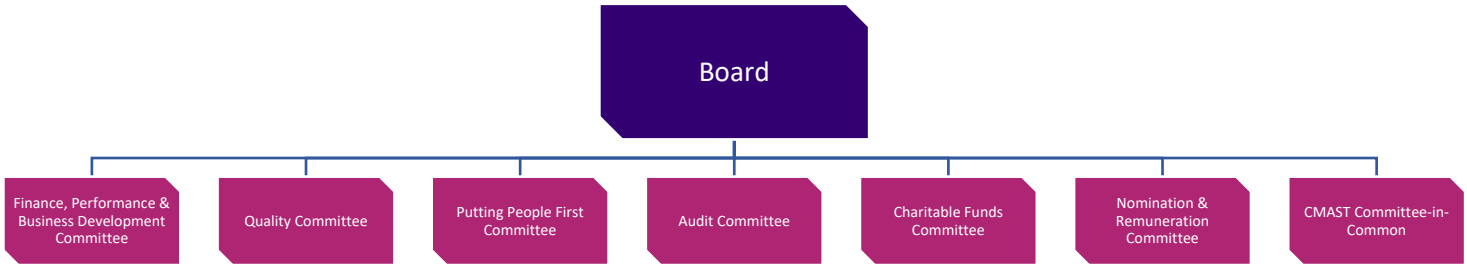
Liverpool Women's NHS Foundation Trust

Trust Board

14 September 2023, 10.30am
Boardroom, LWH & Virtual, via Teams



NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

Location	Boardroom & Virtual via Teams
Date	14 September 2023
Time	10.30am

Item no. 23/24/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
126	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	1030 (5 mins)
127	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
128	Minutes of the previous meeting held on 10 August 2023	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
129	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
130	Service Outline – Maternal Medicine Network	To receive service outline	Presentation	Medical Director	1035 (15 mins)
131	Patient Story	To receive a patient story	Presentation	Chief Nurse	1050 (15 mins)
132	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	1105 (5 mins)
133	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	1110 (5 mins)
MATERNITY					
134a	Perinatal Surveillance Dashboard	To receive	Written	Chief Nurse	1115 (5 mins)
134b	Maternity Incentive Scheme (CNST) Year 5 2023 – Update Paper	To receive	Written	Chief Nurse	1120 (10 mins)
QUALITY & OPERATIONAL PERFORMANCE					
135a	Chair's Report from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1130 (45 mins)
135b	Quality & Operational Performance Report	To receive	Written	Chief Operating Officer	
135c	Whistleblowing / Freedom to Speak up Annual Report 2022/23	For assurance and approval	Written	Chief People Officer	

BREAK – 10 mins					
Board Thank You – 5 mins					
PEOPLE					
136a	Chair's Report from the Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1230 (20 mins)
136b	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	
136c	WDES, WRES, Bank WRES, MWRES Report 2023	For assurance and approval	Written	Chief People Officer	
FINANCE & FINANCIAL PERFORMANCE					
137a	Chair's Reports from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1250 (30 mins)
137b	Chair's Report from the Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
137c	Finance Performance Review Month 4 2023/24	To receive	Written	Chief Finance Officer	
BOARD GOVERNANCE					
138a	Review of Strategic Progress	To note	Written	Chief Finance Officer	1310 (15 mins)
138b	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.*					
139	Corporate Governance Manual – 2023 Update	For approval	Written	Trust Secretary	Consent
140	Constitution Amendments	For approval	Written	Trust Secretary	
CONCLUDING BUSINESS					
141	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1325 (5 mins)
142	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
143	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
144	Jargon Buster	For reference	Written	Chair	

Date of Next Meeting: 12 October 2023

1330 - 1335	*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 Guidance Notes

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 behaviours 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.

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 behaviours 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

Board of Directors

Minutes of the meeting of the Board of Directors held Virtually via Teams at 9.30am on 10 August 2023

PRESENT

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

IN ATTENDANCE

Matt Connor	Chief Information Officer
Phillip Bartley	Assoc. Director of Quality and Governance
Annie Gorski	Public Governor
Lesley Mahmood	Member of the Public
Teresa Williamson	Member of the Public
Rebecca Lunt	Staff Governor
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Sarah Walker	Non-Executive Director
Jackie Bird MBE	Non-Executive Director

Core members	**Sep 23**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Apr**	**May**	**Jun**	**Jul**	**Aug 23**
Robert Clarke - Chair	⚐		⚐	⚐	⚐	⚐	⚐	⚐	⚐	⚐	⚐
Kathryn Thomson - Chief Executive	⚐		⚐	⚐	⚐	⚐	⚐	⚐	⚐	⚐	⚐
Tracy Ellery - Non-Executive Director / Vice-Chair	A		⚐	⚐	⚐	⚐	⚐	A	⚐	A	⚐
Louise Martin - Non-Executive Director	⚐		⚐	⚐	⚐	⚐	⚐	⚐	⚐	A	⚐
Prof Louise Kenny - Non-Executive Director	⚐		A	A	⚐	⚐	⚐	⚐	A	A	⚐
Eva Horgan – Chief Finance Officer	⚐		⚐	⚐	Non-member						
Dianne Brown – Chief Nurse	⚐		⚐	⚐	⚐	⚐	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	🏳	🏳	🏳	🏳	🏳	🏳	🏳	A
Jenny Hannon - Chief Finance Officer / Executive Director of Strategy & Partnerships	Non-member				🏳	🏳	🏳	🏳	A	🏳	🏳
Matt Connor – Chief Information Officer (non-voting)	🏳		🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳

23/24/	
102	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. Apologies were noted as above and no new declarations of interest were made.
103	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
104	**Minutes of the previous meeting held on 13 July 2023** The minutes of the Board of Directors meeting held on 13 July 2023 were agreed as a true and accurate record.
105	**Action Log and matters arising** Updates against action log were noted.
106	**Chair's & CEO announcements** The Chair provided the following updates: • The Liverpool Hospitals Joint Committee continued to develop and enhanced clarity on workplans was now emerging. Particular progress was being made between Liverpool University Hospitals NHS FT (LUHFT) and the Liverpool Heart and Chest FT (LHCFT) regarding strengthened patient pathways for cardiac outcomes. • Representatives from NHS England (NHSE) had visited Liverpool and met with health leaders regarding progress with collaboration opportunities. They had remained clear that a priority for Liverpool was improving the sustainability of women's services. • The Chief Executive recruitment process was underway, and applications had now closed. Interviews were scheduled for the 5 & 6 September 2023. The Chief Nurse reported that the NHSE Maternity Diagnostic Review team had visited the Trust between the 24-27 July 2023. This had been an opportunity for the Trust to showcase good practice and to also highlight ongoing challenges. Whilst a final report was awaited, initial feedback provided by the team was positive. Challenges relating to the impact of the recent CQC inspection, the Trust's financial position (and the current level of maternity tariff) and the isolated site risks had been acknowledged by the team. Recommendations from the visit would be managed via the existing Maternity & Neonatal Transformation Programme.
107	**Perinatal Quality Surveillance & Safety Dashboard**

	The Chief Nurse presented the dashboard highlighting key performance issues, midwifery red flags, and Healthcare Safety Investigation (HSIB) referrals, noting that this was a key role of the maternity safety champion. It was noted that there was one clinical incident that met the SI criteria in June 2023 and was reported via StEIS. This was regarding a Transfusion Associated Circulatory Overload (TACO). This was currently being investigated and was on track for completion by the ICB's deadline. Sickness across the division had reduced in month to 6.21% and in maternity this translated to 6.49% which was a three-month downward trend, and the lowest rate seen since August 2020. There were 93 red flags reported between January 2023–June 2023 which was a reduction of 170 from July 2022-December 2022 where 263 red flags were reported. There were no reports of any harm caused to patients during this time, from the incidents reported as midwifery red flags. There remained a required element of clinical, manual validation, due to some reporting errors but a positive reduction had been demonstrated. Non-Executive Director, Louise Martin, noted that whilst it was clear that there were effective processes for monitoring metrics, it was less evident that demonstrable improvement was being achieved when a need was identified. An example was provided relating to clinical mandatory training for consultant anaesthetists (currently at 28%) and it was asked if there was confidence that the 90% target would be achieved. The Medical Director explained that the training compliance reflected a rolling target that needed to be at 90% compliance by February 2024. There was confidence that robust steps were in place to achieve the 90% rate by this timeframe. Non-Executive Director, Gloria Hyatt, noted continued issues with blood sampling errors and queried whether acceptable progress was being made to reducing the error rate. The Chief Nurse explained that data was now available to identify errors made at an individual level to ensure that support and training was targeted. The DigiCare system, once fully embedded, would remove the need for handwritten labels which would also help to reduce the error rate. The Chair highlighted that there had been an increase in cancelled appointments and asked if this was due to recent Industrial Action. The Chief Operating Officer explained that whilst 'Did Not Attend' (DNA) rates often had multiple underpinning factors, Industrial Action was a contributing factor. The Chief Nurse provided assurance that there were robust procedures for follow-up if an appointment was missed or cancelled. The Board of Directors: • Noted the Perinatal Quality Surveillance & Safety Dashboard for July 2023.
108	Quality & Operational Performance Report The Board considered the Quality and Operational Performance Report. The Chief Operating Officer highlighted the following key points: • It had been 12 months since the implementation of Statistical Process Control (SPC) charts. A review was planned of thresholds and targets across all metrics to ensure that the categorisation remained as appropriate as possible. • A slide had been inserted which demonstrated the impact of Industrial Action during Q1 2023/24 on the cancellations of theatre sessions and outpatient clinics. • Performance against urgent care targets was good with the 4 hr ED target and MAU triage time showing sustained good performance. • The 6-week routine diagnostic target supporting elective recovery remained good and ahead of trajectory. • In terms of elective recovery, there were no patients waiting longer than 78 weeks. NHS providers had been asked to ensure that patients at risk of breaching the 65 week wait target had an outpatient appointment scheduled by the end of September 2023. The Chief Operating Officer reported that the vast majority of the Trust's patients were not waiting for

	their first appointment but rather a procedure. Detailed assurance on this issue was scheduled to be received by the Finance, Performance and Business Development Committee. • The Trust had met with NHSE and the Cheshire and Mersey Cancer Alliance at the end of June 2023 to review the cancer improvement plans. Improving hysteroscopy capacity was a key driver for improvement and plans were in place to divert routine capacity to support getting back to trajectory by October 2023. Work continued to reduce the overall cancer waiting list. The Chair stated that he remained concerned regarding the Trust's cancer performance and asked if there was still confidence in meeting the set improvement trajectories. The Chief operating officer acknowledged that there were still areas that the Trust could improve, and plans were in place for these. There remained some elements outside of the Trust's control e.g., Industrial Action, that would require close monitoring. The Chief Executive added that there was a delay in timely cancer performance data due to the validation process and therefore it might take time before the Board can see the outcomes of the work being undertaken. Non-Executive Director, Louise Martin, noted that both the July 2023 FPBD and Quality Committee meetings had been unable to take full assurance from the performance reports. It was discussed whether it would be possible to take full assurance from a performance report owing to the often-mixed picture of achieving and non-achieving metrics. It was suggested that additional thought be given to the appropriate ask of the Committees and Board when receiving the performance reports. It was also noted that there had been delayed information provided in terms of estates performance to the FPBD Committee and it was agreed that considering the statutory nature of this data, and the risk it posed to the Trust, this should be reported in a timelier way and received by the Board. Action: To include estates performance data in the Quality & Operational Performance Report received by the Board. The Board of Directors received and noted the Quality & Operational Performance Report.
109	Patient Safety Incident Response Framework (PSIRF) Plan The Assoc. Director of Quality and Governance provided an update as to how the Trust had prepared for the implementation of PSIRF, what work had been completed and what would continue to progress during the implementation phase of the framework across the Trust. It was noted that the report detailed the requirements for the Trust Board, so it was aware of its responsibilities in relation to patient safety incident management & improvement. Furthermore, the Trust was required to submit its Patient Safety Incident Response Plan (PSIRP) and Policy to the Integrated Care Board (ICB) for approval prior to 1 September 2023. It was requested that a signed board paper accompanied the plan & policy approving our implementation plan. As such, Trust Board was asked to approve our Patient Safety Incident Response Plan (PSIRP) and Policy. The Chair noted references to 'patient safety partners' throughout the reports and queried what this role would entail. The Assoc. Director of Quality and Governance explained that the role would be performed on a voluntary basis and following consultation with the Patient Experience Team, patients who had a recent lived experience of the Trust's services had been identified. The patient safety partners would help to provide an independent view for investigations. The Chair also asked if the PSIRF would be aligned with the reducing health inequalities agenda. The Chief Nurse confirmed that reducing health inequalities would be 'golden thread' going through all learning activity. The Board of Directors: • took assurance in relation to the work undertaken by the Trust so far in planning for the framework implementation. • approved the Patient Safety Incident Response Plan (PSIRP) and Policy, providing a signed Board paper in support of this.

110	**Workforce Performance Report** The Chief People Officer noted that there were encouraging signs of improving trends across several workforce metrics which demonstrated that grip and control was increasing. It was asserted that the Trust was starting to see signs of improvements following the change of approach to sickness absence – from being less punitive to more psychologically supportive. A significant part of this was a focus on ensuring 'Return to Work' (RTW) interviews were taking place. The Chair queried whether the quality of RTW interviews were audited. The Chief People Officer noted that whilst the quality of the interview was not assessed, evidence suggested that it was the timeliness that was the most significant success factor. The Trust was also encouraging managers to have a quality wellbeing conversation with their direct reports at least annually. Non-Executive Director, Tracy Ellery, suggested that the workforce report could be strengthened with references to the finance report and specifically the on-going impact of the workforce investments made over the previous couple of years. It was noted that this was important as a key driver of future efficiencies would be a reduction in staff costs. Both the Chief People Officer and Chief Finance Officer acknowledged that more work was required to improve the triangulation and integration between the workforce and finance reports. The Board noted the workforce performance report.
111	**Finance Performance Review Month 3 2023/24** The Board received the Month 3 2023/24 finance performance report which detailed the Trust's financial position as of 30 June 2023. The Board was informed that at Month 3, the Trust was reporting an overall net position of a £4,634k deficit which represented a £1k favourable variance to plan. The Chief Finance Officer set out the wider system level Month 3 position noting a year-to-date deficit of £75.4m against a plan of £54.9m deficit with a full year forecast position in line with plan. The Chief Finance Officer reported that the Trust year-to-date break-even position was reliant on non-recurrent items, and that the adjusted position for month 3 (following the removal of key non-recurrent items) would equate to a deficit of £7,223k. The Chief Finance Officer reiterated the necessity to ensure savings were identified and delivered with pace, particularly in relation to reducing pay and other costs. The Recovery Director was in post and a Programme Management Office (PMO) from internal resource had been developed to enhance grip and control and strengthen the Quality Impact Assessment (QIA) process. A three-year recovery plan was in development and an initial draft was scheduled to be presented to the FPBD Committee on 30 August ahead of submission to the Board on 14 September 2023. The Chair queried if the costs of Industrial Action incurred during 2023/24 had been quantified. The Chief Finance Officer noted that an approximate cost of £300k had been identified but due to the inconsistent impact on the case mix during Industrial Action, it was not a straightforward calculation. The Chair continued to note that the Community Diagnostic Centre had underperformed in expected income, and it was asked if this was likely to be an on-going trend. The Chief Finance Officer confirmed that this variance was not expected to continue but it remained under close monitoring. The Board of Directors: • Noted and received the Month 3 2023/24 Finance Performance Review *The following item was received as part of the consent agenda.*
112	**Liverpool Trusts Joint Committee – Committee Assurance Report**

	The Board of Directors noted the assurance report from the Liverpool Trusts Joint Committee.
113	**Review of risk impacts of items discussed** The Chair identified the following risk items: • Improvements in aspects of maternity care still required • Cancer performance remained off target and away from trajectory • Whilst the Trust had achieved its Q1 financial target, this had been achieved via non-recurrent items and a significant risk remained in terms of delivery for the rest of the year. Positive trends in relation to workforce metrics were noted.
114	**Chair's Log** None noted.
115	**Any other business & Review of meeting** None noted. **Review of meeting** No comments noted.
116	**Jargon Buster** Noted.

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
14 September 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
10 August 2023	23/24/108	Quality & Operational Performance Report	To include estates performance data in the Quality & Operational Performance Report received by the Board.	COO	September 2023	Closed	Estates performance included within the performance report
13 July 2023	23/23/084	Staff Story	For the Board to receive an update in six months on the progress made to improve the accessibility of the Trust's estate	COO	December 2023	On track	
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~~ September 2023	On track	Breakdown to be reported to September 2023 FPBD Committee and then next Board meeting following feedback.

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	September 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	September 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~~ September 2023	Open	Requested to defer report to September 2023 to allow the relevant discussions and reviews to take place.

Liverpool Women's
NHS Foundation Trust

CEO Report

Trust Board
September 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*

Lucy Letby Investigation

Following the recent trial verdicts, our thoughts are with the parents and families of the victims and everyone who has been affected.

As detailed in news reports and information provided by Cheshire Police, there is an ongoing investigation relating to the full period of Lucy Letby's career, including training placements at Liverpool Women's Hospital, which took place between October – December 2012 and January – February 2015.

Liverpool Women's NHS Foundation Trust has been liaising with Cheshire Police throughout this investigation and we will continue to do so going forward. As this is an ongoing investigation, we are unable to provide any more information at this time. Any further details will be shared by Cheshire Police in due course.

Anyone relevant to this ongoing investigation is aware and they have been supported throughout by Cheshire Police and the Trust.

If any parents, families, or carers need support, advice or reassurance about the care provided to babies on the Neonatal Unit at Liverpool Women's during the above periods of time, please get in touch with our Patient Experience Team in the first instance by emailing pals@lwh.nhs.uk or call 0151 702 4353 to provide your contact details and a member of our team will get back in touch with you.

Section A - *Internal*

Dame Lorna Muirhead announced as Patron of the Liverpool Women's NHS Foundation Trust's Charity

We are delighted to announce Dame Lorna Muirhead as Patron of the Liverpool Women's NHS Foundation Trust's Charity

Dame Lorna Elizabeth Muirhead DCVO DBE CStJ DL FRCOG (née Fox) is a past President of the Royal College of Midwives and from 2006 until her retirement in 2017 she served as the Lord Lieutenant of Merseyside.

In 1992 Dame Lorna became a member of the Council of the Royal College of Midwives (RCM) and, in 1997 was elected as President. Dame Lorna served two terms of office, until 2004. Throughout this time continued to work as a clinical midwife, at the Liverpool Women's Hospital.

Dame Lorna Muirhead said, "After almost 40 years working as a midwife at the Liverpool Women's I am honoured to be invited to be Patron for Liverpool Women's Hospital Charity and look forward to being involved in the Trust's work again".

Liverpool Women's Chief Executive receives commendation from Merseyside Police

We are very proud of the Trust's Chief Executive, Kathryn Thomson, who has received a Chief Constable's commendation from Merseyside Police for the significant role she played in the aftermath of the terrorist incident at Liverpool Women's in November 2021.

Kathryn was invited by Merseyside Police to attend an event where she received a commendation for the significant leadership role she played in supporting the police response, whilst maintaining the safety of services and the confidence of patients, staff and the wider community.

Merseyside Police said the comments and feedback received from our communities, our partners and local politicians were overwhelming which was testament to the professionalism and commitment of all who were invited to attend this event.

Section A - *Internal*

Liverpool Women's NHS Foundation Trust have been awarded the NHS Pastoral Care Quality Award

This has been awarded to recognise the Trust's work in international recruitment and the commitment to providing high-quality pastoral care to internationally educated nurses and midwives during recruitment processes and their employment.

VCHA Veteran Aware Accreditation Approval

Liverpool Women's NHS Foundation Trust has been successfully accredited as 'Veteran Aware' by the national steering group for the NHS Veteran Covenant Healthcare Alliance.

Particular thanks to Anne Bridson, who has worked so hard in harnessing the great work being done by the Trust and pulled together all of the evidence to support the submission to the VCHA National Steering Group.

The Women's View' August / September 2023

Bringing you the latest news, updates and all things LWH

https://liverpoolwomens.nhs.uk/media/5043/issue-18-v3.pdf

Trust celebrates NHS75 with Kingsley Community Primary School

Also inside this issue…

- Fear of Childbirth Study - volunteers needed
- NHS 75th Birthday Celebrations

Annual Member's Meeting

Thursday 21 September 2023

1-3pm, Virtual via teams.

More details at: www.liverpoolwomens.nhs.uk/amm2023

Section B - *Local*

NHS Cheshire and Merseyside Blog

Next week (w/c 14 August) we will see further industrial action from junior doctors across Cheshire and Merseyside (full update below) followed by a hospital consultant strike over the bank holiday weekend - both of which will have a significant impact on services.

Whilst the breadth and depth of what junior doctors and hospital consultants 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 again 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.

On a lighter note, it was a joy to see the NHS 75th celebrations taking place across Cheshire and Merseyside last month and to mark our one year anniversary at the same time - we hope you managed to enjoy some of the celebrations yourselves.

We held our latest board meeting at the Lewis' building in Liverpool on Thursday 27 July, just 12 months after our first ever board meeting at the same venue.

At the meeting we heard about population health and how we are working with our nine local authorities collectively to tackle the causes of ill health.

Board members also endorsed a proposal for NHS Cheshire and Merseyside to commit to NHS England North West's Black and Minority Ethnic (BAME) Assembly Anti-racist Framework.

The framework supports North West NHS organisations to tackle structural racism and discrimination through collaboration, reflective practice, accountability and action.

We also heard about improved delayed discharge rates in our hospitals although we know our emergency departments continue to face challenges from the added pressures brought on by industrial action.

Our public board meetings will now be bi-monthly with our next one being on 28 September - the same day as our first Annual General Meeting (AGM), which you can read more about in this update.

Graham Urwin - Chief Executive

Full August 2023 update available here

CEO of NHS Cheshire and Merseyside
Graham Urwin

NHS Cheshire and Merseyside Integrated Care Board meeting

Papers and recording for the meeting held on 27 July 2023.

https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/nhs-cheshire-and-merseyside-integrated-care-board/27-july-2023/

Section B - *Local*

Liverpool Health Partners Newsletter
Update from Managing Director Dr Seamus O'Neill

Dear Liverpool,

Hello again everyone and welcome to the August edition of the LHP newsletter. Sincere thanks as ever to Mel and all her regular contributors from our member organisations. You will recall that I am a firm believer that this newsletter, and all our LHP communications, should be an amplification of the good-news stories from health and care across Liverpool City Region and in particular the ones that highlight collaborative working at scale. Loads of great stuff in what follows, and I would draw your attention to the fact that Marga Perez-Casal has just started with us as the new head of SPARK. Marga is well known to most of you having worked in the Liverpool system for many years and is a great addition to our team.

Enjoy the newsletter and as ever, feedback and suggestions welcome.

Kind regards

Séamus

Full Newsletter - https://mailchi.mp/e248d9429a27/news-from-liverpool-health-partners-6247204?e=9bd40ca77e

Cheshire & Merseyside Acute and Specialist Trusts (CMAST) Provider Collaborative Newsletter – August 2023
Please see the appendix to this report.

Section C - *National*

NHSE enforcement guidance

NHS England (NHSE) has published the updated enforcement guidance, together with their response to the enforcement guidance consultation, which was carried out in late 2022. At the time of the consultation, we published an on the day briefing, detailing the proposed changes and NHS Providers' view, which you may find helpful. The NHS enforcement guidance was first introduced in 2013 alongside the NHS provider licence. The changes in this updated version reflect new legislative, statutory and policy requirements, including NHSE's statutory accountability for the oversight of both integrated care boards (ICBs) and NHS providers.

The revised enforcement guidance describes NHSE's enforcement powers and approach in relation to ICBs, NHS trusts, foundation trusts, licensed independent providers of NHS services, and licensed NHS controlled providers. It explains the regulatory and statutory processes in the event of enforcement action and subsequent rights of appeal. The guidance should be read alongside the NHS provider licence and the NHS oversight framework.

Changes to the guidance:

- Introduction of a two-tier approach to ICB enforcement, which ensures parity with NHS provider organisations. This means that undertakings would be used where there is reasonable suspicion of ICB failure to discharge its functions, while directions would follow where NHSE is satisfied there is a failure.
- Revisions to the language to reflect the change from Monitor to NHS England as the regulatory body for NHS foundation trusts.
- The extension of the provider licence to NHS trusts.

What hasn't changed:

- NHSE had planned to introduce new enforcement powers in relation to patient choice but, as changes to the regulations have not yet been made, the current procurement, patient choice and competition regulations remain applicable, with the adjustments from 1 July 2022 set out in the explanatory note on NHSE's website.
- NHSE's enforcement powers in relation to providers have not changed. The revised guidance, however, is aligned with the principles of the oversight framework, which state that NHSE will be working with and through ICBs wherever possible to encourage local resolution before escalation.

Section C - *National*

Government announces major action to improve women's health

A dedicated women's health area that will include important information on a wide array of subjects has been added to the NHS website, the Department of Health and Social Care has announced.

The new area of the website will centralise crucial insight on more than 100 topics, ranging from a new hormone replacement therapy hub, all the way to information on gynaecological conditions, pregnancy, cancer, fertility issues and heart health.

It also includes a section just for adenomyosis thanks to the work of patient groups and the BBC presenter, Naga Munchetty's campaigning around the condition.

Alongside this, the government has also announced it will develop a new AI tool to identify concerning trends in maternity units. The public will be able to look up information on NHS-led IVF treatment in their area with a new tool on the government's website.

Professor Dame Lesley Regan, England's women's health ambassador, has also established a network of champions to drive progress forward.

Each region is also set to benefit from a women's health hub, with each integrated care board set to receive £595,000 to work against local needs, totalling £25m of national investment.

Cancer waiting time standards

Following the clinically-led review of NHS access standards, changes to cancer waiting times standards have been agreed between NHS England and the Department of Health and Social Care. These will come into effect from Sunday 1 October 2023.

Developed by clinical experts and supported by leading cancer charities, there will be three cancer standards, which combine all of the previous standards and cover additional patients:

- the 28-day Faster Diagnosis Standard (75%)
- one headline 62-day referral to treatment standard (85%)
- one headline 31-day decision to treat to treatment standard (96%).

NHSE's letter summarises the changes and supporting information includes monitoring dataset guidance to ensure waiting time data is recorded consistently.

Diagnostic imaging reporting turnaround times

A new set of standards for imaging reporting turnaround times will help providers hit 62-day and faster diagnosis standards given the clear link between reporting delays and faster diagnosis and treatment for patients. The guidance includes the maximum timeframe within which all imaging needs to be reported and next steps for implementation, reporting and monitoring.

CMAST
Cheshire and Merseyside Acute and Specialist Trusts

Cheshire and Merseyside
Health and Care Partnership

CMAST Briefing

August 2023

ICB Update

NHS Cheshire and Merseyside Annual General Meeting

NHS Cheshire and Merseyside's first Annual General Meeting will take place from midday on Thursday 28 September 2023, after its September Board meeting. The AGM will provide an overview of performance and achievements from the NHS integrated care board's first year of operating after being formed on 1 July 2022.

Anyone with an interest in health and care in Cheshire and Merseyside is welcome to come along to the event being held at Halliwell Jones Stadium, Mike Gregory Way, Warrington, WA2 7NE. A process for public questions has been published on the ICB's website

CMAST Update

The Leadership Board met on 1st September. The issues discussed included:

- Specialised Commissioning: including an update on a NW review of Women and Childrens' Services and the process of delegation of some functions to ICBs
- ICB Programme Clinical Leadership and approaches to funding this equitably
- An update on the recommended system approach to Laboratory Information Management Systems (LIMS) and imminent delivery of an OBC for the 5 'host' Trust Boards to support the next step in a consolidated C&M approach and the proposed delegation of the ITT process to CMAST
- The Board noted the recent conclusion of the Lucy Letby trial and future opportunities for system learning
- The Board also noted the development of a quarterly Cancer Alliance report for use by stakeholders

The Boards next meeting will include Trust Chairs where business is expected to include a review of programme delivery - year to date.

Elective Recovery and Transformation Programme

ERF / Activity improvement

Our recovery of activity levels is measured against the same period in 19/20. We are delivering more than 2% higher improvement than the England average, despite a disproportionate rate of industrial action impact. Performance contributes to our financial reward through the ERF scheme.

Waiting times reduction

We have eradicated 104 week waits and are making excellent progress eliminating the 78 week waits, with only a small number remaining – most relate to patient choice and clinically complex cases.

We have reduced the 65-week wait cohort by over 91,000 in the last 15 weeks and now have less than 90,000 to clear before the end of March. We expect our rate of reduction will slow down over the next few weeks due to industrial action and also the holiday period.

Theatres

Our theatre utilisation (capped) performance is now 4th best in the country. We perform slightly lower for uncapped performance which is due to some data anomalies that have been rectified and will show improvement from September.

The theatre academy training progress continues with good engagement. Another round will commence in September, which will be aimed at operational teams as well as theatre teams.

Outpatients

We have commenced technical text message validation for over 52 week waits, and a total of 10,385 patients have received a validation text. We have had a response rate of 76%. Patients are being asked to clarify whether they still need their appointment / treatment, and also if they would be willing to travel to another location for their care. So far 522 patients have responded to say they no longer need their appointment, and 15% of patients that have responded said they would be willing to travel.

We are focussed on clearing long waits for outpatients by the end of October to set us up for achieving the 65-week wait target by the end of March.

Clinical Pathways

ENT

Stakeholders from across Cheshire and Merseyside came together on 15th August to meet with Matthew Trotter and Frank Stafford from the GIRFT ENT National Team for a clinically lead system 'Gateway Review'. Over 60 colleagues from provider trusts, commissioners, places and community services joined for a data driven discussion to consider variation across the system and where there is opportunity to improve patient care. The national team will provide a set of recommendations which will be taken forward by individual trusts and via the ENT network. The network is meeting in-person on 21st September to review the GIRFT recommendations along with the planning and delivery of the CPP improvement roadmap.

Dermatology

The dermatology roadmap has been adopted by the Dermatology Collaborative Alliance with 3 main workstreams: Primary and Community Care, Technology Enhanced pathways and Workforce development. This month we have been focussing on the technology enhanced pathways and in particular completion of a teledermatology implementation review. A teledermatology stocktake review report has been competed with three main issues that require a further option appraisal paper to identify an appropriate model to move forward to full implementation across the system. The option appraisal paper will be completed by end of September, initially for CMAST consideration. Issues remain in dermatology in relation to IT and digital infrastructure with several teledermatology platforms and routes for referral in place. It is recommended that the system consider completing an independent evaluation of available platforms and minimum specifications required for interoperability to inform the future procurement of a system wide solution.

Gynaecology

Gynaecology services has recently joined the CPP programme, and the team are currently pulling together the intelligence and data to support a high-level current state assessment with the clinical network leadership team. The intelligence pack will be ready to share by end of August and a collaboration workshop is planned for 14th September with all providers, Place level representation, local authority, and primary care stakeholders. This level of networking and collaboration for Gynaecology services is a new opportunity to look at the gynaecology service complexities and interdependencies in an effort to assess whole pathways across the system and focus on patient journeys in identifying gaps in current improvement plans.

Orthopaedics

The work across all of the orthopaedic providers in C&M continues through the C&M Trauma and Orthopaedic Alliance. Workstreams have been established to implement improvement opportunities identified through the collaboration and include promoting best practice to improve length of stay and waiting times for patients ensuring we optimise the use of our resources overall. The orthopaedic teams are working to implement clinical risk stratification methodology to enhance waiting list management and identify more opportunities for targeted 'pre-habilitation' for patients awaiting surgery to improve outcomes and experience. The Orthopaedic Alliance are also joining the National Orthopaedic Alliance on a trial basis to explore further collaborative working with the aim of sharing best practice and experience.

Diagnostics Programme

Key Performance Headlines

(June 2023 DMO1)

- 103,435 tests have been delivered in month; this is higher than last month (102,047). YTD over performance in CT is (8% higher than plan), Ultrasound is (5% higher than plan), MRI is (3% higher than plan) and Gastroscopy is (1% higher than plan).
- 79% of patients have waited 6 weeks or less for a test (maintained since May 2023).
- ICS ranking has dropped to 18th out of 42 ICSs even though waiting time performance has been maintained.
- 15,572 patients (21%) have waited 6 weeks or more (slight increase since May 2023).
- The total number of patients waiting for all tests is 76, 047 (relatively static).
- STHK has the highest number and percentage of patients waiting 6 weeks+ (5721 patients 38.8%).

(13 August WLMDS)

- Only 10 52 weeks+ waiters remain. 17 at COCH, 2 at Mid Cheshire, 1 at WUTH & 4 at WHH.
- Only 196 40+ waiters remain. All patients are waiting for an endoscopy, cystoscopy or urodynamics.110 at Mid Cheshire, 69 at COCH, 1 at MWL, 13 at WHH, 3 at LWH.

Pathology

Target Operating Model Delivery Plan

A series of check in events have taken place with Trusts, Primary Care, C&M ICB and NHSE colleagues to set out the reset visions, principles and commitments including the proposed next steps for service configuration in C&M. These concluded on 25 July with over 80 colleagues attending the sessions. The information informs the TOM delivery plan.

LIMS (laboratory Information Management System)

An options appraisal workshop was held on the 24th July to evaluate the options for LIMS and make a recommendation for the best solution: a network wide, pan pathology LIMS solution was identified as the preferred option The preferred option has been supported by C&M DOFs and CMAST CEOs. The core 5 trusts (WHH, WUTH, COCH, MWL and LUFHT) will take an outline business case through their trust Boards. System financial modelling suggests benefits for all, but with cost pressures for some organisations. A system risk and gain share approach is required to help all trusts to agree.

Digital Pathology

An updated remedial action plan from Phillips has been accepted to resolve equipment supply issues.

CMPN Workforce Strategy

Engagement activities have commenced with staff across sites to understand what staff need to prevent them from leaving the service.

Histopathology Improvement Plan

The team has been mobilised to manage the system's histopathology review. The first Task and Finish Group meeting with trust representatives took place and project data outputs were agreed. Key deliverables include improved turnaround times and service resilience.

Endoscopy

- All trusts are now live on the SOLUS Endoscopy system.
- A system bid has been submitted for £15m to NHSE/I for the Endoscopy Transformation Programme – a short form business cases will now be developed.
- All AI polyp detection is now installed at every trust.
- The digital pre assessment has gone live at East Cheshire Trust.

Radiology

Medical Physics Service

The Band 8A Medical Physics Expert is in post and the Cheshire and Merseyside Medical Imaging Physics Service has started. Management of this service has been handed over to the medical physics team at Clatterbridge, the C&M Imaging Network is continuing to provide oversight and assistance for the service. Benefits management methodology has been completed. Monitoring to optimise MR capacity on the 19 scanners that are receiving MRI AAT has begun.

Interventional Radiology

C&M Imaging Network has taken the interventional radiology proposal to the COOs and the Diagnostic Delivery Board, there are plans to share the proposal with the Medical Directors, Directors of Strategy, Directors of Finance and CMAST. C&M Imaging Network has set a date for the IR Summit, 06/10/2023 at WUTH. We are also identifying and meeting stakeholders across the network to identify current issues and potential solutions or actions to resolve these issues.

Cardiology regional solution

A meeting was held with Countess of Chester to discuss onboarding as their current Change Health system is out of contract in October 2023. Information has been requested on their devices, size of echo, archiving potentials at local Trusts PACS. A proposal of works including costs needs to be sourced from Philips. The Countess of Chester have the funding to deliver the project.

Community Diagnostic Centres (CDCs)

- Activity has commenced at the Paddington site in line with revised plan.
- CDC 2 at Congleton has been authorised and plan to rollout is in place (LoA and MoU remain outstanding.
- 108% delivery YTD of plan.
- Additional pathways and tests options relating to system performance, faster diagnostics standards, elective backlog and recovery have been submitted to NHSE for funding and delivery in Q3/4 of 2023/24

Efficiency at Scale (part of Finance, efficiency and value)

Overarching Programme

The programme has been notified that the Patient Safety Incident Reporting Framework (PSIRF) bid to the ICB Transformation Committee has not reached the final stage, but the remaining three bids will be considered by the final panel in September.

Throughout July and August, the programme has attended a number of professional leadership forums including DOFs, CIO's, COOs, DOSs and Co Secs, this will continue over the coming weeks with plans in place for MDs and Directors of Estates in the coming weeks.

Discussions have continued with the national Corporate Services Transformation Programme team, and it has been agreed they will now have monthly meetings with C&M to support and develop core work programmes.

Finance/Legal

Discussions continue with the national team regarding the national financial ledger, supported by the ICB. A further meeting is planned for September and information gathering for the development of a business case has commenced.

Review of 'additional insurance' trust level returns across C&M, highlighted £3.1m expenditure across the system, £2.3m relates to property insurance. Report discussed with SRO and ICB. Discussions have now commenced with national leads regarding potential options.

Medicines Optimisation

The workstream has identified savings of £10m for 23/24 with a continued focus on Place level DOAC, ONS and AMD schemes, work is ongoing.

Further schemes have also been identified, specifically relating to providers for 23/24 with a focus on medicines value optimisation, for example high-cost drugs. New projects to support the Efficiency at Scale programme are currently being considered including medicines value post, Outpatient Parental Antimicrobial Therapy (OPAT) and homecare optimisation.

Procurement

Programme now has now identified 23 strategic projects with a FYE of £6.4m, further schemes are in development with a further £1m opportunity highlighted by the consumables group.

A reporting dashboard has been created with the support of MIAA and is being reviewed regularly by the E@S board and DOF forums.

Further meetings are planned with the Directors of Estates and Chief Information Officers over the coming weeks to discuss possible procurement programmes in these areas.

Workforce

CMAST Workforce Programme

The CMAST Workforce Programme Board met in August, Kathryn Thompson SRO chaired the meeting and has now officially handed over the role to Jan Ross, CEO The Walton Centre. The Board thanked Kathryn for her support to the CMAST Workforce Programme. an update presentation on the Allied Health Professional Faculty was received.

Development of Band 6 Ward & Department Nurse Roles

Members of the working group are currently drafting the key content to be included in the Development Toolkit. The group will meet again on 28th September to review a final draft of the toolkit with colleagues from across the system. In the meantime, group members are also exploring the opportunity to test the Development Toolkit within their individual organisations as a pilot site.

Midwifery - Trainee Nurse Associate (TNA) Role

This project is currently on hold, there is a requirement for the national team to review the regulatory element of TNA maternity. Discussions are taking place with regional and national chief midwives.

Allied Health Professionals Faculty

A workplan for 2023-24 has been completed and mapped against the C&M ICP Interim Strategy, meanwhile a funding bid has been submitted to the C&M People Board for an extension of the AHP Faculty Team until the end of March 2024. The key focus in the coming weeks will be to secure this funding for AHP Faculty team beyond October 2023.

Elective Recovery Workforce

A piece of work to support strategic workforce planning across theatres, surgical hubs and priority clinical pathway specialties. The work will consider future workforce model development and alternative / new role design.

Workforce Efficiency at Scale

A workforce data review has been completed and was presented to the July project board. Key information was presented and will be shared with Chief People Officers at their September meeting. A decision will then be made on key areas to progress.

Quality Focus

There are various pieces of work in place that have a focus on quality for our patients across Cheshire and Merseyside including:

- **Section 136 multi-agency Task and Finish Group**- A round table was held on August 21st with Directors and Deputy Directors of Nursing and Quality across 7 acute provider organisations to scope and agree actions required prior to the cease of the current Prometheus contract (ICB) on October 31st. Actions are focused on ensuring that there are alternative offers in place to support the observation of patients residing in Emergency Departments, meaning that the police can then be released to front line duty.

- **Industrial action after action review-** A task and finish group is in place, the first meeting is scheduled for August 24th when lessons learnt will be shared and actions agreed
- **Patient Experience work-** All Programme boards have added this as a regular agenda item, currently there are draft infographics in place for two programme boards and plans in place for the remaining three. These infographics will be presented at the CEO Leadership board and then to each of the programme boards.

Urgent and Emergency Care – System Control Centre

The urgent and emergency care (UEC) system continues to experience significant pressure across the whole of NHS Cheshire & Merseyside, with the majority of trusts across C&M consistently reporting at OPEL 3 during 2023 to date. The system has been escalated overall at OPEL 3, which is defined as 'the local health and social care system is experiencing major pressures compromising patient flow'.

C&M has shown improvement and greater stability over the last three months for patients admitted, transferred, or discharged within 4 hours. July published performance was at 73.8% against a year-end national recovery target of 76%, better than Northwest (73.0%) but lower than the England level (74%).

The percentage of beds occupied by patients with a length of stay over 14 days was 32.5% at the end of August 2023, whilst length of stay over 21 days continues to account for around a quarter of occupied beds against the 2023/24 Operational Plan of 17%. For the purposes of national UEC tiering a RAG rating is given, and again C&M is one of 4 ICB areas nationally rated as Red on this area. NCTR has NCTR position deteriorated slightly in August to 17.8%.

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/134a***	**Date: 14/09/2023**
Report Title	**Perinatal Quality Surveillance & Safety Dashboard**	
Prepared by	**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 and neonatal 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):			
	For Decisions - in line with Risk Appetite Statement – Y/N ***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 and Neonatal 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*	Comment:

2 – Inability to ensure the on-going sustainability of clinical services and maintain a high standard of care at the current Crown Street site.	
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

EXECUTIVE SUMMARY

This report provides an overview of quality and safety performance in maternity and neonatal services at LWH to provide assurance to the Trust Board and to highlight areas of concern which require further scrutiny.

The requirement for Trust Boards to implement a 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 Information Team have developed a comprehensive perinatal quality surveillance dashboard, which is presented monthly at the Maternity Risk Meeting, the Neonatal Operational Management Meeting and 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.

Perinatal Quality Surveillance Highlight Report August 2023 (July 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:

- To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge, and enquiry.
- That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust board.
- That all maternity Serious Incidents (SIs) are shared with Trust boards and the LMS, in addition to reporting as required to HSIB.
- To use a locally agreed dashboard to monitor maternity and neonatal safety at board meetings.
- 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.
- 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.

Family Health Clinical Dashboard (July 2023)

Areas of concern

Very Concerning – Investigate & Take Action.		
Metric	**Position**	**Narrative**
LocSSIPs – Complete in Theatre	45.29% (Target 100%)	This performance target is related to category 1 caesarean section, After investigation it appears to be linked to the noncompliance with the use of electronic WHO checklist. This metric is overseen by the CSS Division, as

		it related to theatre LocSSIP with oversight at the Trust LocSSIps meeting.
Outpatient Appointments Subsequently Cancelled by Hospital (Maternity)	18.53% (Target <10%)	There has been an in month increase Ion last months target (14.9%) Some outpatient appointments were cancelled due to the Junior Doctors Industrial Action, 5 day strike which took place between the 13th to 18th July 2023. A subsequent issue identified relates to the introduction of the new EPR system resulting in some data quality issues which has further compounded performance against this target. All cancelled appointments were re-scheduled following discussions with clinicians to ensure that all pregnant women received an appointment as per their risk status.
Concerning – Investigate and understand		
Friends and Family Test Positive Results (Maternity)	80.85% (Target 95%) June: 83.97% (Target 95%)	Midwifery Matrons meet on a weekly basis to discuss Friends and Family feedback. Improvements are put into place where any trends or themes are identified. One theme identified is delayed administration of pain relief and medication on the Maternity Ward. This is one area that is being addressed by the Mat Base Improvement Group, which is a pillar of the Maternity Transformation Board. One of the actions implemented is the allocation of an individual midwife per shift to administer medication on a 4hrly basis, to ensure that all women are given prescribed medication and pain relief on time and when required. Another theme is women asking for their partners to be able to stay with them on Mat Base overnight. A project allowing birthing partners to visit Mat Base over a 24hr period is in progress and is being evaluated by the Trust Patient Experience team. Progress updates are given at the weekly Maternity Voices Partnership meetings.
LMS Percentage Of Women Receiving Personalised Care Plan	97.72% June: 95.89% (Target 100%)	We have seen an in month improvement against this metric and improvement work continues K2 documentation is subject to a monthly audit to monitor compliance with completing the data entry requirement for provision of personalised care. Feedback is given to community midwives after each audit, with a targeted plan for community midwives who have not completed the relevant documentation. Trajectory for achieving 100% compliance has been set for October 2023.
Newborn Blood Sampling – avoidable repeat tests	4.84% (Target <=2%)	This remains in status quo. Data is reported quarterly, and the updated data is awaited. The error rate is increasing. The following actions have been taken and are monitored on a weekly basis: • Improvement plan in the process of being drafted and was completed on 31.8.23. • Staff with repeated error rates are required to attend refresher training in how to obtain a correct newborn blood spot. • Linking in with the Trust blood sampling improvement group to identify and implement other areas of best practice.
Newborn Hearing Screening	97.31% (Target >=98%)	Performance was not met as most babies did not attend, despite two appointments being sent as per policy (a hearing test is not mandated). Two parents declined the screening, three babies returned home to the Isle of Man. Whilst 9 babies missed the KPI date, they each did have their hearing screened inside the maximum screening age of three months.
Delayed Inductions of Labour.	1539.0 (Average Time)	There have been 17 more cases of delay in induction of labour reported in this reporting period compared to June 23, due to the high acuity and occupancy in Maternity services. The SLT recognise the issues with ongoing delays in IOL and a T&F Group has been convened along with an Estate reconfiguration being developed and approved by Executive Team,

		with work to commence on 18/9/23 to repurpose the current MLU Estate to make this a multipurpose areas, maximizing the use of this estate and creating a Induction of Labour lounge, which will reduce bottlenecks within the Deliver suite estate which contributes to IOL delay. Reported incidents of delays to commencement of ongoing IOL are used as midwifery red flag indicators within midwifery staffing reports. There are several improvement tasks ongoing within the Division, including the development of a task and finish group, lead by the newly appointed Induction of Labour MW Co-Ordinator and Intrapartum Obstetric Lead. This group is exploring reasons for delays in IOL, including capacity an demand on booking list, clinical space exploration within the intrapartum areas and escalation policies for IOL. The Clinical Director and Lead is in discussing timeframes of delay with regional obstetric leads to standardised categorisation of delayed IOL across the C&M patch.

Sickness Absence

Sickness across maternity has decreased in month to 6.44%%, with a continued downward trend since April 2020.

Core Mandatory, Clinical Mandatory and Specialty Specific Training Compliance

Overall divisional training compliance is 84.12%. Areas of concern are Paediatric Basic Life Support (Neonates) reporting below 50% compliance and stands at 13% with 26 colleagues required to complete the training, also Resuscitation Training Level 3 at 54.55%. All staff who are out of date with resuscitation training have been asked to book training before the end of August 2023.

The second area of concern is Aseptic Non-Touch Technique which is at a compliance of 64.30%. Targeted intervention includes training staff to do cascade training, so that they can target colleagues on shifts who are out of date with ANTT. Trajectory in place to achieve KPI compliance by end of September 2023.

The divisional compliance rates are below -

90.80% Core Mandatory (increase from 88.09% in June 2023)

90.02% Compliance in Maternity PDR (increase from 88% in June 2023)

79.87% Clinical Mandatory Training (increase from 77.4% in June 2023)

80.75% in Specialty specific/local training (increases from 77.41% in June 2023)

Training remains a risk for the Division, and it is noted on the corporate risk register however, whilst not at compliance or sustained, it is acknowledged that improvements are being made and this will continue. Training compliance is discussed on a weekly basis as part of the Divisional oversight plan and will continue until the KPI is achieved.

Clinical training compliance

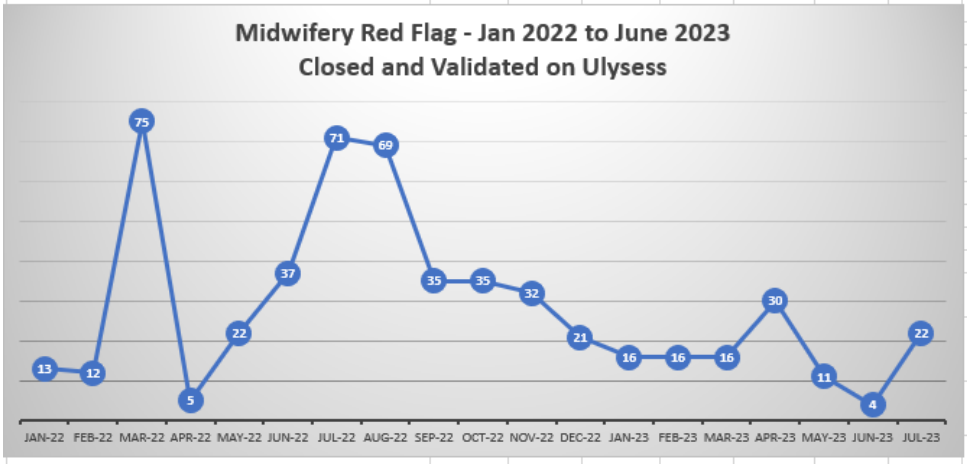
CNST MIS Year 5 Safety Action 8 requires evidence by February 2024 that at least 90% of each maternity unit staff group attendance an ‘in-house’ multi-professional maternity emergencies training session within the last year.

CNST SA8	Staff Group	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	
SA 8b. MPMET	Midwives	79%	87%					NQM, B6, B7, B8.
	Maternity HCA	75%	79%					
	Cons Obstetrician	53%	59%					
	Trainee Obstetrician	x	58%					New rotation in Aug
	Cons Anaesthetist	28%	27%					
	Trainee Anaesthetist	x	36%					New rotation in Aug and Nov
SA 8c. Fetal Surveillance	Midwives	77%	83%					NQM, B6, B7, B8.
	Cons Obstetrician	62%	59%					
	Trainee Obstetrician	x	29%					New rotation in Aug
SA 8d. NLS	Midwives	81%	88%					Delivered on MPMET day
	Cons Neonatologist	100%	100%					
	Trainee Neonatologist	100%	100%					New rotation Mar & Sept
	ANNPs	93%	93%					
	Neonatal Nurses	83%	98%					

- Figures above do not include LTS or Mat Leave- data to be cleansed at the end of reporting period.
- New medical trainees' rotation Aug (Obstetrics), Sept (Neonatal) November (Anaesthetics) New midwifery intake in October- training days built in as part of the orientation period. Additional dates planned to support intakes.
- A newly developed Maternity TNA to align with the requirements of the Core Competency Framework Version 2, has been ratified at Family Health Division and requires sign off at Trust Board. This will then be shared with colleagues in the LMNS inline with the Year 5 MIS scheme requirements.

Midwifery Red Flags

Midwifery Red Flag Event - Validated	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
1:1: Care in Labour Not Supported	5	2	2	2	1	0	0
>30 min Delay in Presentation to Triage	6	2	5	12	1	2	1
>2 hour delay in admission to IOL	5	2	0	0	0	0	2
>4 hour delay in ongoing IOL (LWH MRF)	0	10	6	14	9	1	18
Delay in time critical activity	0	0	1	0	0	0	0
Delay in pain relief >30 mins	0	0	1	0	0	1	1
Missed medication during hospital admission	0	0	0	0	0	0	0
Delayed recognition of and action on abnormal vital s	0	0	0	0	0	0	0
Full clinical examination - presenting in labour	0	0	0	0	0	0	0
Missed or Delay Care (Suturing)	0	0	1	2	0	0	0
Total	16	16	16	30	11	4	22



There were 115 red flags reported between January 2023–July 2023. There were no reports of any harm caused to patients during this time, from the incidents reported as midwifery red flags. There remains a required element of clinical, manual validation, due to some reporting errors but a positive reduction has been demonstrated.

All midwifery red flags events are detailed within the bi-annual midwifery staffing report – due for submission to Trust Board in October 2023. This report will cover all aspects of midwifery staffing and compliance against the refreshed 2023 Birth Rate Plus Report.

Maternity Safety Incident Reporting

In July there were 359 incidents entered across Maternity. Top 5 causes are listed below:

1. Investigations - 87
2. Clinical management - 65
3. Admission/transfer/discharge- 45
4. Staffing levels - 36
5. Midwifery Red Flags 22

All incidents are reviewed and overseen as per Trust process, via daily departmental review, MDT review where required and the weekly Trust Safety meeting. Maternity reports an average of 387 incidents per month. Tolerance level is currently set at 30 which equates to 10% of incidents reported. There is therefore an expectation that 90% (roughly 357) will be reviewed and closed within month. During the past month, Maternity have closed 279 incidents.

Perinatal Mortality – Intrauterine Deaths >24weeks.

During July 2023, there were 3 still birth cases, all of which have been reported to MBRRACE. Each of these were reviewed and a full MDT is scheduled in October, led by the designated Obstetric PMRT lead, and supported by the risk midwife. These cases have been reported to MBRRACE, parental support continues to be provided by the Honeysuckle Team. Details and action plans 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 July 2023.

An investigation report has been returned to the Trust and has been received within the Division. The Governance HSIB Team and Senior Leadership Team, have reviewed the findings of the report and are developing learning strategies to align with the report findings around communication, consent for membranes sweeping at IOL and documentation. Good practice points within the investigation centred around bedside USS prior to commencement of IOL to confirm fetal presentation, that blood loss was weighed and measured at the time of antepartum haemorrhage and appropriately managed VTE scoring and risk assessment. HSIB did not offer any safety recommendations.

Serious Incident Reporting

In July 2023, FHD reported two incidents to STEIS for investigation under the Serious incident Framework.

Both cases related to transfer to acute service for intensive care therapy. Both will be reviewed and remain on track for completion by the ICB deadline.

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 individual actions are monitored and updated with support from the Governance Team.

The Maternity Division communicates learning from serious incidents via the following methods:

- Immediate feedback to staff
- Sharing Lessons of the Week via Microsoft Teams
- Appreciation letters being sent to staff involved in incidents when good practice has been identified.
- Investigating Officer presenting the case at the Trust Safety Check in meeting.
- Cases shared at ward safety and governance meetings.

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 is Executively Led by the Chief Nurse and operationally managed through a designated workstream of the Maternity Transformation Board. The Trust Board and Quality Committee have received an in-depth report into the current scheme compliance in September 2023, measured against the timeframes set within the scheme guidance.

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 in the last month, 4 essential actions have been progressed from Amber to Green.

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**

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 have used an appreciative enquiry framework to re-assess and complete this self-assessment tool in 2023 and evidence is stored in a repository. Majority recommendations have been implemented in the Trust.

The Red areas relate to:

- Development of a Quality Improvement Programme in the Trust, which the corporate Governance team are leading (equates for 2 recommendations).
- Administration post in the Governance team (previous post holder not replaced, however other workforce investment in the team).
- Audit of a Safety Huddle SOP. A Safety Huddle SOP is being drafted and will be subject to audit when completed.

Red	Amber	Green
4	64	114

CQC Maternity Survey (Picker Survey)

The Division are now in receipt of the results of the Maternity CQC 2023 Survey results. A review of the results are ongoing and will be formulated into an action plan, co-produced with the MNVP.

Safety Champions.

There are no safety escalations to be made from Ward to Board in July 2023, any identified concerns have been managed and resolved inter-divisionally.

The provisional NHS England visit feedback in July 2023, identified that some staff weren't aware of who the trust safety champions are and their function therefore a full review and refresh of the safety champion workstream has been completed with the development of an annual workplan and action plan. This has been presented at the Family Health Divisional Board and Quality Committee. Walkrounds have continued and any actions identified have been escalated within Division to SLT for review, action and management. Some highlighted issues with maternity outcomes and Digi care Issues have received support in a resolution from the BLSCs and have resulted in process changes to improve outpatient clinic outcomes.

Saving Babies Lives Care Bundle Version 3.

The Division are now in receipt of the SBLCBV3 Implementation Tool, with access granted through the NHS Futures Platform. In order review compliance with SBLCBV3, a GAP analysis and evidence review is underway with the scheme oversight leads and element leads. A full report and revie of the implementation tool will be performed through the Maternity Transformation Board. The LMNS have submitted compliance targets that will calculate percentage of implementation of the care bundles to align with the trajectories set by the Maternity Incentive Scheme. A further update of SBLCBV3 will be provided in October 2023 to Quality Committee and Trust Board.

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 and Neonatal KPIs that are included within the Power BI dashboards.

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 Perinatal Services at LWH.

NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	23/24/134b	Date: 14 September 2023
Report Title	Maternity Incentive Scheme (CNST) Year 5 2023 – Update Paper	
Prepared by	*Angela Winstanley – Maternity Quality & Safety Matron* *Vicky Clarke – Divisional Manager* *Heledd Jones – Head of Midwifery*	
Presented by	*Dianne Brown – Chief Nurse*	
Key Issues / Messages	This report outlines the scheme requirements for compliance required to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year 5 and the Trust's current RAG status. This paper will outline any identified key risks to the Trusts' ability to declare compliance against the current scheme and detailed discussion of identified risks should be minuted as noted below: Detailed Trust Board Minutes must be made available, with evidence to the following safety action detail: SA 1 – Nil required at this meeting SA 2 – Nil required at this meeting SA 3 - Trust Board Minutes to note the sign off ATAIN and TC Audit and Action Plan. SA 4 – Trust Board should note the current position in relation to compliance of Consultant attendance against RCOG guidance in relation to clinical situations as per the 'Roles and Responsibilities of the Consultant providing acute care in Obstetrics and Gynaecology. SA 5 – Nil required at this meeting SA 6 – Nil required at this meeting SA 7 – Nil required at this meeting SA 8 - The Minutes to note that Trust Board have received and reviewed the revision of the Maternity Training Needs Analysis and have signed off prior to submission to the LMNS and ICB. SA 9 – Trust Board Minutes to note that the Board Level Safety Champions are meeting monthly and that any support of the Trust Board has been identified and implemented. SA 10 – Nil required at this meeting.	

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*
	For Decisions - in line with Risk Appetite Statement – Y			
	The Trust Board is asked to: • ***Receive the current position in relation to CNST Year 5*** • ***Note key risks to compliance***			
Supporting Executive:	***Dianne Brown Chief Nurse***			

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

Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☒

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Family Health Maternity Transformation Board	Monthly	HOM	Monthly progress updates from scheme safety action leads.
Family Health Divisional Board	Monthly	Clinical Director for Family Health and Divisional Manager	Monthly updates to be provided to the FHDB and where required, issues for noncompliance to be escalated and resolved.

EXECUTIVE SUMMARY

This report outlines the scheme requirements for compliance required to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year 5 and the Trust's current status against this.

This paper provides an update to the Board of Directors in relation to the requirements of the Maternity Incentive Scheme Year 5. This report will set out the findings from completed GAP analysis of the scheme requirements against the Trust current position.

MAIN REPORT

Introduction.

NHS Resolution (NHSr) is operating year five of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST.

As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. As in all previous years, the scheme incentivises the completion and embedding of ten maternity and neonatal safety actions.

Trusts that can demonstrate they have achieved all ten safety actions and will recover the element of their contribution relating to the CNST maternity incentive fund and will receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund

Conditions of the scheme.

The Trust Board of Directors must also be aware of the conditions of the scheme, some have been added and are detailed in the July V2.0 2023 release. These are as follows:

- Trusts must achieve all ten maternity safety actions

- There is a scheme end declaration process, which will be overseen by the Chief Nurse and Trust Secretary.

- Trust submissions will be subject to a range of external validation points, these include cross checking with: ---
    - MBRRACE-UK data (safety action 1 standard a, b and c),
    - NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, standard 2 to 7 inclusive),
    - National Neonatal Research Database (NNRD)
    - HSIB for the number of qualifying incidents reportable (safety action 10, standard a).
    - Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

• The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' update at Local Maternity System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.

- Trusts will need to report compliance with MIS between **25th January 2024 and 1 February 2024** at 12 noon and associated approval and governance oversight will be led by the Trust Secretary.

Current Position for Year 5 – September 2023

RAG Rating Guidance	Description
	All workstreams/safety actions on target. Evidence collated to demonstrate compliance.
	Workstreams ongoing, forecasted compliance expected with some evidence collated.
	Risk of Non-Compliance/Safety Action requiring escalation/No evidence to support compliance.

Safety Action Point & Description	Issue / Update for consideration	Status RAG
SA.1 Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Leads: Ae Wei Tang – Consultant Obstetrician Rebecca Kettle – Consultant Neonatologist Susanne Bogan – Governance & Risk Midwife	All eligible births and deaths, from 30.05.2023 to 07.12.2023 must meet the following conditions: A. **100%** all deaths have been reported to MBRRACE within the seven working day timeframe with 100% of deaths having surveillance completed within one month to date from 30.05.2023 - Reporting to MBRRACE has continued as per usual process with no lapses in reporting. –100% Compliance. B. **95%** of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30.05.2023 onwards. - Parental perspectives of care and questions have continued to be collated by the Honeysuckle Team and incorporated into the PMRT reports. All parents have been informed that a review of their care is being performed. C. For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. a) **95%** of reviews should be started within two months of the death - 20 Cases reported to MBRACCE – 90% Compliance presently. Two cases awaiting commencement of review on PMRT database. No anticipated issues with compliance. b) **60%** of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months - Draft format within four months – NA at present - Fully published within six months – NA at present D. Quarterly reports submitted to Trust Executive Board from 30th May 2023. 100% Compliant **Q4 22/23 –** Learning from Deaths Report - Submitted to QC - 30.05.2023. **Q1 23/24** – Learning from Deaths Report – Under development.	**September 2023 -** There are currently no identified concerns with compliance for this safety action. Remain on target for full compliance.
SA.2 Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023. ***September 2023 –*** The Trust are in receipt of provisional data submitted based on July data. This data suggests compliance with 10 of the 11 metrics. Encouragingly, the single metric deemed as non-compliant is a data format	**September 2023 position** – There are currently no identified concerns with compliance for this safety action. Remain on target for full compliance.

Leads: Head and Deputy of Information Richard Strover & Hayley McCabe	issue since the introduction of Digicare/Meditech expanse and has been rectified and resubmitted. There are no issues reported with compliance with this standard. Anticipated to be COMPLIANT 2. MSDS data for July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) ***September 2023*** – provisional submitted July data to MSDS demonstrates a 96.2% compliance with this indicator. Anticipated to be COMPLAINT 3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: A) Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. *B)* Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. Note: *If maternity services have suspended all MCoC pathways, this criteria is not applicable* If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information). ***September 2023 Update*** – The Division invited NHS England into the organisation in July 2023 after the CQC Inspection. The report from the NHS England Team is awaited, after which confirmation is expected if the Trust requires entry in the Maternity Safety Support Programme. C) Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023. COMPLETED D) Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust. COMPLIANT	
SA.3 Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? Leads:	A) Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. **September 2023 Update**– Transitional Care pathways are very well embedded at LWH. A designated, five bed ward, located within the Maternity Base provides Transitional Care. A supporting Transitional Care on the Postnatal Ward SOP is available. - **Compliance** – 100% B) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and	**September 2023** - There are currently no identified concerns with compliance for this safety action. Remain on target for full compliance

Anna Paweletz– Consultant Neonatologist Sarah Brownrigg – ANNP Paula Nelson – ANNP	obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB. **September 2023 Update** – A multidisciplinary review of all term admissions is conducted weekly and has been well embedded in the Division for several years (preceeding the Maternity Incentive schemes). Quarterly reporting to the FHDB has continued and the 2022-2023 ATAIN audit report and action plan, based on the findings of the reviews can be found in the Appendix 4 to this paper. This has been sighted at Family Health Division and will be shared with the LMNS and ICB after Trust Board approval. Quarterly reports on progress with ATAIN audit will be shared with Trust Board within this MIS scheme update. The Transitional Care and ATAIN Audit Report and action plan has been shared with the LMNS on 31.08.2023 via the Year 5 MIS scheme return. **Compliance** – 100% C) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway. **September 2023 Update** As per Transitional Care Admission Criteria: Babies eligible for TC from Neonatal unit and DS include: - Babies from 33 weeks gestation who have been stable for 72 hours and only require an apnoea mattress for monitoring to be removed at 34 weeks gestation - Babies from 33 weeks gestation who are in air and stable for a period of 24 hours following any form of oxygen therapy. - Palliative care when parent/carer doing most of the care - Birth weight below 1.8Kg OR 34-35/40 and well. - Late preterm and term baby admissions are reviewed/audited in the ATAIN audit **Compliance** 100%	
SA.4 Can demonstrate an effective system of clinical workforce planning to the required standard? Leads: Richard Haines Clinical Lead Obstetrics Jill Harrison Clinical Lead Neonatology Jen Deeney Neonatal Nursing Rakesh Parikh	**Obstetric Medical Workforce** 1. NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: - i. currently work in their unit on the tier 2 or 3 rota or - ii. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or - iii. hold an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums **September 2023 Update** – The Temporary Staffing Policy (available on Intranet) addresses the requirements of this safety action. Audit to be completed after 6 months of activity with action plan to address any lapses. Audit findings and action plan to FFP if required, QC and Trust Board in November 2023. 2. Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. **September 2023 Update** – Audit is planned to be completed, using the monitoring and effectiveness tool, after 6 months of activity with action plan	**September 2023** - There are currently no identified concerns with compliance for this safety action. Remain on target for full compliance.

Anaesthetic Workforce	to address any lapses. Audit findings and action plan to FFP if required, QC and Trust Board in November 2023. 3. Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. **September 2023 Update** – Trust Guidance "Emergency Cover Arrangement for Senior Medical Staff Covering Post Graduate Drs Policy" available on Intranet. Audit is planned to be completed after 6 months of activity with action plan to address any lapses. Audit findings and action plan to FFP and Trust Board in November 2023 and detailed minutes should be made available. 4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations 27 listed in the RCOG workforce document: *'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'* into their service when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. **Evidence Required**: Trust positions with the requirements should be shared with the Trust Board, the Board-level safety champions as well as the LMNS. **September 2023 Update** – Audits of compliance of consultant attendance continue within the Division. Audit findings of attendance between January 2023 to July 2023 and associated action plan can be found in Appendix. **Anaesthetic Medical Workforce** 1. A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) **September 2023 Update** – An anaesthetic workforce paper will be prepared by Clinical Director for Anaesthetics and presented in November 2023 scheme update paper and detailed minutes should be made available. **Neonatal Medical Workforce** 1. The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements have not been met in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN) **September 2023 Update**: The Neonatal Unit at LWH complies with the requirements of BAPM and was evidenced in scheme year 4 with a medical workforce review. The review concludes that the BAPM standards required to meet the optimal arrangements for neonatal intensive care medical staffing are in place at LWH and that there was no requirement for a Trust	

	Board approved action plan. An update will be provided to Trust Board in January 2024 and detailed minutes should be made available. **Neonatal Nursing Workforce** 1. The neonatal unit meets the BAPM neonatal nursing standards. If the requirements have not been met in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies. If the requirements had been met previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN). **September 2023 Update**: In April 2023, the Trust Board received (after submission to PPF in March 2023) a biannual staffing paper which contained the Neonatal nursing review and action plan as per the Year 4 scheme. An update paper and action plan will be prepared and will be progressed through relevant committees towards the end of 2023.	
SA.5 Can demonstrate an effective system of midwifery workforce planning to the required standard? Leads: Heledd Jones – Head of Midwifery Alison Murray – Deputy Head of Midwifery	A. A systematic, evidence-based process to calculate midwifery staffing establishment is completed. B. Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. C. The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. D. All women in active labour receive one-to-one midwifery care. E. Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period. **Evidence Required:** Report submitted to Trust Board will comprise evidence to support A, B and C progress or achievement and should include: - A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. - In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in **Board minutes**) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. - Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. - The plan to address the findings from the full audit or tabletop exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. - Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. o The midwife to birth ratio	**September 2023** - There are currently no identified concerns with compliance for this safety action. Remain on target for full compliance.

	o The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. - Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls. **September 2023 Update** – A refreshed Birth-rate Plus report has been received and is tabled to be presented to Quality Committee and Trust Board in October 2023 with all safety action standards addressed and sign off full compliance anticipated.	
SA.6 Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version 2? Leads: Clinical Director Alice Bird – Obstetrics Angela Winstanley – Quality & Safety Matron	1. Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024. (SBLCV3 Guidance can be found in Appendix 4) **Evidence Required:** A new implementation tool will be available by the end of June to help maternity services to track and evidence improvement and compliance with the requirements set out in Version Three. The tool will be based on the interventions, key process and outcome measures identified within each element, so providers can begin implementation of the Care Bundle Version 3 now with confidence, while the tool undergoes final user testing. Providers should use the new national implementation tool to track and compliance with the care bundle once this is made available and share this with the Trust Board and ICB. To evidence adequate progress against this deliverable by the submission deadline in February, providers are required to demonstrate implementation **of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.** **September 2023** – The Division now have access to the Implementation Tool and are in the process of reviewing the current status. All SBLCBV3 elements have assigned leads, with oversight being monitored within the Family Health Division. A more detailed update will be provided in October 2023 2. Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available. **Evidence Required:** Confirmation from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following: - Use of the implementation tool once it is made available. - Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. - Progress against locally agreed improvement aims. - Evidence of sustained improvement where high levels of reliability have already been achieved. - Regular review of local themes and trends with regard to potential harms in each of the six elements. **September 2023 Update** – The Division have a planned meeting on the 26.09.2023 with the LMNS Quality & Safety Lead and Regional Saving Babies Lives Lead.	**September 2023** - There are currently no identified concerns with compliance for this safety action, however this is a complex safety element and a full update will be provided when the analysis of the Implementation tool is completed.

SA.7 Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services? Lead: Heledd Jones Head of Midwifery Yana Richens Director of Midwifery Mahdieh Irvine – MNVP Chair	1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023). Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group. 2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board. 3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions. **September 2023 Update** – The Head of Midwifery will progress this safety action in collaboration with the MVNP Lead. Weekly meetings are held chaired by MVP Chair with attendance from Trust representatives. Quarterly service user meetings led by MVP Chair. 15 steps for Maternity Base completed in April 2023, with a full report submitted by MVP Chair. The HoM and MNVP Lead, as part of the Maternity Transformation Programme will progress an action plan developed in response to the CQC Maternity Annual Survey. A further 15 Steps Project has been planned with the MNVP on the Maternity Assessment Unit. A Vice Chair MNVP Lead has also been appointed.	**September 2023** - There are currently no identified concerns with compliance for this safety action. MNVP and user feedback work is progressing through the Maternity Transformation Programme.
SA.8 Can you evidence that at least 90% of each maternity unit staff group attendance an 'in-house' multi-professional maternity emergencies training session within the last year. Leads: Alison Murray – Midwifery Jonathon Hurst – Neonatal	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework. A training plan should be in place to cover all six core modules of the Core Competency Framework over a 3- year period, starting from MIS year 4 in August 2021 and up to July 2024. 2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. 3. The plan is developed based on the "How to" Guide developed by NHS England Relevant Time scale: 12 consecutive months from the end date used to calculate percentage compliance to meet Safety Action 8 in the Year 4 scheme. **September 2023 Update**: Education leads from across the Division have completed an initial review of the standard and a revision of the Maternity Training Needs Analysis with the required elements of the Core Competency Framework (revised in July 2023 due to MIS Scheme changes) has been ratified at the Family Health Divisional Board in September. This can be found in the Appendix to this paper. The TNA requires Trust Board sign off. **Identified Risk**: There are concerns identified with the ability to meet the compliance targets within the medical workforce (Obstetric and Anaesthetic) of attendance at MPMET and Fetal Surveillance Study Days due to ongoing industrial action. A risk further posed is that of the availability of an MDT within the education faculty and the deliverance of MPMET training days because of ongoing Industrial action. Current training compliance figures for MPMET and Fetal Surveillance can be found on Page 11. To mitigate this several additional MPMET and Fetal Surveillance sessions have been planned, but with the uncertainty of future IA and ability to deliver sessions to an MDT group, with an appropriate MDT faculty, this poses a risk to Year 5 Scheme compliance This has been escalated to the FHD Risk register and the FHD Senior Leadership Team are aware.	**September 2023** - **There are currently some identified concerns with compliance for this safety action.**

Current MPMET, Fetal Surveillance and NLS compliance data:

CNST SA8	Staff Group	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	
SA 8b. MPMET	Midwives	79%	87%				Inclusive of NQM, B6, B7, B8 and Specialist MWs.
	Maternity HCA	75%	79%				
	Cons Obstetrician	53%	59%				
	Trainee Obstetrician	x	58%				New rotation in August 2023.
	Cons Anaesthetist	28%	27%				
	Trainee Anaesthetist	x	36%				New rotation in August and November
SA 8c. Fetal Surveillance	Midwives	77%	83%				Inclusive of NQM, B6, B7, B8 and Specialist MWs
	Cons Obstetrician	62%	59%				
	Trainee Obstetrician	x	29%				New rotation in August 2023
SA 8d. NLS	Midwives	81%	88%				NLS is Delivered on MPMET day
	Cons Neonatologist	100%	100%				
	Trainee Neonatologist	100%	100%				New rotation Mar & Sept
	ANNPs	93%	93%				
	Neonatal Nurses	95%	98%				

SA.9 Can you demonstrate that there are robust processes in place to provide assurance to the Board on Maternity and neonatal safety and quality issues?

Leads:
Dianne Brown Chief Nurse

Rachel McFarland – Obstetric Safety Champion

Angela Winstanley – Midwifery Safety Champion

Srinivasarao Babarao – Neonatal Safety Champion.

A) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.

Evidence Required: The six points are as follows:

1. To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry. Complete
2. That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board. Complete
3. That all maternity Serious Incidents (SIs) are shared with trust boards and the LMS, in addition to reporting as required to HSIB. Complete
4. To use a locally agreed dashboard to include, as a minimum, the measures set out in Appendix 2, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings. Complete
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. Complete

B) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.

Evidence Required: Trust's claims scorecard is reviewed alongside incident and complaint data. Scorecard data is used to agree targeted interventions aimed at

September 2023 - There are currently no identified concerns with compliance for this safety action.

	improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting. C) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures. **Evidence Required:** - Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available no later that July 2023. Completed 100% - Evidence in the Board minutes that the work undertaken to better understand the culture within their maternity and neonatal services has been received and that any support required of the Board has been identified and is being implemented. **September 2023 Update –** The Family Health Divisional Safety Champions have reviewed all the workstreams relating to Safety Champions. An action plan has been developed and a Safety Champions Annual Forward plan has been developed. A detailed action plan has been developed, that will be monitored at the Safety Champions Meetings which will track progress with safety champion requirements. The Perinatal Surveillance Safety Update and Dashboard will continue to be presented at every Trust Board, with updates from the Safety Champions within this paper. The Maternity Safety Champions have asked for clarification from the LMNS how sharing information with the ICB and LMNS will be facilitated, and this is planned to be developed with the introduction of a regional Maternity Safety Oversight Group.	
SA.10 Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme? Leads: Lead Governance Manager for Family Health – Clare Louise Murray Governance Manager Legal Services for NHSr Reporting.	A) Reporting of all qualifying cases to HSIB/CQC//MNSI from 30 May 2023 to 7 December 2023. B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 until 7 December 2023. C) For all qualifying cases which have occurred during the period 30 May 2023 to 7 December 2023, the Trust Board are assured that: i. the family have received information on the role of HSIB/CQC/MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour. **Evidence Required:** **Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying HSIB/CQC/MNSI/EN incidents and numbers reported to HSIB/CQC/MNSI and NHS Resolution **Trust Board** sight of evidence that the families have received information on the role of HSIB/CQC/MNSI and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour. **September 2023 Update**: The Division have reported one case to HSIB since 30.05.2023. A 72 hour review has been undertaken with oversight from Trust Harm and Safety meeting and all activities pertaining to reporting to NHSr, HSIB and Duty of Candour have been executed. A update of compliance will be maintained through the scheme year within this update report and full breakdown of HSIB, NHSr and Duty of Candour information will be provided in December 2023.	**September 2023** - There are currently no identified concerns with compliance for this safety action.

Family Health Division Scheme Management and Leadership

- In the interests of the ability to share and collate evidence for scheme stakeholders, the Information Team have developed a Microsoft Teams Channel. All action leads have access to this channel with action owners given the ability to upload evidence as the scheme progresses throughout the coming year. This allows oversight by the FHD Division Management Team and Maternity Transformation Board.

- Every action has been nominated a lead, with associated actions being given to action owners. Action Leads and owners who are responsible for ensuring their progress, challenges and completions are presented and overseen by the FHD CNST Oversight Group with reporting to the Maternity Transformation Board on a monthly basis.

Schedule of Reporting

Date	Other Relevant Committee	Quality Committee: Reports to receive	Trust Board: Reports to receive.
June 2023	NA	Receive and discuss full current compliance position and requirements of Year 5 MIS scheme.	
July 2023		- MIS Year 5 Scheme Progress	- Perinatal Dashboard - MIS Year 5 Scheme Progress
Aug 2023	NA	No meeting.	No meeting.
Sept 2023	NA	MIS Year 5 Scheme Progress - Q1 ATAIN Audit report and action plan - Q1 Learning from Deaths Report - Consultant Attendance Audit and Action Plan (Jan to July 2023)	- Perinatal Dashboard inclusive of Safety Champion Update - MIS Year 5 Scheme Progress - Q1 ATAIN Audit report and action plan - Q1 Learning from Deaths Report - Consultant Attendance Audit and Action Plan (Jan to July 2023)
Oct 2023	**PPF: *** Bi Annual Staffing paper to contain neonatal workforce review.	- MIS Year 5 Scheme Progress - Neonatal Nursing Workforce Paper	- Perinatal Dashboard - MIS Year 5 Scheme Progress - Neonatal Nursing Workforce Paper
Nov 2023		- MIS Year 5 Scheme Progress - Obstetric Workforce Audit of Compliance - Anaesthetic Workforce Paper	- Perinatal Dashboard - MIS Year 5 Scheme Progress - Obstetric Workforce Audit of Compliance - Anaesthetic Workforce Paper
Dec 2023		- MIS Year 5 Scheme Progress - Neonatal Workforce Review	- Perinatal Dashboard - MIS Year 5 Scheme Progress - Neonatal Workforce Review
Jan 2024		- Final MIS Year 5 Scheme Progress Paper	*ICB Accountable Officer for ICB and Programme Lead for LMNS to be invited.* - HoM, DoM & CD Scheme presentation. - Final MIS Year 5 Scheme Progress Paper with completed Board Declaration Form - Perinatal Dashboard

*Note : Midwifery Staffing Birth Rate Plus Compliance Review to be received and added to reporting schedule upon receipt.

Conclusion

The Trust Board are asked to note the current position in relation to the Maternity Incentive Scheme (CNST) Year 5 and our current compliance position, along with the associated papers found within the appendix.

The Trust Board are asked to be assured by the oversight, detail and governance updates within the paper that that the Division are prepared in their response to the maternity incentive scheme.

Appendix

Safety Action 3:

Q1 23/24 ATAIN and Transitional Care Audit Report and Action Plan.

ATAIN and TC report Q1 2023-2024

Safety Action 4: Medical Workforce

Compliance with Consultant Attendance

Compliance with Consultant Attendai

Safety Action 8: MDT Training.

Maternity TNA 2023-24 v1.1 AMGB.p

Liverpool Women's NHS Foundation Trust

Combined report for

Review of Term and Late Preterm Admissions to the Neonatal Unit

ATAIN 2023-24

and

Transitional Care admissions audit

TC audit 2023-24

Quarter 1 April – June 2023

ANNP Paula Nelson- TC audit

ANNP Sarah Brownrigg- ATAIN

ANNP Deborah Edwards- SBP

Dr Mahalakshmi Neerukonda- ATAIN

Dr Anna Paweletz

Overview

1. Review of Term and Late Preterm Admissions to the Neonatal Unit ATAIN
   1.1. Term admission
   1.2. Late Preterm admissions
   1.3. Thermoregulation
   1.4. Postnatal ward antibiotics administration on NICU

2. Transitional Care admissions Audit
   2.1. Background
   2.2. Aims & Objectives
   2.3. Methodology
   2.4. Audit standards and criteria
   2.5. Results
   2.6. Conclusion
   2.7 Actions

3. Small Baby Pathway
   3.1. Background
   3.2. Objective
   3.3. Methods
   3.4. Standards
   3.5. Results
   3.6. Conclusion
   3.7. Actions
4. Summary

5. Actions

1. Review of Term and Late- Preterm Admissions to the Neonatal Unit ATAIN

Purpose

This report summarises the findings of weekly MDT meetings undertaken jointly by the obstetric and neonatal teams which review all babies delivered at ≥ 34+0 weeks gestation who were admitted to the neonatal intensive care unit (NICU).

From Q3 2022-23 this report also includes data on admission temperatures and postnatal ward administration. From Q4 2022-23 use of antenatal steroids in babies born ≥ 34+0 weeks gestation is included in this report.

Categorisation and Review

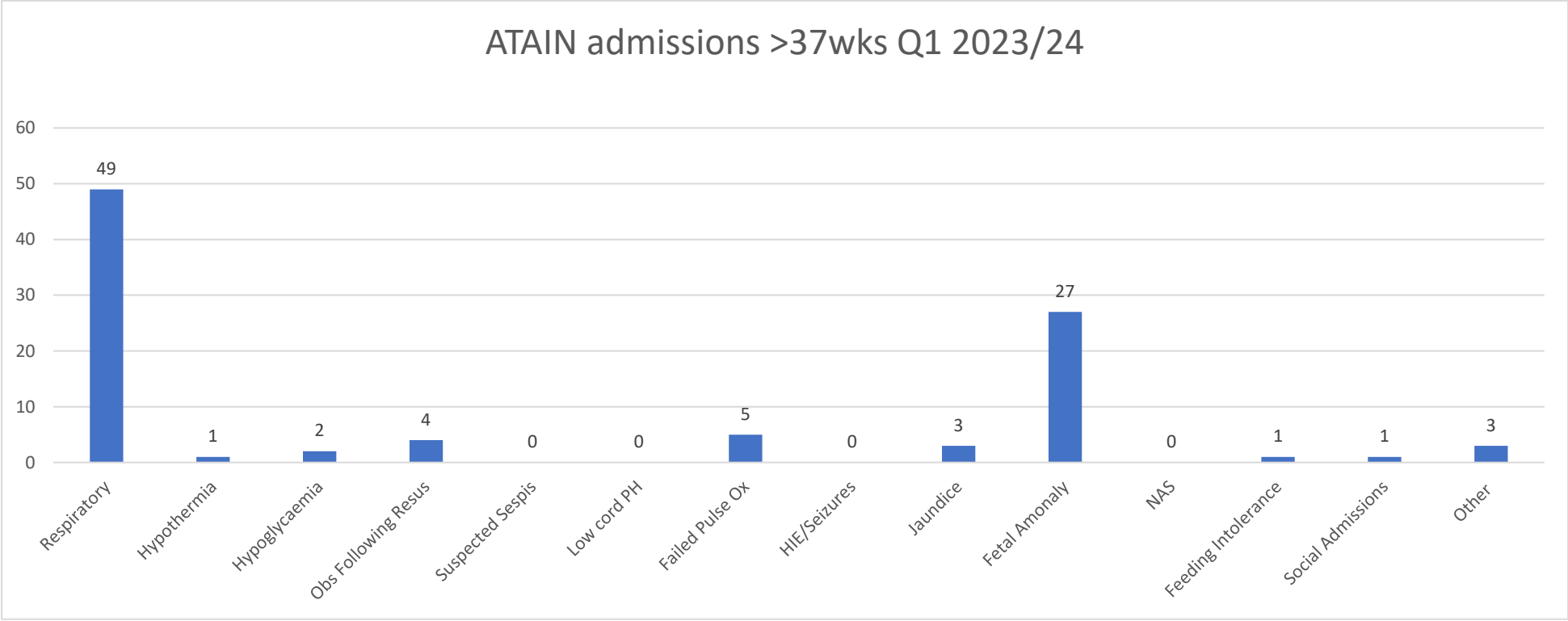
The review team classifies each admission to NICU as follows:

- Appropriate – admission to NICU was unavoidable. This may include expected admissions such as congenital abnormality or unexpected admissions where all care pathways and guidance have been followed but the baby still required NICU support.
- Appropriate but avoidable – issues in care or practice were identified which may have reduced the risk of admission to NICU, for example compliance with care pathways and guidance.
- Inappropriate – identified issues in care that have impacted on the admission to NICU or where the admission could have been avoided by appropriate use of transitional care.

1.1. TERM ADMISSIONS

(Previous quarters shown for comparison)

	Total term livebirths	Term admissions	Appropriate but avoidable	Inappropriate	Total potentially avoidable
Q4 2022-23	1582	64 (4.0%)	8 (12.5%)	1 (1.6%)	9 (14.1%)
Q1 2023-24	1615	96 (5.9%)	10 (10.4%)	1 (1.0%)	11 (11.5%)



A total of 96 infants > 37 week gestation were admitted to NICU, which is an increase compared to previous quarters. Of note is that the neonatal dashboard data records 97 Term infants for the same period. This difference may be as previously explained due to settling down of data and will be address in more detail in the annual report for this financial year. The percentage of Term admissions to total Term live births showed a small increase to 5.9% compared to Q4 2022-23. The most common reason for Term admissions to NICU remain Respiratory distress (n=49, 51%) and Fetal anomaly (n=27, 28%). The number of admissions due to Respiratory distress in this group shows a further increasing trend with 49 babies in Q 1 compared to 32 babies in Q4 in 2022-23. The number of infants with Fetal anomaly increased in Q1 from 16 (10% in Q4) to 27 (28% Q1) which is in line with a variable number of admissions in this category demonstrated over the course of the previous financial year. Reasons for admission included Hypoglycaemia, Hypothermia, Feeding problems, Jaundice, Observation following a resus, Failed pulse Oximetry, Social concerns, and other. The babies admitted for other reasons included a baby admitted for observations as at risk of alloimmune thrombocytopenia. This admission was deemed appropriate. A further infant was admitted to the NICU for observation as mum had Anti Ro antibodies & Sjögren's syndrome. This admission was deemed potentially avoidable, as the patient could have been managed on the postnatal ward. A further infant was admitted for observation of a baseline bradycardia. This admission was deemed potentially avoidable, as this patient's admission temperature was 36.6C. The baby was hypothermic on postnatal ward prior to admission, and it was felt that this could have been reason for baseline bradycardia.

There were 10 Term admissions to the NICU that were deemed appropriate but avoidable:

Respiratory symptoms (n=5)

- 1 infant was admitted at 3hrs of age with respiratory symptoms following an elective Caesarean section. This baby required respiratory support in form of high flow oxygen. This admission was classed as a potentially avoidable admission as baby was noted to have an admission temperature of 35.8C. The Hypothermia may have contributed to worsening respiratory symptoms, as no other cause was found (CRP <4 and septic screen negative).
- 1 infant was admitted with grunting and low saturations at 1 hour of age. The baby required high flow oxygen on NICU. The admission temperature was noted to be 36.0C, therefore this admission was classed as potentially avoidable as Hypothermia may have contributed to worsening respiratory symptoms and no other cause was found (CrP <4 and septic screen negative).
- 1 infant was admitted with a temperature of 36.1C at 1.5hours of age. The baby had been on skin to skin with mum. There were concerns about possible apnoea and a neonatal crash call was made. Baby required IPPV ventilation breaths and was admitted to unit for observations a brief period of oxygen administration (FiO2 23-25% for 2hrs). This admission was classed as potentially avoidable

admission as Hypothermia may have contributed to worsening respiratory symptoms and no other cause was found (CrP <4 and septic screen negative).

- 1 infant was admitted for respiratory symptoms, they required oxygen support for over 24 hours, and therefore met criteria for an appropriate admission from a neonatal perspective. The admission was classed as appropriate but potentially avoidable due to obstetric reasons.
- 1 infant admitted to unit following an elective Caesarean section under GA with respiratory symptoms. The baby required high flow oxygen treatment. This admission is deemed an appropriate admission from a neonatal perspective but potentially avoidable by Obstetric team as mum was not offered steroids in line with the hospital policy at the time.

In both cases the Obstetric team felt antenatal steroids should have been offered prior to delivery.

Hypothermia (n=1)

- 1 infant was admitted with Hypothermia following an elective Caesarean section at 1 hour of age. Baby developed dusky episodes. Admission temperature was 35.9 C. Once Normothermia was achieved no further dusky spells occurred. There were no respiratory problems and no oxygen requirement. This admission was classed as potentially avoidable admission as Hypothermia may have contributed to symptoms and no other cause was found (CrP <4 and septic screen negative).

Hypoglycaemia (n=1)

- 1 infant was admitted with Hypoglycaemia at 5 hours of age. This baby was an infant of a insulin dependent Type 2 Diabetic mother. This admission was deemed as potentially avoidable as admission temperature was 36.2C. Although baby had risk factors for hypoglycaemia, baby was not normothermic and this may have attributed to baby being hypoglycaemic.

Social concerns (n=1)

- 1 infant was admitted to NICU as their mother self-discharged and baby was awaiting foster care placement or was not able to stay with mother. This admission was deemed appropriate but potentially avoidable. Admission to the Neonatal Unit would not have been required if other options were available.

Other (n=2)

- 1 infant was documented to be admitted for observation due to maternal Anti Ro Antibodies and recent diagnosis of Sjögren Syndrome. This admission was deemed a potentially avoidable admission, as baby could have been managed on the postnatal ward, although it was also noted that this baby had a admission temperature of 35.9C and was therefore hypothermic.
- 1 infant was admitted at 41 weeks gestation for a period of monitoring for a variable bradycardia with a low temperature prior to admission. Admission temperature was recorded as 36.6C. Baby was admitted for a septic screen and ECG. The septic screen was was negative. The admission was deemed potentially avoidable as bradycardia was thought to have been due to low temperature prior to admission.

In this quarter no Term infant was admitted to NICU for observations following a head injury sustained from a fall (of maternal bed or other).

There has been 1 Term admission to the NICU that was deemed to be inappropriate.

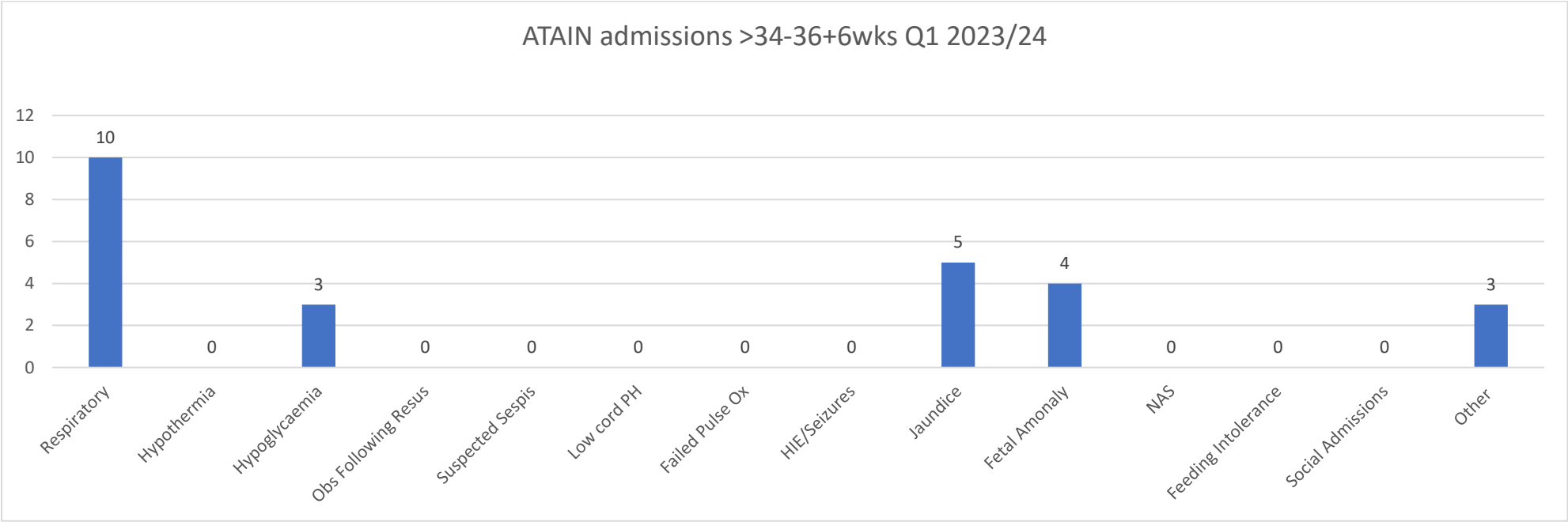
Jaundice (n=1)

- 1 infant was admitted for phototherapy treatment at 18 hours of age as a Bilirubin level (SBR) was thought to be above exchange level. This admission was deemed inappropriate, as the SBR was plotted incorrectly, and the infant did not require quadruple phototherapy treatment. This infant could have received single phototherapy on the postnatal ward and did not need to be admitted to NICU.

1.2. LATE PRE-TERM ADMISSIONS (34+0 to 36+6 week gestation)

(Previous quarters shown for comparison)

	Total late preterm livebirths	Late preterm admissions	Appropriate but avoidable	Inappropriate	Total potentially avoidable
Q4 2022-23	127	41 (32.3%)	7 (17.1%)	0	0
Q1 2023-34	95	25 (26.3%)	1 (0.04%)	0	1 (0.04%)



The most common reason for Late-Preterm admission to NICU remains Respiratory distress (n=10). The number of Late-Preterm admissions with Respiratory distress decreased in this quarter from 27 (in Q4) to 10 (in Q1). Jaundice (n=5), Fetal anomaly (n= 4) and Hypoglycaemia (n=3) remained other common causes for admission in this group, although the numbers remained stable low.

Other reasons for admissions in the Late- Preterm populations (n=3):

- 1 Infant admitted for observation with suspected DSD (disorder of sexual differentiation)
- 1 infant admitted with a low birth weight of 1.5kg
- 1 infant admitted for investigation of SVT (Supraventricular tachycardia)

There was 1 Late- Preterm admissions to the NICU that were deemed appropriate but avoidable.

- 1 Infant was admitted from delivery suite following a category 1 emergency Caesarean section. Baby had an 0xygen requirement at 20mins of age. On admission to NICU he was self-ventilating in air and did not require any further intervention. He was transferred to TC within one hour of admission, therefore deemed a potentially avoidable admission.

There have been no Late- Preterm admissions to the NICU that was deemed to be inappropriate.

In this Q1 no Term or Late- Preterm infants were admitted to NICU due to TC bed unavailability or for observations following head injury.

1.3 THERMOREGULATION

An admission temperature < 36.5C is classed as hypothermia. Although hypothermia was not documented as a primary reason for admission in this quarter, it was a contributing factor. Given the above observations, we have decided to report admission temperatures from Q3 2022-23. A QIP led by the postnatal ward and delivery suite matrons has been initiated to address this and improve thermal management in babies on the postnatal ward, theatres, recovery, and delivery suite.

In Q1 2023-24 at total of 18 babies (16 Term and 2 Late Preterm infants) were found to be hypothermic on admission. 6 of these (all Term infants) were deemed appropriate but avoidable.

Term babies

16 of the 96 (15.4%) Term babies admitted to NICU in Q1 2023-24 were hypothermic with an admission temperature of 36.5C or below.

- 10 babies whose admission was deemed appropriate for other reason were found to be hypothermic on admission.
- 6 of the 10 potentially avoidable admissions were hypothermic when admitted to NICU.
    - 1 Hypothermia primary reason for admission
    - 5 Hypothermia as contributing factor when admitted for other reasons (n=3 Respiratory distress, n=1 Hypoglycaemia, n=1 other reason (maternal Sjögren Syndrome)

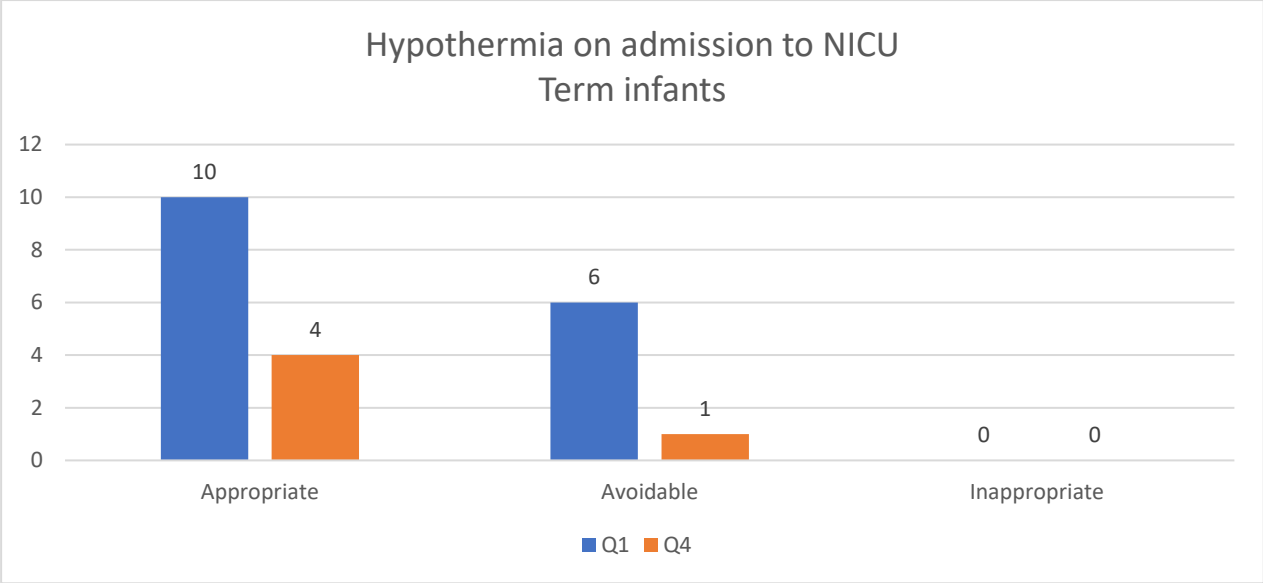
1 further baby was hypothermic prior to admission, but displayed intermitted bradycardia which was thought to have been associated with a low temperature recorded prior to NICU admission. 3 of the 5 babies admitted with Respiratory distress were hypothermic.

The Term baby inappropriately admitted to NICU with jaundice in Q1 was also found to be hypothermic on admission.

Overall, 6 of the 11 (54.5%) potentially avoidable admissions (combined appropriate but avoidable and inappropriate) were hypothermic on admission to NICU.

Q1 has seen an increase in Hypothermia in this group compared to Q4 2022-23. We do recommend that all admissions due to Hypothermia are classed as avoidable. These findings demonstrate an increasing recognition of Hypothermia as a main or contributing factor for Term admissions since admission temperatures were first reported in Q3 2022-23. A QIP led by maternity matrons is under way to address this.

.



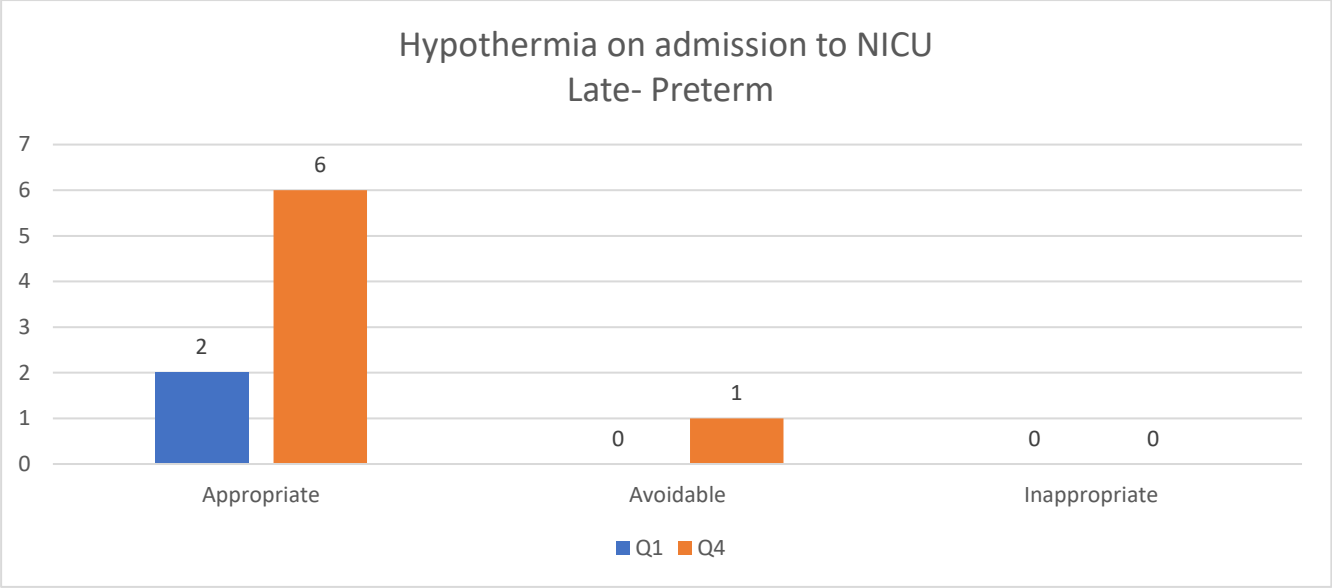
Graph showing proportion of appropriate, avoidable, and inappropriate Term admissions in Q1. In orange Q4 2022-23 data for comparison.

Late-Preterm babies

2 of the 25(0.5%) Late Preterm infants were admitted with a temperature of 36.5C or below. All were deemed appropriate as the infants were admitted for reasons listed below:

- 1 Baby needed high flow oxygen and received 5 days of antibiotics for presumed sepsis and a raised CrP.
- 1 Baby was admitted due to an antenatal diagnosis of Gastroschisis.

Q 1 has seen a marked decrease in Hypothermia in this group compared to Q4 2022-23.



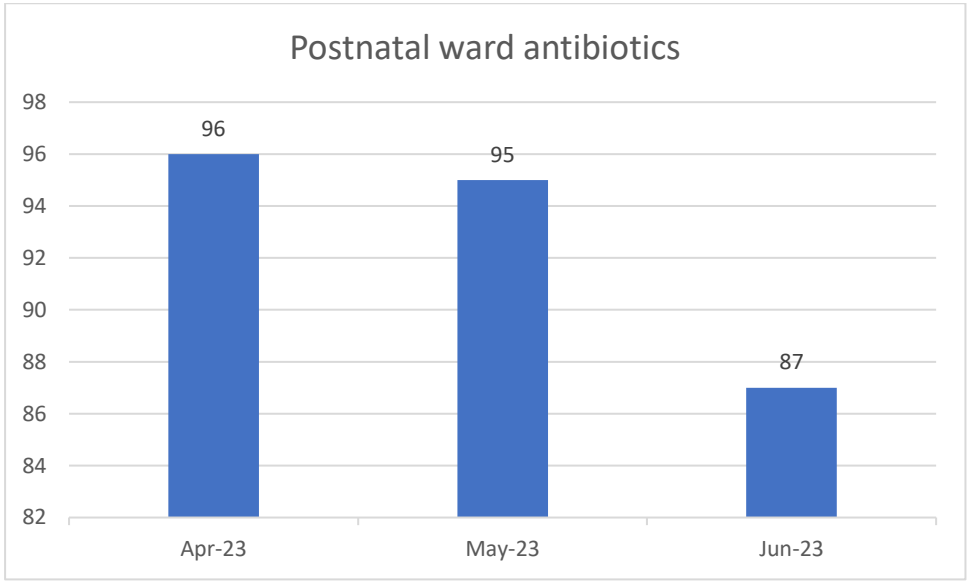
Graph showing proportion of appropriate, avoidable, and inappropriate Late Pre-term admissions in Q1. In orange Q4 2022-23 data for comparison.

In Q4 we additionally reported the proportion of infants in this category who were born by Caesarean section. A thematic review was performed jointly between the obstetric, midwifery, neonatal and anaesthetic team to explore the issues contributing to an increased rate of admissions following Caesarean section. The report is published as an appendix to the Q4 ATAN/TC report and has been included in the combine ATAIN/TC annual report 2022-23.

The above results indicate the need to reduce admissions associated with Hypothermia in both Term and Late-Preterm babies. A Quality Improvement Project (QIP) has been initiated to address thermoregulation of the newborn on the postnatal ward, theatres, recovery area, and delivery suite. This will likely include portable mOm incubators which have trailed at LWH from March 2023. These portable and space saving units could be used as part of a Hypothermia management bundle on postnatal ward, delivery suite, recovery area and TC to manage babies at risk of hypothermia.

1.4 POSTNATAL WARD ANTIBIOTIC ADMINISTRATION ON NICU

In addition to data already provided regarding admission to NICU and in accordance with Safety Action 3 Standard c, we report Term babies transferred to NICU for the duration of a septic screen and administration of antibiotics. This is reported from Q3 2022-23 and includes infants, who are cared for on the postnatal ward and are temporarily transferred to a designated treatment room on NICU for the above purpose. Data for Q1 2023-24 are reported below.



In Q1 2023-24 a total of 278 babies received postnatal antibiotics and were temporarily transferred to NICU to facilitate this. Similarly, in Q4 2022-23 a total of 291 babies received postnatal antibiotics on NICU. These babies remained with their parents on the postnatal ward and were only briefly transferred to NICU treatment room for investigations (blood tests) and administration of antibiotics where indicated. Parents are invited to accompany baby to the unit during this time. Babies are subsequently transferred back to the postnatal ward for continuation of care.

A QIP to facilitate septic screen and administration of antibiotics on the postnatal ward has been initiated in Q3 2022-23 and is ongoing. Funding for 2 cannulation platforms (based in DS and PNW) has been agreed and plans to uniform postnatal ward administration and staff education is ongoing.

2. Transitional Care Admissions Audit

2.1 BACKGROUND / RATIONALE

Transitional care prevents unnecessary separation of mother and baby and reduces admission to the neonatal unit. It is an area for mothers who are well following delivery to care for their baby with the additional support and encouragement from the transitional care team who provide care that exceeds normal routine care.

CNST Maternity Safety Action 3 relates to transitional care activity, specifically asking trusts to demonstrate that they have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme. This audit serves to look at compliance with this action, specifically looking at the use of transitional care in line with unit guidelines (Transitional Care Admission Criteria 2021 (version 11-NICU 34) guideline).

Currently a separate audit report on Avoiding Term Admissions into Neonatal Units (ATAIN) is produced. Since Q1 2022 these reports have been merged and continue to be produced on a quarterly basis.

2.2 AIMS & OBJECTIVES

The aim of this audit is to assess compliance with the Transitional Care (TC) Admission Criteria of LWH (2021 – version 11– NICU 34) between 01.04.2023 and 30.06.2023.

2.3 METHODOLOGY

All babies eligible for admission to the Transitional care unit between 01.04.23 and 30.06.23 were assessed. A BadgerNet search was performed to identify these babies.

Inclusion and exclusion criteria:

Babies that have received at least one day of transitional care, in line with BAPM 2017, HRG definitions, and LWH Transitional Care Guideline.

Babies meeting TC eligibility.

Babies who were still an inpatient on TC on 30/06/23 were excluded from this audit.

The following details were included: date of birth, gestation, birth weight, gender, age at admission to TC, reason for admission to TC (In line with TC guideline on Badger), where the baby was admitted from, if the baby was admitted from NICU if this was due to no TC availability and whether they were referred to the community team at discharge. We also looked for babies who met TC criteria but were cared for on NICU and if there was a delay in getting a TC bed.

TC can provide care for 6 mothers and up to 8 babies, allowing mothers of multiples to care for their babies in this setting.TC capacity was calculated on 8 neonatal beds.

2.4 AUDIT STANDARDS AND CRITERIA

100% of the admissions to transitional care should be in accordance with the admission criteria (as outlined in Transitional Care Admission Criteria 2021 (version 11-NICU 34) guideline.

- Babies 34- 35 weeks gestation as per current TC guideline. To comply with CNST requirements (safety section 3), babies born between 34 and 36+6 weeks gestation who neither had surgery nor were transferred during any admission were included
- Birth weight below 1.8kg
- Admission following joint review from 'Small Babies Pathway (2020)' for TC admission (Babies < 2.5kg and < 35 weeks gestation at birth)
- Admission for nasogastric tube feeding
- Babies >33 weeks gestation who have been stable for 72 hours from Neonatal Unit and

  using apnoea mattress or stable for at least 24 hours off any form of respiratory support
- Other – Specify (Consultant decision, maternal input needed)

- Other topics reviewed (no pre-audit standards set - Benchmarking):
  - Number of special care or normal care days where supplemental oxygen was not delivered in babies between 34 and 36+6 weeks gestation (CNST requirement, safety section 3). This was evaluated for infants initial admitted to NICU.
  - Place admitted from
  - Any delays on gaining a TC bed and if so why
  - Referral to Liverpool Women's Hospital Neonatal Community Outreach team.

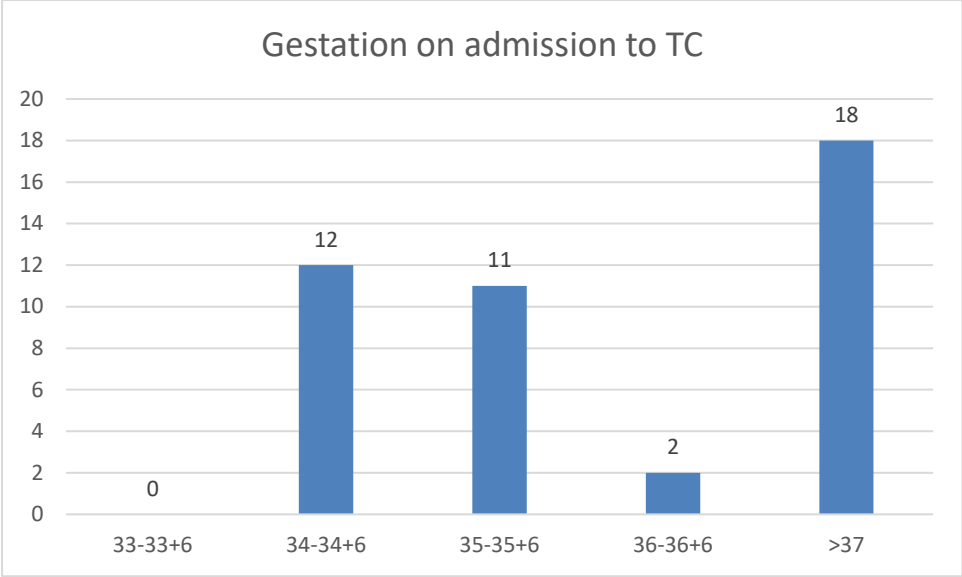
2.5 RESULTS

Between 01.04.2023 and 30.06.2023, there were 43 babies who met the inclusion criteria for TC.

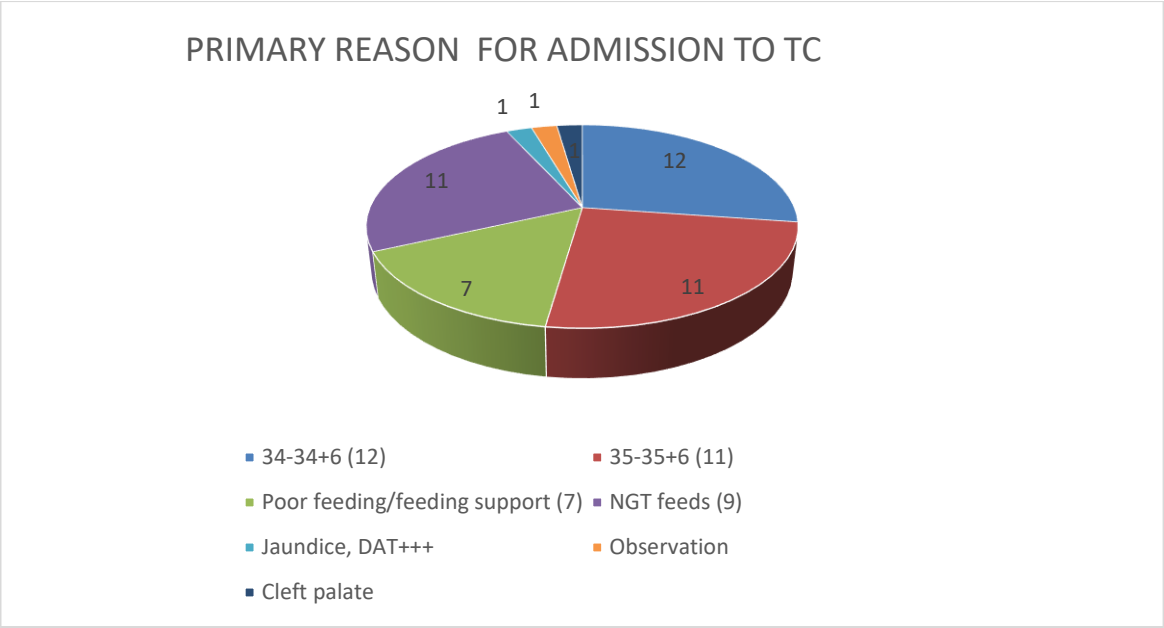
- Average occupancy of the TC unit during this period was 38%
- Average weight 2459g (range 1520g -4150g)
- Gestation range (at admission) 34+0 to 41+1
- 27 male infants, 16 female infants

Length of stay on TC ranged from 1 to 23 days. The average stay was 7.8 days. The average age at TC admission was 2.2 days with a range from day 1-6.

All babies met TC criteria for admission to TC – 100% complaint.


Gestation on admission to TC
20
18
16
14
12
10
8
6
4
2
0
0
12
11
2
18
33-33+6
34-34+6
35-35+6
36-36+6
>37

Primary reason for TC admission



Details per gestation:

33-33+6 = 0

No babies of this gestation this quarter were eligible for TC

34-34+6 = 12

- All admitted with prematurity related feeding issues
- 4 admitted from NICU
- 8 admitted from theatre/ward due to gestation for feeding support

- 3 of these babies also had a birthweight of <1.8kg

35-35+5 = 11

- All admitted with prematurity related feeding issues
- 9 admitted for NGT feeding
- 1 admitted with poor feeding for feeding support
- 2 were also <1.8kg

36-36+6 =2

- Both admitted with poor feeding for NGT feeds

>37 = 18

- 15 admitted due to poor feeding/feeding support
- 1 baby had a cleft lip and palate
- 1 jaundice DAT +++
- 1 with previous pneumothorax for ongoing monitoring
- 9 of these babies required NGT feeds

Benchmarking

TC bed unavailability and delay in obtaining TC bed.

The neonatal bed capacity on TC is 8 beds (6 maternal beds). No babies this quarter were identified to have been admitted to NICU for special care or normal care days who could have been cared for in TC setting.

No babies experienced a delay in getting a TC bed.

Place babies were admitted from

A large proportion of babies were admitted via NICU (16 babies), all admitted to NICU for valid reasons (not focused on in this audit). All remaining admissions were from Delivery Suite (12 babies) and Postnatal Ward (15 babies).

Babies referred to neonatal community outreach team

Of the 43 babies admitted to TC, 14 were eligible and were referred for local community follow up either due to meeting eligibility or deemed to require some additional support. 6 babies were not within the community outreach catchment area and where therefore not followed up. 21 babies did not meet eligibility criteria for community outreach team follow up. 2 babies had been transferred to AHCH following discharged from LWH.

2.6 CONCLUSIONS

This audit demonstrates that transitional care is a busy and active part of the neonatal care provided at Liverpool Women's Hospital. It prevents unnecessary separation of mother and baby and reduces admission to the neonatal unit. It can be seen from the data above that the transitional care service supports the recommendations outlined.

It is important to note that there may be some overlap between the reasons for admission to TC, e.g., 'babies 34 - 35 weeks gestation' and 'babies below 1.8Kg', though for the purpose of this audit, the primary reason documented on Badger was used. The primary reason for admission was documented regardless of Small Baby Pathway criteria which is in the process of moving from paper based to K2 based documentation and is not clearly referenced in the BadgerNet documentation.

TC can provide care for 6 mothers and up to 8 babies, allowing mothers of multiples to care for their babies in this setting. TC occupancy has been variable over the past 12months, ranging from 41 to 49%. In Q1 2023.24 occupancy has dropped slightly to 38%.

There were more boys than girls in this period (27 boys and 16 girls). The length of stay averaged at 7.8 days compared to 8.1 days in the previous quarter. All admissions met TC criteria, all babies meeting TC criteria were cared for in the TC setting and there were no delays in acquiring a TC cot. A large proportion of babies were admitted via NICU (16 babies), all other admissions came from DS and PNW.

23 babies were admitted on gestation criteria, 7 babies due to poor feeding for feeding support, 9 for NGT feeding, 1 baby with jaundice (DAT+++), 1 baby was admitted for additional support with feeding due to cleft palate, 1 baby for observations due to previous pneumothorax.

14 out of 43 babies were eligible for community neonatal outreach support in the Liverpool area, all were reviewed regularly at home after discharge. This demonstrates that a robust referral process to the community team is in place, ensuring adequate support for families post discharge.

Documentation issues raised in previous reports persist. The Small Baby Pathway is in the process of moving from paper based to K2 based documentation. It is not readily available through BadgerNet. There are ongoing efforts to enable the Small Baby Pathway documentation to be recorded electronically. Admission documentation remains poor and frequently absent therefore the primary reason for TC admission was not consistently documented. A documentation QIP to address this issue is ongoing.

In the previous quarter we observed an increase low Maternal mood and requests for early discharge from TC (no data collected) in. Reportedly parents felt the TC layout and environment was having an impact on their mental health. In March 2023 TC was moved to a more suitable area within the postnatal ward. The room has been decorated in a baby friendly way in line with NICU and is bigger and brighter. We have since not had any reports from parents regarding this matter. Fathers and partners are now also encouraged to be resident to provide support to Mothers and be fully involved in baby's care.

In spring 2023 have undertaken a trial of small, portable incubators (mOm incubator) as part of the maternity based QIP (see ATAIN report) to reduce admissions due to hypothermia from postnatal ward, delivery suite and recovery areas. These incubators were also trailed in the TC setting and were found to be well working, space saving and easily accessible for parents. Overall, the incubators were well received, and we are hoping to purchase them for use in TC and within the hypothermia QIP through ATAIN.

2.7 ACTIONS

1. Dissemination of these audit findings to the wider neonatal team – Neonatal MDT and presenting in Neonatal Clinical Governance Day as well as Maternity, Neonatal and Board level safety champions, LMNS and ICS quality surveillance.
2. The Documentation QI project is now in progress, commenced May 2023- There is a focus on admission documentation. The findings will be presented in Neonatal Clinical Governance when available (Emily Hoyle).
3. Quarterly audit and reports to continue as per CNST requirements (Anna Paweletz-neonatologist and Paula Nelson- lead ANNP).
4. Aim to purchase mOm incubators for use in TC once maternity based hypothermia QIP through ATAIN is in place.

3. SMALL BABY PATHWAY

3.1 BACKGROUND

Caring for healthy low birth weight babies on the postnatal ward reduces mother and infant separation, increases the likelihood of establishing lactation, reduces the exposure to pathogenic organisms and reduces the number of unnecessary medical interventions. Low birth weight babies are vulnerable to heat loss in the first hours of life and can develop hypoglycaemia. They therefore require more than routine attention on the postnatal ward.

The Small Baby Pathway (SBP) is embedded in the LWH Neonatal Guidelines and was designed for babies < 2.5kg birth weight. It is a valuable tool in reducing separation of babies and parents and reducing neonatal unit admissions.

Small Baby Pathway Criteria

Babies < 2.5kg are managed on the postnatal ward.

Babies < 2.5kg and reluctant to feed are managed on the postnatal ward with TC nursing input.

Babies < 1.8kg and < 35 week gestation who are well (do not require NICU admission) are identified for TC admission.

The information gathered helps to identify and manage small babies at risk of hypothermia, hypoglycaemia and feeding difficulties.

Babies on the SBP are reviewed and assessed regularly at 2hr, 6hr, 12hr and 24 hours as a minimum. Vitamins and Folic acid are prescribed.

3.2 OBJECTIVE

The SBP data will be included into the combine TC and ATAIN report for CNST from Quarter 3 2022-23. This is to provide a further perspective on how small babies can be managed safely on the postnatal ward, minimising separation between parents and baby.

Limitations

Currently, the SBP is paper based with additional documentation on K2 (postnatal ward based electronic note keeping system). As documentation is inconsistent, there may be babies who although eligible, have not been placed on the SBP. We have for the first time included SBP data into the ATAIN report from Quarter 3 2022-23. We regard this data as preliminary, as a more robust documentation system for the SBP is needed. Work to move SBP to electronic documentation via the K2 system is ongoing.

3.3 METHODS

Information was gathered from the K2 paper proforma, and the K2 postnatal ward based electronic note keeping system. For the purpose of the SBP the following criteria had to be met:

- Birth weight (below or on 2nd centile)

- Gestation (< 37 weeks)

Other information gathered if applicable:

Maternal diabetes mellitus, Maternal Beta Blocker medication (3rd trimester or at time of delivery), Fetal acidosis (cord pH < 7, BE < -16), Family history of metabolic disorder, Suspected/proven sepsis (not symptomatic, babies undergoing septic screen) Hypothermia (< 36.5C), Is the baby on Hypoglycaemia or Postnatal ward sepsis pathway for babies at risk of infection.

3.4 STANDARDS

As outlined in Limitations, the SBP data presented in this report is preliminary. A mixture of electronic and paper-based documentation is inconsistent and therefore only allows an incomplete assessment of the SBP. A more robust documentation system is needed, before the SBP data can be formally audited.

3.5 RESULTS

A total of 74 babies were managed on the Small Baby Pathway between April and June 2023.

81 babies 1.8KG-2.5KG

30 babies ≥1.8KG - <2.3KG

51 babies ≥2.3KG-2.5KG

<u>1.8KG-<2.3KG</u>

A total of 30 babies between 1.8 and 2.3kg were placed on the Small Baby Pathway.

Of these, 11 babies (36.6%) did not require admission to TC or NICU and were able to stay with mum on the PNW and complete the SBP

- 4 babies – had known congenital abnormalities and were therefore admitted to NICU from delivery.
- 0 babies were admitted to NICU as no TC beds were available.
- 5 babies were admitted directly to TC who were <35 weeks gestation, it was felt they would be more appropriately managed on TC rather than the SBP.
- 5 babies were admitted to TC for help with feeding, after initially been managed on the SBP (ranging from 7 hours to day 2 of life and >35 weeks of gestation).
- 3 babies required admission to NICU straight from delivery due to respiratory symptoms/ requiring respiratory support.

- 2 baby required admission to NICU due to low blood sugars /poor feeding after initially been managed on PNW and SBP at 9 & 14 hours of life.

Documentation on K2 (postnatal ward electronic note keeping system) was of a good standard, with only 1 baby only having one SBP review on K2, unsure if other reviews were documented in the paper SBP chart. There appeared to be no delays in commencing babies on the SBP. 1 baby did stay on the SBP despite being admitted to TC (does not require SBP reviews if admitted to TC).

≥2.3KG-2.5KG

A total of 51 babies between 2.3 and 2.5kG were placed on the Small Baby Pathway.

- 30 babies (58.8%) did not require admission to TC or NICU and were able to stay with mum on the PNW and complete the SBP.
- 2 babies with congenital abnormalities/FMU plan for admission straight to NICU.
- 2 babies admitted straight to TC due to gestation & for feeding support from delivery.
- 3 babies were admitted to NICU from PNW due to low TBGs / high lactate / bilious vomiting.
- 5 babies admitted to NICU for respiratory support straight from delivery suite.
- 2 babies were admitted to TC from PNW for feeding support at 14 hours of life and 48 hours.
- 5 babies weighing 2.5KG were not placed on the SBP
- 2 babies not placed on SBP despite their weight being 2.36KG & 2.42KG

Documentation on K2 was good overall. There was no documentation of paper pathways being lost. No babies were late to start the pathway. It was noted that 5 of the babies >2.3KG appeared to stay on the pathway longer than 24hours although they could have stepped off the pathway (feeding improved and or jaundice resolved). Better adherence and documentation of the SBP could reduce medical interventions for babies, reduce hospital stay and workload for the PNW team.

3.6 CONCLUSION

The SBP is a safe and effective way to identify and manage small babies on the postnatal ward. It is a valuable tool in minimizing separation of babies and parents and reducing neonatal unit admissions. Data from the Small Baby Pathway was for the first time included into the combined ATAIN/TC report for CNST from Quarter 3 2022-23. This was to provide a further perspective on how small babies can be managed safely on the postnatal ward. We acknowledge, that due to ongoing difficulties with documentation and data collection, the presented data is limited and only offers an incomplete picture.

A total of 81 babies were placed on the SBP in Quarter 1 2023-24 which represents a reduction from 112 babies in Q4 2022.23., although it is not clear if all eligible babies were managed on the SBP.

- 36.6% of the smaller babies (1.8-2.3kg) were successfully managed on the PNW and avoided TC or NICU admission. A total of 9 babies in this group were appropriately admitted to NICU shortly after delivery (5 symptomatic infants, 4 congenital abnormalities). 5 babies were admitted to TC due to gestation & feeding support which was deemed appropriate. 5 babies were admitted to TC in view of poor feeding after initially being managed on the SBP.
- 58.8% of babies weighing 2.3-2.5kg were successfully manged on the SBP on the PNW. In this group, 4 babies were admitted to TC for feeding support and 10 were admitted to NICU with congenital abnormalities or requiring treatment.

In both groups, it was noted that documentation was much improved on K2 for the SBP reviews. Babies continued to be kept on the SBP resulting in additional blood tests (jaundice monitoring) and workload for the postnatal team.

A better understanding and use of the SBP may help utilise TC capacity better and help reduce Term and Near-Term admissions. In addition, it will help utilise workforce more efficiently and reduce unnecessary admissions to TC and NICU. There is a need to improve the use of the SBP and documentation within it. This has been flagged up with the Postnatal Ward Lead Neonatal Consultant as well as the Information Governance Team. Once a more robust documentation system is embedded, a formal audit of the SBP should be undertaken.

3.7 ACTIONS

- Initial meeting to discuss progress on moving SBP to electronic note keeping system K2 took place on 27/2/23. The SBP has been simplified and copies of the SBP have been sent to K2 to be added onto the system (Dr J Hurst/ Dr R Hutchinson/ D Edwards ANNP/ digital lead midwife Genevieve Cousineau). No recent progress reported for Q1 2023.24.
- Ongoing education of medical/ midwifery and nursing staff regarding the use of SBP, unit intern teaching, induction program and fetal surveillance study day- monthly and ongoing. (D Edwards ANNP/ S Brownrigg ANNP)
- Perform formal audit once SBP documentation once moved to K2 only (D Edwards ANNP)

4 SUMMARY

Changes to the combined ATAIN report from Q3 2022-23.

From Q3 2022-23 the ATAIN report includes data on admission temperatures and postnatal ward antibiotic administration on NICU. In addition to the TC audit, data collected through the Small Baby Pathway (SBP) will be reported within this report. Q4 report also included the result of a Thematic review, undertaken to examine a perceived increase in Term admissions following elective Caesarean Sections at LWH between September and December 2022. This is published as an attachment to Q4 ATAIN/TC report 2022-23.

ATAIN

Overview

The ATAIN report demonstrates a small increase in Term admissions to 5.9% on a background of an overall increased number of total Term live births. The number of Late Preterm admissions showed a decrease compared to Q4. Overall, potentially avoidable admission for Term and Late-Preterm babies remain at a stable low level. Term appropriate but avoidable admission rates remain stable with stable low inappropriate Term admissions (1 infant in this quarter). There was 1 Late- Preterm admissions to the NICU that were deemed appropriate but avoidable with demonstrates a marked decrease compared to Q4 and no inappropriate admissions in this group Respiratory distress remains the most common cause for admission in Term and Late- Preterm infants. In the Term infant group there is a continuing increasing trend with respiratory admissions (49 babies in Q1 compared to 32 babies in Q4 in 2022-23). Hypothermia on admission, particularly in the Term babies remains a concern.

TERM ADMISSIONS

(Previous quarters shown for comparison)

	Total term livebirths	Term admissions	Appropriate but avoidable	Inappropriate	Total potentially avoidable
Q4 2022-23	1582	64 (4.0%)	8 (12.5%)	1 (1.6%)	9 (14.1%)
Q1 2023-24	1615	96 (5.9%)	10 (10.4%)	1 (1.0%)	11 (11.5%)

LATE PRE-TERM ADMISSIONS

	Total late preterm livebirths	Late preterm admissions	Appropriate but avoidable	Inappropriate	Total potentially avoidable
Q4 2022-23	127	41 (32.3%)	7 (17.1%)	0	0
Q1 2023-34	95	25 (26.3%)	1 (0.04%)	0	1 (0.04%)

Hypothermia

An admission temperature < 36.5C is classed as hypothermia. Although hypothermia was not documented as a primary reason for admission in this quarter, it was a contributing factor. Given the above observations, we have decided to report admission temperatures from Q3 2022-23. A QIP led by the postnatal ward and delivery suite matrons has been initiated to address this and improve thermal management in babies on the postnatal ward, theatres, recovery, and delivery suite. In Q1 2023-24 at total of 18 babies (16 Term and 2 Late Preterm infants) were found to be hypothermic on admission.

Term babies

16 of the 96 (15.4%) Term babies admitted to NICU in Q1 2023-24 were hypothermic with an admission temperature of 36.5C or below. 6 of the 10 Term infants (60%) who's admission was deemed appropriate but avoidable were hypothermic on admission to NICU. 1 further baby was hypothermic prior to admission, but displayed intermitted bradycardia which was thought to have been associated with a low temperature recorded prior to NICU admission. 3 of the 5 (60%) Term babies admitted with Respiratory distress were hypothermic. The Term baby inappropriately admitted to NICU with jaundice in Q1 was also found to be hypothermic on admission.

Overall, 6 of the 11 Term babies (54.5%) potentially avoidable admissions (combined appropriate but avoidable and inappropriate) were hypothermic on admission to NICU.

Q1 has seen an increase in Hypothermia in this group compared to Q4 2022-23. We do recommend that all admissions due to Hypothermia are classed as avoidable. These findings demonstrate an increasing recognition of Hypothermia as a main or contributing factor for Term admissions since admission temperatures were first reported in Q3 2022-23. A QIP led by maternity matrons is under way to address this.

Late-Preterm babies

2 of the 25(0.5%) Late Preterm infants were admitted with a temperature of 36.5C or below. All were deemed appropriate. Q1 has seen a marked decrease in Hypothermia in this group compared to Q4 2022-23.

The above results indicate the need to reduce admissions associated with Hypothermia in both Term and Late-Preterm babies.

Respiratory distress

A total of 49 Term and 10 Late-Preterm infants were admitted for Respiratory distress in Q1. This represents an increase in the Term group from 32 admissions in Q4 2022-23 to 49 admissions in Q1 2023-24. 5 of the 10 appropriate but avoidable Term admissions (50%) were baies admitted with Respiratory distress. 3 of these (60%) were hypothermic on NICU admission. Reassuringly, there appears to be a decrease in respiratory admissions in the Late Preterm babies from 27 to 10 in this quarter.

The obstetric guideline for administration of antenatal steroids at LWH has changes in January 2023 in line with recommendations from RCOG. Based on careful review of current available evidence and data from a retrospective cohort analysis performed at LWH between August 2021-February 2022 antenatal steroids are only discussed and offered below 38 weeks gestation. As discussed in the Q4 report and the 2022-23 ATAIN annual report, Hypothermia and change in the obstetric guideline in relation to administration of antenatal steroids in Term babies have been identified as potentially contributing factors to the rise in Respiratory admissions in Term babies.

A Quality Improvement Project (QIP) has been initiated to address thermoregulation of the newborn on the postnatal ward, theatres, recovery area, and delivery suite. We hope that by avoiding Hypothermia admissions of babies with Respiratory distress can also be avoided. The QIP warming bundle will likely include portable mOm incubators which have trailed at LWH from March 2023. We are in discussion to secure funding for these units.

Postnatal ward administration of antibiotics

A QIP to facilitate septic screen and administration of antibiotics on the postnatal ward has been initiated in Q3 2022-23 and is ongoing. Funding for 2 cannulation platforms (based in DS and PNW) has been agreed and plans to uniform postnatal ward administration and staff education is ongoing.

Social admissions and TC bed availability

In this Q1 no Term or Late- Preterm infants were admitted to NICU due to TC bed unavailability.

Head injury

Reassuringly, in this quarter no Term or Late Preterm babies were admitted to NICU following a head injury.

Postnatal Ward Antibiotic Administration on NICU

A QIP to facilitate septic screen and administration of antibiotics on the postnatal ward has been initiated in Q3 2022-23 and is ongoing. Funding for 2 cannulation platforms (based in DS and PNW) has been agreed and plans to uniform postnatal ward administration and staff education is ongoing.

TC audit

Transitional care is a busy and active part of the neonatal care provided at Liverpool Women's Hospital. It prevents unnecessary separation of mother and baby, reduces admission to the neonatal unit and supports the recommendations outlined in the CNST action plan (standard 3).

TC can provide care for 6 mothers and up to 8 babies. 43 babies who met the inclusion criteria were admitted to TC and occupancy has dropped slightly to 38%. The average length of stay was 7.8 days compared to 8.1 days in the previous quarter. All admissions met TC criteria and there were no delays in acquiring a TC cot. Follow up was appropriate and demonstrates that a robust referral process to the community team is in place, ensuring adequate support for families post discharge.

Documentation issues raised in previous reports persist. A documentation QIP to address this issue is ongoing.

In spring 2023 have undertaken a trial of small, portable incubators (mOm incubator) as part of the maternity based QIP (see ATAIN report) to reduce admissions due to hypothermia from postnatal ward, delivery suite and recovery areas. These incubators were also trailed in the TC setting and were found to be well working, space saving and easily accessible for parents. Overall, the incubators were well received, and we are

hoping to purchase them for use in TC and within the Hypothermia QIP through ATAIN. In March 2023 TC was moved to a more suitable area within the postnatal ward. The room has been decorated in a baby friendly way in line with NICU and is bigger and brighter.

Small Baby Pathway

A total of 81 babies were placed on the SBP in Quarter 1 2023-24 which represents a reduction from 112 babies in Q4 2022.23., although it is not clear if all eligible babies were managed on the SBP.

- 36.6% of the smaller babies (1.8-2.3kg) were successfully managed on the PNW and avoided TC or NICU admission.
- 58.8% of babies weighing 2.3-2.5kg were successfully manged on the SBP on the PNW.

In both groups, it was noted that documentation was much improved on K2 for the SBP reviews. Babies continued to be kept on the SBP resulting in additional blood tests (jaundice monitoring) and workload for the postnatal team.

A better understanding and use of the SBP may help utilise TC capacity better and help reduce Term and Near-Term admissions. In addition, it will help utilise workforce more efficiently and reduce unnecessary admissions to TC and NICU. There is a need to improve the use of the SBP and documentation within it. This has been flagged up with the Postnatal Ward Lead Neonatal Consultant as well as the Information Governance Team. Once a more robust documentation system is embedded, a formal audit of the SBP should be undertaken.

ACTIONS

ATAIN Action	Narrative	Owner	Target date	Evidence required	Status
Education and training around prevention and management of hypothermia/hypoglycaemia	Include recorded presentation (monthly) delivered by ANNP at regular Fetal Surveillance sessions ATAIN module for NICU staff (6 monthly)	Fiona Chandler/ Sarah Brownrigg/ Gemma Barber	March 2024 (ongoing)	1. Presentation 2. Records of sessions/attendance	Sessions for study day recorded and available (reduced F2F from Q4 2022-23). **Despite recorded sessions being available no teaching sessions were provided in Q1.** Reinstated from Q2 2023-34 ATAIN 2022 Mat 3 presentation Q4.pptx ATAIN module for NICU staff (planned 09/23)
Start midwives undertaking eLFH ATAIN module	One-off, nationally approved online training	Gemma Barber/ Fiona Chandler	March 2024 (ongoing)	Download of numbers of midwives completing online module	eLFH ATAIN Last update provided: attendance until 4/7/23 – 86.7%

Education/training (around CTG interpretation, risk assessment, escalation process when signs of concern)	To be included in Fetal Surveillance sessions	Ange Winstanley/ Fiona Chandler/ Kate Alldred	June 2024 (ongoing)	1. Presentation 2. Records of sessions/attendance	 RCOG RCM escalation toolkit.pptx  Fetal Surveillance day intro and fetal phsyiol  Place of birth - Gem.pptx - Update from Fiona Chandler 28/6/23: only **1 F2F session only provided** (no clear reason why). **No attendace provided.**
Infants sustaining falls from maternal beds on postnatal ward	1. Falls linked to C/S deliveries 2.Multi agency safe sleep policy to be updated (escalated to local safeguarding board and corporate risk aware), Further incident in Q3	Joan McDonald /Alison Murray/ Susan Cooper/ Louise Shiels	**March 2023**	To update Safe Sleeping policy	1.Plan to purchase "over the bed cots" for mothers who delivered by C/S. Further update awaited (Joan McDonald) + Natalie Hadon to include written info re sleep in cot to website and admission pack- **No update provided since Q3 re purchase of over cot beds.** 2.Multi-agency Safe Sleeping policy expired. Current policy extended as per corporate risk. Once revised needs to be adopted at LWH. Further update awaited (Alison Murray) Awaiting update from safeguarding board/ CDOP panel re out-of-date copy- **No update provided for Q4 or Q1 2023-24**

Develop thermoregulation pathway for Term and Late Preterm babies	QIP to reduce Hypothermia and respiratory admissions	Laura Thorpe/ Joan McDonald/ Sarah Brownrigg	September 2023	Thermoregulation QIP led by intrapartum and postnatal ward Matrons	First meeting planned 01/23 No updates were provided for Q4 QIP being registered and update to be provided by 09/23 mOm incubators trial completed 04/2023 awaiting QIP before funding secured
Development of postnatal antibiotic pathwayThematic review of admissions following CS	Minimise separation by performing septic screens and administering first dose of antibiotics on PNW/ DS	Alex Cleator	September 2023	QIP	QIP ongoing. Funding secured for cannulation platforms. Plan for antibiotic monotherapy on PNW Further update awaited 09/23
TC and SBP Actions					
Improve documentation (SBP/ Badger)TC and SBP Action	Poor use and documentation on SBP narrative Documentation audit ongoing	Richard Hutchinson/ Deborah Edwards Emily Hoyle	January 2024	Move SBP to full electronic documentation system Shared findings of documentation audit	Ongoing First meeting January 2023 Awaiting funding confirmation form Finance department for work on K2. No recent progress reported (last update 21/7/23) Plan for formal audit of SBP once this is established. Planned for Neonatal Clinical Governance

				.	

Liverpool Women's
NHS Foundation Trust

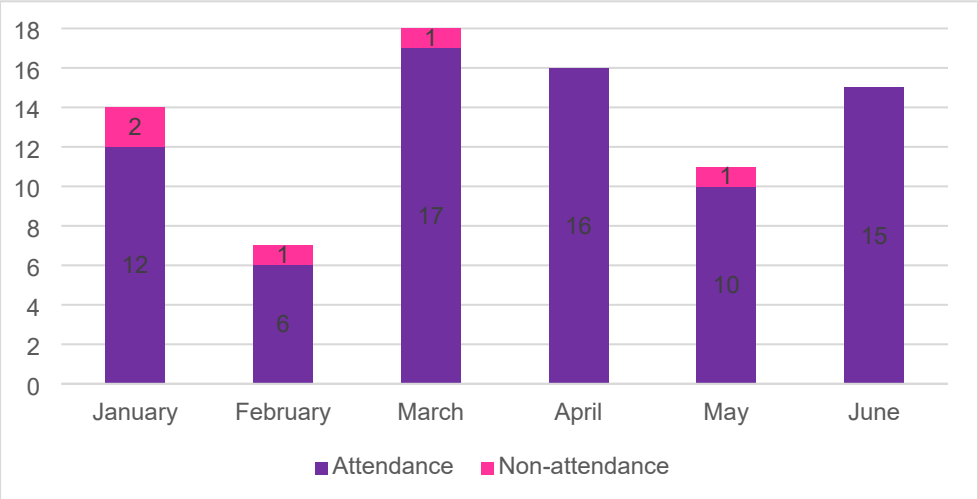
Compliance of consultant attendance: January – June 2023

1. INTRODUCTION

Safety Action 4 of the NHS Resolution Maternity Incentive Scheme (Year 5) requires compliance of consultant attendance for the clinical situations listed in the RCOG 'Roles and Responsibilities of the Consultant' document to be monitored, and shared with the Trust Board, the Board-level safety champions and the LMS at least every 6 months. An action plan must be implemented to prevent further non-attendance to the clinical situations listed in the document.

2. ANALYSIS

There was consultant attendance in 94% (76/81) of identified cases between 1st January 2023 and 30th June 2023:



Data includes caesarean birth for major placenta praevia/women with a BMI >50/<28/40; twins <30/40; 4th degree perineal tear repair; unexpected intrapartum stillbirth; eclampsia; PPH >2L where haemorrhage ongoing and MOH protocol instigated. Does not currently capture high levels of activity; return to theatre; team debrief requested; if requested to do so; early warning score where HDU/ITU care is likely to become necessary; maternal collapse – septic shock/placental abruption.

Comparison with previous audit periods:

Reporting period	Number of cases identified	Compliance (%)
1: January – June 2022	59	81
2: July – December 2022	60	87
3: January – June 2023	82	93

It was encouraging to note an increase in compliance over the three reporting periods. An increase in number of cases identified was also observed; if this is a persistent trend in the next period, a deep dive into the reasons for this will be required.

Analysis of the 5 cases where there was no documented evidence of consultant attendance did not identify any key areas of concern:

- 4 cases occurred at a time when the consultant was resident – they would have been available if required and this may have been appropriate due to level of trainee and a transition towards independent practice.
- In 1 case there was no documented evidence of a request for consultant attendance. There was inadequate documentation to assess if this was because bleeding was not ongoing at the time it was recognised that the weighed blood loss was >2 litres.

There were no complications that occurred because of consultant non-attendance.

There are some ongoing data quality improvements to assist the review process and there are some cases from the mandated attendance list that we cannot identify electronically. It has been requested that an incident form is completed if the consultant does not attend in these circumstances, and none have been submitted to date.

3. RECOMMENDATIONS

Number	Action	Lead	Target completion	Status	Progress
1	Review electronic systems to increase case identification.	Richard Strover/Alice Bird	September 2022		Initial review completed; this will be ongoing as K2 develops therefore to remain on action plan.
2	Reminder to be sent to consultants and postgraduate doctors in training regarding clear documentation in K2 regarding consultant attendance or reason for non-attendance.	Alice Bird	July 2022		Documentation reminder.png Further reminder sent in January 2023. Documentation reminder Jan 23.png Further reminder sent in September 2023. Documentation reminder Sep 23.png
3	Digital team to request 'Consultant	Genevieve Cousineau/Amy Ford	September 2023		On list of K2 optimisations –

	present' field in caesarean section and operative vaginal delivery workflows in K2.				date of release 19/9/23. Team asked to document on K2 in interim.
4	Data to be shared with the LMNS.	Alice Bird	TBC		Data shared with the LMNS in January 2023. LWH have requested timeline from LMNS for future information sharing requests.

Liverpool Women's
NHS Foundation Trust

Maternity Specific Training Needs Analysis (TNA) and Maternity Training Plan (MTP) 2023-2024 v1.1

Alison Murray, Deputy HoM,
Gemma Barber, Maternity Education Lead Midwife

The purpose of this document is to advise maternity staff on maternity specific mandatory training needs and how they may seek to undertake the training required. The purpose of this document is to be transparent regarding the identification of training needs to meet the demands of ensuring safe, effective provision of maternity care. The TNA is specific to Midwives and Maternity Support Workers includes the multi-disciplinary team of Obstetricians at all levels, Obstetric Anesthetists who work within maternity clinical areas.

Every trust is required to evidence a training programme which encompasses a TNA and training plan. It has been agreed nationally that five days annually is required, as an average, to deliver the CCFv2[1] and can be tailored dependent on discipline. This figure should be used as a guide by trusts to plan in training.

The Liverpool Women's NHS Trust (LWHT) is committed to the vision of the National Maternity Review Better Births Report[2] and NHS England's three-year delivery plan[3] for maternity and neonatal services to become safer, with more personalised care, resulting in women and families receiving the highest quality care.

Robust education and training are key components of providing safe care and contribute to creating a supportive learning environment where all staff can learn from incidents and concerns to continuously improve the care we are providing to women, families, and babies.

Following publication of the CNST MIS Year 4 in August 2021, the 21-22 TNA was reviewed and revised further to ensure compliance to Safety Action 8. MIS Year 5[4] released 31st May 2023, the TNA has been reviewed to ensure the implementation and alignment of the CCFv2 modules and the requirement to evidence 90% relevant staff annual attendance and compliance by the 30th November 2023. This was subsequently refreshed following the update of MIS v1.1 in July 2023.

[1] NHS England » Core competency framework v2: Minimum standards and stretch targets
[2] national-maternity-review-report.pdf (england.nhs.uk)
[3] NHS England » Three year delivery plan for maternity and neonatal services
[4] MISyear5-update-July-2023.pdf (resolution.nhs.uk)

1. Clinical Negligence Scheme for Trusts (CNST)

The Maternity Safety Strategy set out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety. LWH continues to follow the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) scheme.

To incentivise improvement in the delivery of best practice, NHS Resolution will be making a reduction in the CNST maternity contributions of trusts that are able to demonstrate compliance with the 10 criteria agreed by National Maternity Champions. Trusts who cannot demonstrate full compliance may be eligible for a smaller discount providing that savings are used to take local action towards meeting the criteria.

The criterion relevant to training is CNST point 8.

A training plan should be in place to implement all six core modules of the Core Competency Framework over a 3-year period, starting from MIS year 4 in August 2021 and up to July 2024.

1	Saving Babies Lives Care Bundle v3
2	Fetal monitoring and surveillance (in the antenatal and intrapartum period)
3	Maternity emergencies and multiprofessional training
4	Equality, equity, and personalised care
5	Care during labour and the immediate postnatal period
6	Neonatal life support

Trusts should update their existing training plans in alignment with Version 2 of the Core Competency Framework. All 6 core modules in V2 of the Core Competency Framework (CCFv2) must be covered as detailed in the minimum standards. Trusts must be able to evidence the four key principles:

1. Service user involvement in developing and delivering training.

2. Training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports. This should include reinforcing learning from what went well.

3. Promote learning as a multidisciplinary team.

4. Promote shared learning across a Local Maternity and Neonatal System.

The training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups at multidisciplinary training days by the end of the 12-month period for Modules 2, 3 and 6 (Fetal Monitoring and Surveillance MPMET- Multi Professional Maternity Emergency Training, Neonatal Life Support which is the 30th November

Compliance for all modules of CCFv1 is 90% for CNST MIS Y5 declaration, with evidence that CCFv2 new elements are incorporated into the training plan

LWH Compliance for Maternity Specific training is 95%.

2. UNICEF BFI and Infant Feeding

LWH is continuing to work towards Baby Friendly Initiative (BFI) accreditation. The Trust is committed to achieving BFI Gold

All Infant Feeding guidelines were updated during 2020 to incorporate updated, evidence-based guidance and a training need identified.

Updates to clinical guidelines are cascaded to staff via the infant feeding team

3. Additional Training for Midwives

For Midwives with additional skills additional training is required on an annual basis

Enhanced maternal care (EMC) is driven by a set of competencies required to care for women with medical, surgical, or obstetric problems during pregnancy – peri- and post-partum – but without the severity of illness that requires admission to a critical care unit. This care can be provided by midwives who have completed post graduate HDU training. In house training is provided by the critical care PEF. Liverpool Woman's Hospital have incorporated the EMC model of care framework to provide assurance that HDU midwives are trained appropriately and meet the criteria to do so and reduces the risk of requiring critical care transfers for Level 2 care.

Newborn infant physical examination (NIPE) Public Health England requires those undertaking NIPE examinations must have training accredited by a Higher Education Institution (HIE) and complete an annual NIPE update training and an annual NIPE practical competency assessment (NIPE Screening Handbook 2021). The Antenatal and Newborn Screening Specialist Midwives identify those staff requiring NIPE training, co-ordinate annual update training and practical competency assessments for staff with an existing accredited NIPE qualification and coordinate NIPE SMART training (electronic NIPE database). The PDM will collaborate with the local HEI to roll out a further programme of NIPE training for midwives who do not currently hold the qualification.

4. Further development Plans for 2023-2024

Specifically targeting community midwife training. Currently the community midwives attend the MPMET training day but a training need has been identified to target homebirth team to receive some additional and specific training on how to deal with emergencies in the community setting. This will be developed through the year and commenced in conjunction with NWAS

MSW training as part of the HEE MSW Transformation Programme all MSW skills were benchmarked and recorded by the MSW Transformation Lead to inform a rolling training programme. This information was reported nationally to HEE and once the programme has been received the PDM will facilitate skills passport completion in line with the HEE MSW Transformation Programme, monitor training compliance and support MSW professional development. A MSW skills passport will be developed and will be completed by all MSWs

5. Midwives new to the Trust

To ensure new staff receive the support they need an induction and orientation programme will be provided which includes in addition to clinical orientation specific to their role-

- Athena K2 system training
- Meditech (Digicare from May ’23) training
- Corporate Induction
- Medical devices
- MPMET
- Fetal Surveillance and SBL days
- Mat 2 and 3
- CCMT (Corporate Clinical Mandatory Training)
- Safeguarding Level 3
- Infant feeding BFI Course
- Blood competencies

New midwives will be assigned a buddy to support them through the induction and orientation into the clinical areas. The Matron is responsible for informing the MEL of the start date of any new midwife at Band 6 or above in advance so a programme of induction and training can be facilitated. The new starter will then attend the Trust induction days and be given an appointment to meet with the MEL to ensure training requirements are agreed.

6. Newly Qualified Midwives

LWH offers newly qualified midwives an 18-month preceptorship programme. In September 2021 LWHT employed 2WTE dedicated Preceptorship Lead Midwives (PLM) to provide clinical managerial and pastoral support to the preceptees. 2WTE additional PLM joined the team in September 2022 to support the intake for October 2022 which has been sustained into 2023.

NQMs have a 4-week induction and orientation programme with regular away days scheduled during the programme, with relevant training facilitated by subject matter experts. A competency framework is provided on commencement at the trust is provided to complete throughout the programme, with the preceptee receiving close supervision and support from the preceptorship leads.

Feedback and evaluations from midwives completing their preceptorship is reviewed to ensure we continually improve the programme for the new preceptee cohort which will it is anticipated support retention and thus improve quality and safety.

Fetal monitoring training forms part of the mandatory training for all new midwives, obstetricians and preceptees. In addition, new staff are allocated time during the supernumerary period with the Fetal Monitoring Specialist Midwife/ Obstetrician for training.

Where an additional training need is identified, preceptorship lead midwives will develop an individual support plan. Preceptees are also able to contact themselves for additional support if personal learning needs are identified.

7. Staff wellbeing

Currently there are 9 PMAs who provide an ad hoc service to staff who require support.

To expand delivery of this service and facilitate changes further training and recruitment is required for sessional PMAs.

8. Ensuring attendance at mandatory maternity training days

Midwives and MSWs

The Maternity Managers have the responsibility for ensuring the Midwifery, Nursing and Maternity Support Worker staff attends training as indicated in the training needs analysis. They are required to ensure that all new staff attend the corporate induction training and any staff new to the maternity services receives a local induction programme and maternity mandatory training sessions as described in the training needs analysis.

Managers have the responsibility to ensure all their staff have been booked onto relevant training. This is recorded on the electronic roster. If managers or staff cancel training the education team need to be informed via email **maternity.training@lwh.nhs.uk**

Non-attendance at a mandatory training session, due to unexpected clinical need, must be agreed through the Matron.

Managers should escalate to their matron if a member of staff has failed to attend training.

Obstetric Consultants, staff grades and doctors in training
It is the Clinical Lead Obstetricians responsibility to ensure that all relevant members of the obstetric team attend relevant training. Individual training portfolios confirm that all training and competency requirements have been met.

To meet CNST Standard 8 all Consultants, staff grade obstetricians and obstetric doctors in training must attend MPMET and Fetal Surveillance annually, their attendance date will be allocated by the medical staffing coordinator.

From April 2023 Obstetric Consultant Support for the delivery of MPMET is written into the Obstetric Consultant work plan

Anaesthetists
It is the Clinical Directors responsibility to ensure that all relevant members of the obstetric anaesthetic team attend training. Individual training portfolios confirm that all training and competency requirements have been met.

To meet CNST Standard 8 all Consultants and relevant anaesthetists in training must attend MPMET annually.

9. Non-attendance at mandatory training

Following each training session, the MEL or person responsible for the training will request the administrator to input the attendees into the training database system and then identify any staff member who has not attended. The PDM or person responsible for the training will send an email to the staff member and the staff member's manager and a new date must be booked. The database will be amended accordingly.

Staff who fail to attend booked sessions where they have been allocated paid study leave will be recorded as having taken unauthorised leave.

For staff who fail to attend a second time, without an acceptable reason, the midwifery matrons will be informed and asked to investigate the reason for non-attendance. In exceptional circumstances it may be necessary to evoke disciplinary

10. Ownership and Responsibilities

Midwifery specific mandatory training provision is coordinated by the Maternity Education Team as outlined. Delivery of training may be undertaken by a range of staff within the Trust. This ensures that subjects are taught by experts where necessary. This section gives a detailed overview of the strategic and operational roles responsible for the development, management, and implementation.

Head of Midwifery (HOM)
The Head of Midwifery will ensure that the training needs analysis is implemented. Receive and act upon any information in relation to problems with attendance at mandatory training days. They will ensure that the Maternity Education Team are aware of any further training and funding opportunities.

Deputy Head of Midwifery (HOM)
The Deputy Head of Midwifery will deputise for the head of midwifery to ensure that the training needs analysis is implemented. Receive and act upon any information in relation to problems with attendance at mandatory training days.

Midwifery Matrons and Managers
These roles have the responsibility for ensuring the Midwifery and Maternity Support Worker staff attends training as indicated in the training needs analysis. Ensuring that all new staff attends the corporate induction training and any staff new to the maternity services receives a local induction programme and maternity mandatory training sessions as described in the training needs analysis.

Maternity Education Lead
MLE has the responsibility for the planning and coordinating of the education and training sessions for post-registration midwives to meet the strategic aims of the Maternity Service and in line with key national reports. This role consists of developing the content for the training sessions as identified in relation to the needs of the maternity service in the community and hospital environment.

Preceptor Lead Midwives
In addition to coordinating the education requirements and providing pastoral care and advice, they will also provide support for new midwives or midwives wishing to consolidate a new skill, in the clinical setting.

Fetal Surveillance Midwife
The role involves developing robust systems of fetal monitoring; this includes consistent training for all staff providing intrapartum care in the classification of CTG and systematic assessment of fetal physiology in response to intrapartum stresses and hypoxia (including competency assessment). Provide one to one feedback when need is identified at Patient Safety meeting. Provide feedback to the maternity risk and clinical meetings.

Role of subject matter experts

Subject specialists are responsible for ensuring that training sessions for their subject area are up to date and reflect the needs of the learners as well as best practice. They are required to updating session annually or as directed by latest evidence and respond to evaluation, taking action to make changes accordingly.

Role of staff members
Individual staff members are required to understand and monitor their own compliance with required mandatory training and has within the required timeframes ensure on going compliance. They should complete training evaluation forms to enable the continuous review and development of courses and keep records of their attendance at all training as evidence of attendance.

11. Training Database for Compliance.

The training spreadsheet is held by ESR on a secure shared folder. These are in an electronic format and are stored on the Trusts server. ESR records all training and can provide training statistics. The completed training is inputted onto OLM (which then links into ESR) by the education teams admin assistant to ensure up to date records are maintained.

ESR will now evidence Maternity Compliance with MPMET & Fetal Surveillance study days.

12. Training Plan for 2023

Core Modules				
		2022 (Year 1)	2023 (Year 2)	2024 (Year 3)
1. Saving Babies Lives Care Bundle		√	√	√
2 Fetal Surveillance in Labour		√	√	√
3. MPMET		√	√	√
4. Personalised Care	Maternal Mental Health	√		
	Vulnerable women and families			√
	Bereavement Care		√	
5. Care during labour and immediate PN Period	Management of Labour	√	√	
	VBAC and Uterine Rupture			√
	GBS in Labour		√	
	Operative Birth- ROBuST			√
	Pelvic Health Perineal trauma			√
	Multiple Pregnancy			√
	Infant feeding	√	√	
	ATAIN		√	
	Mat Crit Care	√		
	Management of Epidural/GA		√	
6. NLS		√	√	√

13. Agendas for Maternity Training Days

MPMET study day-2023.docx

MAt 2 agenda for 2023.docx

Mat 3 Agenda for 2023.docx

CCMT agenda 2023.docx

Fetal surveillance study day 2023.docx

14. Study Days Calendar 23-24

Study%20days%20LWH%20calendar-202

Study days LWH calendar-2024-landsc

15. TNA and Budget

Mat ed budget 23-24 - updated 17.8.23.xlsx

Quality Committee Chair's Highlight Report to Trust Board
25 July 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 an in-depth analysis of current cancer pathways, with an elevated focus by sub-specialty tumour site. A detailed presentation was delivered against each cancer pathway identifying capacity issues, delays in service, and areas of reliance on external partners. It was confirmed that a robust harm review process was in place. The Committee remained concerned about the performance against the cancer metrics, it noted the cancer recovery plan in place and requested a follow up report to the Committee including actions and timescales. • The Committee awaited a response from NHSR in relation to Maternity Incentive Scheme Year 4 Submission. The Family Health Division had undertaken a review of all evidence pertinent to the conditions and requirements of the maternity incentive scheme and remain assured that all aspects of the scheme had been met.	• The Committee noted that the Maternity Incentive Scheme (CNST) Year 5 had recently been released. The report summarised the requirements of the scheme for year 5 and findings from a GAP analysis of the scheme requirements against the Trust's current position. • The Committee received a review of epidural response time as requested following the Month 1 quality performance report metrics. The Committee was assured by the comprehensive look back exercise and noted no evidence that the small decline had been due to increased emergency caesarean section rates nor increases of caesarean sections being performed out of hours. The Committee noted that a repeat audit would be undertaken to determine any factors that are impacting upon the performance for attendance following request for epidural. The Committee suggested that demographic data be added to the audit to determine any potential bias. • The Committee received a review of critical care transfers of women from this Trust (LWH) to an external provider over a 5-year period. The Committee noted the difficulties to access data to provide the report and noted development of a reliable data collection system was a priority to allow ongoing monitoring. The review demonstrated a need for critical care in approximately one patient per month at LWH. There is no evidence that this number is reducing. The Committee noted the establishment of a working group to take action to mitigate the existing risks identified. The Committee recommended that the risks identified by this report be included within the BAF and Corporate Risk Register.
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 that the Trust had received the final Care Quality Commission unannounced inspection (January 2023) and Well Led inspection (February 2023) Report. The Committee was assured of steps taken to date in response of the findings and oversight and completion of required actions. The Committee noted a Board Development Session on CQC Well-Led Reflections is planned for September 2023. (ALL) • The Committee received the Quality and Regulatory update noting reportable key issues in month. (WELL LED)	• The Committee recommended Board approval of the Patient Safety Incident Response Plan and Policy ahead of submission to the ICB.

• The Committee noted the following matters from the Quality Performance report:
  ○ performance against urgent care targets continue to be good and demonstrate a sustained improvement
  ○ Gynaecology elective recovery continues on a positive trajectory in line with the 2023/24 plan
  ○ Infection and prevention control measures of hospital acquired infections of measures of C Diff and MRSA remain at Zero
  ○ Excellent performance relating to: falls risk assessment, new hospital acquired Category 3 pressure ulcers (none), no recorded never events and no Serious Incident actions remain outstanding. (ALL)
• The Committee was assured by the Patient Safety Incident Response Framework (PSIRF) update in relation to the work undertaken in planning for the framework implementation. The Committee reviewed and approved the draft Patient Safety Incident Response Plan and Policy for submission to the Trust Board for approval in August 2023. (ALL)
• The Committee took positive assurance from the Maternity Transformation and Improvement Update, noting sustained improvements within the Maternity Assessment Unit, and the establishment of the Induction of Labour (IOL) Improvement group with a key focus on estate reconfiguration to improve patient flow. (ALL)
• The Committee received the Medicines Management Quarterly Assurance Report Q1 2023/24.
• The Committee took assurance from the Annual Report for Safeguarding Children, Young People and Adults 2022/23; the Complaints Annual Report 2022/23; and the NICE Guidance Annual Report 2022/23. (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. • Noted that 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 would be reviewed to ensure that it provided the Committee and the Board with a clear line of sight on risks relating to patient harm. This review was being undertaken and would be reported to the September 2023 Committee. • Noted that the risks within the Corporate Risk Register had recently been reviewed and updated, referred to appendix 2 of the report 'Corporate Risks and High Scoring Divisional Risks' for assurance.	
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Appropriate debate dedicated to identified reports.	

2. Summary Agenda

2

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
74.	Review of BAF risks: Quality related risks	Assurance	81.	Patient Safety Incident Response Framework – Our PSIRF Journey so far & Patient Safety Incident Response Plan (PSIRP)	Approval
75.	Sub-Committee Chair Reports	Assurance	82.	Review of the last 5 Years of Critical Care Transfers	Information
76.	Quality and Regulatory Update: CQC Inspection Report and Improvement Plans and Reportable Issues Log	Assurance	83.	Maternity Transformation and Improvement Update	Information
77.	Quality Performance Report Month 3, 2023/24	Assurance	84.	Medicines Management Assurance Report, Quarter 1, 2023/24	Assurance
78.	Overview of Cancer Services – in-depth analysis by tumour site	Assurance	85.	Annual Safeguarding Report	Assurance
79.	Provision of Epidural Services for Pain Relief	Assurance	86.	Annual Complaints Report	Assurance
80.	Maternity Incentive Scheme (CNST) Year 5 2023 – Scheme Release Position June 2023	Information	87.	NICE Guidance Annual Report 2022-23	Assurance

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	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	✓	✓	A							

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/135b*		Date: 14/09/2023	
Report Title	Quality & Operational Performance Report			
Prepared by	**Quality & Operational Performance Report**			
Presented by	***Gary Price, Chief Operating Officer, Dr Lynn Greenhalgh, Medical Director and Dianne Brown, Chief Nurse***			
Key Issues / Messages	***Gary Price, Chief Operating Officer***			
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 *If no – please outline the reasons for deviation.*			
	The Board is asked to receive the Month 4 Quality and Operational Performance Report.			
Supporting Executive:	Dianne Brown, Chief Nurse & 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: N/A	Comment:

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

Performance Report Contents

Metrics Summary

Urgent Care targets continue to be performing well. MAU triage within 30 minutes is consistently high and the GED 4 Hr target remains in a positive position with ongoing work to stabilise. This work consists of full pathway review of all aspects of the service.

Routine elective care performance continues in line with our trajectories. Throughout the first 5 months of the year the Trust has lost over a month of activity due to industrial action and we would have been further ahead if this were not the case. Our number of longest waiters continues to reduce in line with our annual plans. Our routine 6-week diagnostic performance continues to perform well.

Our challenges with Cancer Performance are overseen by our Cancer Improvement Plan and through the regional Tier 2 Cancer improvement meetings. Those are supported by the Cheshire and Mersey Cancer Alliance and Liverpool Clinical Laboratories. Rigorous actions to improve diagnostics performance and therefore the 62-day performance are in place that report to Quality Committee and FPBD. The aim of these actions is to improve the cancer performance to the national trajectories in Q3.

Quality Metrics

MAU – positive reporting of MAU triage times within 30 mins noted at 99.93% with triage time within 15 mins at 96.80%. Indicator target for both was >=95%.

MUST – improvements seen in the number of patients screened on admission at 93.57% (target >=95%), however in relation to appropriate referral to dietician if MUST score >2, this indicator is underperforming. Initial indication reflects deterioration in performance occurred during launch of Digicare due to system familiarisation from staff in Gynaecology in-patient ward. Early review since has shown the situation has improved with plans in place for daily oversight from ward manager. It is anticipated this will improve further next month.

Infection control indicators (CDIFF and MRSA) continue to perform well with zero reported.

Complaints – July saw a reduction in the number of complaints received which has supported the continued ability to respond and commence timely investigations, noting no overdue responses. Acknowledging although early days the complaint response rates sit at 100%.

FFT – a reduction in positive FFT responses is noted across maternity and Gynaecology (ED). Both divisions are focusing on improvements from the displeased comments and actions are underway to support the areas of repeated concern as can be seen in the full indicator narratives.

Falls – noted as an area to understand in KPIs. Falls risk assessment and implementation of care plan for patients at risk are underperforming. Similar to MUST issues, on early review this relates to staff familiarisation and usage of DigiCare nursing documentation, over a 2-week period. Analysis post documentation shows much improvement, therefore KPI performance expected to perform better next month.

Recommendation

The Board is asked to receive the Month 4 Quality and Operational Performance Report.

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

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report

August 2023

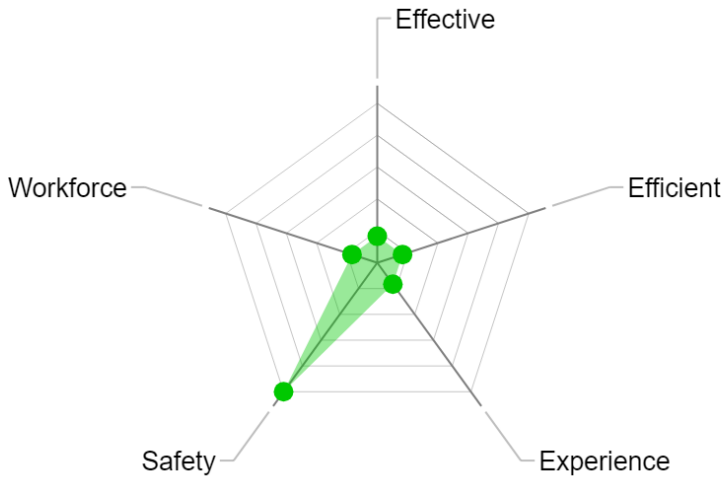
Section 1: Assurance Radar Charts by Trust Values

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'.

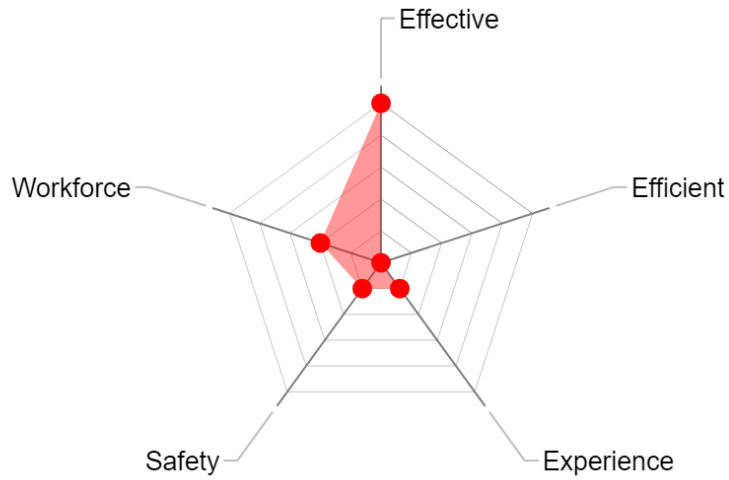
KPIs Passing Target for Six Months	10
KPIs Failing Target	18
KPIs Hit and Miss	6
KPIs No Target	2

KPIs Improving Variation	10
KPIs Concerning Variation	5
KPIs Common Cause Variation	20

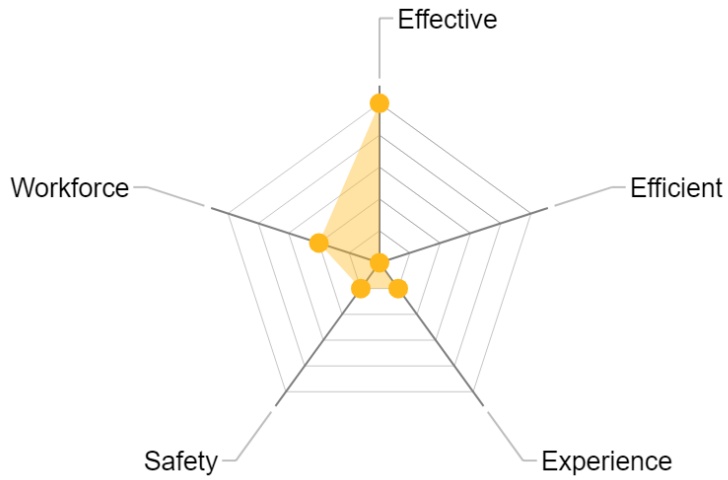
Consistently Passing



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
MAU - Face to face Maternity Triage within 30 Mins	>=	>= 95%	99.93%	P	H
Never Events	<=	0	0	P	L
Serious Untoward Incidents: Number of SUI's with actions outstanding	<=	0	0	P	L
Turnover Rate	<=	<= 13%	9.38%	P	L

Good - Celebrate & Understand

KPI	Target < or >	Target	P	A	V
Complaints: Number Received	<=	<= 15	9	P	
Financial Sustainability Risk Rating: Overall Score	<=	3	3	P	
Infection Control: Clostridium Difficile	<=	0	0	P	
Infection Control: MRSA	<=	0	0	P	
NHSE / NHSI Safety Alerts Outstanding	<=	0	0	P	
Venous Thromboembolism (VTE)	>=	>= 95%	92.61%	?	H

Average - Investigate & Understand

KPI	Target < or >	Target	P	A	V
Neonatal Deaths per 1000 live Births	<=		0		
18 Week RTT: Incomplete Pathway > 52 Weeks	<=	0	1301	?	
18 Week RTT: Incomplete Pathway > 65 Weeks	<=	0	303	?	
Friends & Family Test: In-patient/Daycase % positive	>=	95%	83.87%	?	
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	10		
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	>=	>= 95%	91.16%		
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	>=	>=85%	16.67%		
Cancer: 104 Day Breaches	<=	0	6		
Cancer: 2 Week Wait	>=	>= 93%	84.70%		
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	>=	>=96%	76.32%		
Clinical Mandatory Training Compliance	>=	>= 95%	87.37%		
Diagnostic Tests: 6 Week Wait	>=	>= 99%	91.56%		
Friends & Family Test: A&E % positive	>=	95%	71.43%		
Friends & Family Test: Maternity % positive	>=	95%	80.85%		
Mandatory Training Compliance	>=	>= 95%	93.85%		
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	>=	>= 80%	41.54%		
Serious Untoward Incidents: Open	<=	<5	13		
Sickness Absence Rate	<=	<= 4.5%	5.23%		
Overall size of Elective Waiting List	<=		18408		

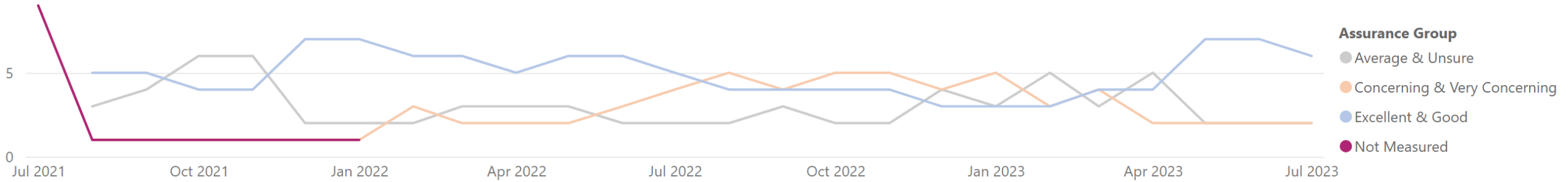
Very Concerning - Investigate & Take Action

KPI	Target < or >	Target	P	A	V
Cancer: 28 Day Faster Diagnosis	>=	>= 75%	39.95%		
Cancer: 62 Day Screening Referrals (Percentage) Rolling 12 Months	>=	>=90%	33.33%		
Proportion of patient activity with an ethnicity code	>=	>=96%	94.58%		
Serious Untoward Incidents: New (Rolling per year)	<=	24 /year	46		

Investigate & Understand

KPI	Target < or >	Target	P	A	V

Section 3: To deliver **Safe** Services



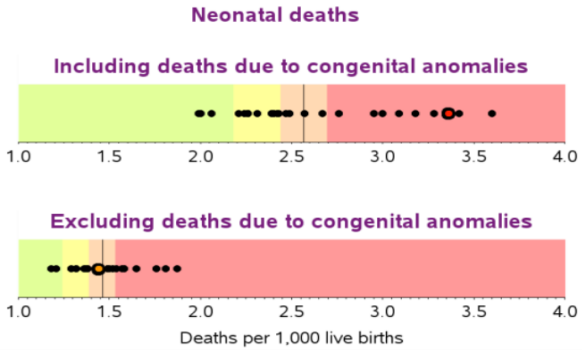
KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
MAU - Face to face Maternity Triage within 30 Mins	Excellent	July 2023	>= 95%	>=	99.93%			
Never Events	Excellent	July 2023	0	<=	0			
Serious Untoward Incidents: Number of SUI's with actions outstanding	Excellent	July 2023	0	<=	0			
Infection Control: Clostridium Difficile	Good	July 2023	0	<=	0			
Infection Control: MRSA	Good	July 2023	0	<=	0			
NHSE / NHSI Safety Alerts Outstanding	Good	July 2023	0	<=	0			
Venous Thromboembolism (VTE)	Good	June 2023	>= 95%	>=	92.61%			
Neonatal Deaths per 1000 live Births	Average	July 2023		<=	0			
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	Average	July 2023	100%	>=	100.00%			
Serious Untoward Incidents: Open	Concerning	July 2023	<5	<=	13			
Serious Untoward Incidents: New (Rolling per year)	Very Concerning	July 2023	24 /year	<=	46			

Neonatal Mortality

- Current Metric in KPI = neonatal deaths/1000 live births
  - Deaths of in-born babies at 24 to 31+6 weeks gestational age at birth/1000 total births (not deaths outside these gestational ages, nor post natal transfers)

- "Learning from deaths" board report:
  - all mortality
  - in-born mortality
  - inborn mortality for 24 – 31+6 week deaths (NNAP)
  - Benchmarks MBRRACE (all deaths > 24 weeks within 28 days) and VON (inborn <1500g)

    Within average after congenital anomalies removed (see chart)

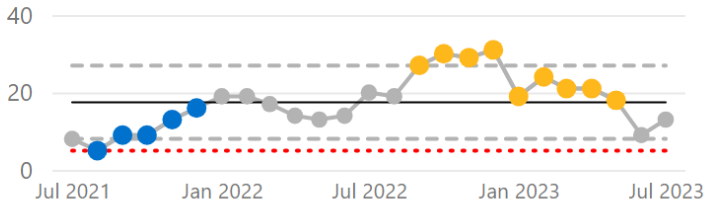


- Future KPIs recommended
  - Neonatal Unit Deaths > 22wks Gest Inborn and Out Born (Number)
  - Neonatal Unit Deaths > 22wks Gest Inborn (Number)
  - Neonatal Unit Deaths > 22wks Gest Out Born (Number)
  - Neonatal deaths per 1,000 total live births (MBRACE - All deaths > 24 weeks who die within 28 days per 1,000 live births)
  - Neonatal deaths 24-31+6 Weeks Inborn babies (NNAP – Denominator is number of 24-31 week admissions and measure is 6.3%)

To deliver **Safe** Services - Exceptions

Serious Untoward Incidents: Open - Chief Nurse

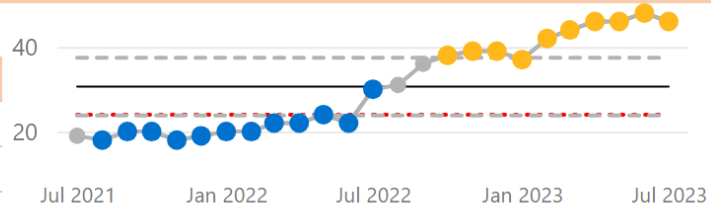
Assurance Category	Concerning
Date	July 2023
Target	<5
Target < or >	<=
Performance	13
Assurance	F
Variation	



There are 13 ongoing SIs, 9 sit with the Gynaecology and 4 within Maternity all SIs are expected to be submitted to the ICB by 18th October
Within Gynae 2 relate to HFC,1 Maternal Death, 1 Ectopic Pregnancy,1 delay in diagnosis,1 delay in treatment,1 wrong diagnosis and 2 Cancer breeches
For Maternity 3 Transfer and a skin injury.
5 of the ongoing SI will fall into the future generations works (4 maternity & 1 Gynae).
SUI will continue to be closed down in advance of PSIRF launch in September

Serious Untoward Incidents: New - Chief Nurse

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



There were 6 SUIs reported in July, 3x Maternity ,2 related to transfers and 1 skin damage. 3x Gynae 2 cancer breeches and 1 delay in treatment. Once PSIRF is launched in September we should start to see a reduction in SI investigations as the framework will no longer exist. Greater focus will be given to learning and repeat causality.

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

To deliver Safe services - Safer Staffing

July 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	80.65%	73.12%	130.65%	101.61%	*/**Day shifts fill rates reflect the long-term and short-term sickness within the inpatient are. The Night duty fill rate is indicative of 3 RN to facilitate senior nurse cover to rotate between the inpatient ward and GED. Due to the low bed occupancy in HDU this has allowed for staff to rotate and support the inpatient ward on days maintaining safe staffing.
Induction & Delivery Suites	78.71%	86.02%	83.66%	96.77%	*The template from RM in DS changed from 13 to 15 MW per shift due to the temporary pause of MCOC model of care in May 2023, and no longer having the availability of 4 on call midwives. 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	85.48%	100.00%	94.93%	114.52%	*/**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	85.48%	48.39%	89.52%	64.52%	*/**There were no episodes of Closure during the month, occupancy was reduced which allowed the safe delivery of Intrapartum and early postnatal care. Within Intrapartum Care clinician is Registered Midwife with Care staff supporting the running of the ward as opposed to providing direct clinical care. Vacant shifts are requested to be filled with bank. Low fill rate of Care Staff is attributed to LTS, of which recruitment of fixed term contracts has occurred- with the MSW currently completing their orientation and training period.
Neonates (ExTC)	89.64%	114.52%	94.06%	79.03%	*/**Fill rates reflect the increased low dependency occupancy in July. Increased need for care staff who provide care in this area. Safe staffing was maintained and CHPPD (Care Hours Per Patient Day) are as would be expected.
Transitional Care	64.52%	112.90%	64.52%	103.23%	*/**Fill rates reflect the increased transitional care occupancy in July. Safe staffing was maintained and CHPPD (Care Hours Per Patient Day) are as would be expected

To deliver Safe services - Safer Staffing

Gynaecology: July Fill Rate

Fill rate – July staffing fill rate on days is reflective of the increase this month of long-term and short-term sickness, alongside maternity leave. Safe staffing has been maintained due to the low bed occupancy of 34.41% in the inpatient area the ability to flexibly rotate staff from the HDU area also due to the low bed occupancy, recorded as 9.54%. The fill rate 130.65% RN on nights remain above the 100% as this is reflective of senior RN cover rotating between GED and inpatient area.

Attendance/ Absence – Sickness and absence for the month of July was reported as 21.10% a significant increase since June when it was recorded as 9.1%. Long term sickness contributed to the high levels of sickness at 84.34% and short-term sickness contributed to 15.68%, reviewing the previous months sickness indicates that those recorded as short-term sick had since moved into long-term sick as not returned to work. Maternity leave accounted for 1.61WTE staff.

Vacancies – No vacancies

Red Flags – No red flags recorded in July.

Bed Occupancy – Bed occupancy for the Gynaecology inpatient ward for July was recorded as 34.41% a decrease from previous month that was recorded as 39.99%

CHPPD – CHPPD – For the month of July the CHPPD overall was reported to be 9.6, an increase on previous month reported as 9.1. The split between Registered and Unregistered care staff was 5.6 for Registered Nurse staff and 4.0 for Health Care Assistants.

Neonates: July Fill Rate

Fill-rate – Occupancy saw a slight rise in July to above the expected standard. The rise was in the LDU and TC areas, however, with ITU and HDU occupancy rates decreased from June, safe staffing has been maintained and fill rates are reflective of acuity and occupancy. The increase in IC activity is reflected in the use of Bank. The escalation policy has had to be used this month; however, no transfers were undertaken. There was a reduction in bank usage by 21.6 % in July reflective of the reduced occupancy of ITU and HDU patients .

Attendance/Absence –Sickness was reported at 8.2% in July. This was an increase of 2.66%. Long term sickness accounted for all the increased sickness in July, with all sickness being managed in line with the attendance management policy.

Vacancies – There have been challenges recruiting to vacant ANNP posts, with 5 WTE posts out to advert currently. There was successful recruitment to all band 6 and band 2 vacancies. Band 5 vacancies were approved in July with interviews planned in August.

Red Flags – No Red Flags

Bed Occupancy – Occupancy was over the expected 80% at 83.1 % with ITU occupancy at 71.8 % and HDU at 68.0%, an increased LDU occupancy of 93.1% Transitional Care occupancy was 78.6% with 7 days in the month at full capacity of 8 patients which is reflective of the care staff fill rates.

CHPPD – Within the critical care areas the care is as expected, showing higher hours of registered nurse care and lower non- registered care. This split of 12.1 hrs of registered nurses and 1.5 unregistered is what is expected, reflecting 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 6.7 hrs by non-registered nurse and less by registered nurses 2.2 hrs, but appropriate for care delivery. Care in TC is more about supporting the family.

To deliver Safe services - Safer Staffing

Maternity: July Fill Rate

Fill-rate – Following the remodelling of the care delivery pathway for MCoC, the move from on call availability to a shift-based model for the Intrapartum element was established. During the temporary suspension, the Delivery Suite planned staffing has increased to 15 RM per shift from 13 MWs per shift. Where staffing requirements could not be met all vacant shifts were escalated to NHSP or on occasion premium rate agency. 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 noting performance was achieved at 99.9%, and 96.5% of those within 15min BSOTS target. Throughout the reporting period MLU was able to remain open supporting flow through all clinical areas. Additional care staff were provided to support clinical postnatal care delivery for postnatal women on Maternity Ward when RM shifts were unable to be filled utilising temporary staffing solutions. Maternity continued to undertake a minimum 4-hourly activity /acuity review, which allows senior midwifery staff to maintain safety by rotating staff to the areas of highest clinical need using risk based responsive decision making.

Attendance/ Absence – Maternity continues to report levels of sickness above the trust threshold of 4.5% which is included in the headroom, within its midwifery and support staff group. Maternity sickness is reported at 6.44% in month, continuing a downward trajectory. STS accounts for 22%, with the top reasons for short term absence being cough/cold or gastrointestinal issues. LTS is 58%. 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 13.59wte all of whom are within the Registered Midwives staffing group.

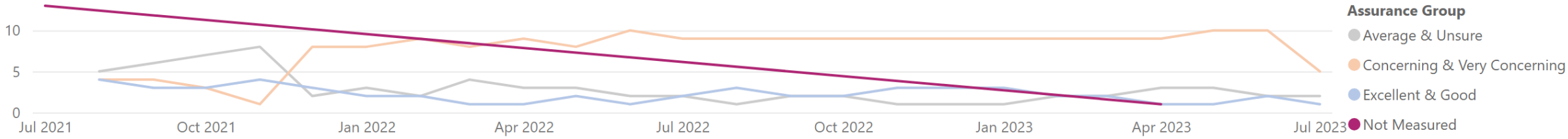
Vacancies – 40.6wte Midwives at Band 5 and 6 are currently undergoing recruitment processes and Maternity is expected to exceed full establishment by M7 when all new starters are in post.

Red Flags – During July, 22 Midwifery Red Flags were identified, which included 1 triage breaches of >30mins, with all undergoing analysis to drive quality improvement as part of the MAU workstreams. There were 18 delays of >4hrs for ongoing IOL (local red flag), which affected patient experience, and 2 delays of >2hrs from admission to commencement of IOL. There was 1 delay of >30mins in facilitating epidural which was the preferred choice of analgesia due to anaesthetic availability, although alternative pharmaceutical analgesia was provided. Apologies were offered to the women.

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. CHPPD was reported at 13.4 in July for Delivery Suite for registered staff which is a decrease from June and reflects the increased complexity, acuity, and occupancy of Delivery Suite in July. 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 this was achieved for 100 % of women in month within the hospital environment.

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 3.7 for July, which was consistent with 3.7 achieved in June. Nationally the refresh of the BirthRate Plus Ward Based Accuity Tool which will provide a real time evidence-based data to support staffing deployment decisions on Maternity Ward is about to go into test in several units. Once available to us, this will provide assurance within this area on the changing complexity of ward-based care in Maternity services here at Liverpool Womens.

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

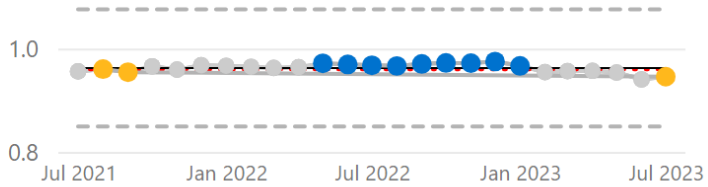


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
18 Week RTT: Incomplete Pathway > 104 Weeks	Excellent	July 2023	0	<=	0	P	L	
18 Week RTT: Incomplete Pathway > 52 Weeks	Average	July 2023	0	<=	1301	?		
18 Week RTT: Incomplete Pathway > 65 Weeks	Average	July 2023	0	<=	303	?		
18 Week RTT: Incomplete Pathway > 78 Weeks	Concerning	July 2023	0	<=	10	F		
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Concerning	July 2023	>= 95%	>=	91.16%	F		
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Concerning	June 2023	>=85%	>=	16.67%	F		
Cancer: 104 Day Breaches	Concerning	June 2023	0	<=	6	F		
Cancer: 2 Week Wait	Concerning	June 2023	>= 93%	>=	84.70%	F		
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Concerning	June 2023	>=96%	>=	76.32%	F		
Diagnostic Tests: 6 Week Wait	Concerning	July 2023	>= 99%	>=	91.56%	F	H	
Overall size of Elective Waiting List	Concerning	July 2023		<=	18408		H	
Cancer: 28 Day Faster Diagnosis	Very Concerning	June 2023	>= 75%	>=	39.95%	F	L	
Cancer: 62 Day Screening Referrals (Percentage) Rolling 12 Months	Very Concerning	June 2023	>=90%	>=	33.33%	F	L	
Proportion of patient activity with an ethnicity code	Very Concerning	July 2023	>=96%	>=	94.58%	F	L	

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

Proportion of patient activity with an ethnicity code - Chief Operating Officer

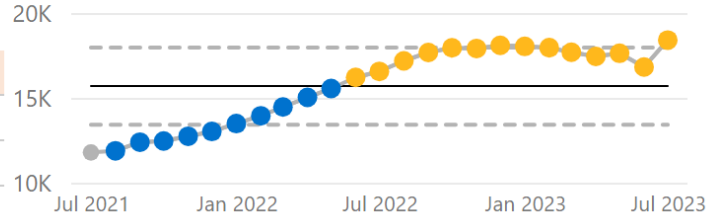
Assurance Category	Very Concerning
Date	July 2023
Target	>=96%
Target < or >	>=
Performance	94.58%
Assurance	F
Variation	L



Although the Trust continues to meet this target there is an ongoing focus to ensure a patients ethnicity is recorded. The main challenge relates to increases in first attendance virtual appointments and fewer contacts with administrative staff prior to the patient attending.

Overall size of Elective Waiting List - Chief Operating Officer

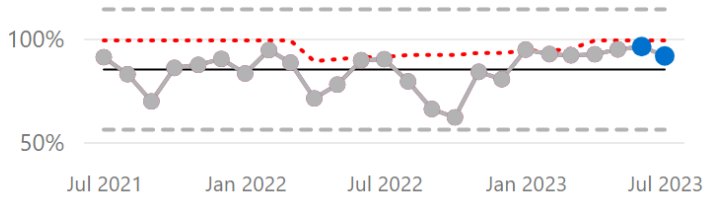
Assurance Category	Concerning
Date	July 2023
Target	
Target < or >	<=
Performance	18408
Assurance	
Variation	H



PTL was reduced prior to Digi Care go live but has since increased following Data Migration. New processes re: booking out of clinics has meant more patients remaining on the waiting list whilst issues are resolved. Task & Finish group was established to clear and this is now demonstrating in an improvement. Continued work around the new Digi Care PTL management will be ongoing through Access Sub-Committee. Reduction in capacity will also impact this figure for August due to Industrial Action

Diagnostic Tests: 6 Week Wait - Chief Operating Officer

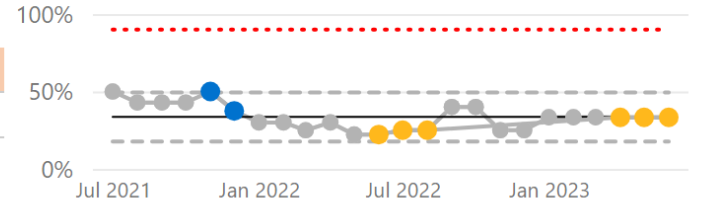
Assurance Category	Concerning
Date	July 2023
Target	>= 99%
Target < or >	>=
Performance	91.56%
Assurance	F
Variation	H



Slight reduction in month however still currently on trajectory. Continued pressures re: Imaging workforce will create challenges for M5 performance so may slightly reduce however expecting recovery in September

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

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

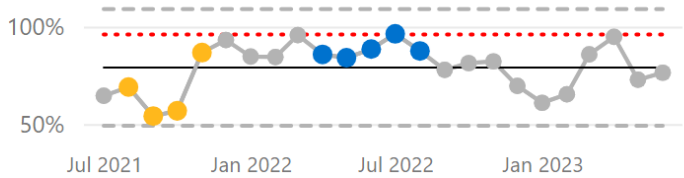


These are patients that are referred from cervical screening programme and are a very low number each month (2-3). They are managed alongside the 2-week cancer referral patients and should then be considered as part of that pathway.

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

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

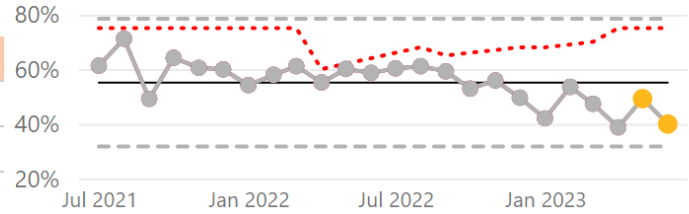
Assurance Category	Concerning
Date	June 2023
Target	>=96%
Target < or >	>=
Performance	76.32%
Assurance	
Variation	



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

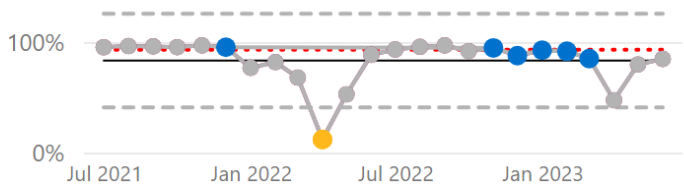
Assurance Category	Very Concerning
Date	June 2023
Target	>= 75%
Target < or >	>=
Performance	39.95%
Assurance	
Variation	



Significant challenges with Hysteroscopy capacity and Histology turnaround. Trust in Tier 2 meeting with NHSE with first meeting held 26th June. This outlined existing pressures and key areas of challenge for the Trust. Trust will be meeting monthly with NHSE to monitor. Weekly tracker of activity being monitored. June saw significant increase in number of diagnostics being performed (418 against a plan f 320). Further challenges will be seen due to Industrial action and digicare go live

Cancer: 2 Week Wait - Chief Operating Officer

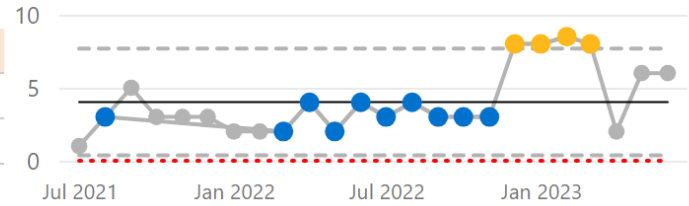
Assurance Category	Concerning
Date	June 2023
Target	>= 93%
Target < or >	>=
Performance	84.70%
Assurance	
Variation	



Performance reduced during June 2023 due to activity lost for Industrial action. July will also be a challenging month with recovery likely t be achieved in September 2023

Cancer: 104 Day Breaches - Chief Operating Officer

Assurance Category	Concerning
Date	June 2023
Target	0
Target < or >	<=
Performance	6
Assurance	
Variation	

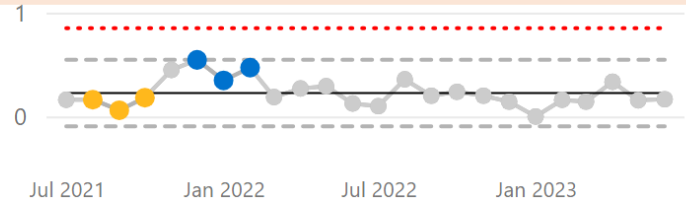


Due to complexity of patients and late referrals from other trusts, patients continue to breach 104 days. Harm reviews conducted for all patients. Paper presented to Quality Committee in July outlining key pressures on pathways and actions being taken to mitigate. Whilst current 62 day backlog is cleared there will continue to be patients that breach 104+ days

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

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

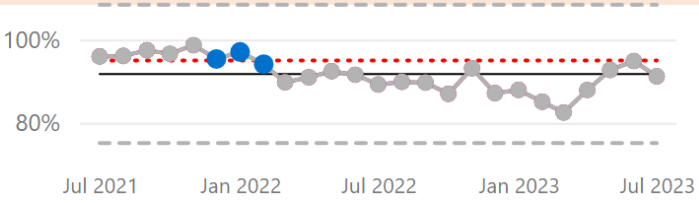
Assurance Category	Concerning
Date	June 2023
Target	>=85%
Target < or >	>=
Performance	16.67%
Assurance	
Variation	



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

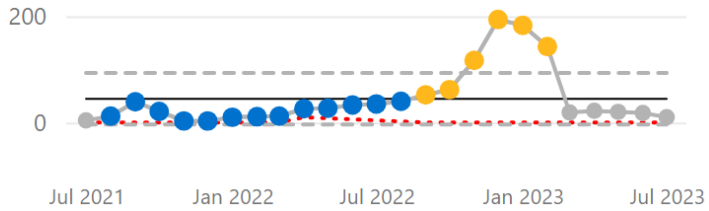
Assurance Category	Concerning
Date	July 2023
Target	>= 95%
Target < or >	>=
Performance	91.16%
Assurance	
Variation	



Significant improvement in performance. EPAU patients now being recorded correctly following discussion with the ICB

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

Assurance Category	Concerning
Date	July 2023
Target	0
Target < or >	<=
Performance	10
Assurance	
Variation	



The Trust continues to manage patients on an individual basis and number of 78+ weeks has redu ced. Those waiting beyond 78 weeks are now patient choice or for complex clinical reasons. Daily and weekly review continues. Capacity impacted by implementation of Digi Care (reduced activity in July) and continued Industrial action currently equating to 1 week per month of lost activity

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Compliant | partial compliant | Non Compliant

Planned Preventative maintenance

PPM Description	Responsibility/ Contractor	HTM/HBN Reference	Frequency				Comments
			Annual	6-Monthly	Quarterly	Monthly	
FIRE							
Fire Alarm Testing (W, 3M)	Tailored Fire						
Fire Doors (M)	Estates						Fire door audit complete - action plan to rectify faults in place - external fire audit in process of being undertake, Maintenance training being booked for maintenance staff
Fire Damper Inspection Test	VSS & Swegon						Contracts now in place and schedules progressing. Some restricted access being addressed.
Fire Fighting Equipment (12m)	Tailored Fire						
Dry Risers (12M)	Tailored Fire						
Fire Hydrants (12M)	Tailored Fire						
Emergency Light test (M,12M)	Estates						Now on PPM system and on target
WATER							
Water Treatment (M) (heating and cooling)	Aquaserv						
Water Tank Cleaning (12M)	Aquaserv						
Water Sampling (M)	Aquaserv						Undertaken by maintenance staff monthly
Water Safety PPMs	Estates						Undetaken by maintenance staff as per programme
SECURITY							
Access Control System (3M)	Clarion						
CCTV (3M)	HESIS						Contract now in place and works scheduled. Security review being undertaken following MI
Intruder Alarm (6M)	Clarion						
Baby Tagging System (3M)	Xtag						
LIFTS							
Passengers & Goods Lift (M, 12M)	Rubax						
Ladder & Access Platforms (6M)	Ladder Safety Services						
ELECTRICAL							
Commercial Dishwashers (6M)	JLA						
Commercial Washing Machine Dryers (6M)	JLA						
Electric Boilers (12M)	JLA						
Kitchen Equipment (6M)	JLA						
Portable Appliances Testing (12M)	OCS						Completed yearly
Food Trolleys (6M)	Socomel						
Weighing Equipment (3M)	Accurate weight						
Fixed Appliance Testing (12M)	Parr group						
Bed Pan Washers service (6M)	Dekomed						
Bed Pan Washers Testing (3M)	Dekomed						
Nurse Calling System (3M)	Austco						being undertaken only a couple of areas left to complete
External Light Cleaning (12M)	Estates						
Internal Light Cleaning (12M)	Estates						
Lightning Protection (12 M)	PTSG						
Generator Testing (W,M,6M,12M)	Ingrams/Estates						
Trend Building Management System (M)	BTS						
LV Distribution System (12M)	Estates						
HV Distribution System (12M)	Ipsum						
Refridgeration (6M) Catering/Domestic	Effective Air						
MEDICAL GASES							
Medical Gases (3M)	Medigas Services						
HVAC (Heating, ventilation and air conditioning)							
Boiler Burners (6M)	Engie						
Pressure Units (6M)	Engie						
Main chiller unit (6M)	Engie						
Air conditioning (6M)	Effective Air						Contract now in place.
Ventilation System(6M) (AHU)	Estates						
NICU Chiller Units (3M)	Carrier						
Ceiling Grills Extract Fans (6M)	Estates						Now on PPM system and schedule in place to complete
OTHER							
Car Park Pay & Display (6M)	Newpark						car parks being reviewed as a project to ensure correct staffing allocated, and barriers working across the trust
Grass Cutting and Grounds Maintenance	Rice lane landscapes						Monthly during March - October
Windows maintenance (12M)	Fenestral						

Notes:

1. Summary of compliance rates.

Month	Water	General PPM's	Reactive maintenance
M1 - 04/23	100%	91%	80%
M2 - 05/23	99%	86%	72%
M3 – 06/23	100%	90%	77%
M4 – 07/23	100%	84%	76%
M5 – 08/23			
M6 – 09/23			
M7 – 10/23			
M8 – 11/23			
M9 – 12/23			
M10 – 01/24			
M11 – 02/24			
M12 – 03/24			

2. Fire strategy - capital confirmed for various projects on 7th June - schedule of works now agreed and ongoing.

Risk register:

2274 - water safety PPMs has impacted on existing resources which will cause increased backlog on reactive maintenance tasks.

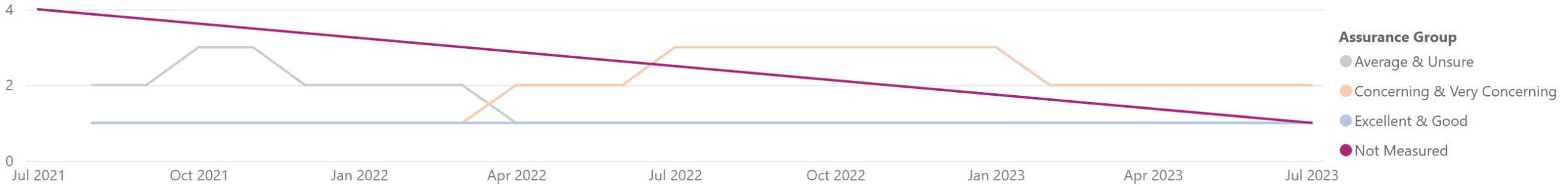
2469 - allocation of resources to carry out water safety checks has not achieved full compliance.

2474 - PPM system not populated, regular maintenance not completed, equipment may breakdown more frequently - PPM system now in place.

All three risks have an impact on resource levels within the department - and although significant improvement has been made the department has experienced some staff turnover with recruitment ongoing, therefore these will remain on risk register until it can be assurred that compliance will be maintained.

Given the continued improvement in water safety and general PPM's compliance it was anticipated that we would be abe to review these risks with a view to reducing or removing them. However, given the decline in compliance, although now improving, a review of these risks will take place in month 10.

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

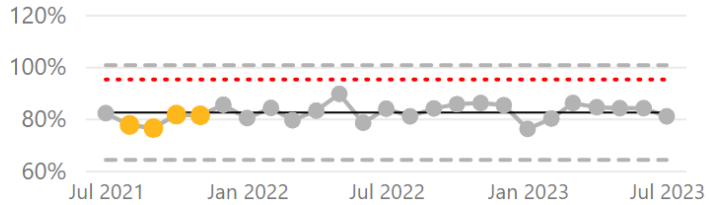


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
C-Gull Recruitment	Not Measured	July 2023		<=	64			
Complaints: Number Received	Good	July 2023	<= 15	<=	9			
Friends & Family Test: In-patient/Daycase % positive	Average	July 2023	95%	>=	83.87%			
Friends & Family Test: A&E % positive	Concerning	July 2023	95%	>=	71.43%			
Friends & Family Test: Maternity % positive	Concerning	July 2023	95%	>=	80.85%			

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

Friends & Family Test: Maternity % positive - Chief Nurse

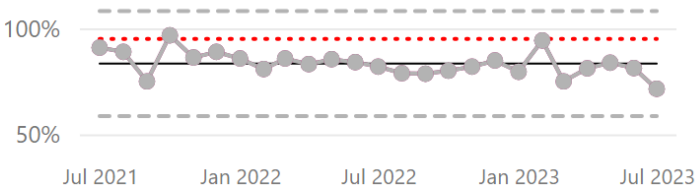
Assurance Category	Concerning
Date	July 2023
Target	95%
Target < or >	>=
Performance	80.85%
Assurance	
Variation	



Continued focus on addressing themes from displeased feedback,, which include delayed discharge, delay in administration of medication and communication. 1 midwife rostered per shift on Mat Base to administer medication. NIPE Midwife allocated to night duty to expedite discharges.

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

Assurance Category	Concerning
Date	July 2023
Target	95%
Target < or >	>=
Performance	71.43%
Assurance	
Variation	



Unfortunately, there continues to be reductions seen in the FFT positive responses . Addressing the themes specifically highlighted in FFT displeased (wait to be seen and access to scans) locally the nurse in Charge is accessible to deal with any concerns the Division have plans to make changes to the EPAU service in an attempt to increase patient satisfaction as well as patient flow

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: New	Safety	5	Y		Y					
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescale	Safety	5	Y		Y					
Serious Untoward Incidents: Number of SUI's with actions outstanding	Safety	5	Y		Y				Y	
Serious Untoward Incidents: Open	Safety	5	Y		Y					
Sickness	Workforce	5	Y		Y	Y				
Turnover	Workforce	5	Y			Y				
Venous Thromboembolism (VTE)	Safety	5	Y		Y					
C-Gull Recruitment	Experience		Y		Y		Y			
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Workforce		Y	Y	Y	Y				

Liverpool Women's NHS Foundation Trust

Board of Directors

COVER SHEET

Agenda Item (Ref)	***23/24/135c***		**Date: 14 September 2023**	
Report Title	**Raising Concerns at Liverpool Women's incorporating Whistleblowing/Freedom to Speak up Annual Report 2022/23**			
Prepared by	***Kevin Robinson, Freedom to Speak Up Guardian*** ***Michelle Turner, Chief People Officer***			
Presented by	***Kevin Robinson, Freedom to Speak Up Guardian*** ***Michelle Turner, Chief People Officer***			
Key Issues / Messages	***To set out the Trust's arrangements for Raising Concerns and for the Guardian to present the Annual Review for 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 – Y ***If no – please outline the reasons for deviation.***			
	The Board is asked to review the report and to • ***take assurance that there are robust processes in place to support the raising of concerns and to support the Guardians in their work*** • ***note the areas of focus for 2023/24 and the ongoing training and leadership activities*** • ***ask the Putting People First Committee to undertake a full review of the current speak up arrangements and the underpinning cultural programmes of work to support that; with a specific focus on the approaches and mechanisms in place to support those members of staff who may have cultural barriers to speaking up.*** • ***Approve the 2022/23 annual report***			
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) *N/A*	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment: Links to CRR outlined in the report.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Whistleblowing / Freedom to Speak Up Annual Report 2022/23 has been received by the PPF Committee and Audit Committee (July 2023). Both Committees recommended the report to the Board.			

EXECUTIVE SUMMARY

The importance of staff, students and volunteers feeling empowered, enabled and safe to speak up and raise concerns about any issue that may impact upon patient safety and care, and staff wellbeing has been starkly reinforced by the early learning from the events leading to the conviction of Lucy Letby, a neonatal nurse.

This paper sets our NHS England's expectations of all Board with regard to Speaking Up in their organisation and the current arrangements in place at Liverpool Women's to provide and further develop a culture where speaking up is actively encouraged, enabled and viewed as a positive action.

The paper also presents the Trust's Freedom to Speak Up Guardian's Annual Report for 2022/23 which has been presented to both the Trust's People Committee and the Audit Committee who were assured by the current arrangements in place and the priority areas of focus for the Guardian service in the coming year.

INTRODUCTION

In their letter of 18 August 2023 NHS England asked NHS Boards to review their processes and arrangements for raisings concerns, ensuring

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods of communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.

5. Boards are regularly reporting, reviewing and acting upon available data.

See link to PRN00719-letter-verdict-in-the-trial-of-lucy-letby.pdf (england.nhs.uk)

The Trust has two Freedom to Speak Up Guardians – one is non-clinical and the other is a medical consultant who works shift patterns including out of hours. One Guardian is from a racially minoritized background. The clinical Guardian (who is a doctor) has picked up some specific responsibilities around engaging with the junior medical workforce, who are often transient through organisations and are known to be less likely to speak up with confidence.

A Freedom to Speak Up Guardian is a member of the Board's People Committee and submits regular updates to the Committee which allows for early identification of any actions to further promote raising concerns, emerging themes or trends and the experience of those who have raised concerns. The Guardian also attends the Board to present their Annual Report to the Putting People First Committee, the Audit Committee and the Board of Directors. A mid-year update is scheduled for February 2024 in this year's Board work programme.

There is a Non-Executive Director of the Board designated Freedom to Speak Up lead – Zia Choudhury – who is available and connected to the Guardians.

The Guardians have regular meetings with the Chairman and the Chief Executive, and separately with the Chief People Officer – with open access to all at any time.

The Trust has a high level of engagement with the Annual NHS Staff Survey and can demonstrate significant improvements in staff awareness and confidence as measured by Staff Survey metrics following a highly visible raising awareness campaign. The Trust is one of the ten most improved organisations in the country this year in terms of the Staff Survey metrics and the National Guardian is due to visit the Trust in November 2023 to listen to its approach to raising awareness and organisational confidence in speaking up.

Whilst the Guardian service remains an important future of enabling Speaking Up, developing and sustaining an organisational culture where raising concerns is viewed as a positive action, encouraged and welcomed, with a resultant high level of confidence in the workforce that they will experience no detriment, is key. For that reason training is provided to all leaders and managers with compliance tracked, internal leadership programmes include leadership behaviours when faced with concerns, and the continued embedding of the fair & just culture principles. In addition, as part of its actively anti-racist programme of work, the Trust is seeking to better support staff from minoritized groups in raising concerns.

This is the annual report completed by the Freedom to Speak Up Guardian to provide the committee with assurance regarding "Speaking Up" and "Whistleblowing". It includes details of those issues that have been formally raised with the Trust and how they have been dealt with.

The Board is asked to review the report and to

- take assurance that there are robust processes in place to support the raising of concerns and to support the Guardians in their work
- note the areas of focus for 2023/24 and the ongoing training and leadership activities
- ask the Putting People First Committee to undertake a full review of the current speak up arrangements and the underpinning cultural programmes of work to support that; with a specific focus on the approaches and mechanisms in place to support those members of staff who may have cultural barriers to speaking up.
- Approve the 2022/23 annual report.

ANNUAL REPORT OF THE FREEDOM TO SPEAK UP GUARDIAN(S) 2022/23

1. Introduction

The Trust is committed to developing and maintaining an open and constructive culture whereby all staff feel comfortable in raising any concerns they might have regarding the Trust and the services that it provides. All staff should feel able to raise concerns in the knowledge that they will be taken seriously, that their concerns will be addressed, and without any fear of reprisal of detriment. While this commitment is based in, and underpinned by our statutory and legal obligations, the Trust's Freedom to Speak Up, Raising Concerns & Whistleblowing Policy encapsulates it in a form that is easily accessible for all staff.

The importance of staff feeling empowered, enabled and safe to speak up and raise concerns about issues that may impact upon patient care and staff wellbeing has been highlighted by the early learning from the events leading to the arrest, trial and conviction of Lucy Letby, a neonatal nurse.

This report is produced on an annual basis to give the committee assurance that the policy is in place, and that it is both appropriate and regularly updated. It also provides a summary of whistleblowing cases over the previous financial year to further provide assurance that the policy is being appropriately implemented.

2. Issues for Consideration

2.1. Trust Policy

The Trust's policy has been further reviewed and updated. This was a result of national guidance being released by the National Guardian office during 2022/23. Following extensive review and updates the policy was launched in January 2023 and is now called "Freedom to Speak Up, Raising Concerns & Whistleblowing Policy". The policy expands the "Speak Up" message that positive improvements/suggestions can be raised at any time via "Speak Up" principles, not just what something is felt to be failing.

2.2. Assurance: Annual Staff Survey Results

The National NHS Staff Survey includes four questions that relate to issues around raising concerns. The table below shows the Trust's results from the previous surveys, together with comparisons against the national comparator (in our case Acute Specialist Trusts) in 2022.

Raising Concerns Questions	LWH 2018	LWH 2019	LWH 2020	LWH 2021	LWH 2022	National 2022
I would feel secure raising concerns about unsafe clinical practice	68.7%	73.1%	70.4%	75.4%	77.8%	71.9%
I am confident that my organisation would address my concern	59.5%	64.0%	63.3%	64.3%	64.3%	56.7%
I feel safe to speak up about anything that concerns me in this organisation	n/a	n/a	66.8%	61.3%	**67.5%**	61.5%
If I spoke up about something that concerned me I am confident my organisation would address my concern	n/a	n/a	n/a	51.8%	55.3%	48.7%

The results show positive results from the staff survey around the questions relating to staff speaking up. Whilst the national picture showed an overall decrease in these scores, the results for LWH, in the table above, showed some noticeable improvements and scoring consistently above the national results in all 4 areas. Whilst there is always room for improvement, it is encouraging to see that the work undertaken over the past few years is having a positive impact for our staff.

The Trust scored in the top 10 most improved organisations in the 2022 survey for the speak up questions. This was recognised by the National Guardian for the NHS, Dr Jayne Chidgey-Clark, who has requested to visit the Trust to observe our practises and procedures. This vist will be taking place during 2023/24.

Formal Concerns Raised with the Trust (Inc. Whistleblowing Declarations / CQC notifications)

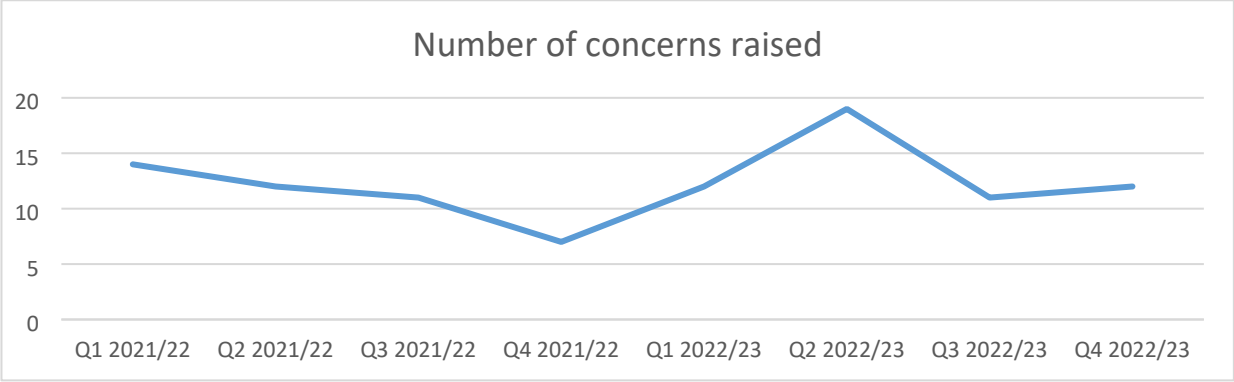
One cased was formally raised with the Trust during the period April 2022 to March 2023:

- It was an anonymous concern raised to the CQC in May 2022 which related to a range of issues including the performance and practice of a member of staff, safety of car parking and staff safety. The individual allegations were reviewed by the Deputy Director of Nursing & Midwifery and Chief Nurse and a written response was sent to the CQC.

2.3. Freedom to Speak Up Guardian (F2SUG)

The chart below demonstrates the Guardian contacts per Quarter and the main themes; this recording is in line with National Guardian requirements and reported externally**.** ****Each case may be reported under more than one heading if concern has multiple elements raised.*

	Total number of concerns raised	Concerns where staff wanted to remain Anonymous	Concerns with element of Patient Safety/quality	Concerns with element of Bullying and Harassment	Concerns where concerns about detriment
Q1 2022/23	**12**	0	5	7	0
Q2 2022/23	**19**	0	11	6	0
Q3 2022/23	**11**	0	9	5	0
Q4 2022/23	**12**	0	7	6	0



In the last 12 months a total of **54** contacts were made to the Freedom to Speak up Guardian (F2SUG) requesting support to raise concerns or where staff want to speak to someone in a safe space to discuss work related issues. This is an increase of 10 contacts (19%) recorded in the previous 12 months.

Concerns throughout the year were raised from a wide variety of staff, with concerns raised by staff of all grades and from all services and teams have spoken to the Freedom to Speak up Guardians. The trend data

would seem to indicate that staff continue feel confident to raise concerns by identifying themselves to the Guardian, although there is still some element of apprehension to share their identity any further, with a number wishing to keep their details confidential at all stages.

During the year, the majority of concerns raised and discussed are related to HR Issues about interactions with them and their managers/ supervisors or other staff members. The training module for managers is designed to help with these interactions and it is hoped that as we increase the compliance with this module, detailed later in this report, some of these issues may reduce.

In the early part of 2022/23, Concerns were raised by maternity staff members relating to the pressures that are being felt in their areas, specifically relating to the Maternity Assessment Unit. Senior leaders in Maternity and relevant Directors became involved and continue to work with the area to provide reassures and support.

Concerns were raised by some staff members relating to recruitment/development opportunities and if the Trust policies and procedures are being consistently followed and adhered to. We are working with staff members who have initiated these discussions to explore these issues further before proceeding to review with relevant areas including HR if required.

Where staff want to speak to someone in a safe space to discuss work related issues, many of these contacts are usually related to Grievance or Interpersonal issues within teams where no formal action is required by the Guardian. They are recorded and monitored with the individual if required to ensure appropriate avenues can be accessed by the staff member.

Concerns continue to be raised where staff members advise they have raised issues with their line managers etc. and they either do not seem to have acted or taken action which is felt to be inconsistent and unfair. It is hoped that the follow up module training along with the continued promotion and uptake of Fair and Just training for manager, which is aimed at giving the managers the skills to review and act on issues by using the fair and just principles, will have a positive effect on reducing the occurrences of these concerns.

Induction and training activities have been undertaken throughout the year. A Freedom to Speak Up Guardian (F2SUG) attends every corporate induction training day to speak to all staff, face to face, about what the Guardians role is for and how we can support all staff to raise concerns.

Feedback to the Guardians is collected at the end of an episode of raising concerns with staff feedback being wholly positive. There has been 2 pieces of negative feedback this year related to the support offered by the Guardians. One of these related to difficulties in meeting with the person raising a concern in an environment they felt was confidential enough. The other related to the outcome of the concern which the person felt the Guardian should have been able to overturn a management decision taken in line with Trust policy.

The F2SUG's are an active member of the Northwest Regional F2SU Guardians network. This work helps to standardise Guardians works across a wider footprint and to create a support structure for Guardians to enable training, learning, and debriefing after difficult cases.

One of The Freedom to Speak up Guardian continues to be heavily involved in the Fair and Just culture project within the Trust and is a certified manager in this methodology. The project has essential links in with the aims and ambitions of the nation Guardian program.

The F2SUG's continue to monitor training, policies and processes undertaken by the Guardians to ensure any national changes are implemented where appropriate.

The National Guardians office continues to undertake case reviews within NHS Trusts and make recommendations for improvement where they see for. These reports are then shared with the F2SUG's. They are then used within LWH for self-reflection and review of any areas of learning.

Training Compliance

The online national Freedom to Speak Up training program is utilised at LWH. The national training program, developed in association with Health Education England, consists of 3 modules:

- **"Speak Up"**

This is core training for all workers and covers what speaking up is, why it matters and it helps staff understand what they can expect from speaking up

- **"Listen Up"**

This is for Managers at all levels and focuses on listening to concerns and understanding the barriers to speaking up. This should be completed in conjunction with Speak Up as to ensure they understand what speaking up is and how they should respond when someone speaks up to them.

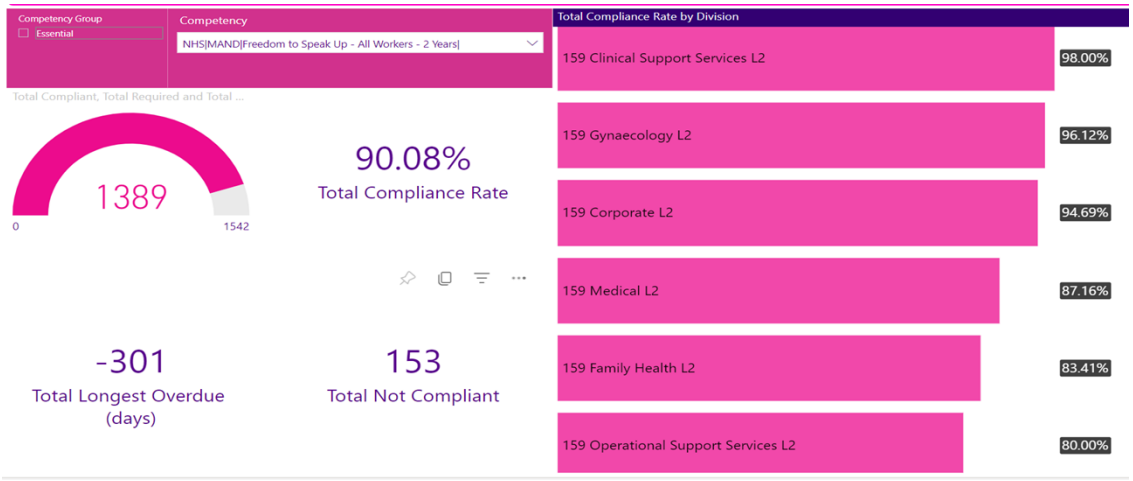
- **"Follow Up"**

For senior leaders, including executive and Non-Executive Directors, lay members and governors. This final module, Follow Up, for senior leaders – including executive and Non-Executive Directors, lay members and governors – will be launched later this year. Senior leaders will be expected to complete all three modules, Speak Up, Listen Up and Follow Up to ensure they have a full understanding of the speaking up process.

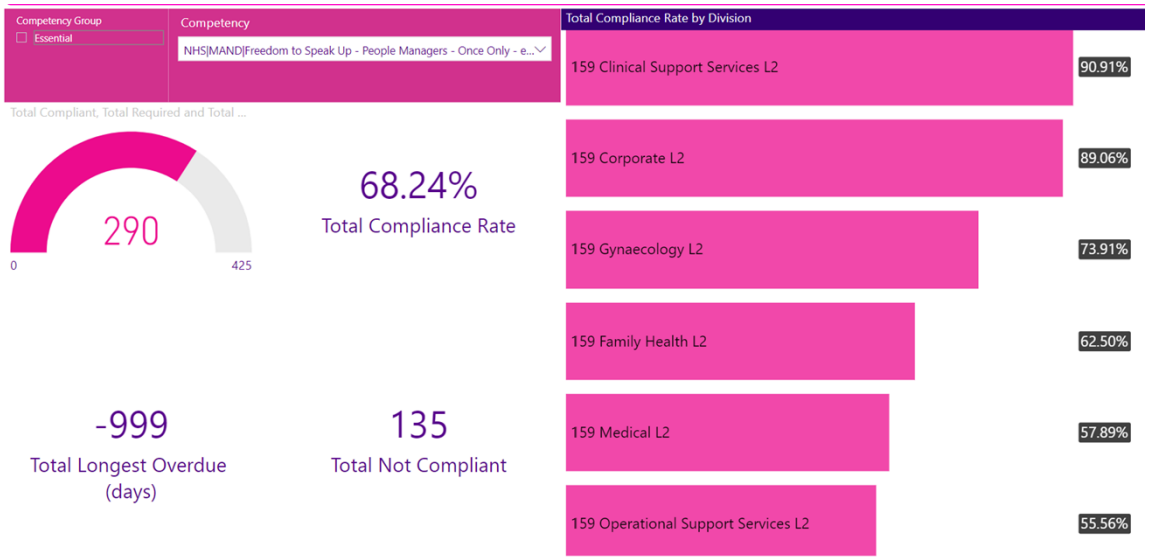
At LWH we currently have the "Speak Up" module and the "Listen Up" module live for our staff, and it is classed as essential training for the identified workforce groups. The "Follow Up" module for senior leaders is due to be launched at LWH during 2023/24.

The compliance numbers for the training are monitored and reported through the Putting People First (PPF) committee. The compliance figures at the end of 2022/23 were:

Speak Up Module – All workers



Listen Up Module – People Managers



2.4. Freedom to Speak Up - Vision and Strategy - 2021-2024

The Trust Freedom to Speak to Speak Up Strategy was launched in September 2021 with the aim of when things go wrong, we need to make sure that lessons are learnt, and improvements made. If we think that something is wrong, it is important that we feel able to speak up so that potential harm is avoided.

Even when things are going well, but could be made better, we should feel able to say something and should expect that what we say is listened to and used as an opportunity for improvement.

Our Board and senior leadership team support this vision by:

- Actively championing Speaking Up
- Providing timely and easy access to the Senior Independent Director when requested
- Ensuring all methods of raising concerns are promoted seeking innovative ways to make speaking up accessible to all staff at all times
- Raising the profile and visible leadership of Freedom to Speak Up
- Modelling the behaviours to promote a positive culture in the organisation

- Providing the time and resources required to deliver an effective Freedom to Speak Up function
- Seeking assurance from Guardians across a range of indicators about the underlying culture in relation to speaking up across the Trust
- Utilise data effectively including triangulation of Speak Up data with quality and engagement metrics
- Ensuring the policy and procedures are being effectively implemented
- Leading the development of a Fair and Just Culture with LWH
- Ensuring that F2SUGs have access to all the information they require (maintaining confidentiality) to adequately assess and understand the cultural drivers in relation to speaking up
- Providing learning to support leaders to recognise and utilise the potential for speaking up to drive improvement
- Provide access to training for all workers, including leaders, to promote a speak up, listen up, follow up culture
- Ensuring that those who speak up are supported, cared for and suffer no detriment.

The strategy contains an associated action plan to help achieve the goals set out. The action plan is actively monitored via the Putting People First (PPF) Committee.

2.5. Freedom to Speak up survey

To help us understand the staff views in relation to Freedom to Speak Up service and Guardians, we have continued to conduct Bi-annual temperature check surveys throughout the year. The aim of survey is to understand people's knowledge of Freedom to Speak up within the Trust and if they know how to contact the Freedom to Speak up guardians. It also purposefully asked if information is visible enough and if it has been seen across the Trust recently to support the promotional campaign started in September 2021. All surveys have full reports presented at the Putting People First Committee.

The timings for these surveys were altered in 2022/23 and they are now conducted in April and October each year. This has resulted in only one temperature check survey being conducted in 2022/23.

The notable results of the October 2022 survey were:

Positive responses compared to the previous survey:

- **96%** of respondents are aware we have Freedom to Speak up Guardians within the Trust – Up from 83%
- **92%** are aware of the role of the guardians and why they are there for them – up from 73%
- **88%** are aware of how to contact the Freedom to Speak up Guardians – up from 59%
- **76%** were comfortable contacting the Guardians with a concern – up from 63%
- **32 %** said F2SU information is NOT visible enough - Down from 62%
- **40%** saying they haven't seen any information displayed across the Trust in the last week. – Down from 60%

The response rate for this survey was lower than the previous survey so we have reviewed how the survey is promoted and initial results from the April 2023 version have already shown a notable increase in responses.

As part of the survey, respondents are asked to provide additional comments or thoughts on the freedom to speak up at Liverpool Women's. What has become clear from the comments in this recent survey is there continues to be a suspicion and a lack of trust relating to the confidentiality side of speaking up that needs to be focussed on for our work in 2023/24. These comments will be used to influence communication key messages over the next 12 months.

2.6. Actions completed from 2021/22 report

The following items which were listed as action for the coming year on the 2022/23 report have been completed:

- Launch of the new Trust Speak Up policy in Jan 2023 which reflects the best practice guidance produced by NHSE and the National Guardian Office.
- Freedom to Speak up cases are now included in Trust Integrated Governance reports
- Further representation on key staff support groups continues to be secured by the F2SUG's.
- Dual work undertaken with the Head of Staff Culture in analyzing the 2022 NHS staff survey results in line with HR absence and performance data

2.7. Actions for the Coming Year Ahead

The following actions are the priorities for the year ahead

- Specific work with the Maternity directorate, with Leaders and Staff to promote the Speak Up messages and ensure the staff are empowered to raise any concerns with their Leaders or the Guardians.
- Development of a Bi-annual Divisional Reports to raise the profile of speaking up at Divisional level.
- Create specific communication and development material to address the concerns within the workforce regarding the confidentiality of speaking up.
- Continue to develop ways to celebrate speaking up across the Trust
- Move towards completion of the Trust Speak up Strategy which is due to conclude in 2024.
- Development of a minimum Data set for reports to Board and PPF which will provide assurance about the Speaking up arrangements in the Trust
- Launch the "Follow Up" training module for Senior leaders and Directors.
- Continue to support the Fair and Just Culture work program within the Trust and embed its principles into all aspects of Trust business.
- Continue to work with Reginal and National Guardians to improve communication and standards of working and reporting of Concerns Raised.
- Continue to Work with the Divisional Leads to identify any trends and themes in concerns raised.

3. Conclusion

This paper demonstrates that the Trust is continuing its work to increase the reach and visibility of the freedom to speak up service. It demonstrates the continued feedback approach being adopted to ensure the service keeps pace with the needs of the staff in the organisation.

The report also provides information on the commitment the Trust is making to ensure all staff, managers, senior managers and Directors are provided with the knowledge and skills to make best use of the Speak Up philosophy. It also provides assurance that any concerns that have been raised have been dealt with appropriately.

This paper provides a retrospective overview of the speaking up process at LWH but there will be undoubtedly extensive learning which will emerge from the Letby case to increase the scrutiny of organisational culture by Boards and at LWH we will have the opportunity to reflect on how we increase openness and transparency at all levels of the organisation.

4. Recommendation(s)

The Board is asked to review the report and to

- take assurance that there are robust processes in place to support the raising of concerns and to support the Guardians in their work
- note the areas of focus for 2023/24 and the ongoing training and leadership activities
- ask the Putting People First Committee to undertake a full review of the current speak up arrangements and the underpinning cultural programmes of work to support that; with a specific focus on the approaches and mechanisms in place to support those members of staff who may have cultural barriers to speaking up.
- Approve the 2022/23 annual report

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

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The GMC Survey report had recently been released. The feedback demonstrated worsening responses from Obstetrics, Gynaecology and Neonates, and some improvement within Anaesthetics. A Task and Finish Group had been instigated to review the results at pace. This work would be incorporated into the Medical Workforce Project (Strategy) work already underway. • The Corporate Services Workforce Assurance Report identified issues of retention particularly within the Finance Department and the impact of pausing recruitment on the corporate workforce. • Industrial action planning continues for the forthcoming strike of junior doctors from 13-18 July 2023 and the consultant strike on 20 & 21 July 2023. Services would operate as a minimum Christmas Day level of cover. • The Committee noted a worsening trend of sickness rates within Gynaecology. It was noted that monthly oversight meetings had been introduced. The Committee recommended increased focus within the Gynaecology division to improve the position.	• Received an overview and key themes from the recently published NHS Long Term Workforce Plan and noted the implications for the Trust. The content of the Putting People First Strategy from 2024 onwards was currently being written and would align to the national workforce plans. • Noted that a Quality Improvement review would be undertaken into sickness rates and processes to evaluate the success, or opposite, of the various interventions in place. • Noted that the external funding for the Wellbeing Coaches was nearing the end of the 12-month agreement. Alternative funding arrangements was actively being sought. • Received the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) (annual statutory reports required from all NHS Trusts). Key findings and actions were noted to drive forward the ambition to be amongst the most inclusive NHS organisations, notably an aim to increase the diversity of senior leaders. The Committee discussed the data in relation to experiences of harassment, bullying or abuse of staff from a racially marginalised background and of staff with a disability or long-term condition and recommended a deep dive to better understand this information. • This Committee received an overview of the key themes and associated actions from the Big Conversation undertaken in April 2023. 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. The Committee asserted the importance of Executive and Non-Executive attendance to the Big Conversation events to ensure valuable engagement with staff.
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 the newly appointed Head of Safeguarding. She advised that she had felt quickly welcomed into the Trust and completed local and corporate inductions upon commencement. She had been supported by her team to apply for the substantive role which she had successfully been appointed to. She noted that the training videos from the Corporate Induction training would benefit from a refresh as had become outdated. It was reflected that work placements at other trusts would benefit staff that have worked at this Trust for a significantly long period. (WELL LED) • The Committee noted demonstrable and positive improvements made within Family Health to improve compliance against their workforce metrics. Encouraging implementation of the revised attendance policy supported by HR colleagues was noted. (WELL LED)	• The Committee endorsed the content of the Whistleblowing/ Freedom to Speak up Annual Report 2022/23 ahead of submission to the Trust Board.

• The Trust was in the top ten most improved in terms of the Freedom to Speak Up sub-score of the NHS Staff Survey 2022. This was recognised by the National Guardian for the NHS, Dr Jayne Chidgey-Clark, who has requested to visit the Trust to observe Trust practises and procedures. (WELL LED) • The Committee took assurance that disciplinary, grievance and dignity at work matters are dealt with appropriately by the Trust. The Committee considered the two lapses in professional registrations and the pressures of the current cost of living concern. A revision of narrative within the policy to reflect on nuances was noted. (WELL LED) • Took positive assurance that the Trust's Freedom to Speak Up, Raising Concerns & Whistleblowing Policy was appropriate and in place, and appropriately implemented to address whistleblowing cases submitted during 2022/23. (WELL LED) • The Committee took assurance from the Midwifery Red Flag update (a midwifery red flag event is a warning sign that something may be wrong with midwifery staffing) noting that the recommendations implemented had ensured more rigor in red flag reporting, validation and presenting themes and trends through Divisional Performance Reviews. (WELL LED)	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the PPF aligned BAF risks, noting no new or closed risks.
- The Committee suggested a narrative review of BAF Risk 1 to ensure that the junior doctor workforce risks were appropriately reflected.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Robust discussion
- The Committee commented that the content of all of the reports discussed had appropriately aligned to the BAF risks .

2. Summary Agenda

No.	Agenda Item	Purpose	Rating	No.	Agenda Item	Purpose	Rating
29	Board Assurance Framework (BAF): Workforce related risks	Assurance		36.	Analysis of Disciplinary, Grievance & Dignity at Work Cases Annual Review, 2022/23	Assurance	
30.	Staff Story - Corporate	Information		37.	Whistleblowing/ Freedom to Speak up Annual Report 2022/23	Assurance	
31.	Workforce Assurance Report: Corporate Services	Assurance		38.	Maternity Red Flag Deep Dive: 6-month review update	Assurance	
32.	Chief People Officer Report	Information		39.	Equality, Diversity and Inclusion including WDES/G WRES/ Bank WRES, MWRES 2023	Information	
33.	An overview of the NHS Long Term Workforce Plan and its implications for LWH Workforce Strategy	Assurance		40.	Review of Culture and Staff Engagement at LWH	Information	
34.	Workforce KPI Dashboard Report	Assurance		41.	Sub Committee Chair Reports & Terms of Reference	Assurance	
35.	Audit and Sickness Report Update	Information		43.			

3. 2023 / 24 Attendance Matrix

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

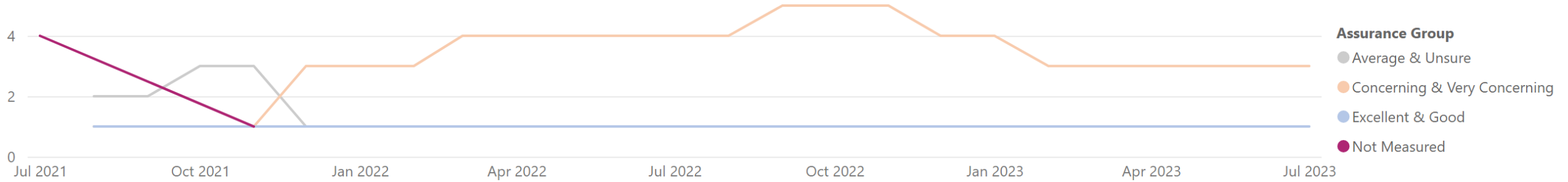
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) Non-Member (NM) *Non-quorate meetings highlighted in greyscale*

Liverpool Women's
NHS Foundation Trust

Trust Board

Workforce Performance Report
August 2023

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

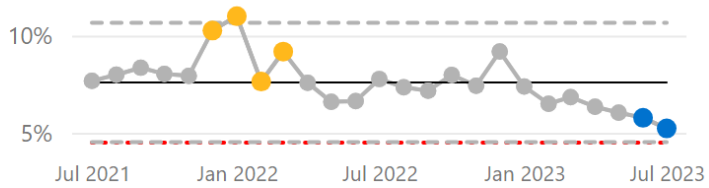


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Turnover Rate	Excellent	July 2023	<= 13%	<=	9.38%	P	L	
Clinical Mandatory Training Compliance	Concerning	July 2023	>= 95%	>=	87.37%	F	H	
Mandatory Training Compliance	Concerning	July 2023	>= 95%	>=	93.85%	F	H	
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Concerning	January 2023	>= 80%	>=	41.54%	F		
Sickness Absence Rate	Concerning	July 2023	<= 4.5%	<=	5.23%	F	L	

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

Sickness - Chief People Officer

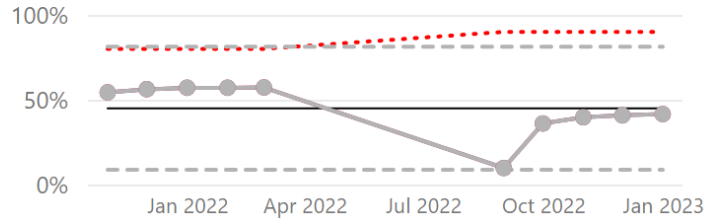
Assurance Category	Concerning
Date	July 2023
Target	<= 4.5%
Target < or >	<=
Performance	5.23%
Assurance	F
Variation	L



Sickness fell by 0.54% in Jul, going down to 5.23%. At a divisional level, it fell in the Family Health (0.10%), Gynaecology division by (1.87%) and Corporate divisions (0.86%) but increased in Clinical Support Services by (0.02%). Gynaecology, Neonatal and Maternity all saw decreases in their sickness within July. COVID sickness has decreased to 0.14%. While Gastrointestinal problems is now the highest reason for absence in the Trust. Sickness absence is reviewed on a weekly basis by divisi

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

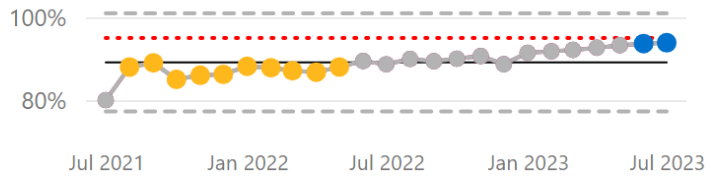
Assurance Category	Concerning
Date	January 2023
Target	>= 80%
Target < or >	>=
Performance	41.54%
Assurance	F
Variation	



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

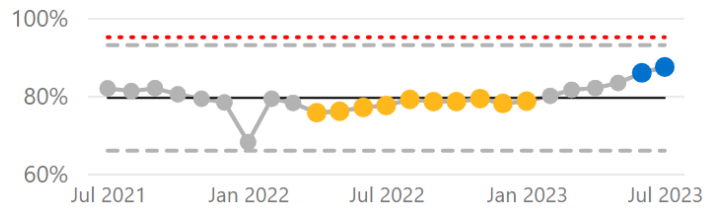
Assurance Category	Concerning
Date	July 2023
Target	>= 95%
Target < or >	>=
Performance	93.85%
Assurance	F
Variation	H



Compliance increased by 0.19% up to 93.85%, which is now just 1.15% 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 91.06% 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	July 2023
Target	>= 95%
Target < or >	>=
Performance	87.37%
Assurance	F
Variation	H



Compliance increased by 1.50%, giving a Trust-wide figure of 87.37%. While there were increases in Clinical Support Services by (1.20%) and Gynae by (1.08%), there where decreases in both Family Health by (10.83%) and Corporate by (0.84%). 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.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/136c***	**Date: 14/09/2023**
Report Title	**WDES, WRES, Bank WRES, MWRES Report 2023**	
Prepared by	Lisa Shoko, Equality, Diversity and Inclusion Manager	
Presented by	Lisa Shoko, Equality, Diversity and Inclusion Manager	
Key Issues / Messages	The Trust is statutorily required to report the Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES). This paper: • Demonstrates the Trust's current position in relation to the EDI strategic ambitions outlined within the Trust Strategy • Presents the annual data pertaining to the Workforce Race Equality Standard (WRES), Medical WRES, Bank WRES and Workforce Disability Standard (WDES) • Sets out the current EDI resources and priority actions proposed for the next 12 months in response to the data	

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 Trust Board is asked to note the contents of the report, be assured that appropriate actions are being taken, and support the ongoing work on the ED&I agenda. This report is required to be approved by the Trust Board as compliant and authorised for publication on the Trust website to fulfil the National requirements for WDES and WRES.			
Supporting Executive:	**Michelle Turner, Chief People Officer**			

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

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

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1 – Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
ED&I Sub-Committee			

EXECUTIVE SUMMARY

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are annual statutory reports required from all NHS Trusts which collate a pre-prescribed set of data in relation to race and disability within the NHS workforce. In 2023 there are two new reports that have been added, these are the Bank WRES and the Medical WRES. LWH is not required to complete a full Bank WRES report as we do not employ sufficient staff to complete this, the National WRES team have confirmed that our bank staff will be covered by the National Bank WRES report completed by NHS Professionals (NHSP).

The WRES and WDES data is collated as of 31st March 2023 for all data with the exception of data taken from the 2022 National Staff Survey. We are statutorily required to report and publish this data and action plans, however the Board are asked to recognise that these are one set of metrics measuring wider inclusion activities.

This paper demonstrates the Trust's current position in relation to the ED&I strategic ambitions outlined within the Trust Strategy, presents the annual data pertaining to the Workforce Race Equality Standard (WRES) and the Workforce Disability Standard (WDES) and sets out the priority actions for the next 12 months.

The WRES data is measured against the following metrics:

- Band distribution of clinical and non-clinical staff – minor improvement in position from previous year.
- Board member and non-Executive Director data – improvement in position from previous year.
- Likelihood of being appointed from interview – decrease in position from previous year.

- Likelihood of entering formal disciplinary process – minor decrease in position from previous year however same number of white staff also entering formal process.
- Number of staff experiencing harassment, bullying or abuse from staff – improvement in position from previous year.
- Equal opportunities for career progression – improvement in position from previous year.

In addition to the required National metrics this paper also considers the rolling headcount of leavers from racially marginalised backgrounds, data disclosure of race within the Trust and LWH scoring as one of the top NHS organisations in a number of factors for the previous year WRES report.

The WDES data is measured against the following metrics:

- Band distribution - minor improvement in position from previous year.
- Likelihood of being appointed from interview – decrease in position from previous year. Although the actual number of candidates disclosing a disability recruited has increased in year.
- Likelihood of entering formal capability process – decrease in position from previous year.
- Number of staff experiencing harassment, bullying or abuse from staff – significant decrease in position from previous year.
- Equal opportunities for career progression – improvement in position from previous year.

In addition to the required National metrics this paper also considers the rate of data disclosure of disabilities within the Trust.

Section 2 of this paper provides more details of these results and section 3 of this paper outlines the actions proposed in response, which will be monitored at the Equality, Diversity and Inclusion Committee meetings.

The Trust Board is asked to note the contents of the report, be assured that appropriate actions are being taken, and support the ongoing work on the ED&I agenda.

This report is required to be approved by the Trust Board as compliant and authorised for publication on the Trust website to fulfil the National requirements for WDES and WRES.

MAIN REPORT

Define the issue

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are annual statutory reports required from all NHS Trusts which collate a pre-prescribed set of data in relation to race and disability within the NHS workforce.

The WRES and WDES data is collated as of 31st March 2023 for all data with the exception of data taken from the 2023 National Staff Survey. In 2023 there will be two new reports, Bank WRES and Medical WRES (MWRES). LWH Bank staff will be reported nationally by the NHS Professionals (NHSP) WRES Report and LWH are required to only report on disciplinary reporting for Bank staff. MWRES template has not been circulated by the national WRES team at the time of writing this report and will therefore follow at future meetings as a separate report.

The WRES and WDES data referenced in this paper illustrate the progress over the past 12 months to strengthen ED&I within the organisation and strategic ambitions outlined in **Our Strategy 2021-2025** to:

Be recognised as among the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)

- Corporate Objectives 2021/22 stated that we would **treble the number of staff from racially minoritized backgrounds in leadership roles (Band 7 and above) by 2022**. Whilst we have not achieved this goal, between April 2020 and April 2022, staff in post increased from 16 to 25. We have modified the original corporate objective to increase by 10 leadership roles each year until we reach 25% of our leadership workforce being from a racially minoritized background.

- Corporate Objectives 2021/22 stated **we will ensure our workforce matches the ward of Riverside in terms of % of staff from racially minoritized backgrounds by 2025**. Riverside ethnicity as detailed in a CCG report 2018 states *23.4% of the population are not white British/Irish, the fourth highest level in the city and 4.4% are 'other ethnic group (including Arab)' ethnicity*. We are currently at 9.5% of our workforce being from a racially minoritized background, therefore we will work in partnership with health, education, local authority and community partners to increase the number of employees from a racially minoritized background by 5% year on year to ensure we achieve Riverside representation by 2025.

Other achievements for ED&I have been outlined within the Annual ED&I report which is saved on the Trust Website.

Key Findings

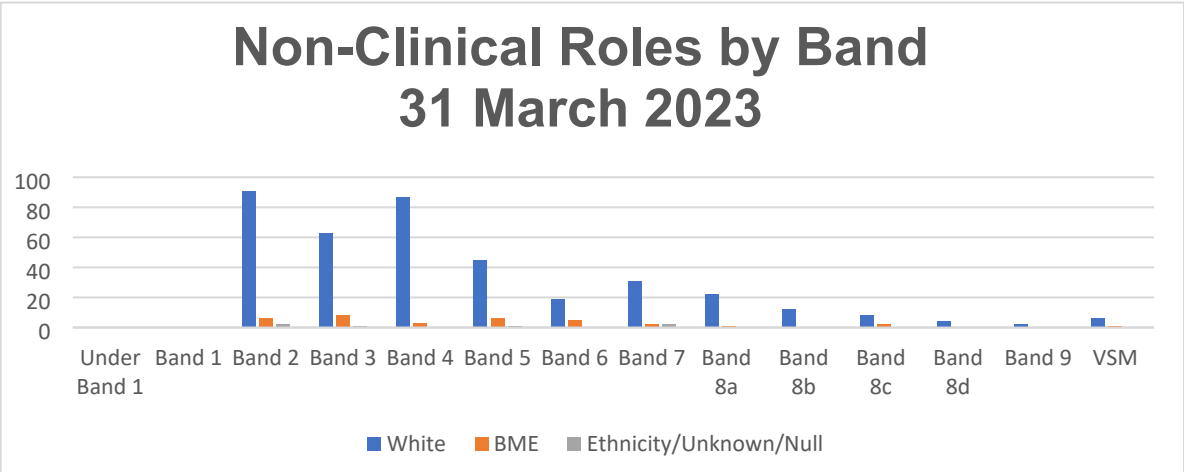
WRES data 2023

Band distribution of clinical and non-clinical staff – minor improvement in position from previous year.

There are twenty-six staff from Agenda for Change pay scales who have not disclosed on ethnicity within ESR, this includes one person at clincial band 8A and one person at clinical Band 8B. There are four staff from medical grades who have not disclosed their race within ESR.

The table below outlines the Non-Clinical Grades by ethnicity.

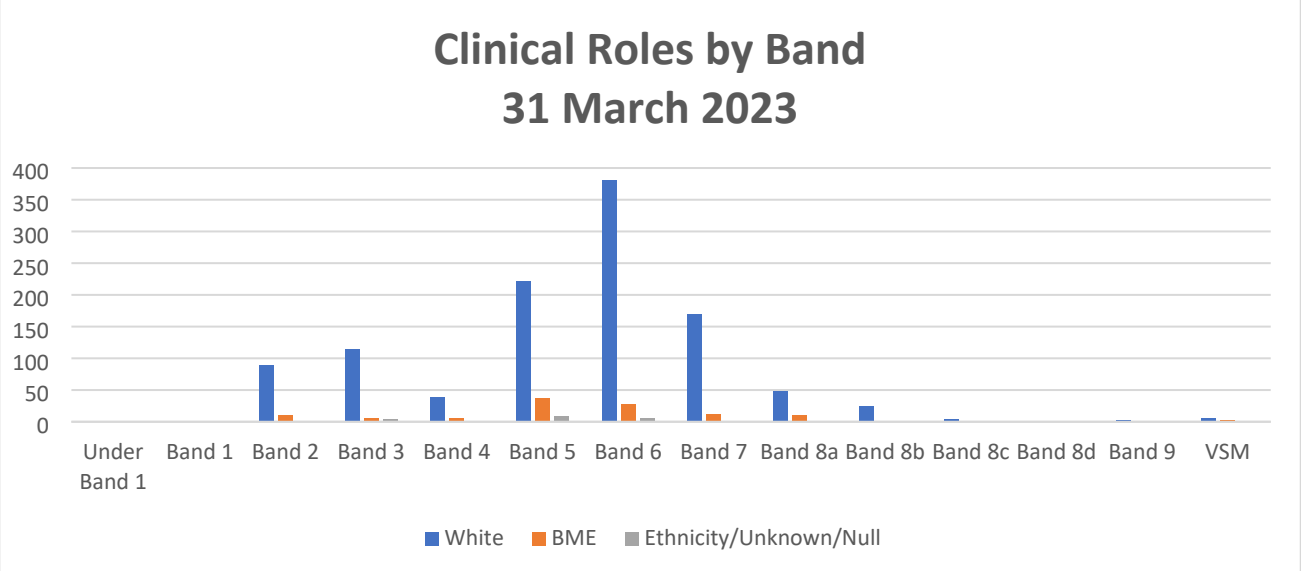
Overall, there has been **an improvement of non-clinical staff at band 7 and above** who are racially marginalised. Band 7 and above there were four people from a racially marginalised background, whereas in 2023 this has **increased to six people**.



There were previously no staff from racially marginalised backgrounds at VSM level however in 2023 this has increased to one. There are no Band 9 and Band 8D's from racially marginalised backgrounds, same as in 2022. There has been an improvement at Band 8C increasing in 2023 from one person from racially marginalised background to two. There are no Band 8B's from racially marginalised backgrounds, same as in 2022. Previously there were two band 8A's and in 2023 this has reduced to one. In 2023 the number of Band 7's from racially marginalised backgrounds has increased to two, previously in 2022 there was one.

The table below outlines the Clinical Grades by ethnicity.

Overall, for **Clinical roles (excludes medics),** band distribution has not changed with **the majority of racially marginalised staff hold clinical Band 5 and Band 6 posts**. Band 7 and above there were eighteen people from a racially marginalised background, whereas in 2023 this has **increased to twenty six people**.

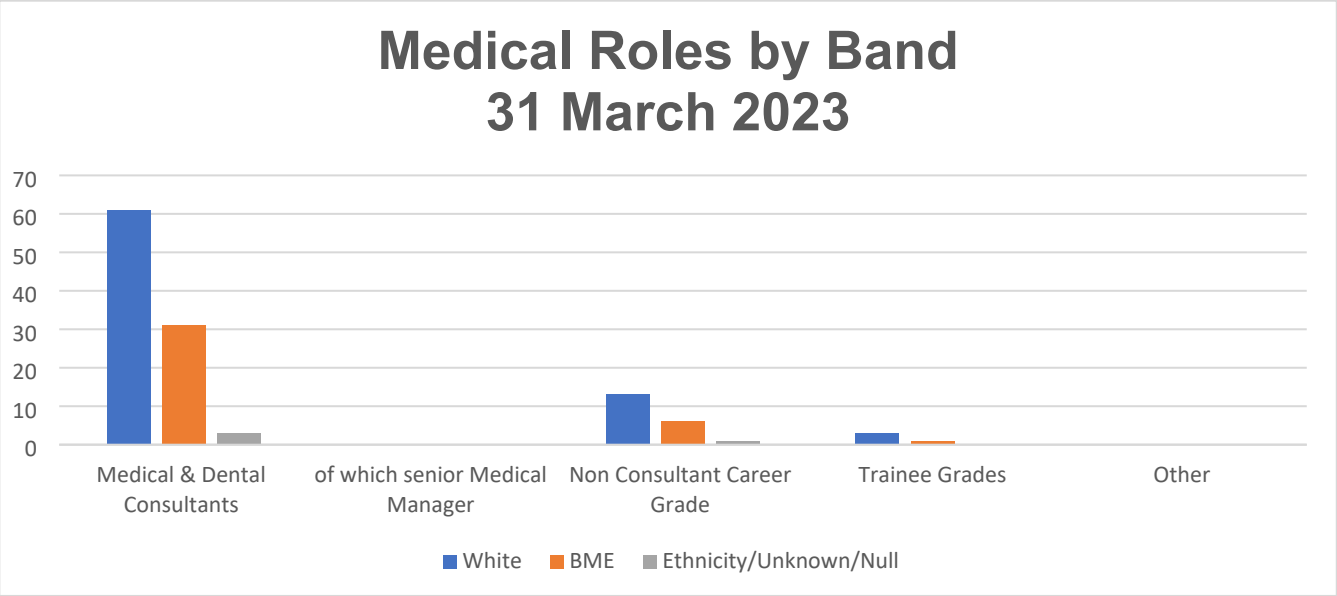


The highest banded clinical role (excluding medics) has improved, there are now 2 VSMs recorded in clinical roles, in 2022 there were none*. There are no Band 9 staff from a racially marginalised background, same as in 2022. The number of racially marginalised staff at Band 8D remains static from 2022 at one. As was the case in 2022, there are no racially marginalized staff at bands 8C and 8B in 2023. There has been an increase at Band 8A's from racially marginalised backgrounds, increasing from nine in 2022 to eleven staff in 2023, with a similar increase at Band 7, increasing from eight in 2022 to twelve in 2023.

**data is being checked in relation to Clinical VSM roles at the time this report was written.*

The table below outlines the Medical Grades by ethnicity.

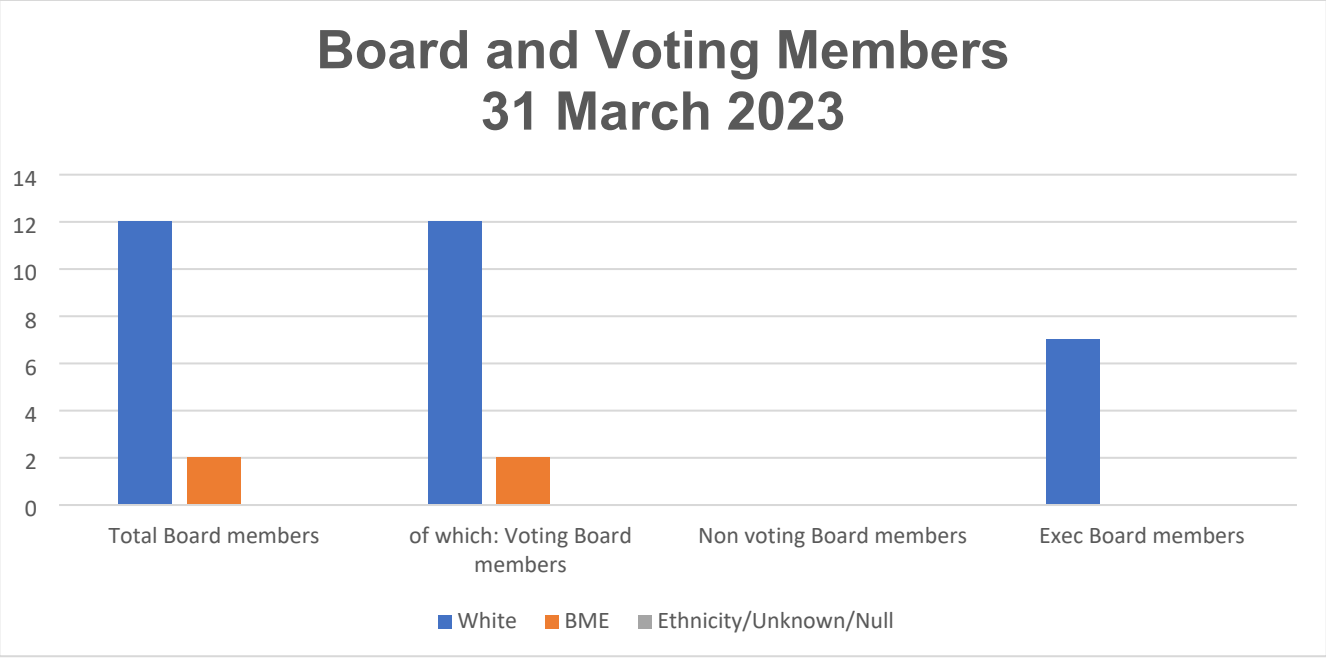
Medical staff figures remain have seen a slight increase of staff from racially marginalised backgrounds, this has increased by three from 2022 to thirty eight in 2023.



The number of Consultants from a racially marignalised background has increase in 2023 to thirty one, whereas in 2022 this was twenty seven. Non-Consultant Career Grades remains static at six people from racially marginalised backgrounds. Trainee grades has reduced in 2023 from two to one staff from a racially marginslised background.

Board member and non-Executive Director data – improvement in position from previous year.

Board member and non-Executive Director data for racially marginalised staff has **reduced from 2022 by one**, in 2023 **there are two Board members from a racially marginalised background**.



In 2022 there was one member of the Board who had not disclosed their ethnicity within ESR, in 2023 all Board members had disclosed their ethnicity. As in 2022, there are seven Executive Board members and all are white, there are no racially marginalised Executive Directors in the Trust.

Likelihood of being appointed from interview – decrease in position from previous year.

Relative likelihood of being appointed from interview if an applicant is of racially marginalised background has **reduced from 46.15% to 31.64% in 2023**. In 2022 the likelihood of racially minoritised candidates being appointed was higher than white candidates, however in 2023 this position has changed, and **it is lower than the likelihood of white candidates being appointed following shortlisting (39.11% in 2023)**.

There were 1778 staff in scope on 31 March 2023, this is an **increase of 193 people in post on 31 March 2023, compared to 31 March 2022**. At 31 March 2023, there were 1564 white staff and 184 racially marginalised staff recruited at LWH.

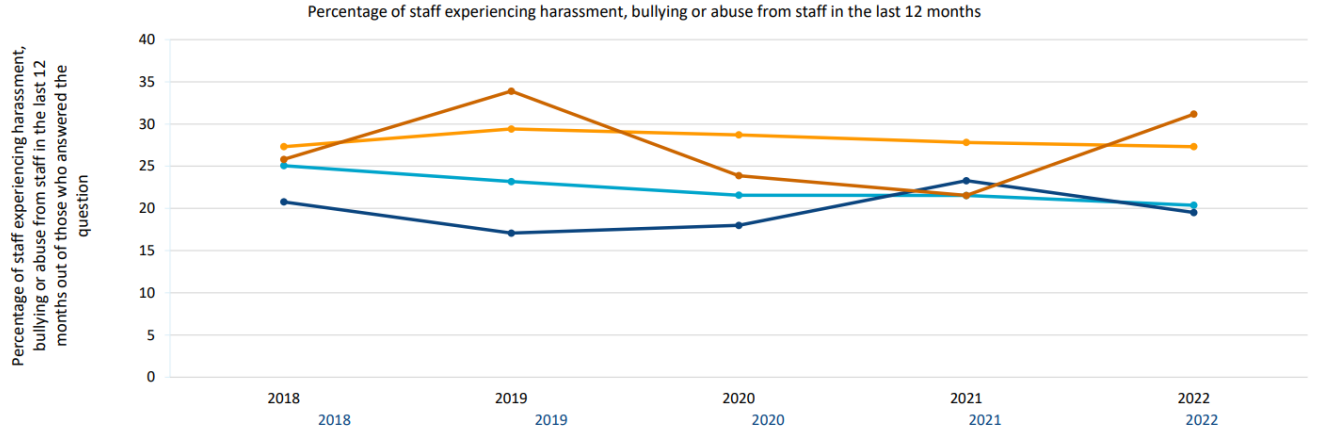
The Trust's overall staffing population of **racially marginalised groups has increased from 9.54% to 10.3% in year**, this is less than 0.7% lower than the overall Liverpool population (11%), although it is clear this is below the local reported average for the Riverside Ward (25%). The Trust has set an ambitious target to increase by 5% year on year until we reach the 25% target to match Riverside Ward.

Likelihood of entering formal disciplinary process – minor decrease in position from previous year.

In 2023/23 there were nine people enter the formal disciplinary process, of these four were from a racially marginalised background, an increase from 2022 (one). Of the overall racially minoritised workforce this is 2.17% entering a formal disciplinary process in 2022/23, compared to only 0.32% of white colleagues.

Number of staff experiencing harassment, bullying or abuse from staff – improvement in position from previous year.

There has been a **statistically significant increase in the number of staff from a racially marginalised background stating they have experienced harassment, bullying or abuse from staff**, this has increased from 21.5% (2021) to 31.2% (2022), compared to their white colleagues where there has been an improvement in year reporting at 19.5% (23.3% in 2021).



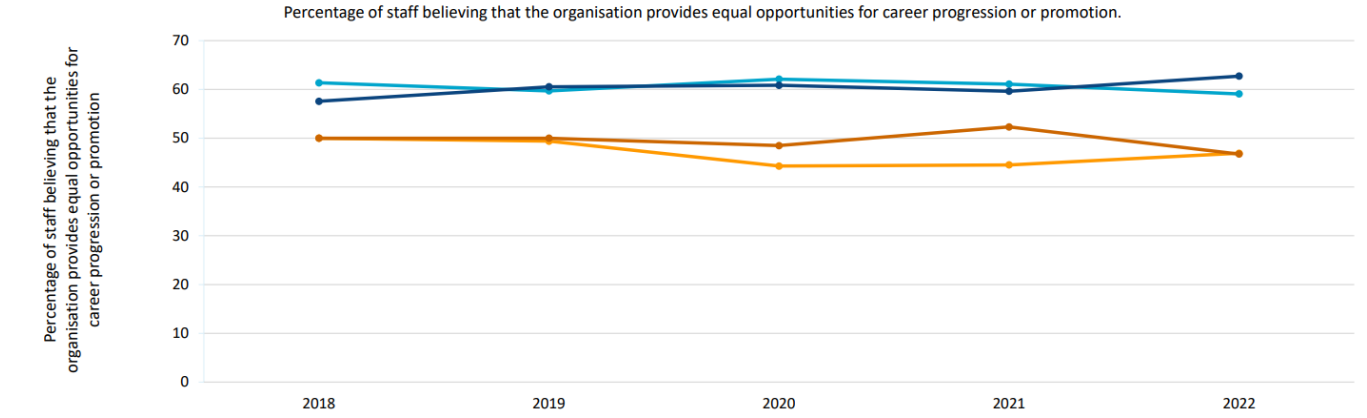
	2018	2019	2020	2021	2022
White staff: Your org	20.8%	17.1%	18.0%	23.3%	19.5%
All other ethnic groups*: Your org	25.8%	33.9%	23.9%	21.5%	31.2%
White staff: Average	25.1%	23.2%	21.6%	21.5%	20.4%
All other ethnic groups*: Average	27.3%	29.4%	28.7%	27.8%	27.3%
White staff: Responses	780	744	706	700	866
All other ethnic groups*: Responses	62	59	67	65	77

*Staff from all other ethnic groups combined

There has been a lot of work in 2022/23 engaging staff from racially marginalised backgrounds and enabling them to feel able to speak up and share their lived experiences, however there are not the same reports in numbers of staff approaching HR, Freedom to Speak Up Guardians or to EDI staff in relation to this, although there are more people sharing verbally through the Race Ethnicity and Cultural Heritage (REACH) Staff Network how it feels for them working at LWH.

Equal opportunities for career progression – improvement in position from previous year

There has been a **statistically significant decrease in the number of racially marginalised staff believing the Trust provides equal opportunities for career progression**, from 52.3% (2021) to 46.8% (2022), compared to 62.7% of white staff this year.



	2018	2019	2020	2021	2022
White staff: Your org	57.6%	60.5%	60.9%	59.6%	62.7%
All other ethnic groups*: Your org	50.0%	50.0%	48.5%	52.3%	46.8%
White staff: Average	61.4%	59.7%	62.1%	61.1%	59.1%
All other ethnic groups*: Average	50.0%	49.4%	44.3%	44.5%	46.9%
White staff: Responses	780	745	705	701	864
All other ethnic groups*: Responses	64	58	66	65	77

*Staff from all other ethnic groups combined

This was not an unexpected response, as during Black History Month the Vice Chair for REACH staff network reported similar findings. The PDR paperwork offers all staff a Career Conversation and in 2022 staff from a racially marginalised background were written to by the Deputy Director for Nursing to ensure these were offered.

Bank WRES

The Trust utilised bank staff from the NHS Professionals Bank, therefore they will be reporting the Bank WRES data, however the national ream asked that the Trust report on likelihood of entering into a formal disciplinary process. In 2022/23 there were no bank staff white or racially marginalised that entered into this process.

Medical WRES

At the time of writing this report the Medical WRES (MWRES) reporting template has not been circulated by the National WRES team, therefore the data in relation to this will be presented separately and inserted into this report for publication at a future date.

WDES Data 2022

Band distribution - improvement in position from previous year.

There are 180 staff from Agenda for Change pay scales who have not disclosed disability status on ESR (status unknown), **disability discourse rates have improved in year with 68 more people disclosing disability status and this is our second year in a row where we have seen an in improvement** in disability disclosures (285 in 2021 and 248 in 2022). **Disability disclosure rates for medical grades has also improved this year,** number for previously this had remained static at 20, whereas on 31 March 2023 this reduced to 15 people. There has been a **recent data disclosure exercise** completed by the Workforce Team and **education on what is classed as a disability under the Equality Act 2010** shared by the EDI leads. In addition to this we are **hearing more lived experience stories from staff with disabilities and long-term conditions, including some senior leaders**. All of these factors will have contributed to staff feeling safe and able to disclose disabilities and long-term conditions on ESR and therefore improving LWH disability data disclosure rates which many NHS Trusts struggle with.

In terms of band distribution for **non-clinical staff bands 2 report higher numbers** of staff disclosing disabilities and long term conditions, whereas for **clinical bands its band 6 that reports the highest numbers** of staff disclosing a disability or long term condition. **There has been an overall improvement from Band 7 and above in disclosure rates for disability and long-term conditions and an increase also in medical grades**. There are 9 staff disclosing having a disability or long-term condition at band 7 and above in non-clinical roles (previously was 8), and 5 staff disclosing having a disability or long term condition at band 7 and above in clinical roles (previously was 3). There are 3 staff disclosing having a disability or long-term medical condition from medical grades (previously none were reported).

Likelihood of being appointed from interview – improvement in position from previous year. Although the actual number of candidates disclosing a disability recruited has increased in year.

In terms of recruitment, **non-disabled candidates are 1.56 times more likely to be appointed from shortlisting stage than disabled candidates** compared to previous year where non-disabled candidates were 1.70 times more likely to be appointed. A figure below 1.00 indicates that disabled staff are more likely than non-disabled staff to be appointed from shortlisting, which demonstrates a slight positive improvement for the 2023 figure compared to 2022.

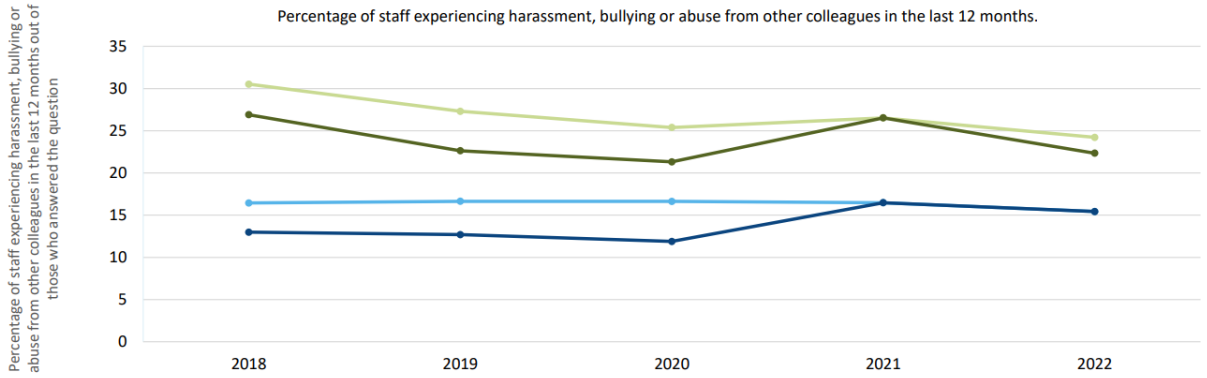
The figure for **appointment of candidates with a disability has increased from 20 to 30** in the period from 1 April 2022 – 31 March 2023. In addition, and the number of candidates disclosing a disability or long-term condition at shortlisting stage has significantly increased.

Likelihood of entering formal capability process – increase in position from previous year.

There were 4 staff entering formal capability process who had declared on ESR as having a disability which is a increase from previous year (zero in 2022), however it is important to note that there has been a data disclosure and educational piece and more people have disclosed disabilities on ESR in 2022/23 than ever before.

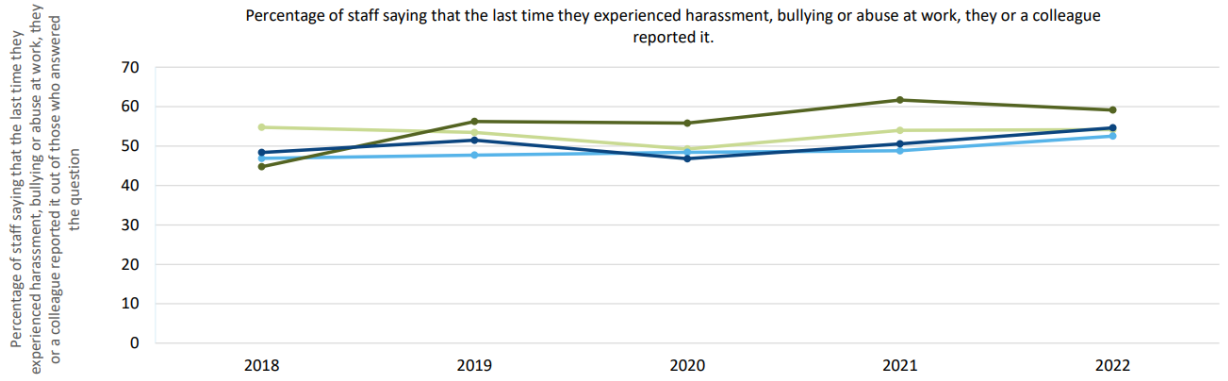
Number of staff experiencing harassment, bullying or abuse from staff – improvement in position from previous year.

The number of staff with a disability or long-term condition reporting they have experienced bullying, harassment or abuse in the workplace from other staff has **decreased in 2022 to 22.3% from 26.5% in 2021,** compared to non-disabled colleagues (15.4% in 2022). This is positive, however remains statistically significantly higher than non-disabled staff (nearly a 7% difference).



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	26.9%	22.6%	21.3%	26.5%	22.3%
Staff without a LTC or illness: Your org	13.0%	12.7%	11.9%	16.5%	15.4%
Staff with a LTC or illness: Average	30.5%	27.3%	25.4%	26.5%	24.2%
Staff without a LTC or illness: Average	16.4%	16.6%	16.6%	16.5%	15.4%
Staff with a LTC or illness: Responses	145	137	122	147	197
Staff without a LTC or illness: Responses	701	662	648	613	739

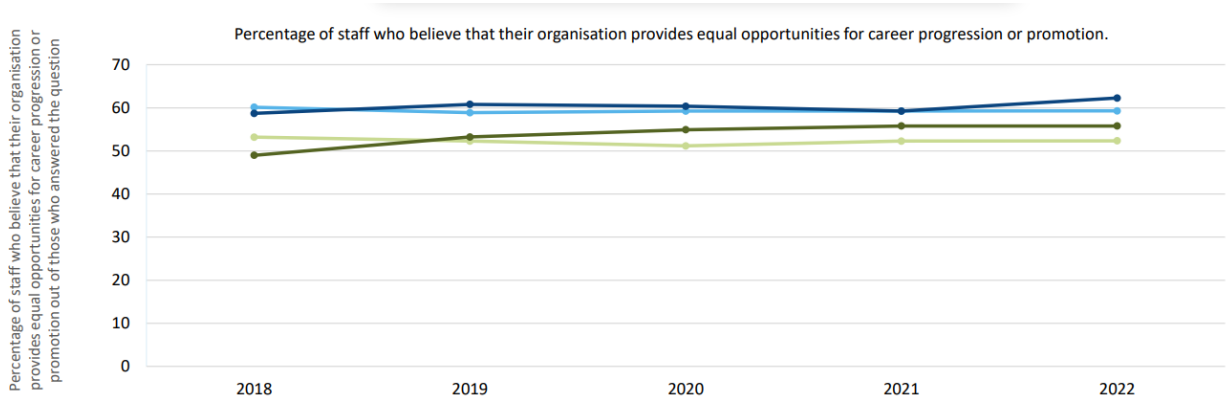
Although there was a statistically significant increase in **the number of disabled staff stated they would report bullying, harassment or abuse** between the 2020 and 2021 staff survey data collected (61.7% in 2021 and 55.8% in 2020), in the 2022 staff survey this **reduced to 59.2% meaning less staff with a disability and long-term condition reported bullying, harassment or abuse.** These figures are not comparable to those reported through HR, Freedom to Speak Up Guardians or to EDI staff, therefore demonstrating there is an improvement in reporting mechanisms required.



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	44.8%	56.3%	55.8%	61.7%	59.2%
Staff without a LTC or illness: Your org	48.4%	51.5%	46.8%	50.6%	54.6%
Staff with a LTC or illness: Average	54.8%	53.4%	49.3%	54.0%	54.2%
Staff without a LTC or illness: Average	46.9%	47.7%	48.4%	48.8%	52.5%
Staff with a LTC or illness: Responses	67	48	43	47	71
Staff without a LTC or illness: Responses	186	169	141	172	205

Equal opportunities for career progression – improvement in position from previous year.

Positively after a three-year increase in the staff with a disability reporting that the Trust provides equal opportunities for career progression, **this position was maintained in 2022**. This is reported at 55.8%, however this remains lower than non-disabled staff which is reported in 2022 as 62.3% which is an increase in year for non-disabled staff (59.3% in 2021).



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	49.0%	53.2%	54.9%	55.8%	55.8%
Staff without a LTC or illness: Your org	58.7%	60.8%	60.4%	59.3%	62.3%
Staff with a LTC or illness: Average	53.2%	52.3%	51.2%	52.3%	52.3%
Staff without a LTC or illness: Average	60.1%	58.9%	59.3%	59.3%	59.3%
Staff with a LTC or illness: Responses	149	139	122	147	199
Staff without a LTC or illness: Responses	700	666	651	616	745

Solutions / Actions

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

Planned actions over the next 12 months which go some way to address concerns raised in WRES and WDES 2023 data, as well as strengthen the overall ED&I agenda. The main focus will be in relation to:

1) Recruitment processes and how we advertise
2) Development of staff to support them to secure promoted roles when they arise
3) Retention of staff from Racially marginalised backgrounds and those with Disabilities and Long-Term conditions
4) Anti-racism statement and education for all staff

Specific actions include:

- We have an ambition to develop a number of volunteers to careers roles to support maternity services, with a view to supporting our strategic ambition to recruit from the Riverside population into these roles
- To support staff with mental health conditions we will bring counselling services in-house, this will sit within the Staff Support Service and enhance the support overall for the mental wellbeing of staff
- To further support staff with mental health conditions there will be a development programme for Mental Health First Aiders to ensure that they receive support and regular development from Consultant Psychologist, Assistant Psychologist and Health and Wellbeing Coaches
- Refresh the reciprocal mentoring programme, training all staff from REACH, DAWN and Pride@LWH staff networks and engaging them in the process matching with an Executive Director or Senior Leader to improve individual learning and organisational learning
- Train REACH, DAWN and Pride@LWH Staff Network colleagues to be Inclusive Panel members on interview panels
- Cascade the anti-racism statement and learning to all staff through a planned schedule for 2023 onwards
- There is ongoing work to improve the reporting of EDI risks through the risk register, particularly enabling a new, confidential and safe way of reporting incidents or concerns in relation to other staff or managers, which will have oversight by the EDI Committee
- There is ongoing work to develop a trauma informed care and support for staff who experience racism
- Whilst the data cleanse in the last year was successful with a third of staff completing and returning, in 2022/23 there will be a concerted effort to improve staff declarations rates even further
- Extension of e-learning package to design and deliver specific ED&I training and education to all staff – improved knowledge will result in benefits for better staff and patient experience
- Education and celebration of the key EDI events: Black History Month, Disability History Month, LGBT+ History Month and key faith observance days/festivals
- Exploration of how the Trust attracts local population to work at LWH, utilising widening participation programmes and alternative ways to advertise and promote our job opportunities
- Monitor the number of staff from racially minoritised backgrounds who attend the Liverpool Women's Leadership Development Programme to support their career development
- Monitor the use of the guaranteed interview scheme for racially minoritised groups and diverse interview panels
- Conduct an assessment of the physical environment to identify any barriers that may hinder accessibility for people with "protected characteristics". The organisation will then take necessary measures to remove those barriers, such as providing wheelchair ramps, installing lifts, improving lighting, and ensuring signage is clear and easy to understand.

Recommendations

The Trust Board is asked to note the contents of the report, be assured that appropriate actions are being taken, and support the ongoing work on the ED&I agenda.

This report is required to be approved by the Trust Board as compliant and authorised for publication on the Trust website to fulfil the National requirements for WDES and WRES.

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
26 July 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 took only partial assurance and noted the following matters from the operational performance report:
  ○ Cancer metrics: the 2-week target continued to be challenged with industrial action. The 62-day performance continued to be challenged by the significant size of the waiting list and the impact of 28-day diagnostic delays. Key actions towards improvements with diagnostics included increasing internal capacity for hysteroscopy and improved provision of services from Liverpool Clinical Laboratories.
  Timeliness and consistency of reported metrics for the period were inconsistent.
• The Committee noted the following key matters from the Finance performance report for Month 3 2023/24:
  ○ Whilst the Trust was reporting an overall net position of a £4,634k deficit which represents a £1k favourable variance to plan, the year-to-date break-even position was reliant on non-recurrent items. Significant concern in relation to the in-year position was raised and the Committee requested an acceleration of schemes to be considered. The Committee requested detailed financial recovery proposals, timescales and aspirations to be submitted to a future meeting.
  ○ Year to date impact of industrial action had been calculated based on actual activity. National teams had indicated that there would be no penalty for underperformance against activity targets for reasons relating to industrial action in Month 1.
  ○ Year to date capital spend reporting below plan. The Committee noted that the financial accountant meets regularly with capital budget holders to ensure spending plans in place.
	• Noted the programme of work underway by the Recovery Director, with a focus on the short-term financial position. Currently focussed on the Cost Improvement Programme and understanding behaviours of spending as two initial workstreams.
	• The Committee received the Performance Recovery Framework which provided an overview of the national Operational Planning priorities for 2023/24 and the Trust plan to recover performance targets in line with those priorities.
	• Noted a new workstream within DigiCare Meditech expanse programme to improve 'Community network links' to improve access to Trust digital systems in community locations.

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 positive assurances from the operational performance report: (ALL) ○ Urgent care targets: continued positive performance and the 4-hour Emergency Department target showed sustained improvement and performance in June 2023.	• The Committee approved the Finance and Procurement Strategy 2023 – 2026.

○ Maternity Assessment Unit (MAU) triage time: continued positive performance and target achieved in June 2023. The MAU triage time would change from 30 minutes to 15 minutes in July 2023 and compliance had been demonstrated. It was noted that additional resource was required to achieve the target. ○ 6-week routine diagnostic target: continued to show improvement against the new target with compliance recorded above 95%. This meets the requirements of NHS England's trajectory to achieve 95% by March 2025 • The Committee took assurance from the successful implementation of the digiCare Electronic Patient Record (EPR) Programme go-live. Significant effort, skill and commitment from many staff across the Trusts digital, clinical, nursing, midwifery and clinical support teams to ensure successful go-live of EPR. (ALL) • The Committee took assurance from the Post Implementation Review of Cost Improvement Programme (CIP) during 2022/23.	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the related BAF risks. No risks closed on the BAF for FPBD Committee.
- The Committee recommended the addition of 'action needed' to the key control section of the BAF report to improve the content of the report and to align to the recovery plan.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- All matters on the meeting agenda discussed fully, valuable contributions and quality of debate.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
70.	Review of BAF risks: FPBD related risks	Assurance	**74.**	Digital Services Update	Assurance
71.	Operational Performance Report Month 3, 2023/24	Assurance	**75.**	Post Implementation Review of Cost Improvement Programme (CIP)	Assurance
72.	Performance Recovery Framework	Information	**76.**	Finance and Procurement Strategy	Approval
73.	Finance Performance Report Month 3, 2023/24	Information	**77.**	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	✓	A	✓							
Jenny Hannon, Chief Finance Officer	✓	✓	✓	✓							
Kathryn Thomson, Chief Executive	✓	✓	A	A							

Gary Price, Chief Operations Officer	✓	A	✓	✓							
Dianne Brown, Chief Nurse	✓	✓	✓	A							
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
30 August 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:
  ○ Cancer 62-day PTL had been impacted by the new Patient Administration System go-live date in July 2023, which had required a reduction in capacity and activity to support implementation. In addition, the impact of further industrial action was resulting in it being increasingly difficult to cover capacity.
  ○ 28 Day Faster Diagnosis Standard: a significant increase of hysteroscopies undertaken during June 2023 compared to planned activity, and similar volumes of work planned for September to November 2023. The additional activity above the planned trajectory would require additional capacity.
• The Committee noted the following key matters from the Finance performance report for Month 4 2023/24:
  ○ the Trust is reporting an overall net position of a £6,443k deficit which represents a £530k adverse variance to plan. Key drivers for the variance remain the same: impact of industrial action; CIP underperformance; and performance against the pay reduction target.
  ○ cash balance (£1.3m at 31 July 2023) was below the minimum level set out in the Treasury Management policy and highlighted that the LWH Trust cash position was a significant outlier within the Cheshire & Merseyside system.
• Received the long-term financial recovery plan and noted to achieve the best-case scenario would be highly challenging and would require significant support and input from system partners to deliver strategic solutions.
	• Noted a review of Gynaecology Emergency Department (GED) was currently underway commissioned to assess recovery and efficiency of the service. Initial findings found change in demand since the service was originally commissioned of both volume and complexity of patients. The Committee agreed to delegate a Chair Action to the Quality Committee to receive the review and reflect on the patient quality and safety aspects of the report.
	• Received a progress update against the Financial Recovery programme of work. The Committee noted limited assurance, due to the early stage of delivery, whilst also noting the positive focus on implementing the appropriate processes, governance and controls.
	• Noted the grip and control initiative and new limitations in place on non-pay expenditure for staff who procure/order stock and supplies to support run-rate improvement.
	• The Committee received and discussed a briefing from the Hewitt Fertility Centre (HFC). The Committee supported the proposed approach by the Fertility service to progress with the proposal. A briefing paper will be submitted to Private Board in September 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**
• Committee received assurances that service provided by Liverpool Clinical Laboratories would improve and agreement reached to improve focus and rigour in relation to Trust oncology samples to accelerate turnaround and improve the 28-day performance position. (ALL) • The Committee had been positively assured by the proactive engagement of staff in the financial recovery process. (WELL LED)	• Chair action to the Quality Committee to receive the Gynaecology Emergency Department (GED) service review and reflect on patient safety in relation to the current commissioned service against service growth and patient complexity. • Recommend approval of the Long-term Financial Recovery Plan to the Trust Board.

Summary of BAF Review Discussion (Board Committee level only)
• BAF not discussed
Comments on Effectiveness of the Meeting / Application of QI Methodology
• All matters on the meeting agenda discussed fully, valuable contributions and quality of debate.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
86.	Operational Performance Report Month 4 2023/24	Information	89.	Long term Financial Recovery Plan	Approval
87.	Finance Performance Report Month 4, 2023/24	Information	90.	Fertility Service Briefing	Information
88.	Financial Recovery	Assurance			

3. 2023 / 24 Attendance Matrix

Core members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Louise Martin, Non-Executive Director (Chair)	✓	✓	✓	✓	✓							
Tracy Ellery, Non-Executive Director	✓	✓	✓	✓	A							
Sarah Walker, Non-Executive Director	A	✓	A	✓	A							
Jenny Hannon, Chief Finance Officer	✓	✓	✓	✓	A							
Kathryn Thomson, Chief Executive	✓	✓	A	A	✓							
Gary Price, Chief Operations Officer	✓	A	✓	✓	✓							
Dianne Brown, Chief Nurse	✓	✓	✓	A	✓							
Matt Connor, Chief Information Officer	✓	✓	✓	✓	A							
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) *Non-quorate meetings highlighted in greyscale*												

Audit Committee Chair's Highlight Report to Trust Board
20 July 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 continued improvements were required regarding the timely close down of internal/external audit recommendations and also in the setting of realistic and deliverable timescales. It was confirmed that increased rigour had been implemented regarding Executive sign off for deadline extensions. • The External Auditor presented the Auditor's Annual Report for the year ended 31 March 2023 which included the Value for Money (VfM) assessment that had not been available at the June 2023 Audit Committee meeting. The external auditor had recorded a significant weakness in arrangements related to deliverability of the financial plan to avoid further cash support. The external auditor did, however, acknowledge the Trust's view that the key drivers of this were outside of the Trust's control and that work continued with system partners to find sustainable solutions. It was also noted that internal grip and control processes had been implemented. An improvement recommendation had been raised by the external auditor that was accepted by Trust management.	• The Committee noted the role that the Trust's assurance committees had in appraising themselves of key internal audit outcomes and gaining assurance that the requisite improvements were being made. • The Committee received an update on the work that had been undertaken to improve the maturity of the Trust's divisional governance arrangements. It was noted that a key finding to date was the amount of duplication between both performance management and assurance meetings that was creating inefficiencies. This work was being progressed by the Corporate Governance team.
Positive Assurances to Provide	**Decisions Made**

• Two internal audit reports were received:
  ○ 2022/23 Recovery Plan (Substantial assurance level)
  ○ 2023/24 Data Security & Protection Toolkit (substantial/moderate assurance level) – n.b. there are two elements to the review – the moderate assurance related to improvements required for medical device management. An EPMA audit is scheduled in the 2023/24 internal audit plan.
• The Committee received an update relating to Anti-Fraud. The Counter Fraud Functional Standard Return (CFFSR) submission against the national counter fraud, bribery and corruption standards (known as the Government Functional Standard 013 for Counter Fraud) was submitted on the 31.05.23, in line with the national deadline. The Trust received a green rating overall and across all 12 component which comprise the CFFSR.
• The Committee noted the continued grip and control in relation to the limited the use of tender waivers. The Committee sought assurance that standards would be maintained following the departure of the Assoc. Director of Procurement. It was noted that current processes and templates utilised were in place across the system and that these would be maintained.
	• The Committee reviewed an updated Corporate Governance Manual and recommended approval to the Board. A key element discussed was the threshold for non-pay expenditure and contracting which was currently an outlier across the system (lower than comparators - £5k). The Committee agreed that this threshold should be retained considering the organisation wide aim for increased grip and control on expenditure.

• It was noted that there had been increased reporting to the Freedom to Speak Up Guardians. The Trust had been recognised as one of the top 10 most improved trusts in this area. • The Committee noted the bi-annual update of the external inspections and accreditations register.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- The VfM lead for the external auditor commented that the meeting had bene effective and each attendee provided an opportunity to speak and be heard.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
023	Follow up of Internal Audit and External Audit Recommendations	To receive and review an update of actions taken.	028	Management of External Visits, Inspections & Accreditations	To receive update
024	MIAA Internal Audit Reports a) Internal Audit Progress Report b) Follow Up of Audit Recommendations Report c) Anti-Fraud Progress Report 2023/24 Insight d) Insight Update	To note the contents and any recommendations from the report.	029	Divisional Governance Improvement	To receive update
025	Auditor's Annual Report for the year ended 31 March 2023	To receive update	030	Corporate Governance Manual review	To receive and note amendments to the Corporate Governance Manual
026	Waiver Report – Q4 Financial Year 2022/23; Q1 Financial Year 2023/24 and summary 2022/23	The Committee is asked to note the Register of Waivers and receive assurance that contracts requiring a waiver are managed appropriately within the Trust's SFI's	031	Chairs reports of the Board Committees a) Finance, Performance and Business Development Committee b) Quality Committee c) Putting People First Committee d) Charitable Funds Committee	Review of Chair's Reports for overarching assurance.
027	Whistleblowing / Freedom to Speak up Annual Report	The committee is asked to accept the assurance provided by this report	032	Board Assurance Framework (BAF)	To receive assurance on the process being undertaken to assess assurances regarding the Strategic Risks

					impacting on the Trust's strategic objectives

3. 2023 / 24 Attendance Matrix

Core members	June	July	October	January	March
Tracy Ellery	✓	A			
Zia Chaudhry	✓	✓			
Jackie Bird	A	✓			

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**23/24/137c**		**Date: 14/09/2023**	
Report Title	**Finance Performance Month 4 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 note the Month 4 financial position.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☒**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – If no – please outline the reasons for deviation.			
	The Board is asked to note the Month 4 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	30/08/23	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 4 the Trust is reporting a £6,443k deficit which represents a £530k adverse variance to plan. This position is supported by £2.6m of non-recurrent items. The forecast outturn is £15,450k deficit, in line with the submitted plan.

CIP is behind the YTD target by £129k. The Trust has a full year target of £8.3m and is focussed on rapid recovery to deliver robust, recurrent savings both in year and in the long term.

The cash balance was £1.3m at the end of Month 4. The average cash balance through the month was £9m.

MAIN REPORT

1. Summary Financial Position

	Plan	Actual	Variance	RAG	R	A	G
Surplus/(Deficit) YTD	-£5.9m	-£6.4m	-£0.5m	6	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast	-£15.5m	-£15.5m	£0.0m	1	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	1	*4*	*3*	*2+*
Cash	£6.0m	£1.3m	-£4.7m	6	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£1.8m	£1.7m	-£0.1m	6	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£1.8m	£1.4m	-£0.4m	6	*>10% off plan*	*Plan*	*Plan or better*
Aligned Payment Incentive	106%	111%	5%	5	*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£0.4m	£2.3m	£1.9m	5	*>£0*		*<£0*
Capital Spend YTD	£2.4m	£1.8m	-£0.6m	6	*>10% off plan*	*Plan*	*Plan or better*

At Month 4 the Trust is reporting a £6,443k deficit, which represents a £530k adverse variance to plan year to date (YTD). This is supported by £2,591k of non-recurrent items. The forecast outturn is £15,450k deficit, which is in line with the submitted plan.

2. Financial Recovery

Underlying Position
As noted above, the YTD position is supported by £2.6m of non-recurrent items. The adjusted position in Month 4 (following removal of key non-recurrent items) is a deficit of £9.0m, which represents an adverse variance of £3.1m against plan.

The key drivers of the underlying year to date position are:

- CIP and additional savings targets required to achieve financial position (£1.0m)

- Nursing, midwifery, and support staff pressures (£1.6m) across maternity, gynaecology, and theatres (in part related to costs of industrial action)
- Medical staffing (£0.3m); driven by Family Health and Gynaecology (£200k of which relates to industrial action)
- Estates (£0.2m); energy and facilities management costs
- Admin and clerical (£0.2m); cost pressures in corporate areas
- Other (net £0.2m benefit against plan).

Whole Time Equivalents (WTEs)

At Month 4 WTEs total 1,666, compared to 1,688 at Month 12 2022/23. There are favourable movements in admin and clerical and in nursing and support staff which have driven a small reduction in pay related expenditure run rate.

Cost Improvement Programme

The Trust has a cost improvement programme target of £8.3m. This equates to 5.3% of expenditure. At Month 4, there is an adverse variance of £129k against the £1,810k target. The Trust is focussed on identifying and implementing robust schemes that will deliver on an ongoing basis.

Finance Recovery Actions

The Trust is taking action on financial recovery and has brought in support to facilitate delivery of enhanced infrastructure, documentation, and governance of the recovery programme, and enable the pace of change required to deliver the challenge. A Project Management Office (PMO) has been established from within existing resources, recovery workstreams have been initiated. A Quality Impact Assessment Assurance Committee has been established to review all Quality Impact Assessments for all transformational schemes and will focus on ensuring the Trust does not lose focus on quality during the financial recovery process.

The Financial Grip and Control Working Group have implemented revised financial approval limits across pay and non-pay, accompanied by a defined set of criteria and exemptions (to ensure clinical safety) for approval of spend.

Additionally, the Trust is producing a financial recovery plan, to be submitted to the Integrated Care Board (ICB) in September, which will articulate the key steps required and support needed to achieve financial sustainability.

3. Divisional Summary Overview

Family Health
The Family Health Division has an adverse variance of £1,216k YTD. £1,036k of this relates to Maternity, with £179k relating to Neonatal. The maternity variance is driven by pay pressures in medical staffing and midwifery staffing (caused by sickness, vacancies, and maternity leave), as well as under-delivery of non-pay CIP.

Gynaecology
The Gynaecology Division has an adverse variance to plan of £1,412k YTD, comprised of £930k in Gynaecology and £482k in the Hewitt Fertility Centre. The Gynaecology variance is driven by nursing and support staff pay pressures and Aligned Payment and Incentive (API) income underperformance (see below for further details). Pay pressures relate to sickness, additional activity, and some cost pressures.

Clinical Support Services

CSS are £801k adverse to plan YTD, driven by Imaging pay (£262k) in relation to staffing pressures, and theatres pay (£367k), driven by nursing, Operating Department Practitioners, and support staff costs, partially mitigated by a vacancy factor in medical staffing.

The Community Diagnostic Centre position is £56k adverse YTD, driven by income underperformance.

4. Aligned Payment and Incentive (API)

Activity targets are set against a baseline of activity delivered in 2019/20 (prior to the impact of COVID). Average activity delivered YTD at Month 4 is 111% of 2019/20 levels, exceeding the Trust's average target for 2023/24 of 106%. 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).

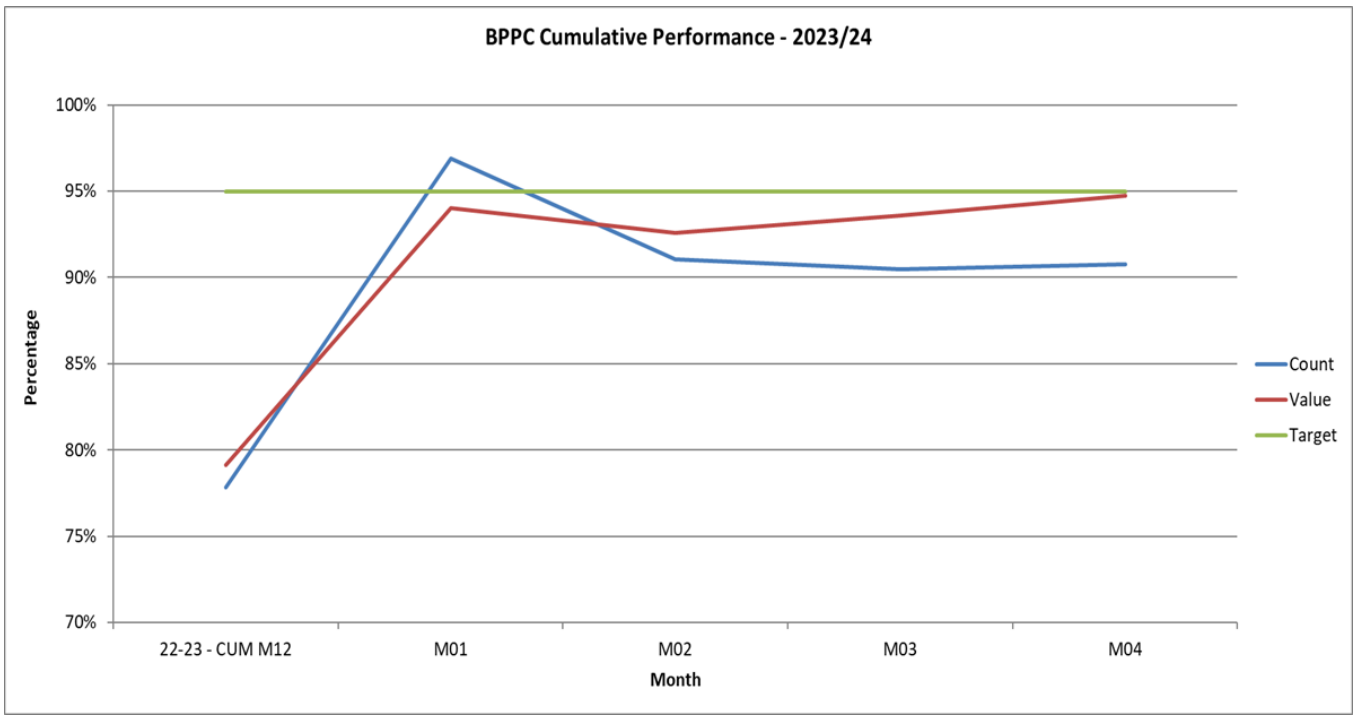
5. Cash and Borrowings

Total cash at the end of Month 4 was £1.3m. This is due to the deficit position year to date and expected working capital movements. The balance increased to £11.3m on 1 August following receipt of income and cash from the ICB, and the average daily cash balance throughout Month 4 was over £9m.

As the Trust has a deficit plan for 2023/24, cash support is required throughout the year. Cash levels are closely monitored 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.

6. Better Payment Practice Code

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



7. Balance Sheet

Other than the movement in cash considered above, the other areas of the balance sheet remain consistent, with a slight increase in receivables in month.

8. Capital Expenditure

The Trust's overall capital programme for 2023/24 equates to £5,154k.

YTD capital spend of £1,794k is £564k behind plan. This includes acceleration of digital spend to ensure the Electronic Patient Record project operates successfully, following the initial go-live date in July. Estates works are ongoing; one refurbishment scheme is behind schedule but is expected to complete early in Quarter 3. Medical equipment purchases are also behind schedule; however, work is progressing to ensure equipment is scoped and ordered.

9. Agency

The Trust has strong controls in place governing the use of temporary staffing. At Month 4, the Trust has a favourable variance of £343k against plan. Actual costs of £242k YTD are predominantly driven by theatres (vacancy), and maternity (sickness and vacancy).

10. Board Assurance Framework (BAF) Risk

There are no proposed changes to the BAF score.

11. Conclusion & Recommendation

The Board is asked to note the Month 4 position.

Appendices

Appendix 1 – Board Finance Pack, Month 4

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M4

YEAR ENDING 31 MARCH 2024

Liverpool Women's
NHS Foundation Trust

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1
NHS IMPROVEMENT RATIOS: M4	
YEAR ENDING 31 MARCH 2024	

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	(3,647)
(b) PDC + Interest Payable + Loans Repaid	888
CSC Ratio = (a) / (b)	**(4.11)**
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	(20,598)
(b) Expenditure	51,217
(c) Daily Expenditure	420
Liquidity Ratio = (a) / (c)	**(49.1)**
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)	6,443
Total Income	(47,393)
I&E Margin	**-13.6%**
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)	-13.60%
I&E Margin (Plan)	-12.60%
I&E Variance Margin	**-1.00%**
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	
AGENCY SPEND	
YTD Providers Cap	585
YTD Agency Expenditure	242
	-59%
NHSI AGENCY SPEND SCORE	**1**
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
INCOME & EXPENDITURE: M4
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	Month 4 Budget	Month 4 Actual	Month 4 Variance	YTD Budget	YTD Actual	YTD Variance	YEAR Budget	YEAR Forecast	YEAR Variance
Income									
Clinical Income	(11,204)	(11,474)	270	(44,720)	(44,746)	25	(134,750)	(136,585)	1,835
Non-Clinical Income	(603)	(765)	162	(2,392)	(2,647)	255	(7,416)	(7,381)	(35)
Total Income	**(11,807)**	**(12,239)**	**432**	**(47,112)**	**(47,393)**	**281**	**(142,166)**	**(143,966)**	**1,800**
Expenditure									
Pay Costs	7,297	7,930	(633)	29,929	32,184	(2,256)	88,336	92,567	(4,231)
Non-Pay Costs	3,233	3,650	(416)	12,878	11,842	1,036	38,631	36,927	1,705
CNST	1,800	1,801	(1)	7,201	7,190	11	21,603	21,604	(0)
Total Expenditure	**12,330**	**13,380**	**(1,050)**	**50,008**	**51,217**	**(1,210)**	**148,570**	**151,097**	**(2,527)**
EBITDA	**523**	**1,142**	**(618)**	**2,896**	**3,824**	**(929)**	**6,404**	**7,131**	**(727)**
Technical Items									
Depreciation	548	488	61	2,193	2,093	100	6,579	6,179	400
Interest Payable	2	2	0	8	6	2	21	21	0
Interest Receivable	(17)	(36)	19	(66)	(177)	111	(200)	(334)	134
PDC Dividend	221	221	(0)	882	882	0	2,645	2,638	7
Profit/Loss on Disposal or Transfer Absorption	0	(7)	7	0	(186)	186	0	(186)	186
Total Technical Items	**754**	**667**	**87**	**3,017**	**2,618**	**399**	**9,045**	**8,319**	**727**
(Surplus) / Deficit	**1,278**	**1,809**	**(532)**	**5,913**	**6,443**	**(530)**	**15,450**	**15,450**	**(0)**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **2a**
WTE: M4
YEAR ENDING 31 MARCH 2024

TYPE	DESCRIPTION	M12	M1	M2	M3	M4	Movement M12 - M4
SUBSTANTIVE	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STA	631.94	648.33	649.61	645.49	636.13	4.19
	ALLIED HEALTH PROFESSIONALS	82.04	81.95	81.35	83.27	83.57	1.53
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICA	11.78	11.31	11.31	12.31	11.31	(0.47)
	REGISTERED HEALTH CARE SCIENTISTS	49.22	53.62	54.54	54.34	55.34	6.12
	HCA & SUPPORT TO CLINICAL STAFF	234.51	237.51	244.48	237.49	242.70	8.19
	MANAGERS & SENIOR MANAGERS	59.92	63.32	64.32	61.32	59.02	(0.90)
	ADMIN AND ESTATES STAFF	13.00	13.00	13.00	14.00	14.00	1.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	288.12	288.08	284.17	285.09	279.25	(8.87)
	MEDICAL AND DENTAL	185.09	190.90	191.67	193.80	190.34	5.25
	ANY OTHER STAFF	14.00	14.00	14.00	14.00	14.00	0.00
SUBSTANTIVE TOTAL		**1,569.62**	**1,602.02**	**1,608.45**	**1,601.11**	**1,585.66**	**16.04**
BANK	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STA	47.33	37.81	43.37	45.40	34.57	(12.76)
	ALLIED HEALTH PROFESSIONALS	17.42	13.00	16.78	15.67	11.15	(6.27)
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICA	-	-	-	-	-	0.00
	REGISTERED HEALTH CARE SCIENTISTS	0.28	0.91	0.64	0.46	0.37	0.09
	HCA & SUPPORT TO CLINICAL STAFF	31.22	25.76	25.13	24.57	21.87	(9.35)
	MANAGERS & SENIOR MANAGERS	-	-	-	-	-	0.00
	ADMIN AND ESTATES STAFF	-	0.23	0.12	0.09	-	0.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	6.25	7.27	6.44	4.36	4.89	(1.36)
	MEDICAL AND DENTAL	2.00	2.80	2.80	2.00	2.00	0.00
	ANY OTHER STAFF	-	-	-	-	-	0.00
TOTAL BANK		**104.50**	**87.78**	**95.28**	**92.55**	**74.85**	**(29.65)**
AGENCY	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STA	8.23	10.49	2.03	0.08	2.11	(6.12)
	ALLIED HEALTH PROFESSIONALS	4.04	1.23	3.26	3.26	2.92	(1.12)
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICA	-	-	-	-	-	0.00
	REGISTERED HEALTH CARE SCIENTISTS	-	-	-	-	-	0.00
	HCA & SUPPORT TO CLINICAL STAFF	-	-	-	-	-	0.00
	MANAGERS & SENIOR MANAGERS	-	-	-	-	-	0.00
	ADMIN AND ESTATES STAFF	1.00	-	-	-	-	(1.00)
	OTHER INFRASTRUCTURE & SUPPORT STAFF	-	1.73	-	-	-	0.00
	MEDICAL AND DENTAL	0.10	-	-	-	-	(0.10)
	ANY OTHER STAFF	-	-	-	-	-	0.00
AGENCY TOTAL		**13.37**	**13.45**	**5.29**	**3.34**	**5.03**	**(8.34)**
TRUST TOTAL		**1,687.49**	**1,703.25**	**1,709.02**	**1,697.00**	**1,665.54**	**(21.95)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M4
YEAR ENDING 31 MARCH 2024

EXPENDITURE £'000	MONTH 4 Budget	MONTH 4 Actual	MONTH 4 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	468	494	(26)	1,870	2,015	(144)	5,411	5,362	49
Medical	2,092	2,202	(110)	8,368	8,685	(317)	25,105	26,081	(976)
Nursing & Midwifery	3,121	3,301	(180)	12,405	13,691	(1,285)	37,631	40,377	(2,747)
Healthcare Assistants	547	659	(112)	2,188	2,528	(340)	6,565	7,500	(935)
Other Clinical	144	402	(258)	1,402	1,754	(352)	2,612	3,436	(824)
Admin Support	764	810	(46)	3,050	3,268	(218)	9,164	9,315	(151)
Agency & Locum	161	61	100	644	243	401	1,848	495	1,352
Total Pay Costs	**7,297**	**7,930**	**(633)**	**29,929**	**32,184**	**(2,256)**	**88,336**	**92,567**	**(4,231)**
Non Pay Costs									
Clinical Suppplies	835	894	(59)	3,338	3,767	(429)	10,031	10,880	(848)
Non-Clinical Supplies	776	1,128	(352)	3,066	2,156	909	8,876	7,144	1,732
CNST	1,800	1,801	(1)	7,201	7,190	11	21,603	21,604	(0)
Premises & IT Costs	871	833	38	3,498	3,310	188	10,467	10,903	(436)
Service Contracts	752	795	(43)	2,976	2,609	367	9,257	8,000	1,258
Total Non-Pay Costs	**5,034**	**5,396**	**(362)**	**20,079**	**19,033**	**1,046**	**60,235**	**58,530**	**1,705**
Total Expenditure	**12,330**	**13,325**	**(995)**	**50,008**	**51,217**	**(1,210)**	**148,570**	**151,097**	**(2,527)**

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

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
BUDGET ANALYSIS: M4
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	MONTH 4 Budget	MONTH 4 Actual	MONTH 4 Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR - Underlying Budget	YEAR - Underlying Actual	YEAR - Underlying Variance	YEAR - Recovery Budget	YEAR - Recovery Actual	YEAR - Recovery Variance
Maternity												
Income	(4,320)	(4,110)	(211)	(16,327)	(16,197)	(131)	(50,625)	(48,291)	(2,334)	(50,625)	(48,291)	(2,334)
Expenditure	2,434	2,588	(154)	9,745	10,651	(906)	29,216	31,655	(2,439)	29,216	31,655	(2,439)
Total Maternity	**(1,887)**	**(1,522)**	**(364)**	**(6,582)**	**(5,546)**	**(1,036)**	**(21,408)**	**(16,636)**	**(4,772)**	**(21,408)**	**(16,636)**	**(4,772)**
Neonatal												
Income	(1,831)	(1,768)	(63)	(7,348)	(7,282)	(66)	(22,093)	(22,121)	27	(22,093)	(22,121)	27
Expenditure	1,470	1,500	(30)	5,881	5,995	(114)	17,643	17,925	(281)	17,643	17,925	(281)
Total Neonatal	**(361)**	**(268)**	**(93)**	**(1,467)**	**(1,287)**	**(179)**	**(4,450)**	**(4,196)**	**(254)**	**(4,450)**	**(4,196)**	**(254)**
Division of Family Health - Total	**(2,247)**	**(1,790)**	**(457)**	**(8,049)**	**(6,833)**	**(1,216)**	**(25,858)**	**(20,832)**	**(5,026)**	**(25,858)**	**(20,832)**	**(5,026)**
Gynaecology												
Income	(2,328)	(2,298)	(30)	(8,867)	(8,648)	(219)	(27,361)	(26,168)	(1,193)	(27,361)	(26,168)	(1,193)
Expenditure	1,425	1,571	(145)	5,720	6,431	(711)	17,123	18,933	(1,810)	17,123	18,933	(1,810)
Total Gynaecology	**(903)**	**(728)**	**(175)**	**(3,148)**	**(2,218)**	**(930)**	**(10,238)**	**(7,235)**	**(3,003)**	**(10,238)**	**(7,235)**	**(3,003)**
Hewitt Centre												
Income	(880)	(599)	(281)	(3,409)	(3,098)	(311)	(10,609)	(9,709)	(901)	(10,609)	(9,709)	(901)
Expenditure	794	827	(33)	3,176	3,346	(171)	9,527	10,039	(513)	9,527	10,039	(513)
Total Hewitt Centre	**(86)**	**227**	**(314)**	**(234)**	**248**	**(482)**	**(1,083)**	**331**	**(1,414)**	**(1,083)**	**331**	**(1,414)**
Division of Gynaecology - Total	**(989)**	**(500)**	**(489)**	**(3,381)**	**(1,970)**	**(1,412)**	**(11,321)**	**(6,905)**	**(4,416)**	**(11,321)**	**(6,905)**	**(4,416)**
Theatres												
Income	0	0	0	0	0	0	0	0	0	0	0	0
Expenditure	1,012	1,130	(118)	4,189	4,651	(463)	12,285	14,131	(1,846)	12,285	14,131	(1,846)
Total Theatres	**1,012**	**1,130**	**(118)**	**4,189**	**4,651**	**(463)**	**12,285**	**14,131**	**(1,846)**	**12,285**	**14,131**	**(1,846)**
Genetics												
Income	(4)	(39)	35	(14)	(55)	41	(42)	(55)	13	(42)	(55)	13
Expenditure	161	81	80	643	561	81	1,928	1,791	136	1,928	1,791	136
Total Genetics	**157**	**42**	**115**	**629**	**507**	**122**	**1,886**	**1,737**	**149**	**1,886**	**1,737**	**149**
Other Clinical Support												
Income	(753)	(568)	(184)	(2,713)	(2,295)	(418)	(9,265)	(6,738)	(2,528)	(9,265)	(6,738)	(2,528)
Expenditure	1,010	938	72	3,890	3,932	(43)	12,231	11,922	309	12,231	11,922	309
Total Clinical Support	**258**	**370**	**(112)**	**1,177**	**1,637**	**(460)**	**2,965**	**5,184**	**(2,219)**	**2,965**	**5,184**	**(2,219)**
Division of Clinical Support - Total	**1,427**	**1,542**	**(115)**	**5,994**	**6,795**	**(801)**	**17,136**	**21,053**	**(3,916)**	**17,136**	**21,053**	**(3,916)**
Corporate & Trust Technical Items												
Income	(1,691)	(2,967)	1,276	(8,433)	(10,503)	2,070	(22,170)	(28,768)	6,598	(22,170)	(31,576)	9,406
Expenditure	4,778	5,525	(747)	19,782	18,953	829	57,663	61,595	(3,932)	57,663	53,710	3,953
Total Corporate	**3,087**	**2,558**	**530**	**11,349**	**8,450**	**2,898**	**35,493**	**32,826**	**2,667**	**35,493**	**22,133**	**13,360**
(Surplus) / Deficit	**1,278**	**1,809**	**(532)**	**5,913**	**6,443**	**(530)**	**15,450**	**26,142**	**(10,693)**	**15,450**	**15,449**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CIP: M4
YEAR ENDING 31 MARCH 2024

		MONTH 4			YTD			FOT		
TYPE	**Scheme**	**Target**	**Actual**	**Variance**	**Target**	**Actual**	**Variance**	**Target**	**Actual**	**Variance**
Income	Income Private Patient	21	17	(4)	49	29	(20)	470	187	(283)
Income	income non-patient care	55	179	123	201	237	37	842	717	(125)
Income	Income Other	61	48	(13)	226	53	(172)	710	660	(50)
Income	Unidentified - Income	0	0	0	0	0	0	0	0	0
Income	Other income	13	2	(11)	11	0	(11)	267	267	0
Total Income		**150**	**245**	**95**	**486**	**320**	**(166)**	**2,289**	**1,831**	**(458)**
Pay	Service re-design - pay	18	4	(14)	72	15	(58)	217	69	(148)
Pay	Establishment reviews	4	86	82	(8)	256	264	20	532	512
Pay	Unidentified - pay	277	0	(277)	282	0	(282)	2,502	2,502	0
Pay	Other - pay	0	0	0	0	0	0	200	200	0
Pay	E-Rostering	2	0	(2)	8	0	(8)	25	17	(8)
Total Pay		**301**	**89**	**(212)**	**355**	**271**	**(84)**	**2,965**	**3,320**	**355**
Non-Pay	Other - Non-pay	11	41	30	45	111	67	184	398	214
Non-Pay	Medicines optimisation	14	0	(14)	55	0	(55)	164	20	(143)
Non-Pay	Service re-design - Non-pay	190	2	(188)	740	979	239	2,262	2,049	(213)
Non-Pay	digital transformation non-pay	10	0	(10)	41	0	(41)	122	0	(122)
Non-Pay	Pathology & imaging networks	0	0	(0)	2	0	(2)	5	0	(5)
Non-Pay	Procurement (excl drugs) - medical devices and clinical consumables	15	0	(15)	56	0	(56)	175	36	(140)
Non-Pay	Fleet optimisation	2	0	(2)	2	0	(2)	20	13	(7)
Non-Pay	Procurement (excl drugs) -non-clinical	4	0	(4)	17	0	(17)	51	4	(47)
Non-Pay	Unidentified - non-pay	11	0	(11)	13	0	(13)	100	665	565
Total Non-Pay		**258**	**43**	**(215)**	**969**	**1,090**	**121**	**3,082**	**3,184**	**102**
Total CIP Delivery		**709**	**377**	**(332)**	**1,810**	**1,681**	**(129)**	**8,336**	**8,336**	**(0)**

Please note CIP reporting at Month 4 is prior to inclusion of financial recovery plan

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
BALANCE SHEET: M4
YEAR ENDING 31 MARCH 2024

BALANCE SHEET £'000	YEAR TO DATE Opening	M4 Actual	Movement
Non Current Assets	102,405	102,132	(273)
Current Assets			
Cash	9,790	1,323	(8,467)
Debtors	9,647	9,638	(9)
Inventories	839	575	(264)
Total Current Assets	**20,276**	**11,536**	**(8,740)**
Liabilities			
Creditors due < 1 year - Capital Payables	(2,002)	(1,403)	599
Creditors due < 1 year - Trade Payables	(26,820)	(14,176)	12,644
Creditors due < 1 year - Deferred Income	(4,492)	(15,227)	(10,735)
Creditors due > 1 year - Deferred Income	(1,530)	(1,519)	11
Loans	(918)	(913)	5
Loans - IFRS16 leases	(50)	(50)	0
Provisions	(628)	(582)	46
Total Liabilities	**(36,440)**	**(33,870)**	**2,570**
TOTAL ASSETS EMPLOYED	**86,241**	**79,798**	**(6,443)**
Taxpayers Equity			
PDC	79,115	79,115	0
Revaluation Reserve	8,679	8,679	0
Retained Earnings	(1,553)	(7,996)	(6,443)
TOTAL TAXPAYERS EQUITY	**86,241**	**79,798**	**(6,443)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
CASHFLOW STATEMENT: M4
YEAR ENDING 31 MARCH 2024

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	(5,917)
Depreciation and amortisation	2,093
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	(2,580)
Net cash generated from / (used in) operations	**(6,404)**
Interest received	194
Purchase of property, plant and equipment and intangible assets	(2,443)
Proceeds from sales of property, plant and equipment and intangible assets	186
Net cash generated from/(used in) investing activities	**(2,063)**
PDC Capital Programme Funding - received	0
Loans from Department of Health - repaid	0
Interest paid	0
PDC dividend (paid)/refunded	0
Net cash generated from/(used in) financing activities	**0**
Increase/(decrease) in cash and cash equivalents	**(8,467)**
Cash and cash equivalents at start of period	9,790
Cash and cash equivalents at end of period	**1,323**

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**

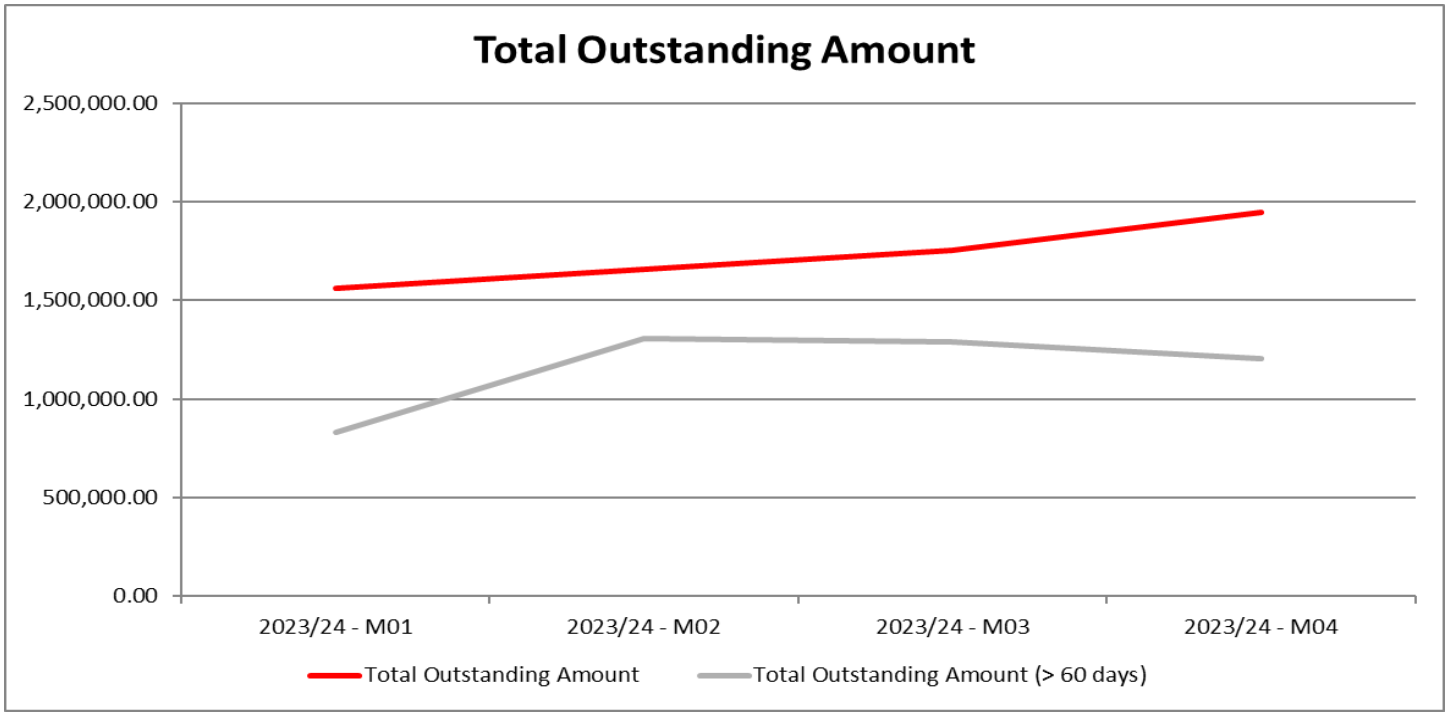
Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CAPITAL EXPENDITURE: M04
YEAR ENDING 31 MARCH 2024

		YTD			YEAR		
Area	Capital Scheme	PLAN	ACTUAL	VARIANCE	PLAN	FOT	VARIANCE
Digital	EPR frontline digitisation	445	487	(42)	560	560	0
Digital	IT/digital investment - infrastructure	255	1,077	(822)	1,290	1,290	(0)
Digital	IT/digital investment - hardware	150	61	89	354	280	74
Digital	Community diagnostic equipment	153	0	153	153	153	0
Digital	Community diagnostic IT	100	0	100	65	65	0
Digital	PACS - image sharing - CAMRIN programme	0	0	0	49	49	0
Estates	Building works/refurbishment - Maternity	300	11	289	350	350	0
Estates	Building works/refurbishment - Neonatal	30	0	30	180	180	0
Estates	Building works/refurbishment - Gynaecology	50	0	50	50	50	0
Estates	Estates programme	210	53	157	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	241	241	0
Medical Equipment	Medical equipment - Clinical Support - Theatres	37	0	37	107	107	0
Medical Equipment	Medical equipment - All other clinical areas	473	99	374	1,041	1,100	(59)
Medical Equipment	Medical equipment - leased blood gas analysers	139	5	134	139	139	(0)
Other	Other	16	0	16	(55)	(41)	(14)
TOTAL CAPITAL		**2,358**	**1,794**	**564**	**5,154**	**5,154**	**(0)**

Note : 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.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 9
AGED DEBTORS BALANCE: M4
YEAR ENDING 31 MARCH 2024

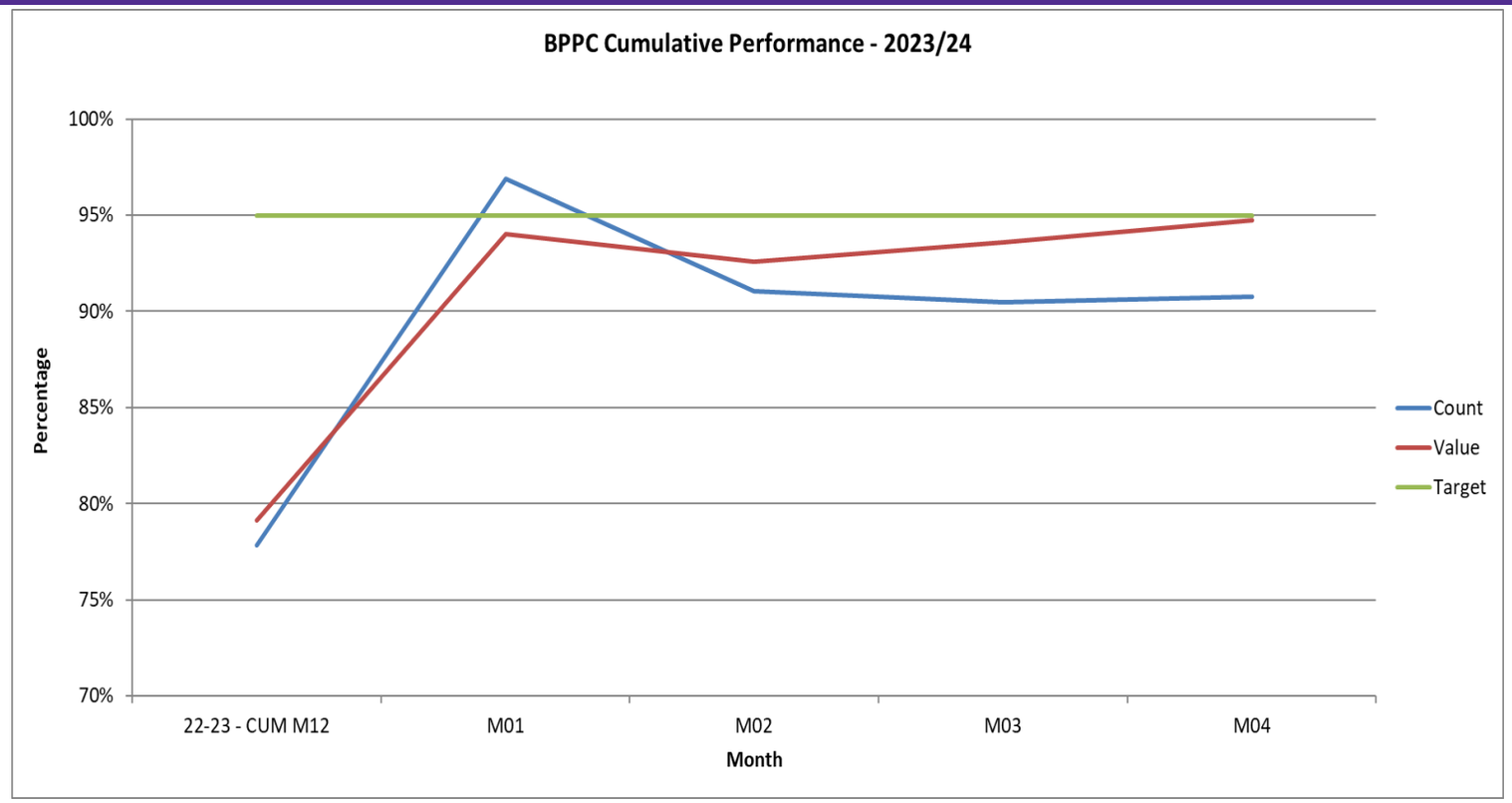


Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **10**
BETTER PAYMENT PRACTICE CODE (BPPC) - CUMULATIVE PERFORMANCE FOR M04
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



	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
Cumulative Performance - Count	97%	91%	90%	91%								
Cumulative Performance - Value (£)	94%	93%	94%	95%								

2023/24 performance TOTAL

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 11
AGENCY USAGE: M4
YEAR ENDING 31 MARCH 2024

		MONTH 4			YTD			FOT		
Division	Directorate	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Family Health	Maternity	0	13	(13)	-	76	(76)	-	94	(94)
Gynaecology	Gynaecology	0	4	(4)	-	27	(27)	-	80	(80)
CSS	Theatres	0	12	(12)	-	61	(61)	-	147	(147)
CSS	CDC	12	2	10	49	17	32	61	17	44
CSS	Imaging	0	27	(27)	-	54	(54)	-	130	(130)
Corporate	All Corporate Directorates	149	2	147	596	7	589	1,787	27	1,760
Total Agency		**161**	**60**	**101**	**645**	**242**	**403**	**1,848**	**495**	**1,353**
Performance against cap/plan		**194**	**60**	**134**	**585**	**242**	**343**	**2,333**	**495**	**1,838**

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/138a*		**Date: 14/09/2023**	
Report Title	**Review of Strategic Progress**			
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 note key strategic developments to July 2023.*			
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 Trust Board is asked to note the strategic progress outlined in this paper.			
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) *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
Executive Committee	02/08/23	Chief Finance Officer	The Committee noted the report.

EXECUTIVE SUMMARY

Between January and July 2023, progress has been made in refreshing and developing several of the Trust's supporting strategies, with a particular focus on developing a new Quality strategy and ensuring all enabling strategies are aligned to support delivery of quality in the Trust. The recent publication of the Cheshire and Merseyside Joint Forward Plan is timely and has provided an opportunity for the Trust to increase and strengthen its alignment to system priorities and its role in their delivery.

In January 2023, following the Liverpool Clinical Services Review and at the request of the Cheshire and Merseyside Integrated Care Board (C&M ICB), the Trust paused its internal Future Generations programme, handing responsibility for the programme to the ICB's newly established Women's Services Committee. The Committee has recently appointed several key programme lead roles, and as such is expected to begin to progress with pace.

MAIN REPORT

1. Introduction

Updates regarding strategic progress were previously reported to the Finance, Performance, and Business Development (FPBD) Committee. It has subsequently been agreed that in addition to the annual review of delivery of the overarching Trust strategy, bi-annual strategic progress reports will be presented directly to the Trust Board to ensure all Board members are sighted on strategy development and delivery.

This paper details the key strategic developments and progress which have occurred to July 2023.

2. Our Strategy

The Trust's overarching strategy, Our Strategy 2021-2025, was developed during 2020/21 and launched in April 2021. Annual reviews of delivery against the strategy are timed to align with and inform the annual planning round, and therefore take place at the end of quarter 2. Outcomes from this review will be presented to the Trust Board held in public in November, detailing the progress made over the last 12 months towards delivering the ambitions and objectives in Our Strategy.

Appointment of Shared Accountable Officer with Liverpool University Hospitals NHS FT (LUHFT)

The Trust has been clear for some time that our preferred strategic direction includes closer collaboration with LUHFT, as it will help us to achieve long term clinical and financial sustainability of services for the benefit of the women, babies, and families we care for.

In August 2023, it was announced that the Trust had secured agreement with the ICB and LUHFT on our ambition to move to a shared Chief Executive Officer model. This is a positive step in providing ongoing stability and delivery of strategic ambitions and objectives (as set out in Our Strategy) for the Trust.

3. Supporting Strategies

The Trust is currently refreshing several of its supporting strategies. The new Research and Innovation Strategy was published earlier this year in March 2023, and the Finance and Procurement Strategy was finalised in July. The Clinical, Quality, and Putting People First strategies are in the process of being refreshed, and the Estates, and Charitable Funds strategies are under development. Further details regarding the progress of each are provided below. Work to begin refreshing the Digital strategy will begin once the new Electronic Patient Record system, DigiCare, is thoroughly embedded.

Quality Strategy

The Quality Committee is responsible for overseeing development, approving, and monitoring delivery of the Quality Strategy.

Ensuring that the Trust prioritises quality and safety within all its services is of paramount importance, particularly during periods where challenging financial targets have been set. The Trust has identified an opportunity to extend the quality and experience ambitions set out in the 'Women, Babies and their Families Experience Strategy' and the 'Clinical and Quality Strategy' and drive closer alignment to system priorities, through the development of a new *Quality Strategy* for Liverpool Women's Hospital.

This new strategy will streamline the Trust's strategic framework, combining and replacing the existing Clinical and Quality Strategy 2020-2025 and the Women, Babies, and their Families Experience Strategy 2021-2026, focusing on the three dimensions of quality (as defined in the Health and Social Care Act 2012): clinical effectiveness, safety, and patient experience.

The new Quality Strategy will ensure even closer alignment with the system's plans and priorities as outlined in the overarching ICS strategy and the Joint Forward Plan. It will align with the Cheshire and Mersey

Women's Health Strategy which is currently under development by the Local Maternity Network and define the Trust's support for the women's health agenda in Liverpool Place.

The Advancing Quality Alliance (AQUA), an NHS health and care quality improvement consultancy organisation, have been engaged by the Trust for a period of 12 months to support this programme of work, further embedding a culture of prioritising quality and focusing on quality improvement. A broad range of staff, service users and patients, and other stakeholders, will be engaged with during the process of development. The Trust will ensure it makes all efforts to listen to a diverse range of voices and under-represented groups, with a strong focus on listening to and acting on patient experience.

Putting People First (PPF) Strategy

The Putting People First Committee is responsible for overseeing development, approving, and monitoring delivery of the Putting People First Strategy.

The Putting People First Committee commenced work to refresh this strategy in February 2023, and have held several workshops with staff. It is being developed in tandem with the Quality Strategy as evidence shows that organisational performance and the quality of care provided is directly influenced by how an organisation behaves toward its staff. The workshops held to date have focussed on Equality, Diversity and Inclusion, Workforce Planning, and Wellbeing and Leadership.

The new NHS Long Term Workforce Plan was published in June 2023; the refresh of the PPF strategy will enable the Trust to demonstrate alignment to this national strategy.

The anticipated launch date of the new PPF strategy is January 2024.

Finance and Procurement Strategy

The FPBD Committee is responsible for overseeing development, approving, and monitoring delivery of the Finance and Procurement Strategy.

The Finance and Procurement Strategy was presented to the FPBD Committee in July 2023. This key enabling strategy sets out five ambitions, aligned to the Trust's aims:

- We will be an outstanding Finance and Procurement team,
- We will facilitate of delivery of sustainable, safe services,
- Our patients, customers and stakeholders will have an outstanding experience,
- We will drive maximum productivity and efficiency,
- Financial governance and legislative compliance will be best in class.

Each ambition is underpinned by a series of objectives.

In addition, the Trust is in the process of producing a 3-year plan focused on financial recovery, which will form part of a system financial recovery plan. The system plan aims to return to overall financial balance within 3 years.

Estates Strategy

The FPBD Committee is responsible for overseeing development, approving, and monitoring delivery of the Estates Strategy.

The Estates Strategy is a key enabling strategy, and will have a twin focus:

- Maintaining quality, safety, and experience within clinical services on site for the duration of the strategy, and enabling delivery of divisional plans

- Supporting delivery of Our Strategy, system plans, and ensuring any investment or development of the current estate is aligned to the vision for the future use of the Crown Street site.

Estates surveys have been commissioned and are progressing, including a Mechanical and Electrical Asset survey, a Buildings and Fabric survey, a full access audit and a space utilisation audit. These audits will be used to support strategic decisions regarding estates utilisation, as well as short to medium term management of backlog maintenance. This will further support operational planning, capital programme decision-making, ensuring funding is strategically targeted over our 5-year plan and achieving best value for money.

The Cheshire and Merseyside (C&M) Health and Care Partnership (HCP) have produced an initial system Estates strategy setting out commitments for the next 5 years. Estates priorities have been included in the system Joint Forward Plan (JFP), with a focus in 8 key areas:

- *Fit for purpose*
- *Maximising utilisation*
- *Environmentally sustainable*
- *Value for money and social value*
- *Services and buildings in the right place*
- *Flexibility*
- *Technology*
- *Working in partnership.*

The anticipated launch date of the estates strategy is Q4 2023/34.

Charitable Funds Strategy

The Charitable Funds Committee is responsible for overseeing development, approving, and monitoring delivery of the Charity Strategy.

The first draft of the new Charity Strategy was presented to the Charitable Funds Committee in June 2023. Initial feedback was received, and work is underway to refine sections as identified by the Committee, with further work ongoing to engage with a broader range of stakeholders, including patients and service users.

A revised draft will be presented to the October 2023 Charitable Funds Committee meeting.

4. Liverpool Clinical Services Review / Future Generations

Women's Services Committee

The Liverpool Clinical Services Review (LCSR) report, published in January 2023, recommended that a sub-committee of the C&M ICB be established to oversee a programme of work to help determine the future of women and families' services delivered across the city region. Three meetings of the Women's Services Committee have been held to date.

The Committee has recently appointed an Independent Clinical Senior Responsible Officer (a consultant obstetrician, gynaecologist, and specialist in maternal medicine) and a dedicated Programme Director. With these key roles in place, it is now expected that the programme will begin to progress with greater pace.

5. Cheshire and Merseyside Integrated Care System

Joint Forward Plan

In May 2023, the Trust Board considered and discussed the Cheshire and Merseyside draft Joint Forward Plan, noting the Trust's engagement and involvement in the development of the plan. The Board provided feedback which was shared with the team at the ICB responsible for producing the plan. The ICB collated all feedback from providers and made amendments to the plan. The final draft was presented to the Trust Board at the June meeting for review and any final comments prior to its publication on 30 June 2023, however neither approval nor endorsement was required.

The publication of the Joint Forward Plan is timely given the current refresh of several the Trust's supporting strategies. It provides an opportunity for the Trust to increase and strengthen its alignment to system priorities and its role in their delivery. Additionally, the Trust is making representations to the ICB and working to influence future iterations of the JFP and system strategy, to ensure that women's health is prioritised appropriately.

6. Women's Health Strategy Update

The national women's health strategy was published in July 2022. 12 months after publication, the government announced a series of new measures aimed at improving the health of women and girls:

- A dedicated area for women and girls on the NHS website has been created, offering information on various women's health topics.
- Support for bereaved parents who have experienced pregnancy loss will be provided, including voluntary certificates and 24/7 care services. A pilot program will explore a "graded model" of miscarriage care to identify medical conditions and prevent further miscarriages.
- £25 million will be distributed nationwide to establish women's health hubs across England.
- An artificial intelligence tool has been developed to identify early risks in maternity units, and clinicians and data scientists will collaborate to analyse data for identifying concerning trends.
- Enhanced IVF transparency will be introduced through a new tool available on the government website providing local information about NHS-funded IVF treatment.
- The Women's Health Ambassador for England, Professor Dame Lesley Regan, has formed a network of women's health champions from every local care system to drive forward improvements in women's health.

Several of the new measures outlined above have the potential to support the Trust in improving healthcare for women and girls. The £25m women's health hub funding will be distributed to equally to ICBs (£595k per ICB), with 75% of the funding available in 2023/24. Systems can use this funding to establish new hubs or expand existing one. The Trust is already working with primary care colleagues to support women's health hubs and is currently looking to expand this work further.

7. Conclusion and Recommendation

During the last period, the Trust has progressed work to refresh its supporting strategies and ensure alignment system strategies and plans. The Trust continues to contribute to the delivery of those plans through engaging with and working closely with system partners.

The Trust Board is asked to note the strategic progress outlined in this paper.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/138b***		**Date: 14/09/2023**	
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.***			
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 July 2023.

EXECUTIVE SUMMARY

The Board Assurance Framework (BAF) is a monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives and to ensure it has appropriate oversight of the Trust's risk profile and risk management arrangements.

The BAF items are aligned to the Board's assurance committees, and since the last Board meeting these were reviewed and discussed during the July 2023 meetings.

Scores for Quarter 2 will be discussed at the September 2023 Committee meetings and reported through to the next Board meeting.

MAIN REPORT

Introduction

The following report provides an update to Board members on the latest review of the BAF items.

The report is intended to allow the members of the Board to review any proposed changes or additions and agree them moving forward. The report is also an opportunity for the Board to make informed judgements as to the level of assurance that they can take and to identify any further action required to improve the management of the identified risks.

Process for reviewing BAF areas during the meeting

As the Board works through the agenda, members are requested to consider the BAF areas contained in Appendix 1 and the associated interdependent 15 and above risks / CRR risks. Keeping these risks in mind should support consideration of whether any assurances provided through the reports received could contribute to mitigation (or escalation) of the BAF risks. These can be noted when the BAF itself is discussed.

In addition, members should consider whether because of the review of assurances and/or identification of risks, whether there is a need to commission additional assurance to be reported to future Board and / or Committee meetings. In particular, the Board needs to ask itself whether it is attaining adequate assurance against its highest scoring risks i.e., are these areas of risk driving the Board and Committee agendas. Any information that has been discussed in the meeting that needs to be shared with other corporate governance meetings should be included in the Chair's Log.

Changes to BAF

The table below also outlines the changes made since the previous iteration.

1 – Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities

- No change to BAF score– (likelihood 4 x consequence 4). Progress has been made in the year, but further work is required to achieve the target risk score.
- No proposed changes to the BAF title
- Controls require a thorough review and rationalisation ahead of next iteration
- Some actions now deemed complete and suggested to move to controls
- The Committee suggested a narrative review of BAF Risk 1 to ensure that the junior doctor workforce risks were appropriately reflected.
- Detailed review planned for the September 2023 PPF Committee

2 – Inability to ensure the on-going sustainability of clinical services and maintain a high standard of care at the current Crown Street site.

- No changes proposed to scoring or assurance ratings
- The June 2023 Committee requested that this risk be reviewed to ensure that it provided the Committee and the Board with a clear line of sight on risks relating to patient harm. This review is being undertaken and the outputs of this will report to the September 2023 Committee.

3 – Failure to deliver an excellent patient and family experience to all our service users

- No changes proposed to scoring or assurance ratings

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

- Grip, control and governance for medical devices (from a cyber perspective) remains an area that requires development.
- No changes proposed to the overall score or assurance ratings

5 – Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term

- No changes proposed to the overall score or assurance ratings

6 – The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative

- No changes proposed to the overall score or assurance ratings

7 - Failure to meet patient waiting time targets

- No changes proposed to scoring or assurance ratings

Appendix 2 has been updated for this iteration.

Recommendation

The Board requested to

- review the BAF risks and agree on their contents and actions.

Liverpool Women's
NHS Foundation Trust

Board Assurance Framework 2023/24

Trust Board

September 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

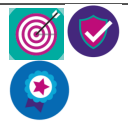
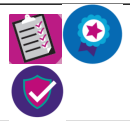
Director Lead	
CEO	Chief Executive
CPO	Chief People Officer
COO	Chief Operating Officer
CFO	Chief Finance Officer
CIO	Chief Information Officer
CN	Chief Nurse
MD	Medical Director

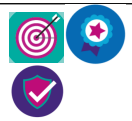
Key to lead Committee Assurance Ratings	
	Green = Positive assurance: the Committee / Board is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity - no gaps in assurance or control AND current exposure risk rating = 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	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	ongoing	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 in place from early 2023 onwards. Suggested to move to controls.	
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	April 2024	This will be included as a major strand of a revised PPF Strategy	
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 has developed a process for the effective sharing of lessons from patient stories through to the Divisions – suggested to move to controls	
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~~ September 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	September 2023	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
  - Medical and surgical expertise
  - Intensive care facilities
- 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
- Use of telemedicine to facilitate consultations both at Crown Street and other site
- Historic controls still in place include:

	○ 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 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

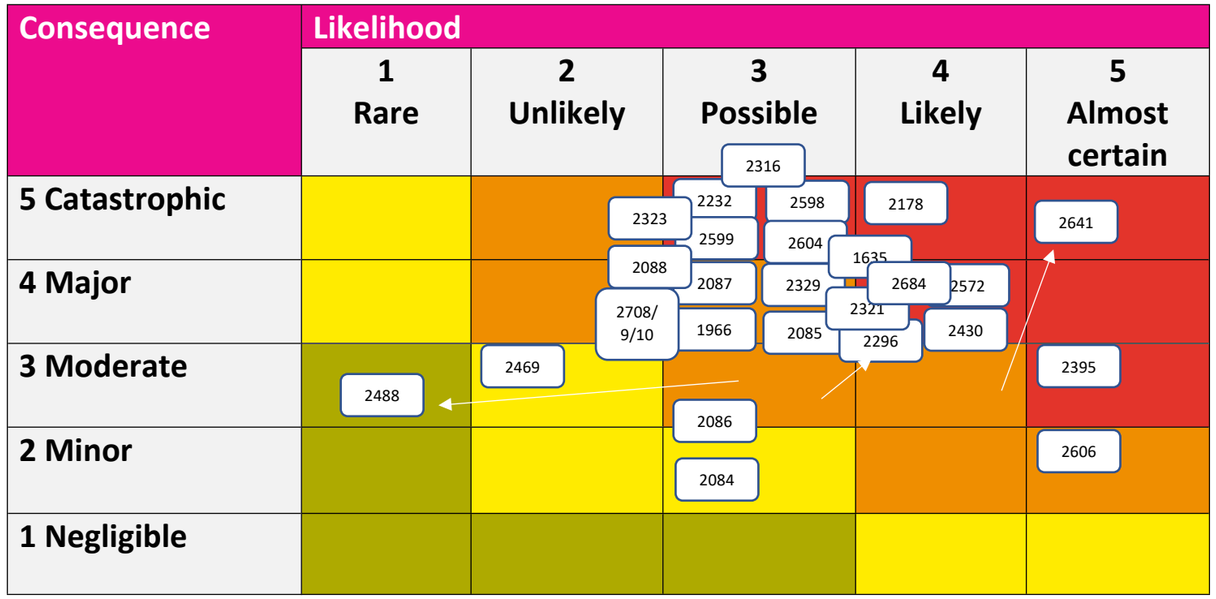
		Assurance Level	Assurance Rating	Overall Assurance Rating		
Key Assurances:	Divisional Board meetings	**1**			**Gaps in Control / Assurance:**	Ability of clinical staff to engage with the system development due to time and financial impact (Actions 2.2 / 1, 2.2 / 3, 2.2 / 4) To improve horizon scanning 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) Lack of 24/7 transfusion laboratory on site leads to delay in patients receiving transfusion. (Action 2.3/4, 2.3/5)
	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**				

	Single Site risk report – provided to July 2022 Board	**2**				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)
	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	

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	20
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	3
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.	12
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.	16
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
2323	Condition: The Trust is currently non-compliant with standards 2,5,6 of the seven-day service standards	15

[Return to Dashboard]

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
2708	The Child Protection Information Sharing (CPIS) System is not being accessed for every unplanned care attendance anyone aged under 18 or all pregnant women. This will lead to children, young people and unborn infants not being identified as being on a child protection plan or being a looked after child.	12
2709	Families and children are at risk of not receiving a co-ordinated approach to early help. The trust is not in a position to evidence early help work undertaken by Front Line Staff leading to the LA and Safeguarding Children Partnership Board raising concerns against the Trust that multi agency policy is not being appropriately implemented.	12
2710	Safeguarding information contained on Bulletin Board within Meditech and the associated safeguarding flags cannot be migrated onto Digicare. This will lead to front line staff being required to check the old system when patients attend and transcribe information onto new record. This is open to human error risk.	12
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	• Women, Babies and their Families experience Strategy 2021 - 2026

	• PALs and Complaints data • Patient Stories to Board • 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 displeased Friends and Family and Bi-Monthly reports from the Divisions 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
	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	**2**				

	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.					QI projects need to be developed from patient voices and experience based co-design 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 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**				
	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		

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, 2418	
3 Moderate			2649		
2 Minor			2084		
1 Negligible					

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

Return to Dashboard

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
- Dedicated DigiCare communications support in place
- Procured and implemented Network Access Control (NAC) solution
- Purchased and implemented software for USB port control
- 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
4/4	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

Return to Dashboard

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.

	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 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.	16
High Scoring (15+) Divisional Risks		

Return to Dashboard

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		

Return to Dashboard

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
- Elective Recovery Programme in place with workstreams to improve performance and reduce waits
- 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
- Locum Consultant in place for Gynaecology to increase clinical capacity

	• 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				• 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	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				LWH BAF 7			
	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				Failure to meet patient waiting time targets			
	Target				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)				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	Q1	Q2	Q3	Q4
LWH BAF	20				20		8		12				20				20				9				16			
LUHFT BAF	8 (8)				1 (9)				6 (10)				10 (10)				5 (9)				11 (9)				2 (9)			
					3 (12)				7 (10)								9 (12)											
					4 (9)				12 (7)																			
					13 (9)																							
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)		9 (4)		1 (6)				11 (12)				3 (12)				9 (4)							
	5 (12)				8 (12)		10 (9)										7 (12)				10 (9)							
	6 (12)																											
AHH BAF	2.1 (15)				1.1 (9)		3.2 (12)						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)														3.6 (9)							
CCC BAF	10 (12)				1 (15)		6 (12)						13 (12)				3 (16)				6 (12)							
	11 (16)				2 (12)								14 (12)															
MC BAF	p.8 (15)				s.8 (16)		f.7 (8)		s.5 (12)				r.12 (8)				p.7 (16)				f.7 (8)							
	p.5 (12)				r.11 (12)		f.5 (12)		s.9 (12)								r.9 (15)				f.5 (12)							
									p.9 (12)								r.13 (15)											
ICB BAF	TBC				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.
13	If we do not deliver agreed milestones in line with the Research Strategy to become a clinically researchactive 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

Clatterbridge Cancer Centre BAF Risks Summary	
1	Quality governance
2	Demand exceeds capacity
3	Insufficient funding

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.

1.4	Access to Children and Young People's Mental Health		4	Board governance		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.
2.1	Workforce Sustainability and Development		5	Environmental sustainability		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	4 Major	5 Almost Certain	20	Clinical Support Service	03/07/2023	02/08/2023	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	20/02/2023	03/09/2023	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	28/06/2023	28/07/2023	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	15/06/2023	15/07/2023	2
1966	Condition: Risk of safety incidents occurring when undertaking invasive procedures.	4 Major	3 Possible	12	Governance	22/06/2023	22/07/2023	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	19/05/2023	18/07/2023	1
2488	Condition: Failure to meet clinical demand for red blood cells	3 Moderate	3 Possible	3	Clinical Support Service	20/06/2023	18/09/2023	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	03/07/2023	01/01/2024	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	21/06/2023	19/09/2023	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	4 Major	4 Likely	16	Clinical Support Service	03/07/2023	01/10/2023	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	30/05/2023	28/11/2023	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	4 likely	16	Human Resources	05/05/2023	24/09/2023	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	05/07/2023	1, 2 & 3
2088	Condition: Lack of on-site specialist staff and services	4 Major	3 Possible	12	Neonatal	09/06/2023	09/07/2023	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	24/05/2023	23/07/2023	2
2395	Condition: Ambulatory gynaecology demand is exceeding current capacity	3 Moderate	5 Almost Certain	15	Gynaecology	24/05/2023	23/07/2023	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	4 Major	3 Possible	12	Human Resources	05/07/2023	04/08/2023	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							
2708	The Child Protection Information Sharing (CPIS) System is not being accessed for every unplanned care attendance anyone aged under 18 or all pregnant women. This will lead to children, young people and unborn infants not being identified as being on a child protection plan or being a looked after child.	3 Moderate	4 Likely	12	Safeguarding	05/07/2023	04/08/2023	2
2709	Families and children are at risk of not receiving a co-ordinated approach to early help. The trust is not in a position to evidence early help work undertaken by Front Line Staff leading to the LA and Safeguarding Children Partnership Board raising concerns against the Trust that multi agency policy is not being appropriately implemented.	3 Moderate	4 Likely	12	Safeguarding	05/07/2023	03/09/2023	2
2710	Safeguarding information contained on Bulletin Board within Meditech and the associated safeguarding flags cannot be migrated onto Digicare. This will lead to front line staff being required to check the old system when patients attend and transcribe information onto new record. This is open to human error risk.	4 Major	3 Possible	12	Safeguarding	05/07/2023	04/08/2023	2
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)

There have been two closed risks for approval by the Corporate Risk Sub Committee.

1 . Risk 2645 – Governance

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.

Rationale for closure: Risk reviewed. Industrial action has since been concluded and the pay offer implemented by the DHSC. Discussed with COO, risk no longer applies. Closed by Allan Hawksey, Head of Risk and Safety, 22/06/2023

2. Risk 2660 - HR

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

Rationale for closure: Outstanding EPP screening has been completed. Closed by Rachel London, Deputy Director of HR, 21/06/2023

There were three escalations for approval by the Sub Committee that have been added to the Corporate Risk Register. There are a further 14 risks that Clinical Support Services are requesting the Sub Committee consider approving for escalation on to the Corporate Risk Register.

1. **Risk 2708 – Safeguarding – Risk score 12 (high) Version 1 created 05/06/2023**

The Child Protection Information Sharing (CPIS) System is not being accessed for every unplanned care attendance anyone aged under 18 or all pregnant women. This will lead to children, young people and unborn infants not being identified as being on a child protection plan or being a looked after child.

2. **Risk 2709 – Safeguarding – Risk score 12 (high) Version 1 created 05/06/2023**

Families and children are at risk of not receiving a co-ordinated approach to early help. The trust is not in a position to evidence early help work undertaken by Front Line Staff leading to the LA and Safeguarding Children Partnership Board raising concerns against the Trust that multi-agency policy is not being appropriately implemented.

3. Risk 2710 – Safeguarding – Risk score 12 (high) Version 3 created 05/07/2023

Safeguarding information contained on Bulletin Board within Meditech and the associated safeguarding flags cannot be migrated onto Digi care. This will lead to front line staff being required to check the old system when patients attend and transcribe information onto new record. This is open to human error risk.

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)	*23/24/139*		**Date: 14/09/2023**	
Report Title	**Corporate Governance Manual – 2023 Update**			
Prepared by	*Mark Grimshaw, Trust Secretary*			
Presented by	*Mark Grimshaw, Trust Secretary*			
Key Issues / Messages	*For the Board to approve the proposed amendments to the Trust's Corporate Governance Manual.*			
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 approve the proposed amendments to the Trust's Corporate Governance Manual.			
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
Audit Committee – July 2023 – comments noted in the main body of the report.			

EXECUTIVE SUMMARY

Amendment to the Corporate Governance Manual was last presented and agreed at the Board in September 2022.

A review of the document has been undertaken with input from the Trust Secretary, Finance Team and Head of Procurement & Contracts and a draft considered at the Audit Committee in July 2023.

Amendments to the document are shown utilising track changes.

MAIN REPORT

The following table provides a summary of the amendments that have been made to the Manual since July 2022:

Version control			
Version	**Section**	**Changes made**	**Date**
12.0	**Throughout**	**References to Head of Governance & Legal amended to Associate Director of Quality and Governance**	**July 2023**
12.0	**Throughout**	**References to the Chief Nurse & Midwife amended to Chief Nurse**	**July 2023**
12.0	**5.0 Table B (section 6)**	**Changes to thresholds and permissions on the recommendation from the Head of Procurement & Contracts**	**July 2023**
12.0	**5.0 Table B**	**Procurement of services and supplies threshold changed to £138,760 (inclusive of VAT) from £122,976**	**July 2023**
12.0	**Throughout**	**Reference of Head of Estates and Facilities replaced with Estates and Facilities Manager**	**July 2023**
12.0	**6.7**	**Removal of the reference to external audit being required to audit the Trust's quality account**	**July 2023**
12.0	**4.0**	**Approved committee membership and terms of reference added.**	**July 2023**
12.0	**Throughout**	**References to NHS Improvement and/or Monitor replaced with NHS England**	**July 2023**

Areas to note

Lower threshold for contracts etc.

A discussion was held at the Audit Committee on whether to increase the threshold for non-pay expenditure and contracting from £5,000 to £10,000. It was explained that the Trust was currently an outlier – the regional average being £15,000. It was agreed by the Committee that such an increase would

be significant and not optimal during a time of maintaining tight financial grip and control. It was therefore recommended to maintain the level at £5,000.

Potential changes to the procurement function

The current Head of Procurement & Contracts is leaving the Trust and the model of delivery of this function remains undefined at the time of review. There are numerous references to this role in the Corporate Governance Manual, particularly in relation to delegated powers, and the document will require updating once the procurement delivery model is finalised.

Impact of system working / structures on delegated authority

One of the impacts of Integrated Care Systems (ICSs) on NHS provider trusts is that they are changing the way that standing financial instructions (SFIs) and schemes of reservation and delegation (SRDs) are used.

In the past, SFIs and SRDs were typically developed and agreed by NHS trusts with arrangements with partners / commissioners agreed on a case-by-case basis. However, with the introduction of ICSs, there is a move towards developing more standardized SFIs and SRDs that can be used across multiple trusts within an ICS. This is because ICSs need to be able to pool resources and share services more effectively. In theory, standardized SFIs and SRDs will help to make this easier by ensuring that all trusts within an ICS are working to the same financial rules and procedures.

In addition to the impact on SFIs and SRDs, ICSs are also having an impact on the way that NHS provider trusts manage their finances. For example, ICSs are encouraging trusts to adopt a more integrated approach to financial planning. This means that trusts are being asked to consider the financial implications of their decisions not just in isolation, but also in the context of the wider ICS.

The move towards standardized SFIs and SRDs is still in its early stages, but it is likely to have a significant impact on the way that NHS provider trusts operate. It is likely that the Trust will be asked to agree delegate authorities as part of joint committee and committee-in-common arrangements as they develop during 2023/24. The Audit Committee will be kept updated of this development and it may be the case that the Corporate Governance Manual may need further review ahead of July 2024.

Recommendation

The Board is asked to approve the proposed amendments to the Trust's Corporate Governance Manual.

Liverpool Women's
NHS Foundation Trust

This is how we do it ….

Corporate Governance Manual

July 2023~~2~~
V1~~2~~1.0

Version control			
Version	**Section**	**Changes made**	**Date**
12.0	Throughout	References to Head of Governance & Legal amended to Associate Director of Quality and Governance	July 2023
12.0	Throughout	References to the Chief Nurse & Midwife amended to Chief Nurse	July 2023
12.0	5.0 Table B (section 6)	Changes to thresholds and permissions on the recommendation from the Head of Procurement & Contracts	July 2023
12.0	5.0 Table B	Procurement of services and supplies threshold changed to £138,760 (inclusive of VAT) from £122,976	July 2023
12.0	Throughout	Reference of Head of Estates and Facilities replaced with Estates and Facilities Manager	July 2023
12.0	6.7	Removal of the reference to external audit being required to audit the Trust's quality account	July 2023
12.0	4.0	Approved committee membership and terms of reference added.	July 2023
12.0	Throughout	References to NHS Improvement and/or Monitor replaced with NHS England	July 2023
11.0	Throughout	Updates post exit from the EU reflected throughout the document	July 2022
11.0	4.0	Approved committee membership and terms of reference added.	July 2022
11.0	6.27.11.10.9	Instances where formal competitive tendering or competitive quotation is not required updated	July 2022
10.0	Throughout	Public Contracts Regulations 2015 to the procurement of services and supplies threshold changed to £122,976 rather than £189,330.	August 2021
10.0	Throughout	Removal of references to 'OJEU'	August 2021
10.0	5.0, Table A	TABLE A – Delegated Authority • Removal of Head of Estates – replaced where appropriate with Director of Estates • 19c – removal of references to outdated legislation	July 2021

		• **35a – inclusion of the ability of Executives to nominate a Deputy to enter the Trust into contracts.** • **35c – addition of Divisional Managers as having operational responsibility to nominate officers to oversee and manage contracts on behalf of the Trust** • **35h – removed – duplication with 35g**	
10.0	**Throughout**	**References to 'CONCODE' removed throughout the document.**	**July 2021**
10.0	**4.1**	**Updated Committee Structures**	**July 2021**
10.0	**3.3.4**	**References to Nominations Committee (Executive Directors) and the Remuneration and Terms of Service Committee and replaced by Nomination & Remuneration Committee**	**July 2021**
10.0	**Throughout**	**Alignment with new Corporate branding**	**July 2021**
10.0	**Throughout**	**Change of job titles:** • **Director of Finance changed to Chief Finance Officer** • **Director of Nursing & Midwifery to Chief Nurse & Midwife**	**July 2021**
10.0	**4.0**	**Approved committee membership, Committee Structure and terms of reference added.**	**July 2021**
9.0	**6.15.1.3**	**Reference to Nomination & Remuneration Committee updated to align with updated Nomination & Remuneration Committee Terms of Reference.**	**September 2020**
9.0	**8.0**	**Board Code of Conduct Updated**	**September 2020**
8.0	**6.0 (6.27.1.6.6)**	**Reasons for a single tender action to be reported to the Audit Committee and through the Board of Directors in the Chair's Report.**	
8.0	**6.0 (6.27.1.6.6)**	**All requests to waive tenders to the Audit Committee quarterly and not directly to the Board of Directors**	**July 2020**
8.0	**5.0, Table B**	**OJEU threshold updated from £181,302 to &189,330**	**July 2020**
8.0	**5.0, Table B (4)**	**Provision 'Requisitioning stock and non-stock items / services against a budget, in line with EU procurements thresholds (subject to periodic review) and quotation and tendering procedures set out under Section 6' amended to 'Approving requisitions, authorising invoices and recommending contract awards'.**	**July 2020**

8.0	**5.0, Table A (35, h)**	**Removal of the provision - 'Decide if late tenders should be considered'.**	**July 2020**
8.0	**5.0, Table A (35, a)**	**Provision added – 'Entering into contracts on behalf of the Trust, regardless of value'**	**July 2020**
8.0	**5.0, Table A (35, b)**	**Removal of Head of Estates from Operational Responsibility**	**July 2020**
8.0	**5.0, Table A (30, e)**	**Insertion of '…in line with national requirements' following the 'prompt payment of accounts' section**	**July 2020**
8.0	**5.0, Table A (34, w)**	**Authority to authorise overtime – limited to Clinical Directors and Chief Operating Officer. To encourage preferred option of utilising the Bank rather than overtime.**	**July 2020**
8.0	**5.0, Table A (34, nn)**	**Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances – provision removed.**	**July 2020**
8.0	**5.0, Table A (34, x)**	**Reference 'authorised approvers' in place of budget holders.**	**July 2020**
8.0	**5.0, Table A (34, k)**	**Addition of '…at recruitment stage' to the provision of the granting of additional increments.**	**July 2020**
8.0	**5.0, Table A (34, q)**	**Remove section on 'Authorise car users' – Trust no longer has a car lease scheme.**	**July 2020**
8.0	**5.0, Table A (34, p)**	**Renewal of fixed term contract – role of Vacancy Control Panel stated.**	**July 2020**
8.0	**5.0, Table A (17, l)**	**Reference to 'All corporate posts to be reviewed by the Vacancy Control Panel and all clinical posts by the Executive team' added to operational responsibility.**	**July 2020**
8.0	**5.0, Table A (33, c)**	**Operational responsibility for Informing staff of their duties in respect of patients' property noted as being Head of Governance and Quality rather than Head of Legal Services.**	**July 2020**
8.0	**5.0, Table A (34, i)**	**Removal of line managers from being authorised to book agency staff. In relation to Nursing and Midwifery agency staff, line managers to be replaced with Heads of Nursing / Midwifery.**	**July 2020**
8.0	**5.0, Table A (34, i)**	**Deputy Chief Nurse and Midwife or Matron listed as having operational responsibility for approving bank usage.**	**July 2020**
8.0	**5.0, Table A (17, i)**	**Responsibility to Identify and implement cost improvements and income generation activities in line with the Operational Plan identified as being all budget holders.**	**July 2020**

8.0	**5.0, Table A (throughout)**	**References to 'business plan' removed from budget section and replaced with operational plan.**	**July 2020**
8.0	**5.0, Table A (17, b)**	**Operational responsibility for budget submissions to the Board identified as Deputy Chief Finance Officer (from Chief Finance Officer)**	**July 2020**
8.0	**5.0, Table A (throughout)**	**Removal of reference to Corporate Administration Manager**	**July 2020**
8.0	**5.0, Table A**	**Caldicott Guardian changed from Chief Nurse and Midwife to Medical Director**	**July 2020**
8.0	**5.0, Table A (throughout)**	**Removal of references to Hewitt Centre Managing Director**	**July 2020**
8.0	**Throughout**	**Change of job titles:** • **Director of Operations changed to Chief Operating Officer** • **Director of Workforce & Marketing to Chief People Officer**	**July 2020**
8.0	**4.2**	**Trust Board Terms of Reference added**	**July 2020**
8.0	**4.0**	**Approved committee membership, Committee Structure and terms of reference added.**	**July 2020**
7.0	**4.0**	**Approved committee membership, Committee Structure and terms of reference added.**	**July 2019**
7.0	**5.0, Table A**	**Section 13 - Conflicts of interest definition of decision-making staff in compliance of the Trust's policy 'Managing conflicts of Interest'**	**July 2019**
7.0	**5.0, Table A**	**Section 22 – Gifts and Hospitality- Threshold increased in line with the Trust Policy 'Managing conflict of Interest' from £25 to £50.**	**July 2019**
6.0	**4.0**	**Approved committee membership and terms of reference added.**	**05.07.18**
5.2	**5.0** **Table B**	**OJEU threshold has changed and been updated. Threshold value amended from £164,176 (ex VAT) to £181,302 (ex VAT).**	**09.01.2018**
5.1	**4.0**	**Change of name of Governance and Clinical Assurance Committee to the Quality Committee** **Amended Terms of Reference of the Quality Committee and Remuneration and Nominations Committee** **Amended Integrated Structure Charts**	**08.01.2018**
4.1	**4.0**	**Board approved Terms of reference added**	**07.07.17**
	Table B – Delegated Financial Limits	**Threshold value amended from £172,514 ex VAT when in fact it should be £164,176 ex VAT.**	**15.06.17**

4.0	**4.0**	**Board approved Terms of reference added**	**30.01.17**
	5.0	**Table B – Delegated Financial Limits**	**30.01.17**
	6.0	**Amendments to Standing Financial Instructions.**	**30.01.17**
	All	**Changes to names throughout the document, i.e. Trust regulator name, job titles of directors, heads of departments.** **Full reformat required to provide consistency.**	**30.01.17**
3.0	**4.0 Terms of reference**	**Board approved Terms of reference added**	**27.07.15**
	Table A	**Amended job titles of Directors.** **Amended waiving requirements to include delegated authority to authorise the use of a waiver.** **Amended thresholds to reflect the revised EU threshold.**	**27.07.15**
	6.0	**Prudential Borrowing Code removed as is no longer a requirement** **The approval limits for Charitable Expenditure updated.**	**27.07.15**
2.0	**4.0 Terms of reference**	**Board approved Terms of reference added**	**03.10.14**
1.1	**6.12.3** **6.13.3.2** **Table A** **Table B**	**Minor amendments approved by Board of Directors in April 2014.**	**05.04.14**

Contents

1. Foreword

1.1. Liverpool Women's NHS Foundation Trust (the Trust) is a public benefit corporation that was established in accordance with the provisions of the National Health Service Act 2006. As a body corporate the Trust has specific powers to contract in its own name and to act as a corporate trustee.

1.2. Corporate governance is the system by which an organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability and probity. Effective corporate governance, along with clinical governance, is essential for a Foundation Trust to achieve its clinical, quality and financial objectives. Fundamental to effective corporate governance is having the means to verify the effectiveness of this direction and control. This is achieved through integrated governance.

1.3. The NHS Act 2006 and subsequent regulations set out the legal framework within which the Foundation Trust operates. The Trust's Constitution sets out who can be members of the Foundation Trust and how it should conduct its business. The Licence is provided by ~~NHS Improvement~~NHS England (the independent regulator of Foundation Trusts) and identifies the conditions of operation. The Accounting Officer Memorandum requires Foundation Trust Boards of Directors to adopt schedules of reservation and delegation of powers and to set out the financial framework within which the organisation operates.

1.4. This corporate governance manual comprises:

- Schedule of matters reserved to the Board of Directors
- Matters delegated by the Board of Directors to its committees
- Scheme of delegation
- Standing Financial Instructions
- Standing Orders for the Board of Directors
- Code of Conduct for the Board of Directors
- Council of Governors' Code of Conduct
- Code of Conduct for NHS Managers
- Standards of Business Conduct for NHS Staff
- Standing Orders for the Council of Governors.

1.5. Compliance with these documents is required of the Foundation Trust, its Executive and Non-Executive Directors, Governors, officers and employees, all of whom are also required to comply with:

- The Trust's Constitution and Provider Licence
- The Accounting Officer Memorandum.

1.6. The Trust must also have agreed its own Standing Orders as a framework for internal governance. Standing Orders for both the Board of Directors and Council of Governors are included in this corporate governance manual.

1.7. All of the above-mentioned documents together provide a regulatory framework for the business conduct of the Foundation Trust.

1.8. The Foundation Trust Board of Directors also has in place Audit, Nomination and Remuneration committees and an established framework for managing risk.

1.9. It is essential that all Directors, Governors, officers and employees know of the existence of these documents and are aware of their responsibilities include within. A copy of this

manual is available on the Trust's website and intranet and has been explicitly brought to the attention of key staff within the organisation and to all staff via the internal communication routes.

1.10. Any queries relating to the contents of these documents should be directed to the Chief Finance Officer, Trust Secretary or myself who will be pleased to provide clarification.

Kathryn Thomson
Chief Executive
July 2023~~2~~

2. Definition and interpretation

2.1. Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this corporate governance manual bear the same meaning as in the NHS Act 2006 and the Constitution. References to legislation include all amendments, replacements, or re-enactments made.

2.2. Headings are for ease of reference only and are not to affect interpretation. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

2.3. In this corporate governance manual, the following definitions apply:

	Definition
The 2022 Act	The Health and Care Act 2022
The 2012 Act	The Health and Social Care Act 2012
The 2006 Act	The National Health Service Act 2006
The 1977 Act	The National Health Service Act 1977
Accounting Officer	The person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act; they shall be the Officer responsible and accountable for funds entrusted to the Foundation Trust in accordance with the NHS Foundation Trust Accounting Officer Memorandum. They are responsible for ensuring the proper stewardship of public funds and assets. The NHS Act 2006 designates the Chief Executive of the NHS Foundation Trust as the Accounting Officer
Agenda Item	• Board of Directors - an item from a Board member (notice of which has been given) about a matter over which the Board has powers or duties or which affects the services provided by the Foundation Trust • Council of Governors – an item from a Governor or Governors (notice of which has been given) about a matter over which the Council has powers or duties or which affects the services provided by the Foundation Trust
Appointing organisations	Those organisations named in the constitution who are entitled to appoint governors
Authorisation	An authorisation given by NHS ~~Improvement~~ England under Section 35 of the 2006 Act
The Board	The Board of Directors of the Foundation Trust as constituted in accordance with the Trust's constitution
Bribery Act	The Bribery Act 2010
Budget	A resource, expressed in financial or workforce terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Foundation Trust
Budget holder	The Director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation
The Chair	Is the person appointed by the Council of Governors to lead the Board and ensure it successfully discharges its overall responsibility for the Foundation Trust as a whole. It means

	Definition
	the Chair of the Foundation Trust, or, in relation to the function of presiding at or chairing a meeting where another person is carrying out that role as required by the Constitution, such person
Chief Executive	The chief officer of the Foundation Trust
Committee	A committee or subcommittee created and appointed by the Foundation Trust
Constitution	The constitution of the Foundation Trust as amended from time to time. Describes the type of organisation, its primary purpose, governance arrangements and membership
Contracting and procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets
Council of Governors	The Council of Governors of the Foundation Trust as constituted in accordance with the Trust's constitution
Director	A member of the Board of Directors
Chief Finance Officer	The chief finance officer of the Foundation Trust
External auditor	The person appointed to audit the accounts of the Foundation Trust, who is called the auditor in the 2006 Act
Financial year	Successive periods of twelve months beginning with 1 April
Foundation Trust	Liverpool Women's NHS Foundation Trust
Foundation Trust contract	Agreement between the Foundation Trust and Clinical Commissioning Groups and/or others for the provision and commissioning of health services
Funds held on Trust	Those trust funds which the Foundation Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under the 2006 Act. Such funds may or may not be charitable
Governor	An elected or appointed member of the Council of Governors
Legal advisor	A properly qualified person appointed by the Foundation Trust to provide legal advice
Licence	The document issued by the sector regulator setting out the conditions of operation for a Foundation Trust
NHS ~~Improvement~~ England(previously known as NHS Improvement and/or Monitor)	The independent regulator (NHS Improvement) took over the responsibilities of its predecessors responsibilities from [1 April 2016] NHS Improvement became part of NHS England in July 2022.
Meeting	• Board of Directors – a duly convened meeting of the Board of Directors • Council of Governors - a duly convened meeting of the Council of Governors
Member	A member of the Foundation Trust
Motion	A formal proposition to be discussed and voted on during the course of a meeting

	Definition
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions
Non commissioner contract	Agreements with non Clinical Commissioning Group to organisations covering the variety of services that the Foundation Trust provides and charges for
Officer	An employee of the Foundation Trust
Partner	In relation to another person, a member of the same household living together as a family unit
Protected property	Property identified in the Licence as being protected. This will generally be property that is required for the purposes of providing the mandatory goods and services and mandatory training and education
Registered medical practitioner	A fully registered person within the meaning of the Medicines Act 1983 who holds a licence to practice under that Act
Registered nurse or midwife	A nurse, midwife or health visitor registered in accordance with the Nurses, Midwives and Health Visitors Act 1997
Secretary	The Secretary appointed under the constitution, the Secretary of the Foundation Trust or any other person appointed to perform the duties of the Secretary, including a joint, assistant or deputy secretary
Standing Financial Instructions	(SFIs) regulate the conduct of the Trust's financial matters
Standing Orders	(SOs) incorporate the Constitution and regulate the business conduct of the Foundation Trust

3. Schedule of matters reserved to the Board of Directors

3.1. General enabling provisions

3.1.1. The Board of Directors may determine any matter it wishes, for which it has authority, in full session within its statutory powers. In accordance with the Code of Conduct and Accountability adopted, the Board explicitly reserves that it shall itself approve or appraise, as appropriate, the following matters detailed in paragraph 3.3 below. All Board members share corporate responsibility for all decisions of the Board and the Board remains accountable for all of its functions, even those delegated to individual committees, subcommittees, directors or officers.

3.2. Duties

It is the Board's duty to:

- Act within statutory financial and other constraints
- Be clear what decisions and information are appropriate to the Board of Directors and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these
- Ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account
- Establish performance and quality measures that maintain the effective use of resources and provide value for money;
- Specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities;
- Establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.

3.3. Reserved matters

3.3.1. Standing Orders

Approval of and changes to Board standing orders.

3.3.2. Matters of Governance

- Approval of and changes to the schedule of matters reserved to the Board of Directors
- Approval of and changes to the standing financial instructions
- Suspension of Board standing orders
- Ratify or otherwise instances of failure to comply with standing orders brought to the Chief Executive's attention in accordance with Standing Orders
- Ratification of any urgent decisions taken by the Chair and Chief Executive, in accordance with the standing orders
- Approval of and changes to codes of conduct
- Approval of the Trust's risk assurance framework
- Approval of the Board's scheme of reservation and delegation
- Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Foundation Trust and approval of any changes
- Approval of the remit and membership of Board committees, including
- Approval of terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board of Directors
- To confirm the recommendations of committees where they do not have executive powers

- To receive reports from committees including those which the Foundation Trust is required by the National Health Service Act 2006 or other regulation to establish and to take appropriate action thereon
- Audit arrangements
- Clinical audit arrangements
- The annual audit letter
- Annual report (including quality report/accounts) and statutory financial accounts of the Trust
- Annual report and accounts for funds held on trust (charitable funds)
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a corporate trustee for funds held on trust
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a bailer for patients' property
- Disciplining Board members or employees who are in breach of statutory requirements or Standing Orders.

3.3.3. Important regulatory matters

- Compliance with the Trust's Licence or any document which replaces it, its constitution, and all statutory and regulatory obligations
- Directors' and officers' declaration of interests and determination of action if required
- Arrangements for dealing with complaints
- Disciplinary procedures for officers of the Trust.

3.3.4. Appointments and dismissals

- Appointment and dismissal of committees (and individual members) that are directly accountable to the Board of Directors excluding the Audit Committee, the Nomination & Remuneration Committee. This does not imply that individual members of all Committees can be dismissed
- Appointment, appraisal, disciplining and dismissal of Executive Directors
- Confirm the appointment of members of any committee of the Foundation Trust as representatives on outside bodies
- Appoint, appraise, discipline and dismiss the Trust Secretary
- Approve proposals received from the Nomination & Remuneration Committee regarding the Chief Executive, Directors and senior employees.

3.3.5. Strategic direction

- Strategic aims, direction and objectives of the Foundation Trust
- Financial plans and forecasts
- Approval of the Trust's annual plan, strategic developments and associated business plans
- Approval of annual revenue and capital budgets
- Approval of all Trust strategies to include, but not be limited to the risk management strategy and human resources strategy
- Approval of capital plans including:
    - Proposals for acquisition, disposal or change of use of land and/or buildings
    - Private finance initiative (PFI) proposals
    - Individual contracts, including purchase orders of a capital or revenue nature in accordance with Delegated Financial Limits, Table B, section 2.
- Approve proposals for action on litigation against or on behalf of the Foundation Trust where the likely financial impact is as shown in the Delegated Financial Limits, Table B, section 2 or contentious or likely to lead to extreme adverse publicity, excluding claims covered by the NHS risk pooling schemes.

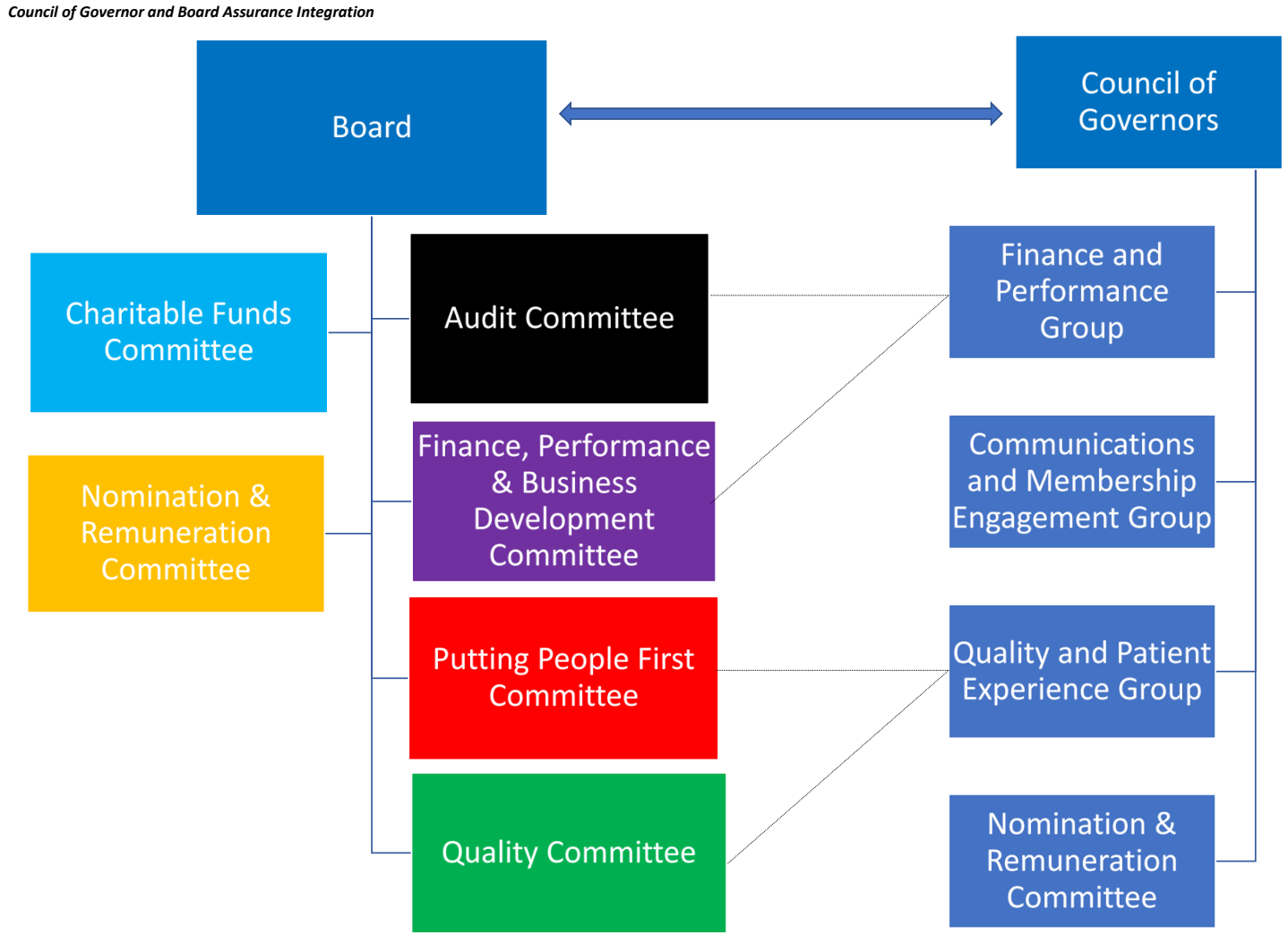
3.3.6. Monitoring performance
Operational and financial performance arrangements at intervals that it shall determine.

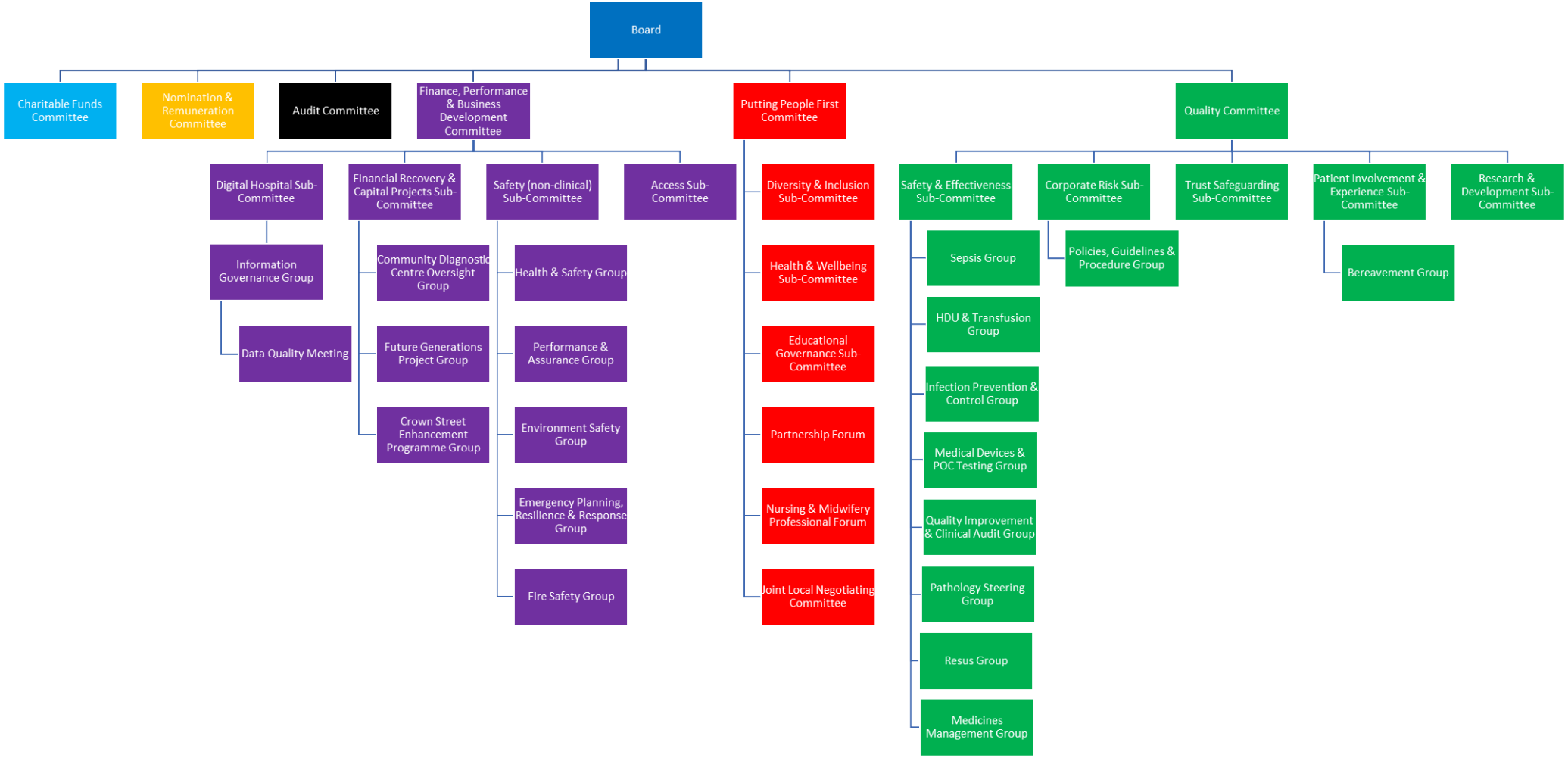
3.3.7. Other matters

- Appointment of bankers
- Approve the opening of bank accounts.
- Approve individual compensation payments.

4. Matters delegated by the Board of Directors to its committees

4.1. Committee Structure




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

Board Committee Non-Executive Director membership.

For additional members please refer to TORs.

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

4.2. Board of Directors Terms of Reference

BOARD OF DIRECTORS TERMS OF REFERENCE	
Role and Purpose:	The Terms of Reference describe the role and working of the Board of Directors (hereafter referred to as the Board) and are for the guidance of the Board, for the information of the Trust as a whole and serve as the basis of the Terms of Reference for the Board's own Committees. The Trust exists to 'provide goods and services for any purposes related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.' The Trust has a Board which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a Committee of directors or to the Chief Executive. The Board consists of Executive Directors, one of whom is the Chief Executive, and Non-Executive Directors, one of whom is the Trust Chair. The nominated deputy for the Chief Executive and Trust Chair, upon appointment to a substantive or acting up role, must be formally recorded in the minutes.
Duties:	The Board leads the trust by undertaking four key roles: • setting strategy; • supervising the work of the executive in the delivery of the strategy and through seeking assurance that systems of control are robust and reliable; • setting and leading a positive culture for the Board and the organisation; • giving account and answering to key stakeholders, particularly the Council of Governors. The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public. Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust). The practice and procedure of the meetings of the Board, and of its committees, are not set out here but are described in the Board's Standing Orders.

GENERAL RESPONSIBILITIES:

The general responsibilities of the Board are:

- to maintain and improve quality of care;
- to work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, effective, accessible, and well governed services for patients, service users and carers;
- to ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity;
- to ensure relationships are maintained with the Trust's stakeholders, regulators, public, governors, staff and patients, such that the trust can discharge its wider duties;
- to exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner;
- to ensure compliance with all applicable law, regulation and statutory guidance.

In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of non-executive and executive directors.

LEADERSHIP

The Board provides active leadership to the organisation by:

- ensuring there is a clear vision and strategy for the Trust that is well known and understood by stakeholders and is being implemented within a framework of prudent and effective controls which enable risk to be assessed and managed;
- ensuring the Trust is a good employer by the development of a workforce strategy and its appropriate implementation and operation;
- implementing effective Board and Committee structures and clear lines of reporting and accountability throughout the organisation.

STRATEGY

The Board:

- sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;

- monitors and reviews management performance to ensure the Trust's objectives are met;
- oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- develops and maintains an annual business plan, with due regard to the views of the council of governors, and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders;
- ensures that national policies and strategies are effectively addressed and implemented within the Trust.

CULTURE, ETHICS AND INTEGRITY

The Board:

- is responsible for setting values, ensuring they are widely communicated and adhered to and that the behaviour of the Board is entirely consistent with those values;
- promotes a patient-centred culture of openness, transparency and candour;
- ensures that high standards of corporate governance and personal integrity are maintained in the conduct of foundation trust business.

GOVERNANCE

The Board:

- ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance and appropriate codes of conduct, accountability and openness applicable to NHS provider organisations;
- ensures that all licence conditions relating to the Trust's governance arrangements are complied with;
- ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
- ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective and safe services taking account of patient and carer experiences and maintaining the dignity of those cared for;
- ensures that all the required returns and disclosures are made to the regulators;

- formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation trust business;
- agrees the schedule of matters reserved for decision by the Board of Directors;
- ensures that the statutory duties of the Trust are effectively discharged;
- Acts as corporate trustee for the Trust's charitable funds.

RISK

The Board:

- ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
- ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement in the development of care plans, the review of quality of services provided and the development of new services;
- ensures there are appropriately constituted appointment and evaluation arrangements for senior positions such as consultant medical staff and those reporting to executive directors.

COMMUNICATION

The Board:

- Ensures an effective communication channel exists between the Trust, its governors, members, staff and the local community.
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback.
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publicly through Board meetings in public and also via the Trust's website.

FINANCIAL AND QUALITY SUCCESS

The Board:

- Ensures that an effective system of finance and quality is embedded within the Trust.
- Ensures that the Trust operates effectively, efficiently and economically.
- Ensures the continuing financial viability of the organisation.
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved.
- Ensures that the Trust achieves the quality targets and requirements of stakeholders within the available resources.

- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

RESPONSIBILITIES OF BOARD MEMBERS

All Members of the Board:

- Have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not impact upon the particular responsibilities of the Chief Executive as the Accounting Officer.
- Have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

Role of the Trust Chair:

The Trust Chair is the guardian of the Board's decision-making processes and provides general leadership of the Board and the Council of Governors.

- Responsible for leading the Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.
- Reports to the Board and is responsible for the effective operation of the Board and the Council of Governors.
- Responsible for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives.

Role of the Chief Executive

- The Chief Executive reports to the Trust Chair and to the Board directly. All members of the management structure report either directly or indirectly to the Chief Executive.
- The Chief Executive is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.
- The Chief Executive is responsible for implementing the decisions of the Board and its Committees, providing information and support to the Board and Council of Governors.

Role of Executive Directors (EDs)

- Share collective responsibility with the Non-Executive Directors as part of a unified Board.
- Shape and deliver the strategy and operational performance in line with the Trust's strategic aims.

Role of Non-Executive Directors (NEDs)

- Bring a range of varied perspectives and experiences to strategy development and decision making.
- Ensure that effective management arrangements and an effective management team are in place.
- Hold the Executive Directors to account for performance of the operational responsibilities.
- Scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. NEDs should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.
- To take an active role in providing advice, support and encouragement to Executive Directors.

Role of the Senior Independent Director (SID)

- Is a Non-Executive Director appointed by the Board in consultation with the Council of Governors to undertake the role. Normally the SID will not be the Vice Trust Chair although this may be the case if the Board deems it necessary.
- Will be available to members of the Foundation Trust and to Governors if they have concerns which, contact through the usual channels of the Trust Chair, Chief Executive, Deputy Chief Executive, Director of Finance and Trust Secretary, has failed to resolve or where it would be inappropriate to use such channels.
- Has a key role in supporting the Trust Chair in leading the Board and acting as a sounding board and source of advice for the Trust Chair. The SID has a role in supporting the Trust Chair in his/her role as Trust Chair of the Council of Governors.

In addition to the duties described here, the SID has the same duties as the other Non-Executive Directors.

Role of the Trust Secretary

The Trust Board shall be supported by the Trust Secretary whose duties in this respect will include:

- agreement of the agenda, for Board and Board committee meetings, with the relevant Chair, in consultation with the Chief Executive;
- collation of reports and papers for Board and committee meetings;
- ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward;
- ensuring that board procedures are complied with;

	• supporting the Chair in ensuring good information flows within and between the Board, its committees, the Council of Governors and senior management; • advising the Board and Board committees on governance matters; • supporting the chair on matters relating to induction, development and training for directors
Membership:	The composition of the Board shall be: • A Non-Executive Chair • Not more than seven other non-executive Directors • Not more than seven executive Directors including: o The Chief Executive (who is the Accounting Officer) o Chief Finance Officer o A registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984) o A registered nurse or registered midwife.
Quorum:	Six Directors including not less than three executive Directors (one of whom must be the Chief Executive or another Executive Director nominated by the Chief Executive) and not less than three non-executive Directors (one of whom must be the Chair or the Vice Chair of the Board of Directors) shall form a quorum. An officer in attendance for an executive Director but without formal acting up status may not count towards the quorum. If a Director has been disqualified from participating in a discussion on any matter and/or from voting on any resolution by reason of declaration of a conflict of interest, that Director shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minute of the meeting. The meeting must then proceed to the next business.
Voting:	All questions put to the vote shall, at the discretion of the Chair, be decided by a show of hands save that no resolution of the Board of Directors shall be passed if it is opposed by all of the non-executive Directors present or by all of the executive Directors present. A paper ballot may be used if a majority of the Directors present so request. In case of an equality of votes the Chair shall have a second and casting vote.

	If at least one third of the Board members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot). If a Board member so requests, her vote shall be recorded by name. In no circumstances may an absent Director vote by proxy. Subject to Standing Order 59, absence is defined as being absent at the time of the vote. An officer who has been appointed formally by the Board to act up for an executive Director during a period of incapacity or temporarily to fill an executive Director vacancy, shall be entitled to exercise the voting rights of the executive Director. An officer attending the Board to represent an executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive Director. An officer's status when attending the meeting shall be recorded in the minutes. Where an executive Director post is shared by more than one person: • Each person shall be entitled to attend meetings of the Board • Each of those persons shall be eligible to vote in the case of agreement between them • In the case of disagreement between them no vote should be case • The presence of those persons shall count as one person.
Attendance:	The Board of Directors may agree that Directors can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting. Directors who are unable to attend a meeting shall notify the Secretary in writing in advance of the meeting in question so that their apologies may be submitted.
Frequency:	Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Secretary will publish the dates, times and locations of meetings of the Board in advance.
Accountability and reporting arrangements:	The Council of Governors is responsible for holding the Board to account, for example by attending Board meetings in public and meeting with the Trust Chair, Chief Executive and Committee Chairs on the day of Board meetings / Council of Governors' meeting. The agenda and minutes of Board meetings will be shared with the Council of Governors.

	The Trust Chair will be responsible for ensuring the Board of Directors adheres to its Terms of Reference and Annual Work Plan. The Board shall self-assess its performance following each board meeting. A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all directors and others as agreed with the Chair and Chief Executive from time to time.
Monitoring effectiveness:	The Board will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Board.
Reviewed by Board of Directors:	*6 April 2023*
Approved by Board of Directors:	*6 April 2023*
Review date:	April 2024
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

4.3. Committees of the Board – Terms of Reference

- Audit Committee
- Nomination & Remuneration Committee
- Quality Committee
- Putting People First Committee
- Finance, Performance and Business Development Committee
- Charitable Funds Committee

AUDIT COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.
Duties:	The Committee is responsible for: **a. Governance, risk management and internal control** The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievements of the Trust's objectives. It will provide an independent and objective view on internal control and probity. In addition, the committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance, reviewing significant financial reports and the judgements contained in them. In particular, the Committee will review the adequacy of: • All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance to external bodies), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board • The process of preparing the Trust's returns to ~~NHS Improvement~~NHS England (which returns are approved by the Board's Finance and Performance Committee) • The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements • The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification • The Trust's standing orders, standing financial instructions and scheme of delegation • The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State directions and as required by the NHS Counter Fraud Authority • The arrangements by which Trust staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In so doing the Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

The Committee will undertake an annual training needs assessment for its own members.

b. Internal audit

The Committee will ensure that there is an effective internal audit function established by management that meets mandatory government and Public Sector Internal Auditing Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- Reviewing the internal audit programme, considering the major findings of internal audit investigations (and management's response), and ensuring coordination between internal and external auditors
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- Annual review of the effectiveness of internal audit.

c. External audit

The Committee shall review the independence, objectivity and work of the external auditor appointed by the Council of Governors and consider the implications and management's response to this work. This will be achieved by:

- Consideration of the appointment and performance of the external auditor, including making recommendations to the Council of Governors regarding the former
- Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure coordination with internal auditors and with other external auditors
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before

submission to the Board and any audit work performed outside the annual audit plan, together with the appropriateness of management's response
- Recommending to the Council of Governors the engagement of the external auditor in respect of non-audit work, taking into account relevant ethical guidance regarding the provision of such services
- Annual review of the effectiveness of external audit.

d. Other assurance functions

The Committee will review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. These will include, but will not be limited to, reviews and reports by the Department of Health, arms length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Resolution, etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc) or the Local Anti-Fraud Specialist.

In addition the Committee will review the work of other Committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality Committee, Finance, Performance & Business Development Committee and Putting People First Committee, and include a review of an annual report of each of the Committees against their terms of reference. In reviewing the work of the Quality Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

The Committee will also review all suspensions of standing orders and variation or amendment to standing orders.

The Audit Committee will report to the Board and to the Council of Governors any matters in respect of which it considers action or improvement is needed.

e. Counter fraud

The Audit Committee will satisfy itself that the Trust has adequate arrangements in place for countering fraud and will approve the appointment of the Local Anti-Fraud Specialist. The Committee will review the outcomes of counter fraud work.

f. Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

	g. Financial reporting The Audit Committee shall monitor the integrity of the Annual financial statements of the Trust. The Audit Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. The Audit Committee will review the Trust's annual report and financial statements before submission to the Board, focusing particularly on: • The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee • Changes in, and compliance with, accounting policies and practices • Unadjusted mis-statements in the financial statements • Major judgemental areas, and • Significant adjustments resulting from the audit • Letter of representation • Qualitative aspects of financial reporting.
Membership:	The Committee membership will be appointed by the Board of Directors from amongst its Non-Executive members and will consist of not less than three members. 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 two members.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	a. Members Members will be required to attend a minimum of 75% of all meetings. b. Officers The Chief Finance Officer, Deputy Chief Finance Officer, Financial Controller and Deputy Chief Nurse & Midwife shall normally attend meetings. At least once a year the Committee will meet privately with external and internal auditors.

	The Chief Executive and other executive directors will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are within the responsibility of that director. The Chief Executive will also be required to attend when the Audit Committee discusses the process for assurance that supports the Annual Governance Statement. The Trust Secretary will attend to provide appropriate support to the Chair and Committee members.
Frequency:	Meetings shall be held at least four times per year. The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Audit Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year and, as part of this report, will provide commentary in support of the Annual Governance Statement (AGS), specifically dealing with the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts. In providing this commentary in support of the AGS the Committee will seek relevant assurance from the Chair of the Board's Quality Committee. Trust standing orders and standing financial instructions apply to the operation of the Audit Committee.
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 Audit Committee:	23 March 2023
Approved by Board of Directors:	13 September 2023
Review date:	March 2024
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

NOMINATION & REMUNERATION COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Nomination and Remuneration Committee (the Committee).
Duties:	The Committee is responsible for: a. Overseeing the recruitment and selection process for the posts of Chief Executive[1] and Executive Directors b. Preparing a description of the role and capabilities required for the Chief Executive and Executive Director posts to reflect the balance of skills, knowledge and experience required c. Succession planning Executive appointments taking into account the challenges and opportunities facing the Trust and the skills and expertise required on the Board d. Reviewing the structure, size and composition of the Executive Director composition of the Board of Directors e. Reviewing Executive Directors' performance. f. Determining the remuneration and terms of service of the Chief Executive and the Executive Management Team g. Determining the annual cost of living award for senior managers (excluding those paid under Agenda for Change arrangements) h. Succession planning for Executive Director appointments i. Overseeing agreement of appropriate contractual arrangements relating to the Chief Executive and Executive Management Team j. Scrutinising any termination payments relating to the Chief Executive or the Executive Management Team, ensuring that they have been properly calculated and take account of any relevant guidance k. To be responsible for any disciplinary issue relating to the Chief Executive or member of the Executive Management Team which may result in their dismissal. The Committee will not be responsible for any disciplinary issue which is short of dismissal l. Such other duties as the Board of Directors may delegate.
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Trust Chair • All Non-Executive Directors Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication).

[1] Note that Chief Executive appointments are subject to approval by the Council of Governors

	Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Chair of the Board of Directors will be the Chair of the Committee. The Vice Chair of the Board will be the Vice Chair of the Committee from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent.
Quorum:	A quorum shall be three members including the Chair or Vice Chair and at least two Non-Executive Directors.
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 Chief Executive and Chief People Officer (or equivalent executive lead for the Trust with responsibility for the human resources functions of the Trust) will be in attendance at its meetings, as and when appropriate and necessary. The Trust Secretary will act as Secretary to the Committee.
Frequency:	Meetings shall be held at least once per year or as required to fill Executive Director vacancies. 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. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Nomination and Remuneration Committee will be accountable to the Board of Directors. The minutes of the Nomination & Remuneration Committee will be formally recorded and submitted to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it or require executive action. Summary minutes will also be circulated to members of the Audit Committee. The Committee will report to the Board annually on its work and performance in the preceding year.

	Trust standing orders and standing financial instructions apply to the operation of the Remuneration and Nomination Committee.
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 Nominations & Remuneration Committee:	14 September 2023
Approved by Board of Directors:	TBC
Review date:	September 2024
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

QUALITY COMMITTEE TERMS OF REFERENCE	
Constitution:	The Committee is established by the Board of Directors and will be known as the Quality Committee (QC) (the Committee).
Duties:	The Committee's responsibilities fall broadly into the following three areas: Strategy and Performance a) Oversee the development and implementation of the Quality Strategy with a clear focus on upholding the tenants of quality (Governance, safety, patient experience and clinical effectiveness). b) Ensure that the Quality Strategy and performance are consistent with the Trust's; Vision and strategic objectives and oversee any initiatives undertaken by the Trust that relates to the development and implementation of the Quality Strategy. c) Review trends in patient safety, experience and outcomes (effectiveness) to provide assurance to the Board on performance and commission 'deep dives' as appropriate. d) To receive assurance that action plans arising from in-patient, out-patient and other care related surveys are being undertaken and make recommendations to the Board as appropriate. e) Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery. Governance f) Oversee the effectiveness of the clinical systems developed and implemented to ensure they maintain compliance with the Care Quality Commission's Fundamental Standards in relation to Quality, Safety, experience and effectiveness. g) Obtain assurance of the Trust's ongoing compliance with the Care Quality Commission registration. h) Review the controls and assurance against relevant quality risks on the Board Assurance Framework and provide assurance to the Board that risks to the strategic objectives relating to quality and safety are being managed and facilitate the completion of the Annual Governance Statement at year end. i) Obtain assurance that the Trust is compliant with guidance from NICE (through receipt of an Annual Report) and other related bodies.

	j) Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices from NHSI, the Care Quality Commission, the Health and Safety Executive and other external assessors. k) Receive the annual clinical audit programme and provide assurance to the Board that clinical audit supports the Trust to provide safe and clinically effective patient care and obtain assurance that there is delivery against agreed annual clinical audit programme. l) Implement and monitor the process for the production of the Trust's year end Quality Report before it is presented to the Trust Audit Committee and Board for formal approval. m) Undertake an annual review of the Quality and Risk Management Strategies to ensure that they reflect all required priorities. n) To have oversight of the Committees performance measures to ensure they are appropriate and provide assurance of compliance and escalate exceptions to Trust Board. o) To review the proposed internal audit plan for all functions areas within the Committees remit e.g. Clinical Audit, Safety, Experience and Effectiveness. p) Review the Trust's Research and Development Strategy and Innovation Strategy prior to their recommendation it to the Board of Directors. q) Approving the terms of reference and memberships of its subordinate committees. Overall r) To approve any matters that, due to time constraints, could not be approved by the Board within the scope of the Committees areas of responsibility. s) Referring relevant matters for consideration to other Board Committees as appropriate. t) Considering relevant matters delegated or referred to it by the Board of Directors or referred by any of the Board Committees. u) Escalating matters as appropriate to the Board of Directors. v) Assurances will be provided from internal and external sources and will be included in a work plan approved by the Committee at the commencement of each financial year.
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors

	• *Medical Director • *Chief Nurse ~~and Midwife~~ • *Chief Finance Officer • *Chief People Officer • *Chief Operating Officer • Deputy Director of Nursing and Midwifery • Associate Director of Quality and Governance • Director of Midwifery • Head of Midwifery *or their nominated representative who will be sufficiently senior and have the authority to make decisions. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be three members including two Non-Executive Directors and one Executive Director (one of whom must be either the Medical Director or Director of Nursing and Midwifery or their deputy). The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	a) Members Members will be required to attend a minimum of 75% of all meetings. b) Officers The Trust Secretary shall normally attend meetings. Other executive directors (including the Chief Executive) and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall usually be held monthly (minimum of 10). Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

	The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.
Accountability and reporting arrangements:	The Quality Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Committee.
Reporting Committees/ Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • Safety and Effectiveness Sub-Committee • Patient Involvement & Experience Sub-Committee • Corporate Risk Sub-Committee • Trust Safeguarding Sub-Committee • Research and Development Sub-Committee • Maternity Transformation Board
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Quality Committee	27 March 2023
Approved by Board of Directors:	06 April 2023
Review date:	March 2024
Document owner:	Mark Grimshaw, Trust Secretary, Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

FINANCE, PERFORMANCE AND BUSINESS DEVELOPMENT COMMITTEE TERMS OF REFERENCE

Constitution:	The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Performance and Business Development Committee (the Committee).
Duties:	The Committee will operate under the broad aims of reviewing financial and operational planning, performance and business development. The Committee's responsibilities fall broadly into the following two areas: **Finance and performance** The Committee will: a. Receive and consider the annual financial and operational plans and make recommendations as appropriate to the Board. b. Review progress against key financial and performance targets c. Review on behalf of the Board, financial submissions (as reported in the Financial Performance Report) or others, as agreed by the Board, to ~~NHS Improvement~~NHS England for consistency on financial data provided. d. Review the service line reports for the Trust and advise on service improvements e. Provide oversight of the cost improvement programme f. Oversee external financing & distressed financing requirements g. Oversee the development and implementation of the information management and technology strategy h. Examine specific areas of financial and operational risk and highlight these to the Board as appropriate through the Board Assurance Framework i. To undertake an annual review of the ~~NHS Improvement~~NHS England Enforcement Undertaking. j. To review and receive assurance on the appropriateness of the Trust's Emergency Planning Resilience & Response processes and procedures. **Business planning and development** The Committee will:

	k. Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management l. Advise the Board and maintain an oversight on all major investments, disposals and business developments. m. Advise the Board on all proposals for major capital expenditure over £500,000 n. Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors • Chief Executive • Chief Finance Officer • Chief Operations Officer • Chief Nurse • Chief Information Officer Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	The quorum for the transaction of business shall be three members including at least two Non-Executive Directors (one of whom must be the Chair and one Executive Director. The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**c. Members** Members will be required to attend a minimum of 75% of all meetings.

	d. Officers Ordinarily the Deputy Director of Finance and Trust Secretary will attend all meetings. Other executive directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.
Frequency:	Meetings shall be held at least 10 times per year. Additional meetings may be arranged if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.
Accountability and reporting arrangements:	The Finance, Performance and Business Development Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Finance, Performance and Business Development Committee.
Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) an Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • Digital Hospital Sub-Committee • Access Sub-Committee

	• Financial Recovery & Capital Expenditure Sub-Committee • Safety (non-clinical) Sub-Committee
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by: Finance, Performance & Business Development Committee	*27 March 2023*
Approved by: Board of Directors	13 September 2023
Review date:	March 2024
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

PUTTING PEOPLE FIRST COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Putting People First Committee (the Committee).
Duties:	The Committee is responsible for: h. Developing and overseeing implementation of the Trust's People Strategy (integrated workforce, wellbeing and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process i. Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee) j. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce k. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors l. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues m. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys n. Reviewing and approving partnership agreements with staff side o. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues p. Monitor and evaluate compliance with the public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics q. Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings r. Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required. s. Receiving and considering issues from other Committees when appropriate and taking any necessary action.

Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • 2 other Non-Executive Director • *Chief People Officer • * Chief Nurse & Midwife • *Chief Operating Officer • Staff Side Chair • Medical Staff Committee representative • Deputy Chief Finance Officer *or their nominated representative who will be sufficiently senior and have the authority to make decisions. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be four members including: • The Chair or at least one other Non-Executive Director • At least one from either Chief People Officer ~~or Director of Nursing and Midwifery~~Chief Nurse • Chief Operating Officer or their Deputy • Either Staff Side Chair or Medical Staff Committee representative • The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**e. Members** Members will be required to attend a minimum of 75% of all meetings. **f. Officers** HR & OD Senior Team, Education Governance Chair, and a representative from the Nursing & Midwifery Board shall normally attend meetings.

	Members may send a nominated representative to attend meetings on their behalf when they are not available, provided they are sufficiently senior and have the authority to make decisions. Other executive directors, officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held at least 10 times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Putting People First Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the subsequent Board of Directors for assurance. Approved minutes will be made available to all Board members upon request. Approved chairs reports will also be circulated to members of the Audit Committee. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Putting People First Committee.
Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; b) an Annual Report setting out the progress they have made and future developments;

	c) Terms of reference The following sub committees/groups will report directly to the Committee: • Equality, Diversity & Inclusion Sub-Committee • Partnership Forum • Professional Forum of Nurses, Midwives & AHP's • Educational Governance Sub-Committee • Joint Local Negotiating Sub-Committee • Great Place to Work Group
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Putting People First Committee:	20 March 2023
Approved by Board of Directors:	*6 April 2023*
Review date:	March 2024
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

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 Nurse • 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:	**g. Members** Members will be required to attend a minimum of 75% of all meetings.

	h. 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:	June 2023
Approved by: Board of Directors	13 July 2023
Review date:	March 2024

Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

5. Scheme of delegation (including the NHS Foundation Trust Accounting Officer Memorandum)

5.1 Introduction

5.1.1 Reservation of powers

The Trust's Standing Orders (for its Board of Directors) provide that "Subject to the scheme of reservation and delegation, and such directions as may be given by statute, the independent regulator or the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Foundation Trust, of any of its functions by a committee or subcommittee, or by a Director or an officer of the Trust in each case subject to such restrictions and conditions as the Board things fit." The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Foundation Trust Board of Directors.

The purpose of this document is to detail how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Foundation Trust policies and procedures. The Board of Directors remains accountable for all of its functions, even those delegated to committees, subcommittees, individual directors or officers. A formal structure is in place for monitoring the functions delegated to committees and subcommittees enabling the Board to receive information and to maintain its monitoring role.

5.1.2 Role of the Chief Executive

All powers of the Foundation Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions they shall perform personally and which functions have been delegated to other directors and officers for operational responsibility.

All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

5.1.3 Caution over the Use of Delegated Powers

Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

5.1.4 Absence of Directors or Officer to whom Powers have been Delegated

In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

Further details about situations where the Accounting Officer is unable to fully discharge their responsibilities are available in the Accounting Officers' Memorandum, sections of which are reproduced below and which is available separately from NHS ~~Improvement~~England.

5.2 Delegation of powers

5.2.1 Delegation to committees

The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors. The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with Standing Order

7.18 committees may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors.

In exercising any delegated power a committee or director must comply with the Foundation Trust's Standing Orders, Standing Financial Instructions and written procedures and with any statutory provisions or requirements. They must not incur expenditure over and above the Foundation Trust's annual budget (excluding the Chief Executive in conjunction with the Chief Finance Officer).

In cases of doubt or difficulty and/or where no policy guidelines exist, decisions should be referred to the Board of Directors.

5.2.2 Delegation to Officers
Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive, the Chief Finance Officer and other directors.

5.2.3 The Accounting Officer Memorandum
The responsibilities of the Accounting Officer are set out in the NHS Foundation Trust Accounting Officer Memorandum[2], relevant sections of which are reproduced below:

Introduction
The National Health Service Act 2006 (the Act) designates the chief executive of an NHS foundation trust as the accounting officer.

The principal purpose of the NHS foundation trust is the provision of goods and services for the purposes of the health service in England. The NHS foundation trust has a general duty to exercise its functions effectively, efficiently and economically.

The Act specifies that the accounting officer has a duty to prepare the accounts in accordance with the Act. An accounting officer has the personal duty of signing the NHS foundation trust's accounts. By virtue of this duty, the accounting officer has the further duty of being a witness before the Public Accounts Committee (PAC) to deal with questions arising from those accounts or, more commonly, from reports made to Parliament by the Comptroller and Auditor General (C&AG) under the National Audit Act 1983.

Associated with these duties are the further responsibilities that are the subject of this memorandum. It is incumbent on the accounting officer to combine these duties with their duties to the board of directors of the NHS foundation trust.
5. It is an important principle that, regardless of the source of the funding, accounting officers are responsible to Parliament for the resources under their control.

General responsibilities
The accounting officer has responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matters. The accounting officer must ensure that:

- there is a high standard of financial management in the NHS foundation trust as a whole
- the NHS foundation trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation
- financial considerations are fully taken into account in decisions by the NHS foundation trust.

Specific responsibilities

[2] NHS Foundation Trust Accounting Officer Memorandum, NHS Improvement (2015)

The essence of the accounting officer's role is a personal responsibility for:

- the propriety and regularity of the public finances for which he or she is answerable
- the keeping of proper accounts
- prudent and economical administration in line with the principles set out in *Managing public money*
- the avoidance of waste and extravagance
- the efficient and effective use of all the resources in their charge.

As accounting officer you must:

- personally sign the accounts and, in doing, so accept personal responsibility for ensuring their proper form and content as prescribed by Monitor (now NHSI/E) in accordance with the Act
- comply with the financial requirements of the NHS provider licence
- ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS foundation trust)
- ensure that the resources for which you are responsible as accounting officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official
- ensure that assets for which you are responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate
- ensure that any protected property (or interest in) is not disposed of without the consent of Monitor
- ensure that conflicts of interest are avoided, whether in the proceedings of the board of directors, or council of governors or in the actions or advice of the NHS foundation trust's staff, including yourself
- ensure that, in the consideration of policy proposals relating to the expenditure for which you are responsible as accounting officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the board of directors.

An accounting officer should ensure that effective management systems appropriate for the achievement of the NHS foundation trust's objectives, including financial monitoring and control systems, have been put in place. An accounting officer should also ensure that managers at all levels:

- have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives
- are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS foundation trust), including a critical scrutiny of output and value for money
- have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

Accounting officers must make sure that their arrangements for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in the *Public Sector Internal Audit Standards*.

5.2.4 Absence of an accounting officer

An accounting officer should ensure that he or she is generally available for consultation, and that in any temporary period of unavailability due to illness or other cause, or during the normal

period of annual leave, there will be a senior officer in the NHS foundation trust who can act on his or her behalf if required.

If it becomes clear to the board of directors that an accounting officer is so incapacitated that he or she will be unable to discharge these responsibilities over a period of four weeks or more, the board of directors should appoint an acting accounting officer, usually the Chief Finance Officer, pending the accounting officer's return. The same applies if, exceptionally, the accounting officer plans an absence of more than four weeks during which he or she cannot be contacted.

The PAC may be expected to postpone a hearing if the relevant accounting officer is temporarily indisposed. Where the accounting officer is unable by reason of incapacity or absence to sign the accounts in time for submission, the NHS foundation trust may submit unsigned copies pending the accounting officer's return. If the accounting officer is unable to sign the accounts in time for printing, the acting accounting officer should sign instead.

5.3 Schedule of Delegated Authority

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The **'Delegated to'** authority is in accordance with the Standing Orders and Standing Financial Instructions. The **'Operational Responsibility'** shown below is the lowest level to which authority is delegated.

- Table A - Delegated Authority
- Table B - Delegated Financial Limits

Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Managers as appropriate.

Table A – Delegated Authority

Delegated matter	Delegated to[3]	Operational responsibility
1. Standing Orders (SOs) and Standing Financial Instructions (SFIs)		
a. Final authority in interpretation of Standing Orders	Chair	Chair
b. Notifying Directors, employees and governors of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Chief Executive	All Line Managers
c. Responsibility for security of the Foundation Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions and financial procedures	Chief Executive	All Directors and Employees
d. Suspension of Standing Orders	Board of Directors	Board of Directors
e. Review suspension of Standing Orders	Audit Committee	Audit Committee
f. Variation or amendment to Standing Orders	Board of Directors	Audit Committee
g. Emergency powers relating to the authorities retained by the Board of Directors	Chair and Chief Executive with two non-executives	Chair and Chief Executive with two non-executives
h. Disclosure of non-compliance with Standing Orders to the Chief Executive (report to the Board of Directors)	All staff	All staff
i. Disclosure of non-compliance with SFIs to the Chief Finance Officer (report to the Audit Committee)	All staff	All staff
j. Advice on interpretation or application of SFIs and this Scheme of Delegation	Chief Finance Officer	Chief Finance Officer with input from Internal Audit
2. Audit arrangements		
a. Ensure an adequate internal audit service is provided	Audit Committee	Chief Finance Officer
b. To make recommendations to the Council of Governors in respect of the appointment, re-appointment and removal of the external auditor and to approve the remuneration in respect of the external auditor	Audit Committee (for recommendation to the Council of Governors for approval)	Chief Finance Officer
c. Monitor and review the effectiveness of the internal audit function	Audit Committee	Chief Finance Officer
d. Review, appraise and report in accordance with Public Sector Internal Audit Standards (PSIAS) and best practice	Audit Committee	Head of Internal Audit

[3] If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

Delegated matter	Delegated to[3]	Operational responsibility
e. Provide an independent and objective view on internal control and probity	Audit Committee	Internal Audit / External Audit
f. Ensure cost-effective audit service(s)	Audit Committee	Chief Finance Officer
g. Implement agreed recommendations	Chief Executive	Relevant Officers
3. Authorisation of Clinical Trials & Research Projects	Chief Executive	Director of Research and Development through the Research and Development committee
4. Authorisation of New Drugs	Chief Executive	Medical Director through the Medicines Management committee
5. Bank Accounts/Cash (including on Trust (Charitable / Non Charitable))		
a. Operation: Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements)	Chief Finance Officer	Deputy Chief Finance Officer
b. Opening bank accounts as approved by the Board of Directors	Chief Finance Officer	Deputy Chief Finance Officer
c. Authorisation of transfers between bank accounts	Chief Finance Officer	In accordance with bank mandate / internal procedures
d. Approve and apply arrangements for the electronic transfer of funds	Chief Finance Officer	In accordance with bank mandate / internal procedures
e. Authorisation of: • BACS schedules • Automated payment schedules • Manual cheques	Chief Finance Officer	In accordance with bank mandate / internal procedures
f. Investments: • Investment of surplus funds in accordance with Treasury Management Investment Policy • Preparation of investment procedures	Chief Finance Officer Chief Finance Officer	Deputy Chief Finance Officer Deputy Chief Finance Officer
g. Petty Cash	Chief Finance Officer	See Delegated Limits Table B (section 2(a))
6. Capital Investment		
a. Programme: Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on Business Plans	Chief Executive	Chief Finance Officer
b. Preparation of Capital Investment Programme	Chief Executive	Chief Finance Officer / Deputy Chief Finance Officer
c. Preparation of a business case for expenditure over £100,000	Chief Executive	Divisional Manager with advice from Chief Finance Officer or Deputy Chief Finance Officer or Divisional Accountant
d. Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Chief Finance Officer	Deputy Chief Finance Officer / ~~Head of~~ Estates and Facilities Manager
e. Authorisation of capital requisitions	Chief Executive	See Delegated Limits Table B (Section 5)

Delegated matter	Delegated to[3]	Operational responsibility
f. Construction industry tax scheme	Chief Executive	Chief Finance Officer
g. Assessing the requirements for the operation of the construction industry taxation deduction scheme	Chief Finance Officer	Financial Controller
h. Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost	Chief Executive	Chief Finance Officer and ~~Head of~~ Estates and Facilities Manager
i. Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences	Chief Executive	Chief Finance Officer
j. Issue procedures to support: • Capital investment • Staged payments	Chief Executive	Chief Finance Officer
k. Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes	Chief Finance Officer	Deputy Chief Finance Officer
l. Issuing the capital scheme project manager with specific authority to commit capital, proceed / accept tenders in accordance with the standing orders and SFIs	Chief Executive	Chief Finance Officer
m. Private Finance: • Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector • Proposal to use PFI must be specifically agreed by the Board of Directors.	Chief Executive Board of Directors	Chief Finance Officer
n. Leases (property and equipment) in accordance Delegated Limits Table B (Section 4)	Chief Executive	Chief Executive or Chief Finance Officer
7. Clinical Audit	Chief Executive	Medical Director
8. Commercial Sponsorship		
Agreement to proposal	Chief Executive	Chief Finance Officer
9. Complaints		
a. Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Executive	Chief Nurse ~~and Midwife~~
b. Responsibility for ensuring complaints relating to a clinical division are investigated thoroughly	Chief Nurse ~~and Midwife~~	Chief Operating Officer and Associate Director of Quality and Governance~~Head of Governance & Legal~~
c. Coordination of the management of medico-legal complaints	Chief Executive	Chief Nurse ~~and Midwife~~ and Head of Quality & Governance ~~& Legal~~
10. Confidential Information		
a. Review of the Trust's compliance with the Caldicott report on protecting patients' confidentiality in the NHS	Chief Executive	Caldicott Guardian (Medical Director)
b. Freedom of Information Act compliance code	Chief Executive	Chief People Officer & Trust Secretary
11. Controlled drugs accountable officer	Medical Director	Head of Pharmacy
12. Data Protection Act		

Delegated matter	Delegated to[3]	Operational responsibility
Review of Trust's compliance	Chief Executive	Chief Information Officer
13. Declaration of Interests		
a. Maintaining a register of interests	Chief Executive	Trust Secretary
b. Declaring relevant and material interests	Board of Directors and Council of Governors	Board of Directors, Council of Governors, Senior Managers, Clinical consultants and all decision-making staff as defined in the Trust policy 'Managing Conflicts of interest'
14. Disposals and Condemnations		
a. Items obsolete, redundant, irreparable or cannot be repaired cost effectively	Chief Finance Officer	(Clinical Director or Divisional Manager or Department Heads) – Approved in accordance with Delegated Limits, Table B Section 8 Head of Procurement or Deputy Chief Finance Officer
b. Develop arrangements for the sale of assets	Chief Finance Officer	(Clinical Director/ Divisional Manager / Department Heads) – Approved in accordance with Delegated Limits Table B Section 8 Head of Procurement or Deputy Chief Finance Officer
c. Disposal of Protected Property (as defined in the Licence	Chief Executive (with authorisation of the Independent Regulator)	Chief Executive
15. Environmental Regulations		
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Finance Officer	~~Head of~~ Estates & Facilities Manager
16. External Borrowing		
a. Advise Board of Directors of the requirements to repay / draw down Public Dividend Capital	Chief Finance Officer	Deputy Chief Finance Officer
b. Approve a list of employees authorised to make short term borrowings for the Trust	Board of Directors	Chief Executive / Chief Finance Officer
c. Application for draw down of Public Dividend Capital, overdrafts and other forms of external borrowing in accordance with approved mandates	Chief Executive	Chief Finance Officer and Deputy Chief Finance Officer
d. Preparation of procedural instructions concerning applications for loans and overdrafts	Chief Finance Officer	Deputy Chief Finance Officer
17. Financial Planning / Budgetary Responsibility		
• **Budget setting**		
a. Submit budgets to the Board of Directors	Chief Finance Officer	Deputy Chief Finance Officer
b. Submit to the Board of Directors financial estimates and forecasts	Chief Finance Officer	Deputy Chief Finance Officer

Delegated matter	Delegated to[3]	Operational responsibility
c. Compile and submit to the Board of Directors an Operational Plan which takes into account financial targets and forecast limits of available resources. The Business Plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan	Chief Executive	Chief Operating Officer and Chief Finance Officer
• **Budget monitoring**		
d. Devise and maintain systems of budgetary control	Chief Finance Officer	Deputy Chief Finance Officer
e. Delegate budgets to budget holders	Chief Executive	Chief Finance Officer
f. Monitor performance against budget	Chief Finance Officer	Deputy Chief Finance Officer and Divisional Accountants
g. Ensuring adequate training is delivered on an ongoing basis to budget holders to facilitate their management of the allocated budget	Chief Finance Officer	Deputy Chief Finance Officer
h. Submit financial monitoring returns in accordance with ~~NHS Improvement~~NHS England's requirements	Chief Executive	Chief Finance Officer
i. Identify and implement cost improvements and income generation activities in line with the Operational Plan	Chief Executive	All budget holders
j. Preparation of annual accounts	Chief Finance Officer	Deputy Chief Finance Officer / Financial Controller
k. Preparation of annual report	Chief Executive	Trust Secretary
• **Budget responsibilities**		
l. Ensure that: • no overspend or reduction of income that cannot be met from virement is incurred; • approved budget is not used for any other than specified purpose subject to rules of virement; • no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment	Chief Finance Officer	Budget Holders All corporate posts are reviewed by the Vacancy Control Panel and all clinical posts by the Executive team
• **Virement**		
m. It is not possible for any officer to vire from non-recurring budgets to recurring, budgets or from capital to revenue / revenue to capital. Virement between different budget holders requires the agreement of both parties	Chief Executive	Refer To Delegated Limits Table B Section 1

Delegated matter	Delegated to[3]	Operational responsibility
• **Financial procedures and systems**		
n. Maintenance and updating of Trust Financial Procedures	Chief Finance Officer	Deputy Chief Finance Officer
o. Accountability for financial control	Chief Executive / Chief Finance Officer	All budget holders
p. Responsibility for: • Implementing the Trust's financial policies and co-ordinate corrective action • Ensuring that adequate records are maintained to explain the Trust's transactions and financial position. • Providing financial advice to members of the Board of Directors and staff • Maintaining such accounts certificates, records, etc to meet statutory requirements • Designing and maintaining compliance with all financial systems	Chief Finance Officer	Deputy Chief Finance Officer
• **Financial systems Information Management & Technology (IM&T)**		
q. Developing financial systems in line with the Trust's IM&T strategy	Chief Finance Officer	Deputy Chief Finance Officer
r. Implementing new systems to ensure they are developed in a controlled manner and thoroughly tested	Chief Finance Officer	Deputy Chief Finance Officer and Chief Information Officer
s. Seeking third party assurances regarding financial systems operated externally	Chief Finance Officer	Deputy Chief Finance Officer
t. Responsibility for the accuracy and security of computerised financial data	Chief Finance Officer	Deputy Chief Finance Officer
u. Ensure that contracts for computer services for financial applications define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage	Chief Finance Officer	Chief Information Officer
v. Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place	Chief Finance Officer	Chief Information Officer
18. Fire precautions		
Ensure that the Fire Precaution and Prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact	Chief Executive	~~Head of Estates~~Estates and Facilities Manager in conjunction with Head of Resilience, Health and Safety
19. Fixed assets		
a. Maintenance of asset register including asset identification and monitoring	Chief Executive	Deputy Chief Finance Officer in conjunction with Financial Controller
b. Approving procedures for reconciling balances on fixed asset accounts in ledgers against balances on fixed asset registers	Chief Finance Officer	Deputy Chief Finance Officer in conjunction with Financial Controller

Delegated matter	Delegated to[3]	Operational responsibility
c. Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with relevant legislation	Chief Finance Officer	Financial Controller in conjunction with Director of Estates
d. Calculate and pay capital charges in accordance with the requirements of the Department of Health / independent regulator	Chief Finance Officer	Deputy Chief Finance Officer
e. Responsibility for security of Trust's assets including notifying discrepancies to the Chief Finance Officer and reporting losses in accordance with Trust procedures	Chief Executive	All staff
20. Fraud (See also 26 & 37)		
a. Monitor and ensure compliance with Secretary of State Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist	Audit Committee	Local Counter Fraud Specialist
b. Notify NHS Protect and External Audit of all suspected Frauds	Chief Finance Officer	Local Counter Fraud Specialist
21. Funds Held on Trust (Charitable and Non Charitable Funds)		
a. Appropriate management of funds held on trust	Charitable Funds Committee	Chief Finance Officer
b. Maintenance of authorised signatory list of nominated fundholders	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
c. Expenditure Limits	Chief Finance Officer	See Delegated Limits Table B Section 7
d. Developing systems for receiving donations	Chief Finance Officer	Deputy Chief Finance Officer
e. Dealing with legacies	Chief Finance Officer	Deputy Chief Finance Officer
f. Fundraising appeals • Preparation and monitoring of budget • Reporting progress and performance against budget	Charitable Funds Committee Chief Finance Officer	Deputy Chief Finance Officer in conjunction with Financial Controller Deputy Chief Finance Officer in conjunction with Financial Controller
g. Operation of Bank Accounts - managing banking arrangements and operation of bank accounts	Chief Finance Officer in conjunction with the Charitable Funds Committee	Deputy Chief Finance Officer
h. Opening bank accounts	Chief Finance Officer in conjunction with Charitable Funds Committee	Deputy Chief Finance Officer
i. Appointing Investment Manager	Charitable Funds Committee	Deputy Chief Finance Officer through Charitable Funds Committee

Delegated matter	Delegated to[3]	Operational responsibility
j. Nominated deposit taker	Charitable Funds Committee	Chief Finance Officer
k. Placing investment transactions.	Chief Finance Officer	Deputy Chief Finance Officer in conjunction with Financial Controller
l. Registration of funds with Charities Commission	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
22. Gifts and hospitality		
a. Keeping of gifts and hospitality register	Chief Executive	Trust Secretary
b. Declaration and registration of all individual and collective items in excess of £50.00 per item	Chief Executive	All staff
23. Health and Safety		
Review of all statutory compliance with legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Chief Executive	Chief Nurse ~~and Midwife~~ with Head of Governance ~~& Legal~~ and Head of Resilience, Health & Safety
24. Infectious Diseases and Notifiable Outbreaks	Chief Nurse ~~and Midwife~~	Director of Infection Prevention & Control
25. Legal Proceedings		
a. Engagement of Trust's Solicitors / Legal Advisors	Chief Executive	Executive Directors
b. Approve and sign all documents which will be necessary in legal proceedings, i.e. executed as a deed	Chief Executive	Executive Directors
c. Sign on behalf of the Trust any agreement or document not requested to be executed as a deed	Chief Executive	Executive Directors
26. Losses, write-offs and special payments		
a. Prepare procedures for recording and accounting for losses and special payments including preparation of a Fraud Response Plan and informing Local Counter Fraud Specialist of frauds	Chief Executive	Chief Finance Officer
b. Setting financial limits	Chief Executive	See Delegated Limits Table B Section 9
b. Losses of cash due to theft, fraud, overpayment and others	Chief Executive	Chief Finance Officer
c. Fruitless payments (including abandoned Capital Schemes)	Chief Executive	Chief Finance Officer
d. Bad debts and claims abandoned	Chief Executive	Chief Finance Officer
e. Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson)	Chief Executive	Chief Finance Officer
f. Reviewing appropriate requirement for insurance claims	Chief Finance Officer	Deputy Chief Finance Officer
g. Compensation payments by court order	Chief Executive	Chief Executive
h. Clinical negligence, covered by membership of CNST/NHSLA scheme	Chief Executive	Chief Nurse and Midwife

Delegated matter	Delegated to[3]	Operational responsibility
i. Ex-gratia payments • Setting financial limits • Other	Chief Finance Officer Chief Executive	See Delegated Limits Table B Section 9 See Delegated Limits Table B Section 9
j. A register of all losses and special payments should be maintained by the Finance Department and made available for inspection	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
k. A report of all losses and special payments should be presented to the Audit committee	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
27. Medical		
a. Clinical Governance arrangements	Medical Director	Associate Director of Quality and Governance~~Head of Governance~~
b. Medical Leadership	Medical Director	Medical Director
c. Programmes of medical education	Medical Director	Medical Director
d. Medical staffing plans	Medical Director	Medical Director
e. Medical Research	Medical Director	Director of Research & Development
28. Medicines inspectorate regulations		
• Review regulations	Chief Executive	Medical Director / Head of Pharmacy
29. Meetings		
a. Calling meetings of the Board of Directors	Chair / Trust Secretary	Chair / Trust Secretary
b. Chair all Board of Director meetings and associated responsibilities	Chair	Chair
30. Non pay expenditure		
a. Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Delegated Limits Table B Section 4	Chief Executive	Financial Controller in conjunction with Deputy Chief Finance Officer
b. Obtain the best value for money when requisitioning goods / services	Chief Executive	Chief Operating Officer, Clinical Directors, Department Heads and Head of Procurement
c. Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement (subject to Delegated Limits Table B Section 4)	Chief Executive	Chief Finance Officer
d. Develop systems for the payment of accounts	Chief Finance Officer	Deputy Chief Finance Officer and Financial Controller
e. Prompt payment of accounts in line with national requirements	Chief Finance Officer	Deputy Chief Finance Officer and Financial Controller
f. Financial Limits for budgetary expenditure and ordering / requisitioning goods and services (including invoice authorisation without orders)	Chief Executive	See Delegated Limits Table B Section 4
g. Approve prepayment arrangements	Chief Finance Officer	Chief Finance Officer

Delegated matter	Delegated to[3]	Operational responsibility
31. Nursing		
a. Compliance with statutory and regulatory arrangements relating to professional nursing and midwifery practice	~~Director of Nursing &Midwifery~~Chief Nurse	Professional nursing and midwifery leads
b. Matters involving individual professional competence of nursing and midwifery staff	Chief Nurse ~~and Midwife~~	Professional nursing and midwifery leads
c. Compliance with professional training and development of nursing and midwifery staff	Chief Nurse ~~and Midwife~~	Professional nursing and midwifery leads
d. Quality assurance of nursing and midwifery processes	Chief Nurse ~~and Midwife~~	Professional nursing and midwifery leads
32. Patient Services Agreements		
a. Negotiation of Foundation Trust Contract and Non Commercial Contracts	Chief Executive	Chief Finance Officer and Chief Operating Officer
b. Quantifying and monitoring out of area treatments	Chief Finance Officer	Director Operations and Deputy Chief Finance Officer
c. Reporting actual and forecast income including payment by results	Chief Finance Officer	Chief Operating Officer and Deputy Chief Finance Officer
d. Costing Foundation Trust Agency Purchase Contracts and Non Commercial Contracts	Chief Finance Officer	Chief Operating Officer and Deputy Chief Finance Officer
e. National Cost Collection Exercise	Chief Finance Officer	Deputy Chief Finance Officer
f. Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Chief Finance Officer	Chief Operating Officer and Deputy Chief Finance Officer
33. Patients' property (in conjunction with financial advice)		
a. Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Chief Executive	Chief Nurse ~~and Midwife~~
b. Prepare detailed written instructions for the administration of patients' property	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
c. Informing staff of their duties in respect of patients' property	Chief Finance Officer	Divisional Managers, Clinical Managers and Legal Services Manager
d. Issuing property of deceased patients (See SFI 6.25). In accordance with Delegated Limits Table B Section 4	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller in conjunction with nominated Divisional Lead
34. Human Resources		
a. Develop Human resource policies and strategies for approval by the Board of Directors including training, industrial relations	Chief People Officer	Chief People Officer
b. Nomination of officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts	Chief People Officer	Divisional Managers or Heads of Departments
c. Ensure that all employees are issued with a contract of employment in a form approved by the Board of Directors and which complies with employment legislation	Chief People Officer	Chief People Officer

Delegated matter	Delegated to[3]	Operational responsibility
• **Staff establishment (including engagement of staff not on the establishment) and re-gradings**		
d. Authority to fill funded post on the establishment with permanent staff	Chief People Officer	Clinical Directors, Divisional Managers or Heads of Departments
e. Additional staff to the agreed establishment with specifically allocated finance	Chief People Officer	Clinical Directors, Divisional Managers or Heads of Departments
f. Additional staff to the agreed establishment without specifically allocated finance	Chief Executive	Chief Finance Officer
g. Self-financing changes to an establishment	Chief People Officer	Human Resources Business Partner and Divisional Accountant
h. Nominate officers to enter into contracts of employment regarding staff, agency staff or non-medical consultancy service contracts	Chief Executive	Chief People Officer
i. Booking of bank staff • Nursing and midwifery • Other	Chief Nurse ~~and Midwife~~ Divisional Manager	Deputy Chief Nurse and Midwife or Matron. Chief Operating Officer
j. Booking of agency staff • Nursing and midwifery • Other	Chief Nurse ~~and Midwife~~ Divisional Manager	Chief Operating Officer, Matron or Heads of Nursing / Midwifery. Chief Operating Officer or Heads of Departments
k. The granting of additional increments at recruitment stage to staff within budget (other than automatic increments)	Chief People Officer	Clinical Directors, Chief Operating Officer or Heads of Departments
l. Re-grading requests / major skill mix changes (all requests shall be dealt with in accordance with Trust procedure)	Chief People Officer	Clinical Directors, Chief Operating Officer or Heads of Departments
m. Waiting list payments (approval of rates of pay and variations to agreed rates)	Chief Executive	Chief Operating Officer, Chief People Officer or Chief Finance Officer
• **Grievance and disciplinary procedures**		
n. Operation of grievance procedure (all grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Chief Operating Officer must be sought when the grievance reaches the level of Clinical Director / Divisional Managers / Heads of Department)	Chief People Officer	As per Trust procedure
o. Operation of the disciplinary procedure (excluding Executive Directors)	Chief People Officer	To be applied in accordance with the Trust's Disciplinary Procedure
• **Terms and conditions of employment**		
p. Renewal of fixed term contract	Chief People Officer	Chief Operating Officer on advice from Vacancy Control Panel

Delegated matter	Delegated to[3]	Operational responsibility
q. Authorise mobile phone use / issue	Chief People Officer	Executive Directors, Chief Operating Officer or Heads of Departments
r. Authorisation of payment of removal expenses, excess rent and house purchases (all staff in accordance with Trust policy and as agreed at interview)	Chief People Officer	Executive Directors, Chief Operating Officer or Heads of Departments
• **Pay**		
s. Presentation of proposals to the Board of Directors for the setting of remuneration and conditions of service for those staff not covered by the Nominations committee	Chief Executive	Chief People Officer
t. Authority to complete standing data forms affecting pay, new starters, variations and leavers	Chief People Officer	Clinical Directors, Chief Operating Officer, Heads of Departments or line or departmental managers
u. Authority to complete and authorise staff attendance record / positive reporting forms	Chief People Officer	Clinical Directors, Chief Operating Officer, professional Heads of Service, Heads of Departments or ward or departmental managers
v. Authority to authorise overtime	Chief People Officer	Clinical Directors & Chief Operating Officer
w. Authority to authorise travel and subsistence expenses	Chief People Officer	Executive Directors, Clinical Directors, Chief Operating Officer, Heads of Departments or authorised approvers.
• **Annual and special leave (refer to leave policies)**		
x. Approval of annual leave	Chief People Officer	Departmental Manager (as per Trust policy)
z. Approval of annual leave carry forward (up to maximum of 5 days)	Chief People Officer	Departmental Manager (as per Trust policy)
aa. Approval of annual leave carry forward of 6 to 10 days (to occur in exceptional circumstances only)	Chief People Officer	Executive Directors, Chief Operating Officer, or Heads of Department
bb. Approval of annual leave carry forward in excess of 10 days	Chief People Officer	Executive Directors
cc. Special leave arrangements for personal, domestic and family reasons including compassionate / bereavement leave, parental leave, paternity leave, carers leave and adoption leave (to be applied in accordance with Trust Policy)	Chief People Officer	Line or Departmental Managers
dd. Special Leave for non-domestic / personal / family reasons including jury service and armed services (to be applied in accordance with Trust Policy)	Chief People Officer	Chief Operating Officer or Heads of Departments
ee. Leave without pay (including short-term unpaid leave and career break)	Chief People Officer	Chief Operating Officer, Heads of Departments or line or departmental managers
ff. Medical Staff leave of absence – paid and unpaid	Chief People Officer	Clinical Director with advice from Medical Director

Delegated matter	Delegated to[3]	Operational responsibility
gg. Time off in lieu	Chief People Officer	Divisional Managers or Line Managers
hh. Maternity Leave - paid and unpaid	Chief People Officer	Automatic approval with guidance
• **Sick leave**		
ii. Extension of sick leave on pay	Chief People Officer	Divisional Managers or Human Resources staff, as per Trust policy
jj. Return to work part-time on full pay to assist recovery	Chief People Officer	Deputy Director of Workforce or Divisional Managers
• **Study leave**		
kk. Study leave outside the UK	Chief Executive	Relevant Executive Director
ll. Medical staff study leave (UK): • Consultant • Career Grade • Non Career Grade	 Medical Director Medical Director Post Graduate Tutor	 Clinical Director Clinical Director Clinical Director
mm. All other study leave (UK)	Chief People Officer	Executive Directors, Clinical Directors, Divisional Managers or Department Heads
• **Retirement (including ill-health retirement)**		
nn. Authorisation of return to work in part time capacity under the flexible retirement scheme	Chief People Officer	Divisional Manager
oo. Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department	Chief People Officer	Divisional Manager
• **Redundancy (as approved by Board of Directors)**	Chief Executive	Chief People Officer
35. Quotation, tendering and contracting procedures		
a. Entering into contracts on behalf of the Trust, regardless of value	Chief Executive	Executive Directors or nominated Deputy
b. Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Chief Finance Officer, Chief Operating Officer and Head of Procurement
c. Nominate officers to oversee and manage contracts on behalf of the Trust	Chief Executive	Chief Finance Officer, Chief Operating Officer ,Head of Procurement or Divisional Managers
d. Set competitive tender authorisation limits (see Delegated Limits Table B, section 6)	Chief Executive	Chief Finance Officer
e. Maintain a register to show each set of competitive tender invitations despatched	Chief Executive	Financial Controller or Head of Procurement
f. Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote	Chief Executive	Chief Finance Officer or Head of Procurement
g. Receipt and custody of tenders prior to opening	Chief Executive	Chief Finance Officer or Head of Procurement

Delegated matter	Delegated to[3]	Operational responsibility
i. Waiving the requirement to request tenders (subject to SFI 6.26.11.6, reported to the Audit Committee)	Chief Executive	Chief Executive or Chief Finance Officer
j. Waiving the requirement to request quotes (subject to SFI 6.26.11.6)	Chief Executive / Chief Finance Officer	Chief Executive or Chief Finance Officer
36. Records		
a. Review Trust's compliance with the Retention of Records Act	Chief Executive	Executive Directors
b. Review the Trust's compliance with the Records Management Code of Practice	Chief Executive	Chief Nurse ~~and Midwife~~, Chief Information Officer, Chief Operating Officer and Heads of Departments
c. Ensuring the form and adequacy of the financial records of all departments	Chief Finance Officer	Deputy Chief Finance Officer
37. Reporting of Incidents to the Police		
a. Where a criminal offence is suspected: • Criminal offence of a violent nature • Arson or theft • Other	Chief Operating Officer	Executive Director on call
b. Where a fraud is involved (reporting to NHS Protect and external audit)	Chief Finance Officer	Local Counter Fraud Specialist in conjunction with Chief Finance Officer
c. Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption	Chief Finance Officer	Local Counter Fraud Specialist in conjunction with Chief Finance Officer
38. Risk Management		
a. Ensuring the Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Chief Operating Officer
b. Developing systems for the management of risk	Chief Operating Officer	Associate Director of Quality and Governance~~Head of Governance & Legal~~
c. Developing incident and accident reporting systems	Chief Operating Officer	Associate Director of Quality and Governance~~Head of Governance & legal~~
d. Compliance with the reporting of incidents and accidents	Chief Operating Officer	All staff
39. Seal		
a. The keeping of a register of seal and safekeeping of the seal	Chief Executive	Trust Secretary
b. Attestation of seal in accordance with Standing Orders	Chief Executive	Chief Executive and Chief Finance Officer (report to Board of Directors)
c. Property transactions and any other legal requirement for the use of the seal	Chair and Chief Executive	Chair or Non-Executive Director and the Chief Executive or their nominated Executive Director
40. Security Management		

Delegated matter	Delegated to[3]	Operational responsibility
Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist	Chief Executive	Chief Operating Officer and Local Security Management Specialist
41. Setting of Fees and Charges (Income)		
a. Private Patient, Overseas Visitors, Income Generation and other patient related services	Chief Finance Officer	Deputy Chief Finance Officer and budget holders
b. Non patient care income	Chief Finance Officer	Divisional Managers, Heads of Departments or Divisional Accountants
c. Informing the Chief Finance Officer of monies due to the Trust	Chief Finance Officer	All Staff
d. Recovery of debt	Chief Finance Officer	Deputy Chief Finance Officer
e. Security of cash and other negotiable instruments	Chief Finance Officer	Deputy Chief Finance Officer
42. Stores and Receipt of Goods		
a. Responsibility for systems of control over stores and receipt of goods, issues and returns	Chief Finance Officer	Clinical Directors, Divisional Managers, Heads of Departments or Head of Procurement
b. Stocktaking arrangements	Chief Finance Officer	Clinical Directors / Divisional Managers, Heads of Departments or Head of Procurement
c. Responsibility for controls over pharmaceutical stock	Head of Pharmacy	Head of Pharmacy and Ward Managers
d. Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items	Chief Finance Officer	Clinical Directors, Divisional Managers, Heads of Departments or Head of Procurement

Table B – Delegated Financial Limits

Delegated matter	Delegated limit	Delegated to[4]
1. Virement		
Authorisation of virement	£100,000 and above	Chief Executive or Chief Finance Officer and reported to Board of Directors
	£50,001 up to £100,000	Chief Finance Officer or Deputy Chief Finance Officer
	Up to £50,000	Divisional Managers, Hewitt Centre Managing Director,, Head of Management Accounts and relevant budget holder, subject to virement signed off by Divisional Accountant
2. Cash and banking		
a. Petty cash disbursements	Up to £50	Petty cash imprest holder
b. Sundry exchequer items	£100 up to £5,000	Deputy Chief Finance Officer or Financial Controller
c. Patient monies	£5,000 and above	Chief Finance Officer or another Executive Director
d. Acceptance of cash transactions	Up to £10,000	Chief Finance Officer, Deputy Chief Finance Officer or Financial Controller
3.Non-establishment pay expenditure		
Nominated officer entering into contracts or agreements with staff not on the establishment:		
a. Where aggregate commitment in any one year (or total commitment) is less than £20,000	Chief Executive	Executive Directors or Divisional Managers
b. Where aggregate commitment in any one year is more than £20,000	Chief Executive	Chief Finance Officer
4. Non-pay expenditure (including invoice authorisation without orders)		
Approving requisitions, authorising invoices and recommending contract awards.	£500,000 and above	Board Approval
	£250,000 up to £500,000	Two Executive Directors – one of which must be the Chief Executive or Chief Finance Officer
	~~£122,976~~£138,760 (inclusive of VAT) up to £250,000	Chief Executive or Chief Finance Officer
	£40,000 up to £138,760 (inclusive of VAT)	Executive Director with advice from Deputy Chief Finance Officer and/or Head of Procurement
	£5,000 up to £40,000	Divisional Manager or Head of Department

[4] If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

Delegated matter	Delegated limit	Delegated to[4]
	Up to £5,000	Budget holder
5. Capital expenditure		
Requisitioning items / services against capital budget	Over £500,000	Board of Directors (minute approval)
	£250,000 up to £500,000	Chief Executive and Chief Finance Officer
	£25,000 up to £250,000	Chief Finance Officer or ~~Director of Operations~~Chief Operating Officer
	Up to £25,000	Chief Finance Officer or project sponsor or delegated nominee
6. Quotation, tendering and contract procedures		
a. Quotations: *Obtaining* a minimum of 3 written quotations for goods / services	£5,000 up to £40,000 including VAT	Head of Procurement & Contracts
~~b~~ b. Competitive tenders: Obtaining a minimum of 3 written competitive tenders for goods / services (in compliance with EC directives as appropriate). ~~Competitive tenders: *Obtaining* a minimum of 3 written competitive tenders for goods / services (in compliance with Public Contracts Regulations 2015 where Find a Tender Service value threshold is exceeded)~~	£40,000 - Prevailing OJEU Limit(s) Currently £138,760 (inclusive of VAT) ~~£40,000 including VAT~~	Head of Procurement & Contracts
~~c~~c. Competitive Tenders: OJEU Tender process or use of compliant framework where applicable. ~~Waiving requirements for tenders, subject to full compliance with standing orders: Tenders~~	£138,760 (inclusive of VAT) ~~£40,000 up to £122,976~~ (~~excluding~~	Head of Procurement & Contracts~~The Chief Finance Officer in the first instance. Should the Chief Finance Officer be absent for an extended period of time; or absent when an urgent requirement occurs relating to either service continuity or patient care; any Executive Director will have delegated authority to authorise the use of a waiver~~
d. Waiving requirements for tenders, subject to full compliance with standing orders: Tenders~~Waiving requirements for quotes, subject to full compliance with standing orders: Quotations~~	~~£~~ £5,000 up to £138,760 (inclusive of VAT) ~~5,000 up to £40,000 including VAT~~	The Chief Finance Officer in the first instance. Should the Chief Finance Officer be absent for an extended period of time; or absent when an urgent requirement occurs relating to either service continuity or patient care; any Executive Director will have delegated authority to authorise the use of a waiver
7. Funds held on trust		
a. Expenditure authorisation (per request) – General Purpose Fund	£40,001 and above	Chief Nurse ~~and Midwife~~ or Deputy Chief Finance Officer plus Chief Finance Officer plus Charitable Funds Committee

Delegated matter	Delegated limit	Delegated to[4]
	£20,001 up to £40,000	Chief Nurse ~~and Midwife~~ or Deputy Chief Finance Officer plus Chief Finance Officer
	Up to £20,000	Chief Nurse ~~and Midwife~~ or Deputy Chief Finance Officer
b. Expenditure authorisation (per request) – Funds other than the General Purpose Fund	£30,000 and above	Nominated fund holder(s) plus Deputy Chief Finance Officer plus Chief Finance Officer and NED plus Charitable Funds Committee
	£10,001 up to £29,999	Nominated fund holder(s) plus Deputy Chief Finance Officer plus Chief Finance Officer and NED
	Up to £10,000	Nominated fund holder(s) plus Deputy Chief Finance Officer
8. Disposals and condemnations		
With current / estimated purchase price	£5,000 and above	Divisional Manager or Deputy Chief Finance Officer with advice of relevant professional lead where appropriate
	Up to £5,000	Divisional Manager or Head of Department with advice of relevant professional lead where appropriate
9. Losses and special payments		
Losses a. Fruitless payments (including abandoned capital schemes)	£250,000 and above	Board of Directors
	£5,000 up to £250,000	Chief Executive or Chief Finance Officer and reported to Audit Committee
	Up to £5,000	Chief Executive or Chief Finance Officer
b. Losses of cash due to theft, fraud, overpayment and others	£50,000 and above	Board of Directors
c. Bad debts and claims abandoned	£1,000 up to £50,000	Chief Executive or Chief Finance Officer and reported to Audit Committee
	Up to £1,000	Deputy Chief Finance Officer
d. Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson)	Up to £1,000	Chief Executive or Chief Finance Officer
Special payments	£50,000 and above	Board of Directors
e. Compensation payments by court order	£2,000 up to £50,000	Chief Executive or Chief Finance Officer
	Up to £2,000	Legal Services Manager
f. Ex-gratia payments to patients / staff for loss of personal effects	£50,000 and above	Board of Directors
	£2,000 to £50,000	Chief Executive or Chief Finance Officer
	Up to £2,000	Legal Services Manager
	£50,000 and above	Board of Directors

Delegated matter	Delegated limit	Delegated to[4]
g. Other ex-gratia payments	Up to £50,000	Chief Executive or Chief Finance Officer
10. Legally binding contracts for clinical service provision or purchase of clinical support services under Foundation Trust contracts		
	£1million annual value and above	Chief Executive or Chief Finance Officer or ~~Director Operations~~Chief Operating Officer
	Up to £1million annual value	Chief Finance Officer or Chief Operating Officer

6 Standing Financial Instructions

6.1 Introduction

6.1.1 The independent regulator sets the Licence for the Foundation Trust that require compliance with the principles of best practice applicable to corporate Governance within the NHS/ Health Sector with any relevant code of proactive ad guidance issued by the independent regulator.

6.1.2 The Code of Conduct and Accountability in the NHS5 requires that each NHS Foundation Trust shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code. They shall have effect as if incorporated in the Standing Orders (SOs) of the Foundation Trust.

6.1.3 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Foundation Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board of Directors and the Scheme of Delegation adopted by the Foundation Trust.

6.1.4 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust and its constituent organisations, including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. The Chief Finance Officer must approve all financial procedures.

6.1.5 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Chief Finance Officer MUST BE SOUGHT BEFORE ACTING. The user of these SFIs should also be familiar with and comply with the provisions of the Foundation Trust's SOs.

FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER, WHICH COULD RESULT IN DISMISSAL.

6.1.6 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.

6.2 Terminology

6.2.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in the constitution and these instructions bear the same meaning as in the National Health Service Act 2006. References in the Constitution to legislation include all amendments, replacements, or re-enactments made.

[5] Code of Conduct, Code of Accountability, Department of Health (1994 & 2004)

6.2.2 Wherever the title Chief Executive, Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other directors or employees who have been duly authorised to represent them. Wherever the term "employee" is used, and where the context permits, it shall be deemed to include employees of third parties contracted to the Foundation Trust when acting on behalf of the Foundation Trust, including nursing and medical staff and consultants practising on the Foundation Trust premises and members of staff of private contractors or trust staff working for private contractors under retention of employment model.

6.3 Responsibilities and Delegation

6.3.1 The Foundation Trust shall at all times remain a going concern as defined by the relevant accounting standards in force. The Board of Directors exercises financial supervision and control by:

(a) Formulating the financial strategy;
(b) Requiring the submission and approval of budgets within overall income;
(c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money) and by ensuring appropriate audit provision; and
(d) Defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

6.3.2 The constitution dictates that the Council of Governors may not delegate any of its powers to a committee or sub-committee. The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the “Reservation of Powers to the Board of Directors” document, published within the Scheme of Delegation. The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Foundation Trust.

6.3.3 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors and as the Accounting Officer for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Foundation Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Foundation Trust’s system of internal control.

6.3.4 The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

6.3.5 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions. All staff shall be responsible for ensuring conformity with the Standing Orders, Standing Financial Instructions and financial procedures of the Foundation Trust.

6.3.6 The Chief Finance Officer is responsible for:

(a) Implementing the Foundation Trust’s financial policies and for co-ordinating any corrective action necessary to further these policies (the SFIs themselves do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes);
(b) Maintaining an effective system of internal financial control, including ensuring that detailed financial procedures and systems incorporating the principles of separation

of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) Ensuring that sufficient records are maintained to show and explain the Foundation Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Foundation Trust at any time and, without prejudice to any other functions of directors and employees to the Foundation Trust, the duties of the Chief Finance Officer include:

(d) The provision of financial advice to other members of the Board of Directors, Council of Governors and employees;

(e) The design, implementation and supervision of systems of internal financial control; and

(f) The preparation and maintenance of such accounts, certificates, estimates, records and financial reports as the Foundation Trust may require for the purpose of carrying out its statutory duties.

6.3.7 All directors and employees, severally and collectively, are responsible for:

(a) The security of the property of the Foundation Trust;

(b) Avoiding loss;

(c) Exercising economy and efficiency in the use of resources; and

(d) Conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

6.3.8 Any contractor or employee of a contractor who is empowered by the Foundation Trust to commit the Foundation Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

6.3.9 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

6.4 Audit

6.4.1 Audit Committee

6.4.1.1 In accordance with Standing Orders, the Board of Directors shall formally establish an Audit Committee with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

(a) Overseeing internal and external audit services;

- Internal audit
  - to monitor and review the effectiveness of the internal audit function

- External audit
  - to assess the external auditor's work and fees on an annual basis to ensure that the work is of sufficiently high standard and that the fees are reasonable
  - to ensure a market testing exercise for the appointment of the external auditor is undertaken at least once every five years
  - to make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the external auditor and to approve the remuneration and terms of engagement of the external auditor
  - to review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements.

(b) Reviewing financial and information systems and monitoring the integrity of the financial statements and any formal announcements relating to the Trust's financial performance and reviewing of significant financial reporting judgements;
(c) Reviewing the effective implementation of corporate governance measures to enable the Foundation Trust to implement best practice as set out in appropriate guidance. This will include the Assurance Framework and control related disclosure statements, for example the Statement on Internal Control and supporting assurance processes, together with any accompanying audit statement, prior to endorsement by the Board of Directors
(d) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical, operational, compliance controls and risk management systems) that support the achievement of the organisation's objectives
(e) Monitoring compliance with Standing Orders and Standing Financial Instructions;
(f) Reviewing schedules of losses and compensations and making recommendations to the Board of Directors.

6.4.1.2 The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

6.4.1.3 Where the Audit Committee feels there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chair of the Audit Committee should raise the matter at a full meeting of the Board of Directors (to the Chief Finance Officer in the first instance).

6.4.1.4 It is the responsibility of the Chief Finance Officer to ensure an adequate internal audit service is provided, and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

6.5 Chief Finance Officer

6.5.1 The Chief Finance Officer is responsible for:
(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control, including the establishment of an effective internal audit function and the coordination of other assurance arrangements;
(b) Ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;
(c) Deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities not involving fraud or corruption;
(d) Ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:
  (i) An opinion to support the statement on the effectiveness of internal controls in accordance with current guidance issued by the Department of Health;
  (ii) Major internal financial control weaknesses discovered;
  (iii) Progress on the implementation of internal audit recommendations;
  (iv) Progress against plan over the previous year;
  (v) Strategic audit plan covering the coming three years;
  (vi) A detailed plan for the coming year.

6.5.2 The Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:
(a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
(b) Access at all reasonable times to any land, premises, members of the Board of Directors and Council of Governors or employee of the Foundation Trust;

(c) The production of any cash, stores or other property of the Foundation Trust under a member of the Board of Directors or employee's control; and
(d) Explanations concerning any matter under investigation.

6.6 Role of Internal Audit

6.6.1 The NHS Foundation Trust Accounting Officer Memorandum requires the Foundation Trust to have an internal audit function.

6.6.2 The role of internal audit embraces two key areas:

- The provision of an independent and objective opinion to the Accounting Officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives
- The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

6.6.3 Internal Audit will review, appraise and report upon:

(a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
(b) The adequacy and application of financial and other related management controls;
(c) The suitability of financial and other related management data;
(d) The extent to which the Foundation Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
    i) fraud and other offences
    ii) waste, extravagance, inefficient administration
    iii) poor value for money or other causes.
(e) Internal Audit shall also independently verify the assurance statements in accordance with guidance from ~~NHS Improvement~~NHS England and the Department of Health.

6.6.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

6.6.5 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Foundation Trust.

6.6.6 The Head of Internal Audit shall be accountable to the Audit Committee. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Auditing Standards (PSIAS). The reporting system shall be reviewed at least every three years. Where, in exceptional circumstances, the use of normal reporting channels is thought to limit the objectivity of the audit, the Head of Internal Audit shall have access to report direct to the Chair or a non-executive member of the Foundation Trust's Audit Committee.

6.6.7 Managers in receipt of audit reports referred to them have a duty to take appropriate remedial action within the agreed timescales specified within the report. The Chief Finance Officer shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate remedial action has failed

to take place within a reasonable period, the matter shall be reported to the Chief Finance Officer.

6.7 External Audit

6.7.1 Duties

6.7.1.1 The Foundation Trust is to have an external auditor and is to provide the external auditor with every facility and all information which they may reasonably require.

6.7.1.2 The external auditor is to carry out their duties in accordance with Schedule 10 of the 2006 Act and in accordance with any directions given by the Independent Regulator on standards, procedures and techniques to be adopted.

6.7.1.3 In auditing the accounts the financial auditor must, by examination of the accounts and otherwise, satisfy themselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

~~**6.7.1.4** The external auditor will also audit the quality report of the Foundation Trust.~~

~~6.7.1.5~~6.7.1.4 The Foundation Trust is required to include an annual governance statement within its annual report and financial accounts which include the quality report. The external auditors have a responsibility to:

- consider the completeness of the disclosures in meeting the relevant requirements; and
- identify any inconsistencies between the disclosures and the information that they are aware of from their work on the financial statements, quality report and other work.

6.7.2 Appointment of External Auditor

6.7.2.1 The external auditor is appointed by the Council of Governors following recommendation from the Audit Committee. 6The Audit Code for NHS Foundation Trusts ("the Audit Code") contains the directions of ~~NHS Improvement~~NHS England with respect of those eligible to be appointed under the National Health Service Act 2006, and with respect to the standards, procedures and techniques to be adopted by the external auditor.

6.7.2.2 A person may only be appointed as the external auditor if they (or in the case of a firm of each of its members) are a member of one or more of the bodies referred to in Schedule 10 of the 2006 Act.

6.7.2.3 The Council of Governors at a general meeting shall appoint or remove the Foundation Trust's external auditor.

6.7.2.4 The Board of Directors may, upon taking the advice of the Audit Committee, resolve that external auditors be appointed to review and publish a report on any other aspect of the Foundation Trust's performance. Approval of the engagement of external auditors on non-audit work will take into account relevant ethical guidance regarding the provision of such services. Any such auditors are to be appointed by the Council of Governors.

6.7.3 Undertaking Work

[6] Audit Code for NHS Foundation Trust, NHS Improvement (2011)

6.7.3.1 NHS ~~Improvement~~ England may require auditors to undertake work on its behalf at the Foundation Trust. In this situation, a tripartite agreement between the Independent Regulator, the auditor and the Foundation Trust will be agreed. This agreement, which will include details of the subsequent work and reporting arrangements, will be in accordance with the principles established in the guidance issued by the Institute of Chartered Accountants in England and Wales in audit 05/03: Reporting to Regulators or Regulated Entities.

6.7.3.2 The auditor may, with the approval of the Council of Governors, provide the Foundation Trust with services which are outside of the scope as defined in the code (additional services). The Foundation Trust shall adopt and implement a policy for considering and approving any additional services to be provided by the auditor.

6.7.4 Liaison with Internal Audit

6.7.4.1 It is expected that the external auditors will liaise with the internal audit function in order to obtain a sufficient understanding of internal audit activities to assist in planning the audit and developing an effective audit approach. The auditors may also wish to place reliance upon certain aspects of the work of internal audit in satisfying their statutory responsibilities as set out in the 2006 Act and the Audit Code. In particular the financial auditor may wish to consider the work of internal audit when undertaking their procedures in relation to the statement on internal control.

6.7.5 Access To Documents

6.7.5.1 The Auditors of the Foundation Trust have a right of access at all reasonable times to every document relating to the Foundation Trust which appears to them necessary for the purpose of their functions under Schedule 10 of the 2006 Act.

6.7.6 Public Interest Report

6.7.6.1 In the event of the External Auditor issuing a Public Interest report the Foundation Trust shall:

- Send the public interest report to the Council of Governors, the Board of Directors and NHS ~~Improvement~~England:
  - At once if it is an immediate report; or
  - Not later than 14 days after conclusion of the audit.
- Forward a report to ~~NHS Improvement~~NHS England within 30 days (or such shorter period as the Independent Regulator may specify) of the report being issued. The report shall include details of the Foundation Trust's response to the issues raised within the Public Interest report.

References in 6.6.5 and 6.6.7 relate equally to internal and external audit.

6.8 Fraud and Bribery

6.8.1 Fraud applies to any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006. Bribery applies in the giving (or offering) or receiving (or requesting) a financial or other advantage in connection with the improper performance of a position of trust, or a function that is expected to be performed impartially or in good faith.

6.8.2 The Foundation Trust shall take all necessary steps to counter fraud and bribery affecting NHS funded services in accordance with Clause 47 of the "Foundation Trust Agency Purchase Contract" (FTAPC) including Schedule 11 and in accordance with:

(a) The NHS Fraud and Corruption Manual published by NHS ~~Protect~~Counter Fraud Authority;

(b) The policy statement "Applying Appropriate Sanctions Consistently" published by NHS ~~Protect~~Counter Fraud Authority;
(c) Any other reasonable guidance or advice issued by CFSMS that affects efficiency, systemic and/or procedural matters
(d) The Fraud Act 2006;
(e) The Bribery Act 2010.

The Chief Executive and Chief Finance Officer shall monitor and ensure compliance with the above.

6.8.3 The Foundation Trust shall nominate a suitable, independent person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

6.8.4 The Local Counter Fraud Specialist shall report to the Foundation Trust Chief Finance Officer and shall work with the staff of NHS ~~Protect~~ Counter Fraud Authority in accordance with the Department of Health Fraud and Corruption Manual.

6.8.5 All allegations of fraud and bribery will be reported and if necessary investigated by the Local Counter Fraud Specialist. All accountable officers should also be aware of their obligation to pass any referrals onto the Local Counter Fraud Specialist at their earliest convenience.

6.8.6 The Local Counter Fraud Specialist will provide a written plan and report, at least annually, on counter fraud work within the Foundation Trust.

6.9 Security Management

6.9.1 The Foundation Trust shall promote and protect the security of people engaged in activities for the purposes of the health service functions of that body, its property and its information in accordance with the requirements of the 'Foundation Trust Contract', having regard to any other reasonable guidance or advice issued by NHS Protect.

6.9.2 The Foundation Trust shall nominate and appoint a local security management specialist as per the Foundation Trust contract.

6.9.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

6.10 Allocations/Payment by Results, Business Planning, Budgets, Budgetary Control, and Monitoring

6.10.1 Preparation and approval of Business Plans and Budget

6.10.1.1 The Chief Executive will compile and submit to the Board of Directors an annual plan that takes into account financial targets and forecast limits of available resources. The annual plan will contain:
(a) A statement of the significant assumptions on which the plan is based;
(b) Details of major changes in workload, delivery of services or resources required to achieve the plan.

6.10.1.2 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets relating to income and expenditure for approval by the Board of Directors. Such budgets will:
(a) Be in accordance with the aims and objectives set out in the annual plan, and the commissioners' local delivery plans;

(b) Accord with workload and workforce plans;
(c) Be produced following discussion with appropriate budget holders;
(d) Be prepared within the limits of available funds;
(e) Identify potential risks;
(f) Be based on reasonable and realistic assumptions; and

6.10.1.3 The Chief Finance Officer shall monitor financial performance against budgets, periodically review it and report to the Board of Directors. Any significant variances should be reported by the Chief Finance Officer to the Board of Directors as soon as they come to light, and the Board of Directors shall be advised of action to be taken in respect of such variances.

6.10.1.4 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled.

6.10.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

6.10.1.6 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders and budget managers to help them manage successfully.

6.10.2 Budgetary Delegation

6.10.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Section 31 of the Health Act 1999. This delegation must be in writing and be accompanied by a clear definition of:
(a) The amount of the budget;
(b) The purpose(s) of each budget heading;
(c) Individual and group responsibilities;
(d) Authority to exercise virement (which cannot be from a non-pay heading into a pay heading) (see also sections 6.10.2.2 and 6.10.2.3 below);
(e) Achievement of planned levels of service; and
(f) The provision of regular reports.

6.10.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

6.10.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

6.10.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive as advised by the Chief Finance Officer.

6.10.3 Budgetary Control and Reporting

6.10.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:
(a) Regular financial reports to the Board of Directors in a form approved by the Board of Directors containing:
    i) Income and expenditure to date showing trends and forecast year-end position;
    ii) Balance sheet, including movements in working capital;
    iii) Capital project spend and projected outturn against plan;
    iv) Explanations of any material variances from plan/budget;

v) Details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation;

(b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder and budget manager, covering the areas for which they are responsible;
(c) Investigation and reporting of variances from financial, and workload budgets;
(d) Monitoring of management action to correct variances;
(e) Arrangements for the authorisation of budget transfers;
(f) Advising the Chief Executive and Board of Directors of the consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the economic and financial impact of future plans and projects; and
(g) Review of the bases and assumptions used to prepare the budgets.

In the performance of these duties the Chief Finance Officer will have access to all budget holders and budget managers on budgetary matters and shall be provided with such financial and statistical information as is necessary.

6.10.3.2 Each budget holder is responsible for ensuring that:
(a) Any planned or known overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors;
(b) Officers shall not exceed the budget limit set;
(c) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and
(d) No permanent employees are appointed without the approval of the Chief Executive or Chief Finance Officer other than those provided for in the budgeted establishment as approved by the Board of Directors.

6.10.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

6.10.4 Capital Expenditure

6.10.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure (the particular applications relating to capital are contained in Section 6.18). A project sponsor will be identified who will assume responsibility for the budget relating to the scheme.

6.10.5 Monitoring Returns

6.10.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation within specified timescales.

6.11 Annual Accounts and Reports

6.11.1 Accounts

6.11.1.1 The Foundation Trust shall keep accounts in such form as NHS ~~Improvement~~ England may with the approval of HM Treasury direct. The accounts are to be audited by the Foundation Trust's external auditor. The following documents will be made available to the Comptroller and Auditor General for examination at their request:

- the accounts;
- any records relating to them; and
- any report of the financial auditor on them.

6.11.1.2 The functions of the Foundation Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

6.11.1.3 In preparing its annual accounts, the accounting officer shall cause the Foundation Trust to comply with any directions given by the Independent Regulator with the approval of the Treasury as to:

- the methods and principles according to which the accounts are to be prepared;
- the information to be given in the accounts;

and shall be responsible for the functions of the Foundation Trust as set out in Schedule 10 to the 2006 Act.

6.11.1.4 The annual accounts, any report of the external auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting. The Accounting Officer shall cause the Foundation Trust to:

- lay a copy of the annual accounts, and any report of the financial auditor on them, before Parliament; and
- once it has done so, send copies of those documents to NHS ~~Improvement~~England.

6.11.1.5 Responsibility for complying with the requirements relating to the form, preparation and presentation of the accounts shall be delegated to the Accounting Officer.

6.11.2 Annual Reports

6.11.2.1 The Foundation Trust is to prepare annual reports and send them to the independent regulator, NHS ~~Improvement~~England. The reports are to give:

- information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual membership of its public constituencies and of the classes of the staff constituency is representative of those eligible for such membership; and
- any other information NHS ~~Improvement~~ England requires.

6.11.2.2 The Foundation Trust is to comply with any decision NHS ~~Improvement~~ England makes as to:

- the form of the reports;
- when the reports are to be sent to them;
- the periods to which the reports are to relate.

6.11.2.3 The external auditors of the Foundation Trust have a responsibility to read the information contained within the Annual Report and consider the implications for the audit opinion and/or certificate if there are apparent misstatements or material inconsistencies with the financial statements.

6.11.2.4 Annual Plans

6.11.2.5 The Foundation Trust is to give information as to its forward planning in respect of each financial year to be submitted in accordance with requirements and timescales set by NHS ~~Improvement~~England. The document containing this information is to be prepared by the Directors, and in preparing the document, the Board of Directors must have regard to the views of the Council of Governors. The Annual Plan must be approved by the Board of Directors.

6.11.3 Other Reports

6.11.3.1 The Foundation Trust is required to publish a separate Quality Account each year as required by the NHS Act 2009 and in the terms set out in the NHS (Quality Accounts) Regulations 2010 and any guidance issued by NHS ~~Improvement~~England.

~~**6.11.3.2** The Foundation Trust is also required to provide the following three types of in-year reports:~~

- ~~regular reports, (quarterly monitoring reports), subject to review;~~
- ~~Exception reports, which may relate to any in-year issue affecting compliance with the Authorisation, such as performance against core national healthcare targets and standards; and~~
- ~~Ad hoc reports, following up specific issues identified either in the Annual Plan or in-year.~~

6.12 Bank and OPG Accounts

6.12.1 General

6.12.1.1 The Chief Finance Officer is responsible for managing the Foundation Trust banking arrangements and for advising the Foundation Trust on the provision of banking services and operation of accounts.

6.12.1.2 The Board of Directors shall approve the banking arrangements.

6.12.2 Bank and OPG Accounts

6.12.2.1 The Chief Finance Officer is responsible for:

(a) Bank accounts including those provided by the Government Banking Service (GBS), and other forms of working capital financing;
(b) Establishing separate bank accounts for the Foundation Trust's non-exchequer funds;
(c) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;
(d) Reporting to the Board of Directors all arrangements made with the Foundation Trust's bankers for accounts to be overdrawn (together with the remedial action taken).

6.12.2.2 All accounts should be held in the name of the Foundation Trust. No officer other than the Chief Finance Officer shall open any account in the name of the Foundation Trust or for the purpose of furthering Foundation Trust activities.

6.12.3 Banking Procedures

6.12.3.1 The Chief Finance Officer will prepare detailed instructions on the operation of bank accounts which must include:

(a) The conditions under which each bank is to be operated;
(b) The limit to be applied to any overdraft; and
(c) Those authorised to sign cheques or other orders drawn on the Foundation Trust's accounts.

6.12.3.2 The Chief Finance Officer must advise the Foundation Trust's bankers in writing of the conditions under which each account will be operated.

6.12.3.3 The Chief Finance Officer shall approve security procedures for any cheques issued without a handwritten signature e.g. lithographed. Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate. All

cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

6.12.3.4 Acceptance of cash will be limited to a maximum of £10,000.

6.12.4 Tendering and Review

6.12.4.1 The Chief Finance Officer will review the banking arrangements of the Foundation Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Foundation Trust's business banking.

6.12.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board of Directors. This review is not applicable to GBS accounts.

6.13 Income, Fees and Charges and Security of Cash, Cheques and other Negotiable Instruments

6.13.1 Income Systems

6.13.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.13.1.2 All such systems shall incorporate, where practicable, in full the principles of internal check and separation of duties.

6.13.1.3 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

6.13.2 Fees and Charges other than Foundation Trust Agency Purchase Contract

6.13.2.1 The Foundation Trust shall follow the Department of Health advice in the NHS Costing Manual in setting prices for non-commercial contracts with NHS organisations other than those covered by the Foundation Trust Agency Purchase Contract and non-NHS organisations.

6.13.2.2 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the guidance in the Department of Health's [7]'Commercial sponsorship: Ethical standards in the NHS' shall be followed.

6.13.2.3 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.13.3 Non-NHS Income

6.13.3.1 In accordance with Part 4 of the Health and Social Care Act 2012 the Foundation Trust shall ensure that the income it receives from providing goods and services for the NHS is greater that its income from other sources.

6.13.3.2 Where the Foundation Trust proposed to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of

[7] Commercial sponsorship: Ethical standards for the NHS, Department of Health (2000)

goods and services for the health service, it will seek approval from the Council of Governors.

6.13.4 Debt Recovery

6.13.4.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts, including a formal follow up procedure for all debtor accounts.

6.13.4.2 Income not received should be dealt with in accordance with losses procedures (see paragraph 6.21 below).

6.13.4.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.13.5 Security of Cash, Cheques and Other Negotiable Instruments

6.13.5.1 The Chief Finance Officer is responsible for:

(a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable (no form of receipt which has not been specifically authorised by the Chief Finance Officer should be issued);

(b) Ordering and securely controlling any such stationery;

(c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Foundation Trust.

6.13.5.2 Official money shall not under any circumstances be used for the encashment of private cheques, nor IOUs.

6.13.5.3 Staff shall be informed in writing on appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques etc.

6.13.5.4 All cheques, postal orders, cash or other negotiable instruments shall be banked promptly intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

6.13.5.5 The Foundation Trust will not accept a cash payment for a single transaction which is in excess of the current limit (€15,000 as at October 2010 or sterling equivalent or £10,000, whichever is lower.) This exempts the Trust from the requirement to register under the 2007 Money Laundering Regulations that came into effect on 15 December 2007.

6.13.5.6 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Foundation Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Foundation Trust from responsibility for any loss.

6.13.5.7 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be monitored and recorded within the Finance Department. Any significant trends should be reported to the Chief Finance Officer and internal audit via the incident reporting system. Where there is prima facie evidence of fraud or corruption, this should follow the form of the Foundation Trust's Fraud and Corruption Response Plan and the guidance provided by NHS Protect .

6.13.5.8 Where there is no evidence of fraud or corruption, the loss should be dealt with in line with the Foundation Trust's Losses and Compensations Procedures (see section 6.20 below).

6.14 Foundation Trust Contracts

6.14.1 Provision of Services

6.14.1.1 The Board of Directors shall regularly review and shall at all times maintain and ensure the capacity and capability of the Foundation Trust to provide Commissioner Requested Services in accordance with the Trust's Licence.

6.14.2 Foundation Trust Contract

6.14.2.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Foundation Trust enters into suitable Foundation Trust Contracts (FTCs) with ~~CCGs and other~~ commissioners for the provision of NHS services. The Foundation Trust will follow the priorities contained within the schedules of the contract, and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- The standards of service quality expected;
- The relevant national service framework (if any);
- The provision of reliable information on cost and volume of services;
- The Performance Assessment Framework contained within the FT;
- That FTC builds where appropriate on existing partnership arrangements.

6.14.3 A good FTC will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Foundation Trust works with all partner agencies involved in both the delivery and the commissioning of the service required.

6.14.4 The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from FTCs. This will include appropriate payment by results performance information.

6.14.5 Non Commissioner Contracts

6.14.5.1 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services – clinical or non-clinical, the responsible executive director should ensure that an appropriate non-commercial contract is present and signed by both parties. This should incorporate:

- A description of the service and indicative activity levels
- The term of the agreement
- The value of the agreement
- The lead officer
- Performance and dispute resolution procedures
- Risk management and clinical governance agreements.

6.14.5.2 Non-commissioner contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement so as to ensure value for money and to minimise the potential loss of income.

6.15 Terms of Service, Allowances and Payment of Members of the Board of Directors and Employees

6.15.1 Nominations and Remuneration Committee (Executive Directors)

6.15.1.1 In accordance with Standing Orders, the Board of Directors has established a Nominations and Remuneration Committee which is responsible for the appointment of Executive Directors and for agreeing the terms of service of Executive Directors. It has clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

6.15.1.2 The terms of reference for the Nominations and Remuneration Committee (Executive Directors) can be found in this Corporate Governance Manual.

6.15.1.3 The Remuneration and Nomination Committee will be accountable to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it or require executive action.

6.15.1.4 The Board of Directors will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

6.15.1.5 **Nominations and Remuneration Committee (Non-Executive Directors)**

6.15.1.6 In accordance with Standing Orders, the Council of Governors have established a Nominations and Remuneration Committee which is responsible for the appointment and setting the terms of appointment of Non-Executive Directors. It will make recommendations to a general meeting of the Council of Governors on the appointment of Non-Executive Directors. It has clearly defined terms of reference, specifying its area of responsibility, its composition and the arrangements for reporting.

6.15.1.7 The terms of reference of the Nominations and Remuneration Committee (Non-Executive Directors) can be ~~found in this Corporate Governance Manual~~requested from the Trust Secretary.

6.15.2 **Funded Establishment**

6.15.2.1 The workforce plans incorporated within the annual budget will form the funded establishment. The establishment of the Foundation Trust will be identified and monitored by the Chief People Officer under delegation from the Chief Executive.

6.15.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or individual nominated within the relevant section of the Scheme of Reservation and Delegation. The Chief Finance Officer is responsible for verifying that funding is available.

6.15.3 **Staff Appointments**

6.15.3.1 No Executive Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

i. Unless authorised to do so by the Chief Executive; and
ii. Within the limit of his approved budget and funded establishment as defined in the Scheme of Reservation and Delegation.

6.15.3.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

6.15.3.3 **Processing of the Payroll**

6.15.3.4 The Chief People Officer in conjunction with the Chief Finance Officer is responsible for:

(a) Specifying timetables for submission of properly authorised time records and other notifications;
(b) The final determination of pay and allowances; including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;
(c) Making payment on agreed dates; and
(d) Agreeing method of payment.

6.15.3.5 The Chief People Officer will issue instructions, taking into account the advice of the Chief Finance Officer and provider of payroll services regarding:

a) Verification and documentation of data;
b) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;
c) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
d) Security and confidentiality of payroll information;
e) Checks to be applied to completed payroll before and after payment;
f) Authority to release payroll data under the provisions of the Data Protection Act;
g) Methods of payment available to various categories of employee;
h) Procedures for payment by cheque, bank credit, or cash to employees;
i) Procedures for the recall of cheques and bank credits;
j) Pay advances and their recovery;
k) Maintenance of regular and independent reconciliation of pay control accounts;
l) Separation of duties of preparing records and handling cash; and
m) A system to ensure the recovery from leavers of sums of money and property due by them to the Foundation Trust.

6.15.3.6 Appropriately nominated managers have delegated responsibility for:

(a) Processing a signed copy of the contract/appointment form and such other documentation as may be required immediately upon an employee commencing duty;
(b) Submitting time records, and other notifications in accordance with agreed timetables;
(c) Completing time records and other notifications in accordance with the Chief People Officer's instructions and in the form prescribed by the Chief People Officer; and
(d) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Chief People Officer must be informed immediately. In circumstances where fraud might be expected this must be reported to the Chief Finance Officer.

6.15.3.7 Regardless of the arrangements for providing the payroll service, the Chief People Officer, in conjunction with the Chief Finance Officer, shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

6.15.4 Contracts of Employment

6.15.4.1 The Board of Directors shall delegate responsibility to a manager for:

(a) Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment and Health and Safety legislation; and
(b) Dealing with variations to, or termination of, contracts of employment.

6.16 Non Pay Expenditure

6.16.1 Delegation of Authority

6.16.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

6.16.1.2 The Chief Executive will set out:

(a) The list of managers who are authorised to place requisitions for the supply of goods and services (see Table B Delegated Financial Limits Section 4) which should be updated and reviewed on an ongoing basis and annually by the Finance Department in conjunction with departmental officers;

(b) Where the authorisation system is computerised, the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system; and

(c) The maximum level of each requisition and the system for authorisation above that level.

6.16.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

6.16.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

6.16.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Foundation Trust with particular reference to the requirements for quotations and tenders detailed in Table B delegated limits of the Scheme of Reservation and Delegation. In so doing, the advice of the Foundation Trust's Procurement Department and advisor on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Executive) shall be consulted.

6.16.2.2 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall only commit expenditure within delegated approval limits with the raising of an official Trust Purchase Order (PO). Invoices received by the Trust without an official PO number quoted will be returned unpaid to the supplier.

6.16.2.3 The Chief Finance Officer shall be responsible for the prompt payment of properly authorised accounts and claims in accordance with the Better Payment Practice Code (BPPC). Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

6.16.2.4 The Chief Finance Officer will:

(a) Advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained and, once approved, the thresholds should be incorporated in the Scheme of Reservation and Delegation and regularly reviewed;

(b) Prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;

(c) Be responsible for the prompt payment of all properly authorised accounts and claims;

(d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) A list of directors/employees (including specimens of their signatures) authorised to approve or incur expenditure. Where the authorisation system is computerised, the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system.

ii) Certification that:
- Goods have been duly received, examined and are in accordance with specification and the prices are correct;
- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- The account is arithmetically correct;
- The account is in order for payment.

iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment. Provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department

v) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as below).

6.16.2.5 Prepayments outside of normal commercial arrangements, for example fully comprehensive maintenance contracts and rental insurance, are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate);

(b) The appropriate officer in conjunction with the Procurement Department must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Foundation Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

6.16.2.6 Official Orders must, where not generated by the Trust's computerised procurement system:

(a) Be consecutively numbered;

(b) Be in a form approved by the Chief Finance Officer;

(c) State the Foundation Trust terms and conditions of trade; and
(d) Only be issued to, and used by, those duly authorised by the Chief Executive.

6.16.2.7 Managers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

(a) All contracts other than for a simple purchase permitted within the Scheme of Delegation or delegated budget, leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;
(b) Contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement;
(c) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health. Where an officer certifying accounts relies upon other officers to do preliminary checking, he/she shall wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms;
(d) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
- Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars
- Conventional hospitality, such as lunches in the course of working visits

(e) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;
(f) All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or on purchasing cards;
(g) Verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order, and clearly marked "Confirmation Order";
(h) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
(i) Goods are not taken on trial or loan in circumstances that could commit the Foundation Trust to a future uncompetitive purchase;
(j) Changes to the list of directors/employees authorised to certify invoices are notified to the Chief Finance Officer;
(k) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;
(l) Petty cash records are maintained in a form as determined by the Chief Finance Officer; and
(m) Orders are not required to be raised for utility bills, NHS recharges and ad hoc services such as private hospital fees. Payments must be authorised in accordance with the delegated limits set for non pay.

6.16.2.8 The Chief Executive and Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the Capital Investment Manual and any other relevant guidance issued by NHS ~~Improvement.~~England. The technical audit of these contracts shall be the responsibility of the relevant Director.

6.16.2.9 Under no circumstances should goods be ordered through the Foundation Trust for personal or private use.

6.16.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

6.16.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with these Acts.

6.17 External Borrowing and Investments

6.17.1 Public Dividend Capital

6.17.1.1 On authorisation as a Foundation Trust, the Public Dividend Capital held immediately prior to authorisation continues to be held on the same conditions.

6.17.1.2 Additional Public Dividend Capital may be made available on such terms the Secretary of State (with the consent of the Treasury) decides.

6.17.1.3 Draw down of Public Dividend Capital should be authorised in accordance with the mandate held by the Department of Health Cash Funding Team, and is subject to approval by the Secretary of State.

6.17.1.4 The Foundation Trust shall be required to pay annually to the Department of Health a dividend on its Public Dividend Capital at a rate to be determined from time to time, by the Secretary of State.

6.17.2 Working Capital Loan Facility

6.17.2.1 The Foundation Trust may be required by NHS Improvement to have a working capital facility. This will be provided by the Trust's banker or other commercial provider if available and cost effective. Such a facility may be of variable term.

6.17.2.2 The Foundation Trust must only draw down against this facility in respect of true working capital needs, and in accordance with the terms and conditions of the facility.

6.17.3 Commercial Borrowing and Investment

6.17.3.1 The Foundation Trust may borrow money from any commercial source for the purposes of or in connection with its functions.

6.17.3.2 The Foundation Trust may invest money (other than money held by it as charitable trustee) for the purposes of or in connection with its functions. Such investment may include forming, or participating in forming, or otherwise acquiring membership of bodies corporate.

6.17.3.3 The Foundation Trust may also give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.

6.17.4 Investment of Temporary Cash Surpluses

6.17.4.1 Temporary cash surpluses must be held only in such public and private sector investments as authorised by the Board of Directors.

6.17.4.2 The Finance, Performance and Business Development committee is responsible for establishing and monitoring an appropriate investment strategy.

6.17.4.3 The Chief Finance Officer is responsible for advising the Board of Directors on investments and shall report periodically to the Board of Directors concerning the performance of investments held.

6.17.4.4 The Chief Finance Officer will prepare detailed procedural instructions on investment operations and on the records to be maintained. The Foundation Trust's Treasury Management Policy will include instructions on funding and investing, safe harbour investments, risk management, borrowing, controls, reporting and performance management. It will also incorporate guidance from ~~NHS Improvement~~NHS England as appropriate.

6.18 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

6.18.1 Capital Investment

6.18.1.1 The Chief Executive:

(a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
(b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and
(c) Shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

6.18.1.2 For capital expenditure proposals, the Chief Executive shall ensure (in accordance with the limits outlined in the Scheme of Delegation):

(a) That a business case is produced, setting out:
    i) An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and
    ii) Appropriate project management and control arrangements; and
    iii) The involvement of appropriate Foundation Trust personnel and external agencies; and
(b) That the Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case.

6.18.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the capital investment manual and any other relevant guidance issued by ~~NHS Improvement~~NHS England.

6.18.1.4 The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme, in accordance with Inland Revenue guidance.

6.18.1.5 The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised budgets.

6.18.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:

(a) Specific authority to commit expenditure
(b) Authority to proceed to tender
(c) Approval to accept a successful tender.

6.18.1.7 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the capital investment manual guidance and any other relevant guidance issued by ~~NHS Improvement~~NHS England, and the Foundation Trust's Standing Orders.

6.18.1.8 The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

6.18.2 Private Finance

6.18.2.1 The Foundation Trust should normally test for PFI when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector, the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;
(b) A business case must be referred to NHS England~~Improvement~~ for approval or treated as per current guidelines;
(c) The proposal must be specifically agreed by the Foundation Trust, in the light of such professional advice as should reasonably be sought, in particular with regard to vires;
(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

6.18.3 Asset Registers

6.18.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

6.18.3.2 The Foundation Trust shall maintain an asset register recording fixed assets. As a minimum, the minimum data set to be held within these registers shall be as specified in the NHS Foundation Trust Annual Reporting Manual as issued by NHS ~~Improvement~~England.

6.18.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder, and be validated by reference to:

(a) Properly authorised and approved agreements, architects' certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;
(b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and
(c) Lease agreements in respect of assets held under a finance lease and capitalised.

6.18.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

6.18.3.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on the Asset Register.

6.18.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the NHS Foundation Trust Annual Reporting Manual issued by NHS ~~Improvement~~England.

6.18.3.7 The value of each asset shall be depreciated using methods and rates as specified in the NHS Foundation Trust Annual Reporting Manual issued by NHS ~~Improvement~~England.

6.18.3.8 The Chief Finance Officer shall calculate and pay capital charges as specified by the Department of Health.

6.18.4 Protected Property

6.18.4.1 A register of protected property is required to be maintained in accordance with requirements issued by ~~NHS Improvement~~NHS England. The property referred to in Condition 9(1) of the Licence, which is to be protected, is limited to land and buildings owned or leased by the Foundation Trust (assets such as equipment, financial assets, cash or intellectual property will not be regarded as protected assets).

6.18.4.2 No protected property may be disposed of (including disposing of part of it or granting an interest in it) without the approval of NHS England~~Improvement~~.

6.18.4.3 This will be achieved through the annual planning process. The annual plan will include proposed changes in the treatment of assets that are protected and proposed disposals and acquisitions.

6.18.4.4 The Foundation Trust is required to notify relevant bodies of the publication date of their plans to allow them to lodge any objections. Twenty-one days is allowed before the plans are then approved.

6.18.4.5 During the year when the proposed changes are made the Asset Register must be updated accordingly. The relevant bodies should then be notified that an updated Asset Register is available.

6.18.4.6 As required by its Licence the Foundation Trust must make the Asset Register available for inspection by the public. The Foundation Trust may charge a reasonable fee for access to this information.

6.18.5 Security of Assets

6.18.5.1 The overall control of fixed assets is the responsibility of the Chief Executive advised by the Chief Finance Officer. Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) Recording managerial responsibility for each asset;
(b) Identification of additions and disposals;
(c) Identification of all repairs and maintenance expenses;
(d) Physical security of assets;
(e) Periodic verification of the existence of, condition of, and title to, assets recorded;
(f) Identification and reporting of all costs associated with the retention of an asset; and
(g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

6.18.5.2 All significant discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

6.18.5.3 Whilst each employee has a responsibility for the security of property of the Foundation Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

6.18.5.4 Any damage to the Foundation Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

6.18.5.5 Where practical, assets should be marked as Foundation Trust property.

6.19 Stock, Stores and Receipt of Goods

6.19.1 Stocks are defined as those goods normally utilised in day to day activity, but which at a given point in time have not been used or consumed. There are three broad types of store:

(a) Controlled stores – specific areas designated for the holding and control of goods;
(b) Wards and departments – goods required for immediate usage to support operational services;
(c) Manufactured Items – where goods and consumables are being made or processes are being applied which add to the raw material cost of the goods.

6.19.2 Such stocks should be kept to a minimum and for:

(a) Controlled stores and other significant stores (as determined by the Chief Finance Officer) should be subjected to an annual stock take or perpetual inventory procedures; and
(b) Valued at the lower of cost and net realisable value.

6.19.3 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any pharmaceutical stocks shall be the responsibility of the Head of Pharmacy. The control of any fuel oil shall be the responsibility of the ~~Head of~~ Estates and Facilities Manager.

6.19.4 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager.

6.19.5 Wherever practicable, stocks should be marked as NHS property.

6.19.6 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

6.19.7 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

6.19.8 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

6.19.9 The designated manager shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also 6.20, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

6.19.10 Receipt of Goods

6.19.10.1 All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification. A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available.

6.19.10.2 All goods received shall be entered onto an appropriate goods received/stock record (whether a computer or manual system) on the day of receipt. If goods received are unsatisfactory, the records shall be marked accordingly. Further, where the goods received are found to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately.

6.19.10.3 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note to satisfy themselves that the goods have been received. The Finance Department will make payment on receipt of an invoice. This may also apply for high-level low volume items such as stationery.

6.19.11 Issue of Stocks

6.19.11.1 The issue of stocks shall be supplied by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer. Where a 'topping up' system is used, a record shall be maintained as approved by the Chief Finance Officer. Regular comparisons shall be made of the quantities issued to wards/departments etc, and explanations recorded of significant variations.

6.19.11.2 All transfers and returns shall be recorded on forms/systems provided for the purpose and approved by the Chief Finance Officer.

6.20 Disposals and Condemnations, Insurance, Losses and Special Payments

6.20.1 Disposals and Condemnations

6.20.1.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

6.20.1.2 When it is decided to dispose of a Foundation Trust asset, the head of department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

6.20.1.3 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;

(b) Recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

6.20.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

6.21 Losses and Special Payments

6.21.1 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Chief Finance Officer must also prepare a fraud response plan that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

6.21.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their directorate manager or head of department, who must immediately inform the Chief Finance Officer who will liaise with the Chief Executive or

inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Chief Finance Officer who will liaise with the Chief Executive.

6.21.3 Where a criminal offence such as theft or arson is suspected, the Divisional Manager or departmental head must immediately inform the police and obtain a crime number, which should be forwarded to the Chief Finance Officer. In cases of fraud, bribery or corruption, or of anomalies which may indicate fraud, bribery or corruption, the Chief Finance Officer must inform their Local Counter Fraud Officer, who will inform NHS ~~Protect~~ Counter Fraud Authority before any action is taken and reach agreement on how the case is to be handled.

6.21.4 The Chief Finance Officer must notify NHS ~~Protect~~ Counter Fraud Authority and the external auditor of all frauds.

6.21.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:
(a) The Board of Directors, and
(b) The external auditor, and
(c) NHS Protect (through LSMS).

6.21.6 The Board of Directors shall approve the writing-off of all losses and special payments in accordance with the Scheme of Delegation.

6.21.7 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Foundation Trust's interests in bankruptcies and company liquidations.

6.21.8 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

6.21.9 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

6.22 Insurance

6.22.1 The Chief Finance Officer shall ensure that insurance arrangements exist in accordance with the risk management programme.

6.23 Compensation Claims

6.23.1 The Foundation Trust is committed to effective and timely investigation and response to any claim which includes allegations of clinical negligence, employee and other compensation claims. The Foundation Trust will follow the requirements and note the recommendations of the Department of Health, and the NHS ~~Litigation Authority~~Resolution ~~(NHSLA),~~ in the management of claims. Where appropriate external insurance has been contracted, this will be within the above mentioned requirements and recommendations. Every member of staff is expected to co-operate fully, as required, in assessment and management of each claim.

6.23.2 The Foundation Trust will seek to reduce the incidence and adverse impact of clinical negligence, employee and other litigation by:

- Adopting prudent risk management strategies including continuous review
- Implementing in full the NHS Complaints Procedure, thus providing an alternative remedy for some potential litigants
- Adopting a systematic approach to claims handling in line with the best current and cost effective practice

- Following guidance issued by the NHS ResolutionLA relating to clinical negligence
- Achieving compliance with the relevant core Care Quality Commission standards
- Implementing an effective system of clinical governance.

6.23.3 The Chief Nurse and Midwife in association with the Medical Director is responsible for clinical negligence, for managing the claims process and informing the Board of Directors of any major developments on claims related issues.

6.24 Information Technology

6.24.1 Responsibilities and duties of the Chief Finance Officer

6.24.1.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Foundation Trust, shall:

(a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Foundation Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (updated 2000) and the Computer Misuse Act 1990;

(b) Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) Ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks;

(e) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

6.24.1.2 The Chief Finance Officer shall satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

6.24.1.3 The Foundation Trust has published and maintains a Freedom of Information (FoI) Publication Scheme as approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

6.24.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

6.24.2.1 In the case of computer systems which are proposed General Applications (i.e. those applications which a number of NHS organisations wish to sponsor jointly), all responsible directors and employees will send to the Chief Finance Officer:

(a) Details of the outline design of the system;

(b) In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

6.24.3 Contracts for Computer Services with other health bodies or outside agencies

6.24.3.1 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation, or any other agency, shall clearly

define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

6.24.3.2 Where another health organisation, or any other agency, provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

6.24.4 Requirement for Computer Systems which have an impact on corporate financial systems

6.24.4.1 Where computer systems have an impact on corporate financial systems, the Chief Finance Officer shall satisfy themselves that:

(a) Systems acquisition, development and maintenance are in line with corporate policies, such as an Information Management and Technology Strategy
(b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
(c) Chief Finance Officer staff have access to such data; and
(d) Such computer audit reviews as are considered necessary are being carried out.

6.24.5 Risk Assessment

6.24.5.1 The Chief Finance Officer shall ensure that risks to the Trust arising from the use of information technology are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

6.24.5.2 The Foundation Trust shall disclose to ~~NHS Improvement~~NHS England and directly to any third parties, as may be specified by the Secretary of State, information, if any, as specified in the Licence. Other information, as requested, shall be provided to ~~NHS Improvement~~NHS England.

6.24.5.3 The Foundation Trust shall participate in the national programme for information technology, in accordance with any guidance issued by ~~NHS Improvement~~NHS England.

6.25 Patients' Property

6.25.1 The Foundation Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

6.25.2 The Chief Executive is responsible for ensuring that patients, or their guardians as appropriate, are informed before or at admission by

- Notices and information booklets
- Hospital admission documentation and property records
- The oral advice of administrative and nursing staff responsible for admissions

that the Foundation Trust will not accept responsibility or liability for patients' property brought into its premises, unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt.

6.25.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. The said instructions shall cover the necessary arrangements for withdrawal of cash or

disbursement of money held in accounts of patients who are incapable of handling their own financial affairs. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

6.25.4 A patient's property record, in a form determined by the Chief Finance Officer, shall be completed in respect of the following:
(a) Property handed in for safe custody by any patient (or guardian as appropriate); and
(b) Property taken into safe custody, having been found in the possessions of:
- Mentally disordered patients
- Confused and/or disorientated patients
- Unconscious patients
- Patients dying in hospital
- Patients found dead on arrival at hospital (property removed by police).

A record shall be completed in respect of all persons in category (b), including a nil return if no property is taken into safe custody.

6.25.5 The record shall be completed by a member of the hospital staff, in the presence of a second member of staff and the patient (or representative) where practicable. It shall then be signed by both members of staff and by the patient, except where the latter is restricted by physical or mental incapacity. Any alterations shall be validated by signatures as requested for the original entry on the record.

6.25.6 Where Department of Health instructions require the opening of separate accounts for patients' monies (separate from those containing Foundation Trust monies), these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

6.25.7 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Works and Pensions. For long stay patients, the Chief Executive shall ensure that positive action is taken to use their funds effectively and so reduce balances accruing.

6.25.8 Refunds of cash handed in for safe custody will be dealt with in accordance with current Department of Works and Pensions guidance. Property other than cash, which has been handed in for safe custody, shall be returned to the patient as required by the officer who has been responsible for its security. The return shall be receipted by the patient, or guardian as appropriate, and witnessed.

6.25.9 The disposal of property of deceased patients shall be effected by the officer who has been responsible for its security. Such disposal shall be in accordance with written instructions issued by the Chief Finance Officer. In particular, where cash or valuables have been deposited for safe custody, they shall only be released after written authority has been given by the Chief Finance Officer. Such authority shall include details of the lawful kin or other person entitled to the cash and valuables in question.

6.25.10 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

6.25.11 Property handed over for safe custody shall be placed into the care of the appropriate administrative staff. Where there are no administrative staff present, the property shall be placed into the care of the most senior member of nursing staff on duty.

6.25.12 In respect of deceased patients, if there is no will and no lawful next of kin the property vests in the Crown and particulars shall, therefore, be notified to the Treasury Solicitor.

6.25.13 Any funeral expenses necessarily borne by the Foundation Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any element of the estate held by the Foundation Trust may be appropriated towards funeral expenses, upon the authorisation of the Chief Finance Officer.

6.25.14 Staff should be informed, on appointment, by the appropriate departmental or senior manager, of their responsibilities and duties for the administration of the property of patients.

6.25.15 Where patients' property or income is received for specific purposes and held for safekeeping, the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

6.26 Funds held on Trust

6.26.1 General

6.26.1.1 The Foundation Trust has a responsibility as a corporate trustee for the management of funds it holds on trust. The management processes may overlap with those of the organisation of the Foundation Trust. The trustee responsibilities must be discharged separately, and full recognition given to its dual accountabilities, to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

6.26.1.2 The reserved powers of the Board of Directors and the Scheme of Delegation make clear where decisions where discretion must be exercised are to be taken and by whom.

6.26.1.3 As management processes overlap, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

6.26.1.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

6.26.1.5 Charitable Funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the Trust and the objectives of which are for the benefit of the NHS in England. They are administered by the Foundation Trust Board of Directors acting as the Charitable Funds Committee (the trustees).

6.26.1.6 The Chief Finance Officer shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Foundation Trust as trustees of non-exchequer funds, including an Investment Register.

6.26.2 Existing Charitable Funds

6.26.2.1 The Chief Finance Officer shall arrange for the administration of all existing funds. A Deed of Establishment must exist for every fund, and detailed codes of procedure shall be produced covering every aspect of the financial management of charitable funds, for the guidance of fund managers. The Deed of Establishment shall identify the restricted nature of certain funds, and it is the responsibility of fund managers, within their delegated authority, and the Charitable Funds Committee, to ensure that funds are utilised in accordance with the terms of the Deed.

6.26.2.2 The Chief Finance Officer shall periodically review the funds in existence, and shall make recommendations to the Charitable Funds Committee regarding the potential for rationalisation of such funds within statutory guidelines.

6.26.2.3 The Chief Finance Officer shall ensure that all funds are currently registered with the Charities Commission in accordance with the Charities Act 1993 or subsequent legislation.

6.26.3 New Charitable Funds

6.26.3.1 The Chief Finance Officer shall recommend the creation of a new fund where funds and/or other assets received for charitable purposes cannot adequately be managed as part of an existing fund. All new funds must be covered by a Deed of Establishment, and must be formally approved by the Charitable Funds Committee.

6.26.3.2 The Deed of Establishment for any new fund shall clearly identify, inter alia, the objects of the new fund, the nominated fund manager, the estimated annual income and, where applicable, the Charitable Funds Committee's power to assign the residue of the fund to another fund contingent upon certain conditions e.g. discharge of original objects.

6.26.4 Sources of New Funds

6.26.4.1 All gifts accepted shall be received and held in the name of the Charity and administered in accordance with the Charity's policy, subject to the terms of specific funds. As the Charity can accept gifts only for all or any purposes relating to the NHS, officers shall, in cases of doubt, consult the Chief Finance Officer before accepting any gift. Advice to the Board of Directors on the financial implications of fund raising activities by outside bodies or organisations shall be given by the Chief Finance Officer.

6.26.4.2 All gifts, donations and proceeds of fund-raising activities which are intended for the Charity's use must be handed immediately to the Chief Finance Officer via the Finance Department to be banked directly to the Charitable Funds Bank Account.

6.26.4.3 In respect of donations, the Chief Finance Officer shall:

(a) Provide guidelines to Officers of the Foundation Trust as to how to proceed when offered funds. These will include:
- The identification of the donors intentions;
- Where possible, the avoidance of creating excessive numbers of funds;
- The avoidance of impossible, undesirable or administratively difficult objects;
- Sources of immediate further advice; and
- Treatment of offers for personal gifts.

(b) Provide secure and appropriate receipting arrangements, which will indicate that donations have been accepted directly into the appropriate fund and that the donor's intentions have been noted and accepted.

6.26.4.4 In respect of Legacies and Bequests, the Chief Finance Officer shall be kept informed of and record all enquiries regarding legacies and bequests. Where required, the Chief Finance Officer shall:

(a) Provide advice covering any approach regarding:
- The wording of wills;
- The receipt of funds/other assets from executors.

(b) After the death of a testator, all correspondence concerning a legacy shall be dealt with on behalf of the Charity by the Chief Finance Officer who alone shall be empowered to give an executor a good discharge;

(c) Where necessary, obtain grant of probate, or make application for grant of letters of administration;

(d) Be empowered to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and

(e) Be directly responsible, in conjunction with the Charitable Funds Committee, for the appropriate treatment of all legacies and bequests.

6.26.4.5 In respect of fund-raising, the final approval for major appeals will be given by the Board of Directors. Final approval for smaller appeals will be given by the Charitable Funds Committee. The Chief Finance Officer shall:

(a) Advise on the financial implications of any proposal for fund-raising activities;
(b) Deal with all arrangements for fund-raising by and/or on behalf of the Charity, and ensure compliance with all statutes and regulations;
(c) Be empowered to liaise with other organisations/persons raising funds for the Charity, and provide them with an adequate discharge;
(d) Be responsible for alerting the Charitable Funds Committee and the Board of Directors to any irregularities regarding the use of the Charity's name or its registration numbers; and
(e) Be responsible for the appropriate treatment of all funds received from this source.

6.26.4.6 In respect of Trading Income (see also NHS Charitable Funds Guidance Chapter 6), the Chief Finance Officer shall:

(a) Be primarily responsible, along with designated fund managers, for any trading undertaken by the Charity; and
(b) Be primarily responsible for the appropriate treatment of all funds received from this source.

6.26.4.7 In respect of Investment Income, the Chief Finance Officer shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

6.26.5 Investment Management

6.26.5.1 The Charitable Funds Committee shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the approved investment policy. The issues on which the Chief Finance Officer shall be required to provide advice to the Charitable Funds Committee shall include:

(a) The formulation of investment policy which meets statutory requirements (Trustee Investment Act 1961) with regard to income generation and the enhancement of capital value;
(b) The appointment of advisers, brokers and, where appropriate, investment fund managers and:
- The Chief Finance Officer shall recommend the terms of such appointments, and for which
- Written agreements shall be signed by the Chief Executive

(c) Pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;
(d) The participation by the Charity in common investment funds and the agreement of terms of entry and withdrawal from such funds;
(e) That the use of assets shall be appropriately authorised in writing and charges raised within policy guidelines;
(f) The review of the performance of brokers and fund managers;
(g) The reporting of investment performance.

6.26.5.2 The Chief Finance Officer shall prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for Charitable Funds.

6.26.6 Expenditure from Charitable Funds

6.26.6.1 Expenditure from Charitable Funds shall be managed on a day to day basis by the Financial Accountant and by the Charitable Funds Committee in accordance with delegated

limits on behalf of the Corporate Trustee. In so doing, the committee shall be aware of the following:

(a) The objects of various funds and the designated objectives;
(b) The availability of liquid funds within each trust;
(c) The powers of delegation available to commit resources;
(d) The avoidance of the use of exchequer funds to discharge endowment fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;
(e) That funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Foundation Trust; and
(f) The definitions of "charitable purposes" as agreed by the Department of Health with the Charity Commission.

6.26.6.2 Delegated authority to incur expenditure which meets the purpose of the funds is set out in the Scheme of Delegations. Exceptions are as follows:

(a) Any staff salaries/wages costs require Charitable Funds Committee approval;
(b) No funds are to be "overdrawn" except in the exceptional circumstance that Charitable Funds Committee approval is granted.

6.26.7 Banking Services

6.26.7.1 The Chief Finance Officer shall advise the Charitable Funds Committee and, with its approval, shall ensure that appropriate banking services are available in respect of administering the Charitable Funds. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

6.26.7.2 Asset Management

6.26.7.2.1 Assets in the ownership of or used by the Charitable Fund shall be maintained along with the general estate and inventory of assets of the Foundation Trust. The Chief Finance Officer shall ensure:

(a) That appropriate records of all donated assets owned by the Charitable Fund are maintained, and that all assets, at agreed valuations are brought to account;
(b) That appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;
(c) That donated assets received on trust shall be accounted for appropriately;
(d) That all assets acquired from Charitable Funds which are intended to be retained within the funds are appropriately accounted for.

6.26.8 Reporting

6.26.8.1 The Chief Finance Officer shall ensure that regular reports are made to the Charitable Funds Committee and Board of Directors with regard to, inter alia, the receipt of funds, investments and expenditure.

6.26.8.2 The Chief Finance Officer shall prepare annual accounts in the required manner, which shall be submitted to the Board of Directors within agreed timescales.

6.26.8.3 The Chief Finance Officer shall prepare an annual trustees' report and the required returns to the Charity Commission for adoption by Charitable Funds Committee and subsequently the Board of Directors as Corporate Trustee.

6.26.9 Accounting and Audit

6.26.9.1 The Chief Finance Officer shall maintain all financial records to enable the production of reports as above, and to the satisfaction of internal and external audit.

6.26.9.2 Distribution of investment income to the charitable funds and the recovery of administration costs shall performed on a basis determined by the Chief Finance Officer.

6.26.9.3 The Chief Finance Officer shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He/she will liaise with external audit, and provide them with all necessary information.

6.26.9.4 The Charitable Funds Committee and subsequently the Board of Directors shall be advised by the Chief Finance Officer on the outcome of the annual audit.

6.26.10 Taxation and Excise Duty

6.26.10.1 The Chief Finance Officer shall ensure that the Charity's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

6.27 Tendering, Quotation and Contracting Procedures

6.27.1.1 Duty to comply with Standing Orders and Standing Financial Instructions

6.27.1.1.1 The procedure for making all contracts by or on behalf of the Foundation Trust shall comply with the Trust's Standing Orders and Standing Financial Instructions (except where Suspension of Standing Orders is applied). In particular reference should be made to the Trust Delegated Authorities Table A Section 35 and Table B Section 6 Delegated Financial Limits of this Corporate Governance Manual.

6.27.1.2 EU Directives Governing Public Procurement

6.27.1.2.1 Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions. Details of EU thresholds and the differing procedures to be adopted can be obtained from the Supplies Departments (see paragraph 6.27.1.4.1).

6.27.1.2.2 NHS ProCure22 was launched in 2016 as a standardised approach to the procurement of healthcare facilities. It is based upon long term relationships with selected supply chains that have the ability to work with NHS bodies across the whole life cycle of a capital scheme. For further details see the ProCure22 website at www.procure22.nhs.uk

6.27.1.3 Formal Competitive Tendering

6.27.1.3.1 The Foundation Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

6.27.1.3.2 Where the Foundation Trust elects to invite tenders for the supply of healthcare these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

6.27.1.3.3 Formal tendering procedures are not required where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the limit set in the Scheme of Reservation and Delegation; or

(b) the supply is proposed under special arrangements negotiated by the Department of Health in which event the said special arrangements must be complied with; or
(c) regarding disposals as set out in Standing Financial Instruction 'Disposals and Condemnations'.

6.27.1.4 Fair and Adequate Competition

6.27.1.4.1 No company must be given any advantage over its competitors, which might hinder fair competition between prospective contractors or suppliers. In this context see also the section on awarding contracts in the section below containing Standards of Business Conduct for NHS Staff.

6.27.1.4.2 The Foundation Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

6.27.1.5 Items which subsequently breach thresholds after original approval

6.27.1.5.1 Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Foundation Trust record.

6.27.1.6 Waiving of Formal Tendering / Quotation Procedures

6.27.1.6.1 There is no exemption from formal procedures if the total financial value exceeds the threshold. In this instance, and in accordance with the Public Contract Regulations 2015, tendering/quotation procedures cannot be waived.

6.27.1.6.2 Formal tendering procedures <u>may be waived</u> in the following circumstances:
(a) In very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures;
(b) Where the requirement is covered by an existing contract;
(c) Where national or other framework agreements are in place and have been approved by the Board of Directors;
(d) Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
(e) Where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;
(f) Where specialist expertise is required and is available from only one source;
(g) When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
(h) Where there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
(i) For the provision of legal advice and services providing that any legal firm or partnership commissioned by the Foundation Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Chief Finance Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

6.27.1.6.3 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

6.27.1.6.4 Competitive tendering cannot be waived for building and engineering construction works and maintenance without Departmental of Health approval.

6.27.1.6.5 Where it is decided that competitive tendering or quotation is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded on the Trust's standard Waiver Request Form. The originating department should submit the completed Waiver Request Form for approval in advance of any requisitioning activity to the Chief Finance Officer / Chief Executive.

6.27.1.6.6 All requests to waive tenders should be reported to the Audit Committee on a quarterly basis.

6.27.1.6.7 Exceptionally a single tender action may be permitted. However it should not be used retrospectively i.e. after a contract has been awarded nor should it be used for administrative convenience or to avoid competition. In all cases the reasons should be documented and reported by the Chief Finance Officer to Audit Committee and through to the Board via the Chair's Report.

6.27.1.7 Competitive Tenders and Quotations

6.27.1.7.1 Wherever practicable, at least three competitive tenders or quotations shall be obtained for the supply of goods or services in accordance with the Trust Delegated Financial Limits Table B Section 6.

6.27.1.7.2 In respect of any formal procurement exercises to be undertaken over the £5,000 threshold, the Head of Procurement's advice must be sought prior to commencement of the exercise. The Head of Procurement will lead any procurement exercises which exceed the Find a Tender Service procurement threshold.

6.27.1.8 Contracting / Tendering Procedure

6.27.1.8.1 Invitation to Tender

6.27.1.8.1.1 All invitations to tender on a formal competitive basis shall state the date and time as being the latest time for the receipt of tenders and no tender will be considered for acceptance unless submitted via the Trust's accepted method of receiving completed tender responses. All tenders must be received in this way and no exceptions will be made.

6.27.1.8.1.2 Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

6.27.1.8.1.3 Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

6.27.1.8.1.4 Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Contract conditions as are applicable. Every tenderer must give a written undertaking not to engage in collusive tendering or other restrictive practice.

6.27.1.8.1.5 Selection and award criterion must always be established in advance of tender selection taking place. Subsequent decisions to vary these criteria will be closely scrutinised before final approval is given. Further to Procurement Policy Note 06/20's application to NHS Trusts from April 2022, a minimum weighting of 10% must be given to Social Value in any tender award criteria.

6.27.1.8.1.6 Before the due date of the tender, the electronic tendering portal will issue an automatic notification to the directors responsible for receiving and the releasing of electronic tenders.

6.27.1.8.2 Receipt and safe custody of tenders

6.27.1.8.2.1 Formal competitive tender documents will be received electronically via the Trust's electronic tendering portal.

6.27.1.8.2.2 The Chief Executive or their nominated representative will be responsible for ensuring a secure system is in place for the safe custody of tenders. Electronic tenders received will be kept 'locked' in a secure electronic tender box within the electronic portal until the tender deadline for receipt of completed tender responses.

6.27.1.8.2.3 The electronic tenders will remained sealed until the electronic seal is removed by the Chief Executive's designated receiving officer. The date and time of receipt of each tender will be recorded on the electronic tender portal along with any tenders that have been received after the tender deadline, which will include details of the date and time the late tender(s) was/were received.

6.27.1.8.2.4 The Chief Executive shall designate a Releasing Officer, not from the originating Department, to release the electronic tenders which have had the seal removed by the receiving officer. Appropriate records will be provided by the electronic portal, as below.

6.27.1.8.2.5 Tenders will be held by the electronic tender portal under electronic seal until the closing date and time have been reached.

6.27.1.8.3 Opening tenders and Register of tenders

6.27.1.8.3.1 The rules relating to the opening of tenders should be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

6.27.1.8.3.2 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened (i.e. the electronic seal will be removed) at one time in the presence of the Chief Executive or his/her nominated Executive Director together with one other Executive Director who is not from the originating Department (i.e. the department sponsoring or commissioning the tender).

6.27.1.8.3.3 The involvement of Finance Department staff in the preparation of a tender proposal will not preclude the Chief Finance Officer from serving as one of the two Executives to open and release tenders. All Executive Directors are authorised to open and release tenders and for this purpose the Foundation Trust Secretary will count as a Director for the purposes of opening tenders.

6.27.1.8.3.4 Should a tender be procured directly by an Executive Director, that officer should not be present at the opening or releasing of tenders.

6.27.1.8.3.5 The electronic tender portal will provide an extensive audit trail of the time of the tenders being opened and the time they are released to the evaluation team.

6.27.1.8.3.6 No tender shall be amended after it has been received except to correct bona fide errors endorsed as such by the Chief Executive or his nominated Executive Director. Any corrections shall be recorded.

6.27.1.8.3.7 On completion of the opening and releasing arrangements, all accepted tenders will be made available to the issuing department via the electronic tender portal.

6.27.1.8.3.8 Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e. those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (See 6.27.1.8.4.2 below).

6.27.1.8.4 Admissibility

6.27.1.8.4.1 In considering which tender to accept, the designated Officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Executive.

6.27.1.8.4.2 Tenders received after the due time and date may be considered only if the Chief Executive or nominated Executive Director decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Executive or nominated Executive Director shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted, the late arrival of the tender should be reported to the Board of Directors at its next meeting.

6.27.1.8.4.3 Incomplete tenders i.e. those from which information necessary for the adjudication of the tender is missing and amended tenders i.e. those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt should be dealt with in the same way as late tenders under Section 6.26.11.9.4.2 above.

6.27.1.8.4.4 Where examination of tenders reveals errors that would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their offer.

6.27.1.8.4.5 Necessary discussions with a tenderer of the contents of their tender, in order to elucidate technical points etc, before the award of a contract, need not disqualify the tender.

6.27.1.8.4.6 Formal pre-contract discussions must have the written consent of the Chief Executive and at least two Officers must be present and all details must be confirmed in writing.

6.27.1.8.4.7 If for any reason the designated officers are of the opinion that the tender received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

6.27.1.8.4.8 Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

6.27.1.8.4.9 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or if the process of evaluation and adjudication has not started.

6.27.1.8.4.10 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or their nominated officer.

6.27.1.8.5 Acceptance of formal tenders

6.27.1.8.5.1 Where only one tender is sought and/or received, the Chief Executive and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Foundation Trust, obtaining an independent assessment if required.

6.27.1.8.5.2 A tender other than the lowest (if payment is to be made by the Trust), or other than the highest (if payment is to be received by the Trust) shall not be accepted unless there are good reasons to the contrary. Such reasons shall be set out in a permanent record and be reported to the Board.

6.27.1.8.5.3 A financial appraisal should be undertaken by the Chief Finance Officer of successful tenderers who bid for contracts in excess of £50,000 and for all contractors bidding for financial services.

6.27.1.8.5.4 All tender documentation should be treated as confidential and should be retained for inspection / audit.

6.27.1.8.5.5 Note, unsuccessful bidders will be debriefed by the Head of Procurement involved, as required.

6.27.1.8.5.6 A contract cannot be concluded until the expiry of a period of at least 10 calendar days with effect from the day following the date on which the contract award decision is sent to the tenderers concerned if fax or electronic means are used; or, if other means of communication are used, before the expiry of a period of either at least 15 calendar days with effect from the day following the date on which the contract award decision is sent to the tenderers and candidates concerned.

6.27.1.8.5.7 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender (see also 6.27.1.8.4.6 above).

6.27.1.8.5.8 The lowest tender, if payment is to be made by the Foundation Trust, or the highest, if payment is to be received by the Foundation Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

6.27.1.8.5.9 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

6.27.1.8.5.10 The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

6.27.11.9.5.11 All tenders must be treated as confidential and will be retained within the secure electronic tender portal for inspection.

6.27.11.9.6 Tender reports to the Board of Directors

6.27.11.9.6.1 Reports to the Board of Directors will be made for spend above £500,000 to be approved in line with delegated limits.

6.27.11.9.7.1 **Responsibility for maintaining list**

6.27.11.9.7.1.1A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Foundation Trust is satisfied. All suppliers must be made aware of the Foundation Trust's terms and conditions of contract.

6.27.11.9.7.1.2 **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

6.27.11.9.7.1.3 **Financial Standing and Technical Competence of Contractors**

The Chief Finance Officer may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

6.27.11.9.7.1.4 **Exceptions to using approved contractors**

6.27.11.9.7.1.4.1 If in the opinion of the Chief Executive and the Chief Finance Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

6.27.11.9.7.1.4.2 An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

6.27.11.10 **Quotations: Competitive and non-competitive**

6.27.11.10.7 **Quotation Procedures**

6.27.11.10.7.1 Quotations must be obtained in writing as specified in the Delegated Financial Limits Table B Section 6 of this Corporate Governance Manual.

6.27.11.10.7.2 Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Foundation Trust.

6.27.11.10.7.3 Quotations should be in writing unless the Chief Finance Officer or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

6.27.11.10.7.4 Wherever practicable, requests for quotations and quotation responses should be provided via the electronic tendering portal. This electronic tendering portal will allow for all quotations to be received electronically and will record the time and date of receipt.

6.27.11.10.7.5 If quotations are to be received outside of the electronic tendering portal they should be opened by the nominated Receiving Officer.

6.27.11.10.7.6 Where only one quotation is received the Foundation Trust shall, as far as practicable, ensure that the price to be paid is fair and reasonable, obtaining an independent assessment if required.

6.27.11.10.7.7 A quotation other than the lowest (if payment is to be made by the Foundation Trust), or other than the highest (if payment is to be received by the Foundation Trust) shall not be accepted unless there are good reasons to the contrary. Such reasons shall be set out in a permanent record and be reported to the Board.

6.27.11.10.7.8 All quotation documentation should be treated as confidential and should be retained either via the electronic tendering portal of in hard copy format for inspection / audit.

6.27.11.10.8 **Non-Competitive Quotations**

6.27.11.10.8.1 Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.(i) and (ii) of this SFI) apply.

6.27.11.10.8.2 **Quotations to be within Financial Limits**

6.27.11.10.8.

2.1 No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Finance Officer.

6.27.11.10.9 Instances where formal competitive tendering or competitive quotation is not required

6.27.11.10.9.1 Where competitive tendering or a competitive quotation is not required the Foundation Trust should adopt one of the following alternatives:

(a) The Foundation Trust shall use the NHS Supply Chain or nominated procurement partner for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate.

(b) If the Foundation Trust does not use the NHS Supply Chain - where tenders or quotations are not required, because expenditure is below the levels defined in the Scheme of Reservation and Delegation, the Foundation Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.

6.27.11.11 Private Finance for capital procurement

6.27.11.11.1 The Foundation Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the independent regulator, ~~NHS Improvement~~NHS England, for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Foundation Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

6.27.11.12 Compliance requirements for all contracts

6.27.11.12.1 The Board may only enter into contracts on behalf of the Foundation Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Foundation Trust's Standing Orders and Standing Financial Instructions;

(b) Public Contracts Regulations 2015and other statutory provisions;

(c) Any relevant directions including the NHS FREM, Estate code and guidance on the Procurement and Management of Consultants;

(d) Such of the NHS Standard Contract Conditions as are applicable.

(e) Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Foundation Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Foundation Trust.

6.27.11.13 Foundation Trust Contracts / Healthcare Services Agreements

6.27.11.13.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the requirements of the law. A contract with a Foundation Trust, being a Public Benefits Corporation, is a legal document and is enforceable in law.

6.27.11.13.2 The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board of Directors (refer to Scheme of Reservation and Delegation).

6.27.11.14 Disposals (See also Section 6.20 Condemnations and Disposals)

6.27.11.14.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;

(b) Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Foundation Trust;

(c) items to be disposed of with an estimated sale value of less than that defined on the Scheme of Delegation, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

6.27.11.15 In-house Services

6.27.11.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Foundation Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

6.27.11.15.2 In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Finance Officer representative.

6.27.11.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

6.27.11.15.4 The evaluation team shall make recommendations to the Board of Directors.

6.27.11.15.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Foundation Trust.

6.27.11.16 Applicability of SFIs on Tendering and Contracting to funds held in trust

6.27.11.16.1 These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Foundation Trust's trust funds and private resources.

6.27.12 Acceptance of Gifts and Hospitality by Staff

6.27.12.1 The Chief Finance Officer shall ensure that all staff are made aware of the Foundation Trust policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the [8]Department of Health Standards of Business Conduct for NHS Staff.

6.27.13 Retention of documents

6.27.13.1 **Context**

6.27.13.1.1 All NHS records are public records under the terms of the Public Records Act 1958 section 3 (1) – (2). The Secretary of State for Health and all NHS organisations have a duty under this Act to make arrangements for the safe keeping and eventual disposal of all types of records. In addition, the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 must be achieved.

6.27.13.1.2 Accountability

6.27.13.1.2.1 The Chief Executive and senior managers are personally accountable for records management within the organisation. Additionally, the organisation is required to take positive ownership of, and responsibility for, the records legacy of predecessor organisations and /or obsolete services. Under the Public Records Act 1958 all NHS employees are responsibility for any records that they create or use in the course of their duties. Thus any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations.

6.27.13.1.2.2 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in the [9]Department of Health guidance, Records Management: NHS Code of Practice.

6.27.13.1.3 **Types of Record Covered by The Code of Practice**

6.27.13.1.3.2 The guidelines apply to NHS records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the media on which they are held:

- Patient health records (electronic or paper based)
- Records of private patients seen on NHS premises;
- Accident and emergency, birth and all other registers;
- Theatre registers and minor operations (and other related) registers;

[8]Standards of business conduct for NHS staff (HSG(93)5), NHS Management Executive, 1993
[9]Records Management: NHS Code of Practice, Department of Health 2006 & 2009

- Administrative records (including e.g. personnel, estates, financial and accounting records, notes associated with complaint handling);
- X-ray and imaging reports, output and other images;
- Photographs, slides and other images;
- Microform (i.e. fiche / film)
- Audio and video tapes, cassettes, CD-ROM etc.
- Emails;
- Computerised records;
- Scanned records;
- Text messages (both outgoing from the NHS and incoming responses from the patient).

6.27.13.1.3.3 The documents held in archives shall be capable of retrieval by authorised persons.

6.27.13.1.3.4 Documents held in accordance with the Records Management Code of Practice shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

6.27.14 Risk Management

6.27.14.1 The Chief Executive shall ensure that the Foundation Trust has a programme of risk management which must be approved Board of Directors and monitored by the Quality committee.

6.27.14.2 The programme of risk management shall include:

(a) A process for identifying and quantifying risks and potential liabilities;
(b) Engendering among all levels of staff a positive attitude towards the control of risk;
(c) Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
(d) Contingency plans to offset the impact of adverse events;
(e) Audit arrangements, including internal audit, clinical audit, health and safety review;
(f) Decisions on which risks shall be insured;
(g) Arrangements to review the risk management programme.

6.27.14.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of internal control within the Annual Report and Accounts, as required by current guidance.

6.27.15 Insurance arrangements

6.27.15.1 The Board shall decide if the Foundation Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

6.27.15.2 Arrangements to be followed by the Board of Directors in agreeing Insurance cover:

(a) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

(b) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.
(c) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

6.27.15.3 **Standard Areas for Commercial Insurance Cover**

(a) Foundation Trust's may enter commercial arrangements for insuring motor vehicles owned by the Foundation Trust including insuring third party liability arising from their use;
(b) Where the Foundation Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and
(c) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Foundation Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Foundation Trust's powers to enter into commercial insurance arrangements the Finance Director should consult ~~NHS Improvement~~NHS England or the Department of Health as appropriate.

6.27.15.4 Consideration for Other Areas of Insurance Cover

6.27.15.4.1 As a Foundation Trust the Board need to consider the adequacy of insurance cover recognising the Public Benefit Corporation status. Key areas to consider include:

(a) Directors and Officers Liability – Recognising the cover available through the NHSLA, consideration is required to the adequacy of the cover in respect of selling assets, entering into contracts and insolvency indemnity cover
(b) Property Damage – consider the provision for underwriting claims.
(c) Business interruption resulting from property damage-consider the provision to cover for loss of income.

7 Standing Orders for the Board of Directors

These are contained in the Trust Constitution

8. Code of Conduct for the Board of Directors

8.1 Introduction

8.1.1 High standards of corporate and personal conduct are an essential component of public services. As an NHS foundation trust, Liverpool Women's NHS Foundation Trust is required to comply with the principles of best practice applicable to corporate governance in the NHS/health sector and with any relevant code of practice. The purpose of this code is to provide clear guidance on the standards of conduct and behaviour expected of all directors.

8.1.2 This code, with the Trust's Constitution, Corporate Governance Framework and Code of Conduct for Governors forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the foundation trust. The code is intended to operate in conjunction with the principles of the NHS Foundation Trust Code of Governance, the NHS Constitution, requirements set out within the 2006 Health and Social Care Act, and all subsequent amendments, and Regulation 5 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Fit and Proper Persons: Directors. The code applies at all times when directors are carrying out the business of the foundation trust or representing the foundation trust.

8.2 Principles of public life

8.2.1 All directors are expected to abide by the Nolan principles of: selflessness, integrity, objectivity, accountability, honesty, transparency and leadership:

Selflessness
Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

8.3 General principles

8.3.1 Foundation Trust Boards of Directors have a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public. The Board of Directors therefore undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct. The Board of Directors will lead in ensuring that the provisions of the Constitution, the Standing Orders, Standing Financial Instructions and accompanying Scheme of Delegation conform to best practice and serve to enhance standards of conduct. The Board of Directors expects that this Code will inform and govern the decisions and conduct of all directors.

8.4 Confidentiality & access to information

8.4.1 Directors must comply with the Foundation Trust's confidentiality policies and procedures. Directors must not disclose any confidential information, except in specified lawful circumstances.

8.4.2 Information on decisions made by the Board of Directors and information supporting those decisions should be made available in a way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation and directors must not seek to prevent a person from gaining access to information to which they are legally entitled.

8.4.3 The Foundation Trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation which will be followed at all times by directors.

8.5 Register of interests

8.5.1 Directors are required to register all relevant interests on the Board of Directors' Register of Interests in accordance with the provisions of the Trust's Constitution. It is the responsibility of each director to update their register entry if their interests change. The register is held by the Trust Secretary. Directors must send notification of any updates to the Trust Secretary and request confirmation that the register has been updated. Failure to register a relevant interest in a timely manner may constitute a breach of this Code.

8.6 Conflicts of interest

8.6.1 Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Foundation Trust. Directors have a further statutory duty not to accept a benefit from a third party by reason of being a director or for doing (or not doing) anything in that capacity.

8.6.2 If a director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the Chairman or Trust Secretary. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before the Trust enters into the transaction or arrangement.

8.6.3 The Chairman will advise directors in respect of any conflicts of interest that arise during Board of Directors meetings, including whether the interest is such that the director should withdraw from the meeting for the period of the discussion. In the event of disagreement, it is for the Board of Directors to decide whether a director must withdraw from the meeting. The Trust Secretary will provide advice on any conflicts that arise between meetings.

8.7 Bribery

8.7.1 The Bribery Act 2010 introduces a new, clearer regime for tackling bribery that applies to all businesses (including NHS organisations) based or operating in the UK. It covers all sorts of bribery, the offering and receiving of a bribe, directly or indirectly, whether or not it involves a public official, in the UK or abroad.

8.7.2 The Board of Directors has a responsibility to protect both the Trust and the wider NHS from bribery or corruption. Directors shall at all times comply with the Bribery Act 2010 and with the Trust's policy. Directors will not request or receive a bribe from anybody, nor imply that such an act might be considered. This means not agreeing to receive or accept a financial or other advantage from any source as an incentive or reward to perform improperly the function or activities of the Liverpool Women's NHS Foundation Trust.

8.8 Gifts & hospitality

8.8.1 The Board of Directors will set an example in the use of public funds and the need for good value in incurring public expenditure. The use of the Foundation Trust for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Board of Directors is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Foundation Trust in the eyes of the community.

8.8.2 The Board of Directors has adopted a policy on gifts and hospitality, within its Standards of Business Conduct, which will be followed at all times by directors. Directors must not accept gifts or hospitality other than in compliance with this policy.

8.9 Whistle-blowing

8.9.1 The Board of Directors acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this Code and other concerns of an ethical nature. The Trust has adopted a whistle-blowing policy (concerns reporting procedure) that is available for staff.

8.9.2 This policy reflects the provisions of the Public Interest Disclosure Act 1998, which gives protection from dismissal, harassment, fear of reprisal or other detrimental treatment to "workers" (this term means Trust employees, agency or bank staff, the staff of one of our contractors, or volunteers) who wish to report information, which they reasonably believe, is in the patient or public interest. This enables staff to express concerns safely, so that issues are raised at an early stage and in the right way. Directors will understand and fulfil their responsibilities in respect of the Trust's Whistleblowing Policy and the Public Interest Disclosure Act 1998.

8.10 Personal conduct

8.10.1 Directors are expected to conduct themselves in a manner that reflects positively on the Foundation Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Foundation Trust into disrepute.

8.10.2 Specifically directors must:

- Act in the best interests of the Foundation Trust and adhere to its Values, expected Behaviours and this Code of Conduct.
- Respect others and treat them with dignity and fairness.
- Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion.
- Be honest and act with integrity and probity.
- Contribute to the workings of the Board of Directors as a Board of Directors member in order for it to fulfil its role and functions.
- Recognise that the Board of Directors is collectively responsible for the exercise of its powers and the performance of the foundation trust
- Raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate.
- Recognise the differing roles of the Chairman, Vice-Chairman, Senior Independent Director, Chief Executive, Executive Directors and Non-Executive Directors.
- Make every effort to attend statutory meetings.
- Adhere to good practice in respect of the conduct of meetings and respect the views of others.
- Take and consider advice on issues where appropriate.
- Acknowledge the responsibility of the Council of Governors to represent the interests of the Foundation Trust's members and partner organisations in the governance and performance of the Foundation Trust and to hold Non-Executive Directors to account for the performance of the Board of Directors, and to have regard to the views of the Council of Governors.
- Not use their position for personal advantage or seek to gain preferential treatment; nor seek improperly to confer an advantage or disadvantage on any other person.
- Accept responsibility for their performance, learning and development.

8.11 Eligibility Criteria

8.11.1 The Trust's Provider Licence requires that the Trust will not appoint as a director any person who is an unfit person, and shall ensure termination is enforced promptly on discovering any director to be an unfit person, except with the approval in writing of Monitor.

8.11.2 The Trust's Constitution also sets the approved criteria, which deem a person to be an unfit person to become or continue as a Director of the Foundation Trust, as follows:

- s/he is a member of the Council of Governors, or a Governor of an NHS body or another NHS Foundation Trust;
- s/he is a member of a Local Involvement Network, its successor organisation, Local Healthwatch, or any of its successor organisations;
- s/he is the spouse, partner, parent or child of a member of the Board of Directors of the Trust;
- s/he is a member of a Local Authority's committee which scrutinises health matters.;
- s/he is a Director or member of a Clinical Commissioning Group with whom the Trust contracts;
- s/he been adjudged bankrupt or her estate has been sequestrated and in either case s/he has not been discharged;

- s/he has made a composition or arrangement with, or granted a Trust deed for, her creditors and has not been discharged in respect of it;
- s/he is the subject to a sex offender order;
- s/he has within the preceding five years been convicted in the British Islands of any offence:
- against a woman or child; or
- any other offence for which a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed
- s/he is the subject of a disqualification order made under the Company Directors Disqualification Act 1986;
- in the case of a non-executive Director, s/he is no longer a member of one of the public constituencies or an individual exercising functions for a University providing a medical or dental school to a hospital of the Trust;
- s/he is a person whose tenure of office as a Chair or as a member or Director of a health service body has been terminated on the grounds that her appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
- s/he has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;
- in the case of a non-executive Director s/he has refused without reasonable cause to fulfil any training requirement established by the Board of Directors; or
- s/he has refused to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors.

8.11.3 In addition, Regulation 5 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Fit and Proper Persons Directors states that Directors should be of good character, have the required skills, experience and knowledge and as such that their health enables them to fulfil the management function.

8.11.4Furthermore, Directors would be excluded from office if they have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying out a regulated activity, or discharging any functions relation to any office or employment with a service provider.

8.11.4 Directors will notify the Trust Secretary immediately if any of the above criteria apply to their personal or professional circumstances.

8.12 Removal of a Director under the Fit and Proper Person Test

8.12.1 In addition to the Trust Disciplinary Rules which apply to all staff there is a requirement for Directors to be Fit and Proper Persons and to meet the Care Quality Commission Fit and Proper Person Test (FPPT) on an ongoing basis under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

8.12.2 Where a Director fails to meet the FPPT then consideration will be given to removing that person from their role of Director.

8.12.3 Directors should be of good character, have the required skills, experience and knowledge and as such that their health enables them to fulfil the management function. To pass the FPPT none of the criteria of unfitness should apply, which include bankruptcy, sequestration and insolvency, appearing on a barred list and being prohibited from holding Directorships under other laws. Directors should not have been involved or complicit in any serious misconduct, mismanagement of failure of care in carrying on a regulated activity.

8.12.4 An individual can be appointed as a Director with the expectation that they develop specific competence to undertake the role within specified timescales. Failure to do so may result in the FFPT not being met.

8.12.5 Where information is discovered that suggests an individual is not of good character after appointment to a role (e.g. through annual checks or through information provided to, or discovered by, the Trust) then appropriate and timely action will be taken to investigate and rectify the matter. Immediate action will be taken to protect people receiving services from risk or potential risk.

8.12.6 In such cases the Chair or Deputy Chairman may suspend a Non-Executive Director or the Chief Executive where this is deemed appropriate. The Chief Executive may suspend an Executive Director and he/she, will notify the Chair of the reasons for this decision and the Chair shall forthwith call a meeting of the Board Nominations and Remuneration Committee to consider what actions should be taken. All concerns will be investigated quickly and due diligence in all such investigations demonstrated.

8.12.7 For concerns regarding a Non-Executive Director the Council of Governors Nominations and Remuneration Committee, supported by the Chief People Officer or other nominated person, will investigate the concerns and make a recommendation to the Chair and to the Council of Governors on the continued fitness of the Director where concerns are substantiated. Where the Director is deemed not to be a fit and proper person then action, as is proportionate, up to and including the termination of their engagement with immediate effect will be considered.

8.12.8 For concerns regarding an Executive Director or other Director level appointment, then an investigating officer will be appointed by the Chief Executive or Chief People Officer. The Investigating Officer may be an employee or Director of the Trust or may be a person or organisation engaged to undertake this role. They will investigate and present a case to a Director or Chief Executive of the Trust who will determine an outcome to be recommended in the first instance to the Board Nominations and Remuneration Committee and thereafter to the Board of Directors. Proportionate action up to summary dismissal will be taken as appropriate.

8.12.9 Where concerns are substantiated but an individual is retained as a Director, the rationale for this will be recorded and made available to those that need to be aware of this.

8.12.10 Where an individual appointment is terminated because they no longer meet the FPPT then this will be reported to the Regulator and to any appropriate professional body.

8.13 Compliance

8.13.1 All Directors will be required to:

- prior to appointment, and annually thereafter, give an undertaking to abide by the provisions of this Code of Conduct by signing the declaration below.

9. Code of Conduct for the Council of Governors

This Code seeks to outline appropriate conduct for the Council of Governors and addresses both the requirements of office and the personal behaviour of individual Governors. Ideally any sanctions for non-compliance would never need to be applied, however a Code is considered an essential guide for Foundation Trust (FT) Governors. The Code is intended to operate in conjunction with the Code of Governance, the constitution, with standing orders and 'Your Statutory Duties, A reference guide for Foundation Trust Governors', Monitor August 2013.

As a member of the Council of Governors sometimes dealing with difficult and confidential issues, Governors are required to act with discretion and care in the performance of their role. They will be required to maintain confidentiality with regard to information gained via their involvement with the Trust.

1. Qualifications for Office

Governors must continue to comply with the qualifications required to hold office throughout their period of tenure. The Trust Secretary should be advised of any changes in circumstances which disqualify the Governor from continuing in office. An example of this would be if a public Governor joined the Trust as an employee, at which point they would no longer be able to hold office as a public Governor.

All Governors will be expected to understand, agree and promote the Trust's Equal Opportunities policy in every area of their work.

One of the key objectives of the governing body is to promote social inclusion through its activities and as such the development and delivery of initiatives should not prejudice any part of the community on the grounds of age, race, disability, marital status, sexual orientation or religious belief.

2. Role of Governors and the Council of Governors

- To hold the Non-Executive Directors (NEDs) individually and collectively to account for the performance of the Board of Directors
- To represent the interests of the members of the Foundation Trust as a whole and the interests of the public, bringing a fair and open-minded view on all issues
- To appoint and, if appropriate, remove the Chair
- To appoint and, if appropriate, remove the other Non-Executive Directors
- To decide the remuneration and allowances and other terms and conditions of office of the Chair and the other Non-Executive Directors
- To approve the appointment of the Chief Executive
- To appoint and, if appropriate, remove the NHS Foundation Trust's auditor
- To receive the NHS Foundation Trust's annual accounts, any report of the auditor on them, and the annual report.
- Put forward views on the Foundation Trust's forward plan and communicate the Trust's plans to members
- To adhere to the seven principles of public life, as defined by the Nolan Committee (further information at www.public-standards.org.uk). The seven principles are:
    - Selflessness
    - Integrity
    - Objectivity
    - Accountability
    - Openness
    - Honesty
    - Leadership
- To actively support and promote the principles of the Foundation Trust and contribute to its success

- To adhere to the Trust's policies and procedures and support its objectives
- To lead the Trust's membership strategy, including membership recruitment
- To engage and consult with the membership of the Trust
- To encourage members to become future Governors
- To recognise that their role is a collective one whereby Governors exercise collective decision making in the meeting room which is recorded in the minutes. Outside the meeting room a Governor has no more rights and privileges than any other member.
- To undertake an advisory role to the Board of Directors.

In addition, individual Governors are required:
- To attend Council of Governor meetings
- To contribute to the workings of the Council, ensuring that it fulfils its role and functions.

It should be noted that the functions allotted to the Council of Governors are not of a managerial nature.

3. Confidentiality

In the course of their duties Governors may receive information which is confidential. All Governors are required to respect the sensitivity of the information they are made privy to as a result of their position and to adhere to the Trust's policy in this regard. Information made available to Governors in confidence must remain confidential. Failure to maintain confidentiality may result in removal from the Council of Governors.

4. Conflicts of Interest

Governors should act with the utmost integrity and objectivity and in the best interests of the Trust in performing their duties. They should not use their position for personal advantage or seek to gain preferential treatment. They should declare any conflicts of interest which may arise at the earliest opportunity. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. It is then for the Chair to advise whether it is necessary for the governor to refrain from participating in discussion of the item or withdraw from the meeting. If in any doubt they should seek advice from the Trust Secretary. It is important that conflicts of interest are addressed and are seen to be actioned in the interests of the Trust and all individuals concerned.

5. Register of Interests

There is a Register of Interests which records any pecuniary and non-pecuniary interests declared by Governors that might create a conflict of interest. It also records 'nil' returns. It is the responsibility of each governor to update their register entry if their interests change following initial completion at induction and on an annual basis. A pro forma is available from the Trust Secretary. Failure to declare interests may result in removal from the Council of Governors.

6. Council of Governor meetings

Governors have a responsibility to attend meetings of the Council of Governors. When this is not possible they should submit an apology to the Trust Secretary in advance of the meeting.

Absence from the Council of Governor meetings without good reason established to the satisfaction of the Council of Governors is grounds for disqualification. Absence from three consecutive meetings will result in the member being deemed to have resigned their position unless the grounds for absence are deemed to be satisfactory by the Council of Governors.

Governors are expected to attend for the duration of each meeting.

7. Personal Conduct

Governors are required to adhere to the highest standards of conduct in the performance of their duties. In respect of their interaction with others they are required to:

- Adhere to good practice in respect of the conduct of the meetings and respect the views of their fellow members, both elected and appointed
- Be mindful of conduct which could be deemed to be unfair or discriminatory
- Treat the Trust's employees and fellow members with respect and in accordance with the Trust's policies
- Recognise that the Council of Governors and the Board of Directors and its management team have a common purpose, i.e. the success of the Trust, and to work together as a team to this end
- Governors should conduct themselves in such a manner as to reflect positively on the Trust and in accordance with the seven principles of public life (see above). When attending external meetings or any other events at which they are present, it is important for Governors to be ambassadors for the Trust.

8. Fit and Proper Person

In order to comply with the Trust's Provider Licence, Governors are asked to confirm the following:

☐ I have not been adjudged bankrupt or my estate has not been sequestrated and (in either case) has not been discharged

☐ I have not made a composition or arrangement with, or granted a trust deed for, my creditors and have not been discharged in respect of it

☐ I have not within the preceding five years been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on me

☐ I am not subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986

9. Accountability

Governors are accountable to the membership and should demonstrate this by attending members' meetings and other key events which provide opportunities to interface with their electorate in order to best understand their views.

10. Training and Development

Training and development are essential for the Council of Governors in respect of the effective performance of their role and Governors will be expected to both contribute to the formulation of a training programme for the Council and to actively participate in training events which are arranged for them. Governors may be removed from the Council of Governors if they have refused without reasonable cause to undertake any training which the Council of Governors requires all Governors to undertake.

11. Visits to Trust premises

Where the Governors wish to visit the premises of the Trust in a formal capacity as opposed to individuals in a personal capacity, the Council of Governors should liaise with the Trust Secretary to make the necessary arrangements. When attending Trust premises in the formal capacity of Governor, Governors must wear their identity badge which clearly indicates that they are a Governor of Liverpool Women's NHS Foundation Trust.

12. Non-compliance with the Code of Conduct

Non-compliance with this Code may result in action being taken as follows:

- Where misconduct takes place, the Chair shall be authorised to take such action as may be immediately required, including the exclusion of the person concerned from a meeting
- Where such misconduct is alleged, it shall be open to the Council of Governors to decide by simple majority of those in attendance, to lay a formal charge of misconduct
- The individual will be notified in writing of the charge/s, detailing the specific behaviour which is considered to be detrimental to the Trust and inviting their response for consideration by the Council of Governors within a defined timescale
- The Governor will be invited to address the Council in person if the matter cannot be resolved satisfactorily through correspondence
- The Council of Governors will decide by simple majority of those present and voting whether to uphold the charge of conduct detrimental to the Trust
- The Council of Governors may impose such sanctions as shall be deemed appropriate, ranging from the issuing of a written warning as to the member's future conduct, to the removal of the individual from office
- In order to aid participation by all parties it is imperative that all Governors observe the points of view of others and conduct likely to give offence will not be permitted. The Chair will reserve the right to ask any member of the Council who, in his or her opinion, fails to observe the Code to leave the meeting.

This Code of Conduct does not limit or invalidate the right of the Council of Governors or the Trust to act under the Constitution.

All Governors will be required to prior to appointment, and upon reappointment, give an undertaking to abide by the provisions of this Code of Conduct by signing the declaration below.

13. Acceptance and Declaration

I, _____ (print name) confirm that I have received, read and understood the Code of Conduct of Liverpool Women's NHS Foundation Trust.

I confirm that I agree to abide by the Code of Conduct of Liverpool Women's NHS Foundation Trust and understand that failure to do so may result in removal from the Council of Governors.

Position: _____

Signature: _____

Date: _____

10. Code of Conduct for NHS Managers[10]

10.1 Introduction

The Code of Conduct for NHS Managers sets out the standards of conduct expected of NHS Managers. It serves two purposes:

- to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make
- to reassure the public that these important decisions are being made against a background of professional standards and accountability.

10.2 The Code

10.2.1 As an NHS manager, I will observe the following principles:

- make the care and safety of patients my first concern and act to protect them from risk;
- respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- be honest and act with integrity;
- accept responsibility for my own work and the proper performance of the people I manage;
- show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community;
- take responsibility for my own learning and development.

10.2.2 This means in particular that I will:

- respect patient confidentiality;
- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of the public and patients;
- be guided by the interests of the patients while ensuring a safe working environment;
- act to protect patients from risk by putting into practice appropriate support and disciplinary procedures for staff; and
- seek to ensure that anyone with a genuine concern is treated reasonably and fairly.

10.2.3 I will respect and treat with dignity and fairness, the public, patients, relatives, carers, NHS staff and partners in other agencies. In my capacity as a senior manager within the NHS I will seek to ensure that no one is unlawfully discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin. I will also seek to ensure that:

- the public are properly informed and are able to influence services;
- patients are involved in and informed about their own care, their experience is valued, and they are involved in decisions;
- relatives and carers are, with the informed consent of patients, involved in the care of patients;
- partners in other agencies are invited to make their contribution to improving health and health services; and
- NHS staff are:
  - valued as colleagues;
  - properly informed about the management of the NHS;
  - given appropriate opportunities to take part in decision making.

[10] Based on Code of Conduct for NHS Managers published by the Department of Health, 2002 time to time amended.

- given all reasonable protection from harassment and bullying;
- provided with a safe working environment;
- helped to maintain and improve their knowledge and skills and achieve their potential; and
- helped to achieve a reasonable balance between their working and personal lives.

10.2.4 I will be honest and will act with integrity and probity at all times. I will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to my own duties or the functions of my employer.

10.2.5 I will seek to ensure that:

- the best interests of the public and patients/clients are upheld in decision-making and that decisions are not improperly influenced by gifts or inducements;
- NHS resources are protected from fraud, bribery and corruption and that any incident of this kind is reported to the NHS Protect;
- judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and are properly founded; and
- open and learning organisations are created in which concerns about people breaking the Code can be raised without fear.

10.2.6 I will accept responsibility for my own work and the proper performance of the people I manage. I will seek to ensure that those I manage accept that they are responsible for their actions to:

- the public and their representatives by providing a reasonable and reasoned explanation of the use of resources and performance;
- patients, relatives and carers by answering questions and complaints in an open, honest and well researched way and in a manner which provides a full explanation of what has happened, and of what will be done to deal with any poor performance and, where appropriate giving an apology; and
- NHS staff and partners in other agencies by explaining and justifying decisions on the use of resources and give due and proper consideration to suggestions for improving performance, the use of resources and service delivery.

10.2.7 I will support and assist the Accountable Officer of my organisation in his or her responsibility to answer to Parliament, Ministers, the Department of Health and the Independent Regulator of Foundation Trusts in terms of fully and faithfully declaring and explaining the use of resources and the performance of the local NHS in putting national policy into practice and delivering targets.

10.2.8 For the avoidance of doubt, nothing in paragraphs 10.2.3 to 10.2.7 of this Code requires or authorises an NHS manager to whom this Code applies to:

- make, commit or knowingly allow to be made any unlawful disclosure;
- make, permit or knowingly allow to be made any disclosure in breach of his or her duties and obligations to his or her employer, save as permitted by law.

10.2.9 If there is any conflict between the above duties and obligations and this Code, the former shall prevail.

10.2.10 I will show my commitment to working as a team by working to create an environment in which:

- teams of frontline staff are able to work together in the best interests of patients;
- leadership is encouraged and developed at all levels and in all staff groups; and
- the NHS plays its full part in community development.

10.2.11 I will take responsibility for my own learning and development. I will seek to:

- take full advantage of the opportunities provided;
- keep up to date with best practice; and
- share my learning and development with others.

10.2.12 I will also uphold the seven principles of public life as outlined by the Nolan Committee:

- Selflessness – holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family or their friends
- Integrity – holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties
- Objectivity – in carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit
- Accountability – holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office
- Openness – holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands
- Honesty – holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest
- Leadership – holders of public office should promote and support these principles by leadership and example

10.3 Implementing the Code

10.3.1 The Code should be seen in a wider context that NHS managers must follow the 'Nolan Principles on Conduct in Public Life' (see paragraph 8.2.11 above), the 'Corporate Governance Codes of Conduct and Accountability', the 'Standards of Business Conduct', the 'Code of Practice on Openness in the NHS' and standards of good employment practice.

10.3.2 In addition many NHS managers come from professional backgrounds and must follow the code of conduct of their own professions as well as this Code.

10.3.3 In order to maintain consistent standards, the Trust will consider suitable measures to ensure that managers who are not their employees but who:

- manage their staff or services; or
- manage units which are primarily providing services to their patients also observe the Code.

10.3.4 It is important to respect both the rights and responsibilities of managers. To help managers to carry out the requirements of the Code, the Trust will provide reasonable learning and development opportunities and seek to establish and maintain an organisational culture that values the role of managers. NHS managers have the right to be:

- treated with respect and not be unlawfully discriminated against for any reason;
- given clear, achievable targets;
- judged consistently and fairly through appraisal;

- given reasonable assistance to maintain and improve their knowledge and skills and achieve their potential through learning and development; and
- reasonably protected from harassment and bullying and helped to achieve a reasonable balance between their working and personal lives.

10.4 Breaching the Code

10.4.1 Alleged breaches of the Code of Conduct will be promptly considered and fairly and reasonably investigated. Individuals must be held to account for their own performance, responsibilities and conduct where employers form a reasonable and genuinely held judgement that the allegations have foundation. Investigators should consider whether there are wider system failures and organisational issues that have contributed to the problems. In order to learn from and prevent future breaches of the Code, it is necessary to look at the wider causes of alleged breaches.

10.4.2 Local employers should decide whether to investigate alleged breaches informally or under the terms of local disciplinary procedures. It is essential however that both forms of investigation should be, and be seen to be, reasonable, fair and impartial. If Chief Executives or Directors are to be investigated, the employing authority should use individuals who are employed elsewhere to conduct the investigation. The NHS Confederation, the Institute of Healthcare Management and the Healthcare Financial Management Association are among the organisations who maintain lists of people who are willing to undertake such a role.

10.5 Application of the Code

10.5.1 The Code codifies and articulates certain important contractual obligations that apply to everyone holding management positions. These include Chief Executives and Directors who as part of their duties are personally accountable for achieving high quality patient care.

10.5.2 The Trust will:

- incorporate the Code into the employment contracts of Chief Executives and Directors and include the Code in the employment contracts of new appointments to that group
- identify any other senior managerial posts, i.e. with levels of responsibility and accountability similar to those of Director-level posts, to which they consider the Code should apply
- include the Code in new employment contracts as appropriate
- incorporate the Code into the employment contracts of existing postholders as appropriate.
- investigate alleged breaches of the Code by those to whom the Code applies promptly and reasonably as at paragraphs four to five
- provide a supportive environment to managers (see paragraph 10.2.5 above).

See also Standards of Business Conduct for NHS Staff, included in this manual

11. Standards of Business Conduct for NHS Staff

11.1 Introduction

11.1.1 These guidelines are based on recommendations by the NHS Management Executive to assist NHS employers and staff in maintaining strict ethical standards in the conduct of NHS business. They cover:

- the standards of conduct expected of all NHS staff where their private interests may conflict with their public duties; and
- the steps which NHS employers should take to safeguard themselves and the NHS against conflict of interest
- Action checklist for NHS Managers -*Part C* (omitted from this extract)
- Short guide for staff - *Part D*
- Ethical Code of the Chartered Institute of Purchasing and Supply (CIPS) (reproduced courtesy of IPS) - *Part E.*

11.1.2 The guidance is in four parts:

- Part A - brief summary of the main provisions of the Bribery Act 2010
- Part B - general policy guidelines
- Part C – Short guide for staff
- Part D - Ethical Code of the Chartered Institute of Purchasing and Supply (CIPS).

Part A

Bribery Act 2010

Bribery is generally defined as an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage, on behalf of oneself or another.

The Act repeals the UK's existing anti-corruption legislation – the Public Bodies Corrupt Practices Act 1889, the Prevention of Corruption Acts of 1906 and 1916 and the common law offence of bribery – and provides an updated and extended framework of offences to cover bribery both in the UK and abroad.

Zero Tolerance

Bribery is a criminal offence. Liverpool Women's NHS Foundation Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor do we or will we, accept bribes or improper inducements. This approach applies to everyone who works for us, or with us. To use a third party as a conduit to channel bribes to others is a criminal offence. We do not, and will not, engage indirectly in, or otherwise encourage, bribery.

Proactively combatting bribery has clear benefits for this Trust and the wider NHS. It helps prevent:

- adverse damage to or criticism of the organisation's reputation and funding;
- the potential diversion and/or loss of resources from NHS care;
- unforeseen and unbudgeted costs of investigations and/or defence of any legal action; and,
- a negative impact on patient/stakeholder perceptions.

Part B

General policy guidelines

Responsibility of the Trust
The Trust is responsible for ensuring that these guidelines are brought to the attention of all employees; also that machinery is put in place for ensuring that they are effectively implemented.

Responsibility of NHS staff
It is the responsibility of staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. This primary responsibility applies to all NHS staff, i.e. those who commit NHS resources directly (e.g. by the ordering of goods) or those who do so indirectly (e.g. by the prescribing of medicines). A further example would be staff who may have an interest in a private nursing home and who are involved with the discharge of patients to residential facilities.

Guiding principle in conduct of public business
It is a long established principle that public sector bodies, which include the NHS, must be impartial and honest in the conduct of their business, and that their employees should remain beyond suspicion. It is also an offence under the Bribery Act 2010 for an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage, on behalf of oneself or another (see Part A).

A breach of the provisions of the Act renders employees liable to prosecution and may also lead to loss of their employment and superannuation rights in the NHS.

NHS staff are expected to:
- ensure that the interest of patients remains paramount at all times;
- be impartial and honest in the conduct of their official business;
- use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.

It is also the responsibility of staff to ensure that they do not:
- abuse their official position for personal gain or to benefit their family or friends;
- seek to advantage or further private business or other interests, in the course of their official duties.

Implementing the guiding principles
Casual gifts
Casual gifts offered by contractors or others, e.g. at Christmas time should be politely but firmly declined.

Any gifts received from or offer of gifts by a contractor or potential contractor must be reported immediately to the Chief Executive. In the context of these instructions contractor means any supplier of goods and/or services to the Trust. Exception may be made only for items of a trivial nature, otherwise staff should decline all offers of gifts.

Articles of low intrinsic value such as diaries or calendars, or small tokens of gratitude from patients or their relatives, need not necessarily be refused. In cases of doubt staff should either consult their line manager or politely decline acceptance.

Hospitality
Modest hospitality provided it is normal and reasonable in the circumstances, e.g. lunches in the course of working visits, may be acceptable, though it should be similar to the scale of hospitality which the NHS as an employer would be likely to offer.

Visits to contractors or potential contractors or to another site to inspect their installations must be made at the Trust's expense and not the contractor's. Exception to this rule may be granted by the Chief Executive where reasonable. Otherwise only minimal hospitality should be accepted from a contractor or potential contractor and an immediate explanation must be given to the Chief Executive if a breach of the rules occurs. As with gifts, unless of a minor nature hospitality and entertainment should be declined.

Staff should decline all other offers of gifts, hospitality or entertainment. If in doubt they should seek advice from their line manager.

Any item/s of gifts and hospitality accepted, which are over the value of £25.00, should be entered into the gifts and hospitality register held in the Chief Executive's office.

Declaration of interests
For conflict of interests please refer to the Trust policy 'Managing Conflicts of interest' which sets out the requirement for staff to disclose any conflict or perceived conflict with the Trust's activities.

All NHS staff should therefore declare such interests to their employer, either on starting employment or on acquisition of the interest, in order that it may be known to and in no way promoted to the detriment of either the employing authority or the patients whom it serves.
One particular area of potential conflict of interest, which may directly affect patients, is when NHS staff hold a self-beneficial interest in private care homes or hostels. While it is for staff to declare such interests to their employing authority, the employing authority has a responsibility to introduce whatever measures it considers necessary to ensure that its interests and those of patients are adequately safeguarded. This may for example take the form of a contractual obligation on staff to declare any such interests. Advice on professional conduct issued by the General Medical Council recommends that when a doctor refers a patient to a private care home or hostel in which he or she has an interest, the patient must be informed of that interest before referral is made.
In determining what needs to be declared, employers and employees will wish to be guided by the policy referred to above and to the following documents that can be found on NHS England's website at https://www.england.nhs.uk/ourwork/coi/.
The Trust will:

- ensure that staff are aware of their responsibility to declare relevant interests
- keep a register of all such interests and make them available for inspection by the public
- develop a local policy, in consultation with staff and local staff interests, for implementing this guidance. This may include the disciplinary action to be taken if an employee fails to declare a relevant interest or is found to have abused his or her official position, or knowledge, for the purpose of self-benefit, or that of family or friends.

Preferential treatment in private transactions
Individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of their NHS employer. (This does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interest, on behalf of all staff - for example, NHS staff benefits schemes.)

Contracts
All staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign purchase orders, or place contracts for goods, materials or services, are expected to adhere to professional standards of the kind set out in the Ethical Code of the CIPS, reproduced at Part D.

Favouritism in awarding contracts

Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of NHS Standing Orders and of EC Directives on Public Purchasing for Works and Supplies. This means that:

- no private, public or voluntary organisation or company which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the NHS employer, such as a long-running series of previous contracts
- each new contract should be awarded solely on merit, taking into account the requirements of the NHS and the ability of the contractors to fulfil them.

The Trust will ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

Warnings to potential contractors- Trust bribery statement
NHS employers will wish to ensure that all invitations to potential contractors to tender for NHS business include a notice warning tenderers of the consequences of engaging in any corrupt practices involving employees of public bodies.

Liverpool Women's NHS Foundation Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor do we or will we, accept bribes or improper inducements. This approach applies to <u>everyone</u> who works for us, or with us. To use a third party as a conduit to channel bribes to others is a criminal offence. We do not, and will not, engage indirectly in, or otherwise encourage, bribery.

Outside employment
NHS employees are advised not to engage in outside employment which may conflict with their NHS work, or be detrimental to it. They are advised to tell the Trust if they think they may be risking a conflict of interest in this area: the Trust will be responsible for judging whether the interests of patients could be harmed, in line with the principles in 'Implementing the guiding principles' above.

Second employments must also be considered carefully. These activities should neither take precedence over an officer's main employment with the Trust nor should engagement in these activities in any way affect an officer's efficient discharge of duties under his or her main employment. Where an officer has reason to believe that this or her second employer has any business dealings whatsoever with the Trust the fact must be reported to the Chief Executive.

For full time staff, the main employment of officers necessarily takes precedence over any other paid or voluntary activities undertaken. Employees should not engage in any second or spare time job which affects in any way their performance or discharge of their duties with this Trust.

Second or spare time jobs are permissible without the need for registration or authorisation where the activity is not with a supplier or contractor to the Trust or not with any other NHS organisation.

Extra jobs, whether regular or occasional, should not be with a supplier to the Trust unless specifically approved by the Chief Executive who will keep a register detailing the personnel, the activity, the employer, and any other such details as deemed desirable.

Details of such situations must be submitted as and when these arise and confirmed on an annual basis.

Particular care must be taken to disclose any employment, even if only on a temporary or supply basis, with another NHS or private health care body.

Private practice
Consultants (and associate specialists) employed under the Consultant Contract are permitted to carry out private practice in NHS hospitals subject to the conditions outlined in the handbook and in accordance with the Code of Conduct for Private Practice

Other grades may undertake private practice or work for outside agencies, providing they do not do so within the time they are contracted to the NHS, and they observe the conditions in the paragraph above. All hospital doctors are entitled to fees for other work outside their NHS contractual duties (paragraph 41 of the TCS of Hospital Medical and Dental staff) e.g. examinations and reports for life insurance purposes. Hospital doctors and dentists in training should not undertake locum work outside their contracts where such work would be in breach of their contracted hours. Career grade medical and dental staff employed by NHS Trusts may agree terms and conditions different from the National Terms and Conditions of Service.

Rewards for Initiative
The Trust will identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that it receives any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by their employees in the course of their NHS duties. Most IPR are protected by statute e.g. patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. To achieve this, the Trust will build appropriate specifications and provisions into the contractual arrangements which they enter into *before* the work is commissioned, or begins. They should always seek legal advice if in any doubt in specific cases.

With regard to patents and inventions, in certain defined circumstances the Patents Act gives *employees a right* to obtain some reward for their efforts, and employers should see that this is effected. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

In the case of collaborative research and evaluative exercises with manufacturers, NHS employers should see that they obtain a fair reward for the input they provide. If such an exercise involves additional work for an NHS employee outside that paid for by the NHS employer under his or her contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should however be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

Commercial sponsorship for attendance at courses and conferences
Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where the employee seeks permission in advance and the employer is satisfied that acceptance will not compromise purchasing decisions in any way.
On occasions when NHS employers consider it necessary for staff advising on the purchase of equipment to inspect such equipment in operation in other parts of the country (or exceptionally, overseas), employing authorities will themselves want to consider meeting the cost, so as to avoid putting in jeopardy the integrity of subsequent purchasing decisions.

Commercial sponsorship of posts - “linked deals”
Pharmaceutical companies, for example, may offer to sponsor, wholly or partially, a post for the Trust. The Trust will not enter into such arrangements, unless it has been made abundantly clear to the company concerned that the sponsorship will have no effect on purchasing decisions by the Trust.

Where such sponsorship is accepted, monitoring arrangements will be established to ensure that purchasing decisions are not, in fact, being influenced by the sponsorship agreement.

Under no circumstances should employers agree to "linked deals" whereby sponsorship is linked to the purchase of particular products, or to supply from particular sources.

"Commercial in-confidence"
Staff should be particularly careful of using, or making public, internal information of a "commercial in-confidence" nature, *particularly if its disclosure would prejudice the principle of a purchasing system based on fair competition. This principle applies whether private competitors or other NHS providers are concerned,* and whether or not disclosure is prompted by the expectation of personal gain (see the paragraphs above and Part D).

However, NHS employers should be careful about adopting a too restrictive view on this matter. It should certainly not be a cause of excessive secrecy on matters which are not strictly commercial per se. For example, the term "commercial in confidence" should not be taken to include information about service delivery and activity levels, which should be publicly available. Nor should it inhibit the free exchange of data for medical audit purposes, for example, subject to the normal rules governing patient confidentiality and data protection. In all circumstances the overriding consideration must be the best interests of patients.

Disciplinary action
Failure to follow the principles and the guidance in this Code may result in disciplinary action and possibly prosecution under the Bribery Act 2010.

Officers should take action to report as soon as possible any instance where they feel the guidelines have been broken, accidentally or otherwise, by themselves or others. It should be emphasised that the crime occurs when any money, gift or consideration has been offered, requested or received and the recipient then shows favour or partiality to the donor. The recipient should be prepared to, and be able to demonstrate that any gift or hospitality was not received corruptly. Money should never be accepted. Prompt disclosure and registration are important acts to refute the charge of corruption.

Part C

Short guide for staff
Do:
- make sure you understand the guidelines on standards of business conduct, and consult your line managers if you are not sure
- make sure you are not in a position where your private interests and NHS duties may conflict (3)
- declare to your employer any relevant interests. If in doubt, ask yourself:
  - am I, or might I be, in a position where I (or my family/friends) could gain from the connection between my private interests and my employment?
  - do I have access to information which could influence purchasing decisions?
  - could my outside interest be in any way detrimental to the NHS or to patients' interests?
  - do I have any other reasons to think I may be risking a conflict of interest?
  - if still unsure - declare it!
- adhere to the ethical code of the Chartered Institute of Purchasing and Supply if you are involved in any way with the acquisition of goods and services
- seek your employer's permission before taking on outside work, if there is any question of it adversely affecting your NHS duties (special guidance applies to doctors)
- obtain your employer's permission before accepting any commercial sponsorship.

Do not:

- accept any gifts, inducements or inappropriate hospitality
- abuse your past or present official position to obtain preferential rates for private deals
- unfairly advantage one competitor over another or show favouritism in awarding contracts
- misuse or make available official “commercial in confidence” information.

If in doubt seek advice from the Trust Secretary on 0151 702 4033 or if you wish to report any concerns in relation to fraud or corruption contact the Trust’s LCFS on 07800 617 012 , the Fraud and Corruption Reporting Line 0800 028 4060 or www.reportnhsfraud.nhs.uk.

Part D

Chartered Institute of Purchasing and Supply - Ethical Code (Reproduced by kind permission of CIPS)

Introduction
The code set out below was approved by the CIPS Council on 11 March 2009 and is building on CIPS members.

- maintain the highest standard of integrity in all my business relationships
- reject any business practice which might reasonably be deemed improper
- never use my authority or position for my own personal gain
- enhance the proficiency and stature of the profession by acquiring and applying knowledge in the most appropriate way
- foster the highest standards of professional competence amongst those for whom I am responsible
- optimise the use of resources which I have influence over for the benefit of my organisation
- comply with both the letter and the intent of:
  - the law of countries in which I practise
  - agreed contractual obligations
  - CIPS guidance on professional practice
- declare any personal interest that might affect, or be seen by others to affect, my impartiality or decision making
- ensure that the information I give in the course of my work is accurate
- respect the confidentiality of information I receive and never use it for personal gain
- strive for genuine, fair and transparent competition
- not accept inducements or gifts, other than items of small value such as business diaries or calendars
- always declare the offer or acceptance of hospitality and never allow hospitality to influence a business decision
- remain impartial in all business dealing and not be influenced by those with vested interests.

See also Code of Conduct for NHS Managers, included in this manual.

12. Standing Orders of the Council of Governors –

These can be found in the Trust Constitution

13. Procedure for amending the Corporate Governance Manual

13.1 Procedure for Reviewing and Updating

13.1.1 Background

This manual sets out how the Trust operates and regulates itself. This is of vital importance in the public sector where the use of public funds and the performance and conduct of the organisation is under constant scrutiny.

13.1.2 Annual Review

The manual will be reviewed annually. It will be reviewed by the Trust Audit Committee in July. Thereafter it will be presented to the Board of Directors for formal approval and adoption at the next available meeting.

All changes[11] to the manual will be reviewed by the Audit Committee. These changes will be clearly highlighted in the updated Manual which is presented for subsequent adoption to the Board of Directors.

Following adoption, the Chief Executive and the Trust Secretary are responsible for ensuring that all directors, governors and trust staff are made aware of the manual and their responsibilities in respect of it. An up-to-date version of the manual will at all times be available on the Trust's intranet and website.

Where there are proposed changes to the manual that require initial review and approval by the Council of Governors, this will be done prior to consideration by the Audit Committee and the Board of Directors.

Care should be taken to ensure that all changes are consistent with the Trust's Constitution. Any proposed changes to the Constitution must first be approved by the Trust's members and ~~NHS Improvement~~NHS England as per paragraph 23 of the Constitution.

Changes to Standing Financial Instructions, Scheme of Delegation of Board powers and associated section or which have financial implications or impact must always be routed through the Trust's Finance Department, where the Deputy Chief Finance Officer will ensure all financial aspects of the change are given due consideration and approval. These changes must be subsequently approved by the Finance, Performance and Business Development Committee ahead of consideration by the Audit Committee and Board of Directors.

The Trust Secretary will co-ordinate the submission of Corporate Governance Manual changes for approval to the Audit Committee, the Board of Directors and the Council of Governors as required.

13.1.3 Periodic Updating

The manual will be reviewed annually when necessary changes will be made. However it is recognised that changes may need to be made in-year to reflect legislative, constitutional, operational or other requirements i.e. periodic updating.

In such circumstances the same procedures must be followed, in due order, as specified above in respect of the annual review.

[11] With the exception of minor changes such as an organisational name change which will be reported for noting to the next available Audit Committee

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2022/23/140*		**Date: 14/09/2023**	
Report Title	**Constitution Amendments**			
Prepared by	*Mark Grimshaw, Trust Secretary*			
Presented by	*Mark Grimshaw, Trust Secretary*			
Key Issues / Messages	*For the Board to consider suggested amendments to the Constitution to a) align with the Health and Care Act 2022 and b) update governor constituencies.*			
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.*			
	For the Board to consider, and if deemed appropriate, approve the suggested amendments to the Constitution.			
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

Council of Governors	20 July 2023	Trust Secretary	The Council of Governors approved the proposed amendments

EXECUTIVE SUMMARY

This report outlines the proposed amendments to the Trust's Constitution.

MAIN REPORT

Making amendments to the Constitution

The Trust's Constitution states that:

44.1 The Trust may make amendments of its constitution only if:

44.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments; and

44.1.2 More than half of the members of the Board of Directors of the trust voting approve the amendments.

44.2 Amendments made under paragraph 44.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

44.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

44.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and

44.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

Proposed Amendments

Regulatory updates

The Health and Care Act 2022 has given Foundation Trusts increased powers to delegate service delivery. This means that Foundation Trusts can now delegate more services to other organisations, such as private companies or charities. The Trust does not have plans to use such powers at the current time, but it is necessary for the Constitution to reflect the updated legislation.

The 'Model Constitution' (a document that was adopted by the majority of NHS Foundation Trusts) has been updated across the Cheshire & Merseyside system with the support of law firm Hill Dickinson.

The key change is noted below (to section 4 'Powers':

Powers

1.1 The powers of the Trust are set out in the 2006 Act.

1.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

1.3 Any of these powers may be delegated to a committee of Directors or to an executive Director.

1.4 The Trust may enter into arrangements for the carrying out, on such terms as the Trust considers appropriate, of any of its functions jointly with any other person.

1.5 The trust may arrange for any of the functions exercisable by the trust to be exercised by or jointly with any one or more of the following:

1.5.1 A relevant body;

1.5.2 A local authority within the meaning of section 2B of the 2006 Act;

1.5.3 A combined authority.

1.6 The trust may also enter into arrangements to carry out the functions of another relevant body, whether jointly or otherwise.

1.7 Where a function is exercisable by the trust jointly with one or more of the other organisations mentioned at paragraph 4.5, those organisations and the trust may:

1.7.1 Arrange for the function to be exercised by a joint committee of theirs;

1.7.2 Arrange for the trust, one or more of those other organisations, or a joint committee of them, to establish and maintain a pooled fund

in accordance with section 65Z6 of the 2006 Act.

1.8 The Trust must exercise its functions effectively, efficiency and economically.

1.9 In making a decision about the exercise of its functions, the trust must have regard to all likely effects of the decision in relation to:

1.9.1 The health and well-being of (including inequalities between) the people of England;

1.9.2 The quality of services provided to (including inequalities between benefits obtained by) individuals by or in pursuance of arrangements made by relevant bodies for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England;

1.9.3 4.9.3 Efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.

1.10 In the exercise of its functions, the trust must have regard to its duties under section 63B of the 2006 Act (complying with targets under section 1 of the Climate Change Act 2008 and section 5 of the Environment Act 2021, and to adapt any current or predicted impacts of climate

change in the most recent report under section 56 of the Climate Change Act 2008).

1.11 For the purposes of this section, "relevant body" means NHSE, an integrated care board, an NHS trust, a NHS foundation trust (including the trust) or such other body as may be prescribed under section 65Z5(2). "Relevant bodies" means two or more of these organisations as the context requires.

1.12 The arrangements under this paragraph 4 shall be in accordance with:

1.12.1 any applicable requirements imposed by the 2006 Act or regulations made under that Act

1.12.2 any applicable statutory guidance that has been issued and

~~**1.3.1**~~ otherwise on such terms as the trust sees fit.~~The affairs of the Trust are to be conducted by the Board of Directors, the Council of Governors and the members in accordance with this constitution and the Trust's NHS provider licence.~~

The Board is asked to consider acceptance of this amendment.

Suggested amendments to Membership Constituencies and Appointed Governors

Updating the Constitution also provides an opportunity to review current Membership Constituencies. A significant driver for change relates to the fact that Liverpool City Council have updated the electoral wards following a boundary review. This does have (small) implications on the Trust's current public constituencies e.g., Central has become smaller with some wards now being classed as 'North' and some as 'South' – see Appendix 1 for further detail. It is not a necessity that the Trust changes its boundaries, but it is suggested that there is a strong argument to be coterminous with the local authority.

Should the changes be accepted, there will be implications on the 2023 election timetable. As the Constitution amendments can only be approved at the Annual Member's Meeting (21 September 2023), elections against such updates (should they be agreed) will need to take place after this point. This will delay the election outcome by approximately three months and will result in some existing governors having a longer term of office and newly elected governors having a shorter term of office.

The role of partner (appointed) governors in an NHS Foundation Trust is to represent the interests and perspectives of partner organizations within the governance structure of the Trust. Partner governors play a crucial role in fostering effective partnerships and collaboration between the Trust and its partner organizations. Their involvement helps ensure that the Trust's services are coordinated, integrated, and responsive to the needs of the local population, while promoting effective multi-agency working for the benefit of patients and the wider community.

The Trust currently has eight appointed governors – chosen several years ago to reflect the Trust's strategic partners and provide a link to key stakeholders in the community.

- Three governors, one each to be appointed by Liverpool City Council, Sefton Borough Council and Knowsley Borough Council
- One governor appointed by Liverpool University
- One governor appointed from a) Liverpool Hope, b) LJMU or c) Edge Hill
- One governor appointed from the student body of the four local universities

- Two governors from:
    - Four faith organisations (CofE, Catholic, Muslim and Jewish denominations)
    - A multitude of community and voluntary sector (CVS) organisations (57 currently listed)

As the Trust takes an opportunity to review its governor constituencies, it is felt germane to review the appointed / partner governor cohort to ensure that the identified organisations remain best placed to meet the aims listed above. There are also challenges to the administration of appointing governors utilising the current phrasing in the Constitution. Where one governor needs to be appointed from a range or choice of organisations, the Constitution is silent about the method of selection. This is currently being managed by the Trust Secretary via a 'first come, first served' basis after an email which is not optimal and can be particularly challenging for the CVS governor role (57 organisations). The Trust has also been challenged to achieve consistent engagement for the student governor role. Whilst there is value in the idea it can be difficult to transact due to its transient nature.
A discussion was held at a Governor Communications and Membership Engagement Group meeting on 29 June 2023 and the following suggestions were made:

- It was questioned why the Trust has local councillor representation from Knowsley and Sefton but not from other city region authorities when patients are drawn from these areas. It was suggested that a representative from a regional body might be better placed.
- There was agreement that utilising 'umbrella' groups to represent the CVS, young people and multi-faiths would be better that retaining a long list in the Constitution.
- It was suggested that the Trust should seek input from Primary Care Networks due to their function in local population health and health inequalities – key strategic aims for the Trust and wider Integrated Care System.

Incorporating these comments would result in an appointed governor cohort that would looks as follows:

Eight appointed governors:

- One from Liverpool City Council
- One from a local authority that has a role in and/or link with the Liverpool City Region Combined authority
- One from Central Liverpool Primary Care Network
- One from the University of Liverpool
- One governor appointed from a) Liverpool Hope, b) LJMU or c) Edge Hill
- One governor from an umbrella organisation representing the Community and Voluntary Sector
- One governor from an umbrella organisation representing the views of young people
- One governor from an umbrella organisation representing a multi-faith perspective

Next Steps

Should the Board agree the amendments, the amendment will be presented to the Annual Members' Meeting for final approval. If agreed, the constitution will be finalised and reported to NHS England.

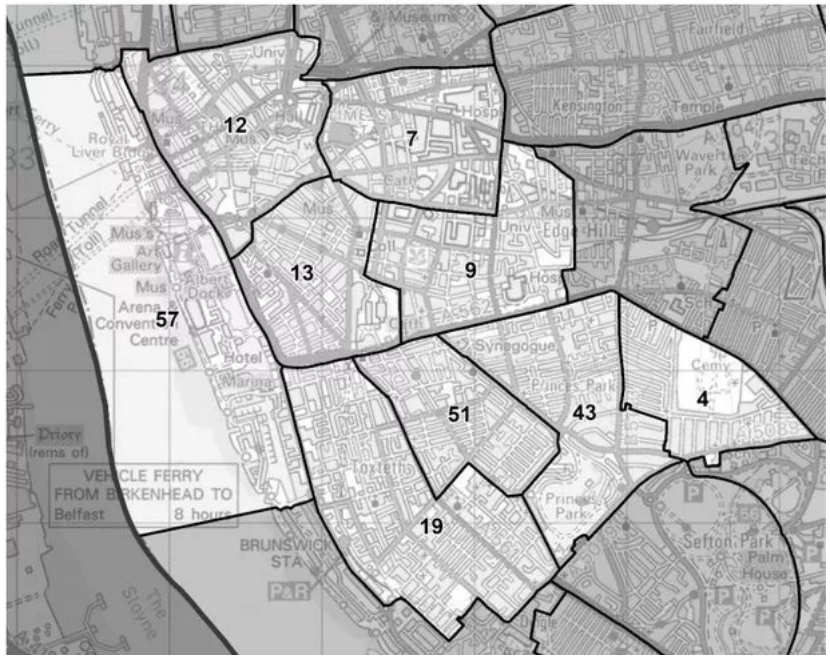
Recommendation

For the Board to consider, and if deemed appropriate, approve the suggested amendments to the Constitution.

Appendix 1 – Governor Constituencies

Electoral Wards for Central Liverpool

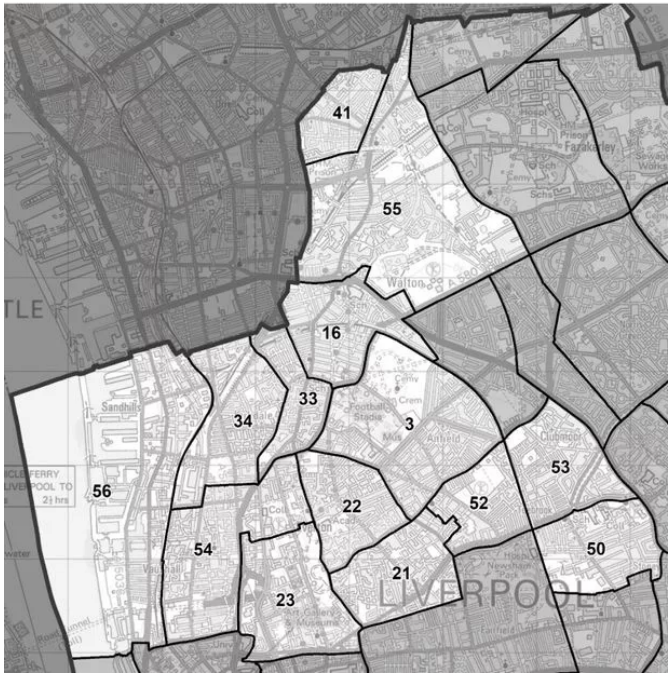
Current	**Post Boundary changes**
Everton	**City Centre South (13)**
Central	**City Centre North ward (12).**
Yew Tree	**Brownlow Hill (7)**
Knotty Ash	**Canning (9)**
Kensington & Fairfield	**Waterfront South ward (57)**
Tuebrook & Stoneycroft	**Arundel (4)**
Old Swan	**Dingle (19)**
Picton	**Princes Park (43)**
Childwall	**Toxteth (51)**
Wavertree	**Kensington and Fairfield (32)**
Church	**Smithdown (46)**
Greenbank	**Broadgreen (6)**
Riverside	**Church (11)**
Princes Park	**Edge Hill (20)**
	Old Swan East (39)
	Old Swan West (40)
	Penny Lane (42)

	Wavertree Garden Suburb (58)
	Wavertree Village (59)
Central West  	Central East 

Electoral Wards for North Liverpool

Current	**Post Boundary changes**
Fazakerley	**Anfield (3)**
Warbreck	**County ward (16).**

County	**Walton (2)**
Clubmoor	**Vauxhall (2)**
Norris Green	**Everton East (21)**
West Derby	**Everton North (22)**
Kirkdale	**Everton West (23)**
	Kirkdale East (33)
	Kirkdale West (34)
	Orrell Park (41)
	Stoneycroft (50)
	Tuebrook Brekside Park (52)
	Tuebrook Larkhill (53)
	Waterfront North ward (56).
	Norris Green (38)
	Yew Tree (64)
	Clubmoor East (14)
	Clubmoor West (15)
	Croxteth (17)
	Croxteth Country Park (18),
	Fazakerley East (24)
	Fazakerley North (25)
	Fazakerley West (26)
	Knotty Ash and Dovecot Park (35)
	Sandfield Park (44)

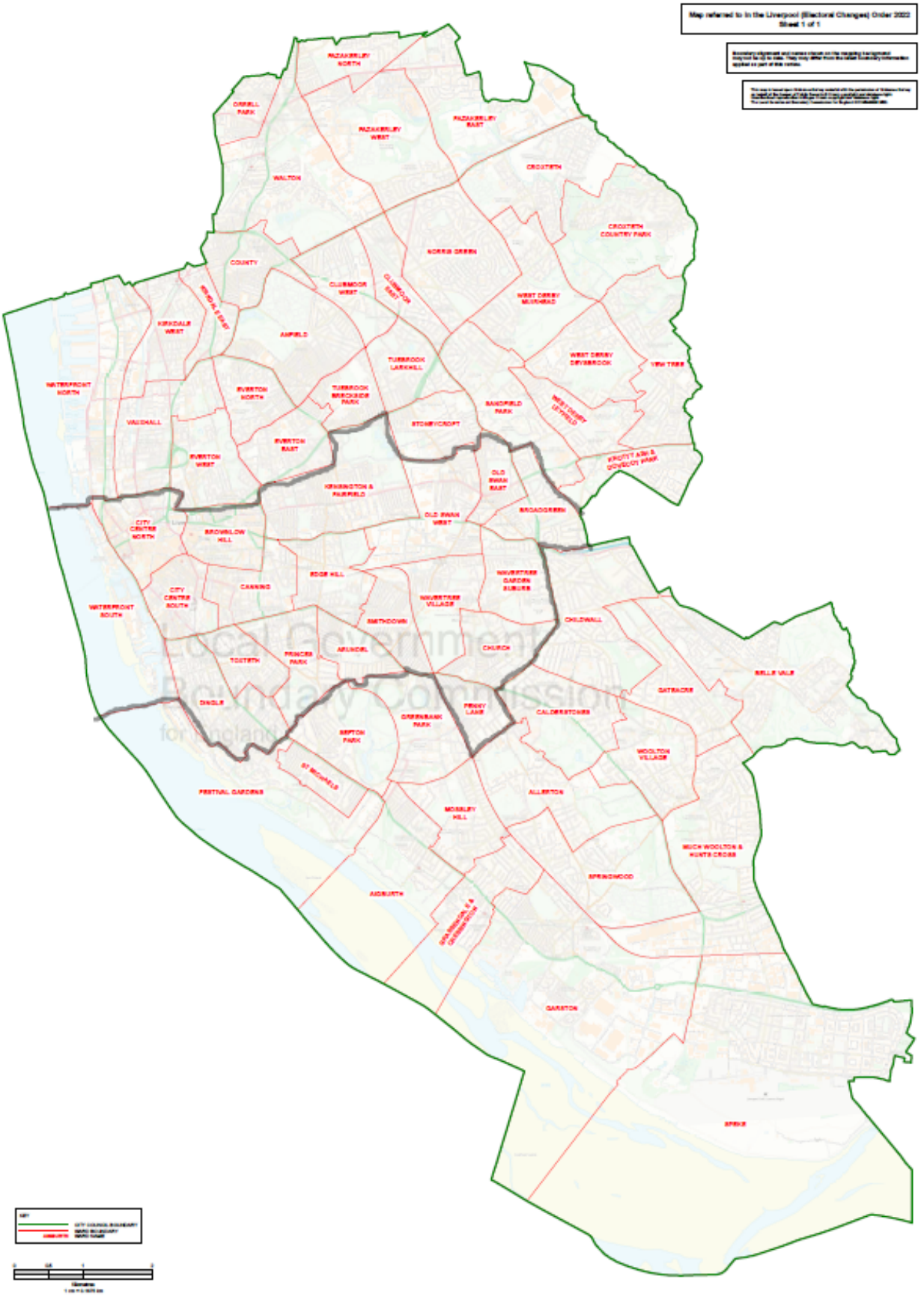
	West Derby Deysbrook (60)
	West Derby Leyfield (61)
	West Derby Muirhead (62).
North West  	North East 

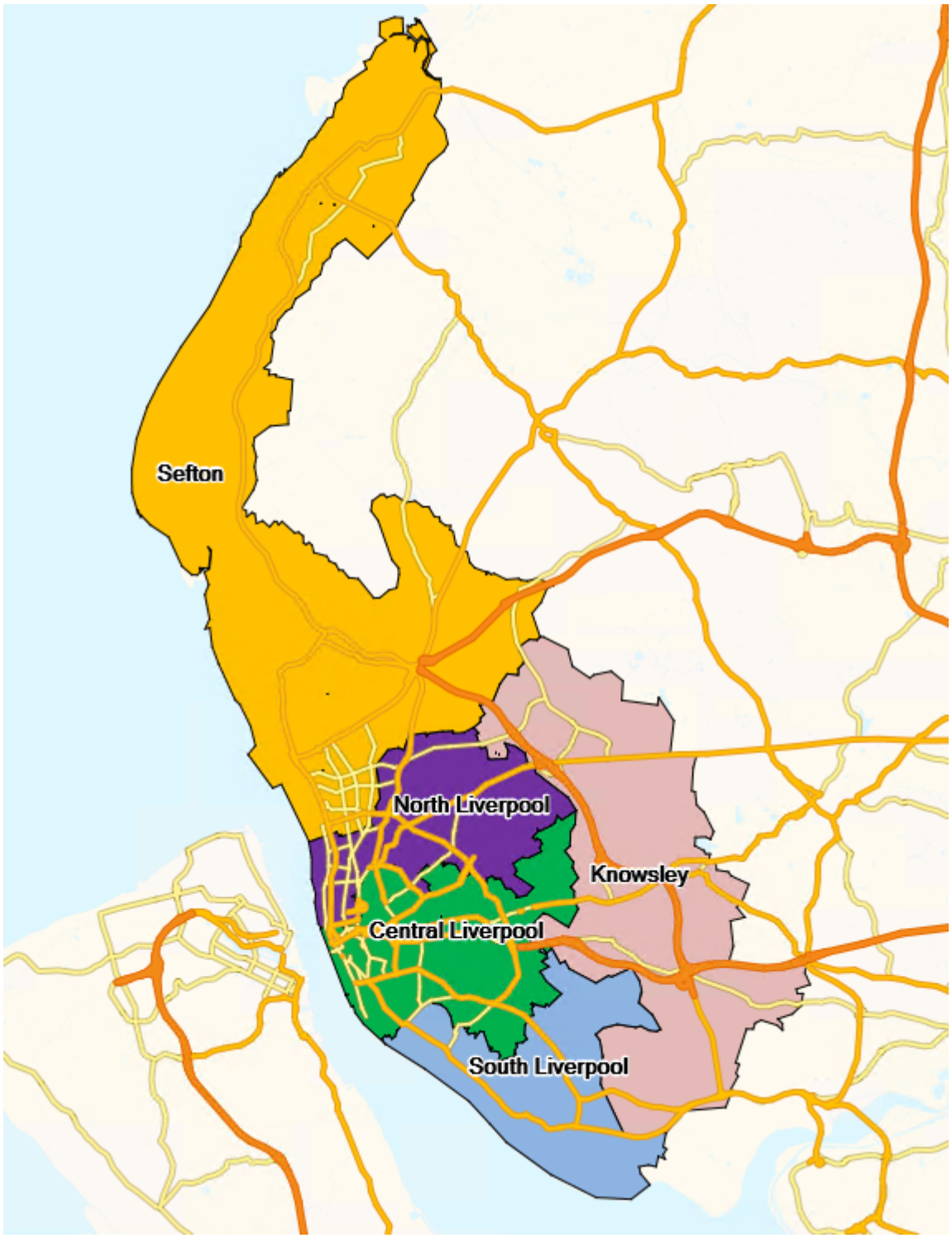
Electoral Wards for South Liverpool

Current	**Post Boundary changes**
Allerton & Hunts Cross	**Garston (28)**
Woolton	**Speke (47).**
Belle Vale	**Aigburth (1),**
St Michael's	**Festival Gardens (27),**
Speke- Garston	**Grassendale and Cressington (30)**
Cressington	**Greenbank Park (31),**
Mossley Hill	**Mossley Hill (36),**
	Sefton Park (45)
	St Michaels (49)
	Belle Vale (5)
	Childwall (10)
	Much Woolton and Hunts Cross (37)
	Allerton (2),
	Calderstones (8),
	Gateacre (29),
	Springwood (48)
	Woolton Village (63)

South West

South East


Map referred to in the Liverpool (Electoral Changes) Order 2022
Sheet 1 of 1
FAZAKERLEY NORTH
FAZAKERLEY WEST
FAZAKERLEY EAST
CROXTETH
CROXTETH COUNTRY PARK
NORRIS GREEN
WEST DERBY MUIRHEAD
WEST DERBY DERBYBROOK
VIEW TREE
WEST DERBY LEYFIELD
KIRKDALE WEST
KIRKDALE EAST
ANFIELD
CLUBMOOR WEST
CLUBMOOR EAST
TURBROOK LARKHILL
TURBROOK BRECKSIDE PARK
STONEYCROFT
SANDFIELD PARK
KIRKBY A36 & GOWDALL PARK
WATERFRONT NORTH
VAUXHALL
EVERTON NORTH
EVERTON WEST
EVERTON EAST
KENSINGTON & FAIRFIELD
OLD SWAN EAST
OLD SWAN WEST
BROADGREEN
CITY CENTRE NORTH
BROWNLOW HILL
EDGE HILL
CANNING
CITY CENTRE SOUTH
WATERFRONT SOUTH
WAVERTREE GARDEN SUBURB
WAVERTREE VILLAGE
SMITHDOWN
CHILDWALL
TOXTETH
PRINCES PARK
ARUNDEL
CHURCH
DINGLE
GREENBANK PARK
PENNY LANE
CALDERSTONES
GATEACRE
BELLE VALE
WOOLTON VILLAGE
ST MICHAELS
FESTIVAL GARDENS
ALLERTON
MOSSLEY HILL
MUCH WOOLTON & HUNTS CROSS
SPRINGWOOD
AIGBURTH
GARSTON
SPEKE
Local Government Boundary Commission for England


Sefton
North Liverpool
Knowsley
Central Liverpool
South Liverpool

Appointed Governor – Constitution Extract

1. Appointed Governors appointed by the following appointing organisations (to be reviewed by the Council of Governors every three years) in accordance with a process agreed by those organisations with the Trust Secretary:
   1.1. Three governors, one each to be appointed by Liverpool City Council, Sefton Borough Council and Knowsley Borough Council;
   1.2. One governor appointed by Liverpool University;
   1.3. Two governors appointed jointly by the following:
      1.3.1. Faith Organisations
         1.3.1.1. Diocese of Liverpool
         1.3.1.2. Archdiocese of Liverpool
         1.3.1.3. Liverpool Muslim Society
         1.3.1.4. Liverpool Progressive Synagogue
      1.3.2. Community & Voluntary Organisations
         1.3.2.1. Autism Initiatives
         1.3.2.2. Blackburn House
         1.3.2.3. Bliss
         1.3.2.4. Bradbury Fields (Formerly Liverpool Voluntary Society for the Blind)
         1.3.2.5. Breckfield & North Everton Neighbourhood Council
         1.3.2.6. British Heart Foundation
         1.3.2.7. BROOK
         1.3.2.8. Children's Cancer Support Group
         1.3.2.9. City Church / The Crossing Point
         1.3.2.10. Common Purpose Merseyside
         1.3.2.11. Croxteth & Gilmoss Community Federation
         1.3.2.12. Down’s Syndrome Association
         1.3.2.13. Eldonian Community Trust Ltd.
         1.3.2.14. Fazakerley Community Federation
         1.3.2.15. Getting Involved Group (Liverpool Learning Disability)
         1.3.2.16. Granby Somali Women’s Group
         1.3.2.17. Greenbank Project
         1.3.2.18. Irish Community Care
         1.3.2.19. Kirkdale Neighbourhood Community Centre
         1.3.2.20. Kuumba Imani Millennium Centre

1.3.2.21. Liverpool Action for Blind People
1.3.2.22. Liverpool Arabic Centre
1.3.2.23. Liverpool Association of Disabled People
1.3.2.24. Liverpool Council for Voluntary Services
1.3.2.25. Liverpool Local Partnership Enterprise
1.3.2.26. Liverpool PSS (Liverpool Volunteer Doula)
1.3.2.27. Lowlands (West Derby Community Association)
1.3.2.28. Mary Seacole House
1.3.2.29. Marybone Youth & Community Association
1.3.2.30. Mencap Liverpool
1.3.2.31. Mersey Region Epilepsy Association
1.3.2.32. Merseyside Centre for Deaf People
1.3.2.33. Merseyside Disability Federation
1.3.2.34. Merseyside Jewish Community
1.3.2.35. Merseyside Welfare Rights
1.3.2.36. Minerva Women's Groups
1.3.2.37. MRANG (Merseyside Refugee & Asylum Seekers Pre & Post Natal Support Group)
1.3.2.38. National Childbirth Trust (Liverpool Branch)
1.3.2.39. Netherley Valley Childcare Initiatives
1.3.2.40. Nigerian Community Association
1.3.2.41. NSPCC (Northwest Branch)
1.3.2.42. Pakistan Association – Liverpool
1.3.2.43. People First Merseyside
1.3.2.44. PSS (Post Natal Depression Service & LivPiP)
1.3.2.45. RNIB (Royal National Institute of Blind People)
1.3.2.46. Salvation Army, Ann Flower House
1.3.2.47. Sands (Liverpool Still Birth and Neonatal Charity)
1.3.2.48. Shine (Association for Spina Bifida & Hydrocephalus)
1.3.2.49. Soroptimist Liverpool
1.3.2.50. SWAN Women’s Centre
1.3.2.51. Volunteer Centre Liverpool
1.3.2.52. The Wavertree Society
1.3.2.53. West Everton Community Council
1.3.2.54. WHISC (Women’s Health and Information Support)

1.3.2.55. Women's Institute (Liverpool)

1.3.2.56. Yew Tree Children's Centre

1.3.2.57. Young Persons Advisory Service

1.4. One governor appointed jointly by:

1.4.1. Liverpool Hope University

1.4.2. Liverpool John Moores University

1.4.3. Edge Hill University

1.5. One Student Governor appointed jointly by the student councils of:

1.5.1. University of Liverpool

1.5.2. Liverpool Hope University

1.5.3. Liverpool John Moores University

1.5.4. Edge Hill University

NHS
Liverpool Women's
NHS Foundation Trust

Jargon Buster

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

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

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

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

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

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

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

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

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

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

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

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

G

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

H

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

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

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

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

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

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

N

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

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

O

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

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

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

Q

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

R

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

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

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

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

V

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

W

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

Y

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