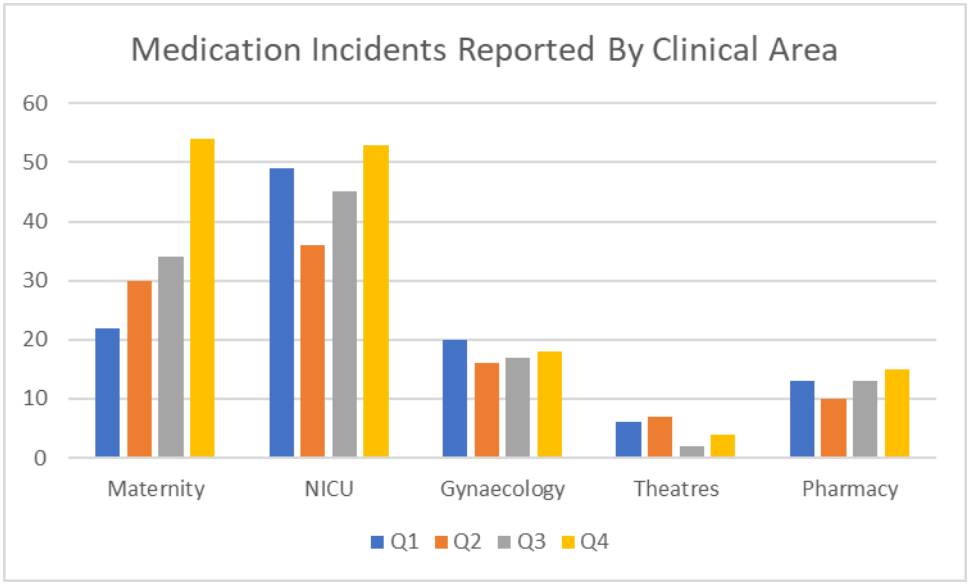
HEADLINE - Three new risks have been added to the Medicines Management risk register following the CQC visit in January. These relate to the following.

- There is a lack of assurance of compliance with Trust oxygen guidance because there is no regular audit review of oxygen prescriptions across the Trust – **Risk approved at MMG. Risk owner Deputy Chief Pharmacist (DCP). Risk target date is 30/09/2023 and the risk has 2 ongoing actions currently being managed by the DCP**
- There is a lack of assurance that all inpatients in an acute setting have a reconciled list of their medicines within 24 hours of admission because there is inaccurate performance information for medicines reconciliation rates across the Trust and no regular audit review - **Risk approved at MMG. Risk owner Deputy Chief Pharmacist (DCP). Risk target date is 30/09/2023 and the risk has 4 ongoing actions currently being managed by the DCP**
- There is a lack of assurance that patients who are prescribed treatments for medical termination of pregnancy do not receive their medication as intended because patients who are undergoing early medical termination of pregnancy do not receive follow up communication from the external pharmacy provider to ensure compliance with prescribed treatments - **Risk approved at MMG. Risk owner Deputy Chief Pharmacist (DCP). Risk target date is 30/09/2023 and the risk has 2 ongoing actions currently being managed by the DCP**

<u>Ulysses Data</u>

Total number of medication incidents reported per quarter during 22/23 compared to 21/22





Key Themes

The number of medication incidents reported through 22/23 has increased. Members of the Medicines Safety Group (MSG) continue to encourage the reporting of medication incidents so The Trust can learn from these incidents and prevent patient harm.

There were 487 patient safety incidents relating to Medication across 22/23 – 117 in Q1, 98 in Q2, 121 in Q3 and 151 in Q4. All incidents were graded as low / minor harm or less except for 3 incidents:

In Q3, a maternity patient did not receive their Anti D which resulted in a Serious Incident investigation. Actions identified from this investigation have been incorporated into the Division's ongoing action plan which is being monitored via the Safety and Effectiveness Sub Committee meeting.

In Q4, a maternity patient did not receive the correct dose of Fragmin with resulted in a further Serious Incident investigation. This investigation remains ongoing, and the learning will be discussed at the Safety and Effectiveness Sub Committee once the investigation has been finalised. A further incident related to an incorrect dose of medication within Theatres which did not meet the Serious Incident threshold. This is subject to ongoing Concise Review.

Actions & Improvements

Division	Area noted for improvement	What are we doing to improve the position both short and long term	Committee/division/ person responsible	Timescales for completion
All areas	Learning from medication incidents across the Trust.	LOTW shared with senior staff across all areas for dissemination across teams. *Oxygen patient safety & physical safety following recent NatPSA Alert regarding the use of oxygen cylinders; Compliance aids.*	MSG	Ongoing as per Risk Register.
All areas	Learning from medication incidents across the Trust.	Weekly Safety Check In covering topics including. *Oxygen cylinder alert; VTE assessments; Vitamin K documentation; CD incidents; PGDs; Look a Like & Sound a Like (LASA) medicines; Antiplatelets & Anticoagulants.*	MSG	Ongoing as per Risk Register.
All areas	Safe and secure storage of medications.	Matrons to complete monthly nursing audit (Medicines 2nd week of month). Actions discussed and reviewed at MSG.	MSG	Ongoing. Subject to monthly review at MSG.
All areas	Safe and secure storage of medications.	Trust wide audit of safe and secure storage of medications in all clinical areas. Action plans discussed and reviewed at MMG.	MMG	Ongoing. To be discussed at MMG scheduled in July for potential closure.
All areas	Support for prescribing during junior doctor strikes across NHS.	Increased workload for NMPs across the Trust to ensure ongoing patient safety for prescribing and efficient discharges of patients from hospital.	Pharmacy & MMG	Closed. Support in place. Ulysses will continue to be monitored for any emerging themes, patterns, or trends.
All areas	Change to single practitioner checks for the administration of Fragmin.	Education and training of staff around the importance of following the six rights of administration when giving Fragmin to patients across the hospital.	MSG & MMG	Closed. Support in place. Ulysses will continue to be monitored for any emerging themes, patterns, or trends.

Theatres	Safe and secure storage of medications.	In accordance with national guidance all local anaesthetic agents must now be stored separately from other drugs and intravenous fluids.	MSG & MMG	Closed. Meds storage in Theatres has now been improved with new drugs cupboards. Ulysses will continue to be monitored for any emerging themes, patterns or trends.
All areas	Attendance at NMP Educational Forum in March.	Raising profile of NMP work across Trust and increasing CPD opportunities for staff.	MMG	Ongoing. Next Educational Forum scheduled for July 23.

3. Health & Safety

HEADLINE – In Q4, there were 23 non-clinical health and safety related incidents reported, one less incident from the previous quarter. The majority of incidents were reported by the Maternity Directorate, with Gynaecology Division, Neonatal Services, Clinical Support Services Division, and Corporate function reporting four, three, six and one incidents, respectively. All incidents were appropriately managed, and all processes were followed.

A breakdown of all non-clinical health and safety incidents, reported in quarter 4, are detailed in the table below:

	MATERNITY	GYNAECOLOGY & RMU	CLINICAL SUPPORT SERVICES	NEONATES	CORPORATE FUNCTION	TOTAL
STAFF INCIDENTS						
PERSONAL INJURY/ILL HEALTH	1	1	2	1		5
COSHH			1	1	1	3
ENVIRONMENT		1	2			3
NEEDLESTICK INCIDENTS	6	1	1	1		9
SLIPS, TRIPS & FALLS	1	1				2
TOTAL	8	4	6	3	1	22

PATIENT & VISITOR RELATED INCIDENTS						
INJURY				1		1
TOTAL				1		1

Improvements and actions:

Work remains ongoing within the team to increasingly raise the profile of the Health and Safety Team making Health and Safety everyone's business. The Health and Safety Group meeting chaired by the Head of Risk and Safety continues to be well attended by all Divisions.

CAS continued to be well managed, and alerts actioned within defined deadlines. A recent NatPSA has prompted a review of our CAS Policy and Processes for assurance.

4. Complaints, PAL's & PALS +

HEADLINE - Complaints in Q4 22/23 saw an increase of 1 complaint compared to the previous quarter, and an increase of 4 compared to the same quarter in 21/22. Gynaecology Services division, which incorporates Gynaecology and the Hewitt Fertility Centre services, accounted for 50% of the received volume, although The Trust are continuing to see a sustained increase in the number of complaints received relating to the Hewitt Fertility Centre when comparing previous levels.

These continue to be almost exclusively from fee paying patients where they are requesting part or full reimbursement of the costs incurred due to their dissatisfaction with the services provided. Discussions are continuing with the Gynaecology Divisional team and Patient Experience team to try and understand the reasons for the increase and how they can be managed, including how we can speed up the responses in relation to these requests. A refund policy has been developed and is awaiting formal approval, the aim is for this to be formally approved by June 2023.

The number of PALS + cases dealt with this quarter is consistent, with Hewitt Fertility Centre conducting the majority of these, with the hope that these will address concerns at an earlier stage. Work continues to fully utilise the PALS + process provisions to achieve early resolution of concerns and provide more timely outcomes for people raising concerns. The trends show that this has a positive impact on reducing the number of complaints needing to be raised when it is consistently used.

656 PALS cases were received in this quarter which is an increase of 69 cases overall. Initial end of quarter review has highlighted a few areas which have been repeatedly raised in this quarter:

Initial end of quarter review has highlighted a few areas which have contributed towards this:

- Patients continuing to contact PALS trying to gain information about appointments and associated delays due to capacity.
- Communications queries were recorded as the main category in 41% of the total cases for the quarter with appointments accounting for 34% of the cases recorded. Communications cases have decreased by 5% although appointment issues have increased 8% since last quarter.

- The most cases received by a division was 305 (46%) PALS cases which were received this quarter by Gynaecology. With the busiest month being noted as January 23.
- Appointment provision is continuing to be a point of dissatisfaction from patients who feel they are experiencing extended waits and the severity of their own condition is not being considered in this decision. There is no specific mention of any strike action affecting this in the concerns although it is bound to have had a knock-on effect.
- Patients are continuing to contact the patient experience team due to being unable to contact the correct admin or clinical area or having left messages, no return calls being made, or experiencing long waits when contacting GED and MAU. Issues are also started to be noted of Hewitt patients trying to contact out of hours support which is provided via the GED also. This trend is being monitored to access the scale of this potential issue.

Improvements and actions:

As telephony software (Netcall) allows for greater reporting capabilities which allows greater scrutiny and reporting of any issues. 2 workstreams are still underway reviewing the clinical call performance in both the Maternity Assessment Unit (MAU) and the Gynaecology Emergency Department (GED). Patient Experience Team have requested to be involved in both groups. There is Patient Experience representation on the workstream looking at the MAU improvements and this is already underway. The currently has been no update relating to the GED workstream or commencement date.

Appointments and difficulties in contacting the trust about these continue to be prevalent themes in the PALS cases received by the Trust. Patients are all aware nationally of the waiting lists across the NHS and that fear of not getting their own appointment is leading to an increase in more forceful queries being raised to try and expedite their own case. **Divisions are currently reviewing appointment capacity and increasing weekend appointment slots (provided by Medinet). There are plans to launch a text messaging system to remind patients of their appointments slots with the opportunity for patients to respond and to either confirm or cancel and reduce non-attendance.**

Significant increases in the number of complaints for the HFC has also put additional pressure on the resources normally required to address complaints in this area. **The position has started to improve as more IO's are trained and are made available to complete reports.**

5. Clinical Effectiveness and Audit

HEADLINE – The Trust received 15 Clinical Audit Reports including Action Plans in Quarter 4.

1. Key successes from Clinical Audits completed Quarter 4

- Identification of issues regarding documentation can now be to be relayed to digital team.
- LWH guideline for the management of antepartum/intrapartum haemorrhage has now been updated to reflect NICE Guidelines 121 standards.
- There was good documentation in the hospital notes regarding the decision of DNACPR. There was good discussion with the family in all cases which was documented.
- Staff are recognising the dying phase appropriately.
- All patients and relatives had the opportunity to be involved in discussions relating to their end-of-life care plan.

- There was evidence of an individualised plan of end-of-life care in 50% cases, which is an improvement from the previous 2021 audit.
- The K2 team will be promoting teaching videos for staff to access on how to complete safe sleep assessments correctly.

2. **Key themes to be actioned as a result of Clinical Audit reports received in Quarter 4 which are monitored via the Clinical Audit & Effectiveness Team and Quality Improvement Group (QIG).**

- Lesson of the week to be circulated to all staff (midwives and support staff) in the postnatal ward on completing checklists prior to discharge.
- Education surrounding care of the dying patient remains a priority for staff within the trust. There appears to be an issue with accurate recording of decisions made and recording is inconsistent. This improvement work remains ongoing following a recent audit demonstrating 50 % compliance. This work will be overseen by the Lead MacMillian Nurse and improvements reported via an updated audit.

Improvements and actions:

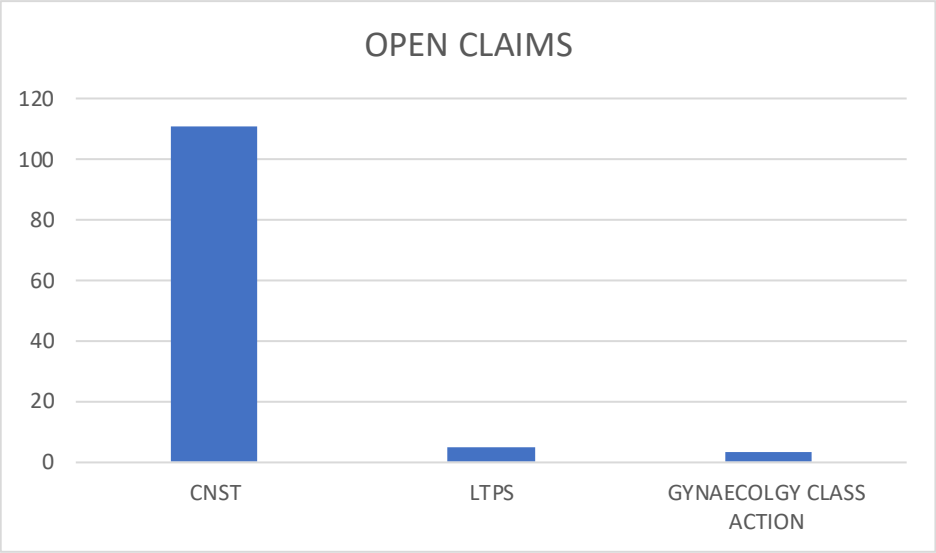
Where audits have determined that the level of expected standards have not been met, there are significant Divisional action plans formulated to address issues highlighted. All audits are reviewed by the Quality Improvement Group (QIG) and actions either approved or amended and updated where required. These are divisionally led and monitored by the Clinical Audit and Effectiveness (CAE) Department. The outcome of such action plans is subsequently reported back in to QIG where a further audit may be required. There is considerable oversight of all audits by QIG and the Continuous Improvement Team Department.

6. Legal Services

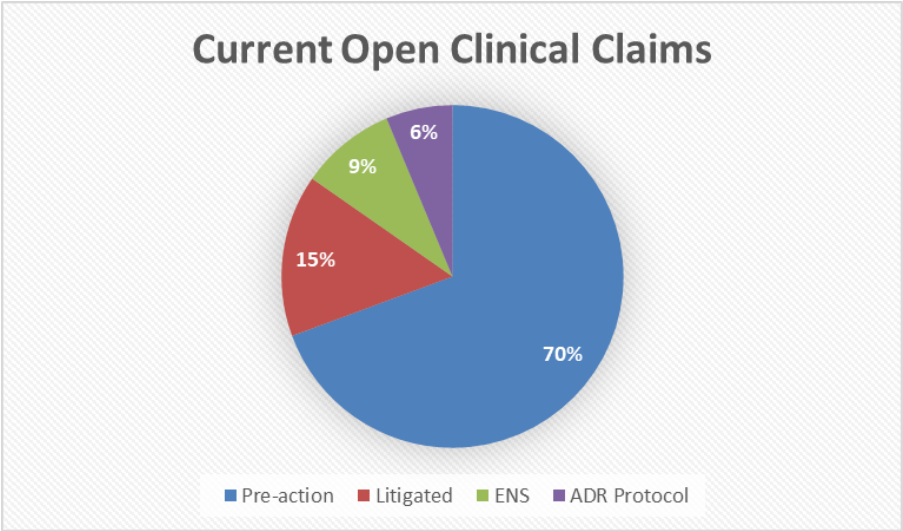
HEADLINE – To date in this financial year, the Trust has agreed settlements totalling £557051. The previous financial year's settlements totalled £1609988. Damages settlements in 2021/22 totalled £42551491.36

The Claims data has been generated using data extracted from the legal team's local database, supplemented by the NHS Resolution (NHSR) claims management system.

1. Currently there are 116 Active "open" claims (111 Clinical claims - 5 non-clinical – 3 Gynaecology Class Claim cases).



2. The current procedural position of these claims are as follows;



3. The following table represents new and settled CNST (Clinical Negligence Scheme for Trusts), LTPS (Liability to Third Parties Scheme), ENS (Early Notification Scheme) and Inquest files over the past 12 months;

Month	CNST		LTPS		ENS		Inquest	
	New	Settled	New	Settled	New	Closed	New	Closed
April 2022	2	2	2	1				
May 2022	10	2					2	
June 2022	3			1			1	
July 2022	6	1	1		1			
August 2022	7	1	1					

September 2022	3				2			
October 2022	1		1	1	2		1	1
November 2022	4	2		1		1		
December 2022	3	1	1			1		
January 2023	3	2						
February 2023	4	1	1	3			1	
March 2023	6	1	1					1
April 2023	6	3		1				
Total	**58**	**16**	**8**	**8**	**3**	**2**	**5**	**2**

Improvements and actions:

Following training provided by both Hill Dickinson and NHSR, the Trust are emphasising a new approach to continuous analysis of claims and ensuring lesson learning is developed throughout the division. The legal team are assisting the divisions with this by sending ongoing new monthly claims data as well as monthly settled and closed claims data – this contains admissions made and financial information. Alongside this, in real time new claim notifications are provided to divisions which encloses a copy of the proceedings to assist with early evaluation and review. Engagement with the divisional and governance teams has increased allowing the sharing and evaluation of data between the legal and clinical teams to increase.

Early identification continues to remain a focused area, with the review of SI's for potential early reporting to NHSR. The legal team are working with the governance team mangers with this, which supports the GIRFT best practice guidance.

The scorecards contine to provide insight on Trust themes and trends and can be utiliesed as quality and improvement tools which provides insight into the Trusts claims over the past 10 years to support learning from where there has been harm.

7. Patient Experience

HEADLINE – Divisional FFT "you said, we did" reports are now a standing item on the Patient Involvement and Experience Subcommittee. This enables greater visibility and promotion of the improvements being implemented from the FFT and allows this learning to be shared across the various divisions who attend this meeting.

Friends and Family Test (FFT) – overview

FFT reports are scheduled and sent to all divisions on a weekly basis highlighting the comments that need reviewing and addressing, both positive and negative. Divisions have been encouraged to consult with the patient experience team if there are any specific reports that they need creating to assist with this review. F&F review is included in the Divisional reports required to be presented. KPI has been introduced to monitor the response initially to the displeased responses provided.

FFT results for Q4 2022/23

Number of responses received

Total	Maternity	Gynaecology	Genetics	Reproductive Medicine (RMU)
2721	335	1918	65	86

Overall experience score (satisfaction report) – this score is based on the responses to the question "Please rate your overall experience (Poor=1 to Good=10)"

Trust score %	Maternity %	Gynaecology %	Genetics %	Reproductive Medicine (RMU) %
89.99 ↓	82.85 ↓	90.80 ↓	94.31 ↑	87.18 ↓

Recommendation score - this score is based on the responses to the question "*Thinking about the service we provided, overall, how was your experience of our service*?"

Trust score %	Maternity %	Gynaecology %	Genetics %	Reproductive Medicine (RMU) %
92.04 ↓	87.82 ↑	92.52 ↓	94.69 ↑	86.98 ↓

Improvements and actions:

Divisional FFT "you said, we did" reports are a standing item on the Patient Involvement and Experience Subcommittee (PIESC). This enables greater visibility and promotion of the improvements being implemented from the FFT and allows this learning to be shared across the various divisions who attend this meeting.

These are also displayed in the patient and public areas of the relevant area. This is to promote the work done and also encourage more responses and patients see their feedback making a difference.

Below are some examples shared at the PIESC covering Q4 22/23.

You said – Doctors knowing medical history – OPD

We did –. Themes relating to medical attitudes and behaviour have additionally been shared with the Divisional clinical lead for discussion at team meetings.

You said – Long Wait to be seen

We did – The outpatient Department has implemented the use of a refreshment trolley for oncology patients who may be experiencing longer than expected waits for clinic and have strengthened communication with patients awaiting all clinics by verbalising delays over 30 minutes instead of only utilising the message board.

You said – Delayed discharge.

We did - Maternity ward Management team have an improvement plan with a focus on the discharge process to initiate a timely discharge this includes the TTO process, twilight NIPE midwife for early discharge and midwifery led discharge of increased risk patients. With the implementation of the above changes, it is anticipated that an increased number of families will be able to go home before 12 noon.

You said – Miscommunication of information verbally between staff providing care

We did – Reintroduction of Safety Briefs across all areas. Ongoing work addressing handover of care including bedside handover by clinicians to encourage involvement and participation in care. Maternity base has introduced a new SBAR (Situation, background, assessment, recommendation) handover to ensure all information is handed over to ensure patient s do not have to repeat any medical issues.

8. Quality Improvement

/

HEADLINE – The functions of the Quality Improvement Team and the Clinical Audit and Effectiveness were merged from 1 April to form the Continuous Improvement Team.

Key areas of activity from Q4 2022/23

- The recently appointed Head of Continuous Improvement has completed an initial evaluation of current projects, systems, and practice.
- The Quality & Safety Facilitator was appointed in September but has not been able to assume their full range of responsibilities due to recruitment issues for their vacated post.
- AQUA has been engaged to provide support the review of the Trust's quality strategy and learning and development plan.
- A commitment has been secured for representation from the team at corporate inductions.
- 9 additional improvement projects registered in Q4, with a continued upward trend.

Plans for Q1 and beyond – a re-focus and a shared vision

Initial engagement with representatives from AQUA has confirmed the need to address Trust culture and work towards a shared culture and vision of continuous improvement. Further meetings will take place in Q1 to refine roles, responsibilities, and timescales.

Priorities to make this happen are as follows.

- Clearly defined and agreed improvement priorities within divisional and corporate teams
- An improved focus on safety and health inequalities within projects
- Clearer evidence of embedded learning
- Creating robust reporting structures, through Quality Improvement Group (QIG) through to Quality Committee
- Fuelling staff motivation through the communication of success stories, positive feedback, and actions
- Being data driven, being clear about post benefit analysis
- Enhance the QI tools, training offer and processes currently in place
- Creation of digital platforms to support our continuous improvement work
- Learning from other organisations, locally & nationally

Improvements and actions:

The interest in registering new continuous improvement projects continued in Q4. Project leads have benefitted from practical support and guidance. The team needs to identify projects which have not been formally registered.

9. Serious Incidents and identified learning

***HEADLINE* – There were 14 serious incidents declared to the Integrated Care Board (ICB) during Q4 (an increase of 6 from Q3) – 2 in January 7 in February and 5 in March. 3 of these cases were subsequently de-escalated with the ICB. All of these cases had had Executive oversight and sign off**

Serious Incidents declared and final reports submitted to the ICB

All Serious Incidents had full duty of candour completed and an investigating officer appointed by the Divisions at the point of declaration to the ICB. This enabled investigations to be expedited as quickly as possible to ensure any immediate learning identified could be implemented and shared across the Divisions.

There were no themes, patterns or trends identified within quarter 4 in addition to future Generations concerns other than the below.

There was a sadly a Maternal Death within Gynaecology. Appropriate immediate reviews have been completed.

The case is subject to an ongoing Coroner's Inquest, investigation by the Trust and External Investigation by the Healthcare Safety Investigation Branch (HSIB) The final SI report will be concluded in June and will be reported through relevant governance structures.

Overdue actions from previous submitted SI's / Serious Incidents

There were no overdue serious incident submissions due with the ICB that had not had an appropriate extension request during Q4. 5 Cases within the Gynaecology Division had extension requests submitted during this period.

There were 2 Serious Incidents Submitted in January 2023.

There were 2 Serious Incidents Submitted in February 2023.

There were 3 Serious Incidents Submitted in March 2023 with 3 De-Escalations agreed.

Whilst the Trust ongoing action plans are not currently externally reportable, the Ulysses System is now being used more effectively to manage divisional action plans. All action plans are updated on to the system following SI submission to the ICB and are monitored Divisionally and Corporately for compliance and reported to the Safety and Effectiveness Sub Committee monthly.

As of 31 March 2023, there were 15 out of 25 action plans that had actions overdue. These were subsequently escalated to all Heads, Divisional Managers and Safety Leads to action and all Divisions agreed to have a plan in place to resolve overdue actions which will be monitored via Divisional Governance meetings in addition to the Safety and Effective Sub Committee.

Dissemination of learning from serious incidents

The Trust communicates learning from serious incidents via a number of ways such as the following:

- Learning and engagement teams events held online Trust wide for all services to present and discuss learning
- The weekly safety check in for all services to present and discuss learning
- Governance Boards within the divisions to share learning
- Trust wide shared learning portal to upload all divisional learning such as 7-minute briefings accessible to all staff
- The Safety and Effectiveness Sub Committee serious incident report
- Staff communications via secure social media
- SBARS

Improvements and actions:

Learning from all incidents is key to being able to demonstrate that the Trust is a Learning Organization. The Corporate Team continues to work in detail with the divisions to recognise how learning from incidents is captured and evidenced, how it is disseminated to new and existing colleagues, that is becomes embedded as part of practice and culture and that there is tangible evidence that learning has been addressed immediately, embedded after 6, 12 months and beyond and that learning continually evolves from current intelligence and is used to mitigate recurrences as much as practicable.

10. Divisional Triangulation and Integrated Governance Reports Q3

The following reports have been submitted to the Safety and Effectiveness Sub Committee by the Divisions covering Q4

Key points requested from Divisions are:

- Key areas of risk affecting patient safety and quality of services
- Divisional plans to manage and mitigate those risks
- Evidence of embedded learning Divisionally and cross Divisionally
- Audit of embedded learning within 6 months of learning being identified (As per Ockenden within Maternity but that expectation is across all Divisions) and how assurance is gained, 6 months, 12 months and beyond that learning is embedded, practice and culture has changed and there is clear tangible evidence of improved patient safety outcomes.

Actions and improvements

Neonates

Medication errors / administration / prescribing

- The neonatal medicine safety group is led by a neonatal consultant and Band 7 nurse.
- All prescribing errors are managed by the neonatal consultant and administration errors managed by the neonatal band 7 nurse.
- The neonatal unit have developed the Medication Error Assessment Tool (MEAT) which is a scoring tool.
- Once the MEAT tool has been scored against the medication administration error depending on the score will determine the action required by the staff member who made the error. This can be a reflection,

extra education input, a statement, re attend the neonatal intravenous administration study day and complete further competencies and assessed during completion of these competencies.

Investigations

- Blood sampling errors are the top investigation incidents in this quarter.
- The neonatal unit are part of the trusts working group to address all blood sampling errors.
- Within the neonatal unit they have a blood sampling working group led by a neonatal consultant.
- Blood sampling errors relate mainly to the quality of the sample.
- Examples of improvements relate to new lancets which are available in different sizes.

Clinical Support Services

- In 22-23 Theatres had a significant investment in their workforce establishment, which has led to a large increase in new staff members with limited experience. Of these new starters the majority have completed their supernumerary period with only 4 Scrub Nurse's and 6 HCA's with training still outstanding.
- Imaging continues to progress against their workforce recovery plan but have had high levels of turnover. A number of risks in relation to the issue of staff shortages within the Imaging Department are on the Risk Register (2549 & 2519) and are being monitored and reviewed. Imaging have managed to recruit an additional 3 sonographers who have been undergoing their supernumerary period.
- A New Quality Lead is also now in post for the Imaging Department. Now that the workforce has stabilised and there has been significant improvements made in regard to Imaging Governance Processes as mentioned in more detail above, the Division expects incidents to gradually decrease and performance compliance to increase.

CONCLUSION

This report seeks to provide assurance as to the Governance Systems in place in LWH and that staff are being open by reporting incidents, clinical and non-clinical, to ensure patients and staff safety is maintained. The Ulysses data clearly demonstrates a continuous positive reporting culture across all Clinical Divisions and Corporate Services

There remains ongoing work across all Divisions via their integrated governance reports but with a particular focus on Maternity and Gynaecology to be able to demonstrate:

- Key areas of risk affecting patient safety and quality of services
- Divisional plans to manage and mitigate those risks
- Evidence of embedded learning Divisionally and cross Divisionally
- Audit of embedded learning within 6 months of learning being identified (As per Ockenden within Maternity but that expectation is across all Divisions) and how assurance is gained, 6 months, 12 months and beyond that learning is embedded, practice and culture has changed and there is clear tangible evidence of improved patient safety outcomes

It can be demonstrated particularly with Clinical Support Services and the Neonatal Directorate reports that the services have oversight of some of their key areas of risk, plans to manage and mitigate but evidence of embedded learning requires strengthening.

With respect to Gynaecology and Maternity services, where the majority of Trust SUIs occur, SUIs and associated action plans are being progressed but there remains some limited, but improved, evidence of embedded learning an improved patient safety outcomes as a result.

It is expected and directed from the Corporate Team that Q1 IGR reports identify the Divisional key areas of risk, have robust plans in place and that evidence of learning is shared with plans to embed and / or provide assurance as to the audit process that learning has been embedded sustained where improved patient safety and quality outcomes can be demonstrated back up with quality data.

It is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place with ongoing support from the Corporate Team and that there is positive progress in managing risk across the Divisions with Senior Management having oversight of such risk.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/097*		Date: 13/07/2023	
Report Title	Mortality and Learning from Deaths Report Quarter 4, 22/23			
Prepared by	Lidia Kwasnicka, Gynaecologist; Ai-Wei Tang, Consultant Obstetrician; Rebecca Kettle, Consultant Neonatologist and **Chris Dewhurst, Deputy Medical Director.**			
Presented by	**Lynn Greenhalgh, Medical Director**			
Key Issues / Messages	The Board is asked to review the contents of the paper and take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	It is it is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths. In addition, as per The Learning from Deaths framework requirements the board are requested to note: *• number of deaths in our care* *• number of deaths subject to case record review* *• number of deaths investigated under the Serious Incident framework* *• number of deaths that were reviewed/investigated and as a result considered due to problems in care* *• themes and issues identified from review and investigation* *• actions taken in response, actions planned and an assessment of the impact of actions taken.* *• the care issues identified in the antenatal management from referring trusts. It is recommended that a review of antenatal care findings from the previous PMRT reviews is undertaken and if any common themes identified that this is presented to the local maternity system*			
Supporting Executive:	Lynn Greenhalgh Medical Director			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

EXECUTIVE SUMMARY

This "Mortality and Learning from Deaths" paper presents the mortality data for Q4 2022/23 with the learning from the reviews of deaths from Q3 2022/23. The 'learning' can take some time after the death occurs due to the formal processes and MDT review process that occur. This results in the learning being presented a quarter behind the data.

In quarter 4 there were the following deaths:

Adult deaths	**0**
Direct Maternal Deaths	**1**
Stillbirths	**4 (excluding ToP)**
Neonatal deaths	**17 (including 6 in-utero transfers and 3 post-natal transfers)**

The annualised data for 22/23 is:

Adult deaths	**3 (1 unexpected)**
Direct Maternal Deaths	**1**
Stillbirths	**3.5/1000 births (excluding ToP) cf. 4.9/1000 in 21/22**
Neonatal deaths	**6.4/1000 live births (inborn mortality) cf. 3.6/1000 in 21/22**

There was one maternal death in Q4 22/23. There was also a death in Q3 22/23 of a woman who delivered at LWH after transferring her care from another area outside of Cheshire and Mersey. She subsequently died outside of C+M with her death reported to us in Q4.

The stillbirth rate was lower in 23/24 than last year and is similar to 2020-21. Benchmarking data is presented for 23/24 which shows that LWH stillbirth rate is below the average for similar sized maternity services.

There was an increase in Neonatal mortality in 2022/23 with 6.4/1000 live births (n=58) deaths in 2022/23 compared with 3.6/1000 live births in 2021/22 (41 in 21/22). The

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

The MBRRACE data for 2021 was reported in 2021 and is included in this paper. Given LWH outlier status there is a requirement for these data and actions to prevent unavoidable deaths to be reviewed by the Trust board. Given we had already identified high stillbirth rates in 2021, a thematic review of stillbirths and an ODN review of mortality has already been presented to the board for this period.

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

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.

- the care issues identified in the antenatal management from referring trusts. It is recommended that a review of antenatal care findings from the previous PMRT reviews is undertaken and if any common themes identified that this is presented to the local maternity system

MAIN REPORT

This is the quarter 4 2022/23 mortality report for adults, stillbirths and neonates. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust. This is in accordance with recommendations by the National Quality Board "National Guidance on Learning from Deaths" and the Care Quality Commission. It outlines the work taking place operationally and being overseen by the Safety and Effectiveness Sub - Committee and Quality Committee.

The data presented in this report relates to Q4 2022-23. The learning relates to deaths in Q3 2022-23. This is due to the multidisciplinary review of deaths not occurring in the quarter when the death occurred.

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

1 Adult Mortality

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

1.1 Obstetric Mortality Data Q4 2022/23

There was 1 direct maternal death (deaths within 42 days of delivery) in Q4. This related to the death of a woman at 18 weeks gestational age who deteriorated whilst an in-patient at LWH. She was transferred to LUFHT where she sadly died. This death will be investigated via HSIB and the coroner.

1.2 Learning from Obstetric Mortality Data Q3 2022/23

There was a death of a woman in late Q3 who was originally booked in a hospital outside of the Cheshire and Merseyside network. She delivered at LWH due to a fetal/neonatal condition which resulted in a neonatal death. She was discharged to her local hospital subsequently home, where she died unexpectedly. This is not recorded as an LWH maternal death death due to the antenatal and postnatal care being provided by another organisation. This death will be investigated via HSIB and the coroner with the Trust contributing to these investigations. The learning will be presented in due course.

In Q3 2021/22, there was one death of a woman who died approximately 8 weeks after delivery. This case is subject to a Coronial investigation and, as per the requirements of the Ockenden review, a multiagency review has been completed. The Coroner's inquest has not yet taken place but is planned for Q2/3 22/23. The internal SI has been completed with learning included in previous 'Learning from Deaths' report. The outcome from the Coroner's investigation will be included in this report when available.

1.3 Gynaecology Mortality data Q4 2022/23

There were 0 deaths within Gynaecology Oncology in Q4 2022/23.
There were 0 unexpected deaths within Gynaecology services in Q4 2022/23.

1.4 Learning from Gynaecology Mortality Q3 2022/23

There were no deaths to review from Q3 2022/23. From Q2 2022/23 There was one death of a woman who had surgery at LWH before being transferred to LUFHT where she later died. This death is reported as an LUFHT death but was subject to SI at both organisations. The learning form this SI included that CT scanning, rather than abdominal x-ray is indicated in the management of post-surgery bowel obstruction. The lack of onsite surgical team, CT scan and radiology was identified as the root cause.

Of note we are aiming to identify deaths of women who die following in-patient transfer and/or in the post operative period, who die in other organisations. Whilst these deaths are not included in our required reporting data, we recognise the potential learning that is within these cases.

2 Stillbirths

2.1 Stillbirth data

There were 4 stillbirths, excluding terminations of pregnancy (TOP) in Q4 2022/2023. This has resulted in an adjusted stillbirth rate of 2.3/1000 live births for Q3. This is the lowest stillbirth rate for past 3 years although caution must be taken in interpreting small numbers.

STILLBIRTHS	Apr-22	May - 22	June-22	July-22	Aug-22	Sept-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	TOTAL 2022/23
Total Stillbirths	3	4	3	7	3	3	2	2	6	2	4	1	40
Stillbirths (excluding TOP)	1	4	2	3	3	1	1	2	5	1	3	0	26
Births	602	654	613	645	659	656	649	596	619	630	519	613	7455
Overall Rate /1000	3.3	6.1	4.9	10.9	4.6	3.0	4.7	6.7	9.7	3.2	7.7	1.6	5.4
Rate (excluding TOP)/1000	1.7	6.1	3.3	4.7	4.6	1.5	1.6	3.4	8.1	1.6	5.8	0	3.5
Pregnancy loss 22-24 weeks (excluding TOP)	0	0	0	0	0	1	1	1	1	1	0	0	5

Table 1 Stillbirth rates > 24 weeks for 2022-23. The annual stillbirth rate is 3.5/1000 births

Quarter	Rate 2019/20	Rate 2020/21	Rate 2021/22	Rate 2022/23
Q1	4.0	5.5	4.0	3.7
Q2	4.1	2.5	5.3	3.6
Q3	1.5	2.7	5.1	4.3
Q4	1.7	3.2	5.0	2.3
ANNUAL	2.9	3.4	4.9	3.5

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

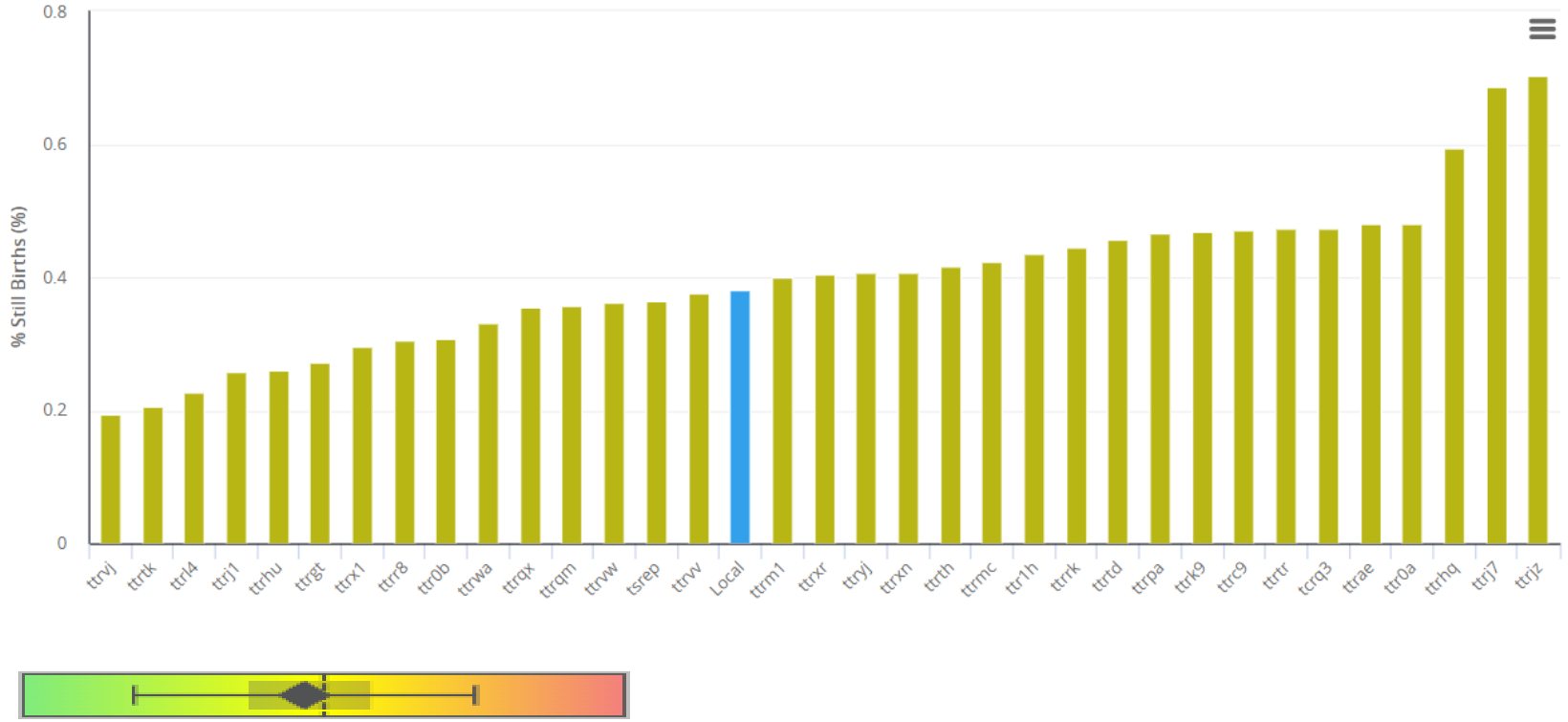


Figure 1 and 2. Stillbirth data for with LWH benchmarked against other large maternity services (>7000 deliveries) 2022-23. The blue bar and triangle are LWH data demonstrating the observed rate is below the average for comparator organisations

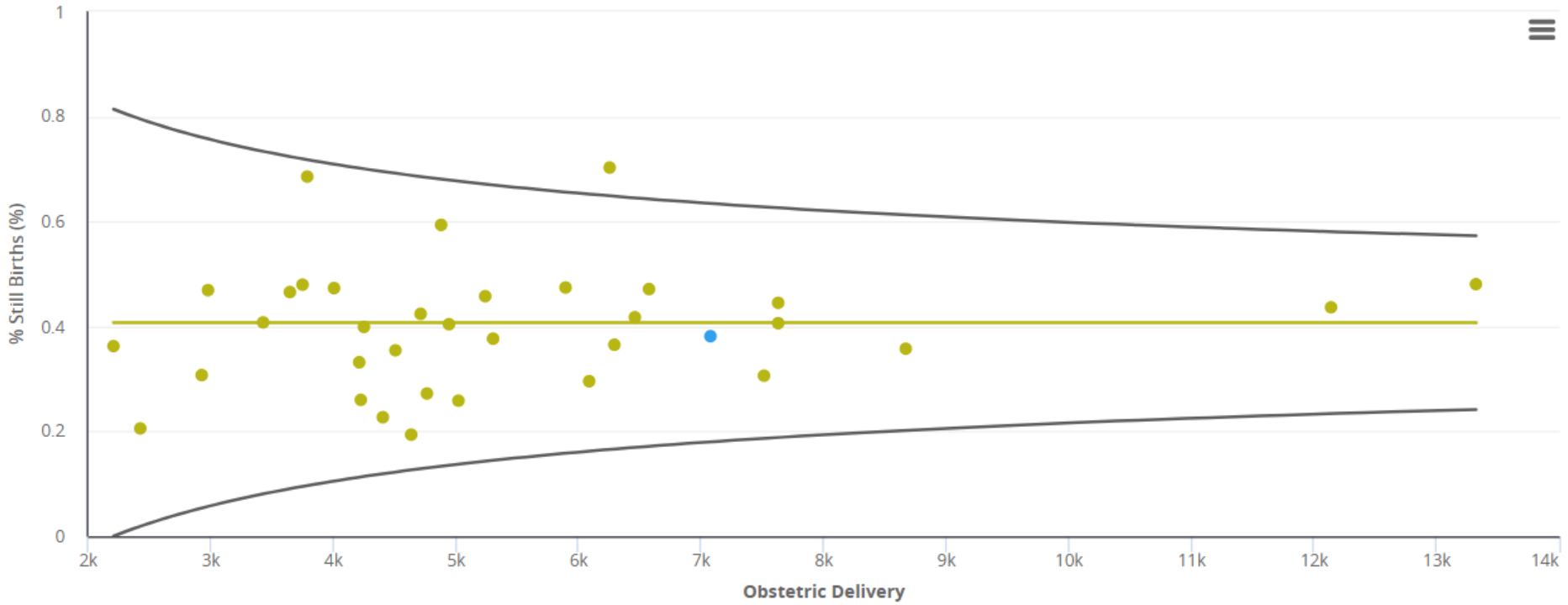


Fig 3 Funnel Plot demonstrating LWH stillbirth rate is within the expected range and below average for comparator trusts

The stillbirth rate for Q4 22/23 is the lowest since 2019/20. The stillbirth rate in 2022-23 is also lower than seen in 2021-22. There was one pregnancy losses (excluding TOP) born between 22 – 24 weeks gestational age.

All stillbirths in Q4 were of white ethnicity and spoke English as a first language. 3/5 (60%) of pregnancy losses from 22 weeks gestational age live in the most deprived decile. 4/5 (80%) were non-smokers.

2.1 Learning from Stillbirth and PMRT reviews Q3 2022-23 N=11

All eligible cases (Stillbirths > 22 weeks but excluding ToPs) underwent a full multidisciplinary team PMRT review with external clinician presence. Care from across the antenatal and intrapartum period was subject to clinical and managerial scrutiny. All bereaved parents were invited to be involved in the review process by submitting comments and questions via the Honeysuckle Team for discussion at the MDT Review.

The reviews of Q3 stillbirths (n=11) identified that 4 (37%) cases had no antenatal care issues identified and 6 (55%) had care issues identified which would not have changed the outcome of the pregnancy. There was 1 case (9%) where care care issues were identified which may have affected the outcome of the pregnancy. This was related to a delay in arranging investigations following CTG. The antenatal CTG guideline is being updated and a change to FMU scanning procedures has been implemented.

5 (45%) cases had issues identified in the postnatal care. Of note, incomplete investigations being completed occurred and has been highlighted in previous reports. A pictogram has been developed to assist in ensuring all investigations are completed.

Grade	Care in antenatal period	Percentage (%)	Care provided after Stillbirth	Percentage (%)
A	4	36.4	6	54.5
B	6	54.5	3	27.3
C	1	9.1	2	18.2
D	0	0	0	0

Table 3 PMRT review panel grading of care provided in cases of Stillbirth (N=11)

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

3. Neonatal Mortality

3.1 Neonatal mortality Data Q4 2022/23

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

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	March-23	Total
Total Mortality	3	7	3	7	3	4	5	5	6	**7**	**3**	**7**	58
INBORN Neonatal Mortality	**2**	**4**	**3**	**5**	**3**	**4**	**5**	**5**	**5**	**6**	**2**	**6**	**48**
BORN + DIED LWH Neonatal Mortality	---	---	---	---	---	---	1	2	3	***5***	***2***	***5***	
Births	602	654	613	645	659	656	649	596	619	**630**	**519**	**613**	7455
INBORN Neonatal Mortality Rate/1000LB	**3.3**	**6.1**	**4.9**	**7.6**	**4.6**	**6.1**	**7.7**	**8.4**	**8.1**	**9.5**	**3.9**	**9.8**	**6.4**

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

Quarter	NMR all babies	NMR *in born*
Q1 (22_23)	7.0	4.8
Q2 (22_23)	7.2	6.2
Q3 (22_23)	8.6	8.0
Q4 (22_23)	9.6	7.9
Annual	7.8	6.4

Table 5: Neonatal Mortality Rate per quarter. Annual inborn mortality was 6.4/1000 live births.

In this quarter there was a total of 17 deaths. 6/17 (35%) of these babies were born following an in-utero transfer from another hospital provider. 3/17 was a postnatal transfer (18%). The cause of death was attributed to congenital anomalies in 3/17 (18%) of deaths. 11/17 babies (65%) were born at < 28 weeks gestational age.

16/17 (94%) were born to mothers of white British background. All (100%) families spoke English as a first language. In 13 babies, deprivation data was obtainable with 4/13 (30%) born to mothers in the lowest decile for deprivation.

The annual inborn mortality rate for neonatal deaths is higher in 2022/23 than in 2021/22 (6.4/1000 vs 3.6/1000) The previous year's mortality rate was particularly low and it may be that this is "regression to the mean". However, a review of the annual neonatal mortality for 2022/23 will be undertaken. This will include a review of the data related to IUTs and antenatal care received in other organisations. On reviewing the benchmarking data reported through the Vermont Oxford Network, it is reassuring that the mortality for in-born babies <1500g remains low for 2022. (see below).

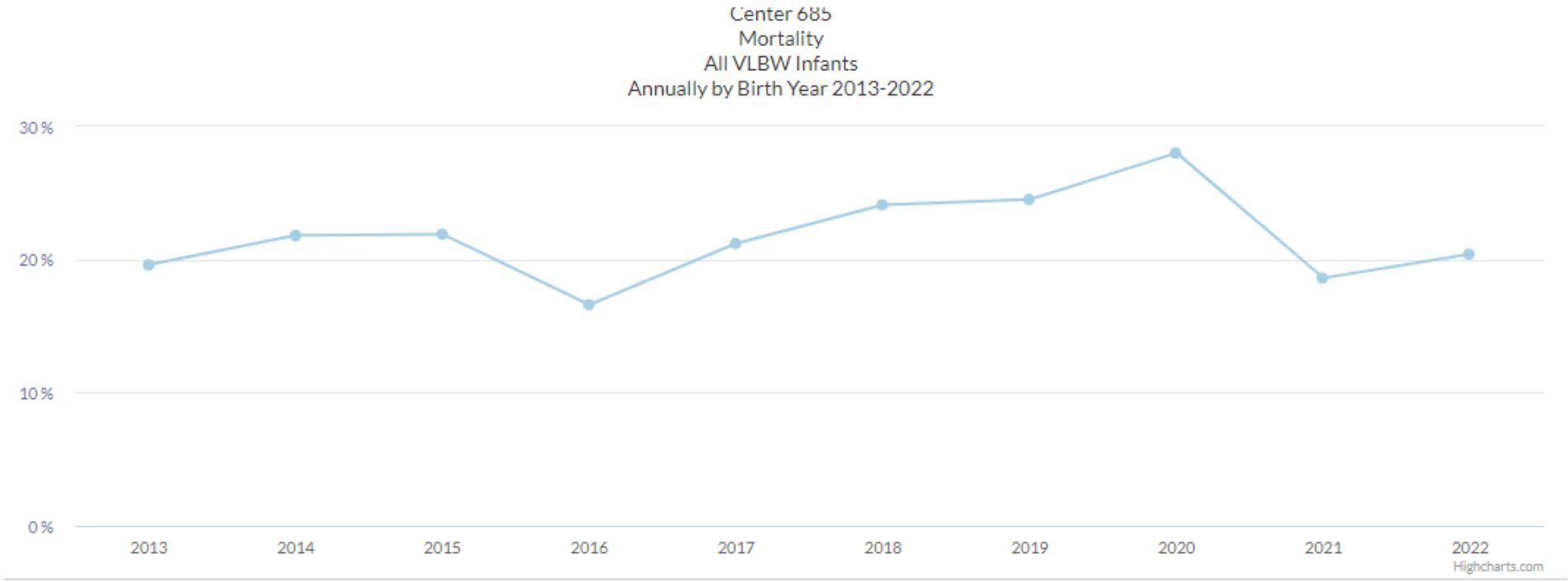


Figure 3. Mortality for inborn VLBW babies (<1500g) 2013 - 2022. This demonstrates the improvement in mortality in this population in 2021 has been sustained in 2022.

3.3. Learning from neonatal mortality reviews for Q3

There were 9 deaths subject to a PMRT review. There were no cases identified with care issues which were likely to have made a difference to the outcome. There was 1 (25%) cases where issues were identified in the antenatal care that may have affected the outcome. This was related to the escalation of ruptured membranes from the MAU. The MAU triage process is being reviewed as part of a the MAU QI project.

There were two cases (22%) where neonatal care issues that may have affected the outcome. One related to insertion of a line that was thought to be venous but was, in fact, arterial. This has been subject to an SI with an action plan developed to manage line

insertion. The other identified several issues relating to hypothermia, a delay in blood transfusion and positioning of the endotracheal tube. All have actions assigned and will be monitored within division.

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

Other Learning included the following:

- Non-colocation with other paediatric specialities remains an issue, resulting in delayed transfer for specialist input.

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

4. MBRRACE Report for Perinatal Mortality in 2021 (see Appendix for report)

In May 2023, the MBRRACE data for 2021 was published. MBRRACE report on stillbirths and neonatal deaths within 28 days of life (extended perinatal mortality). These data provide benchmarking data for perinatal services, with LWH compared against other trusts with a level 3 NICU and neonatal surgery service.

The data is stabilised and adjusted to account for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity, and (for neonatal deaths only) gestational age at birth. Of note, however, the adjustment for deprivation is at the quintile level. This means that populations such as Liverpool's can appear to be similar to those in other cities (eg Manchester), however if deprivation deciles are reviewed, the populations look different (e.g. Liverpool having 49.6% and Manchester having 33.2% in the lowest decile).

The LWH data for 2021 shows that the stabilised and adjusted mortality is >5% higher than the average for similar trusts. As LWH is >>5% higher than the average for similar trusts, the Trust should review their PMRT and HSIB investigations to identify any avoidable causes of mortality in their organisation. This information should also be discussed at trust board level and shared with Local Maternity and Neonatal Systems and Integrated Care Boards to ensure early action and support. (see letter in appendices). This has already been completed with the thematic review of stillbirths presented to QC in Q2 22/23 and the neonatal review of mortality by the ODN including this time-period. Action plans for both reducing stillbirths and neonatal mortality have been developed and monitored through division.

It is important to note that as we provide both surgical and cardiac services via our FMU, neonatal unit and in partnership with Alder hey Children's Hospital we have higher rates of babies born with congenital abnormalities. Once congenital anomalies are removed from the MBRRACE data, the mortality rates for LWH are all within 5% of the average for comparator trusts. This is the first time the mortality for neonatal deaths has been within this measure (see Fig 4 below).

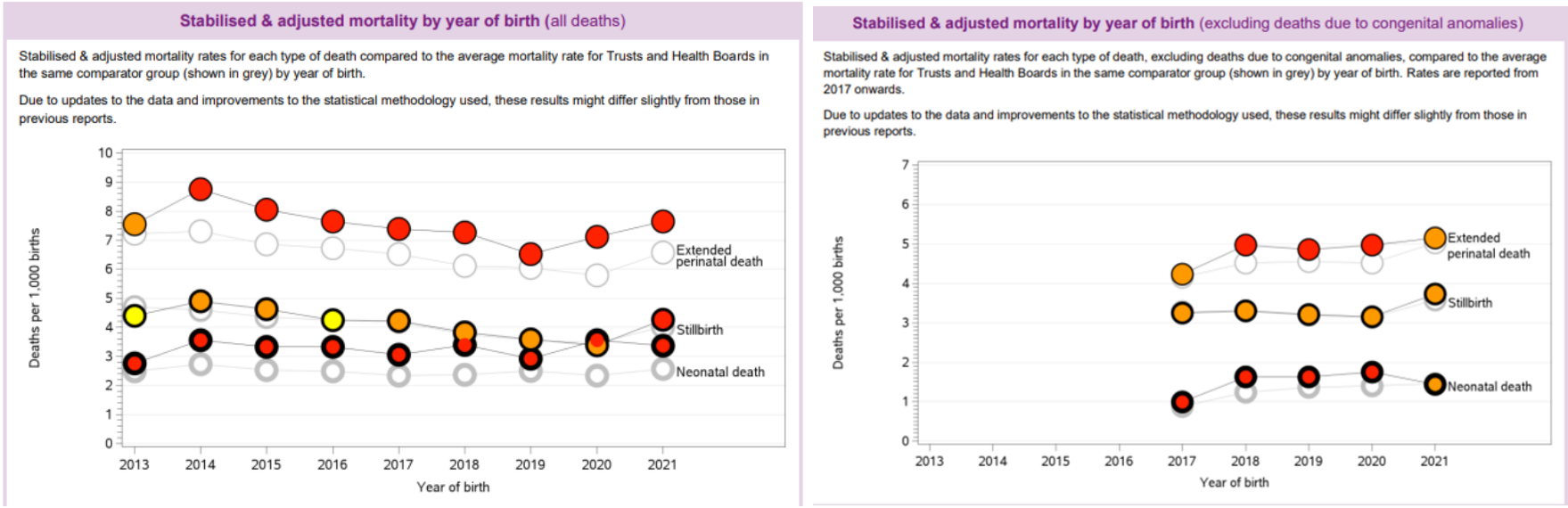


Fig 4. Stabilised and Adjusted Mortality per year of birth. Left = includes congenital anomalies. Right = excludes congenital anomalies.

5. Recommendations

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

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.

The increased mortality rate for neonatal in-born babies will be reviewed with data presented to QC.

It is recommended that the Trust board via QC receive the MBRRACE data for 2021 and are assured that both the neonatal and stillbirth data have already been reviewed as part of the focus on neonatal mortality and stillbirths.

6. Appendices

Available to Board members in the supporting documents folder in AdminControl

			
Q4 SB report 2022-23.docx	Q4 Neonatal Death mortality report with	MB116-2021-rep (1).pdf	PRN00462_MBRRAC E-UK Perinatal Morta
Stillbirth report	Neonatal Mortality Report	MBRRACE report 2021	MBRRACE letter May 2023

Liverpool Women's
NHS Foundation Trust

Jargon Buster

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

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

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

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

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

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

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

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

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

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

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

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

G

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

H

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

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

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

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

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

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

N

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

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

O

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

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

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

Q

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

R

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

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

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

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

V

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

W

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

Y

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