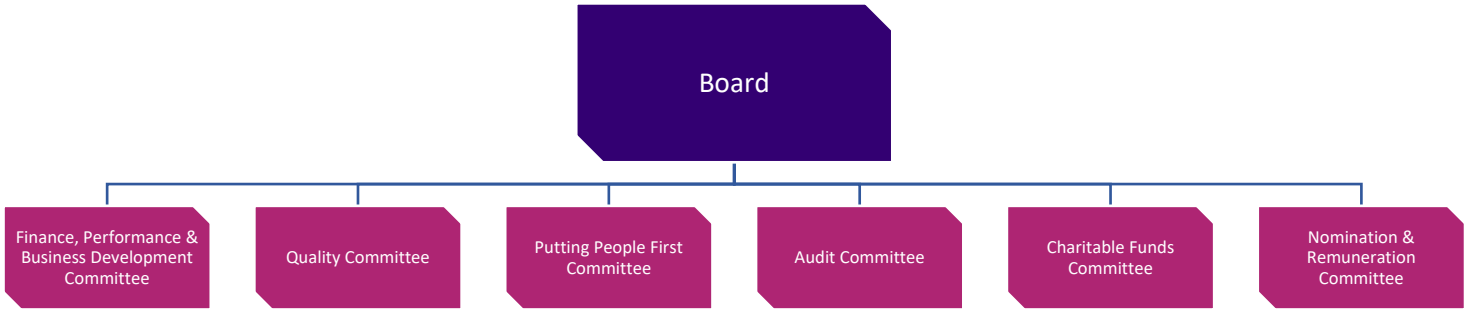
Liverpool Women's NHS Foundation Trust

Trust Board

14 March 2024, 10am
Boardroom, LWH



Liverpool Women's NHS Foundation Trust

Trust Board

Location	Boardroom, LWH
Date	14 March 2024
Time	10am

AGENDA					
Item no. 23/24/	Title of item	Action	Process	Item presenter	Time
PRELIMINARY BUSINESS					
268	Introduction, Apologies & Declaration of Interest	To receive	Verbal	Chair	10.00 (5 mins)
269	Meeting Guidance Notes	To receive	Written	Chair	
270	Minutes of the previous meeting held on 8 February 2024	To approve	Written	Chair	
271	Action Log and matters arising	To receive	Written	Chair	
272	Chief Executive announcements	To receive	Verbal	Chief Executive	10.05 (10 mins)
MATTERS FOR CONSIDERATION					
273	Quality, Operational & Workforce Performance Report	To receive	Written	Chief Operating Officer	10.15 (15 mins)
274	Finance Performance 2023/24 and Financial Planning 2024/25	To receive and approve	Written	Chief Finance Officer	10.30 (15 mins)
275	CQC Inspection Report and Improvement Plans	Take assurance	Written	Chief Nurse	10.45 (15 mins)
276	Staff Survey 2023 – Overview of Key Themes	To receive	Written	Chief People Officer	11.00 (15 mins)
277	Governance and Assurance Framework Review	To receive and approve	Written	Trust Secretary	11.15 (20 mins)
278	LWH Improvement Plan Update 1	To note	Written	Chief Transformation Officer	11.35 (10 mins)
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.*					
None					
CONCLUDING BUSINESS					

279	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	11.45 (5 mins)
280	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
281	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
282	Jargon Buster	For reference	Written	Chair	
Finish Time: 11.50					

Date of Next Meeting: 11 April 2024

11.50 – 12.00	*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 in the Boardroom and Virtually via Teams at 9.30am on 8 February 2024

PRESENT

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

IN ATTENDANCE

Matt Connor	Chief Digital Officer
Heledd Jones	Head of Midwifery (item 250 only)
Richard Diamond	Estates and Facilities Manager (item 247 only)
Anne Bridson	Learning and Development Facilitator (item 247 only)
Issy Garnell	Supported Apprentice (item 247 only)
Dr Kat Pavlidi	Guardian of Safe Working Hours (item 251d only)
Nicola Pittaway	Freedom to Speak Up Guardian (item 252c only)
Dr Srinivasarao Babarao	Freedom to Speak Up Guardian (item 252c only)
David Flory CBE	Trust Chair, Designate
Pat Denny	Public Governor
Jackie Sudworth	Public Governor
Lesley Mahmoud	Member of the Public
Felicity Dowling	Member of the Public
Teresa Williams	Member of the Public
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Tracy Ellery	Non-Executive Director / Vice Chair

Core members	**Feb 23**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb 24**
Robert Clarke - Chair	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑
James Sumner – Chief Executive	Non-member									⚑	⚑	⚑
Kathryn Thomson - Chief Executive	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	NM		⚑
Tracy Ellery - Non-Executive Director / Vice-Chair	⚑	⚑	A	⚑	A	⚑	⚑	⚑	⚑	⚑	⚑	A

Louise Martin - Non-Executive Director	🏳	🏳	🏳	🏳	A	🏳	A	🏳	🏳	🏳	🏳	🏳
Prof Louise Kenny - Non-Executive Director	🏳	🏳	🏳	A	A	🏳	🏳	🏳	🏳	🏳	A	🏳
Dianne Brown – Chief Nurse	🏳	A	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	A	🏳
Gary Price - Chief Operating Officer	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳
Michelle Turner - Chief People Officer	🏳	A	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳
Dr Lynn Greenhalgh – Chief Medical Officer	🏳	🏳	🏳	A	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳
Zia Chaudhry – Non-Executive Director	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳
Gloria Hyatt – Non-Executive Director	🏳	🏳	A	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳
Sarah Walker – Non-Executive Director	🏳	🏳	🏳	🏳	🏳	A	🏳	🏳	A	🏳	🏳	🏳
Jackie Bird – Non-Executive Director	🏳	🏳	🏳	🏳	🏳	A	A	🏳	🏳	🏳	🏳	🏳
Jenny Hannon - Chief Finance Officer / Executive Director of Strategy & Partnerships	🏳	🏳	🏳	A	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳
Matt Connor – Chief Information Officer (non-voting)	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳

23/24/	
242	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. Apologies were noted as above. The Chief Digital Officer noted that from the 1 February 2024, he had started in his joint role at Liverpool University Hospitals NHS Foundation Trust. The register of interests would be updated accordingly.
243	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
244	**Minutes of the previous meeting held on 11 January 2024** The minutes of the Board of Directors meeting held on 11 January 2024 were agreed as a true and accurate record.
245	**Action Log and matters arising** Updates against action log were noted.
246	**Board thank you** The following Board thank you's were presented: • Dr Robert Macdonald – presented by the Chief Medical Officer for service and dedication to the Trust. • Joanne Bruce – presented by the Chief Nurse for her action is resuscitating a newborn baby recently discharged from the neonatal unit during a home visit.
247	**Staff Story – Accessibility Improvements** The Chief Operating Officer reminded members of a staff story shared in July 2023. At that time, Issy, then on a work placement, had highlighted accessibility challenges within the organisation, particularly concerning change facilities and general building access. She had returned to update the

	Board on the improvements since her last visit. Issy recounted her personal connection to the Trust, having been cared for in the neonatal unit as a baby, and provided assurance to the Board on the progress made, including the installation of a washing, and changing facility, enabling her to take on a supported apprenticeship role. The Chief Operating Officer recognized Issy's contributions to bringing these issues to light and outlined additional measures taken, including an access audit to inform capital plans, leading to immediate improvements and long-term projects. The Trust had received positive feedback for these initiatives from both patients and staff. The Chief People Officer and the Estates & Facilities Manager discussed ongoing accessibility challenges, specifically with automatic door systems, and confirmed the organisation's inclusion on a database for families needing special facilities. The Chair acknowledged the importance of continuous improvement and thanked Issy for her valuable feedback, underlining the Trust's commitment to inclusivity and support for all employees.
248	Chair's announcements The Chair announced the resumption of the Shadow Board initiative, first undertaken in 2019/20. This program aimed to provide aspiring directors within the Trust an opportunity to simulate Board responsibilities, presenting reports and discussing their management strategies in a coaching environment. Supported by NHS experts, the Shadow Board included modules on directorial challenges and action learning sets for personal development reflection. Additionally, Shadow Board members had been invited to observe future Board meetings. A Council of Governors Nomination and Renumeration Committee had recently met to review Non-Executive Directors' performance, discussing succession planning due to upcoming vacancies. Louise Martin had opted not to seek a three-year extension to her terms, agreeing instead to a three-month extension, with decisions pending the full Council meeting on 22 February 2024. Professor Louise Kenny had also indicated an intention to leave in advance of her term end in February 2025. Concluding, the Chair expressed gratitude for the support received during his tenure, marking this meeting as his last with the Trust. The Board noted the update.
249	Chief Executive Report The Chief Executive shared highlights from his report noting recent events and areas of strategic focus. The CQC's informal feedback from a visit undertaken on 15 January 2024, visit was promising with no major concerns raised. The feedback had also indicated the potential lifting of the Section 29 warning notice issued in January 2023, subject to formal confirmation and the issuing of the final report. This progression marked a significant milestone for the Trust demonstrating its commitment to addressing the concerns highlighted by the CQC. The Chief Executive continued to outline the Trust's status in the National Oversight Framework, noting its placement in segment three, which necessitated monthly local oversight through the Integrated Care Board. Efforts to transition from segment three to two were underscored, emphasising the importance of establishing realistic exit criteria in collaboration with the oversight bodies. Once the exit criteria had been finalised, this would be shared with the Public Board. Furthermore, the report highlighted several operational achievements, including the Trust's recognition in health tech innovation and its efforts in enhancing fertility treatments, showcasing the organisation's dedication to medical advancement and patient care.

	The Board discussed the financial implications of immediate safety actions included within the improvement plan and the necessity of integrating quality and safety measures into the Trust's operational plan, emphasising the critical nature of these improvements for patient and staff welfare. The Chief Executive extended gratitude to the outgoing Chair for his leadership and contributions, reflecting on the collaborative efforts that have led to the organisation's current successes and laying the groundwork for its future endeavours. The Board of Directors noted the report.
250	Maternity Staffing report 1st July- 31st December 2023 The Maternity Staffing Report from July 1st to December 31st, 2023, presented to the Board, underlined the Trust's adherence to the CNST Maternity Incentive Scheme Year Five requirements. The biannual midwifery staffing audit, aligned with the Birth Rate Plus tool, confirmed the establishment's compliance with recommended staffing levels, including a significant headroom for midwives and maternity support workers. Following a Birth Rate Plus audit in April 2023, the Trust successfully filled all midwifery vacancies, notably achieving zero vacancies, and addressed sickness absence rates, which showed a marked improvement from the previous year. The report detailed a positive midwife to birth ratio, surpassing national recommendations and reflecting a continuous effort to enhance service quality. Despite challenges, red flags, especially around induction of labour, were being actively addressed through quality improvement projects and estate refurbishments to improve patient experience. The Trust also noted a shift in the landscape of operative births, influenced by NICE guidelines and changing patient preferences, necessitating adjustments in workforce planning to accommodate increased demands. Non-Executive Director, Sarah Walker, queried if the increase the C-Section rate was driven primarily by elective or emergency patients. The Head of Midwifery confirmed that highest proportion of C-Sections were elective. Prof. Louise Kenny suggested that it would be useful for future reports to include benchmarking on operative rates including assisted delivery. Action: For future midwifery staffing reports to include benchmarking on operative rates including assisted delivery. Non-Executive Director, Louise Martin, highlighted an increase in reported clinical incidents and asked if the Trust was satisfied that this was attributable to a healthy reporting culture and not an indication that there was increased patient harm. The Head of Midwifery confirmed that the service had not seen an increase in number of incidents that resulted in harm. Strategic workforce planning was highlighted by the Board as essential to managing the complexity of care, with a significant portion of care falling into higher complexity categories. The Trust committed to regular Birth Rate Plus audits to ensure accurate data capture and effective workforce alignment. Whilst it was acknowledged that the purpose of the report was to provide assurance on the appropriateness of immediate midwifery staffing levels, there was agreement that it would be important for the Board and its Committees to discuss future planning to address the evolving needs of maternity care. The Board emphasised the need for a proactive and comprehensive approach to staffing and operational strategies to maintain high standards of care and safety. The Board resolved to: • Receive the report. • Noted the assurances provided for how safe staffing was managed, recruited, and retained to keep women and babies safe within Maternity services.

251a	**Chair's Report from the Quality Committee** The Board considered the Chair's Reports from the Quality Committee meeting held 30 January 2024. Non-Executive Director, Sarah Walker, Committee Chair, noted: • the investigation into maternal deaths and patient deterioration, emphasising the need for appropriate risk identification and escalation. The Committee acknowledged the need for targeted resources and financing to address identified issues, including ethnic bias, ensuring swift remediation. The transparency and honesty within the report were acknowledged, reflecting a commitment to learning and improvement. • High cancer referral rates and the challenges they present were noted, alongside the positive reception of a research paper. The Chief Executive discussed the significance of addressing the length of wait on the waiting list, particularly for cancer patients and those at risk due to extended waiting times. He highlighted the necessity of medium-term planning to understand and mitigate the risks within the group of people waiting for care. This underscored the urgent need to understand the details of those waiting, beyond just managing the longest waiters, to identify and reduce potential risks to patient health. The Board of Directors received and noted the Chair's Report from the Quality Committee meeting held on 30 January 2024.
251b	**Quality & Operational Performance Report** The Board considered the Quality & Operational Performance Report. The Chief Operating Officer highlighted the Trust's performance in urgent care metrics, which had surpassed national standards, despite challenges as a result of industrial action. Positive feedback from the CQC regarding Maternity Assessment Unit (MAU) triage had underscored the staff's resilience and dedication during these periods. The Chief Operating Officer outlined the Trust's approach to elective recovery, highlighting the strategic plan to eliminate 65-week waits by the end of March 2024, alongside the positive performance in routine diagnostics which was supporting mutual aid initiatives. The Board discussed how best to address the challenges posed by the extensive waiting list size. The Chief Executive emphasised the necessity of a long-term, comprehensive strategy to make substantive inroads into reducing the backlog. Collaborative efforts with Cheshire and Mersey ICB, the Royal College, and NHS England were highlighted as crucial to learning and sharing best practices nationwide. The focus on general gynaecology had revealed a strategic area for capacity improvement, especially since a substantial percentage of patients were discharged at their first appointment. The challenge of meeting the 28-day diagnostic standard was acknowledged, with the Board informed of the detailed progress and the comparative analysis with other trusts facing similar challenges. The rising referral rates, particularly for suspected cancer, were discussed as both an operational challenge and a strategic priority. Non-Executive Director, Louise Martin, asked if there had been engagement with Primary Care. The Chief Operating Officer accepted the necessity for strategic engagement with primary care providers. Collaborative work had commenced, and this was aimed at enhancing referral quality and managing patient flow effectively. Initiatives included educating GPs on best practice, such as conducting pelvic examinations prior to cancer referrals, which aligned with NICE guidelines. These efforts were expected to mitigate the spike in referrals and contribute to a more efficient patient care pathway, ultimately improving patient outcomes and operational efficiency within the Trust. The Board of Directors received and noted the Quality & Operational Performance Report.

251c	**Mortality and Learning from Deaths Report Quarter 2, 2023/24** The Chief Medical Officer presented the mortality data for Q2 2023/24 with the learning from the reviews of deaths from Q1 2023/24. Particular attention was drawn to two recent maternal deaths (one in Q4 2022/23 and one in Q2 2023/24). The Maternity and Newborn Safety Investigations (MNSI) programme report for the latter was awaited but had been received for the former. The review process led by MNSI highlighted the critical need for comprehensive investigations to understand and mitigate such incidents fully. This case, among others, brought to the forefront the complexities surrounding maternal care, including the challenges posed by multiple independent investigations and the nuanced dynamics of cultural and social inequalities impacting maternal outcomes. The Board's discussion highlighted some concerns about the potential for varying conclusions from different investigative bodies, underscoring the urgency for a more integrated approach to learning from deaths. The conversation also ventured into the broader systemic issues, such as health inequalities and systemic biases, revealing the multifaceted challenges in providing equitable maternal care. Moreover, the necessity for clearer communication with families and among care teams was emphasised, advocating for improvements in how findings and actions were conveyed to ensure meaningful change. Additionally, it brought attention to incidents and deaths attributable to the hospital's isolated site, advocating for systemic improvements. The Board reflected on a 10-year review of maternal deaths, and Non-Executive Director, Louise Martin called for further assurance on the impact of actions taken and the need for the recommendations to explicitly address cultural factors. **Action: For the Trust's 10-year review of maternal deaths report to be updated to include further assurance on the impact of actions taken to date and for the recommendations to explicitly address cultural factors.** The Chief Medical Officer noted that the Trust's stillbirth rate had remained below the national average but expressed caution regarding the statistical reliability owing to the small sample size. It was confirmed that all neonatal deaths had been reviewed utilising the Perinatal Mortality Review Tool (PMRT). Approximately 50% of neonatal deaths had been subject to an in-utero transfer and this was being explored further. Non-Executive Director, Prof. Louise Kenny, that the termination of pregnancies should feature in future reports acknowledging the significant workload these cases can entail. The Board of Directors resolved to: • Escalate concerns about the potential for varying conclusions from different investigative bodies, and advocate for a more integrated approach to learning from deaths • Take assurance that there were adequate governance processes in place when learning from deaths. • Note the: o number of deaths in our care o number of deaths subject to case record review o number of deaths investigated under the Serious Incident framework o number of deaths that were reviewed/investigated and as a result considered due to problems in care o themes and issues identified from review and investigation o actions taken in response, actions planned and an assessment of the impact of actions taken.

251d	Guardian of Safe Working Hours Quarter 3 2023/24 The Guardian of Safe Working Hours presented the report. Six exception reports were submitted relating to a difference in hours of work and loss of natural breaks. One work schedule review took place relating to starting hours. No educational exception reports were submitted. It was noted that there has been an increase in rota gaps, particularly in anaesthetics due to the need for additional shifts to support tier one anaesthetic doctors. However, neonates and genetics departments had seen stability in their staffing. The Guardian of Safe Working Hours covered the efforts to encourage junior doctors and their supervisors to submit exception reports where necessary, highlighting the importance of workforce planning in addressing staffing issues. The Chief Medical Officer referenced the improvement plan, a programme of which aimed to support the postgraduate doctors, including the development of Advanced Nurse Practitioner roles and additional post graduate doctor shifts to fill unsociable hours, thereby aiding in the recovery process, and ensuring safe care. The Board also discussed the strategic approach to making clinical fellow roles more attractive, the financial implications of covering shifts in-house versus using agency staff, and the importance of having a complete and safe rota. The resilience and contribution of postgraduate doctors were commended, and the item concluded with an acknowledgment of the challenges ahead and a commitment to addressing them through planned strategies. The Board of Directors noted the report.
251e	Maternal Death HSIB Report and response The Board received a detailed report in relation to an independent review of a maternal death in March 2023. The Maternity and Newborn Safety Investigations (MNSI) completed an independent investigation into a maternal death which included interviews with staff involved, a full review of documentation, site visits and included involvement from the family. The report provided a summary of the case, immediate actions taken at the time and further actions taken considering feedback and recommendations from the external case review. Key themes identified included the impact of systemic racism – presenting as cultural bias and stereotyping - on the provision of safe and effective care, and the inability to adequately recognise a deteriorating condition. Relevant external escalations and reporting had been completed in line with good practice and the Trust had been recognised by MNSI for its openness and transparency in both the reporting and escalation of the incident and during the investigation process. It was agreed that the immediate and planned actions in response to the death and the broader issues of systemic cultural bias and stereotyping identified in the MNSI report required a comprehensive response from the Trust. The Trust formally responded to the MNSI's escalation of concerns, detailing actions taken and plans for ensuring such incidents did not recur. Key areas of focus included improving pain management and documentation, enhancing the escalation process for managing patient deterioration, and addressing health inequalities and cultural biases. The Trust has committed to embedding and sustaining cultural and behavioural changes, with a significant emphasis on understanding and improving the patient experience for women from diverse backgrounds. This included innovative approaches like volunteer interpreters and refreshed training programs emphasising anti-racism. Additionally, the Trust was engaging in thematic learning from other incidents and reviews of best practices to guide its response to the failings in care highlighted by the investigation. The two Trust wide improvement ambitions relating to the deterioration of patient and active anti-racist culture work would form part of the Trust 2024/25 priorities for Quality and would report

	appropriately through the Improvement governance process. The early work from these workstreams would inform the model of care for the new medical emergency team which would be implemented early in 2024. The Board agreed that it was important to ensure that actions were linked and comprehensive – avoiding a 'piecemeal' approach. It was also asserted that listening to the patient was fundamental and that the Trust should have the right escalation and treatment for every patient. The Board of Directors resolved to: • accept and note the report presented, the actions completed and further planned interventions to address the issues raised.
252a	Chair's Report from the Putting People First Committee The Board considered the Chair's Report from the PPF Committee meeting held on 22 January 2024. Committee Chair, Gloria Hyatt, noted the following key issues: • The Committee received the Audit and Sickness Report update and actions to effectively manage and improve sickness absence rates in the Trust including the completion of return-to-work interviews and wellbeing conversations. The Gynaecology Division was identified as a department with significant challenges and had been asked to review their position and check appropriate resources were in place. The importance of local leaders' knowledge and understanding of their team members to improve sickness absence rates within their departments was noted. A further 6-month update would be presented to the Committee. • The Trust had secured 12-months funding to participate in a NHS England staff retention programme. • The Committee reviewed the PPF aligned BAF risks and discussed the proposal to reduce the risk score from 16 to 12 of 'BAF Risk 1 - Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities'. It was highlighted that this risk related to the workforce in its entirety and positive indicators collectively suggested a favourable trajectory for workforce engagement and satisfaction. It was acknowledged that risks remained, particularly in relation to postgraduate doctors and rota gaps, continued vigilance and proactive measures would be crucial for sustaining and building upon these improvements throughout the year. The Board of Directors resolved to: • receive and note the Chair's Report from the PPF Committee meeting held on 22 January 2024.
252b	Workforce Performance Report The Board considered the Workforce Performance Report, and the Chief People Officer highlighted the following key issue: • Flu and Covid-19 vaccine take up remained low although this was consistent across the NHS. The Trust recognised the risk to its patient cohort and working to understand the reasons for vaccine hesitancy from staff. The Board noted the workforce performance report.
252c	Freedom to speak up – Bi-annual Update The report, presented by the Freedom to Speak Up Guardians, provided a bi-annual update on the Freedom to Speak Up process at the Trust. The report noted an increase in concerns raised, with themes focusing on HR issues and policy adherence. It also detailed compliance with training modules and the outcomes of the biannual temperature check survey on speaking up culture. The Board of Directors was informed about a recent MIAA audit, which had provided significant assurance with NHSE expectations, and the outcomes following a review of NHSE's letter post-Lucy Letby trial verdict.

	The report underscored the importance of a culture that supported speaking up, with efforts to address any identified gaps in processes and training. Non-Executive Director, Sarah Walker, queried when the Trust could make a judgement regarding when an increase in contacts was suggestive of an issue rather than being an indicator of a positive reporting culture. The Chief People Officer explained that most of the issued raised with the Guardian related to cultural behaviours and themes were captured and analysed on a quarterly basis. Areas and services had been challenged where there had been a growth in concerns. The Chief Executive asserted that the Integrated Performance Report needed to be more explicit about incident reporting and the level of harm (and any potential linkages) to provide assurance to the Board. The Chief Digital Officer confirmed that this would be reviewed, particularly in terms of how to present utilising 'Making Data Count' methodology. Non-Executive Director and Freedom to Speak Up Champion, Zia Chaudhry, noted the positive assurance that a dedicated physical space for Freedom to Speak Up discussions was in progress. He also stated that it would be important to reschedule the visit with the National Guardian to showcase good practice. The Chief Operating Officer queried if the Freedom to Speak Up Guardian network was still operational and if so, whether the Trust was engaged in this to support developing best practice. The Guardians confirmed that they attended the North West Freedom to Speak Up Guardian network. The Board of Directors resolved to: • Note the contents of the report and the ongoing approach to promoting Freedom to Speak at Liverpool Women's Hospital • Note MIAA's Significant Assurance finding following its audit of the Trust's processes for Speaking Up • take assurance from the Guardians' assessment of the Trust's compliance with NHSE's expectations of Trusts with respect to Freedom to Speak Up
253a	Chair's Report from the Finance, Performance and Business Development Committee The Board considered the Chair's Report from the FPBD Committee meeting held on 31 January 2024. Committee Chair, Louise Martin, noted the following key issues: • The Committee noted the continuing financial pressures facing the Trust and had requested further detail on the 2023/24 Cost Improvement Programme (CIP) delivery and CDC performance at the next scheduled meeting. • The Committee asked for further assurance on the work to reduce overdue appointments. • Whilst the 2024/25 planning guidance had yet to be published, the Committee received a presentation on the approach and current assumptions. A significant risk was noted in relation to the 2024/25 CIP Target expectations of 5%. • The Committee took positive assurance from the Digital Services Update noting that the DigiCare Programme was now in an optimisation phase. The Board of Directors resolved to: • receive and note the Chair's Report from the FPBD Committee meeting held on 31 January 2024.
253b	Chair's Report from the Audit Committee The Board considered the Chair's Report from the Audit Committee meeting held on 25 January 2024. Committee Member, Jackie Bird, noted the following key issues: • In reviewing the Follow up of Internal Audit and External Audit Recommendations, the Committee noted that there had been several re-opened recommendations following review from both MIAA and internal staff due to a need to strengthen the evidence for closure. This

	has been communicated to Executive leads to ensure clear ownership and a potential need for training for review leads had been identified.
	• Three internal audit reports were received:
	  o 2023/24 Risk Management [Core Controls] [High Assurance]
	  o 2023/24 Financial Reporting and Integrity [High Assurance]
	  o 2023/24 Assurance Framework Review [Meets Requirements]
	• The Committee reviewed and approved a five-year extension to the Memorandum of Understanding (MoU) that had existed between MIAA and all providers in Cheshire and Merseyside since 2019 for both internal audit and anti-fraud services.
	
	The Board of Directors resolved to:
	• receive and note the Chair's Report from the Audit Committee meeting held on 25 January 2024.

253c	Chair's Report from the Charitable Funds Committee The Board considered the Chair's Report from the Charitable Funds Committee meeting held on 22 January 2024. Committee Chair, Zia Chaudhry, noted the following key issues: • The Committee considered wider implications of not spending funds on designated fundraising campaigns in a timely manner. The Committee was informed that a new process had been implemented to ensure fundraising campaigns were approved by appropriate governance mechanisms ahead of initiating fundraising publicly. The Committee noted an Executive action to re-consider the escalation process for the fundraising team to raise matters with the Trust. • It was confirmed that a higher percentage basis of distribution of charity monies was transacted on patient welfare initiatives compared to staff welfare initiatives and the Committee was assured that this was being regularly monitored. • The Committee supported the additional focus by the Charity on increasing participation in corporate events within the region and engaging with corporate organisations for donations. The Board of Directors resolved to: • receive and note the Chair's Report from the Charitable Funds Committee meeting held on 22 January 2024.
253d	Finance Performance Review Month 9 2023/24 The Chief Finance Officer presented the Month 9 2023/24 finance performance report which detailed the Trust's financial position as of 31 December 2023. At Month 9 the Trust is reporting a £14.7m deficit, which represented a £2.7m adverse variance to plan year to date (YTD). This was supported by £2.9m of non-recurrent items. The reported forecast outturn at Month 9 was a £23.4m deficit, which represented a £8.0m adverse variance to the full year submitted plan. This position had been reported to Cheshire and Merseyside Integrated Care Board (C&M ICB). This position was in line with the revised variance that was formally approved by the Board on 11 January 2024. It was noted that there was system level focus on productivity and Whole Time Equivalent (WTE) growth and that this would need to be closely monitored at Trust level. It was noted that the expected CIP level for 2024/25 would be 5% and the Chief Finance Officer stated that this would be a significant challenge for the Trust. Whilst the 2024/25 planning guidance had yet to be published, the Trust was utilising assumptions to develop the plan. Indications had been provided that the Trust's Clinical Negligence Scheme for Trusts (CNST) premium would increase for 2024/25 and representations had been made to the ICB regarding how the cost was allocated across the whole system. The timeline for seeking Board approval for the plan was not yet available.

	The Trust ended Month 9 with a cash balance of £6.1m, £2.4m above plan, owing to NHS Resolution funds and payment timings, with an average balance of £11.5m. The Trust received £21.4m from the ICB, with repayments due over the next three months, and secured £21.2m in distressed finance, maintaining cash levels within national thresholds. Daily cash monitoring continued to minimise risk, with the impact on PDC and interest forecasts updated for quarter 4. The Trust has strong controls in place governing the use of temporary staffing. At Month 9, the Trust had a favourable variance of £1.3m against plan. Actual costs of £0.5m YTD were predominantly driven by theatres (vacancy), and maternity (sickness and vacancy). There was no usage of maternity agency spend in Month 8 and 9, due to successful recruitment of substantive midwives. The Trust's capital programme for 2023/24 totals £5.2m. YTD expenditure is £1.5m behind plan, an improvement from the Month 8 position. The Trust was forecasting to meet the plan by year end. In Month 9 the Trust had been informed that £0.3m of the approved Targeted Investment Fund (TIF) investment in ambulatory service infrastructure had been allocated to 2023/24, to enable the Trust to move forward with the project without delay. The total capital programme was therefore now forecast as £5.4m. The Chair queried if the Trust had confirmation of the financial criteria for exiting National Oversight Framework Segment 3. The Chief Finance Officer explained that the standard criteria would require the Trust to not access distressed financing. This was not currently achievable for the Trust without systemic change and therefore there had been agreement to not include this in the criteria. However, the Trust remained under extensive financial scrutiny and therefore it remained important to continue to demonstrate robust grip and control. The Board of Directors: • Noted and received the Month 9 2023/24 Finance Performance Review
253e	Immediate Quality and Safety Actions Investment The Chief Finance Officer explained that several immediate actions were required to improve quality and safety at the Trust, in the context of delivering high risk and tertiary services from an isolated site. The cost impact (£3m in total) resulting from delivery of these actions would fall into the 2024/25 financial year and beyond, and consequently would form part of the annual planning process – the ICB had indicated their awareness of this. However, as the actions required immediate progression, they were presented to the Trust Board for approval ahead of financial and operational plan approval. The Chief Finance Officer confirmed that the ICB had challenged an element of the proposed non-clinical spend. The rationale for each action was outlined to the Board. Non-Executive Director, Louise Martin, sought assurances that the Trust had received confirmation of the ICB's awareness of the proposed additional investment and asked if it would impact the Trust's ability to exit from National Oversight Framework Segment three. It was confirmed that the ICB had not opposed the Trust's proposals during formal meetings and an invitation had been extended to the ICB Chief Finance Officer to visit the Trust to further explain the necessity of the identified actions. The Chief Finance Officer added that the other elements of the exit criteria would not be achieved without the identified investments. The Board of Directors resolved to: • Approve recommendation of investment of £2.9m revenue costs and £0.1m capital (as part of the Trust's overall capital programme) in 2024/25 to support the delivery of the immediate actions in the Trust improvement plan.
254a	Charitable Funds Strategy

	The Chief Finance Officer explained that over the last 12 months, the Fundraising Team had developed a new strategy for the Liverpool Women's Hospital Charity. Development of the strategy had been supported by the strategy team and overseen by the Charitable Funds Committee. The Charitable Funds Committee reviewed the strategy on 22 January 2024, and it was now presented for Trust Board approval. The Board of Directors approved the Charitable Funds Strategy.
254b	Board Assurance Framework This Trust Secretary provided an outline of each BAF risk, the proposed scoring for Quarter 3 2023/24 and any comments made by the Board's Committees during recent meetings. • BAF Risk 1 - 1 – Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities o The Board considered the proposal to reduce the risk score from '16' to '12'. The PPF Committee debated the proposed risk score reduction at its meeting in January 2024. It was highlighted that the risk related to the workforce in its entirety and positive indicators collectively suggested a favourable trajectory for workforce engagement and satisfaction. It was acknowledged that risks persisted, particularly in relation to postgraduate doctors and rota gaps and that continued vigilance and proactive measures would be crucial for sustaining and building upon these improvements throughout the year. It was noted that the scoring would also be related to the approval of staffing elements included within the improvement plan. o The Board agreed to reduce the risk score from '16' to 12'. • BAF Risk 2 - Inability to ensure the on-going sustainability of clinical services and prevent patient harm by maintaining a high standard of care at the current Crown Street site. o The Board agreed to maintain the risk score at '20'. • BAF Risk 3 – Failure to deliver an excellent patient and family experience to all our service users. o The Board agreed to maintain the risk score at '8'. • 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~~ Impact to the safety of patient care services due to the lack of effective Digital Systems adoption, Strategy implementation and Cyber Security breaches influenced through cyber threats, staffing and financial resources. o The Board agreed to change the name of the BAF risk (as above) o The Board debated reducing the BAF risk score from '16' owing to well developed controls and assurances. It was agreed that it would be germane to maintain the score at '16' until the DigiCare optimisation phase was more mature. • BAF Risk 5 - Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term. o It was proposed to increase the risk score from '16' to '20' as the likelihood of the risk had been assessed at Quarter 3 as '5 - almost certain' rather than '4 - likely. At Month 9, the Trust was reporting an adverse variance to plan of £2.7m year to date and a full year adverse variance forecast of £8m. o The Board agreed to increase the risk score to '20'. • 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 o The Board agreed to maintain the risk score at '6'. • BAF Risk 7 - Failure to meet patient waiting time targets. o The Board agreed to maintain the risk score at '16. The Board of Directors • Reviewed the BAF risks and agree on their contents and actions.

	• Agreed the suggested Q3 scores.
255	Review of risk impacts of items discussed The Chair identified the following risk items: • The Trust's current segmentation (3) in the National Oversight Framework • The need to be forward looking regarding the implications of increasing C-Section and Induction of Labour rates on workforce and service delivery. • The increasing total volume of the Trust's patient waiting list. • The impact of systemic racism – presenting as cultural bias and stereotyping - on the provision of safe and effective care. • The Trust's financial position, particularly the CIP challenge in 2024/25.
256	Chair's Log None noted.
257	Any other business & Review of meeting The Board noted its thanks to the Chair for his commitment and leadership shown at the Trust during his eight years in office. Review of meeting No comments noted.
258	Jargon Buster Noted.

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
14 March 2024

Key	Complete	On track	Risks identified but on track	Off Track

Meeting Date	Ref	Agenda Item	Action Point	Owner	Action Deadline	RAG Open/Closed	Comments / Update
8 February 2024	23/24/251c	Mortality and Learning from Deaths Report Quarter 2, 2023/24	For the Trust's 10-year review of maternal deaths report to be updated to include further assurance on the impact of actions taken to date and for the recommendations to explicitly address cultural factors.	Chief Nurse	April 2024	On track	
8 February 2024	23/24/250	Maternity Staffing report 1st July- 31st December 2023	For future midwifery staffing reports to include benchmarking on operative rates including assisted delivery.	Chief Nurse	July 2024	On track	
9 November 2023	23/24/185b	Workforce Performance Report	For future workforce reports to include a more granular understanding of staff morale, break compliance and frequency of shift changes in areas beyond maternity.	Chief People Officer	~~February 2024~~ April 2024	Risks identified	To be considered as part of an overall review of the Integrated Performance Report.
14 September 2023	23/24/134a	Perinatal Quality Surveillance & Safety Dashboard	To provide a briefing to the Board explaining the long-term increase in the C-Section and Induction of Labour rate.	MD	~~November 2023~~ April 2024	Risks identified	Requested that this action be deferred due to current capacity challenges in the obstetric consultant workforce.
14 September 2023	23/24/131	Patient Story	To explore the formalisation of collaboration and joint working with mental health care providers relating to the Trust's menopause service.	MD	April 2024	On track	

Liverpool Women's
NHS Foundation Trust

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	11.01.2024	To receive additional detail regarding the capital expenditure variance attributed to 'other'.	FPBD	February 2024	Closed	Board received additional detail at February 2024 meeting.
Delegated	11.01.2024	To receive data on cancer referral pathways including a breakdown of those admitted following attendance at the Gynaecology Emergency Department.	Quality	February 2024	Closed	Received in the Quality Report (item 23/24/184)
Delegated	11.01.2024	To receive an overview of the Trust's approach for compliance with the Maternity Incentive Scheme Year 6 once the criteria is made available ensuring that this demonstrates adequate ambition.	Quality	March 2024	Open	
Delegated	09.11.2023	To receive an update on the work underway to review the model of care currently provided at the HDU and for this to also consider the evolving health needs of the population.	Quality Committee	February 2024	Closed	Update provided to the Committee in item 23/24/185
Delegated	09.11.2023	To explore the potential opportunities to support the Trust's Volunteer Service.	CFC	~~January 2024~~ April 2024	Open	Discussion underway between Volunteer team and Fundraising to explore potential funding support.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/273*		Date: 14/03/2024	
Report Title	Quality, Operational & Workforce Performance Report			
Prepared by	*Joe Downie, Deputy Chief Operating Officer*			
Presented by	*Gary Price, Chief Operating Officer, Dr Lynn Greenhalgh, Medical Director, Dianne Brown, Chief Nurse & Michelle Turner, Chief People Officer*			
Key Issues / Messages	*Key headlines from the Quality, Operational & Workforce Performance Report, noted within the report.*			
Action required	Approve ☐	Receive X	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.*			
	To receive the report.			
Supporting Executive:	Gary Price, Chief Operating Officer			

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

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *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
Key metrics reviewed and discussed at the Board Committees in February 2024. Information provided in the Executive Summary.			

EXECUTIVE SUMMARY

Performance Report Contents

Metrics Summary

Urgent Care Metrics have continued to perform above the 23/24 national set targets for the 4 hr ED performance (76%) however an increase of 12% in AED attendances in M10 has reduced performance to 85% compared to M9. We expect to achieve 90% end of 23/24. Maternity Assessment Unit triage continues with excellent performance above 95% which is now embedded.

Elective Recovery against the 65+ weeks trajectory has deteriorated due to the impact of Industrial Action and the significant increase in Rapid Access referrals which impacts elective capacity. Committees were appraised of the challenges being seen across the rest of the system to deliver the 65+ position. In line with other providers in Cheshire & Merseyside, the Trust is expecting to have a number of patients above 65+ weeks at the end of March 2024. The Trust is expecting to have a year-end position of 85 patients. 24/25 draft planning guidance outlines the requirement of Trusts to clear 65+ week patients by the end of Q2 24/25. The Trust is aiming to achieve this by the end of Q1 24/25. Discussions took place in committees regarding planning expectations for 2024/25 activity delivery. It was identified that a combination of a productivity stretch within Theatres, transformation of outpatient pathways and additional capacity would be required to reduce the overall size of the patient waiting list and achieve national planning guidance priorities.

Diagnostic wait performance continues to be good and is likely to be sustained to year end with an expectation that the Trust will achieve above 90% in line with system requirements, with the expectation the Trust achieves >95% for M12.

Committees were updated on the significant improvements that have been made to the 28 Day Faster Diagnosis Standard in February, with performance improving by 23% in month to 55% (unvalidated) which takes the Trust just under the trajectory set by NHSE as part of Tier 2 monitoring. Work continues to achieve 60% compliance by the end of March 2024 which would bring the Trust in line with national gynaecology performance. Performance against the 62-day standard is projected to improve following the improvement in 28 Day FDS in Q4, which will be seen from Q1 24/25. Committees were updated on the significant increase seen in referrals with M10 demonstrating highest referrals on record. Committees were updated on 24/25 proposals for Cancer Performance which will be confirmed as part of the planning discussions and updated at future committees.

The Quality Committee in its February meeting received a detailed summary of the actions underway to respond to the deterioration in the positive feedback within the Family and Friends Test from the Gynaecology Emergency Department (GED). Several actions have been completed which has included the relocation of Early pregnancy services from within the Gynaecology Emergency Department. It is anticipated that the improvement demonstrated in month will continue.

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report

February 2024

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	9
KPIs Hit and Miss	13
KPIs No Target	1

KPIs Improving Variation	11
KPIs Concerning Variation	4
KPIs Common Cause Variation	18

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
MAU - Face to face Maternity Triage within 30 Mins	>=	>= 95%	99.59%	P	H
Proportion of patient activity with an ethnicity code	>=	>=96%	97.70%	P	H
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	>=	100%	100.00 %	P	H
Turnover Rate	<=	<= 13%	10.52%	P	L
C-Gull Recruitment	>=		255		H

Good - Celebrate & Understand

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 104 Weeks	<=	0	0	P	
18 Week RTT: Incomplete Pathway > 78 Weeks	<=	0	1		L
Complaints: Number Received	<=	<= 15	5	P	
Diagnostic Tests: 6 Week Wait	>=	>= 99%	96.24%		H
Infection Control: Clostridium Difficile	<=	0	0	P	
Infection Control: MRSA	<=	0	0	P	
NHSE / NHSI Safety Alerts Outstanding	<=	0	0	P	
Serious Untoward Incidents: Number of SUI's with actions outstanding	<=	0	0	P	
Serious Untoward Incidents: Open	<=	<5	2		L
Venous Thromboembolism (VTE)	>=	>= 95%	95.79%		H

Average - Investigate & Understand

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 52 Weeks	<=	0	1581		
18 Week RTT: Incomplete Pathway > 65 Weeks	<=	0	254		
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	>=	>= 95%	85.03%		
Cancer: 31 Day decision to treat to treatment	>=	>=96%	76.32%		
Cancer: 62 Day referral to Treatment	>=	>=85%	15.22%		
Friends & Family Test: In-patient/Daycase % positive	>=	95%	92.45%		
Number of Open Patient Safety Incident Investigations	<=	8	19		
Total Number of Patient Safety Incident Investigations (Rolling)	<=	30	19		

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
Friends & Family Test: Maternity % positive	>=	95%	88.14%	F	
Mandatory Training	>=	>= 95%	92.83%	F	H
Mandatory Training (Clinical)	>=	>= 95%	88.22%	F	H
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	>=	>= 80%	34.07%	F	
Serious Untoward Incidents: New (Rolling per year)	<=	24 /year	29	F	
Sickness Absence Rate	<=	<= 4.5%	7.18%	F	
Never Events	<=	0	2	?	H

Very Concerning - Investigate & Take Action

KPI	Target < or >	Target	P	A	V
Cancer: 28 Day Faster Diagnosis	>=	>= 75%	34.87%	F	L
Friends & Family Test: A&E % positive	>=	95%	67.95%	F	L
Overall size of active patient waiting list	<=	<= 16500	18724	F	H

Investigate & Understand

KPI	Target < or >	Target	P	A	V

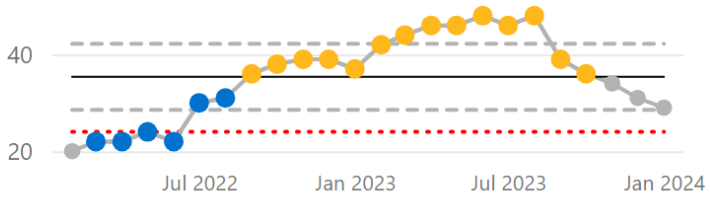
Section 3: To deliver **Safe** Services

KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Infection Control: Clostridium Difficile	Good	January 2024	0	<=	0			
Infection Control: MRSA	Good	January 2024	0	<=	0			
MAU - Face to face Maternity Triage within 30 Mins	Excellent	January 2024	>= 95%	>=	99.59%			
Never Events	Concerning	January 2024	0	<=	2			
NHSE / NHSI Safety Alerts Outstanding	Good	January 2024	0	<=	0			
Number of Open Patient Safety Incident Investigations	Average	January 2024	8	<=	19			
Serious Untoward Incidents: New (Rolling per year)	Concerning	January 2024	24 /year	<=	29			
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	Excellent	August 2023	100%	>=	100.00%			
Serious Untoward Incidents: Number of SUI's with actions outstanding	Good	January 2024	0	<=	0			
Serious Untoward Incidents: Open	Good	January 2024	<5	<=	2			
Total Number of Patient Safety Incident Investigations (Rolling)	Average	January 2024	30	<=	19			
Venous Thromboembolism (VTE)	Good	January 2024	>= 95%	>=	95.79%			

To deliver **Safe** Services - Exceptions

Serious Untoward Incidents: New - Chief Nurse

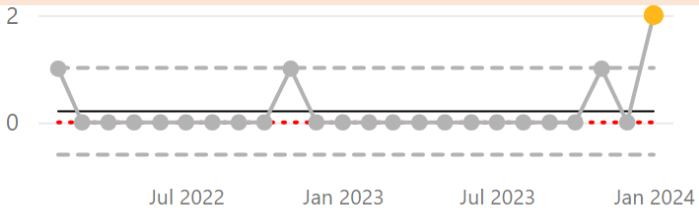
Assurance Category	Concerning
Date	January 2024
Target	24 /year
Target < or >	<=
Performance	29
Assurance	F
Variation	



The Trust Launched PSIRF in September 23 which has made the New SUI's a now redundant KPI, However the SUI KPI is being kept open until all ongoing SUI's (2 remaining) have been submitted to the ICB, estimated early 2024

Never Events - Medical Director

Assurance Category	Concerning
Date	January 2024
Target	0
Target < or >	<=
Performance	2
Assurance	?
Variation	H



The Trust have declared 2x Never Events.
One within Maternity involving a retained catheter tubing and another in CSS involving a retained swab, Both incidents have been reported to the ICB and investigations are underway within the services.

To deliver Safe services - Safer Staffing

January 2024					
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	84.68%	69.89%	146.77%	88.71%	*January staffing fill rate on days is reflective of the increase this month of both long- and short-term sickness, alongside maternity leave. Safe staffing has been maintained due to the low bed occupancy of 42.08% in the inpatient area and the ability to flexibly rotate staff from the HDU which is based on the inpatient ward when there are no patients. The bed occupancy on HDU was recorded as 73%. The fill rate 146.77% RN on nights remains above the 100% as this is reflective of senior RN cover rotating between GED and the inpatient area.
Induction & Delivery Suites	80.65%	65.59%	76.77%	70.97%	*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. Midwives who continued working in the hybrid model are rostered for one Intrapartum shift per week and contribute to the overall establishment for Delivery Suite. Approval for this way of working has been gained from Quality Committee to support the workforce developing and maintaining skills until review in Q3 24/25 Vacant shifts are requested to be filled with bank and agency up to planned staffing numbers.
Maternity & Jeffcoate	80.27%	96.77%	87.10%	97.58%	*/**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 at earliest opportunity
MLU	89.52%	79.03%	77.42%	90.32%	*/**There were no episodes of closure during the month, occupancy was reduced which allowed the safe delivery of Intrapartum and early postnatal care. Due to high acuity and high numbers of IOLs in Delivery Suite, on occasions staff were redeployed meeting the needs of complexities of women using our service.
Neonates (ExTC)	91.34%	79.03%	89.81%	85.48%	Fill rates reflect the neonatal unit occupancy in January. Total occupancy over the month was 68%. A reduction in total occupancy of 12.4%. Occupancy in ITU areas reduced to 72% % from 88.2% in November. */**The number of and acuity of the babies on the unit is reflected in the RN and care staff fill rates throughout the month. Safe staffing was maintained and CHPPD (Care Hours Per Patient Day) are as would be expected.
Transitional Care	41.94%	119.35%	67.74%	87.10%	Fill rates reflect the transitional care occupancy in January. Most of the care is provided by care staff who are clinical support workers in this area thus higher numbers of care staff than registered staff. */**TC occupancy remained low at 52% therefore some shifts only required 1 member of staff which was either a clinical support worker or an RN, hence the increased percentage of fill rates in care staff. Safe staffing was maintained and CHPPD (Care Hours Per Patient Day) are as would be expected.

To deliver Safe services - Safer Staffing

Gynaecology: January Fill Rate

Fill rate – The underfilled staffing rate for January on the day shift reflects the Long-term sickness and Maternity Leave. Safe staffing has been maintained due to the low bed occupancy in the inpatient ward and the High Dependency Unit (HDU). The low bed occupancy allowed the manager to rotate staff from the HDU to support the inpatient area. The high fill rate 146.77% RN on nights remains above the 100% as this is reflective of senior RN cover rotating between GED and the inpatient area to provide senior clinical leadership and to maintain safety out of hours.

Attendance/ Absence – – sickness and absence for the month of January was recorded as 10.04%, a reduction from December which was recorded 12%. Long term sickness accounts for 69.87% which has decreased compared to the previous month recorded as 83.20%, conversely short-term sickness has increased to 30.13%. Maternity leave in January accounted for 1.61% WTE staff.

Red Flags – No reg flags reported in January.

Bed Occupancy –Bed occupancy for the Gynaecology inpatient unit is recorded as 42.08%, with the High Dependency Unit bed occupancy recorded as 73%.

CHPPD – For the month of January the CHPPD overall was reported to be 7.9, an increase compared to the previous month, which was 7.5. The split between Registered and unregistered care staff was 4.9 for Registered Nurse staff and 3.0 for Health Care Assistant.

Neonates: January Fill Rate

Fill rate – Occupancy reduced across the acute area of the neonatal unit in January with occupancy in all areas being below 80%. Total occupancy for January was 68%. Safe staffing has been maintained and fill rates are reflective of acuity and occupancy. There were no patients transferred out of LWH to deliver elsewhere due to capacity, however there was a request for transfer of a 31+4 week lady from within the local network which was refused by the consultant, due to high acuity of ITU patients with the unit on red status. The referring maternity unit advised that this patient should be transferred to deliver at a level 2 unit, the appropriate escalation and process was followed. There were 3 incidents reported of a delay in repatriation of a baby to their local neonatal unit, which were escalated appropriately to the Northwest Neonatal ODN.

Attendance/ Absence – Sickness was reported at 7.47% in January, which is an increase from the previous month, the top reason for sickness in January was cough, cold and flu. Long term sickness has reduced from 59.08% and all sickness is being managed in line with the attendance management policy. In cases where staff are experiencing stress, anxiety, and depression, they have been signposted to LWH staff support and are being contacted regularly by team leaders.

Vacancies – Turnover remained static in January at 12.69% with 2 leavers in January. There were 6.45 band 6 vacancies, and 22 band 5 vacancies on the neonatal unit in January, the majority of which are from staff being promoted to newly created band 6 and 7 posts for the Liverpool Neonatal Partnership (total of 18 posts with 15 nurses from LWH being successfully appointed). Vacancies have been approved and advertised on Trac. There are also 4 band 5 vacancies on Transitional care and 2.9 band 2 support workers which have been approved at vacancy panel and out to advert in to be interviewed in late February.

There have been ongoing challenges recruiting to seven band 8a vacant ANNP posts therefore the advert was withdrawn and a plan to move to hybrid clinical fellow/ ANNP posts made. Interviews for these posts took place in December 2023. Three applicants were successful and will commence in July 2024. The remaining 8a vacancy has been converted to 8b posts and have been approved at vacancy panel in early February.

Red Flags – There are no Neonatal Nursing red Flags reportable.

Bed Occupancy –The total unit occupancy reduced below the expected 80% at 68% in January, with all areas being below expected in occupancy in January. Occupancy rates for January per area were: ITU 72%, HDU 79.6%, LDU 58.5% and TC 52%.

CHPPD – Within the critical care areas the care hours provided in January are as would be expected for babies being nursed in ITU with 14.5 care hours per patient day (CHPPD) overall. The breakdown shows higher hours of registered nurse care and lower non-registered care. This split of 13.2 hrs of registered nurses and 1.3 healthcare support workers, and as expected considering that most of these babies need care by a nurse qualified in speciality.

In Transitional care, the care hours per patient day provided in January shows higher hours of care provided by non-registered carers than registered nurses with total care hours per patient day of 8.7 hours, the split is 5.7 care hours provided by the care staff and 3.0 hours provided by registered nurses which is reflective of the care model in transitional care.

To deliver Safe services - Safer Staffing

Maternity: January Fill Rate

Fill-rate – Where planned staffing requirements could not be met due to unavailability, all vacant shifts were escalated to NHSP to attempt to cover with 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, with daily reporting into the LMNS and consideration of mutual aid to other providers if able to support.

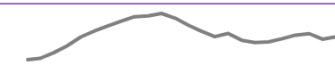
Attendance/ Absence – Maternity continues to report levels of sickness above the Trust threshold of 4.5% which is included in the headroom, within its Midwifery and support staff group. Sickness in month decreased to 7.91%, from December and at the same point last year, sickness was 11.59%. 47% was STS with the leading cause being cough/cold/flu, which due to short notice reporting provided challenges in fill with temporary staffing solutions for both registered and care staff. Maternity LTS is 53% which represents 20 cases, of which 5 have resolutions scheduled for February. Divisional LTS management meeting led by HR and DHoM also take place with the Managers/ Matrons, with escalation meetings for short term absence patterns are also ongoing as required. Robust management practice continues, and assurance can be provided that where there is LTS sickness, cases are managed in line with policy with the majority of current LTS cases within the 0–3-month timescale. Maternity leave equates to 17.92 wte (21 headcount) all of whom are within the Registered Midwives staffing group and is reflective of a changing age profile of the workforce.

Vacancies – The Maternity Service has recruited into all current and projected vacancies with a cohort of NQ Midwives receiving NMC PIN and commencing in Month 11 to a period of induction and orientation. A proactive approach to recruitment continues with Open Day being planned in March to showcase services and employment opportunities at LWH for NQM and Experienced Midwives.

Red Flags – During January 9 Midwifery Red Flags were identified which continues to be a significant decrease. 1:1 Care in Labour was maintained at 100%. Reported red flags include 4 delays of >12hrs for ongoing IOL (regional red flag), which affected patient experience, and 5 instances of >30mins between presentation and triage. A full analysis was completed by the MAU Matron and 4 of these occurred simultaneously due to a significant spike in attendances. The department had 300 attendances more than January 2023 and managed to maintain triage within 15mins at 95.16% and 99.59% of women were seen within 30mins of presentation.

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. 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. 100% of women received 1:1 care by a Midwife. 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 January which is consistent with the previous months. The BirthRate Plus Ward Based Acuity Tool has been launched on 29 January which provides real time evidence-based data to support staffing deployment decisions on Maternity Ward. Analysis from the Implementation will focus in February on the data reliability to have confidence in the assurance of this as an evidence-based tool to aid decisions.

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

KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Cancer: 62 Day referral to Treatment	Average	December 2023	>=85%	>=	15.22%			
18 Week RTT: Incomplete Pathway > 104 Weeks	Good	January 2024	0	<=	0			
Cancer: 31 Day decision to treat to treatment	Average	December 2023	>=96%	>=	76.32%			
Cancer: 28 Day Faster Diagnosis	Very Concerning	December 2023	>= 75%	>=	34.87%			
Diagnostic Tests: 6 Week Wait	Good	January 2024	>= 99%	>=	96.24%			
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Average	January 2024	>= 95%	>=	85.03%			
Proportion of patient activity with an ethnicity code	Excellent	January 2024	>=96%	>=	97.70%			
18 Week RTT: Incomplete Pathway > 78 Weeks	Good	January 2024	0	<=	1			
18 Week RTT: Incomplete Pathway > 65 Weeks	Average	January 2024	0	<=	254			
18 Week RTT: Incomplete Pathway > 52 Weeks	Average	January 2024	0	<=	1581			
Overall size of active patient waiting list	Very Concerning	January 2024	<= 16500	<=	18724			

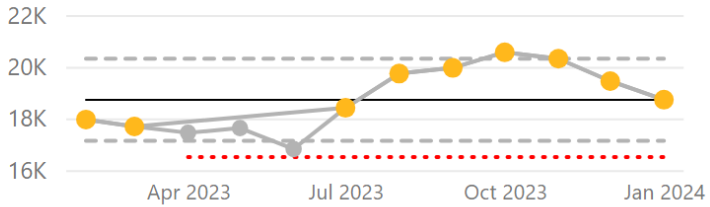
*Following KPI's have nationally set targets as part of Operational Planning Guidance for 23/24:

18 Week RTT: Incomplete Pathway > 52 Weeks (KPI002T)
18 Week RTT: Incomplete Pathway > 65 Weeks (KPI498)
Diagnostic Tests: 6 Week Wait (KPI204)
Cancer: 28 Day Faster Diagnosis (KPI359)
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge (KPI008)

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

Overall size of active patient waiting list - Chief Operating Officer

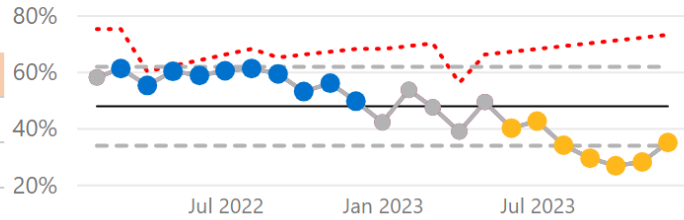
Assurance Category	Very Concerning
Date	January 2024
Target	<= 16500
Target < or >	<=
Performance	18724
Assurance	F
Variation	H



Overall size of waiting list has reduced following additional activity and validation of waiting lists. Continued work required to bring down further. Position will likely increase following periods of Industrial Action. Work is ongoing to bring the total number to pre-Digi Care go live figures. A significant amount of activity is required to reduce the patient waiting list to pre- COVID levels. Annual planning discussions for 24/25 is aiming to incorporate additional activity to address this

Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

Assurance Category	Very Concerning
Date	December 2023
Target	>= 75%
Target < or >	>=
Performance	34.87%
Assurance	F
Variation	L



Number of hysteroscopy procedures performed has doubled since July. Weekly tracker of activity being monitored. All routine activity has been converted to Rapid Access to support the position. Impact of actions is demonstrated in KPI467.
Performance is now starting to improve and the division remain on the agreed trajectory.

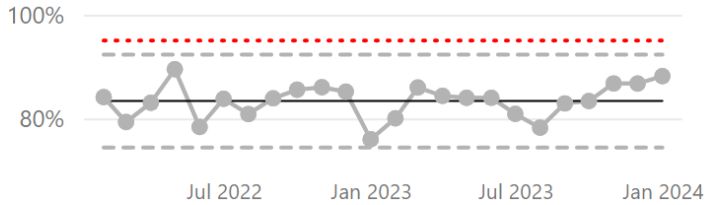
Section 5: To deliver the best possible **Experience** for patients and staff

KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
C-Gull Recruitment	Excellent	January 2024		>=	255		H	
Complaints: Number Received	Good	January 2024	<= 15	<=	5	P		
Friends & Family Test: In-patient/Daycase % positive	Average	January 2024	95%	>=	92.45%	?		
Friends & Family Test: Maternity % positive	Concerning	January 2024	95%	>=	88.14%	F		
Friends & Family Test: A&E % positive	Very Concerning	January 2024	95%	>=	67.95%	F	L	

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

Friends & Family Test: Maternity % positive - Chief Nurse

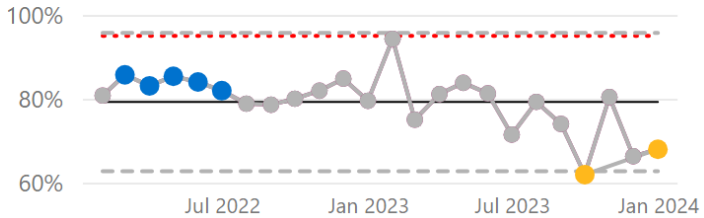
Assurance Category	Concerning
Date	January 2024
Target	95%
Target < or >	>=
Performance	88.14%
Assurance	
Variation	



Number of FFT responses remain low in maternity services. Regional NHSE midwifery team asked when FFT process would be due for review.

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

Assurance Category	Very Concerning
Date	January 2024
Target	95%
Target < or >	>=
Performance	67.95%
Assurance	
Variation	



Themes relating to waiting in GED to see a Dr, as well as access to ultrasound continue to contribute to the concerning levels of positive patient feedback for the department, in an attempt to see this improve work is ongoing to develop the EPAU to a standard where early pregnancy activity can be sceduled for patients outside of the emergency department, potentially freeing up capacity in the department. In adition the CD is reviewing medical leadership / staffing model

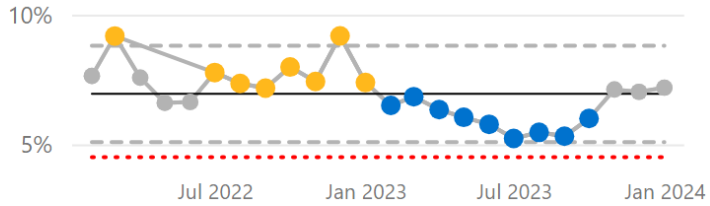
Section 6: To develop a well led, capable, motivated and entrepreneurial **Workforce**

KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Turnover Rate	Excellent	January 2024	<= 13%	<=	10.52%	P	L	
Mandatory Training	Concerning	January 2024	>= 95%	>=	92.83%	F	H	
Mandatory Training (Clinical)	Concerning	January 2024	>= 95%	>=	88.22%	F	H	
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Concerning	January 2024	>= 80%	>=	34.07%	F		
Sickness Absence Rate	Concerning	January 2024	<= 4.5%	<=	7.18%	F		

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

Sickness - Chief People Officer

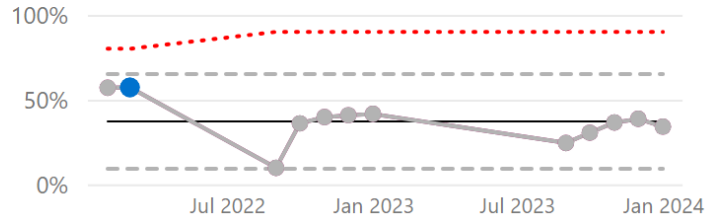
Assurance Category	Concerning
Date	January 2024
Target	<= 4.5%
Target < or >	<=
Performance	7.18%
Assurance	
Variation	



All areas saw a decrease in Long term sickness. Again Cold, Cough, Flu – Influenza is the new main reason for absence followed by Anxiety/stress and Gastrointestinal problems. Sickness absence is reviewed on a weekly basis by divisional management teams with a particular scrutiny of return-to-work meetings which are seeing an increase in compliance. All divisions are now producing monthly infographics to visualise for staff the levels and impact of sickness absence.

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

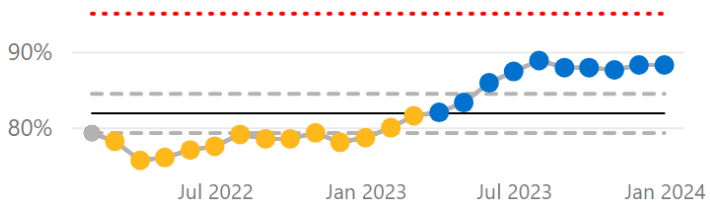
Assurance Category	Concerning
Date	January 2024
Target	>= 80%
Target < or >	>=
Performance	34.07%
Assurance	
Variation	



As at 12 February compliance for Flu vaccines was reported as 40.6% and Covid 26.4%. Vaccinations are still taking place in areas and staff can request a vaccines by emailing covid vaccines email address

Mandatory Training (Clinical) - Chief People Officer

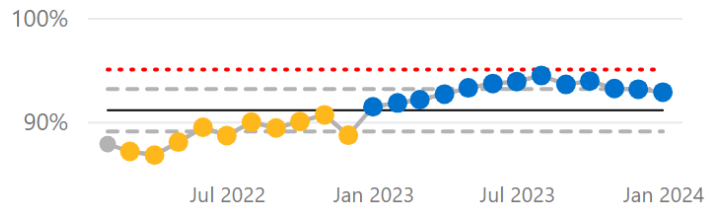
Assurance Category	Concerning
Date	January 2024
Target	>= 95%
Target < or >	>=
Performance	88.22%
Assurance	
Variation	



Compliance remained at 88.22%. Both Gynae (1.37%) and CSS (1.51%) saw decreases, while Corporate (2.70%) and Family Health (0.46%) saw increases. From the large areas, Gynae saw a decrease of 1.55%, while the other two areas Maternity (0.53%) and Neonates (0.24%) saw increases. Compliance continues to be reviewed on a weekly basis by divisional management teams. Validation sessions have just taken place and will impact on CMT figures until staff can update their training.

Mandatory Training - Chief People Officer

Assurance Category	Concerning
Date	January 2024
Target	>= 95%
Target < or >	>=
Performance	92.83%
Assurance	
Variation	



Compliance decreased by 0.28% down to 92.83%. 4 divisions have decreased in January, CSS by (0.62%), Corporate by (0.34%), Gynae by (0.61%), Family Health by (0.26%) All are still above 90%. Neonates saw an increase of 1.10% while the following decreased Gynae by 1.07% and Maternity 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

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	
Cancer: 28 Day Faster Diagnosis	Effective	5	Y	Y	Y			Y	Y	
Complaints: Number Received	Experience	5	Y		Y					
Diagnostic Tests: 6 Week Wait	Effective	5	Y	Y	Y			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	Workforce	5	Y		Y	Y				
Mandatory Training (Clinical)	Workforce	5	Y		Y	Y				
MAU - Arrival to Triage within 30 Mins	Safety	5	Y	Y	Y		Y			Y
Never Events	Safety	5	Y		Y					
NHSE / NHSI Safety Alerts Outstanding	Safety	5	Y		Y		Y			Y
Overall size of active patient 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					
Cancer: 31 Day decision to treat to treatment	Effective		Y	Y	Y				Y	
Cancer: 62 Day referral to Treatment	Effective		Y	Y	Y				Y	
C-Gull Recruitment	Experience		Y		Y		Y			
Number of Open Patient Safety Incident Investigations	Safety		Y		Y					
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Workforce		Y	Y	Y	Y				
Total Number of Patient Safety Incident Investigations (Rolling)	Safety		Y		Y					

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.
(none)	**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.
(none)				**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

Appendix 3 – Perinatal Dashboard

INTRODUCTION

The Perinatal Quality Surveillance & Safety dashboard provides an overview of quality and safety performance in maternity and neonatal services at LWH to give assurance to the Trust Board and to highlight areas of concern which require further scrutiny.

MAIN BODY

The requirement for Trust Boards to implement a locally agreed dashboard, is a required standard of the Maternity Incentive Scheme (MIS). 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 Perinatal Quality Surveillance & Safety dashboard is presented monthly at the Maternity Risk meeting, the Neonatal Operational Management meeting, and at Family Health Divisional Board, following which it is cascaded by the maternity safety champions to staff via e-mail, closed social media groups and clinical departmental meetings.

	Metric	Standard/ National Standard	Dec-23	Jan-24
Perinatal	1:1 Care in Labour	100% CNST	100.00%	100.00%
	Stillbirth Number >24 weeks (Adjusted)	Actual Number	3	2
	Stillbirth Adjusted % per 1,000 Birth		1.65	1.72%
	Apgar <7 @ 5 Minutes (>37wks)	<1.6%	1.30%	1.53%
	Term Admission to NICU	<6%	5.11%	4.66%
	Women in reciept of CoC	100%	18.80%	16.96%
	BAME in reciept of CoC	100%	39.60%	32.22%
	Social Depravation of CoC	No standard	20.62%	18.69%
	Provision of Epidural in Labour	No standard	17.69%	19.42%
	Coroner Reg 28 Made to Trust	Actual Number	0	0
	MNSI Referals Accepted	Actual Number	1	0
Workforce	MNSI Completed Reports Returned	Actual Number	0	2
	Supernumary Shift Leader	100% CNST	100%	100%
	Midwifery Sickness	% of Workforce <=5%	8.61%	7.91%
	Midwife to Birth Ratio (in Post)	<=28	20	19
	Midwifery Vacancy	% of Workforce	2.20%	0.00%
Feedback	Rostered Cons Hrs on DS	>60	106.5	106.5
	Number of Formal Complaints	Actual Number	1	1
	Number of Maternity Incidents over 30 days	Actual Number	26	26
	Number of PALS/PALS +	Actual Number	43	43

Perinatal Quality Surveillance & Safety narrative

Midwifery Red Flags:	9 red flags were reported during January 2024, a reduction of 11 from the previous month. The most reported red flag incident in month related to a delay of 30 minutes or more between presentation and triage, with 5 incidents reported. Four incidents were regarding delays of over 12 hours during ongoing induction of labour. Of note, in November 2023 the MRF flag for reporting delays in the ongoing process of Induction of Labour was amended from >4hs to >12hs in line with other Maternity providers in Cheshire and Mersey. Total of 305 Midwifery Red Flags reported in 2023 compared to 427 in 2022.
MNSI Referral Details:	There were no cases reported to MNSI in January 2024. There are five cases currently being investigated by MNSI. These are all on track and progressing within the timeframes set out by MNSI. One has been received in draft and will be reviewed and returned as per process.
Maternity Serious Safety Incidents	There were no PSIIs declared during January 2024 across maternity. There are 26 incidents that remain open 30 days after they were input onto the system, all are in the process of being investigated. All incidents are reviewed each morning (Monday to Friday) at the Daily Huddle and issues for escalation are highlighted. There are two staff members currently providing focused support for reviewing and investigating the incidents within the Web Holding File and the Governance Team continue to provide support and guidance for any member of staff that needs assistance in updating or closing incidents.
Perinatal Mortality.	Number of Neonatal Perinatal Deaths in January 2024: Number of Stillbirth Perinatal Deaths in January 2024**: 1** All cases have been reported to MBRRACE and parental support continues to be provided by the Honeysuckle Team. The process for reporting PMRT cases has been reviewed and strengthened, particularly in Neonatal, to ensure all timeframes are met and reviews are held in a timely manner.
FHD Risk Register.	Risks are reported and monitored at Family Health Divisional Board and at the LMP Operational Programme Board, to demonstrate mitigation and risks remain on track. There are currently five risks scoring at 15 or above, as detailed below:

ID	Description	Current Score	Target Score	Progress
2088 Neo	Lack of onsite specialist staff and services, no co-location of neonatal and paediatric services	20	10	On track
2743 Mat	In ability to comply with National guidance for the management of women with pre-existing and pregnancy related diabetes leading to poor outcomes and failure of implementation of SBL3	16	9	On track
2746 Mat	Lack of DSN due to short and long term sickness leading to no DSN support for the women with diabetes in pregnancy - failure to comply with local and national guidelines	16	4	On track
2430 Neo	Network outlier for pre-term mortality - rate is higher than the national average	16	6	On track
2667 Neo	Delay in access to timely radiography out of hours and impact on delays in diagnosis and treatment of baby	15	10	On track

Family Health Division have a total of 46 open risks on the Risk Register - Maternity services have 39 Risks and Neonatal have 7.
All Risk Status are in date.
All Risk descriptions have been updated to reflect condition, cause, and consequence descriptors. Focus will be on reviewing risks that have no outstanding actions to determine if it needs to remain open or can be incorporated into BAU.
Governance team provide ongoing support and risk register management training for all staff across the Division.

Family Health Safety Champions.

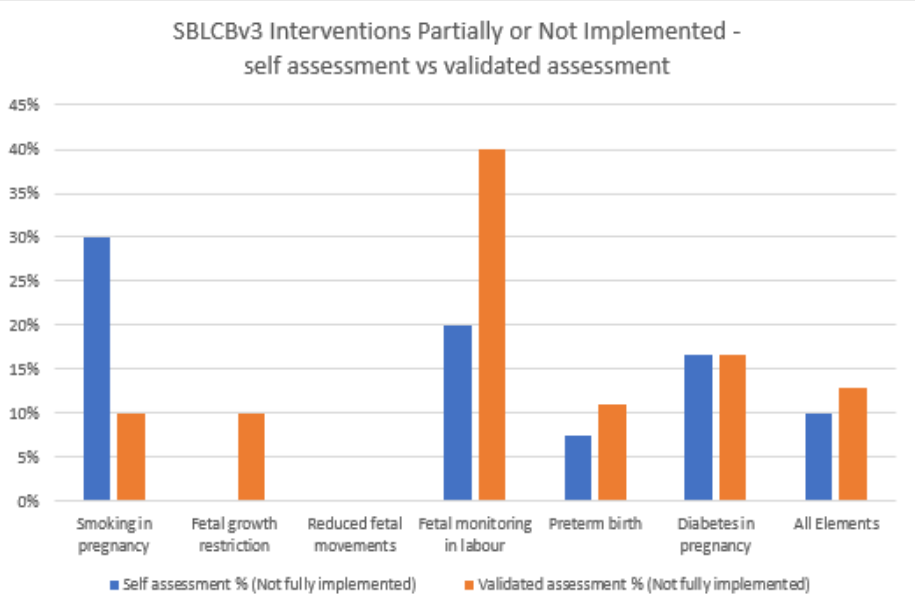
Safety Champions Walkaround January 2024 - Area Visited: Maternity Base.

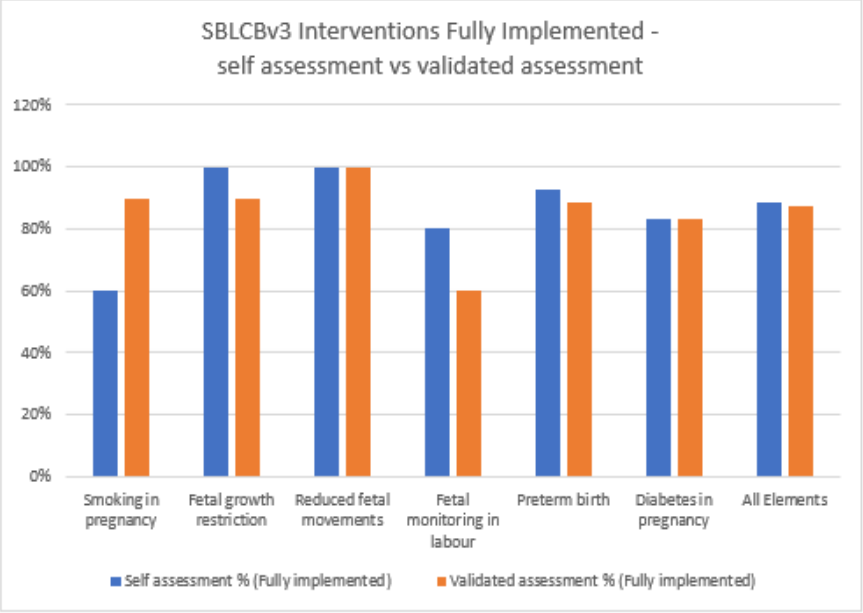
Issue Highlighted:
Digital Equipment (Computers, Printers, Blood Sample Labelling Machines) not always available, equipment and computers not always ready for use, some waiting for repair. Not all computers are connected to a printer, some systems not available on all computers.
Action:
Digital diagnostic completed on Mat Base on the 15.1.2024. New equipment including new laptops to be ordered for ward areas. Computer at every bedside requested. Mobile phlebotomy cart/mobile phone in every room. Increase of printer provision, with improved connectivity.
Issue Highlighted:
Midwifery staff keen to use knowledge and education gained in university to commence EON examinations at start of employment, rather than waiting for a protracted amount of time and further VIVA examination.
Action:
Highlighted to Deputy Head of Midwifery, Consultant Neonatologist and Neonatal Safety Champion. Neonatal Safety Champion, Dr S Babarao is further investigating with Preceptorship Team, Screening Team, and Neonatal Education Consultant Lead. Further feedback to follow.
after the review.

	Issue Highlighted: K2 System doesn't currently have a gestational specific chart for plotting results of SBRs/Bilirubin Results. Charts currently paper based and not always available for ward (Linked to issues with printer availability as they are printed from Badger Net). **Action:** Escalated to K2 Digital MW and possibility for integration into Version 6 of K2. Work ongoing got scope out feasibility as LWH use bespoke charts rather than the nationally recognised charts. K2 System developers are aware and ongoing discussion and development plans underway.
MNVP Feedback.	A formal evaluation of the overnight visiting trial on Mat Base has concluded recommending that 24hr visiting continue as per feedback from service users. Positive feedback was obtained from a listening event with families at the NEST (Non-English-speaking antenatal clinic). 15 steps undertaken on the Neonatal Unit which was positively evaluated by service users.
Midwifery Sickness	Sickness absence is a continuing challenge in midwifery; however, improvements are being seen in the overall sickness rate which reduced to 7.91% throughout January 2024. Weighting in the service for January 2024 is towards LTS cases at 53% in Maternity. This equates to 20 cases, five of which have dates for resolution throughout February and March 2024. Divisional sickness reviews continue as does the emphasis on completing return to work interviews.
Saving Babies Lives	- Quarterly SBL improvement discussions continue with the LMNS with the most recent held on 4th March 2024. the SBLCBV3 Lead attended this Q3 Feedback meeting where an up-to-date initial validated position was provided. - As can be seen in the graphic below, the Division is very pleased to report a continued improvement journey with embedding SBLCBV3 with positive progress made, especially in relation to Element 1 – Smoking in Pregnancy. The introduction of the inhouse tobacco dependency service has progressed this element to 90% compliance. - There are several continued spot check audit requirements that provide assurance and evidence of interventions within each of the elements- of which are completed by subject matter experts within the Division. However, as natural variance in some of these clinical audits and training compliance is seen, there may always be some element of non-compliance. This is not a reflection of non-committal to the implementation of the interventions – more a recognised reflection of variance in some clinical care provision. - A further LMNS validated position will be given at the end of March 2024, as there is now, until 11th March 2024, more opportunity to upload further evidence to support this positive position. It is anticipated that the overall fully implemented elements will continue an upwards trajectory. This finalised position will be reported on in the April 2024 Perinatal Quality Surveillance and Safety Dashboard Paper. - There is no requirement for the SBLCV3 to be 100% compliant in terms of the MIS scheme but Trusts must be able to demonstrate their best endeavours towards implementing all 6 elements of the bundle. **Saving Babies Lives Care Bundle – <u>Initial</u> March 2024 Position (further update to be given at end of March 2024)**

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	90%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Partially implemented	90%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	60%	CNST Met
Element 5	Preterm birth	Partially implemented	93%	Partially implemented	89%	CNST Met
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%	CNST Met
All Elements	TOTAL	Partially implemented	89%	Partially implemented	87%	CNST Met





Conclusion

The Family Health Division requests that the Trust Board receive this paper and seek assurance that perinatal quality surveillance and 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.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**23/24/274**		**Date: 14/03/2024**	
Report Title	**Finance Performance 2023/24 and Financial Planning 2024/25**			
Prepared by	***Jen Huyton, Deputy Chief Finance Officer / Deputy Director of Strategy***			
Presented by	***Jenny Hannon, Chief Finance Officer / Executive Director of Strategy and Partnerships***			
Key Issues / Messages	***To receive the Month 10 financial position and 2024/25 planning update.***			
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 receive the Month 10 Financial Position and the update on 2024/25 planning. ***The Board is asked to approve the proposed soft facilities management contract extension in accordance with Standing Financial Instructions.***			
Supporting Executive:	***Jenny Hannon, Chief Finance Officer / Executive Director of Strategy and Partnerships***			

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

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Finance, Performance and Business Development Committee	28/02/24	CFO	The financial position was received. The proposed plan for 2024/25 was discussed and noted.

EXECUTIVE SUMMARY

Financial Position

The Trust has a challenging financial plan for 2023/24 of £15.5m deficit. At Month 10 the Trust reported a £17.2m deficit which represents a £4.0m adverse variance to plan year to date (YTD). This position is supported by £2.6m of non-recurrent items. The forecast outturn reported at Month 10 was a £23.4m deficit, which represents an £8.0m adverse variance to plan. This adverse forecast variance was submitted to the Cheshire and Merseyside ICB as part of a review of delivery of the full year plan in November 2023. The Trust is on target to deliver the revised forecast outturn.

Cost Improvement Programme (CIP) delivery is behind the YTD target by £1.3m and is forecast to be £1.0m behind the full year target by Month 12, with £2.6m of the forecast delivered non-recurrently.

The cash balance was £7.0m at the end of Month 10. This includes £6.0m of national cash support received with a further £14.1m due in February and March.

2024/25 Plan

The 2024/25 plan is currently set at a deficit of £34.6m. The plan assumes delivery of national activity and access targets, and delivery of £3.0m of Cost Improvement. The capital plan remains capped at £5.0m as per previous years, plus additional Public Dividend Capital (PDC) funding approved by NHS England to expand the Trust's ambulatory capacity during 2024/25.

Soft Facilities Management (FM) Contract

The Trust's soft FM contract expires in June 2024. It is proposed to extend the current contract to 30 September 2025 (total value £2.6m), with an option for a further 9 months to 30 June 2026, via a direct award.

Recommendations

The Board is asked to receive the Month 10 position and the update on the 2024/25 planning position.

The Board is asked to approve the contract award to the incumbent provider, as described above.

MAIN REPORT

1. Summary Financial Position

	Plan	Actual	Variance	RAG	R	A	G
Surplus/(Deficit) YTD	-£13.2m	-£17.2m	-£4.0m	6	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast M10	-£15.5m	-£23.4m	-£8.0m	1	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	1	*4*	*3*	*2+*
Cash	£2.9m	£7.0m	£4.1m	5	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£6.5m	£5.2m	-£1.3m	5	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£6.5m	£3.1m	-£3.4m	6	*>10% off plan*	*Plan*	*Plan or better*
Aligned Payment Incentive	102%	97%	-5%	6	*>10% off plan*	*<10% off plan - plan*	*Plan or better*
Non-Recurrent Items YTD	£0.9m	£2.6m	£1.7m	6	*>£0*		*<£0*
Capital Spend YTD	£4.8m	£3.3m	-£1.6m	5	*>10% off plan*	*Plan*	*Plan or better*

At Month 10 the Trust is reporting a £17.2m deficit, which represents a £4.0m adverse variance to plan year to date (YTD). This is supported by £2.6m of non-recurrent items, of which £1.7m is unplanned. The reported forecast outturn at Month 10 was £23.4m deficit, which represents a £8.0m adverse variance to the full year submitted plan. This is in line with the Trust's revised forecast outturn submitted in November and formally approved by the Trust Board on 11 January 2024. This position includes the impact of industrial action which took place in December and January (£0.8m) and has been reported to Cheshire and Merseyside Integrated Care Board (C&M ICB).

The Trust is currently in NHS Oversight Framework segment 3 (NOF3) and has jointly developed exit criteria with the ICB.

2. Financial Recovery

Underlying Position
As noted above, the YTD position is supported by £2.6m of non-recurrent items, of which £1.7m was unplanned. The adjusted position in Month 10 (following removal of key non-recurrent items) is a deficit of £19.7m.

The key drivers of the underlying year to date position are consistent with that reported in previous months, and are summarised below:

Drivers of Underlying Position	£m
Drivers of Position:	
Undelivered CIP (non-pay and income CIP targets)	- 1.3
Industrial action costs and income impact to Month 10	- 1.9
API underperformance (excluding industrial action)	- 0.5
Impact of pay award	- 0.3
Inability to unwind prior year pay investment	- 1.8
Investment in maternity post CQC inspection	- 0.6
Excess inflation and other non-pay pressures	- 0.3
Cost of distressed finance	- 0.2
Other operational pressures	- 0.9
Mitigation:	
Anaesthetic consultant vacancies	0.8
Interest receivable above plan	0.3
Other non-recurrent items (e.g. profit on disposal)	1.0
Impact of National Measures:	
Reduction in activity targets by 4%	0.5
Non-recurrent income - in respect of Industrial Action	1.0
Non-recurrent income - in respect of cost of distressed finance	0.2
	- 4.0

Workforce
Whole Time Equivalents (WTEs) are shown in Appendix 1. At Month 10 WTEs total 1,704, compared to 1,688 at M12 2022/23, with an overall shift away from temporary (bank and agency) towards substantive staff. Between Month 9 and Month 10, WTEs have increased by 16.6. This is driven by an increase in bank staff in Month 10, required to maintain clinical service delivery following a reduction in substantive staff (leavers) which occurred during Month 9.

Enhanced controls have been implemented regarding agency spend including Divisional oversight and enhanced senior approvals required, resulting in an agency spend of 0.6% of the Trust's pay costs. This benchmarks well within the Cheshire and Merseyside system and nationally (Trusts are expected to be at or below 3.7% in 2023/24). At Month 10, the Trust has a favourable variance of £1.2m against plan. Actual costs of £0.6m YTD are driven by theatres (vacancy), imaging, and maternity (sickness and vacancy).

Cost Improvement Programme
The Trust has a cost improvement programme target of £8.3m (5.3% of expenditure). At Month 10, the Trust is forecasting delivery of £7.3m, which represents an adverse variance to target of £1.0m. Forecast delivery was revised at Month 9 to take account of likely non-delivery of a very high-risk income scheme of £1.0m (relating to out of area low volume activity). At Month 10, there is an adverse variance of £1.3m against the £6.5m target. £1.3m of CIP was recognised in month, including recognition of non-recurrent savings identified.

Industrial Action
The net impact of industrial action in December and January (£0.8m) has been included in the YTD position. Providers and systems were instructed to exclude the impact of industrial action taking place in February from forecasts, as this was announced after initial Month 10 reporting was complete.

On 5 March the Trust received notice that it would receive £0.5m in additional income to mitigate the costs of industrial action in December, January, and February, and that there is an expectation that Trusts would manage any remaining impact. This will be fully assessed within Month 11 reporting.

3. Income Performance

Total Activity Performance

While the majority of the Trust's income is fixed under current contracting arrangements, a proxy YTD position (as though all activity were under a PbR regime), is provided to Divisions to indicate financial performance linked to activity. Key highlights by Division are as follows:

- Gynaecology - activity is £1.1m behind plan YTD. Underperformance is driven by industrial action and the new electronic patient record (Digicare) implementation, and is predominantly against day case and elective activity, which also fall under the Aligned Payment Incentive (API) payment mechanism. This results in an actual loss of income to the Trust (unlike non-elective activity).
- Hewitt Fertility Centre - activity is £0.5m ahead plan YTD, driven by transfer of activity from Cheshire West.
- Maternity – activity remains £0.3m behind plan YTD, as at Month 9. The highest impact is in deliveries, which fall under fixed payment, therefore there is no adverse financial impact to the Trust in-year.
- Neonates – activity remains £0.1m ahead of plan YTD, consistent with Month 9. Occupancy in ITU has remained consistently higher than HDU and SCBU in recent periods, adversely impacting expenditure.
- CSS Division – activity remains in line with plan YTD.

Aligned Payment Incentive (API)

At Month 10, the Trust has delivered 97% (in terms of £s) and 98% (in terms of activity) of its adjusted 2019/20 baseline year to date. The Trust's agreed average activity target for 2023/24 was 106%, subsequently reduced to 102% (as part of national measures introduced to mitigate the impact of industrial action).

Overall, the API position is behind plan by £1.1m at Month 10. The YTD underperformance is due to a combination of the following:

- Industrial action
- DigiCare – impact specifically in Month 4
- Case mix changes (daycase to inpatient)
- Procedures being carried out elsewhere.

4. Cash and Borrowings

The Trust's cash and bank balance at the end of Month 10 was £7.0m. The Trust forecasts cashflow on a rolling 13-week basis and cash levels are monitored daily. The average cash balance in Month 10 was £11.7m (£12.1m on average from Month 1 to Month 10).

The Trust received £21.4m in cash advances from the ICB to December 2023. This will be repaid in full in quarter 4, with the final payment of £7.8m due to be made on 1 March 2024. The Trust has received agreement from the national provider finance team for up to £21.2m of national distressed finance, to be paid across quarter 4. This will enable the Trust to remain within the national cash threshold of the higher of £1m/2days expenditure, but below the Trust's own threshold of 15 days expenditure/ £6m.

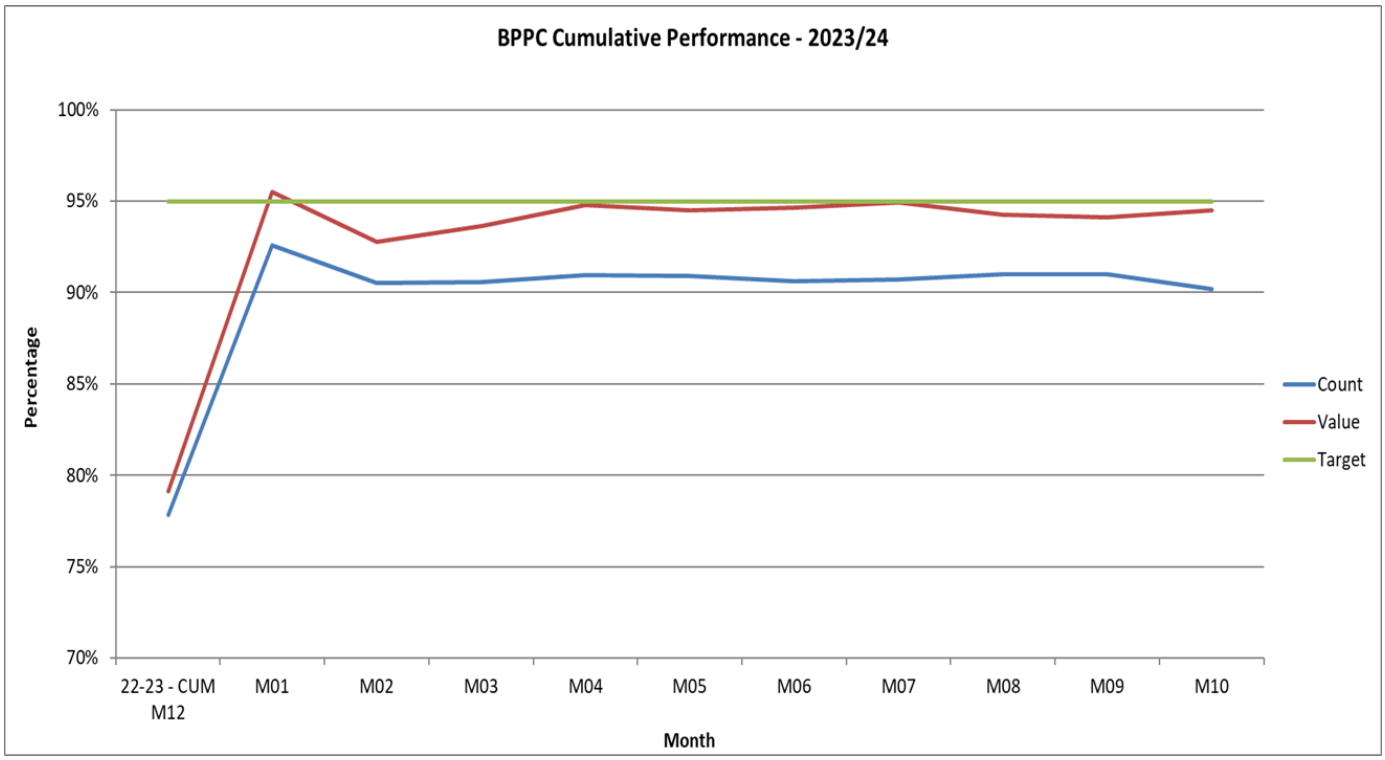
National Revenue Support payments of £6m were received in each of January and February. The final application, for £8.1m, has been approved and funds are anticipated on 11 March 2024.

The Trust has indicated its likely ongoing need for cash support in 2024/25 to the ICB.

The impact of the distressed finance and reduced cash in quarter 4 has been reflected in the forecast Public Dividend Capital (PDC) and interest to year end.

5. Better Payment Practice Code (BPPC)

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 chart below shows the performance percentages by both count and value for the current and previous financial year.



6. Balance Sheet

In Month 10 debtors reduced by £1.7m, as NHS debtors invoiced for quarter 3 have now been paid. Payables increased by £0.7m but will reduce significantly in Month 11 due to timing of payments to Liverpool Clinical Laboratories. Other areas of the balance sheet are consistent with the previous month.

7. Capital Expenditure

The Trust's capital programme for 2023/24 now totals £5.4m, following receipt of additional Public Dividend Capital (PDC) in respect of the ambulatory scheme. The overall available capital spend available for additions has also increased by £0.2m, as the net book value of assets disposed in the year is net off with the Trust's capital allowance. This has enabled more funding for capital variations that have arisen during the year.

Overall, the capital plan is expected to be completed by year end with variations to date accommodated within the plan. Year to date, the programme is £1.6m behind plan.

8. 2024/25 Planning Update

The Trust has now submitted its first draft plan for 2024/25. Finance, activity, and workforce plans are produced in parallel and have been derived from detailed demand and capacity modelling, safe staffing and establishment reviews, medical job planning, budget setting, CIP planning, and reviews of cost pressures and capital schemes proposed for 2024/25.

The plan is set to deliver activity at 109% of adjusted 2019/20 levels (in line with national expectations), which will be achieved through a combination of increased productivity (focused on theatres and day case activity), pathway transformation within Rapid Access Clinics (RAC) and fixed term investment in insourcing capacity for outpatients. This will:

- Reduce the Trust's waiting list by 4,500 by the end of March 2025.
- Ensure there are no patients waiting over 65 weeks by June 2024 (ahead of the national expectation of September 2024).
- Ensure there are no patients waiting over 52 weeks by March 2025 (in line with the national expectation).
- Ensure that the 28-day Faster Diagnosis Standard is met for 70% of patients by March 2025 (compared to 55% currently).
- Ensure that the 62-day cancer treatment target is met for 50% of patients by March 2025 (compared to 20% currently).

As at 6 March 2024, the Trust's proposed plan is a deficit of £34.6m, which equates to 24% of revenue:

This is an increase of £11.2m from the 2023/24 outturn. Key movements are summarised in the bridge below:

2023/24 OUTTURN	**£m**
	- 23.4
Commisisoner Income Changes	- 1.6
Other NR Items 23/24	- 2.3
Convergence, Tariff, CIP	0.1
Core capacity 23/24	- 1.0
New Pressures 24/25	
CNST above tariff assumptions	- 1.1
Depreciation Increase (EPR)	- 0.5
Distressed Finance	- 0.2
Contractual/SLA/Excess Inflation	- 0.8
Immediate Quality and Safety Investment	- 3.0
Activity 109% delivery	- 0.3
Other pressures	- 0.7
2024/25 PLAN	**- 34.6**

The plan assumes delivery of £3.0m of CIP, which equates to 1.7% of expenditure. This is less than the system expectation of approximately 5%, however the Trust has assessed this as a realistic level of savings given ongoing work to ensure quality and safety improvement across the organisation, and its limited scope to impact expenditure run rate, noting the requirement for safe staffing levels (pay represents 61% of the Trust's operating expenditure) and the Trust's fixed clinical negligence scheme (CNST) payments (a further 14% of operating expenditure).

The capital plan for 2024/25 remains capped at £5.0m in line for 2024/25, plus additional Public Dividend Capital (PDC) funding approved by NHS England to expand the Trust's ambulatory capacity during 2024/25.

The Trust's underlying deficit is driven by three key areas, which are well known and understood:

- The maternity tariff is insufficient to cover costs of delivering safe maternity services, exacerbated by disproportionate clinical negligence (CNST) costs.
- As a small organisation, the Trust has limited economies of scale.
- The Trust has increased costs and a level of inherent inefficiency as a result of delivering services from an isolated site (costs of addressing clinical safety risks).

The Trust remains an efficient organisation, maintaining a National Cost Collection Index of 103 (latest published metric, based on data from 2021/22), despite the drivers of its structural deficit noted above.

There are ongoing discussions with the Cheshire and Mersey ICB as well as NHS England regional and national teams regarding planning, and further plan submissions are expected in mid-March and April 2024.

9. Soft Facilities Management Contract

The Trust's soft facilities management (FM) contract is due for renewal (expiring 30 June 2024). Options were discussed at the meeting of the Finance, Performance and Business Development Committee (FPBD) in November 2023, and it was recommended to extend the current contract for an initial period to 30 September 2025 (total contract value £2.6m), with an option for a further 9 months to 30 June 2026, via a direct award. The costs of the soft FM service are included in the 2024/25 plan.

The Trust Board is asked to approve this contract award as per Standing Financial Instructions.

10. Board Assurance Framework (BAF) Risk

There are no proposed changes to the BAF score this period, which remains at 20 (likelihood 5, consequence 4).

11. Conclusion & Recommendation

The Board is asked to receive the Month 10 position and the update on the 2024/25 planning position.

The Board is asked to approve the contract extension to the incumbent provider.

Appendices

Appendix 1 – Board Finance Pack, Month 10

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M10

YEAR ENDING 31 MARCH 2024

Liverpool Women's
NHS Foundation Trust

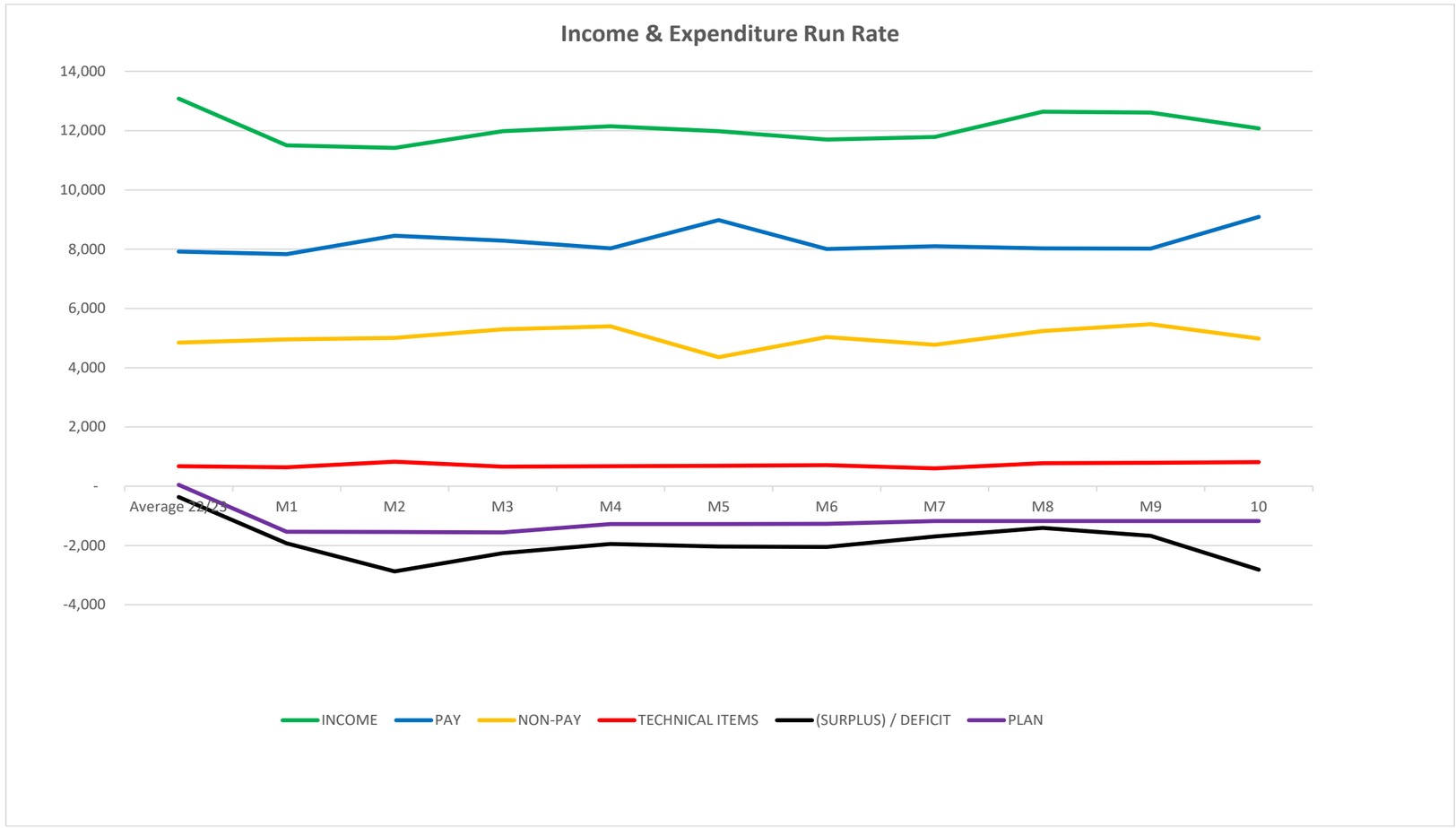
Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M10
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	Month 10 Budget	Month 10 Actual	Month 10 Variance	YTD Budget	YTD Actual	YTD Variance	YEAR Budget	YEAR Forecast	YEAR Variance
Income									
Clinical Income	(11,502)	(11,350)	(152)	(114,519)	(113,939)	(580)	(137,517)	(137,204)	(313)
Non-Clinical Income	(636)	(556)	(80)	(6,143)	(6,309)	166	(7,416)	(7,356)	(59)
Total Income	**(12,139)**	**(11,907)**	**(232)**	**(120,662)**	**(120,248)**	**(414)**	**(144,933)**	**(144,560)**	**(372)**
Expenditure									
Pay Costs	7,541	8,624	(1,083)	76,082	82,315	(6,234)	91,102	100,298	(9,196)
Non-Pay Costs	3,216	3,149	68	32,194	30,886	1,308	38,631	38,729	(98)
CNST	1,800	1,800	0	18,003	17,148	854	21,603	20,305	1,298
Total Expenditure	**12,558**	**13,573**	**(1,015)**	**126,278**	**130,350**	**(4,072)**	**151,337**	**159,332**	**(7,996)**
EBITDA	**419**	**1,666**	**(1,247)**	**5,616**	**10,102**	**(4,486)**	**6,404**	**14,772**	**(8,368)**
Technical Items									
Depreciation	548	580	(32)	5,483	5,307	176	6,579	6,467	113
Interest Payable	1	1	(0)	18	13	5	21	17	4
Interest Receivable	(17)	(52)	35	(167)	(492)	325	(200)	(553)	353
PDC Dividend	220	231	(11)	2,205	2,309	(104)	2,645	2,801	(156)
Profit/Loss on Disposal or Transfer Absorption	0	53	(53)	0	(69)	69	0	(69)	69
Total Technical Items	**752**	**812**	**(60)**	**7,539**	**7,068**	**471**	**9,045**	**8,663**	**382**
(Surplus) / Deficit	**1,172**	**2,478**	**(1,306)**	**13,154**	**17,170**	**(4,015)**	**15,450**	**23,435**	**(7,986)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2
WTE: M10
YEAR ENDING 31 MARCH 2024

TYPE	DESCRIPTION	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	Movement M9 - M10	Movement M12 - M9
SUBSTANTIVE	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	631.94	648.33	649.61	645.49	636.13	640.11	636.48	658.66	668.25	655.72	654.84	(0.88)	22.90
	ALLIED HEALTH PROFESSIONALS	82.04	81.95	81.35	83.27	83.57	85.45	86.39	86.27	85.87	84.95	84.68	(0.27)	2.64
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	11.78	11.31	11.31	12.31	11.31	12.31	14.31	12.31	14.31	14.31	13.31	(1.00)	1.53
	REGISTERED HEALTH CARE SCIENTISTS	49.22	53.62	54.54	54.34	55.34	57.34	60.98	65.47	67.23	67.63	65.43	(2.20)	16.21
	HCA & SUPPORT TO CLINICAL STAFF	234.51	237.51	244.48	237.49	242.70	241.16	247.75	242.56	235.98	232.33	233.53	1.20	(0.98)
	MANAGERS & SENIOR MANAGERS	59.92	63.32	64.32	61.32	59.02	62.57	62.09	60.39	57.99	60.69	62.59	1.90	2.67
	ADMIN AND ESTATES STAFF	13.00	13.00	13.00	14.00	14.00	15.00	15.00	15.00	15.00	15.00	15.00	0.00	2.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	288.12	288.08	284.17	285.09	279.25	276.78	278.59	275.93	276.62	276.69	275.37	(1.32)	(12.75)
	MEDICAL AND DENTAL	185.09	190.90	191.67	193.80	190.34	197.14	200.02	195.05	195.72	194.66	193.97	(0.69)	8.88
	ANY OTHER STAFF	14.00	14.00	14.00	14.00	14.00	14.00	14.00	13.60	13.99	13.99	13.00	(0.99)	(1.00)
SUBSTANTIVE TOTAL		**1,569.62**	**1,602.02**	**1,608.45**	**1,601.11**	**1,585.66**	**1,601.86**	**1,615.61**	**1,625.24**	**1,630.96**	**1,615.97**	**1,611.72**	**(4.25)**	**42.10**
BANK	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	47.33	37.81	43.37	45.40	34.57	30.12	36.07	36.62	39.71	32.91	43.19	10.28	(4.14)
	ALLIED HEALTH PROFESSIONALS	17.42	13.00	16.78	15.67	11.15	10.48	13.45	13.31	14.60	10.70	16.84	6.14	(0.58)
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	-	-	-	-	-	-	-	-	-	-	-	0.00	0.00
	REGISTERED HEALTH CARE SCIENTISTS	0.28	0.91	0.64	0.46	0.37	0.27	1.60	1.16	0.60	0.45	0.22	(0.23)	(0.06)
	HCA & SUPPORT TO CLINICAL STAFF	31.22	25.76	25.13	24.57	21.87	19.20	18.79	19.07	21.07	18.64	25.08	6.44	(6.14)
	MANAGERS & SENIOR MANAGERS	-	-	-	-	-	-	-	-	-	-	-	0.00	0.00
	ADMIN AND ESTATES STAFF	-	0.23	0.12	0.09	-	0.05	-	-	0.07	0.07	-	(0.07)	0.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	6.25	7.27	6.44	4.36	4.89	6.82	4.20	2.34	5.35	3.17	3.79	0.62	(2.46)
	MEDICAL AND DENTAL	2.00	2.80	2.80	2.00	2.00	1.94	1.97	0.93	0.03	0.03	2.15	2.12	0.15
	ANY OTHER STAFF	-	-	-	-	-	-	-	-	-	-	-	0.00	0.00
TOTAL BANK		**104.50**	**87.78**	**95.28**	**92.55**	**74.85**	**68.88**	**76.08**	**73.43**	**81.43**	**65.97**	**91.27**	**25.30**	**(13.23)**
AGENCY	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	8.23	10.49	2.03	0.08	2.11	2.76	2.68	3.14	-	-	-	0.00	(8.23)
	ALLIED HEALTH PROFESSIONALS	4.04	1.23	3.26	3.26	2.92	2.60	3.28	2.90	2.95	0.21	1.05	0.84	(2.99)
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	-	-	-	-	-	-	-	-	-	-	-	0.00	0.00
	REGISTERED HEALTH CARE SCIENTISTS	-	-	-	-	-	-	-	-	-	-	-	0.00	0.00
	HCA & SUPPORT TO CLINICAL STAFF	-	-	-	-	-	-	-	-	-	-	-	0.00	0.00
	MANAGERS & SENIOR MANAGERS	-	-	-	-	-	-	-	-	-	-	-	0.00	0.00
	ADMIN AND ESTATES STAFF	1.00	-	-	-	-	-	-	-	-	-	-	0.00	(1.00)
	OTHER INFRASTRUCTURE & SUPPORT STAFF	-	1.73	-	-	-	-	-	-	-	-	-	0.00	0.00
	MEDICAL AND DENTAL	0.10	-	-	-	-	-	-	-	0.95	-	-	0.00	(0.10)
	ANY OTHER STAFF	-	-	-	-	-	-	-	-	-	-	-	0.00	0.00
AGENCY TOTAL		**13.37**	**13.45**	**5.29**	**3.34**	**5.03**	**5.36**	**5.96**	**6.04**	**3.90**	**0.21**	**1.05**	**0.84**	**(12.32)**
TRUST TOTAL		**1,687.49**	**1,703.25**	**1,709.02**	**1,697.00**	**1,665.54**	**1,676.10**	**1,697.65**	**1,704.71**	**1,716.29**	**1,682.15**	**1,704.04**	**21.89**	**16.55**



Note: Non-recurrent items have been removed from the figures above

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
CIP: M10
YEAR ENDING 31 MARCH 2024

TYPE	Scheme	MONTH 10			YTD			FULL YEAR		
		Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Income	Income Non-Patient Care	126	103	-24	- 853	- 542	-311	- 1,109	- 685	-424
	Income Other	61	47	-14	- 591	- 278	-313	- 713	- 372	-341
	Income Private Patient	63	222	159	- 344	- 434	90	- 470	- 441	-29
	TOTAL INCOME	**250**	**371**	**121**	**- 1,788**	**- 1,255**	**- 534**	**-2,292**	**-1,498**	**-793**
Pay	Service re-design - pay	2	-	-2	- 21	- 1	-20	- 25	- 1	-24
	Establishment reviews	4	110	107	- 13	- 653	640	- 20	- 743	722
	E-Rostering	-	185	185	-	- 185	185	- 200	- 503	303
	Other - pay	18	58	40	- 181	- 138	-43	- 217	- 157	-60
	Unidentified - pay	277	-	-277	- 1,946	-	-1,946	- 2,502	-	-2,502
	TOTAL PAY	**301**	**353**	**52**	**- 2,161**	**- 977**	**- 1,184**	**-2,965**	**-1,404**	**-1,561**
Non-Pay	digital transformation	10	-	-10	- 101	-	-101	- 122	-	-122
	Fleet optimisation	2	3	1	- 16	- 23	8	- 20	- 29	9
	Medicines optimisation	14	3	-11	- 136	- 46	-90	- 164	- 52	-112
	Other - Non-pay	23	115	92	- 180	- 370	190	- 226	- 1,055	829
	Pathology & imaging networks	0	-	0	- 4	-	-4	- 5	-	-5
	Procurement (excl drugs) - medical devices and clinical consumables	15	0	-14	- 145	- 9	-137	- 175	- 10	-165
	Procurement (excl drugs) -non-clinical	1	1	0	- 5	- 3	-3	- 6	- 4	-3
	Service re-design - Non-pay	190	170	-20	- 1,881	- 2,473	592	- 2,262	- 2,815	553
	Estates and Premises transformation	-	-	0	-	- 10	10	-	- 80	80
	Unidentified - non-pay	11	-	-11	- 78	-	-78	- 100	- 389	289
	TOTAL NON-PAY	**266**	**292**	**26**	**- 2,547**	**- 2,933**	**386**	**-3,080**	**-4,433**	**1,354**
	TOTAL CIP DELIVERY	**817**	**1,016**	**199**	**- 6,496**	**- 5,164**	**- 1,332**	**(8,336)**	**(7,336)**	**(1,000)**

Note: The value above reflects the actual CIP delivered and reported to both the ICB and NHSE.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5a
CASHFLOW STATEMENT: M10
YEAR ENDING 31 MARCH 2024

CASHFLOW STATEMENT	
£'000	**Actual**
Cash flows from operating activities	(15,404)
Depreciation and amortisation	5,306
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	6,904
Net cash generated from / (used in) operations	**(3,194)**
Interest received	496
Purchase of property, plant and equipment, ROU and intangible assets	(4,621)
Proceeds from sales of property, plant and equipment and intangible assets	245
Net cash generated from/(used in) investing activities	**(3,880)**
PDC distressed funding received	6,000
PDC Capital Programme Funding - received	0
Loans from Department of Health - repaid	(306)
Interest paid	(10)
PDC dividend (paid)/refunded	(1,373)
Net cash generated from/(used in) financing activities	**4,311**
Increase/(decrease) in cash and cash equivalents	**(2,763)**
Cash and cash equivalents at start of period	9,790
Cash and cash equivalents at end of period	**7,027**

Finance Support	2023/22 Q4 £000	2023/24 Q1 ACTUAL £000	2023/24 Q2 ACTUAL £000	2023/24 Q3 ACTUAL £000	2023/24 M10 ACTUAL £000	2023/24 M11 ACTUAL £000	2023/24 M12 FOT £000	2023/24 Total £000
ICB cash support	6,000	6,800	9,600	5,000	0	0	0	21,400
ICB cash repayment	(6,000)	0	0	0	(5,850)	(7,775)	(7,775)	(21,400)
National cash support	4,500	0	0	0	6,000	6,000	8,100	20,100
Total support required	**4,500**	**6,800**	**9,600**	**5,000**	**150**	**(1,775)**	**325**	**20,100**
DH Loan repayment	612	0	306	0	0	0	306	612
DH Loan outstanding year end	918							306

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5b
CASHFLOW ROLLING FORECAST: M10
YEAR ENDING 31 MARCH 2024

	Actual Apr-23	Actual May-23	Actual Jun-23	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Forecast Feb-24	Forecast Mar-24
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening cash	**9,730**	**8,686**	**4,738**	**2,870**	**1,223**	**3,501**	**6,130**	**8,444**	**6,443**	**6,090**	**7,083**	**2,308**
Income flows												
ICB income	7,632	7,593	7,747	6,623	7,702	7,825	7,971	7,758	7,759	10,516	8,460	7,996
NHS England	2,258	2,433	3,714	3,862	3,402	2,435	4,618	2,347	2,327	2,343	2,360	2,110
NHS Trust/FT	243	225	233	223	75	172	331	366	463	270	150	245
Private patients	320	88	355	220	355	430	543	225	244	278	280	300
Overseas	16	16	16	16	16	16	16	16	10	16	23	20
ICR/RTA scheme	4	4	4	4	4	4	4	4	4	5	5	5
Non-NHS (Wales/Man)	314	100	314	314	314	290	101	102	102	225	132	450
R&D	133	65	102	133	150	55	10	100	94	100	200	332
HEE/other E&T	366	15	20	316	77	89	0	0	0	0	0	0
Other	99	17	50	49	50	50	20	68	101	234	190	83
Bank interest	16	51	57	57	35	42	51	65	57	49	33	33
Total operating inflows	**11,401**	**10,606**	**12,612**	**11,817**	**12,180**	**11,408**	**13,665**	**11,051**	**11,161**	**14,036**	**11,833**	**11,574**
Expenditure flows												
Wages and salaries	(3,684)	(3,799)	(5,958)	(3,880)	(4,092)	(4,277)	(4,079)	(4,009)	(4,018)	(4,052)	(4,100)	(4,100)
HMRC	(1,826)	(1,917)	(1,946)	(3,544)	(1,919)	(1,981)	(2,166)	(1,952)	(1,919)	(1,960)	(1,960)	(1,960)
Pensions	(1,133)	(1,147)	(1,200)	(1,301)	(1,203)	(1,213)	(1,291)	(1,227)	(1,244)	(1,258)	(1,250)	(1,250)
CNST - cash movement	(2,347)	(2,347)	(2,347)	(2,347)	(2,353)	(2,353)	(2,353)	(2,353)	(2,353)	(2,353)	0	0
Other expenditure (ex depn)	(3,503)	(3,743)	(5,531)	(5,328)	(3,289)	(2,907)	(5,344)	(4,393)	(4,014)	(3,279)	(3,571)	(3,044)
VAT recovery	0	0	0	0	1,266	100	215	100	254	211	100	100
PDC/Loan	0	0	0	0	0	(1,628)	0	0	0	0	250	(1,815)
Interest payable	(2)	(2)	(2)	(2)	(2)	(9)	(2)	(2)	(1)	(2)	(2)	(1)
Capital plan	(500)	(400)	(500)	(362)	(560)	(50)	(289)	(216)	(219)	(500)	(800)	(653)
Total operating outflows	**(12,995)**	**(13,355)**	**(17,484)**	**(16,764)**	**(12,152)**	**(14,318)**	**(15,309)**	**(14,052)**	**(13,514)**	**(13,193)**	**(11,333)**	**(12,723)**
Other cash in/outflows												
ICB cash support	6,000	0	800	3,400	2,200	4,000	2,000	1,000	2,000	(5,850)	(7,775)	(7,775)
National/local distressed finance sup	0	0	0	0	0	0	0	0	0	6,000	6,000	8,100
National payroll	0	0	3,105	0	0	0	0	0	0	0	0	0
Accrued/Deferred income	(200)	(500)	(200)	(100)	0	(100)	0	0	0	0	(1,000)	0
Capital creditors	(1,250)	(700)	(400)	0	50	250	0	0	0	0	0	0
LUHFT payment	(4,000)	0	(300)	0	0	0	0	0	0	0	(2,500)	(500)
NHS Resolution MIS	0	0	0	0	0	1,389	1,957	0	0	0	0	0
TOTAL CASH IN GBS ACCOUNT	**8,686**	**4,738**	**2,870**	**1,223**	**3,501**	**6,130**	**8,444**	**6,443**	**6,090**	**7,083**	**2,308**	**984**
Barclays, bank rec and cash in hand	47	74	86	109	253	217	575	70	31	(56)	10	10
TOTAL CASH HOLDING	**8,733**	**4,812**	**2,956**	**1,332**	**3,754**	**6,347**	**9,019**	**6,513**	**6,121**	**7,027**	**2,318**	**994**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CAPITAL EXPENDITURE: M10
YEAR ENDING 31 MARCH 2024

		YTD			FULL YEAR - ORIGINAL PLAN			FULL YEAR - REVISED PLAN		
Area	Capital Scheme	YTD PLAN	YTD ACTUAL	VARIANCE	PLAN	FOT	VARIANCE	PLAN	FOT	VARIANCE
IT	EPR frontline digitisation	550	797	(247)	560	867	(307)	910	867	43
IT	IT/digital investment - Infrastructure Investment	575	1,135	(560)	1,290	1,442	(152)	1,238	1,442	(204)
IT	IT/digital investment - Hardware	280	129	151	354	167	187	140	167	(27)
IT	Community diagnostic equipment	153	0	153	153	0	153	0	0	0
IT	Community diagnostic IT	100	0	100	65	0	65	25	0	25
Estates	Building works/refurbishment - Maternity	950	113	837	950	350	600	350	350	(0)
Estates	Building works/refurbishment - Neonatal	180	0	180	180	75	105	80	75	5
Estates	Building works/refurbishment - Gynaecology	190	0	190	300	0	300	0	0	0
Estates	Estates programme	500	512	(12)	560	717	(157)	714	717	(3)
Medical Equipment	Medical equipment - Clinical Support - Fluoroscopy	262	0	262	241	0	241	0	0	0
Medical Equipment	Medical equipment - Clinical Support - Theatres	107	83	24	107	83	24	89	83	6
Medical Equipment	Medical equipment - All other clinical areas	738	675	63	1,041	1,255	(214)	1,257	1,255	2
Medical Equipment	Medical equipment - leased blood gas analysers	139	32	107	139	139	0	139	139	0
F&F	Furniture & Fittings	0	0	0	0	57	(57)	57	57	0
Estates	PALS - Office reconfig	0	0	0	0	8	(8)	8	8	0
Medical Equipment	Bariatric Bed	0	0	0	0	34	(34)	34	34	0
All	Pending schemes	0	0	0	0	17	(17)	0	17	(17)
Accounting	Contingency/VAT savings/slippage	0	(49)	49	(905)	0	(905)	0	0	0
Accounting	Disposals at Net Book Value	0	(176)	176	0	(176)	176	(5)	(176)	171
CDEL ALLOCATION		**4,724**	**3,251**	**1,473**	**5,035**	**5,035**	**(0)**	**5,035**	**5,035**	**0**
Other funding sources										
CSE	Ambulatory Scheme	0	25	(25)	0	250	(250)	250	250	(0)
Gynaecology	Bereavement Suite - gynaecology - CHARITY	70	0	70	70	70	0	70	70	0
CSS	PACS - image sharing - CAMRIN programme	49	0	49	49	49	0	49	49	0
TOTAL CAPITAL PLAN		**4,843**	**3,276**	**1,567**	**5,154**	**5,404**	**(250)**	**5,404**	**5,404**	**(0)**

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/275*		Date: 14/03/2024	
Report Title	CQC Inspection Report and Improvement Plans			
Prepared by	Mark Campbell, Head of Continuous Improvement, Yana Richens, Director of Midwifery Vicky Clarke, Divisional Manager, Family Health			
Presented by	Dianne Brown – Chief Nurse			
Key Issues / Messages	The Trust has received the final report into the findings of the Care Quality Commission unannounced inspection in January 2024. The report highlights the steps taken to date in response of the findings and provides assurances re oversight and completion of required actions including next steps.			
Action required	Approve ☐	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to take assurance as to the process in place to drive improvement following the CQC inspection.			
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:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

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

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

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

Following the inspection, a comprehensive action plan was developed by leaders across the Trust to address the findings of the report. Progress has been subject to regular monitoring and reported through established governance structures. All of the actions relating to breaches of regulation (Must Do's and Should Do's) for Maternity services have been completed.

Follow up inspection - January 2024

CQC carried out a focused inspection of Maternity services on 15 January 2024. This was specifically in relation to the requirements of the Warning Notice.

CQC have formally notified the Trust that the requirements of the Warning Notice have been met and as such the Warning Notice has been lifted.

The Trust is now in receipt of the final inspection report and an action plan has been subsequently developed. Whilst the CQC visit was explicitly in relation to the warning notice the final CQC report identified 3 actions the Trust 'must' take to comply with its legal obligations and a further 4 actions the Trust 'should' take. These will be managed and monitored at divisional level, reporting through Divisional Boards and into Safety & Effectiveness Sub-Committee.

This paper provides an update in response to the actions taken by the Trust in relation to the findings of the latest inspection. A comprehensive paper in relation to our CQC action plans for both 2023 and 2024 will be provided to Quality Committee in March 2024 and then Trust Board in April 2024.

MAIN REPORT

The Care Quality Commission (CQC) carried out an unannounced focussed inspection of maternity services at the Crown Street site at 2pm on Monday 15 January 2024. The inspection was to follow up on the Warning Notice that was served in February 2023.

The feedback received from CQC was largely positive. However, some concerns were raised as follows.

- 5 sets of observation records showed that observations (MEOWS) were not always fully completed or completed in a timely way.

- 4 sets of CTGs showed that 'fresh eyes' were not always completed in line with the local policy requirements.
- CQC were not able to see that we had access to data to monitor performance of time to medical review on MAU.
- CQC observed shift handovers which they found to be effective on delivery suite but there were some issues on Mat Base.
- CQC found some out-of-date consumables on some of the emergency trolleys.

Remedial Action

The following immediate actions have been taken in response to the report findings.

- weekly MEWS audits completion continues by department managers with an increased focus on improved compliance and targeting 'hot spot' areas. Regular staff feedback and training sessions where necessary are provided. We have improved visibility of MEWS compliance through the introduction of a real time whiteboard within Maternity Base. Weekly meetings take place to review compliance rates and 50 case notes are sampled for audit purposes. Week commencing 26th February 24 we reached 70 % compliance.

- The BirthRate Plus Ward Based Acuity Tool was launched on the 29th of January, which provides real time evidence-based data to support staffing deployment decisions on Maternity Ward. The initial findings have led to immediate changes being introduced which include midwifery staffing realignment into maternity base workforce establishment, Supernumerary shift leader role allocated to each shift, Supernumerary Bleepholder 24/7 service based on Maternity Base overnight to increase senior visibility and oversight.

- Revised daily equipment checking process implemented in clinical areas, this includes allocation of equipment checking to a star midwife. All equipment checks are overseen by Maternity Bleep holders, who have real time compliance dashboard information and can deploy staff members to complete if there have been any omissions. This will also be subject to spot check review.

- Chairs reporting from Family Health Divisional Board into Executive Committees has been introduced monthly.

- Family Health Division SLT have met with informatics team to review KPI's and amend data collection processes. Time to Medical Review information is accessible and available via the electronic whiteboard and regular periodic audits of this data are carried out by Clinical Director. Robust SOP and escalation protocols are in place to escalate delay in medical review.

All improvement actions are monitored and managed through Maternity and neonatal Transformation Workstream 4 - **Standards and structures that underpin safer, more personalised, and equitable care**

Post Inspection

On Thursday 8 February 2024, the trust received the draft inspection report which detailed the improvements that had been made since the 2023 inspection. The Trust were subsequently informed the Warning Notice had been lifted as the requirements of it had been met. No challenges have been made against the findings of the report which was published on 28 February 2024.

The Report concluded that the Trust 'must' Improve the following.

- Staff complete and record full sets of observations in the intrapartum period and effectively monitor for deterioration. Regulation 12 (2)(a)

- Clinical decision making in relation to the frequency of observations is recorded. Regulation 17 (2)(c)
- There are sufficient shift leadership on Matbase to keep women, babies and staff safe. Regulation 18 (1)

The Report concluded that the Trust 'should' Ensure the following:

- Systems and processes are in place to accurately collect data to assess and monitor performance in relation to time to medical review and 1:1 care in labour.
- All departments are represented at twice daily safety checks to effectively identify, escalate and mitigate risks.
- Staff respond appropriately to activated baby alarms.

The report also required the Trust to Consider:

- Reviewing the systems and processes used for checking emergency equipment.

Response to Report Findings

An improvement plan was developed by Maternity colleagues in response to the final report. The plan was shared on 19 February 2024 Family Health Senior Leadership Team and Trust Executive Team. The Maternity aspects of the action plan are being managed by Family Health Divisional triumvirate with input and oversight from HOM/Divisional Manager and CD. Governance and oversight is managed through Maternity and Neonatal Transformation Workstream 4, into Family Health Divisional Board, reporting into Safety & Effectiveness Sub Committee, Quality Committee and Trust Board for executive oversight.

	Maternity
Must Do	
Behind schedule or at risk of slippage	0
On track	3
Completed	0
Completed and sustained	0

	Maternity
Should Do	
Behind schedule or at risk of slippage	0
On track	4
Completed	0
Completed and sustained	0

Sharing the Inspection Report

The final report was received by the trust on Wednesday 21st February. It has been disseminated to Family Health Senior Leadership Team and this will be managed monthly through Maternity and Neonatal Transformation Governance framework with oversight from Family Health Divisional Board with Executive oversight via Safety and Effectiveness Committee.

The report has also been shared externally with Local Maternity and Neonatal System, Local Higher Education Institutes, Regional Chief Midwifery Officer.

Monitoring completion of the action plan

Action plan oversight will be monitored via Family Health Divisional Board and progress will be tracked as follows.

- Progress updates and escalation will be reported monthly to Maternity and Neonatal Transformation workstream 4 with onward reporting to Family Health Divisional Board.
- Regular reporting through established Trust governance structures.
- Additional oversight through MIAA review Date TBC.
- Performance monitoring through Power BI dashboards and reporting to ensure improvements are maintained.
- BBAS accreditation scheme to include environment, nursing audits, training Compliance and equipment checks.

Next steps

- Divisional Boards will continue to oversee the required closure and completion of actions supported by the Corporate Governance Team in advance of the relevant deadlines, which will include Executive review and sign off.
- A comprehensive paper in relation to our CQC action plans for both 2023 and 2024 will be provided to Quality Committee in March 2024 and then Trust Board in April.
- Incidental actions (those not directly addressed by a ‘Must’ or ‘Should’ action) contained within the report will be managed and monitored at divisional level, reporting through Divisional Boards and into Safety & Effectiveness Sub-Committee.
- The Family Health Division will also look at creating an overarching all-encompassing improvement plan which will I include CQC Actions, MSSP action plan and the annual national maternity in patient survey conducted by picker.

Conclusion & Recommendation

There has been significant progress to address the actions identified by the Trust following the inspections by CQC in 2023.

The Board is asked to take assurance that work is progressing with divisional and governance colleagues through Divisional Boards to drive further improvements following the latest inspection.

Performance and sustainability will be reported through the Executive Committee and into the relevant committees and Trust Board as outlined above.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET				
Agenda Item (Ref)	*23/24/276*	Date: 14/03/2024		
Report Title	Staff Survey 2023 – Overview of Key Themes			
Prepared by	Rachel London, Deputy Chief People Officer			
Presented by	Michelle Turner, Chief People Officer			
Key Issues / Messages	***The paper provides an overview of the key themes of the NHS Staff Survey 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): NA			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board of Directors is asked to receive the contents of the paper and the performance of the Trust in this important national survey and consider any further actions which would contribute to improved staff experience at LWH.			
Supporting Executive:	Michelle Turner, Chief People Officer			

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

Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
NA			

EXECUTIVE SUMMARY

The paper provides an overview of the key themes of the 2023 NHS Staff Survey. The NHS National Staff Survey is the most comprehensive measurement of staff satisfaction in the NHS and data is used as an indicator of overall organisational performance in national benchmarking including NOF exit criteria.

As in previous years, the Trust benchmarks more favourably when compared to Acute Trusts (122 organisations) than our official comparator group of Acute Specialist Trusts (a small cohort of 13 specialist hospitals).

The 2023 Staff Survey had a response rate of 52%, significantly higher than the national average response rate for acute organisations (45%) and slightly below the average response rate for acute specialist Trusts (54%).

The Trust saw no statistically significant changes to scores across the 9 themes of the survey, maintaining the positive improvements of last year. However, individual questions identified areas of improvement or deterioration, and will inform the organisation's ongoing cultural programme to drive a positive and engaging workplace culture and experience.

The report provides further detail and analysis of the staff survey results, utilising both comparators, and outlines the approach to responding to the Survey's findings. Divisional performance is attached at Appendix B.

Progress will be monitored through Divisional Boards and the People & OD Executive Group. The Board level People Committee will retain oversight of progress against the aims of the People Strategy.

MAIN REPORT

1. Introduction

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

The 2023 National Staff Survey was conducted from September to December 2023, with the results being published nationally in March 2024. As in previous years, the Trust surveyed all its staff.

Feedback from the NHS Staff Survey. is supplemented by the *Let's Talk* pulse surveys which run 3 times per year, the twice yearly '*Big Conversation'* and the *Great Place to Work Group*, as well as local and divisional forums.

As in previous years, the comparator group for the purposes of benchmarking is 'Acute Specialist Trusts' (a group of 13). The Trust has previously made representations that its services may be better aligned with the 'Acute Trust' category (122 in group). For the purposes of this report, we benchmark ourselves against both comparator groups.

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

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

- We are a team.

There are an additional two key themes in the survey:

- Staff engagement.
- Morale.

2. National Trends

Nationally, the 2023 NHS Staff Survey had a response rate of 48% which is an increase from 46% in 2022 and the highest to date. Four of the 6 People Promise elements that can be reported show improvements in 2023. Two People Promise elements remain similar – but all have improved. (Due to data issues with the questions relating to physical violence experienced at work, NHS England have to date been unable to publish national results for all of the 7 People Promise elements of the survey).

The 2023 scores for the themes of Employee Engagement and Morale have both increased since 2022, stopping the downward trend over the last two years. The biggest improvements identified nationally have been in morale +0.21, we are always learning +0.25, we work flexibly +0.19 and burnout +0.18. This year saw the introduction of four new questions, sexual violence, hybrid working and nutrition.

3. Summary of Results at Liverpool Women's

Overall, at Liverpool Women's, there were *no statistically significant changes* across the 9 themes of the Staff Survey. This compares to 2022 when LWH saw statistically significant improvement in 5 areas; however, it is positive to note that there are no areas of deterioration.

People Promise element	2022 score	2023 score
We are compassionate and inclusive	7.51	7.43
We are recognised and rewarded	5.95	6.01
We each have a voice that counts	6.98	6.92
We are safe and healthy	6.13	6.35
We are always learning	5.53	5.48
We work flexibly	5.94	6.13
We are a team	6.90	6.86
Staff Engagement	7.07	7.04
Morale	5.96	5.92

Individual questions within the theme categories showed a greater variance in scores and will be explored later in the report, however there are certain metrics which are focused on as a key determinant of overall staff experience.

- **Engagement Overall Score** (The score is made up of questions relating to motivation, involvement, and advocacy) **7.04%** (7.07% in 2022; 6.89 in 2021)
- **'I would recommend my organisation as a place to work' 62.5%** (61.31% in 2022; 56.45% 2021)
- '**If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation' 73.88%** (71.58% in 2022; 69.16% 2021)

	LWH	Acute Specialist Trusts Average (our Comparator)	Acute Trusts Average
Engagement Score	7.04	7.35	6.91
Recommend as a place to work	62.46%	71.12%	60.52%

Recommend as a place to have care	73.88%	87.82%	63.3%

As in previous years, our scores on these key metrics *are lower than the average for Acute Specialist Trusts* but *higher than the average for Acute Trusts.*

Where have we done better than last year? (Based on a percentage point increase)

Question	LWH 2022	LWH2023	Average result from comparator (specialist Trusts)	Average results for Acute Trusts
More staff are satisfied with levels of pay	27.3%	31.28%	32.24%	30.61%
More staff are able to meet conflicting demands on their time at work	39.74%	45.98%	48.59%	46.63%
More staff feel there are enough staff in the organisation	28.15%	32.19%	41.18%	31.75%
Fewer staff feel worn out at the end of a shift	44.49%	41.54%	38.16%	43.17%
Fewer staff feeling unwell because of work-related stress	42.5%	37.89%	37.5%	41.57%
Fewer staff experiencing harassment/bullying/ abuse from managers	9.82%	7.73%	9.06%	10.49%
More staff feel the organisation is committed to balancing work and home life	41.98%	46.32%	52.54%	48.43%
Fewer staff have experienced discrimination on the basis of gender	30.40%	22.78%	22.35%	19.22%
Fewer staff have experienced discrimination on the basis of religion	12.2%	6.02%	3.42%	4.47%

Where do we need to improve?

Question	LWH 2022	LWH 2023	Average result from comparator (specialist Trusts)	Average result for Acute Trusts
Fewer staff felt they could access Learning and Development opportunities	62.63%	58.06%	63.98%	59.52%
Fewer staff felt they had opportunity for career progression	56.18%	51.65%	55.54%	55.89%
Fewer staff feel they have adequate supplies to do their role	58.55%	51.53%	65.10%	56.88%
Fewer staff experiencing physical violence have reported it	74.35% (17/23 staff)	53.34% (17/32 staff)	74.08%	69.76%
Slightly more staff are experiencing physical violence from patients / public	2.32% (22 staff)	3.58% (32 staff)	4.53%	13.32%
Fewer staff felt they were involved in deciding on changes affecting their department	58.39%	54.49%	56.14%	51.5%
More staff have experienced discrimination on the basis of ethnic background (in 2021 figure was 23.78%)	36.57% (19/53 staff)	47.89% (29/61 staff)	46.73%	51.38%
More staff have experienced discrimination on the basis of disability (in 2021 figure was 16.51%)	7.64% (4/53staff)	13.21% (8/61 staff)	10.42%	9.01%
Fewer staff felt their employer had made reasonable adjustments to enable them to do their work	73.29% (81/111 staff)	69.64% (75/108 staff)	74.84%	73.19%

4. New Questions

New questions on sexual safety at work, and food and nutrition were added to the NHS Staff Survey this year:

- Staff who said they have been the target of unwanted behaviour of a sexual nature from patients/public. **1.29% = 12 staff** (Comparator 4.9%)

- Staff who said they have been the target of unwanted behaviour of a sexual nature from colleagues **1.91%=17 staff** (Comparator 3.71%)
- Staff who felt they could eat nutritious and affordable food when working **42.23%** (comparator 55.16%).

5. Summary of issues and priorities for action

- The 2023 Staff Survey does not point to a significant shift in a positive or negative direction in respect of staff experience at LWH.
- The increase in numbers of staff experiencing discrimination based on ethnicity and disability is of immediate concern albeit anticipated, as the Anti-Racism and inclusion programmes of work are proactively targeted to raise awareness that discrimination will not be tolerated at LWH and encourage the raising of concerns.
- Sexual Safety at work is a priority area of focus with the Trust having already signed the NHS Sexual Safety Charter which committed the Trust to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. Signatories to the charter committed to implementing all ten commitments by July 2024; the Board will receive a further update in July.
- Immediate action is required to ensure that affordable and nutritious food options are available to staff outside of 'office' hours and this is already being reviewed this year via a procurement process.
- A review will be undertaken in respect of access to necessary materials, goods and supplies required to ensure that any financial grip and control has not impacted adversely on ability to order essential supplies given the continued deterioration in this score over the last three years.
- The responses around learning and development need further interrogation to ensure there is equity of access, as there are more opportunities on offer than in any year previously, and a very robust process for the allocation of TNA and CPD monies for staff training.
- Action has already been taken to identify a lead for Reasonable adjustments for the Trust who will support managers & staff and oversee the procurement process for equipment to ensure both a rapid response and value for money.
- It is positive to see that investments in staffing and robust workforce planning processes have led to an improvement in staff feeling their department is appropriately staffed.
- The establishment of the psychologist led Staff Support Service continues to have high demand of c20 staff per month accessing the service but does appear to positively correlate with a reduction in work related stress being reported through the survey.
- Ongoing focus on improving flexible working opportunities in clinical areas is reflected in percentage point increases in scores in these areas.
- The Trust was successful in bidding for a 12 month 'People Promise Manager' role funded by NHS England which will support a programme of 'mid-career development' for nurses, midwives and AHPS, focused on career enrichment and retention in this important group of staff. In addition, through realignment of roles within the HR team, a role has been redefined to provide a specific focus on staff experience.

6. Next steps

The existing People Strategy pillars are aligned to leadership, staff experience, workforce supply and inclusion. The staff survey feedback will further inform these programmes of work, and those that sit within the Improvement Programme – specifically the Actively Anti Racist Programme and the Safety Culture programme.

Divisions already have access to the results for their areas and will use this information to further develop and refine the divisional annual people plans which will include their top 3 areas for improvement in response to their local teams' feedback.

There will be a Big Conversation on **18th May 2024** where every department will be visited by a senior manager and staff can feedback their ideas for improvement. The quarterly Pulse survey will continue

An enhanced integrated workforce performance report is in development which will provide the Board with regular sight of employee feedback trends throughout the year, including updates on the 3 x a year 'Let's Talk' Pulse survey feedback.

The Trust is currently analysing the free text comments; however, initial review would indicate that these broadly correlate to the areas of poorer performance within the survey itself and for which established programmes of improvement are already underway.

7. Conclusion and Recommendations

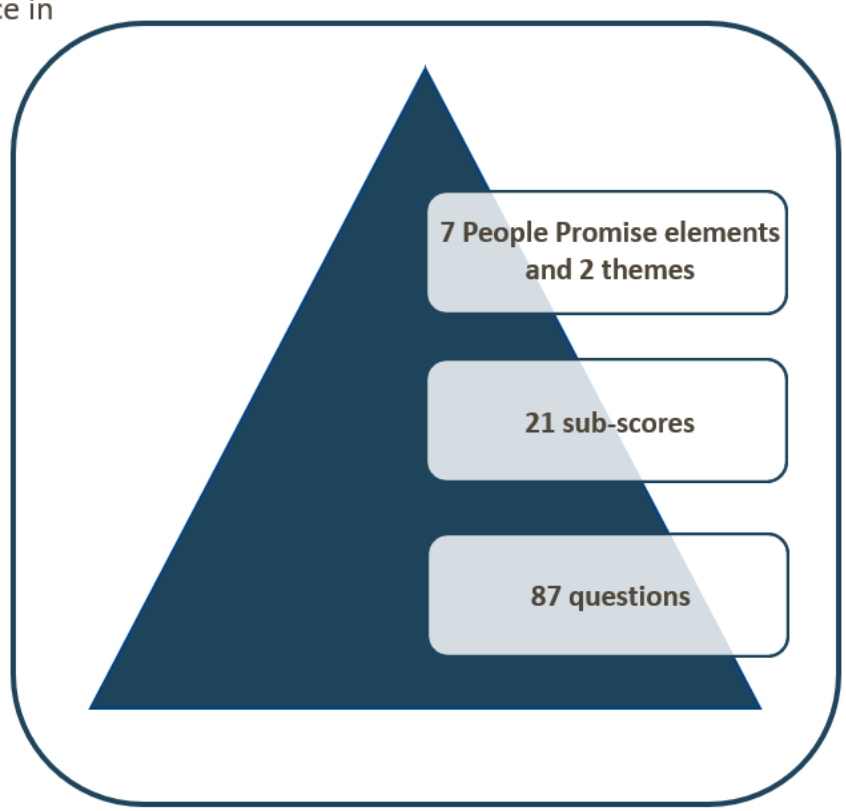
The staff survey provides useful intelligence to inform ongoing work plans with the objective of creating a supportive work environment that fosters staff well-being, enhances patient care, and ensures the long-term sustainability and engagement of the workforce.

The Board of Directors is asked to receive the contents of the paper and the performance of the Trust in this important national survey and consider any further actions which would contribute to improved staff experience at LWH.

Appendix A

The **People Promise summary indicators** provide an overview of staff experience in relation to the seven elements of the People Promise:

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



Scores are also reported for two of the ten themes previously reported:

- *Staff Engagement*
- *Morale*

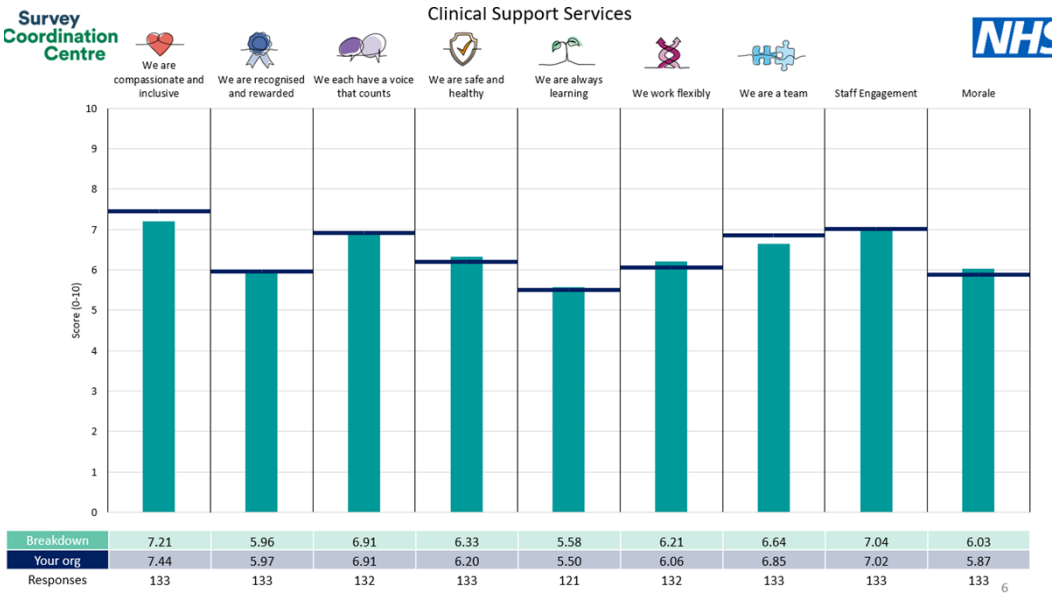
The score for each People Promise element and theme is based on between two and four sub-scores*, with each sub-score calculated from the responses to between one and nine aligned questions. Sub-scores are also reported.

*With the exception of the People Promise element "*We are recognised and rewarded*" which uses no sub-scores in its calculation

Appendix B Divisional & Medical Staff Breakdown

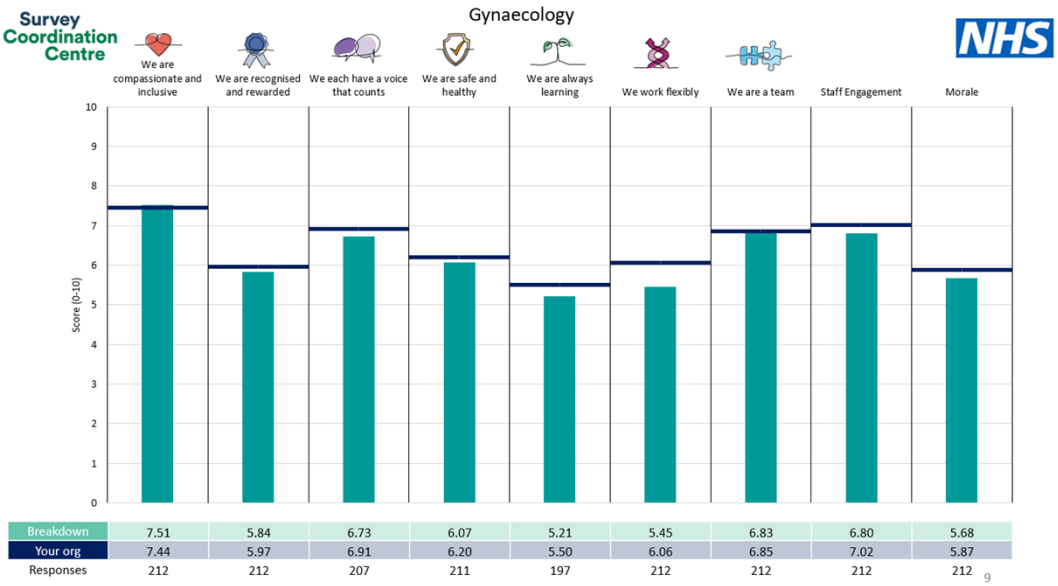
Clinical Support Services

The Division had a response rate of 56%, a decline from 2023 when it was 67%. Divisional scores meet or exceed the Trust average with the exception of 'We are compassionate and inclusive' and 'We are a team'.



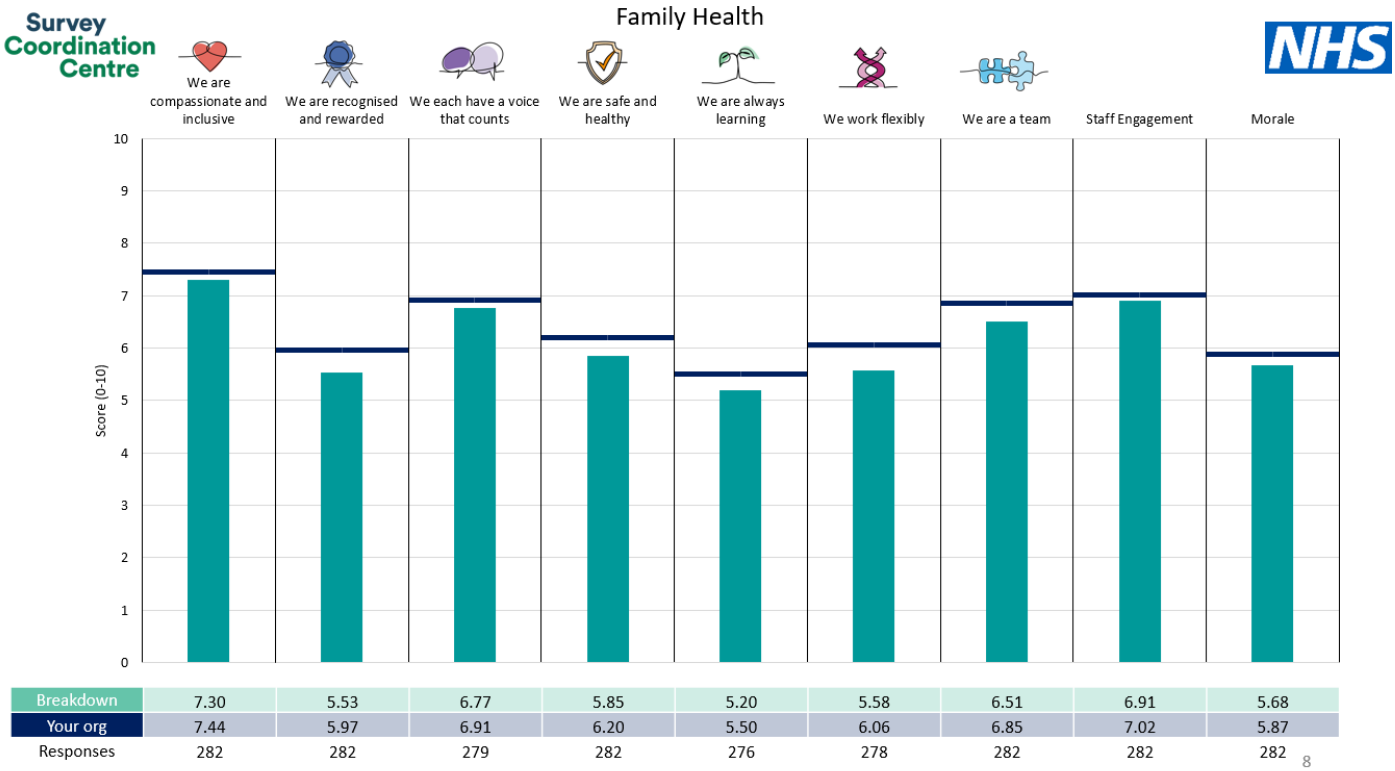
Gynaecology

The Division had a response rate of 56%, a decline from 2023 when it was 63%. Divisional scores are lower than the Trust average, with the exception of 'We are compassionate and inclusive' and 'We are a team' which are in line with the Trust average.



Family Health

The Division had a response rate of 39%. As in previous years, the Division score lower than the Trust average for all questions.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.30	5.53	6.77	5.85	5.20	5.58	6.51	6.91	5.68
Your org	7.44	5.97	6.91	6.20	5.50	6.06	6.85	7.02	5.87
Responses	282	282	279	282	276	278	282	282	282

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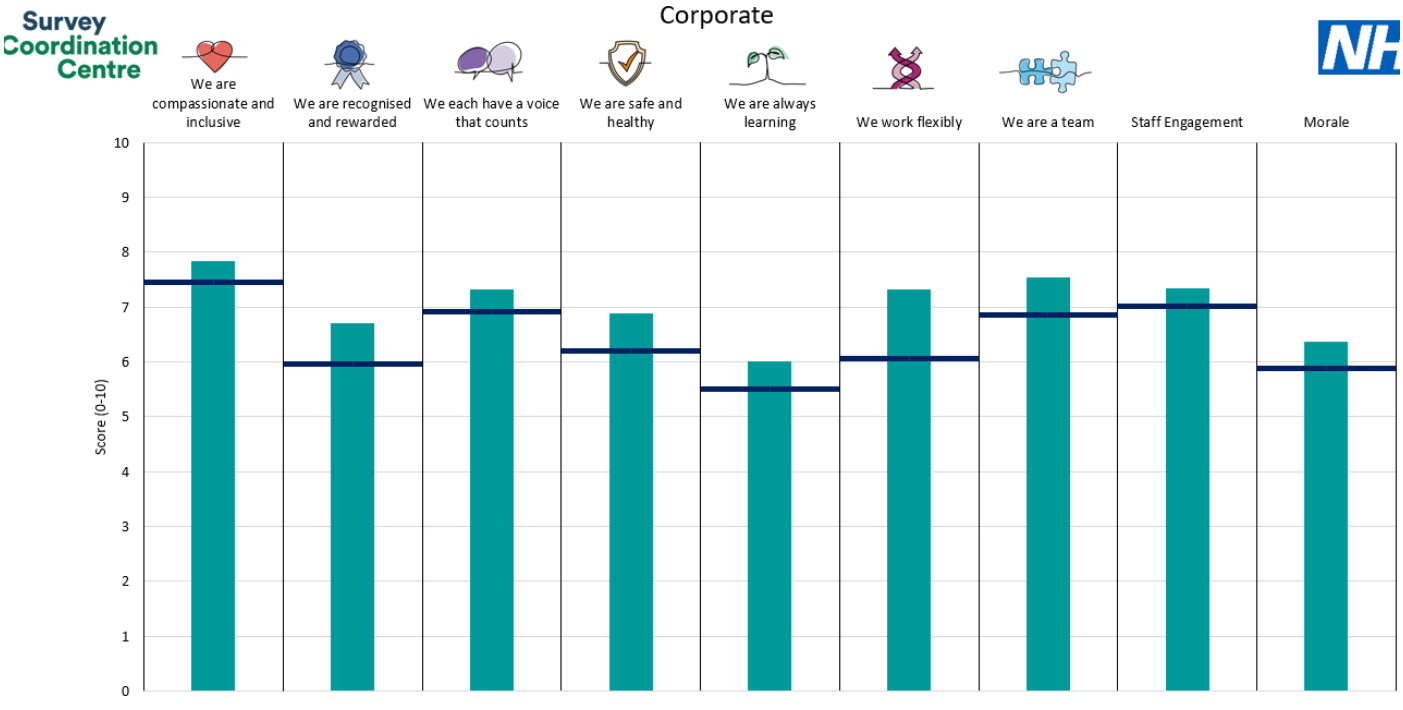
Corporate

As in previous years, Corporate staff have the highest response rate at 76% and the highest positivity scores across all themes of the survey.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.83	6.71	7.32	6.89	6.00	7.32	7.54	7.34	6.37
Your org	7.44	5.97	6.91	6.20	5.50	6.06	6.85	7.02	5.87
Responses	193	193	192	191	183	191	193	193	193

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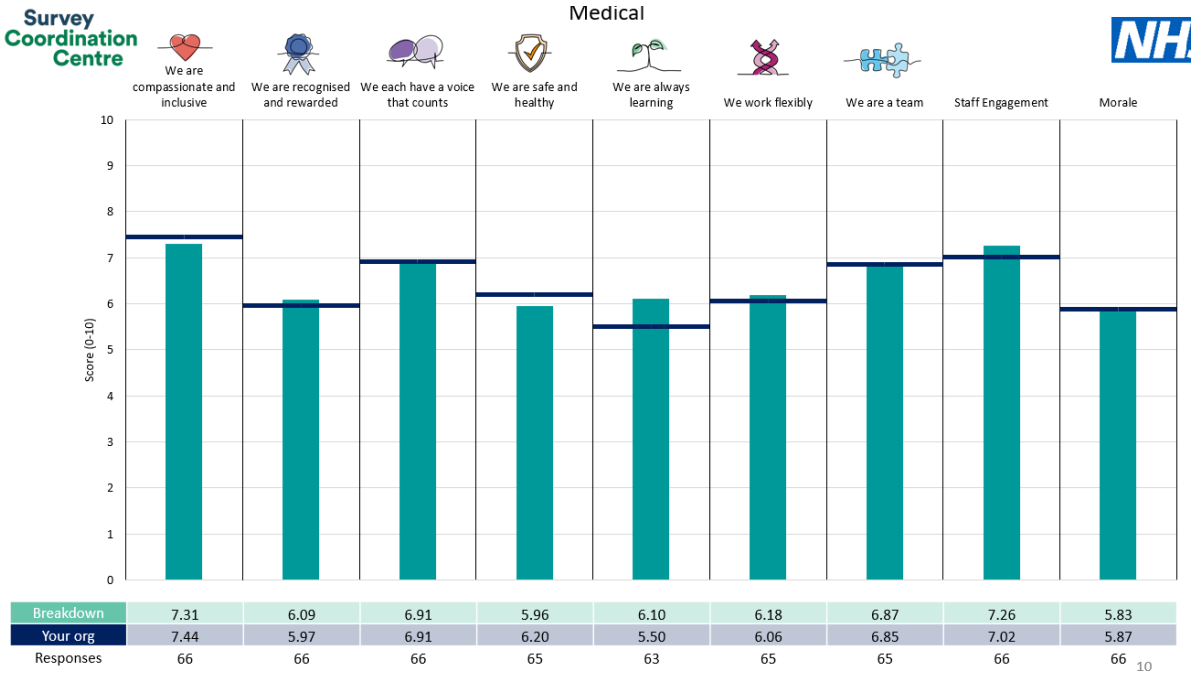
Medical Staff The response rate for medical staff was 56.4%, an improvement on 46% in 2022. As in previous years, medical staff score equal or above the Trust average score, with the exception of 'We are compassionate and inclusive' and 'We are safe and healthy' which is lower.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.31	6.09	6.91	5.96	6.10	6.18	6.87	7.26	5.83
Your org	7.44	5.97	6.91	6.20	5.50	6.06	6.85	7.02	5.87
Responses	66	66	66	65	63	65	65	66	66

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Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/277*		**Date: 14/03/2024**	
Report Title	Governance and Assurance Framework Review			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***The Trust's governance framework is under review to address increased demands from systemic challenges and provide improved clarity between operational and assurance roles.*** ***Planned reforms include clarifying roles by separating management and assurance, streamlining meetings to focus on strategy, and enhancing operational oversight with an Executive Risk and Assurance Group (ERAG).*** ***These changes aim to improve management efficiency and are to be monitored through assurance processes to ensure they meet strategic objectives effectively.***			
Action required	Approve ☒	Receive ☒	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is asked to receive the report and approve the proposed changes to the Trust's Governance and Assurance Framework.			
Supporting Executive:	James Sumner, Chief Executive			

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
Board Development	Jan 24 & Feb 24	Chief Executive / Trust Secretary	Outlined in the report

EXECUTIVE SUMMARY

The Trust has implemented a comprehensive governance and assurance framework, which has undergone iterative improvements year-over-year based on annual effectiveness reviews. The framework provides the basis for the Trust's internal control arrangements, which are annually audited. For the period from 1 April 2022 to 31 March 2023, the Trust received a "Substantial Assurance" opinion, indicating a well-functioning system of internal control.

The Trust faces ongoing operational and financial challenges driven by systemic factors. In response, there has been an increase in assurance reporting to the Board and its Committees, especially during the 2023/24 period. Whilst this increase aimed to enhance control and oversight, this approach has demanded considerable management capacity and, at times, precipitated a reduced clarity between operational management and assurance, necessitating a re-evaluation of the governance and assurance model.

To address these challenges, the Trust is planning to implement key changes to its governance structure and assurance framework. These changes include:

1. Separating operational management from assurance activities to clarify roles and responsibilities, thus avoiding governance complications.

2. Reducing the frequency of Board and Committee meetings to focus on strategic matters, thereby freeing up management capacity for operational delivery.

3. Streamlining the Trust's operational oversight arrangements through the development of an Executive Risk and Assurance Group (ERAG), tasked with providing advice and assurance on operational management effectiveness, particularly in risk management.

The Trust plans to update its Corporate Governance Manual, revise its Risk Management Strategy, and update the Board Assurance Framework to reflect strategic risks and controls. A communication plan will be developed to explain changes to staff, with a focus on training requirements.

The success of these changes will be monitored through various assurance processes, including the Audit Committee, internal audit plans, and a potential external Well-Led Review. These measures will ensure that the governance and assurance framework adjustments achieve the desired outcomes, supporting the Trust's continuous improvement efforts and strategic objectives.

Recommendations

The Board is asked to receive the report and approve the proposed changes to the Trust's Governance and Assurance Framework.

MAIN REPORT

Introduction

The Trust has a comprehensive governance structure in place which has been well established with iterative improvements made year to year following an annual Board and Committee effectiveness review process. This structure provides the basis for the Trust's internal control arrangements which are tested each year by Internal Audit with outcomes reported in the annual Head of Internal Audit Opinion. The overall opinion for the period 1 April 2022 to 31 March 2023, reported to Audit Committee on 16 June 2022, was as follows:

"Substantial Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently."

The Trust has needed to manage several challenges in recent years, the most significant of which have systemic drivers and therefore are likely to continue to require an operational and strategic response for the foreseeable future. In terms of governance and assurance, the response to this challenge has been to increase the volume of assurance reporting through the Board and its Committees, particularly during 2023/24. The Board has undertaken a review of these processes and approach via two development sessions held in January and February 2024. In part this has been to support the annual Board and Committee effectiveness review and a well-led self-assessment process. This review has also been driven, however, by a recognition that to fulfil its ambition of being an 'outstanding' Trust, the Trust needs to strengthen its governance and assurance processes, and that this will require a different approach.

This report outlines the drivers for change, the intended approach, enablers, and next steps, and how the Trust will monitor and assess whether these changes have resulted in the desired outcome. In reviewing the content of this report, the Board is requested to approve the changes to the governance and assurance framework and the attendant actions to take this forward to delivery.

Drivers for Change

The Trust faces a challenging operational and financial landscape, the solutions to which are likely to require long-term actions with the support of system partners. In terms of governance and assurance, the response to these challenges has been to increase the volume of assurance reporting through the Board and its Committees, particularly during 2023/24. For example, the number of public Board meetings increased during 2023/24 to 13 from 11 in 2022/23. The rationale for this increase in oversight is that it provided additional grip and control to oversee the necessary improvements. To some extent, this has been a successful approach. For example, whilst the Trust has continued to face a large financial deficit, there has been recognition at Board and system level that there has been demonstrable effective grip and control. Agency spend has remained below the set target and the Trust's reference costs continue to benchmark well against NHS parameters. Similarly, the Trust has recently demonstrated to the Care Quality Commission sufficient improvements in its maternity service that has resulted in the Section 29A Warning Notice being removed.

However, it is likely that the Trust will continue to need to demonstrate improvement during 2024/25, most acutely via the NHS England National Oversight Framework – the Trust is currently placed in segment three – necessitating regular oversight meetings with Cheshire & Merseyside Integrated Care Board. The Trust is currently agreeing the exit criteria to move into segment two and developing an Improvement Programme approach that will enable the Trust to not only focus resource effectively to meet the criteria but to also develop mitigations rapidly for the most pressing patient safety risks.

In its reflections during the development sessions, the Board has acknowledged that the current governance and assurance model, if continued without amendment, would be unsustainable for the organisation considering the level of management capacity that it has demanded, particularly in terms of the volume of report production. To be

successful, the Improvement Programme will also require significant management capacity. Change is therefore required to correct the balance between providing time and resource for delivery against the time and resource for accounting for delivery.

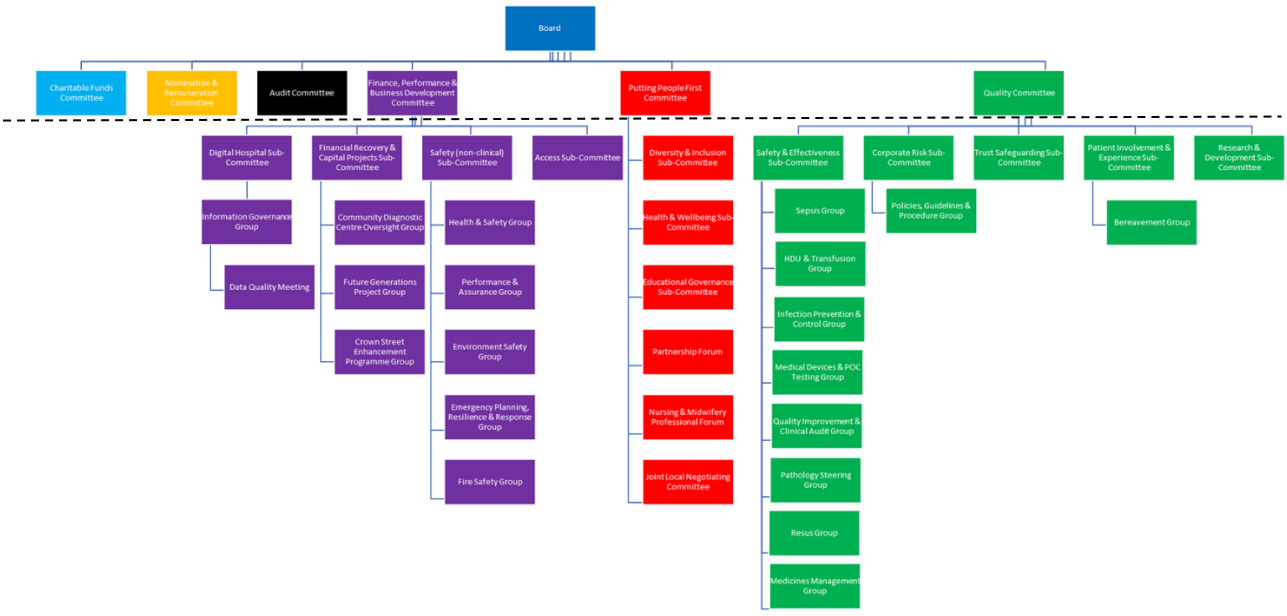
Utilising the Trust's governance and assurance framework to provide additional grip and control has somewhat inevitably led to reduced clarity between the boundaries of operational management and assurance. It is becoming increasingly recognised that whilst culture and behaviours influence this issue, structures can be set up in a way that also facilitate this lack of separation. In the article "Assurance: where does the pyramid point?" by the Good Governance Institute[1], the complexity of implementing assurance within public sector frameworks is highlighted. It argues for a definitive separation between management functions and assurance activities to avoid governance complications, such as diminished oversight and ineffective assurance mechanisms. The piece compares the operational frameworks within NHS organisations, illustrating that the more successful ones feature managerial teams reporting straight to executive leaders, whereas the less successful ones tend to have these teams report to the Board and its Committees. This arrangement can introduce governance difficulties, primarily due to the reduced clarity between management responsibilities and governance duties.

A predominant focus on operational matters at the Board and its Committee can also diminish opportunities for these to fulfil their primary purpose i.e., seeking assurance that the Executive is developing the appropriate responses to ensure that the Trust is meeting its strategic objectives and mitigating the most significant risks to the delivery of these objectives. In reviewing the efficacy of the Governance and Assurance processes, it is germane to ensure that structures are established that provide the best opportunity to emphasise appropriate roles and accountabilities.

Outline of key changes

Separation of Operational Management and Assurance Structures

1) *Separation of Board Committees and Sub-Committee structure*
   The Trust's current assurance structure looks as follows:



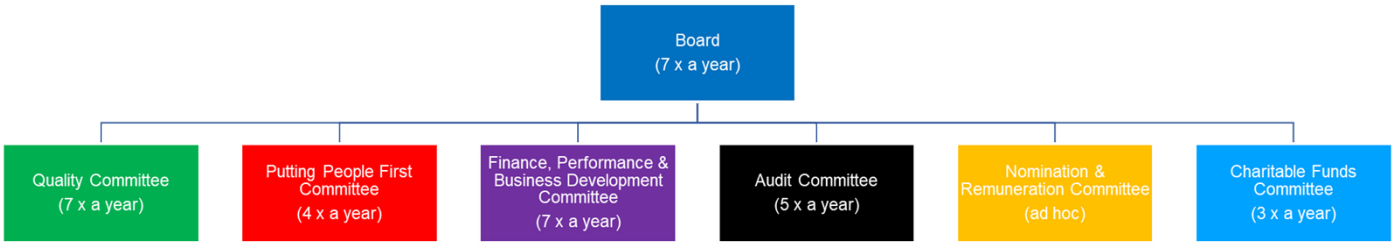
[1] https://www.good-governance.org.uk/publications/insights/assurance-where-does-the-pyramid-point

There are a significant number of sub-committee meetings that directly report into the Board Committees. This is contributing to the reduced clarity between operational management and assurance. It is therefore proposed that the meetings below the 'dotted line'(see diagram above) are restructured, reporting into an Executive-Led group (see section below on the Executive Risk and Assurance Group [ERAG]).

2) *Reducing the frequency of the Board and its Committees – enabling a refocus onto statutory and strategic matters*

The current frequency of assurance meetings is resource intensive with much of the agendas during 2023/24 focussed on immediate operational issues – please see Appendix B for a detailed review of Committee activity during the year. These reviews demonstrate that a significant number of additional items (above those set on the 2023/24 work programmes) have been received during the year. Reducing the frequency to the pattern outlined below will support the following two objectives a) reducing the level of management capacity required to service and attend the meetings, releasing this to focus on delivery, and b) enabling the Board and its Committees to refocus onto statutory assurance, strategy development, and risks to strategic delivery via the Board Assurance Framework. Appendix C outlines updated draft work programmes to demonstrate how this could be achieved, and Appendix B outlines how items previously received could be reallocated to operational management under the ERAG structure. The Board has a scheduled development session in March 2024 to consider the underpinning programmes under the Improvement Plan portfolio headings. Once agreed, it will be a key role for the Committees to receive assurance on the medium to long-term programmes and this will be factored into the finalised work programmes.

Draft updated Terms of Reference for the Committees can be found in Appendix C. It should be noted that apart from a change of template, the respective Terms of Reference have not required considerable amendment as these had always recognised the need for a strategic focus. No changes have been suggested to the Audit Committee hence its omission from the appendices to this report.



Streamlining and strengthening the Trust's operational oversight arrangements

While a primary goal of the governance and assurance review is to decrease the number of assurance meetings, it's crucial that this reduction does not compromise the Board's oversight and comprehension of essential operational issues. In fact, enhancing operational oversight is a fundamental objective of this initiative. Through this enhancement, the Board will receive more focused assurance, escalated with greater discernment through a strengthened management process.

The development of an Executive Risk and Assurance Group (ERAG) will be a fundamental element of this process. The ERAG will provide advice and assurance to the Chief Executive and the Board of Directors about the effectiveness of operational management of the Trust, with specific reference to risk. The ERAG will take on the role of the operational leadership of the Trust, ensuring delivery of strategy and effective management of the Trust's key risks through interrogation of evidence about the effectiveness of risk treatment actions. The ERAG will also provide a corporate view on Trust-wide issues of current concern ensuring co-ordination between Divisions. Ultimately, the

ERAG will provide the formal mechanism to support the Chief Executive in effectively discharging his responsibilities as Accountable Officer. To fulfil this role, the ERAG will have an underpinning reporting structure, led thematically by Executives. This structure is currently being finalised with agreed terms of reference, work programmes and scheduling with an expected 'go live' date in April 2024. The ERAG will produce a monthly assurance report to be received at each public Board meeting and circulated to Board members in a month when it does not have a formal meeting. A draft example of this report can be found in Appendix E.

For the ERAG structure to be effective, the Trust is intending to place risk at the centre of its operational performance arrangements. This will enable key issues to be escalated with discernment and assurance from the wards to the Board. Whilst the Trust has well established risk management processes, this will require a review to ensure that they align with the objectives of this review. A Board development session is planned in March 2024, and this will inform an updated Risk Management Strategy, scheduled to be tabled for approval in April 2024.

A fortnightly Improvement Programme Board is also being established, the primary purpose of which will be to seek assurance on progress being made against the Improvement Programme portfolio programmes. This will report to the Board of Directors via a monthly dashboard – please see Appendix F for a worked example.

Overall, these two reporting lines should provide the Board with strengthened assurance that the Trust's 'yesterday, today, and tomorrow' risks, issues and improvement actions are either being adequately managed and/or escalated. Those matters that require a more strategic and medium to long-term view will be given due attention and scrutiny via the Board and its Committees.

The interaction between the operational management and assurance elements of the governance and assurance framework is illustrated in Appendix A.

Links to the Well-Led Framework

It is good practice for the Board to undertake an annual review against the NHS England Well-Led Framework. The Board will recall that an external Well-Led review was undertaken by Grant Thornton with a final report shared with the Trust in June 2021 and with the Board ahead of the July 2021 meeting.

The high-level output from the external review was as follows:

NHSI Well-Led framework			
#	Question	Trust rating 2020	GT rating 2021
1	Is there the leadership capacity and capability to deliver high quality, sustainable care?		
2	Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?		
3	Is there a culture of high quality sustainable care?		
4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?		
5	Are there clear and effective processes for managing risk, issues and performance?		
6	Is appropriate and accurate information being effectively processed, challenged and acted on?		
7	Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?		
8	Are there robust systems and processes for learning continuous improvement and innovation?		

Since that point, Grant Thornton undertook a desktop based follow up and the action plan was updated (and reported to the Board in September 2022) with the outcomes from this together with a review of the following key governance documents:

- Updated Code of Governance for NHS Providers
- Addendum to Your statutory duties – reference guide for NHS foundation trust governors
- Guidance on good governance and collaboration

- Supporting the ICB – NHS Trusts governance readiness – Good Governance Institute

Work has progressed against this action plan and the outcomes of this have been made available to the Board via AdminControl. Whilst most actions have been closed, there remain several areas that require further work – these can be summarised as follows:

- Setting clear objectives for reducing health inequalities and ensuring that performance reports are disaggregated by ethnicity and deprivation where relevant, with metrics related to the wider determinants of health.

- Continuing to strengthen the Trust's governance arrangements and ensuring that system priorities can be signposted throughout the whole organisation.

- To continue to embed the Trust's Improvement approach in day-to-day operations and show how this is supporting system priorities.

These actions will be taken forward via this Governance and Assurance Review together with the programmes that will be identified for the 'well-led' portfolio of the Trust's Improvement Programme.

Risks, enablers and next steps

Fundamentally, this proposal presents a significant change to the Trust and how it carries out its business. This does not come without an element of risk. These are outlined below and should Board approval for the outlined changes be forthcoming, the following next steps will be necessary to take this forward and help to mitigate the potential risks.

- Risk – significant change for the organisation – important to maintain operational oversight on current and emerging risks.
    - Updating the Trust's Corporate Governance Manual and combining this with the Governance and Performance Framework. This will provide a single document and 'version of the truth' for how the Trust manages its business. The updated Committee Terms of Reference and work programmes will form part of this document following their review at the scheduled meetings during March 2024.
        - Committees to review Terms of Reference and Work Programmes – *March 2024*
        - Document for approval – *April 2024 Board*
    - Developing a communications plan for staff explaining the changes to the Governance and Assurance framework and support to navigate new processes and templates. This may also identify on-going training requirements in relation to risk management and understanding 'making data count' methodology.
        - *April 2024*

- Risk - An effective risk management process is central to the success of the proposed model.
    - A revised Risk Management Strategy is in development recognising the importance of effective risk management to the appropriate escalation of issues to the Executive and the Board.
        - Board Development Session – *March 2024*
        - Document for approval – *April 2024 Board*
    - Updating the Board Assurance Framework to ensure that the Trust's key strategic risks are reflected and that medium to long-term controls have been identified against each of these. This will help to inform Board and Committee work programmes for 2024/25.
        - Board Development Session – *March 2024*
        - Document for approval – *April 2024 Board*

How will we know this is working?

The Trust committed to a continuous improvement approach, and this should apply to its governance and assurance processes. During its development sessions, the Board has acknowledged that the proposed changes are relatively extensive and will therefore take time to embed. However, it is important to ensure and monitor that the intended outcomes and benefits are being realised. The following assurance processes will support the Trust in this aim:

- *Audit Committee* – In its role in monitoring the effectiveness of the Trust's internal control systems and risk management framework, the Committee will receive regular updates during 2024/25 on the efficacy, or otherwise, of the updated arrangements.
- *MIAA internal audit plan* – The 2024/25 internal audit plan includes an internal audit into the effectiveness, or otherwise, of the revised framework.
- *Board and Committee Effectiveness Review* – This will provide an opportunity to reflect one year on and seek further improvements if necessary.
- *External Well-Led Review* – In line with good practice, the Trust is due to seek an external well-led review in 2025/26 at the latest to comply with the Code of Governance. This would provide an opportunity to test the effectiveness of arrangements once they have had time to become embedded.

Recommendation

The Board is asked to receive the report and approve the proposed changes to the Trust's Governance and Assurance Framework.

Appendices

Appendix A – Draft Governance and Assurance Framework diagram

Appendix B – Committee Effectiveness Reviews

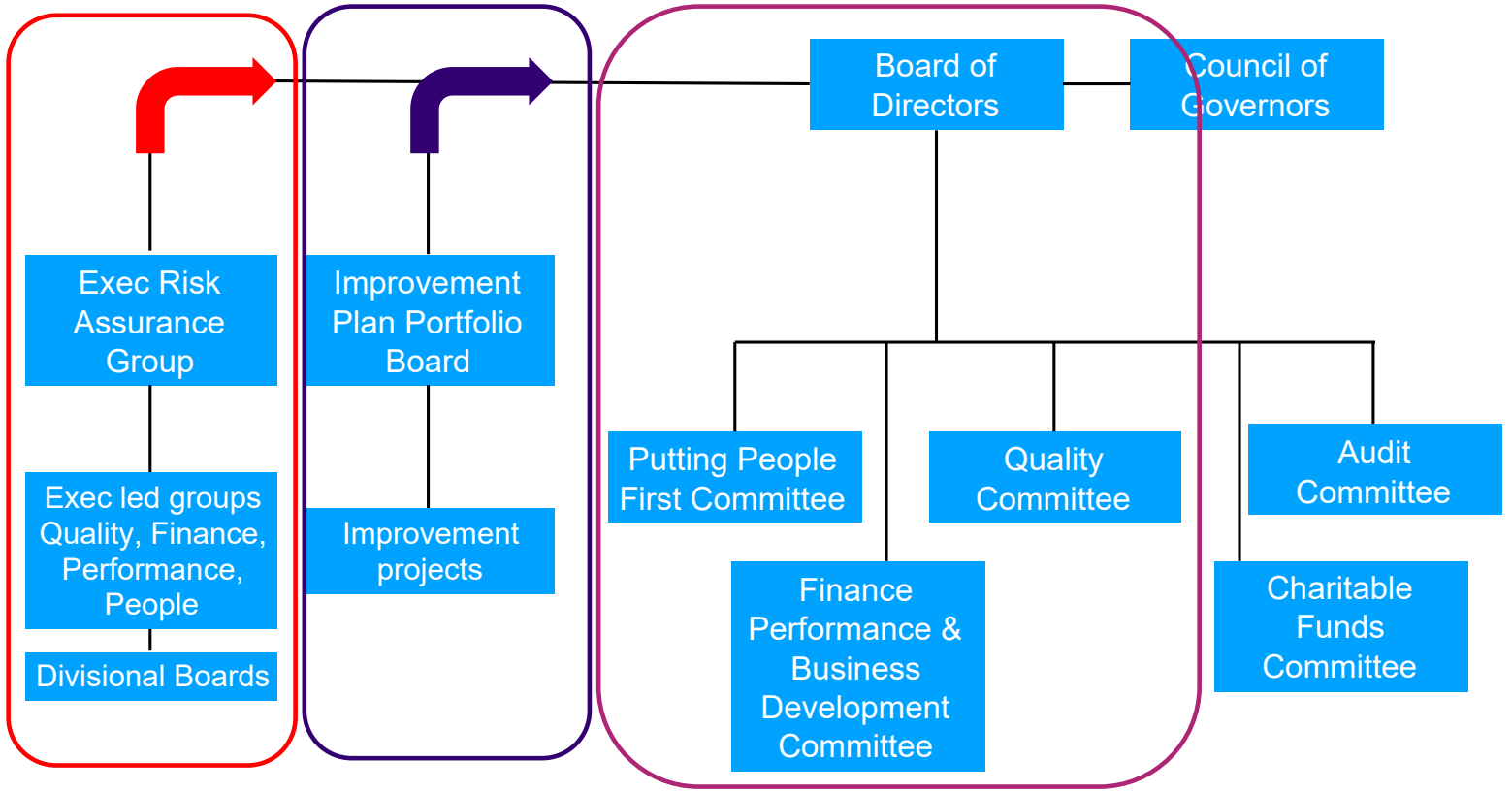
Appendix C – Draft Committee Terms of Reference

Appendix D – Draft Board & Committee 2024/25 work programmes

Appendix E – Mock Executive Risk and Assurance Group Board report

Appendix F – Mock Improvement Programme Portfolio Board Dashboard report

Appendix A - Draft Governance and Assurance Framework diagram



Operational Assurance Function
ERAG report to Board covers divisional and exec risks combined with narrative and an Integrated performance report (monthly)

Improvement Assurance Function
Improvement Plan Dashboard, Milestones, Benefits and KPIs (monthly)

Medium to long term focus
Annual cycle of business (assurance reports)
Strategies
Longer term plans

Board Sub-Committee Effectiveness Review and Proposed Amendments to the Committee Business Cycle 2024/25

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

Quality Committee

The Quality Committee last reviewed its annual business cycle in March 2023 and is therefore scheduled to complete a further review in order to set the business cycle for 2024/25.

During 2023/24, there had been 14 additional items (above the agreed work programme) received by the Committee, six of which were remitted Chair actions (**in bold**). This demonstrates better management of utilising the business cycle and receiving appropriate ad hoc escalation reports to review emerging issues.

- Patient Safety Incident Response Framework;
- Clinical Mandatory Training;
- Complaint Response Deep Dive;
- DigiCare Reporting Assurance Report;
- The NHS Prevention Pledge;
- **Review of Serious Untoward Incidents 2022-2023;**
- **Review into the most appropriate method of measuring Caesarean Section (emergency and total) rates;**
- **Overview of Cancer Services – in-depth analysis by tumour site;**
- Provision of Epidural Services for Pain Relief;
- Review of the last 5 Years of Critical Care Transfers;
- **Gynaecology Emergency Department (GED) service review;**
- **Review of the Revised Model of Care for Midwifery Continuity of Care (MCoC);**
- Maternal Death MNSI formerly HSIB Action/ Improvement plan;
- **Review of High Dependency Unit /Enhanced Maternity Care provision**

During 2023/24, the following amendments to the business cycle were suggested and agreed:

- Annual Review of Litigation - added to workplan and received in May 2023
- Clinical incidents attributable to the isolation of LWH services from other specialist services - added to workplan in June 2023 to receive on a quarterly basis.
- Maternity Transformation and Improvement Update – received monthly in response to the CQC inspection visit and subsequently de-escalated from the workplan as improvements evidenced and maintained.
- It is worth noting that the Palliative and End of Life Care Bi-Annual Report had not been received by the Committee since its inclusion on the business cycle in 2022/23, however it is recommended that the Committee should be receiving assurance on palliative care on an annual basis.

As part of the proposed changes to the Trust's Governance and Assurance Framework, further amendments to the business cycle are recommended to allow the Board Committees to fulfil their primary purpose to seek assurance that the Executive is developing the appropriate responses to ensure that the Trust is meeting its strategic objectives and mitigating the most significant risks to the delivery of these objectives. These changes are listed below:

- Controlled Drugs Annual Report – new addition to strengthen medicines management assurance reporting.

- Remove from the business cycle:
    - Quality Performance Report – remove and report through the Executive Risk & Assurance Structure
    - Clinical incidents attributable to the isolation of LWH services from other specialist services – information should be reported within the incident reporting process.
    - Medicines Management Assurance Report – remove and report through the Executive Risk & Assurance Structure
    - LocSSIPs / NatSSIPs Quarterly Assurance Report – remove and report through the Executive Risk & Assurance Structure
    - Safety Champion Update (quarterly) - Information to be included in the Integrated Performance Report within the Perinatal Dashboard
    - Annual Health and Safety Report – reposition to the FPBD Committee
    - Safeguarding Quarterly report – remove and report through the Executive Risk & Assurance Structure
    - Patient Survey/s (to be reported by exception) – remove and report through the Executive Risk & Assurance Structure
    - Ward Accreditation Scheme – remove and report through the Executive Risk & Assurance Structure
    - Corporate Objectives: 6 monthly and year-end review & Objective Setting – remove as corporate objectives replaced with integrated plan and to be reported to the Trust Board.
    - Subcommittee chairs reports and Terms of Reference – remove and report through the Executive Risk & Assurance Structure
    - Annual Review of Risk Management Strategy - removed from Committee business. Continue to be reviewed by Audit Committee and approved by Board
    - Risk Appetite Statement – removed from Committee business. Continue to be reviewed by Audit Committee and approved by Board.

Committee	Report	Move to	Group
Quality Committee	Monthly Quality Performance Report	to	Integrated Performance Report, Executive Risk & Assurance Structure
Quality Committee	Medicines Management Assurance Report	to	Executive Risk & Assurance Structure
Quality Committee	LocSSIPs / NatSSIPs Quarterly Assurance Report	to	Executive Risk & Assurance Structure
Quality Committee	Safety Champion Update (quarterly)	to	Information to be included in the Integrated Performance Report within the Perinatal Dashboard
Quality Committee	Annual Health & Safety Report	to	Finance, Performance & Business Development Committee
Quality Committee	Safeguarding Quarterly Report	to	Executive Risk & Assurance Structure
Quality Committee	Patient Survey/s (to be reported by exception)	to	Executive Risk & Assurance Structure
Quality Committee	Clinical incidents attributable to the isolation of LWH services from other specialist services (added to workplan in June 2023)	to	Remove from group structure and include within incident reporting process
Quality Committee	Ward Accreditation Scheme – annually	to	Executive Risk & Assurance Structure
Quality Committee	Corporate Objectives: 6 monthly and year-end review & Objective Setting	to	Integrated Planning (Group)
Quality Committee	Subcommittee chairs reports and Terms of Reference	to	Executive Risk & Assurance Structure

Quality Committee	Annual Review of Risk Management Strategy	to	Audit Committee and Board
Quality Committee	Risk Appetite Statement	to	Audit Committee and Board

Finance, Performance & Business Development Committee

During 2023/24, there was evidence of the Committee utilising the business cycle effectively and receiving appropriate ad hoc escalation reports to review emerging issues.

The Finance, Performance & Business Development Committee last reviewed its annual business cycle in March 2023 and is therefore scheduled to complete a further review in order to set the business cycle for 2024/25.

During 2023/24, there had been six additional items (above the agreed work programme) received by the Committee:

- Cheshire & Mersey Finance Strategy
- External asset survey on the estate
- Performance Recovery Framework
- Financial Recovery plan
- 2022/23 National Cost Collection pre-submission planning report, Trust Costing Strategy 2023/24, and National Cost Collection (NCC) Exercise Final Submission
- Distressed Finance Application

The following additional reports were considered under procurement matters during 2023/24:

- Digital Maternity Contract Review
- Fertility Service Briefing
- Soft Fm Contract Extension
- Ambulatory Business Case

During 2023/24, the following amendments to the business cycle were suggested and agreed:

- Finance and Procurement Strategy Annual review – added to workplan in July 2023 to receive on an annual basis
- Assurance regarding third party service provider controls (SLA's) – increased frequency of reporting from bi-annually to quarterly as of November 2023.
- Strategic Progress review - agreed to submit strategic reports directly to Trust Board as of July 2023.
- HFMA Improving Financial Sustainability Checklist self-assessment annual update – removed from workplan in October 2023 and remitted to the Finance Recovery Board to monitor and escalate matters if required.
- National Cost Collection Index – NCC submission received November 2023 and added to workplan.

As part of the proposed changes to the Trust's Governance and Assurance Framework, further amendments to the business cycle are recommended to allow the Board Committees to fulfil their primary purpose to seek assurance that the Executive is developing the appropriate responses to ensure that the Trust is meeting its strategic objectives and mitigating the most significant risks to the delivery of these objectives. These changes are listed below:

New additions for 2024/25:

- Three-year financial plan
- Patient Level Information and Costing Systems (PLICS)
- Health and Safety Annual Report – remitted from Quality Committee

- Estates Return Information Collection (ERIC)
- Safe and Sustainable Annual Report (to include Fire Safety Annual Report, Premises Assurance Model, Violence, Prevention and Reduction Standards)
- Estates Strategy
- Digital Generations Strategy 2020-2024 Annual review – increase to bi-annual review to replace monthly reporting.
- Corporate Objectives – remove and replace with Annual Integrated Plan and to be reported to the Trust Board.

Remove from workplan:

- Finance Performance Report – remove and report through the Executive Risk & Assurance Structure
- Operational Performance Report – remove and report through the Executive Risk & Assurance Structure
- Crown Street Enhancement Progress Review – remove and report through the Executive Risk & Assurance Structure
- Community Diagnostic Centre Oversight – remove and report through the Executive Risk & Assurance Structure
- Post Implementation Review of CDC 2022/23 – remove and report through the Executive Risk & Assurance Structure
- Annual Estates and Facilities Compliance Report - replace with Safe and Sustainable Annual Report to FPBD, an output from the Safe and Sustainable Group
- Major procurement decisions (ad-hoc as necessary) – remove and report through the Executive Risk & Assurance Structure
- Assurance regarding third party service provider controls (include review of HR Shared service contracts) – remove and report through the Executive Risk & Assurance Structure
- Skills Development Network Accreditation (annual) – remove and report through the Executive Risk & Assurance Structure
- Security Management Annual Report - Replaced with Violence, Prevention and Reduction Standards which should be included within the Safe and Sustainable Annual Report
- Subcommittee chairs reports and Terms of Reference – remove and report through the Executive Risk & Assurance Structure
- Risk Appetite Statement – removed from Committee business and continue to be reviewed by Audit Committee and approved by Board

Committee	Report	Move to	Group
FPBD Committee	Finance Performance Report	to	Executive Risk & Assurance Structure
FPBD Committee	Operational Performance Report	to	Executive Risk & Assurance Structure
FPBD Committee	Crown Street Enhancement Progress Review	to	Executive Risk & Assurance Structure
FPBD Committee	Digital Services Update (including IG matters)	to	Executive Risk & Assurance Structure
FPBD Committee	Community Diagnostic Centre Oversight	to	Executive Risk & Assurance Structure
FPBD Committee	Post Implementation Review of CDC 2022/23	to	Executive Risk & Assurance Structure
FPBD Committee	Assurance regarding third party service	to	Executive Risk & Assurance Structure

	provider controls (quarterly update as of Nov 23)		
FPBD Committee	Major procurement decisions	to	Executive Risk & Assurance Structure
FPBD Committee	Skills Development Network Accreditation (annual)	to	Executive Risk & Assurance Structure
FPBD Committee	Corporate Objectives	to	Integrated Planning (Group)
FPBD Committee	Subcommittee chairs reports and Terms of Reference	to	Executive Risk & Assurance Structure
FPBD Committee	Security Management Annual Report	to	Replaced with Violence, Prevention and Reduction Standards. This should be provided within the Safe and Sustainable Annual Report.
FPBD Committee	Annual Estates and Facilities Compliance Report	to	Replaced with Safe and Sustainable Annual Report to FPBD, an output from the Safe and Sustainable Group
FPBD Committee	Risk Appetite Statement	to	Audit Committee and Board

Putting People First Committee

The Putting People First Committee last reviewed its annual business cycle in March 2023 and is therefore scheduled to complete a further review in order to set the business cycle for 2024/25.

During 2023/24, three workshops were held to consider the future direction of the People Strategy. There had been seven additional items (above the agreed work programme) received by the Committee, two of which were remitted Chair actions (**in bold**).

- **Maternity Red Flag Deep Dive: 6-month review update and one further update**
- Midwifery Preceptorship: Feedback
- Mandatory Training Audit Progress Report and two further updates
- An overview of the NHS Long Term Workforce Plan and its implications for LWH Workforce Strategy
- **Nursing, Midwifery and AHP Leadership structure review**
- Medical Workforce Project (Strategy)
- Safeguarding Update, Domestic Abuse and Sexual Violence Charter

During 2023/24, the following amendments to the business cycle were suggested and agreed:

- Staff Support Service Report – added to the wok plan in May 2023 and received in January 2024

It is worth noting that the following item appeared on the workplan but was not discussed during the year due to workforce pressures within the HR team:

- Talent Management & Leadership Development Review

As part of the proposed changes to the Trust's Governance and Assurance Framework, further amendments to the business cycle are recommended to allow the Board Committees to fulfil their primary purpose to seek assurance that the Executive is developing the appropriate responses to ensure that the Trust is meeting its strategic objectives and mitigating the most significant risks to the delivery of these objectives. These changes are listed below:

- DBS Annual Self-Declaration Compliance – new addition

- Remove from the business cycle:
    - Workforce Performance Report – remove and report through the Executive Risk & Assurance Structure
    - Policies for Approval & Policy Audit Update – remove and report through the Executive Risk & Assurance Structure
    - Service Workforce Assurance – remove and report through the Executive Risk & Assurance Structure
    - Medical Appraisal & Revalidation Quarterly Report – remove and report through the Executive Risk & Assurance Structure
    - Staff Listening Events Report – to be captured within Culture update report and Staff Survey update to PPF Committee and to Board
    - Review of External Contracts – remit to the FPBD Committee to include within the 'Assurance regarding third party service provider controls' report
    - Communications, Marketing and Engagement Strategy Annual Review – remit to the FPBD Committee which also receives an update on the marketing strategy on an annual basis.
    - Staff Support Service Report – remove and report through the Executive Risk & Assurance Structure
    - Flu Campaign Annual Update – remove and report direct to Board
    - Corporate Objectives: 6 monthly and year-end review & Objective Setting – remove as corporate objectives replaced with integrated plan and to be reported to the Trust Board.
    - Subcommittee chairs reports and Terms of Reference – remove and report through the Executive Risk & Assurance Structure
    - Risk Appetite Statement – removed from Committee business and continue to be reviewed by Audit Committee and approved by Board

Committee	Report	Move to	Group
PPF Committee	Workforce Performance Report	to	Integrated Performance Report under the Executive Risk & Assurance Structure
PPF Committee	Policies for Approval & Policy Audit Update	to	Executive Risk & Assurance Structure
PPF Committee	Service Workforce Assurance	to	Executive Risk & Assurance Structure
PPF Committee	Medical Appraisal & Revalidation Quarterly Report	to	Executive Risk & Assurance Structure
PPF Committee	Staff Listening Events Report	to	be captured within Culture update report and Staff Survey update to PPF Committee and to Board
PPF Committee	Review of External Contracts	to	Executive Risk & Assurance Structure
PPF Committee	Communications, Marketing and Engagement Strategy Annual Review	to	Finance, Performance & Business Development Committee
PPF Committee	Staff Support Service Report	to	Executive Risk & Assurance Structure
PPF Committee	Flu Campaign Annual Update	to	Board only
PPF Committee	Corporate Objectives	to	Integrated Planning (Group)
PPF Committee	Subcommittee chairs reports and Terms of Reference	to	Executive Risk & Assurance Structure
PPF Committee	Risk Appetite Statement	to	Audit Committee and Board

Charitable Funds Committee

During 2023/24, there was evidence of the Committee utilising the business cycle effectively.

The Charitable Funds Committee last reviewed its annual business cycle in June 2023 and is therefore scheduled to complete a further review in order to set the business cycle for 2024/25.

Four meetings had been scheduled however the meeting was held three times during the year.

There are currently no recommended changed to the business cycle for 2024/25 and it is recommended that the Committee reduce its meeting frequency to three times a year.

QUALITY COMMITTEE

TERMS OF REFERENCE (DRAFT)

Authority/Constitution

1. The Committee is established by the Board of Directors and will be known as the Quality 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.

2. 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.

3. 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.

Purpose

4. The Committee exists on behalf of the Board of Directors to:

    - Seek, review and scrutinise assurances that strategic priorities for quality have been identified, and that effective and appropriate systems are in place to drive evidence-based quality improvement and clinical outcomes.
    - Seek, review and scrutinise assurances that patients, carers and families are receiving outstanding services that are safe, compassionate, fair and consistent in quality.

Duties

5. The Committee is responsible for:

6. **Strategy**

    a) To seek assurance, providing challenge and scrutiny as necessary, regarding the identification, implementation, and delivery of priorities within the Trust's Quality Strategy; ensuring it is consistent with the Trust's vision and improvement programme.

    b) To provide support and challenge with regards to continuous quality improvement, and to receive assurance of such aligned to the Quality Strategy, with a clear focus on upholding the tenants of quality (governance, safety, patient experience, and clinical effectiveness)

    c) Review trends in patient safety, experience and outcomes (effectiveness) impacting on strategic or transformation programmes to provide assurance to the Board and commission 'deep dives' as appropriate.

d) To seek and receive assurance that learning is embedded from in-patient, outpatient and other care related surveys; and this leads to improvements in the experiences of patients, service users and carers. Make recommendations to the Board as appropriate.

e) To seek assurance, providing challenge and scrutiny as necessary, regarding the development and implementation of priorities to address equality, diversity and health inequalities as they relate to access, experience and outcomes for the people who need our services.

f) Review the Trust's Research and Development Strategy and Innovation Strategy prior to their recommendation to the Board of Directors; and seek assurance regarding their ongoing delivery.

7. **Governance and risk**

g) Seek assurance that the organisational systems and processes in relation to clinical governance (quality, safety, patient experience, and clinical effectiveness) are robust, effective and well-embedded so that priority is given to identifying and managing risks to the quality of care.

h) Review the controls and assurances against relevant quality risks on the Board Assurance Framework (BAF) and provide assurance to the Board that risks to the strategic priorities relating to quality and safety are being managed. Identify and escalate any new or emerging issues impacting on the BAF.

i) To receive assurance regarding the robustness of the quality impact of financial recovery plans, and that risks to quality and safety are considered, mitigated and monitored.

j) 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.

k) 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.

l) To review the proposed internal audit plan for all functions areas within the Committees remit e.g. clinical audit, safety, experience and effectiveness.

8. **Compliance**

m) Ensure clinical systems maintain compliance with the CQC's fundamental standards and obtain assurance of the Trust's ongoing compliance with the CQC registration. Escalate issues to the Board of Directors as necessary.

n) Obtain assurance that the Trust is compliant with guidance from NICE (through receipt of an Annual Report) and other related bodies.

o) Consider external and internal reports to seek assurance regarding the robustness of management responses in relation to quality and patient safety resulting from improvement reviews / notices from NHSE, the CQC, HSSIB, HSE etc. and other bodies / external assessors.

Ensure that learning is embedded, and this leads to improvements in the experiences of patients, service users and carers.

p) Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on their delivery.

q) Review and receive assurances regarding the compliance of statutory reporting requirements including, but not limited to: safeguarding, infection prevention and control, learning from deaths, Guardian of Safe Working, maternity services, and medicines management.

9. **Overall**

r) To seek assurance, providing challenge and scrutiny as necessary regarding other priorities / areas of focus as agreed by the Board and the Quality Committee, which will be identified within the Committee's workplan.

s) 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.

t) Referring relevant matters for consideration to other Board Committees as appropriate.

u) Considering relevant matters delegated or referred to it by the Board of Directors or referred by any of the Board Committees.

v) Escalating matters as appropriate to the Board of Directors.

Membership

10. 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 Medical Officer
    - *Chief Nurse
    - *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.

11. 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.

12. 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.

13. 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 Chief Nurse or their deputy). The Chair of the Trust may be included in the quorum if present.

14. **Voting**

15. 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.

Requirements of Membership

16. **Members**

17. Members will be required to attend a minimum of 75% of all meetings.

18. **Officers**

19. The Committee will co-opt additional members to attend as and when required.

20. Other executive directors (including the Chief Executive) and officers of the Trust will be invited to attend and contribute to the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

21. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.

22. The Trust Secretary will attend to provide appropriate support to the Chair and Committee members.

Equality Diversity & Inclusion

23. In conducting its business, members must demonstrably consider the equality and diversity implications of decisions they make and consider whether in the management of risk control, the Trust achieves positive change around inclusion, equality, and diversity.

Conflicts of Interest

24. If any of the Members has an interest, financial or otherwise, in any matter and is due to be present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the Trust's Conflicts of Interests Policy. The Chair of the meeting will determine how a conflict of interest should be managed. The Chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

Reporting

25. The Quality Committee will be accountable to the Board of Directors.

26. A Chair's report will be submitted to the next following Board of Directors to provide assurance regarding matters discussed and to highlight / escalate key issues and risks. Approved minutes will be made available to all Board members.

27. The Committee will report to the Board annually on its work and performance in the preceding year.

28. Trust standing orders and standing financial instructions apply to the operation of the Committee.

Administration of Meetings

29. Meetings shall be held seven times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.

30. The Secretary will plan to ensure that Committee is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chair and members.

31. Agendas and papers will be circulated at least five working days in advance of the meeting.

32. Minutes will be circulated to members as soon as is reasonably practicable.

Review

33. The Terms of Reference of the Quality Committee shall be reviewed and submitted for approval to the Board of Directors at least annually.

Version Control Schedule

Date	Version no	Main changes proposed	Date approved by Audit Committee	Date ratified by Board of Directors (thereby come into force)
March 2024	1	Development of the Terms of Reference – alignment with updated template		

FINANCE, PERFORMANCE & BUSINESS DEVELOPMENT COMMITTEE

TERMS OF REFERENCE (DRAFT)

Authority/Constitution

1. The Committee is established by the Board of Directors and will be known as the Finance, Performance and Business Development 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.

2. 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.

3. 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.

Purpose

4. The Committee exists on behalf of the Board of Directors to seek, review and scrutinise assurances that strategic priorities for finance, performance and business development have been identified, and that effective and appropriate systems are in place to drive evidence-based improvement and outcomes.

Duties

5. The Committee is responsible for:

6. **Finance and Performance**

   a) Review progress against the Trust's long-term financial planning
   b) Receive and consider the annual financial and operational plans and make recommendations as appropriate to the Board.
   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 England for consistency on financial data provided.
   d) Oversee the development and implementation of the Digital Strategy
   e) Examine specific areas of financial and operational risk and highlight these to the Board as appropriate through the Board Assurance Framework
   f) To undertake an annual review of the NHS England Enforcement Undertaking.
   g) To review and receive assurance on the appropriateness of the Trust's Emergency Planning Resilience & Response processes and procedures.

7. **Business Planning & Development**

h) 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.
i) Advise the Board and maintain an oversight on all major investments, disposals and business developments.
j) Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy.

Membership

8. 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 Finance Officer
    - *Chief Nurse
    - *Chief Operating Officer
    - *Chief Digital Officer

    *or their nominated representative who will be sufficiently senior and have the authority to make decisions.

9. 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.

10. 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.

11. A quorum shall be three members including two Non-Executive Directors and one Executive Director. The Chair of the Trust may be included in the quorum if present.

12. **Voting**

13. 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.

Requirements of Membership

14. **Members**

15. Members will be required to attend a minimum of 75% of all meetings.

16. **Officers**

17. The Committee will co-opt additional members to attend as and when required.

18. Other executive directors (including the Chief Executive) and officers of the Trust will be invited to attend and contribute to the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

19. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.

20. The Trust Secretary will attend to provide appropriate support to the Chair and Committee members.

Equality Diversity & Inclusion

21. In conducting its business, members must demonstrably consider the equality and diversity implications of decisions they make and consider whether in the management of risk control, the Trust achieves positive change around inclusion, equality, and diversity.

Conflicts of Interest

22. If any of the Members has an interest, financial or otherwise, in any matter and is due to be present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the Trust's Conflicts of Interests Policy. The Chair of the meeting will determine how a conflict of interest should be managed. The Chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

Reporting

23. The Finance, Performance and Business Development Committee will be accountable to the Board of Directors.

24. 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.

25. The Committee will report to the Board annually on its work and performance in the preceding year.

26. Trust standing orders and standing financial instructions apply to the operation of the Committee.

Administration of Meetings

27. Meetings shall be held seven times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.

28. The Secretary will plan to ensure that Committee is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chair and members.

29. Agendas and papers will be circulated at least five working days in advance of the meeting.

30. Minutes will be circulated to members as soon as is reasonably practicable.

Review

31. The Terms of Reference of the Finance, Performance and Business Development Committee shall be reviewed and submitted for approval to the Board of Directors at least annually.

Version Control Schedule

Date	Version no	Main changes proposed	Date approved by Audit Committee	Date ratified by Board of Directors (thereby come into force)
March 2024	1	Development of the Terms of Reference – alignment with updated template		

PUTTING PEOPLE FIRST COMMITTEE

TERMS OF REFERENCE (DRAFT)

Authority/Constitution

1. The Committee is established by the Board of Directors and will be known as the Putting People First 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.

2. 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.

3. 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.

Purpose

4. The Committee exists on behalf of the Board of Directors to seek assurance regarding the development, implementation and effectiveness of the Trust's People, and Equality, Diversity and Inclusion strategies that supports the Trust's vision, values and overarching strategic direction.

Duties

5. The Committee's responsibilities are as follows:

   a) Seek assurance, providing challenge and scrutiny as necessary, regarding the identification, implementation, and delivery of priorities within the Trust's People Strategy (integrated workforce, wellbeing and organisational development strategy); ensuring it is consistent with the Trust's vision and improvement programme.
   b) Seek assurance, providing challenge and scrutiny as necessary, regarding the development and implementation of priorities within the Equality, Diversity and Inclusion Strategy.
   c) Seek assurance, providing challenge and scrutiny as necessary, regarding the development and implementation of priorities to address health inequalities as they relate to people and workforce.
   d) Seek assurance in relation to strategic workforce planning to meet the future needs of patients and service users, aligned to Trust and system strategies, and the quality and effectiveness of plans to deliver them.
   e) Seek assurance regarding the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place.
   f) Review workforce trends impacting on strategic or transformation programmes to provide assurance to the Board and commission 'deep dives' as appropriate.
   g) Review the controls and assurances against relevant people risks on the Board Assurance Framework (BAF) and provide assurance to the Board that risks to the strategic priorities

relating to the workforce are being managed. Identify and escalate any new or emerging issues impacting on the BAF.

h) Seek assurance regarding the effectiveness of any changes in practice required following any internal or external inquiries that significantly impact on workforce issues.
i) Seek assurance regarding the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys.
j) Monitoring and oversight of the Trust's commitments relating to freedom to speak up / whistleblowing and escalate any issues or concerns to the Board of Directors.
k) Review and receive assurances regarding the compliance of statutory reporting requirements including, but not limited to: Guardian of Safe Working, safer staffing, medical appraisal and revalidation.
l) Seek assurance regarding the Trust's approach to ensuring compliance with relevant legal and regulatory requirements, including equality, diversity, and human rights legislation.
m) Seek assurance, providing challenge and scrutiny as necessary regarding other priorities / areas of focus as agreed by the Board and the Putting People First Committee, which will be identified within the Committee's workplan.
n) Escalating matters as appropriate to the Board of Directors.

Membership

6. 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 People Officer
    - *Chief Nurse
    - *Chief Operating Officer
    - Staff Side Chair
    - Medical Staff Committee representative
    - Education Governance Chair

    *or their nominated representative who will be sufficiently senior and have the authority to make decisions.

7. 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.

8. 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.

9. A quorum shall be three members including two Non-Executive Directors and one Executive Director (one of whom must be either the Chief People Officer or Chief Nurse or their deputy). The Chair of the Trust may be included in the quorum if present.

10. **Voting**

11. 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.

Requirements of Membership

12. **Members**

13. Members will be required to attend a minimum of 75% of all meetings.

14. **Officers**

15. The Committee will co-opt additional members to attend as and when required.

16. Other executive directors (including the Chief Executive) and officers of the Trust will be invited to attend and contribute to the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

17. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.

18. The Trust Secretary will attend to provide appropriate support to the Chair and Committee members.

Equality Diversity & Inclusion

19. In conducting its business, members must demonstrably consider the equality and diversity implications of decisions they make and consider whether in the management of risk control, the Trust achieves positive change around inclusion, equality, and diversity.

Conflicts of Interest

20. If any of the Members has an interest, financial or otherwise, in any matter and is due to be present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the Trust's Conflicts of Interests Policy. The Chair of the meeting will determine how a conflict of interest should be managed. The Chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

Reporting

21. The Putting People First Committee will be accountable to the Board of Directors.

22. 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.

23. The Committee will report to the Board annually on its work and performance in the preceding year.

24. Trust standing orders and standing financial instructions apply to the operation of the Committee.

Administration of Meetings

25. Meetings shall be held seven times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.

26. The Secretary will plan to ensure that Committee is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chair and members.

27. Agendas and papers will be circulated at least five working days in advance of the meeting.

28. Minutes will be circulated to members as soon as is reasonably practicable.

Review

29. The Terms of Reference of the Putting People First Committee shall be reviewed and submitted for approval to the Board of Directors at least annually.

Version Control Schedule

Date	Version no	Main changes proposed	Date approved by Audit Committee	Date ratified by Board of Directors (thereby come into force)
March 2024	1	Development of the Terms of Reference – alignment with updated template		

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE (DRAFT)

Authority/Constitution

1. 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).

2. 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.

Purpose

3. The Committee's primary purpose is to:

    - Oversee the management and monitoring of the charitable funds held by the Trust on behalf of the Charity.
    - Provide assurance to the Board that the administration of the Charity is conducted in accordance with:
        - Applicable legislation, including the Charity Commission Act 2011, the Trustee Act 2000, and any relevant NHS regulations.
        - The Charity's governing document.
        - Principles of good governance and financial management.
    - Support the achievement of the Charity's objectives, as outlined in its governing document, to enhance patient care and services provided by the Trust.

Duties

4. The Committee's responsibilities fall broadly into the following areas:

5. **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.

6. **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.

7. 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.

8. 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

9. 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 Finance Officer (or nominated deputy)
    - Chief Nurse
    - Financial Accountant
    - Head of Fundraising
    - Chief Information Officer

10. 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.

11. 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.

12. A quorum shall be three members including two Non-Executive Directors and one Executive Director. The Chair of the Trust may be included in the quorum if present.

13. **Voting**

14. 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.

Requirements of Membership

15. Members

16. Members will be required to attend a minimum of 75% of all meetings.

17. Officers

18. The Committee will co-opt additional members to attend as and when required.

19. Other executive directors (including the Chief Executive) and officers of the Trust will be invited to attend and contribute to the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

20. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.

21. The Trust Secretary will attend to provide appropriate support to the Chair and Committee members.

Equality Diversity & Inclusion

22. In conducting its business, members must demonstrably consider the equality and diversity implications of decisions they make and consider whether in the management of risk control, the Trust achieves positive change around inclusion, equality, and diversity.

Conflicts of Interest

23. If any of the Members has an interest, financial or otherwise, in any matter and is due to be present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the Trust's Conflicts of Interests Policy. The Chair of the meeting will determine how a conflict of interest should be managed. The Chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

Reporting

24. The Charitable Funds Committee will be accountable to the Board of Directors.

25. 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.

26. The Committee will report to the Board annually on its work and performance in the preceding year.

27. Trust standing orders and standing financial instructions apply to the operation of the Committee.

Administration of Meetings

28. Meetings shall be held seven times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.

29. The Secretary will plan to ensure that Committee is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chair and members.

30. Agendas and papers will be circulated at least five working days in advance of the meeting.

31. Minutes will be circulated to members as soon as is reasonably practicable.

Review

32. The Terms of Reference of the Charitable Funds Committee shall be reviewed and submitted for approval to the Board of Directors at least annually.

Version Control Schedule

Date	Version no	Main changes proposed	Date approved by Audit Committee	Date ratified by Board of Directors (thereby come into force)
March 2024	1	Development of the Terms of Reference – alignment with updated template		

Trust Board	WORK PLAN 2024/25																		
							Quarter 1				Quarter 2		Quarter 3			Quarter 4			25/26
						2024/25 MEETING DATE	6 Apr	11 May	8 June	29 June	13 Jul	14 Sep	12 Oct	9 Nov	14 Dec	11 Jan	15 Feb	14 Mar	11 Apr
						PAPER/REPORT DEADLINE TO TRUST SECRETARY	*30 Mar*	*03 May*	*W/shop*	*Ext/Ord*	*05 Jul*	*06 Sep*	*W/shop*	*01 Nov*	*06 Dec*	*W/shop*	*07 Feb*	*W/shop*	*03 Apr*
	Action	**Item Purpose**	**Outline areas to be considered within the report**	**BAF alignment**	**Executive Lead**	**Assurance / Oversight Committee or Group**													
Standing Items																			
Staff Thank you – above and beyond	For noting		N/A	**1**	**EXECS**	-	✓	✓			✓	✓		✓	✓		✓		✓
Patient Story / Staff story	For noting	To provide the Trust Board with a story that outlines the experience of one of the Trust's Patients.	N/A	**3**	**CN**	**QC PPF**	✓	✓			✓	✓		✓	✓		✓		✓
Minutes of Previous meeting	For Approval	N/A	N/A	**-**	**TS**		✓	✓	✓	✓	✓	✓		✓	✓		✓		✓
Action Log / Matters Arising	For Noting	N/A	N/A	**-**	**TS**		✓	✓	✓	✓	✓	✓		✓	✓		✓		✓
Chairs Report - Verbal	For noting	To provide details of the Chair's commitments on a monthly basis.	N/A	**-**	**Chair**		✓	✓	✓	✓	✓	✓		✓	✓		✓		✓
Chief Executives Report - written	For noting	To provide details of key activities locally & nationally, and partnership matters.	To include CMAST and ICB updates		**TS**		✓	✓	✓	✓	✓	✓		✓	✓		✓		✓
Board Committee Assurance Reports (CR), Terms of Reference (TOR) & Annual Effectiveness Reviews (AR)	For Assurance	To receive assurance / escalation of risks and mitigations from the Committees To ensure the Committee Terms of Reference are appropriate and any changes have Trust Board approval. To report the outcome of the evaluation of the Board and its committees and determine what changes are necessary to ensure that the Board and its committees deliver their objectives.	• FPBD Committee • Audit Committee • Charitable Funds Committee • Quality Committee • PPF Committee • Nominations and Remunerations Committee Process Analysis Outcomes Recommendations		**Executive Leads**	**ALL**	✓ **+ToR/ AR**	✓			✓	✓		✓	✓		✓		✓ **+ToR/A R**
Integrated Performance Report (contained within CEO Update item)	For Assurance	To receive analysis of Trust Performance on a monthly basis	• Quality Performance Report • Operational Performance Report • Workforce Performance Report • Finance Performance Report • Safe Staffing / Fill rates • Incident reporting • Maternity Incentive Scheme • Research metrics	**ALL**	**Executive Leads**	**ALL**	✓	✓			✓	✓		✓	✓		✓		✓
Executive Risk and Assurance Group Report	For Assurance	To receive an assurance report of the discussions held at Assurance and Risk Committee.	To receive an assurance report of the discussions held at Assurance and Risk Committee.		**Executive Leads**	Executive Risk and Assurance Group													
Review of risk impacts of items discussed	For Noting	N/A	N/A	**-**	Chair	-	✓	✓			✓	✓		✓	✓		✓		✓

Trust Board	WORK PLAN 2024/25																				
							Quarter 1				Quarter 2		Quarter 3			Quarter 4			25/26		
						2024/25 MEETING DATE	6 Apr	11 May	8 June	29 June	13 Jul	14 Sep	12 Oct	9 Nov	14 Dec	11 Jan	15 Feb	14 Mar	11 Apr		
						PAPER/REPORT DEADLINE TO TRUST SECRETARY	*30 Mar*	*03 May*	*W/shop*	*Ext/Ord*	*05 Jul*	*06 Sep*	*W/shop*	*01 Nov*	*06 Dec*	*W/shop*	*07 Feb*	*W/shop*	*03 Apr*		
	Action	**Item Purpose**	**Outline areas to be considered within the report**	**BAF alignment**	**Executive Lead**	**Assurance / Oversight Committee or Group**															
Any other business	For Noting			-			✓	✓			✓	✓		✓	✓		✓		✓		
Review of meeting	For Noting	N/A	N/A	-	Chair	-	✓	✓			✓	✓		✓	✓		✓		✓		
Chair's Log	For Noting			-			✓	✓			✓	✓		✓	✓		✓		✓		
Jargon Buster	For Noting	N/A	N/A	-			✓	✓			✓	✓		✓	✓		✓		✓		
Operational Plan 2024/25 *(Annual Integrated Plan)*	For Approval	To consider and if deemed appropriate approve the Annual Plan.	TBC	**All**	**COO**	**FPBD**					✓										
Sustainability Annual Report (Green plan)	For Assurance	To consider and if deemed appropriate approve the Annual Plan	• Environmental performance by site • Energy review by site • Highlights of sustainability work undertaken • Outline of future plans		**COO**	**FPBD**															
Infection Prevention and Control Annual Report	For Assurance	To provide an overview of measures undertaken to reduce and control the risk of healthcare associated infections in the Trust for patients, staff and visitors	• Governance and Monitoring • IPC Team • Surveillance • COVID-19 • Policies and guidelines • Education and training • IPC Audit • Hospital cleanliness • Decontamination • Water safety • Antibiotic stewardship • Forward Plan	**2 & 3**	**CN**	**QC**					✓										
Medical Revalidation Annual Report	For Assurance	To outline the Trust's position with regards to compliance with revalidation requirements.	**TBC**	**1**	**MD**	**PPF**								✓							
Emergency Preparedness, Resilience & Response Annual Report	For Approval	To review and approve the Trust EPRR on an annual basis,	**TBC**	**2**	**COO**	**FPBD**		✓													
Emergency Preparedness, Resilience & Response NHSE/I Core Standards Annual Assurance Report	For Approval	https://www.england.nhs.uk/wp-content/uploads/2022/07/PRN00235-emergency-preparedness-resilience-and-response-eprr-annual-assurance-process-for-2023-24-letter-may-2.pdf	**TBC**	**2**	**COO**	**FPBD**										✓					
Guardian of Safe Working Hours	For Assurance	To receive assurance on junior doctor working practices on a quarterly basis with an aggregate annual report	• Immediate Safety Concerns • High Level Data across sites • Locum bookings • Summary and actions taken	**1**	**MD**	**PPF**	✓ **(Q4)**					✓ **(Q1)**		✓ **(Q2)**			✓ **(Q3)**		✓ **(Q4)**		
Complaints Annual Report	For Assurance	To provide an overview of the management of complaints by the Trust during 2022-23. The report also identifies key themes and trends raised by those who use our services,	Identify the key themes and trends raised by those who use our services, providing assurance that changes to practice have been implemented as a result.		**CN**	**QC**															

Trust Board	WORK PLAN 2024/25																			
							Quarter 1				Quarter 2		Quarter 3			Quarter 4			25/26
						2024/25 MEETING DATE	6 Apr	11 May	8 June	29 June	13 Jul	14 Sep	12 Oct	9 Nov	14 Dec	11 Jan	15 Feb	14 Mar	11 Apr
						PAPER/REPORT DEADLINE TO TRUST SECRETARY	*30 Mar*	*03 May*	*W/shop*	*Ext/Ord*	*05 Jul*	*06 Sep*	*W/shop*	*01 Nov*	*06 Dec*	*W/shop*	*07 Feb*	*W/shop*	*03 Apr*
	Action	**Item Purpose**	**Outline areas to be considered within the report**	**BAF alignment**	**Executive Lead**	**Assurance / Oversight Committee or Group**													
		providing assurance that changes to practice have been implemented as a result.																	
Integrated Governance Report	For Assurance	To provide an overview of themes and learning/associated actions identified during the quarter.	To provide a thematic review and learning in relation to SIs, incidents (including Health and Safety) complaints, claims, inquests, patient experience and compliance with patient safety alerts.	**ALL**	**CN**	**QC**	✓ **(Q3)**				✓ **(Q4)**	✓ **(Q1)**		✓ **(Q2)**					✓ **(Q3)**
Learning from Deaths	For Assurance	To provide an overview of the learning from deaths in line with meeting learning candour and accountability requirements.	• To provide an overview of the learning from deaths in line with meeting learning candour and accountability requirements. This report should incorporate information regarding unexpected deaths escalated to a serious incident and complaints. • To receive assurance from the Hospital Leadership Teams on the learning from deaths • Receive assurance on the Learning from Deaths review process and champion quality improvement that leads to actions that improve patient safety. Further, receive assurance that information is published on the organisation's approach, achievements and challenges	**2 & 3** **MD**	**MD**	**QC**	✓ **(Q3)**				✓ **(Q4)**		✓ **(Q1)**		✓ **(Q2)**				✓ **(Q3)**
Seven Day Service Annual Review – *Board Sign off*	For Assurance	This new measurement system replaces the previous self-assessment survey and consists of a standard measurement and reporting template, which all providers of acute services will complete with self-assessments of their delivery of the 7DS clinical standards.	To provide information on the latest NHSE seven day service standards and assurance that the Trust is meeting the four priorities (access to consultant-directed assessment - clinical standard 2, diagnostics - clinical standard 5, interventions - clinical standard 6 and ongoing review - clinical standard 8.	**2**	**MD**	**QC**								✓					
Whistleblowing Bi-Annual Report/ Freedom to Speak Up Guardian	For Assurance	To receive an update on the FTSU process	• FTSU service utilization • Summary of activity • September report to	**1**	**CPO**	**PPF**						✓					✓		

Trust Board	WORK PLAN 2024/25																			
							Quarter 1				Quarter 2		Quarter 3			Quarter 4			25/26	
						2024/25 MEETING DATE	6 Apr	11 May	8 June	29 June	13 Jul	14 Sep	12 Oct	9 Nov	14 Dec	11 Jan	15 Feb	14 Mar	11 Apr	
						PAPER/REPORT DEADLINE TO TRUST SECRETARY	*30 Mar*	*03 May*	*W/shop*	*Ext/Ord*	*05 Jul*	*06 Sep*	*W/shop*	*01 Nov*	*06 Dec*	*W/shop*	*07 Feb*	*W/shop*	*03 Apr*	
	Action	**Item Purpose**	**Outline areas to be considered within the report**	**BAF alignment**	**Executive Lead**	**Assurance / Oversight Committee or Group**														
			include benchmark of the Trust against national picture for the previous year. • March Group report and April Board report to include 1/2 way progress on the FTSU Board self assessment actions. • Data pertaining to the last full quarter available • Key themes for the incomplete quarter within which a report is delivered.																	
Culture Update		To receive an update on progress of Culture and Staff Engagement at LWH			**CPO**	**PPF**	✓				✓									
Bi-Annual Safe Staffing	For Assurance	To receive an overview of nurse staffing capacity in line with the in line with the National Institute for Clinical Excellence (NICE) safe staffing and National Quality Board (NQB) standards.	To identify risks, provide assurance on mitigations and track / monitor improvement.	**1**	**CN**	**PPF**	✓							✓						✓
Staff Survey Annual	For Assurance	To present the results of the survey and the resulting action plan.	• Key findings and actions resulting from national staff survey • Summary of staff engagement approach and quarterly pulse surveys • Spotlight on violence and aggression • Detail of action plans, both Trust-wide and local	**1**	**CPO**	**PPF**	✓													✓
Equality, Diversity & Inclusion Annual Report	For Assurance	To provide the Board with an update.	Workforce Profile Patient profile Equality Delivery System (EDS) Assessment EDI Delivery plan outcomes (from previous operational year) Progress monitoring of EDI Strategy	**1**	**CPO**	**PPF**	✓													✓
WRES & WDES Report 2023 and Gender Pay Gap report	For Assurance	To provide an update regarding the annual report and actions taken. To receive assurance of compliance with reporting requirements for Gender Pay Gap as set out in the Equality Act 2010.	• EDI WRES/WDES Plan • Monitoring and delivery of Plan • Priorities •Compliance •Key findings and reasons resulting from pay gap calculations •Actions required to address pay gap	**1**	**CPO**	**PPF**						✓								
Flu Vaccine Campaign Annual Report	For Assurance	To provide assurance the Trust is doing everything as possible as an employer to	Self-assessment against the best practice management checklist for	**1**	**CPO**	**PPF**								✓						

Trust Board	WORK PLAN 2024/25																				
							Quarter 1				Quarter 2		Quarter 3			Quarter 4			25/26
						2024/25 MEETING DATE	6 Apr	11 May	8 June	29 June	13 Jul	14 Sep	12 Oct	9 Nov	14 Dec	11 Jan	15 Feb	14 Mar	11 Apr
						PAPER/REPORT DEADLINE TO TRUST SECRETARY	*30 Mar*	*03 May*	*W/shop*	*Ext/Ord*	*05 Jul*	*06 Sep*	*W/shop*	*01 Nov*	*06 Dec*	*W/shop*	*07 Feb*	*W/shop*	*03 Apr*
	Action	**Item Purpose**	**Outline areas to be considered within the report**	**BAF alignment**	**Executive Lead**	**Assurance / Oversight Committee or Group**													
		protect patients and staff from seasonal flu	health care worker vaccination																
Annual Report, Quality Account and Annual Accounts	For Approval	To consider and if deemed appropriate approve the Annual Report / Annual Accounts / and Annual Governance Statements.	• Audited annual report and accounts • Auditor's Engagement Pack • Letter of Representation	5	CFO/TS/ CN	AC QC FPBD				✓									
Charity Annual Report and Accounts	For Approval	To consider and if deemed appropriate approve the Charitable Funds Accounts	• Audited charity annual report and accounts • Auditor's Engagement Pack • Audit Findings letter to Trustees • Letter of Representation	**5**	**CFO**	**CFC**									✓				
Revenue and Capital Budgets	For Approval	Approval of the annual budget.	• Process undertaken to develop the budget and operating plan • Financial and strategic context • Proposed revenue and capital budgets for the year for recommendation to the Trust Board	**2 & 5**	**CFO**	**FPBD**	✓												✓
Long Term Financial Plan	For Approval	To consider and if deemed appropriate approve the budget and updated LTFM.	To provide the 3-year financial plan for approval.		**CFO**	**FPBD**	✓												
Compliance with Provider Licence General Condition 6	For Assurance	To provide assurance to the Committee on the position of the Trust's FT Provider License.	Introduction Self-Assessment for 2023/24 Recommendation	**-**	**TS**	**-**				✓									
Compliance with Provider Licence FT4 – Corporate Governance Statements	For Assurance	To provide assurance to the Committee on the position of the Trust's FT Provider License.	Introduction Self-Assessment for 2023/24 Recommendation	**-**	**TS**	**-**				✓									
Review of Corporate Governance Manual / Governance Framework. Ad-hoc	For Approval	To review and approve any amendments to the Corporate Governance Manual.	Analysis Performance Recommendations	**-**	**TS**	**-**						✓							
Annual HEE Self-Assessment for Placement Providers 2023 for Submission to NHSE	For Approval	To approve ahead of submission to NHS England		**1**	**CPO**	**PPF**							✓						
Board Assurance Framework	For Decision			**All**	**CN**	**ALL**	✓	✓			✓	✓		✓	✓		✓		✓
Risk Management Strategy	For Assurance	Monitoring of the Risk Management Strategy	• Governance arrangements • Strategic aims and objectives • Delivery plan • Key risks and mitigations, including timelines and expected outcomes • High level road map	**All**	**CNM**	**Audit**	✓												✓
Risk Appetite Statement	For Approval	For the Board to review its risk appetite statement and to outline how it will be	Analysis Performance Recommendations	**All**	**CNM**	**ALL**	✓												✓

Trust Board	WORK PLAN 2024/25																			
							Quarter 1				Quarter 2		Quarter 3			Quarter 4			25/26
						2024/25 MEETING DATE	6 Apr	11 May	8 June	29 June	13 Jul	14 Sep	12 Oct	9 Nov	14 Dec	11 Jan	15 Feb	14 Mar	11 Apr
						PAPER/REPORT DEADLINE TO TRUST SECRETARY	*30 Mar*	*03 May*	*W/shop*	*Ext/Ord*	*05 Jul*	*06 Sep*	*W/shop*	*01 Nov*	*06 Dec*	*W/shop*	*07 Feb*	*W/shop*	*03 Apr*
	Action	**Item Purpose**	**Outline areas to be considered within the report**	**BAF alignment**	**Executive Lead**	**Assurance / Oversight Committee or Group**													
		utilised in decision-making in the forthcoming year.																	
Register of sealings				-	TS	-	✓												✓
Well led governance review	For Assurance	Update following well-led governance review completion.	Analysis Performance Recommendations	All	CEO/TS	-									✓				
Trust Board Terms of Reference	For approval			-	TS	-	✓												✓
Partnership Update	For Assurance			6	CFO	-					✓				✓				
Update from Women's Services Programme Board	For Assurance																		
Update from Improvement Programme Board	For Assurance																		
Maternal Medicine Network Update				All	MD							✓							
Strategy Update	For Assurance	Monitoring of the Our Strategy	• Governance arrangements • Strategic aims and objectives • Delivery plan • Key risks and mitigations, including timelines and expected outcomes • High level road map		CFO							✓						✓	
Review of non-executive director champion roles	For Assurance	To assess the efficacy of the Board champion role from the previous year, to consider any new regulatory requirements and to refresh the role allocation as required.	Analysis Performance Recommendations		TS			✓											

Quality Committee — WORKPLAN 2024/25

							Quarter 1		Quarter 2	Quarter 3		Quarter 4	
						2024/25 MEETING DATE	23 April 2024	25 June 2024	23 July 2024	29 Oct 2024	26 Nov 2024	28 Jan 2025	25 Mar 2025
						PAPER/REPORT DEADLINE	15 April	17 June	15 July	21 Oct	18 Nov	20 Jan	17 Mar
	Action	Item purpose	Outline areas to be considered within report	BAF alignment	Report to Board	Executive Lead							
STANDING ITEMS													
Minutes of Previous meeting	Approval					TS	✓	✓	✓	✓	✓	✓	✓
Actions/Matters Arising	Noting					TS	✓	✓	✓	✓	✓	✓	✓
Chairs Report - Verbal	Noting					Chair	✓	✓	✓	✓	✓	✓	✓
Review of risk impacts of items discussed	Noting					Chair	✓	✓	✓	✓	✓	✓	✓
Any other business	Noting					Chair	✓	✓	✓	✓	✓	✓	✓
Review of meeting	Noting					Chair	✓	✓	✓	✓	✓	✓	✓
MATTERS FOR DISCUSSION To deliver safe services; To deliver the best possible experience for patients and staff; To participate in high quality research to deliver the most effective outcomes													
Patient Quality Experience Story (quarterly)	Information					CN	✓		✓		✓		✓
Review of BAF risks	Assurance				✓	CN	✓	✓	✓	✓	✓	✓	✓
Quality and Regulatory update – internal reviews (CQC assessments; CQC Insight Tool) and External guidelines, statute best practice etc. to be reported by exception	Information					CN	✓	✓	✓	✓	✓	✓	✓
Annual Quality Account (review prior to Audit C/Board)	Information				✓	MD							
Integrated Governance Assurance Report	Assurance				✓	CN	✓ (Q4)		✓ (Q1)	x(Q2)	✓ (Q2)		✓ (Q3)
Mortality and Perinatal Report (Learning from Deaths)	Assurance				✓	MD	✓ (Q4)		✓ (Q1)		x (Q2)	✓ (Q2)	✓ (Q3)
Seven Day Working Board Assurance – 6 monthly	Assurance				✓	MD	✓			✓			
Equality, Diversity and Inclusion Update (bi-annual)	Information					CN		✓			✓		
Public Health Agenda and Equalities (annual)	Information					CN		✓					
CNST Progress Report	Information				✓	CN			✓				✓
Palliative and End of Life Care Report (bi-annual)	Information					MD							
Annual Review of Litigation	Assurance					CN				✓			
Review of Clinical & Quality Strategy (bi-annual)	Assurance					MD	✓				✓		
Research and Innovation Strategy Review	Assurance					MD							✓ (annual)
Clinical Audit Work Plan & Annual Report	Assurance					MD	✓ (WP)		✓ (AR)				
Infection Prevention and Control Annual Report	Assurance				✓	CN		✓					
Safeguarding Annual Report	Assurance					CN			✓				
Research & Development Annual Report	Assurance					MD		✓					
NICE Annual Report	Assurance					MD			✓				
Complaints Annual Report	Assurance					CN			✓				
Controlled Drugs Annual Report	Assurance					MD							
General Governance Arrangements													
Quality Committee Effectiveness, Terms of Reference, and Business Cycle	Information					TS							✓
CONSENT AGENDA / SHARED FOR INFORMATION													
Integrated Performance Report	Information						✓	✓	✓	✓	✓	✓	✓

Finance, Performance and Business Development Committee						WORKPLAN 2024/25								
							Quarter 1		Quarter 2	Quarter 3		Quarter 4	
						2024/25 MEETING DATE	24 April 2024	26 June 2024	24 July 2024	30 Oct 2024	27 Nov 2024	29 Jan 2025	26 Mar 2025
						PAPER/REPORT DEADLINE	16 April	18 June	16 July	22 Oct	19 Nov	21 Jan	18 Mar
	Action	Item purpose	Outline areas to be considered within report	BAF alignment	Report to Board	Executive Lead							
STANDING ITEMS													
Minutes of Previous meeting	Approval					TS	✓	✓	✓	✓	✓	✓	✓
Actions/Matters Arising	Noting					TS	✓	✓	✓	✓	✓	✓	✓
Chairs Report - Verbal	Noting					Chair	✓	✓	✓	✓	✓	✓	✓
Review of risk impacts of items discussed	Noting					CFO	✓	✓	✓	✓	✓	✓	✓
Any other business	Noting					Chair	✓	✓	✓	✓	✓	✓	✓
Review of meeting	Noting					Chair	✓	✓	✓	✓	✓	✓	✓
MATTERS FOR DISCUSSION To be ambitious and efficient and make best use of available resources													
Review of Board Assurance Framework Risks	Assurance				✓	CFO	✓	✓	✓	✓	✓	✓	✓
Three-year Financial Plan	Information				✓	CFO	✓	✓	✓	✓	✓	✓	✓
Revenue and capital budget for 2025/26	Information				✓	CFO							✓
Analytical Review of unaudited Annual Accounts (prior Audit)	Information				✓	CFO	✓						
Post Implementation Review of Cost Improvement Programme (CIP)	Assurance					CFO	✓				✓ (H1)		
Annual Business Case Post Implementation Reviews	Assurance					CFO					✓		
Patient Level Information and Costing Systems (PLICS)	Information					CFO							
National Cost Collection index	Information					CFO					✓		
Annual Integrated Plan	Information				✓	COO							✓
Market share intelligence (annual)	Assurance					CFO							✓
Safe and Sustainable Annual Report	Assurance					COO	✓						
Delivery a Net Zero NHS and Trust Green Plans	Information				✓	COO	✓						
Estates Return Information Collection	Assurance					COO							
Modern Slavery Act 2015 Annual review	Approval					TS						✓	
Communications, Marketing and Engagement Strategy Annual Review	Assurance					CPO				✓			
Finance and Procurement Strategy Annual review	Assurance					CFO			✓				
Digital Generations Strategy 2020-2024 Bi-Annual review	Assurance				✓	CIO							
Emergency Planning Resilience & Response (EPRR) Annual Report	Assurance				✓	COO	✓						
EPRR NHSE/I Core Standards Annual Assurance Annual Report	Assurance				✓	COO				✓			

Health and Safety Annual Report	Assurance					COO							
Estates Strategy	Assurance					COO							
General Governance Arrangements													
FPBD Committee Effectiveness Review, Terms of Reference & Business Cycle	Information				✓	TS							✓
CONSENT AGENDA / SHARED FOR INFORMATION													
Integrated Performance Report	Information						✓	✓	✓	✓	✓	✓	✓

Putting People First Committee	WORKPLAN 2024/25									
							Quarter 1	Quarter 2	Quarter 3	Quarter 4
						2024/25 MEETING DATE	*April 2024 OR June*	*July 2024 OR Sept*	*Oct 2024 OR Nov*	*Jan 2025 OR March*
						PAPER/REPORT DEADLINE				
	Action	**Item purpose**	**Outline areas to be considered within report**	**BAF alignment**	**Report to Board**	**Executive Lead**				
STANDING ITEMS										
Minutes of Previous meeting	Approval					TS	✓	✓	✓	✓
Actions/Matters Arising	Noting					TS	✓	✓	✓	✓
Chairs Report - Verbal	Noting					Chair	✓	✓	✓	✓
Review of risk impacts of items discussed	Noting					Chair	✓	✓	✓	✓
Any other business	Noting					Chair	✓	✓	✓	✓
Review of meeting	Noting					Chair	✓	✓	✓	✓
MATTERS FOR DISCUSSION To develop a well led, capable, and motivated workforce										
Staff Experience Story (quarterly)	Information					CPO	✓	✓	✓	✓
Review of BAF risks	Assurance				✓	CPO	✓	✓	✓	✓
Director of Workforce Report	Information					CPO	✓	✓	✓	✓
Workforce Planning Return	Information					CPO				✓
Bi-Annual Safer Staffing Review / Workforce Planning Horizon Scan	Assurance				✓	CNM		✓ **Q4 & Q1**		✓ **Q2&Q3**
Talent Management & Leadership Development Review	Information					CPO	✓			
HEE Quality Framework Annual Self-Assessment Submission to NHSE	Approval				✓	MD		✓		
HENW GMC survey feedback report and action plan	Information					MD		✓	✓	
Freedom to Speak Up Guardian Bi-annual Update	Information					F2SUG	✓		✓	
Whistleblowing Annual Report/ Freedom to Speak Up Guardian	Assurance				✓	F2SUG		✓		
Disciplinary and Grievance processes annual review	Assurance					CPO		✓		
Fair and Just Culture Update	Information				✓	CPO		✓		✓
Guardian of Safe Working Hours (Junior Doctors) Quarterly Report	Assurance				✓	MD	✓ **(Q4 AR)**	✓ **(Q1)**	✓ **(Q2)**	✓ **(Q3)**
Staff Engagement and NHS Staff Survey Annual Results & Action Plan (Annual and Bi-annual Review)	Information				✓ (annual)	CPO		✓ **(bi-annual)**		✓ **(annual)**
Equality, Diversity and Inclusion including WRES/WDES/Gender Pay Gap	Assurance				✓	CPO		✓		✓
Equality, Diversity and Inclusion Annual Report including Equality Objectives	Information				✓	CPO				✓
Director of Medical Education Annual Report	Information					MD			✓	✓
Medical Appraisal & Revalidation Annual Report & submission to NHSE	Approval				✓	MD		✓		
Pharmacy Revalidation Annual Report	Assurance					MD		✓		
Volunteer Strategy Achievements Annual Report	Assurance					CPO	✓			
Putting People First Strategy Annual Review	Assurance					CPO				✓
Equality, Diversity and Inclusion Strategy	Information					CPO				
DBS Annual Self-Declaration Compliance	Assurance					CPO				✓
General Governance Arrangements										
PPF Committee Effectiveness Review, Terms of Reference and Business Cycle					✓	TS				✓
CONSENT AGENDA / SHARED FOR INFORMATION										
Integrated Performance Report	Information						✓	✓	✓	✓

Charitable Funds Committee		WORKPLAN 2024/25							
							Quarter 1	Quarter 3	Quarter 4
						2024/25 MEETING DATE	17 June 2024	21 Oct 2024	20 Jan 2025
						PAPER/REPORT DEADLINE	10 June	14 Oct	13 Jan
	Action	Item purpose	Outline areas to be considered within report	BAF alignment	Report to Board	Executive Lead			
STANDING ITEMS									
Minutes of Previous meeting	Approval					TS	✓	✓	✓
Actions/Matters Arising	Noting					TS	✓	✓	✓
Chairs Report - Verbal	Noting					Chair	✓	✓	✓
Review of risk impacts of items discussed	Noting					Chair	✓	✓	✓
Any other business	Noting					Chair	✓	✓	✓
Review of meeting	Noting					Chair	✓	✓	✓
MATTERS FOR DISCUSSION									
Charity Strategy Review	Assurance					CFO			✓
Quarterly Charity and Finance Integrated Report	Assurance					CFO	✓	✓	✓
Approval of Annual Report and Accounts (include independent investigating accountant report/letter with final report)	Approval				✓	CFO	✓ (Draft)	✓	
Revenue & Capital Budget for 2023/24	Information					CFO			✓
CF Applications Impact Annual review	Information					CFO	✓		
Review of expenditure - fundraising costs versus other	Assurance					CFO			✓
Financial Services Support Costs: Annual Benchmarking Review	Information					CFO	✓		
Investment Report	Information					CFO	✓	✓	✓
Annual review of investments	Information					CFO			✓
Authorisation of funding applications expenditure (as required)	Approval					CFO	✓	✓	✓
Review of Fundholders and Funds	Information					CFO		✓	
General Governance Arrangements									
CFC Effectiveness Review, Terms of Reference & Business cycle	Information				✓	TS			✓

KEY CODE	Q=Quarter	WP=Work plan	AR=Annual Report	AP=Annual Plan	OS=Objective Setting
Deferred	Red text: new to workplan				
Item considered as planned					
Item considered following deferral					

Board of Directors

COVER SHEET

Meeting Date	Thursday, 14 March 2024	**Item Reference**	23/24/xxx
Report Title	Executive Risk and Assurance Group – February 2024		
Author	Mark Grimshaw, Trust Secretary		
Responsible Director	James Sumner, Chief Executive		

Purpose of Report	The purpose of this report is to provide an update to the Board of Directors on the matters discussed at the Executive Risk & Assurance Group meeting on X February 2024.
Executive Summary	A summary of the key areas for the attention of Board of Directors is detailed within this report for information
Key Areas of Concern	The following key areas for the attention of the Board of Directors are as follows for information:

Action Required by the Board of Directors	The Board of Directors is asked to note the update.

AGENDA ITEMS DISCUSSED

The Executive Risk and Assurance Group received and discussed the following agenda items:

- CEO Report
- Divisional Board Reports
- Key risks
- Clinical incidents attributable to the isolation of LWH services from other specialist services Quarter 2
- Maternal Death MNSI formerly HSIB Action/ Improvement plan
- Operational Performance Report Month 9, 2023/24
- Finance Performance Report Month 9, 2023/24
- 2024/25 Planning Update
- PPF Workforce Performance Report
- Audit and Sickness Report Update

MATTERS FOR ESCALATION FROM ERAG FOR BOARD OF DIRECTORS (for information)

Maternal Death MNSI formerly HSIB Action/ Improvement plan

The Group had a detailed and robust discussion in relation to a maternal death in March 2023. The Maternity and Newborn Safety Investigations (MNSI) completed an independent investigation into the Maternal death which included interviews with staff involved, a full review of documentation, site visits and with involvement from the family. The report received provided a summary of the case, immediate actions

taken at the time and further actions taken considering feedback and recommendations from the external case review. Key themes identified included Ethnicity and health inequalities and recognition of deteriorating condition. Relevant external escalations and reporting had been completed in line with good practice and the Trust had been recognised and praised by MNSI for its openness and transparency in both the reporting and escalation of the incident and during the investigation process. The Group noted actions identified and in progress to address the areas of improvement relating to policy, and two Trust wide improvement collaboratives relating to deterioration of the patient and cultural bias that would embed and sustain the required change to prevent reoccurrences. The two Trust wide improvement ambitions would form part of the Trust 2024/25 priorities for Quality and will report appropriately through the Improvement governance process.

Operational Performance Report Month 9, 2023/24

The Group noted the following matters from the operational performance report:

- Cancer performance continues to be challenged, as high referral rates impact upon faster diagnosis standard and the 62-day metric performance based on current backlog clearance. The Committee was informed of actions being taken as part of a Suspected Cancer Referral Optimisation Plan in partnership with primary care.
- Overall, it was noted that Industrial Action had negatively impacted the Trust's progress against its performance targets and there would be significant challenges to meet targets and trajectories by year-end. However, there was confidence that capacity was in place to make and sustain improvement.

Finance Performance Report Month 9, 2023/24

The Group noted that at Month 9 2023/24 the Trust was reporting an overall net position £14.7m deficit, which represents a £2.7m adverse variance to plan year to date, supported by £2.9m of non-recurrent items. The reported forecast outturn at Month 9 is £23.4m deficit, which represents an £8.0m adverse variance to plan.

2024/25 Planning Update

Whilst the 2024/25 planning guidance had yet to be published, the Group received a presentation on the approach and current assumptions. A significant risk was noted in relation to the 2024/25 Cost Improvement Target expectations of 5%.

Workforce Performance Report

The workforce performance report identified that sickness rates had marginally increased, PDR performance had decreased slightly, mandatory training had remained static, and turnover had increased. Initial listening events had been held in the neonatal department in relation to recruitment and retention and any potential impact from the Lucy Letby trial on the profession.

RECOMMENDATION

The Board of Directors is asked to note the contents of the report.

Board of Directors

COVER SHEET

Meeting Date	Thursday, 14 March 2024	**Item Reference**	23/24/xxx
Report Title	Improvement Plan Update		
Author	Tim Gold, Chief Transformation Officer		
Responsible Director	James Sumner, Chief Executive		

Purpose of Report	To provide Delivery Assurance on Phase 1 of the Trust's Improvement Plan.
Executive Summary	The Improvement Plan is in its development phase with key programmes being established.
Key Areas of Concern	None specifically to report – see 12+ Risks below
Trust Strategy and System Impact	The Improvement Programme benefits both the Trust and aligns with broader healthcare goals. Firstly, achieving segment two strengthens the Trust's commitment to excellence, enhancing its reputation and attracting talent. This directly supports the "triple aim" by focusing on quality care, leading to better health outcomes, and efficient resource use. Secondly, the plan aligns with the NHS Cheshire and Merseyside's priorities of quality, equity, and efficiency. By achieving segment two, the Trust contributes to the overall success of the regional healthcare system. In essence, moving to segment two benefits the Trust, the NHS triple aim, and the regional healthcare system.

Links to Board Assurance Framework	*TBC*	***Risk Score to be inputted***
Links to Corporate Risk Register (scoring 12+)	*TBC*	***Risk Score to be inputted***

Assurance Level	1. SUBSTANTIAL - Good system of internal control applied to meet existing objectives

Action Required by the Board of Directors	The Board of Directors is asked to note progress of the Improvement Plan, as per the heatmap, including existing risks to delivery and controls.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Improvement Programme Portfolio Board	TBC	CTO	Outlined in the report

Liverpool Women's
NHS Foundation Trust

Liverpool Women's NHS Foundation Trust

Improvement Plan

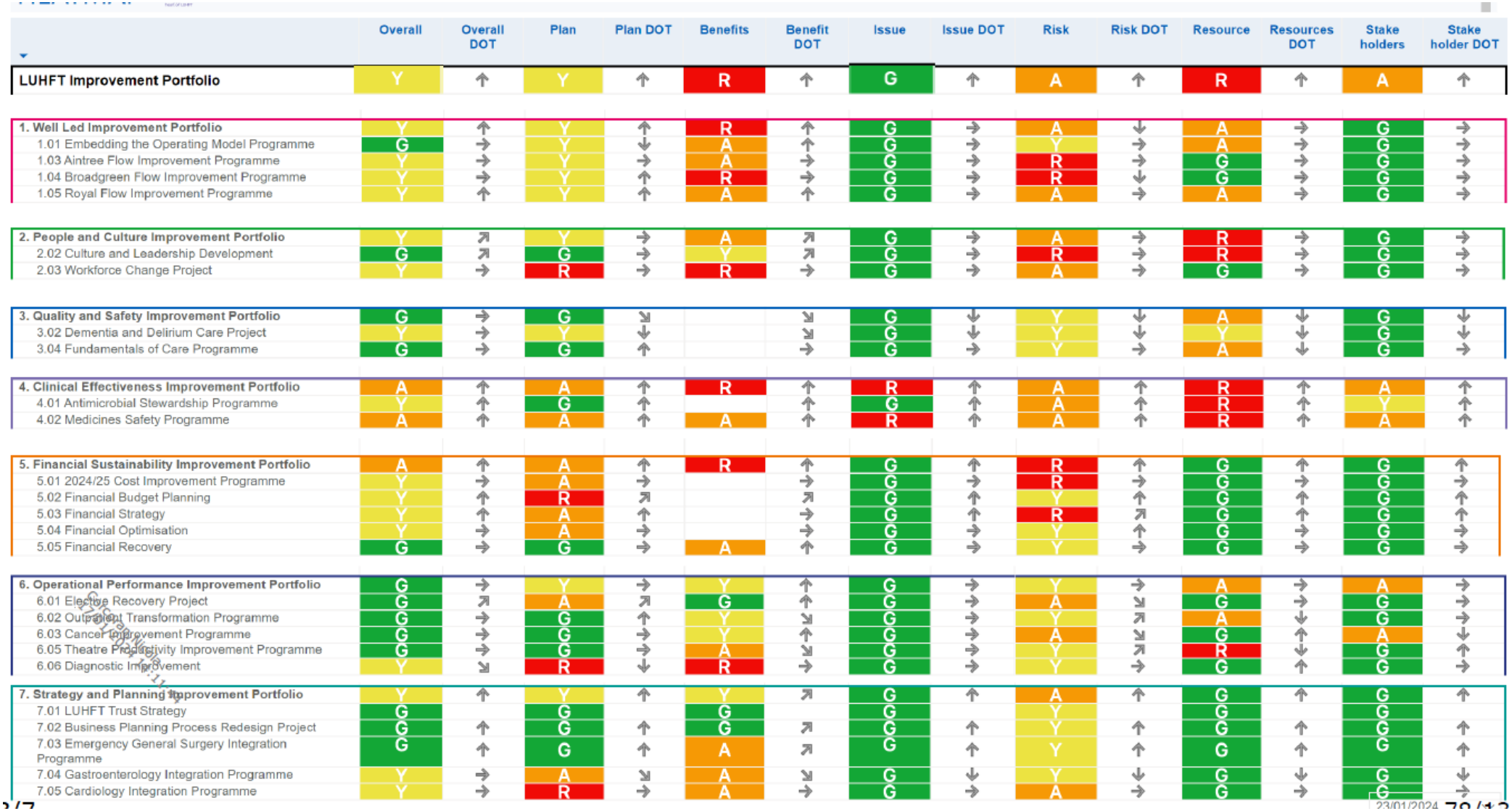
Trust Board – 14 March 2024

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

Recap on LWH Improvement Portfolio Phase 1

Senior Responsible Owner:	*Dr Lynn Greenhalgh, Medical Director*	*Gary price, Chief Operating Officer*	*Michelle Turner, Chief People Officer*	*Jenny Hannon, Chief Finance Officer*	*James Sumner, Chief Executive*
Exec Portfolio:	P1 Quality, Safety & Clinical Effectiveness	P2 Operational Performance	P3 People & Culture	P4 Financial Sustainability	P5 Well Led
Programme / Project:	*Deteriorating Patient Collaborative*	*Improve Cancer Performance AND exit Tier 2 in partnership with C&M Cancer Alliance*	*Improve safety culture for patients & Staff*	*Creation of three year financial recovery plan*	*Development of Continuous Improvement Culture*
	Recruit to Resident 24/7 Obstetric Consultant Rota	*Theatre Productivity Improvement*	*Actively anti-racism programme*		*Programme Delivery in place*
	Implement MET Team	*Outpatient Improvement Programme*			*Streamline governance/assurance system inc. IPR*
	Enhance workforce to respond to onsite emergency				*Improve partnership governance*
	Delivery of CQC/MSSP actions				
	Medicine Safety Programme w/LUHFT				

HEATMAP



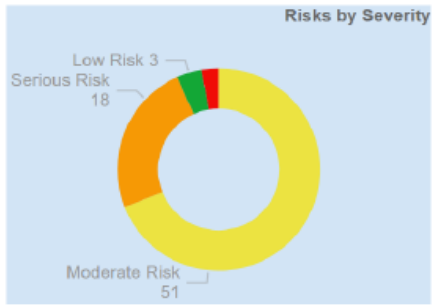
	Overall	Overall DOT	Plan	Plan DOT	Benefits	Benefit DOT	Issue	Issue DOT	Risk	Risk DOT	Resource	Resources DOT	Stake holders	Stake holder DOT
LUHFT Improvement Portfolio	Y	↑	Y	↑	R	↑	G	↑	A	↑	R	↑	A	↑
1. Well Led Improvement Portfolio	Y	↑	Y	↑	R	↑	G	→	A	↓	A	→	G	→
1.01 Embedding the Operating Model Programme	G	→	Y	↓	A	↑	G	→	Y	→	A	→	G	→
1.03 Aintree Flow Improvement Programme	Y	→	Y	→	A	→	G	→	R	→	G	→	G	→
1.04 Broadgreen Flow Improvement Programme	Y	→	Y	↑	R	→	G	→	R	↓	G	→	G	→
1.05 Royal Flow Improvement Programme	Y	↑	Y	↑	A	↑	G	→	A	→	A	→	G	→
2. People and Culture Improvement Portfolio	Y	↗	Y	→	A	↗	G	→	A	→	R	→	G	→
2.02 Culture and Leadership Development	G	↗	G	→	Y	↗	G	→	R	→	R	→	G	→
2.03 Workforce Change Project	Y	→	R	→	R	→	G	→	A	→	G	→	G	→
3. Quality and Safety Improvement Portfolio	G	→	G	↘		↘	G	↓	Y	↓	A	↓	G	↓
3.02 Dementia and Delirium Care Project	Y	→	Y	↓		↘	G	↓	Y	↓	Y	↓	G	↓
3.04 Fundamentals of Care Programme	G	→	G	↑		→	G	→	Y	→	A	↓	G	→
4. Clinical Effectiveness Improvement Portfolio	A	↑	A	↑	R	↑	R	↑	A	↑	R	↑	A	↑
4.01 Antimicrobial Stewardship Programme	Y	↑	G	↑		↑	G	↑	A	↑	R	↑	Y	↑
4.02 Medicines Safety Programme	A	↑	A	↑	A	↑	R	↑	A	↑	R	↑	A	↑
5. Financial Sustainability Improvement Portfolio	A	↑	A	↑	R	↑	G	↑	R	↑	G	↑	G	↑
5.01 2024/25 Cost Improvement Programme	Y	→	A	→		→	G	→	R	→	G	→	G	→
5.02 Financial Budget Planning	Y	↑	R	↗		↗	G	↑	Y	↑	G	↑	G	↑
5.03 Financial Strategy	Y	↑	A	↑		→	G	↑	R	↗	G	↑	G	↑
5.04 Financial Optimisation	Y	→	A	→		→	G	→	Y	↑	G	→	G	→
5.05 Financial Recovery	G	→	G	→	A	↑	G	→	Y	→	G	→	G	→
6. Operational Performance Improvement Portfolio	G	→	Y	→	Y	↑	G	→	Y	→	A	→	A	→
6.01 Elective Recovery Project	G	↗	A	↗	G	↑	G	→	A	↘	G	→	G	→
6.02 Outpatient Transformation Programme	G	→	G	↑	Y	↘	G	→	Y	↗	A	↓	G	→
6.03 Cancer Improvement Programme	G	→	G	→	Y	↑	G	→	A	↘	G	↑	A	↓
6.05 Theatre Productivity Improvement Programme	G	→	G	→	A	↘	G	→	Y	↗	R	↓	G	↑
6.06 Diagnostic Improvement	Y	↘	R	↓	R	→	G	→	Y	→	G	↑	G	→
7. Strategy and Planning Improvement Portfolio	Y	↑	Y	↑	Y	↗	G	↑	A	↑	G	↑	G	↑
7.01 LUHFT Trust Strategy	G		G		G		G		Y		G		G	
7.02 Business Planning Process Redesign Project	G	↑	G	↑	G	↗	G	↑	Y	↑	G	↑	G	↑
7.03 Emergency General Surgery Integration Programme	G	↑	G	↑	A	↗	G	↑	Y	↑	G	↑	G	↑
7.04 Gastroenterology Integration Programme	Y	→	A	↘	A	↘	G	↓	Y	↓	G	↓	G	↓
7.05 Cardiology Integration Programme	Y	→	R	→	A	→	G	→	A	→	G	→	G	→

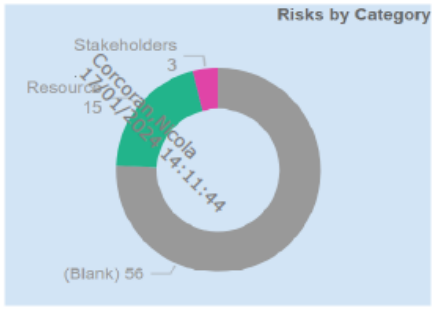
SUMMARY UPDATE

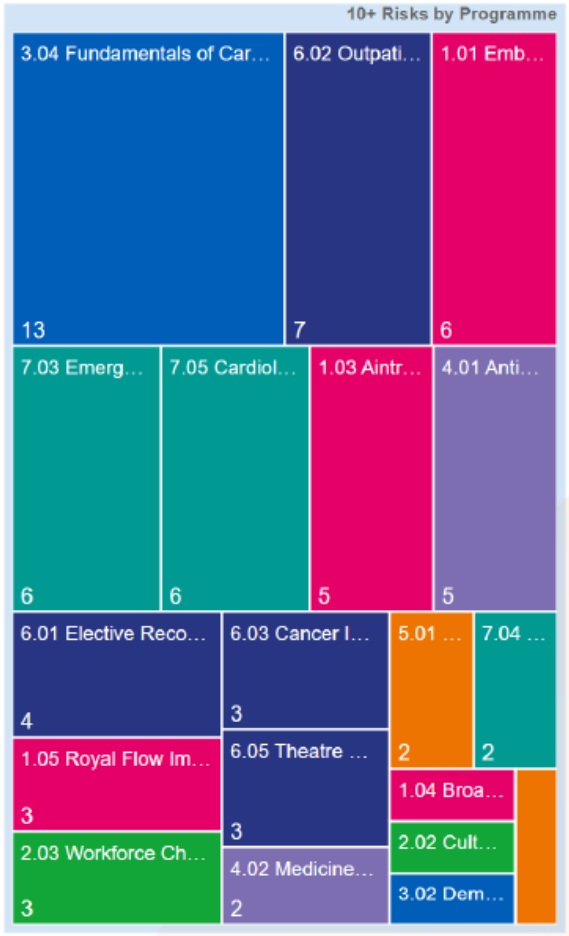
	Overall	Overall DOT	Plan	Plan DOT	Benefits	Benefit DOT	Issue	Issue DOT	Risk	Risk DOT	Resource	Resources DOT	Stake holders	Stake holder DOT
LUHFT Improvement Portfolio	Y	↑	Y	↑	R	↑	G	↑	A	↑	R	↑	A	↑
1. Well Led Improvement Portfolio	Y	↑	Y	↑	R	↑	G	→	A	↓	A	→	G	→
2. People and Culture Improvement Portfolio	Y	↗	Y	→	A	↗	G	→	A	→	R	→	G	→
3. Quality and Safety Improvement Portfolio	G	→	G	↘		↘	G	↓	Y	↓	A	↓	G	↓
4. Clinical Effectiveness Improvement Portfolio	A	↑	A	↑	R	↑	R	↑	A	↑	R	↑	A	↑
5. Financial Sustainability Improvement Portfolio	A	↑	R	↑		↗	G	↑	R	↑	G	↑	G	↑

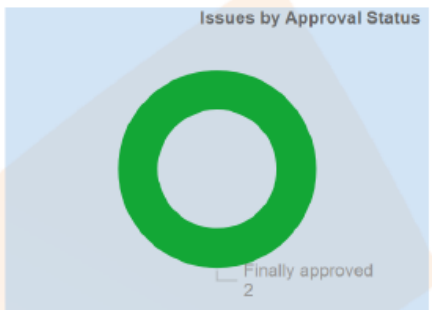
Summary Update

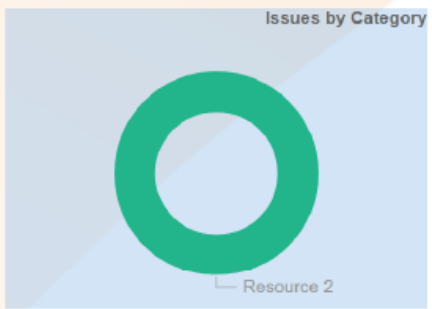
RISKS AND ISSUES REPORT

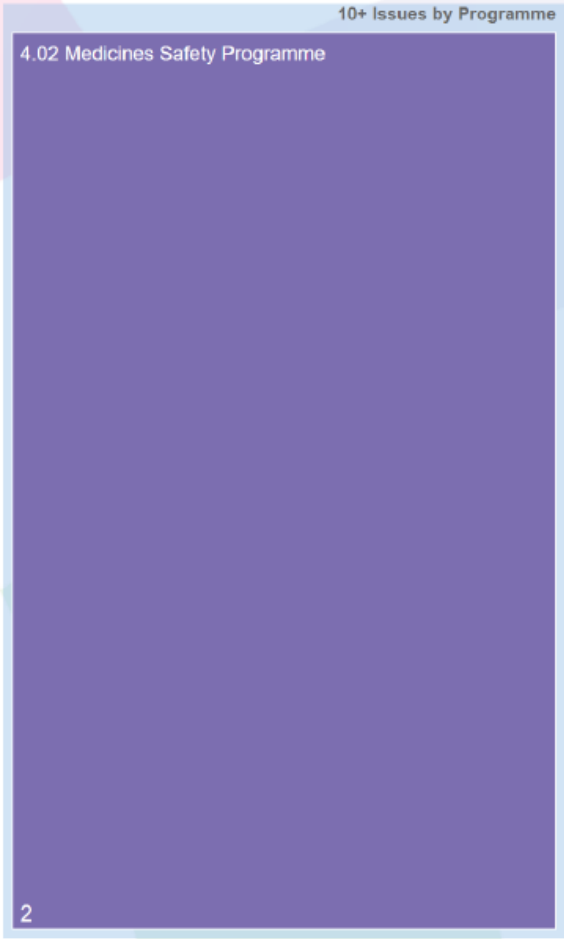












IMPROVEMENT PORTFOLIO SUMMARY UPDATE

	Summary Update
P1 Quality, Safety & Clinical Effectiveness	
Dr Lynn Greenhalgh, Executive SRO	

Executive Portfolios	Overall	Overall DoT	Plan	Plan DoT	Benefits	Benefits DoT	Issues	Issues DoT	Risk	Risk DoT	Resource	Resource DoT	Stake holders	Stake holders DoT
6. Operational Performance Improvement Portfolio	G	→	G	→	R	→	G	→	Y	→	Y	↗	G	→
6.01 Elective Recovery Project	G	↘	A	→	G	→	G	→	A	→	G	→	G	→
6.02 Outpatient Transformation Programme	G	↘	Y	↓	Y	→	G	→	Y	→	Y	→	G	→
6.03 Cancer Improvement Programme	G	↘	G	→	Y	→	G	→	A	→	G	→	A	→
6.05 Theatre Productivity Improvement Programme	G	↗	G	↗	R	↑	G	↑	G	↑	Y	↑	G	↑
6.06 Diagnostic Improvement	Y	→	R	→	R	→	G	→	G	→	G	→	G	→

SIGNIFICANT ISSUES AND RISKS

ID	Project Name	Issue Title	Score	Controls in Place	Manager	Last Reviewed

Outputs


BENEFITS
LUHFT Improvement Plan
OUR IMPROVEMENT JOURNEY
Putting you at the heart of LUHFT
RTT Incomplete Waiters > 65 Weeks % Sep-23
RTT Incomplete Waiters > 78 Weeks % Sep-23
Cancer 2 Week Wait Aug-23
Cancer 28 Day Faster Diagnosis Aug-23
Cancer 31 Day First Treatment Aug-23
Cancer 62 Day First Treatment Aug-23
Cancer PTL 63-104 Days Urgent Suspected % Sep-23
Cancer PTL > 104 Days Urgent Suspected % Sep-23

Delivery Domains	Green (G) On Track 4 Points	Yellow (Y) Slightly Off-Track 3 Points	Amber (A) Off-Track 2 Points	Red (R) Requires Intervention 1 Point
Overall Delivery Health	Portfolio/programme/project is on track across all delivery areas- no areas assessed as *requires intervention.* **≥12**	Portfolio/programme/project is slightly off track in some delivery areas - no more than one area assessed as *requires intervention.* **≥11 ≤8**	Portfolio/programme/project is off track in some delivery areas - no more than one area assessed as *requires intervention.* **≥7 ≤4**	Portfolio/programme/project is significantly off track. Two or more areas are assessed as *requires intervention. Exception report required.* **≤3**
Plan A general tolerance of 2 weeks should be built into the projects in the Improvement Plan, unless a hard deadline is appropriate	Portfolio/programme/project is delivering to the plan and milestones set within the Project Initiation Document and/or approved change request document. **≥85% ON TRACK**	Portfolio/programme/project is slightly off track the plan delivery timeframes set within the Project Initiation Document and/or approved change request document. **≥70% ≤84% ON TRACK**	Portfolio/programme/project plan has experienced some slippage (tolerance breeched) to delivery milestones but critical path could be maintained with recovery actions. **≥55% ≤69% ON TRACK**	Portfolio/programme/project plan has breached agreed tolerances and is unlikely deliver to the current delivery plan. **≤54% ON TRACK**
Benefits KPIs are to be agreed including timeframes of measurement.	Portfolio/programme/project is on track to deliver (or delivering) the KPIs defined in the PID. All agreed KPIs are 'passing' or are trending in a positive direction. **≥85% PASSING / POSITIVE TRENDING**	Portfolio/programme/project is on track to deliver (or delivering) the KPIs defined in the PID. Most agreed KPIs are 'passing' or are trending in a positive direction. **≥70% ≤84% PASSING / POSITIVE TRENDING**	Portfolio/programme/project is on track to deliver (or delivering) the KPIs defined in the PID. Some agreed KPIs are 'passing' or are trending in a positive direction. **≥55% ≤69% PASSING / POSITIVE TRENDING**	Portfolio/programme/project is on track to deliver (or delivering) the KPIs defined in the PID. Some agreed KPIs are 'passing' or are trending in a positive direction. **≤54% PASSING / POSITIVE TRENDING**
Issues	Portfolio/programme/project has a weighted average 'Issue Score' of **≤5**	Portfolio/programme/project has a weighted average 'Issue Score' of **≥6 ≤9**	Portfolio/programme/project has a weighted average 'Issue Score' of **≥10 ≤11**	Portfolio/programme/project has a weighted average 'Issue Score' of **≥12**
Risks	Portfolio/programme/project has a weighted average 'Risk Score' of **≤5**	Portfolio/programme/project has a weighted average 'Risk Score' of **≥6 ≤9**	Portfolio/programme/project has a weighted average 'Risk Score' of **≥10 ≤11**	Portfolio/programme/project has a weighted average 'Risk Score' of **≥12**
Resources	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 'resource' is **≤5**	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 'resource' is **≥6 ≤9**	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 'resource' is **≥10 ≤11**	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 'resource' is **≥12**
Stakeholders	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 'stakeholders' is **≤5**	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 'stakeholders' is **≥6 ≤9**	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 'stakeholders' is **≥10 ≤11**	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 7 'stakeholders' is **≥12**

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/278*		Date: 14/03/2024	
Report Title	LWH Improvement Plan Update 1			
Prepared by	***Tim Gold; Chief Transformation Officer LUHFT & LWH***			
Presented by	***Tim Gold; Chief Transformation Officer LUHFT & LWH***			
Key Issues / Messages	***To provide an update on the work being undertaken to mobilise the LWH Improvement Plan.***			
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 note progress on the work undertaken by the Executive and wider organisation to mobilise a trust-wide Improvement Plan.			
Supporting Executive:	***Tim Gold; Chief Transformation Officer LUHFT & LWH***			

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Discussed at Board Development sessions and Senior Leadership Forums	Jan-March 24	CEO & CTO	Detailed in the report.

EXECUTIVE SUMMARY

1. Define the issue

Liverpool Women's Hospitals Foundation Trust (LWH) has a clear ambition to shape and deliver a trust wide Improvement Plan. Work is now required to properly scope, resource and launch the programme of work within the Trust.

2. Key Findings

Learning from others embarking on this journey makes clear that several building blocks need to be in place to govern and deliver the change successfully. Examples of these building blocks include dedicated Executive Time, robust governance and reporting, clear management of scope, consistent communication across the organisation and a clear understanding of the stakeholders who can influence success or failure.

3. Solutions / Actions

A comprehensive Mobilisation Plan (summarised below and presented in full in Appendix 1) has been created to launch the LWH Improvement Plan and embed the above learning from the outset. The plan will be delivered over a c. 10 week period concluding in early May 2024.

4. Recommendations

The Board is asked to note the work being taken by the Executive Team and wider organisation to define and launch the LWH Improvement Plan.

INTRODUCTION

Liverpool Women's Hospitals Foundation Trust (LWH) has a clear ambition to shape and deliver a trust wide Improvement Plan. The Improvement Plan is intended to bring mitigation to a number of strategic risks and opportunities, including:

- LWH's Crown Street site being an isolated site and requiring co-location with some of LUHFT's services in the longer term;
- LWH being brought into segment 3 of the NHS Oversight Framework and now having a set of "Exit Criteria" that need to be delivered in order to return to segment 2;
- Ongoing CQC and MSSP actions to evidence delivery of;
- A need to define the potential for collaboration between LWH, LUHFT and wider partners; and
- A significant underlying financial deficit.

This paper summarises for Board the actions being undertaken by the Executive Team and wider organisation to mobilise the LWH Improvement Plan within the organisation.

ANALYSIS

The Trust recognises that to deliver a Trust wide Improvement Plan at scale and pace will require a robust delivery and reporting model for managing transformation. Given the scale of the challenge and scrutiny from external stakeholders, it will also be important to learn lessons from other organisations embarking on a similar journey.

Learning from Others

The Liverpool University Hospitals Foundation Trust (LUHFT) Board have recently undertaken a lessons learnt review, facilitated by NHS England, to consider the success factors from the first Phase of their Improvement Plan, summarised in Figure 1 below.

1. **Portfolio management and Improvement Plan Delivery Unit approach (IPDU)** critical for delivery of improvement at scale and pace.
2. **Dedicated Executive Team and Board time (Portfolio Board)** to lead the Improvement Plan – part of the day job but time needs to be created and prioritised.
3. **Executives close to both assurance and delivery**, e.g. Exec SROs also chairing weekly huddles with their teams to support delivery.
4. **Inputs (plan milestones) and outputs (performance KPIs in SPC)** both need to be tracked at Exec level to manage delivery of Exit Criteria and hold nerve on improvement journey when required.
5. **Proactive stakeholder engagement and communications** gain traction internally and inform NHS Partners at Place, Region, ICB and National Teams.
6. **Partner support critical to gain early momentum**, e.g. NHSE Improvement Director to embed IPDU or Deloitte to improve financial grip and control.

Fig 1: LUHFT Lessons Learnt From their Improvement Plan Phase 1.

Mobilising the LWH Improvement Plan (LWH IP)

A Mobilisation Plan has been developed to incorporate the above learning and to ensure that the Improvement Plan is established correctly from the outset. The Mobilisation Plan has three objectives:

1. *Define and launch the first phase of the LWH Improvement Plan*
2. *Establish an infrastructure to drive delivery, clear accountability and reporting to Trust Board; and*

3. *Establish and embed the Transformation Delivery Unit (TDU) within LWH to support delivery and engagement with partners.*

The plan will deliver its objectives over c. ten weeks by working through four workstreams:

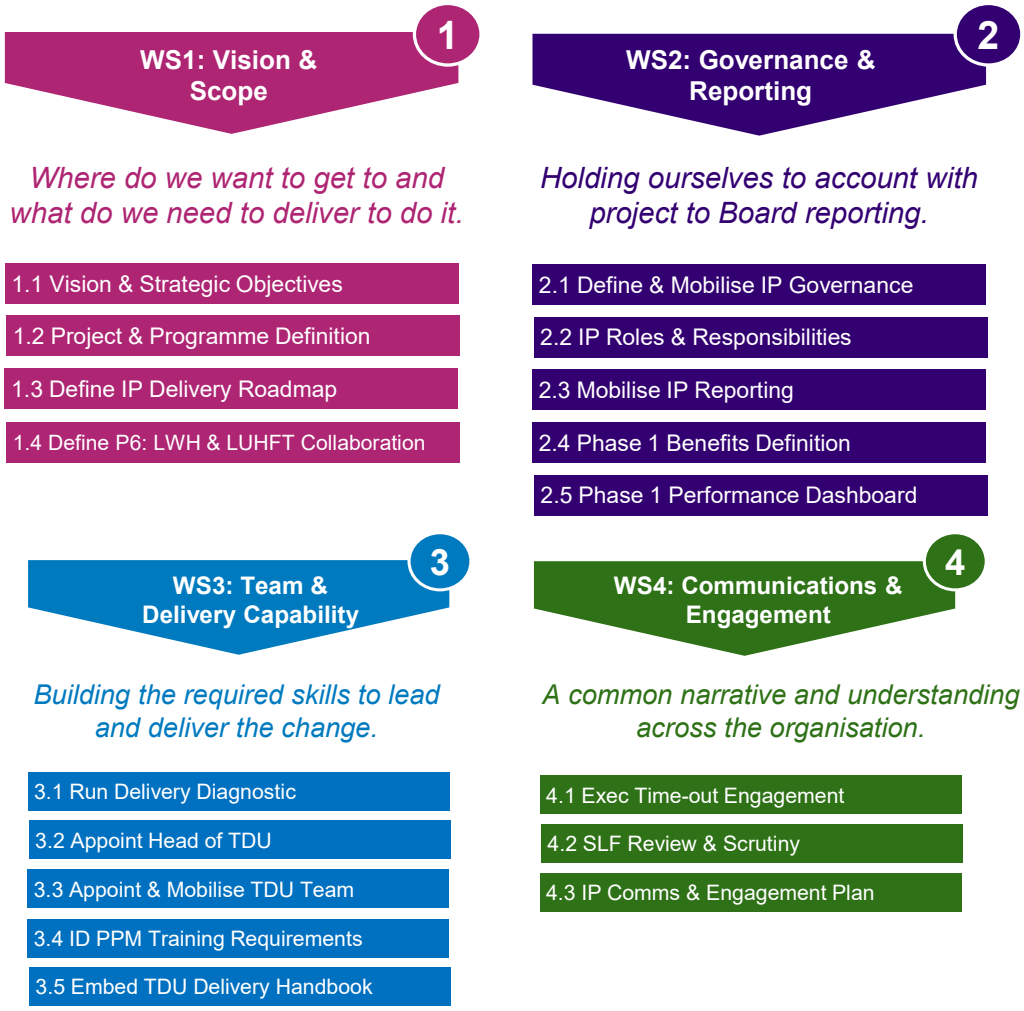


Fig 2: LWH Improvement Plan Mobilisation Plan.

The Mobilisation Plan is set out in full in Appendix 1.

Developing the LWH Improvement Plan

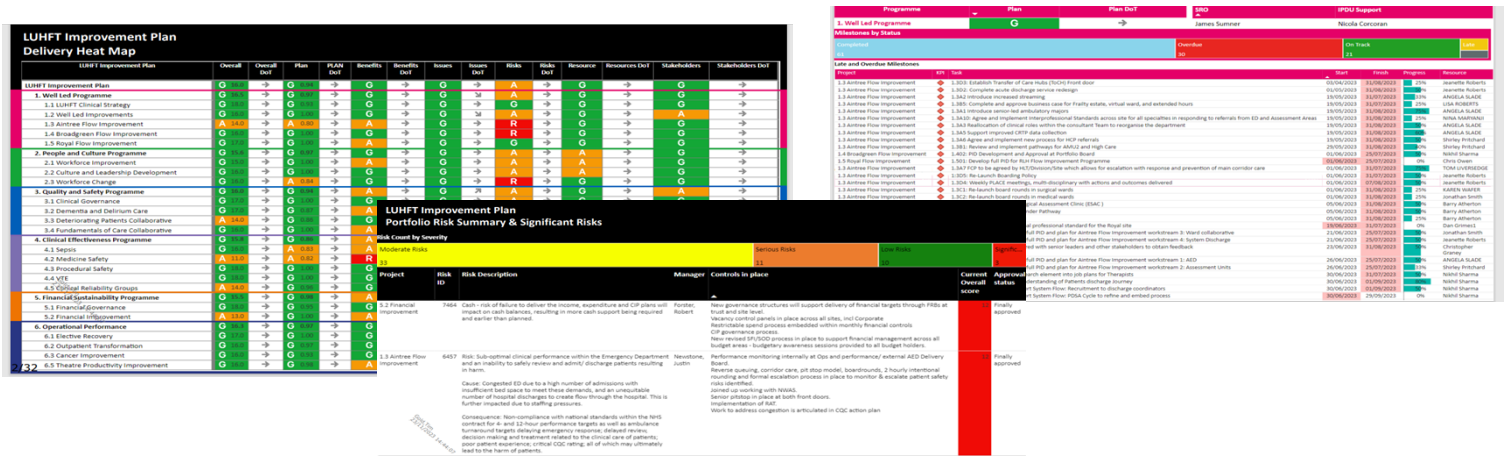
Work has started to develop the detail of the Improvement Plan, including development of Project Initiation Documents and delivery plans. The Executive Team are also dedicating Team Away Day time on 13th March to develop the Vision, Strategic Objectives and year 1 priorities for the Improvement Plan. This plan will then be shared and refined with the wider organisation through the Senior Leaders' Forum (SLF) and future Trust board updates.

Embedding Reporting Tools to Drive Improvement Plan

As set out above, a key lesson learned from the LUHFT Improvement Plan has been created a small dedicated team to drive delivery and consistent, integrated reporting from project to Trust Board. LUHFT have developed a project management delivery assurance system using Microsoft Office 365 applications that have enabled increased visibility and transparency for milestone, risk and issue tracking. The system provided semi-automated reporting functionality that minimised the need to transfer project information

from a project plan or risk register into a highlight report, saving time, reducing errors and maintaining a 'single version of the truth'. Collaborative work has begun between the LWH Business Intelligence (BI) and LUHFT BI teams to bring this suite of Power BI reports over to LWH, planned to conclude by the end of April.

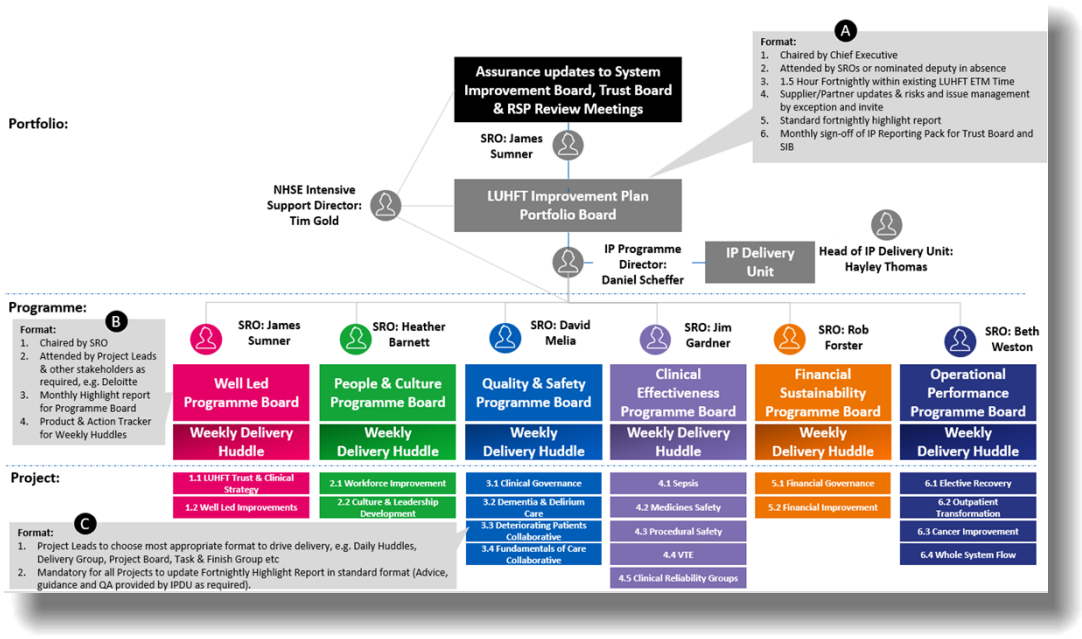
Fig 3: Portfolio Heat Map, Milestone Delivery & % Complete Charts, Risk Summaries live from Corporate Risk System



Improvement Plan Governance

Having dedicated governance for the Improvement Plan, demarked from Business as Usual reporting is also a critical success factor for the delivery of large scale transformation programmes. Work has begun to design the right governance model for the LWH Improvement Plan and an example model is set out below for information.

Fig 4: Example Improvement Plan Governance Model



RECOMMENDATION

The Board is asked to note the work being taken by the Executive Team and wider organisation to define and launch the LWH Improvement Plan, including a comprehensive mobilisation plan targeted for completion in early May 2024.

Liverpool Women's NHS Foundation Trust

Mobilising the LWH Improvement Plan

March 2024

[DRAFT FOR DISCUSSION]

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

Mobilising the LWH Improvement Plan
What are we trying to achieve?

Mobilisation Objectives:

1. Define and launch the first phase of the LWH Improvement Plan
2. Establish an infrastructure to drive delivery, clear accountability and reporting to Trust Board
3. Establish and embed the Transformation Delivery Unit (TDU) within LWH to support delivery and engagement with partners

Mobilisation Workstreams:

1 WS1: Vision & Scope

Where do we want to get to and what do we need to deliver to do it.

- 1.1 Vision & Strategic Objectives
- 1.2 Project & Programme Definition
- 1.3 Define IP Delivery Roadmap
- 1.4 Define P6: LWH & LUHFT Collaboration

2 WS2: Governance & Reporting

Holding ourselves to account with project to Board reporting.

- 2.1 Define & Mobilise IP Governance
- 2.2 IP Roles & Responsibilities
- 2.3 Mobilise IP Reporting
- 2.4 Phase 1 Benefits Definition
- 2.5 Phase 1 Performance Dashboard

3 WS3: Team & Delivery Capability

Building the required skills to lead and deliver the change.

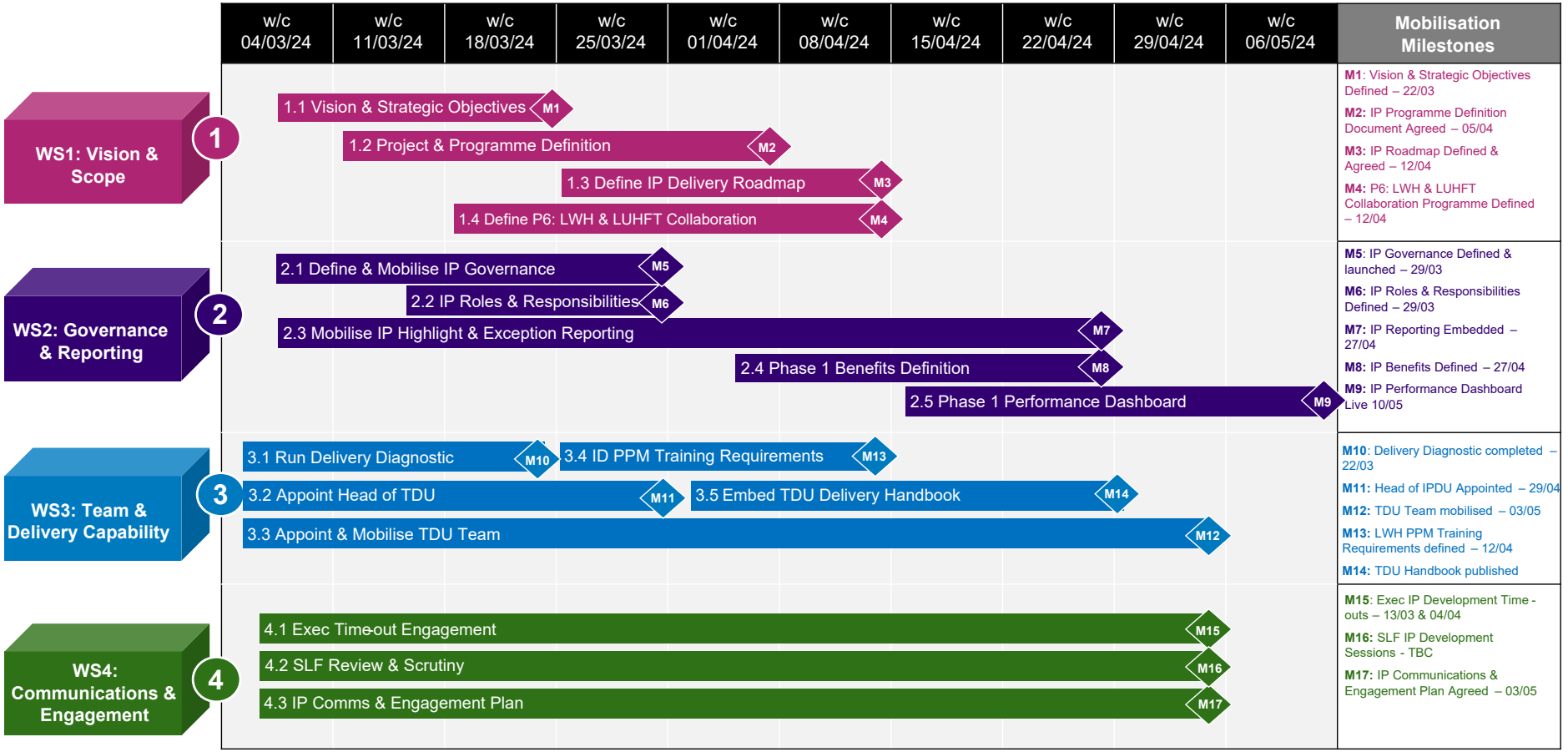
- 3.1 Run Delivery Diagnostic
- 3.2 Appoint Head of TDU
- 3.3 Appoint & Mobilise TDU Team
- 3.4 ID PPM Training Requirements
- 3.5 Embed TDU Delivery Handbook

4 WS4: Communications & Engagement

A common narrative and understanding across the organisation.

- 4.1 Exec Time-out Engagement
- 4.2 SLF Review & Scrutiny
- 4.3 IP Comms & Engagement Plan

Mobilising the LWH Improvement Plan – 10 Week Plan



Mobilisation Steps
WS1 Vision & Scope

#	Mobilisation Activity	Key Tasks
1.1	Vision & Strategic Objectives	• Exec Team development of a clear articulation (vision statement and small number of strategic objectives) for what this phase of the LWH Improvement Plan and each contributing programme is trying to achieve • Share and refine Vision & Strategic Objectives through Senior Leaders' Forum (SLF) • Approve IP Vision & Strategic Objectives through Trust Board
1.2	Project & Programme Definition	• Confirm Improvement Plan has the right Projects and Programmes in the Portfolio to deliver the Vision & Strategic Objectives • Augment additional projects/programmes if required • Define scope and delivery approach clearly in Project Initiation Documents (PIDs) or Project Charters • Executive sign-off or all IP PIDs and Project Charters • Summarise and present Improvement Plan scope with Trust Board
1.3	Define IP Delivery Roadmap	• Workshop the logical sequencing and dependencies of key IP milestones • Document in Transformation Map or Gantt chart • Share and refine roadmap with SLF • Approve IP Delivery Roadmap with Trust Board
1.4	Define P6: LWH & LUHFT Collaboration	• Define the programme of work that will review and design the collaboration opportunities between LWH and LUHFT and define the implementation plan to get there

Mobilisation Steps
WS2 Governance & Reporting

#	Mobilisation Activity	Key Tasks
2.1	Define & Mobilise IP Governance	• Define the governance model required to provide project to Board reporting and assurance • Develop ToR for IP governance groups and approve through Executive • Approve ToR for Portfolio Board with Trust Board • Communicate summary of Improvement Plan Governance with SLF
2.2	IP Roles & Responsibilities	• Define IP Roles & Responsibilities (SRO, Project Lead, IPDU Support etc) • Approve R&R with Executive and share through SLF
2.3	Mobilise IP Reporting	• Define Highlight Reporting process and develop Power BI reports • Launch IP reporting across LWH • Define and embed IP risk and issue management • Define and embed IP milestone tracking and change control process
2.4	Phase 1 Benefits Definition	• Define the qualitative and quantitative benefits targeted through the Improvement Plan and how they will be measured (e.g. continuous improvement, phased trajectory, peer benchmarking etc) • Hand over benefits requirements to BI team for dashboard production
2.5	Phase 1 Performance Dashboard	• BI team iteratively produce IP Performance Dashboard, periodically reviewing through Exec Team • IP Performance Dashboard launched in LWH and used to review Project and Programme progress in key IP governance groups

Mobilisation Steps
WS3 Team & Delivery Capability

#	Mobilisation Activity	Key Tasks
3.1	Run Delivery Diagnostic	• Undertake delivery diagnostic to assess current programme and project management maturity • Review results and update mobilisation plan as required
3.2	Appoint Head of Transformation Delivery Unit (TDU)	• Run internal recruitment process to appoint the LWH Head of Transformation Delivery Unit (TDU)
3.3	Appoint & Mobilise TDU Team	• Allocate TDU support resources (from LUHFT IPDU) to support Improvement Plan delivery
3.4	Identify Programme & Project Management Training Requirements	• Use Delivery Diagnostic and SLF engagement to identify LWH Programme and Project Management Training requirement and other associated delivery skills, e.g. Quality Improvement (QI)
3.5	Embed TDU Handbook	• Document TDU processes and ways of working in a Transformation Delivery Unit Handbook and share/communicate within the organisation

Mobilisation Steps
WS4 Communications & Engagement

#	Mobilisation Activity	Key Tasks
4.1	Exec Time-out Engagement	• Allocated to dedicated Executive time for creating the LWH Improvement Plan • Key tasks include: Vision and Strategic Objectives development, Portfolio definition, stakeholder mapping and engagement, Roadmap creation and Benefits identification (how to measure success), providing assurance to Trust Board that Improvement Plan is well developed and fit for purpose
4.2	SLF Review & Scrutiny	• Run sessions with SLF during the mobilisation phase to engage the wider leadership team on plan development, provide check and challenge on IP scope, benefits and share the TDU approach and ways of working
4.3	IP Communications & Engagement Plan	• Following work to develop the LWH Improvement Plan and stakeholder map, the Ip Communications and Engagement Plan will be produced to define key points of engagement and communication within the IP, and communication and engagement channels and how and when they will be used to support Improvement Plan delivery

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