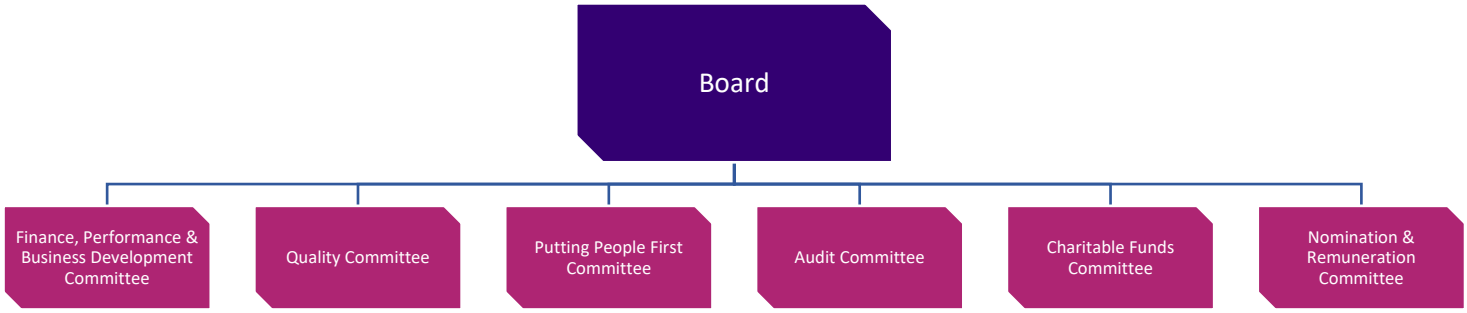
Liverpool Women's NHS Foundation Trust

Trust Board

11 April 2024, 09.30am
The June Henfrey Suite
Blackburne House



Liverpool Women's NHS Foundation Trust

Trust Board

Location	The June Henfrey Suite, Blackburne House
Date	11 April 2024
Time	9.30am

AGENDA					
Item no. 24/25/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
001	Introduction, Apologies & Declaration of Interest	Note	Verbal	Chair	09.30 (5 mins)
002	Patient Story	Note	Presentation	Deputy Chief Nurse	09.35 (15 mins)
003	Minutes of the previous meeting held on 14 March 2024	Approve	Written	Chair	09.50 (5 mins)
004	Action Log and any urgent matters arising	Note	Written	Chair	
PERFORMANCE					
005	Chief Executive Report • Quality, Operational and Workforce Performance Report • Executive Risk & Assurance Group ToR and Improvement Plan Portfolio Board ToR	Note / Approve	Written	Chief Executive	09.55 (30 mins)
006	Finance Report & Financial Planning	Assurance	Written / Presentation	Chief Finance Officer	10.25 (10 mins)
007	LWH Improvement Plan Mobilisation Update 2	Note	Written	Chief Transformation officer	10.35 (10 mins)
QUALITY, SAFETY & EFFECTIVENESS					
008	Mortality and Learning from Deaths Report Quarter 3, 2023/24	Assurance	Written	Chief Medical Officer	10.45 (10 mins)
009	Integrated Governance Report Quarter 3, 2023/24	Assurance	Written	Deputy Chief Nurse	10.55 (10 mins)
010	Bi-annual staffing paper update, July 2023-December 2023 (Q2 & Q3)	Assurance	Written	Deputy Chief Nurse	11.05 (10 mins)
BREAK – 11.15 – 11.30 Board Thank you – 11.30 – 11.40					
PEOPLE & CULTURE					

011	Equality & Diversity Reports • E&D Annual Report • EDS Report • Gender pay gap	Receive & Approve	Written	Chief People Officer	11.40 (20 mins)
GOVERNANCE					
012	Corporate Governance Manual	Approval	Written	Trust Secretary	12.00 (10 mins)
013	Risk Management Strategy	Approval	Written	Head of Risk and Safety	12.10 (10 mins)
014	Committee Chair's Reports	Note	Written	Committee Chairs	12.20 (15 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.*					
015	Corporate Objectives 2023/24: Final Outturn Review	Receive	Written	Trust Secretary	Consent
016	Board Committee Annual Reports, 2024/25 Cycles of Business and Terms of Reference	Approval	Written	Trust Secretary	
017	Digital.Generations Strategy Review	Receive	Written	Chief Digital Information Officer	
018	Board Assurance Framework	Note	Written	Trust Secretary	
CONCLUDING BUSINESS					
019	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	12.35 (5 mins)
020	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
021	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
022	Jargon Buster	For reference	Written	Chair	
Finish Time: 12.40					

Date of Next Meeting: 9 May 2024

The Board of Directors is invited to adopt the following resolution:

'That the Board hereby resolves that the remainder of the meeting to be held in private, because publicity would be prejudicial to the public interest, by reason of the confidential nature of the business to be transacted'. [Section (2) of the Public Bodies (Admission to Meetings) Act 1960]

Liverpool Women's NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held in the Boardroom at 10am on 14 March 2024

PRESENT

David Flory CBE	Chair
James Sumner	Chief Executive
Jenny Hannon	Chief Finance Officer / Executive Director of Strategy & Partnerships / Deputy Chief Executive
Zia Chaudhry MBE	Non-Executive Director
Michelle Turner	Chief People Officer
Gary Price	Chief Operating Officer
Gloria Hyatt MBE	Non-Executive Director
Jackie Bird MBE	Non-Executive Director
Prof. Louise Kenny CBE	Non-Executive Director / SID

IN ATTENDANCE

Matt Connor	Chief Digital Officer
Tim Gold	Chief Transformation Officer
Nashaba Ellahi	Deputy Director of Nursing & Midwifery
Yana Richens	Director of Midwifery
Lesley Mahmood	Member of the Public
Felicity Dowling	Member of the Public
Teresa Williams	Member of the Public
Dr Alice Marsden	Locum Consultant in Clinical Genetics
Andrew Duggan	Head of Communications
Hollie Holding	Deputy Trust Secretary, Liverpool University Hospitals NHS Foundation Trust
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Tracy Ellery	Non-Executive Director / Vice-Chair
Louise Martin	Non-Executive Director
Sarah Walker	Non-Executive Director
Dianne Brown	Chief Nurse
Dr Lynn Greenhalgh	Chief Medical Officer

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

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

23/24/	
268	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. Apologies were noted as above and no new declarations of interest were made.
269	**Meeting guidance notes** The Board received the meeting attendees' guidance notes. It was confirmed that the principles contained within the meeting guidance notes were adequately embedded with attendees and therefore they would not be tabled as an item at future meetings.
270	**Minutes of the previous meeting held on 8 February 2024** The minutes of the Board of Directors meeting held on 8 February 2024 were agreed as a true and accurate record.
271	**Action Log and matters arising** Updates against action log were noted. The Chief People Officer provided assurance that work was being undertaken to close action 23/24/185b by the updated deadline (April 2024). The Chair sought an update against the work being undertaken in response to the findings in the Maternity and Newborn Safety Investigations (MNSI) report that was tabled at the February 2024 Board meeting. The Chief Executive confirmed that the following actions were in place: • Review of staff culture initiated. • Review of the use of the National Early Warning Score (NEWS) and the Modified Early Obstetric Warning System (MEOWS) • Development of KPIs for sepsis screening • Additional resource identified to strengthen delivery of the anti-racism agenda.

	The Chair remarked that the required response was multifaceted and queried the most effective mechanism to provide on-going assurance to the Board. The Chief Executive stated that it would be vital that the Board could be assured that the Improvement Plan covered the various issues adequately. Once this was in place, monthly reports would be provided to the Board on the status of the various actions and programmes of work.
272	Chief Executive Announcements The Chief Executive provided an update on several significant developments affecting the Trust. Initial discussions centred around the financial position at both the national NHS level and within the Cheshire & Merseyside system. There were significant pressures at all levels of the NHS and an area of particular focus and challenge related to workforce growth. Within this context, it was noted that the Board had recently approved an additional £3m of expenditure to deliver on aspects of the Improvement Plan, a proportion of which related to staffing resources. Whilst this underscored the Board's commitment to quality and safety, it would also be important to demonstrate effective grip and control and that the Trust was working to address the need for financial improvement. The Chief Executive also highlighted a recent stakeholder communication regarding the Women's Hospital Services in Liverpool Programme Board. An indicative programme plan had been developed and this reflected the unlikelihood that a new hospital building, co-located with an adult acute site, would be built within a five-to-ten-year timescale. Recognising that clinical risks owing to the current isolated site were materialising, discussions were held on alternative solutions for citywide women's healthcare. A clinical stakeholder group meeting had been scheduled for 3 May 2024, and this would bring together clinical stakeholders from involved hospitals to begin deliberations on the optimal solutions ahead of a public consultation phase. Non-Executive Director, Zia Chaudhry, queried if indicative timescales had been identified. The Chief Executive confirmed that steps had been identified together with relevant decision 'gateways'. It was likely that timescales would need to flex and respond to the external environment. The most important aspect was ensuring that the process was thorough, robust, and inclusive. The Chair and Non-Executive Directors expressed the importance of engaging all stakeholders, including the public and families, emphasising the necessity of incorporating lived experiences into the planning process. The Chief Executive noted positive engagement from trusts involved in the Programme Board. The Chair concluded by emphasising the shared risk across stakeholders and the essential role of public input in the process, leading to an action to regularly include updates from the Programme Board in the Trust's public board meetings for consistent communication. Action: To receive a report from the Women's Service Programme Board at each public Board meeting. The Trust's Improvement Plan was another focus, with the Executive Team having recently detailed the upcoming year's work across various programme headings. Further detail on the improvement plan would be provided under item 278 and in a Board Development session scheduled for later in the day. The Board noted the update.
273	Quality, Operational & Workforce Performance Report The Chief Operating Officer proceeded to provide an update on the Trust's performance, particularly noting that urgent care metrics had consistently surpassed the national targets for the four-hour emergency department wait times during the 2023/24 period. Despite an uptick in emergency attendances in the Month 10, impacting performance negatively, projections remained positive with an expectation to maintain over 90% performance by the fiscal year-end. The Maternity Assessment Unit's triage had also maintained performance above 95% for several months which provided a level of assurance that improvements were embedded. The Trust also anticipated continued strong

	performance in diagnostic wait times, with expectations to meet and exceed system requirements by year-end. A discussion on cancer performance noted ongoing challenges, with the Trust remaining in tier two oversight with the Cancer Alliance. However, there had been a significant monthly improvement in the 28-day faster diagnosis standard in February 2024, improving by 23% to 55%, just below NHS England's established trajectory. The Trust aimed to reach 60% compliance by the end of the fiscal year, aligning with national gynaecology performance standards. The Deputy Director of Nursing and Midwifery addressed performance in the Friends and Family Test for the Gynaecology Emergency Department, detailing plans to improve patient experience, including reallocating certain patient cohorts. Workforce metrics presented by the Chief People Officer showed notable improvements over a 12-month period, particularly in maternity services, attributed to enhanced staffing levels and well-being initiatives. Vaccination compliance for flu and COVID-19 remained low, and the Chief People Officer noted that planning ahead of next year's campaign had started early to review opportunities for improvement. Owing to the issue being seen across the NHS and other sectors, the Trust was also making representations to suggest a national campaign to improve future compliance rates. Non-Executive Director, Gloria Hyatt, expressed some concerns regarding data timeliness, with Month 10 data only being received in March 2024. This generated a wider discussion regarding the Integrated Performance Report and the Chief Executive noted that a programme to enhance the report had been included on the Improvement Plan. The importance of incorporating benchmarking information and enhanced clarity on serious untoward incident reporting were highlighted by the Board as two key aspects for improvement. Action: To review benchmarking data and utilise this to help set trajectories for key performance indicators within an updated Integrated Performance Report. The Chair underscored the importance for the Board to understand the effects of Industrial Action comprehensively, noting the substantial nature of the Trust's waiting list. He stressed the importance of ensuring that effective measures were being undertaken to decrease the waiting list to the necessary extent. The Board of Directors received and noted the Quality, Operational & Workforce Performance Report.
274	Finance Performance 2023/24 and Financial Planning 2024/25 The Chief Finance Officer presented the report noting that at Month 10 the Trust reported a £17.2m deficit which represented a £4.0m adverse variance to plan year to date (YTD). This position was supported by £2.6m of non-recurrent items. The forecast outturn reported at Month 10 was a £23.4m deficit, which represented 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. Since this point, the Trust had been informed that it would receive an additional £700k of income to support the costs of Industrial Action (estimated costs c. £800k). The Trust was on target to deliver the revised forecast outturn. The Cost Improvement Programme (CIP) delivery was behind the YTD target by £1.3m and was 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 included £6.0m of national cash support received with a further £14.1m due in February and March 2024. Non-Executive Director, Jackie Bird, asked if the Trust had made plans to mobilise the recurrent elements of the 2023/24 CIP plan that had not yet been delivered. The Chief Finance Officer confirmed that the 2024/25 CIP plan was more in line with the levels that had been achieved in previous years and that that the plan did include not yet delivered elements from the 2023/24 list.

	The Chair sought clarification on the statement in the report regarding the Trust's inability to unwind prior year pay investments. The Chief Finance Officer explained that the Trust had been provided with a target by the Integrated Care Board (ICB) to unwind c £2.5m of pay investments in 2023/24. A detailed review had been undertaken, led by the Chief People Officer, and it had been concluded that, due to safety concerns, most of this investment could not be unwound. The Chief Finance Officer continued to outline details of the 2024/25 financial plan. The initial plan set a deficit of £34.6m. Since this point, the Trust had received an additional £1.9m system top-up to cover the CNST premium gap. The £3m investment to support the delivery of the Improvement Plan had been reviewed and it had been determined that elements could be funded via capital rather than revenue – this would further support reducing the deficit target. In addition, the Trust was working in partnership with Liverpool University Hospitals NHS Foundation Trust (LUHFT) to explore collaborative opportunities that would result in savings for both organisations. As a result, the planned deficit was now £31.5m. The Chief Finance Officer stated that there had been positive engagement across the Trust in developing the 2024/25 CIP and it was felt that a 1.8% recurrent target was deliverable. The Chair acknowledged the financial challenges confronting the Trust and the broader NHS, stressing the Board's responsibility to maintain a clear understanding of the financial situation. He emphasised the necessity of balancing Board focus between aspects within the Trust's control and those necessitating external assistance and change. The Chief Finance Officer noted that the request to approve the Soft FM contract extension had been deferred and that a report would be tabled to a future meeting. The Board of Directors: • Noted and received the Month 10 2023/24 Finance Performance Review • Noted and received the update on 2024/25 financial planning.
275	CQC Inspection Report and Improvement Plans The Deputy Director of Nursing & Midwifery explained that the Trust had received the final report into the findings of the Care Quality Commission unannounced inspection in January 2024. She continued to highlight the steps taken to date in response of the findings and providing assurance regarding the oversight and completion of required actions including next steps. The CQC had formally notified the Trust that the requirements of the Warning Notice had been met and as such the Warning Notice had been lifted. The Chief Executive noted that progress against the CQC action plan (both from the 2023 and 2024 inspections) was being reported to the ICB via the monthly System Oversight Group as part of the Trust's exit criteria from the National Oversight Framework segment three. It was expected that assurance would be provided by May 2024 that the actions had been closed out, precipitating the removal of this element from the exit criteria. Non-Executive Director, Jackie Bird, observed that many actions identified from the inspection addressed fundamental issues. She questioned how the Trust planned to correctly implement these basic actions from the outset. The Deputy Director of Nursing & Midwifery confirmed that the Trust's 'Be Brilliant [ward] Accreditation Scheme' (BBAS) was being reviewed to ensure that these issues were being identified and the appropriate action taken in response. The Chief Executive added that it would be important to embed a safety culture across the Trust to ensure that the correct behaviours were in place – this was a key programme within the Improvement Plan. The Board of Directors took assurance as to the process in place to drive improvement following the CQC inspection.

276	**Staff Survey 2023 – Overview of Key Themes** The Chief People Officer presented an overview of the key themes of the 2023 NHS Staff Survey. 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 nine themes of the survey, maintaining the positive improvements of the previous year. However, individual questions identified areas of improvement or deterioration, and would inform the organisation's ongoing cultural programme to drive a positive and engaging workplace culture and experience. As in previous years, the Trust benchmarked more favourably when compared to Acute Trusts (122 organisations) than the official comparator group of Acute Specialist Trusts (a small cohort of 13 specialist hospitals). The Trust wanted to demonstrate ambition and make improvements to meet and exceed the standards in the Acute Specialist Trust group. The Chair queried if any aspects of the results had been unexpected. The Chief People Officer stated that the numbers of staff who had said that they had been the target of unwanted behaviour of a sexual nature by both patients/public and colleagues was a concern. Sexual Safety at work was a priority area of focus with the Trust having already signed the NHS Sexual Safety Charter. Signatories to the Charter had committed to implementing all ten commitments by July 2024; the Board would receive a further update at this point. The Chief Transformation Officer noted that aspects of this work would be included within the Improvement Plan. The Chief People Officer observed that incidents like these had not been commonly escalated through the Trust's reporting system, indicating a level of tolerance among the workforce. It was emphasised that staff should be motivated to report such incidents, with the assurance that the Trust would provide them with full support. Other aspects that required immediate action included: • Ensuring that affordable and nutritious food options were available to staff outside of 'office' hours. • A review in respect of access to necessary materials, goods and supplies required to ensure that any financial grip and control had not impacted adversely on ability to order essential supplies given the continued deterioration in this score over the last three years. Non-Executive Director, Gloria Hyatt, queried what the drivers were behind the increase in staff members experiencing discrimination based on a disability. The Chief People Officer confirmed that this increase had been anticipated due to the work undertaken during the year to encourage staff to declare a disability. A staff group was in place to identify and drive improvements and a recent outcome had been to speed up the implementation of reasonable adjustments. The Board of Directors received the report.
277	**Governance and Assurance Framework Review** The Trust Secretary explained that the Trust's governance and assurance framework, continuously refined through annual reviews, had achieved a "Substantial Assurance" rating for its internal control system for the period ending 31 March 2023. In response to ongoing challenges, the Trust had increased assurance reporting to enhance oversight, which, while beneficial, had reduced the clarity between operational management and assurance and required an unsustainable level of management support. To address this and improve efficiency, changes to the Trust's governance and assurance processes were proposed – based on discussions held at Board Development sessions. These included delineating operational management from assurance activities, optimising meeting frequencies for strategic focus, and introducing an Executive Risk and Assurance Group (ERAG) for effective operational oversight. Additionally, updates to the Corporate Governance Manual and Risk Management Strategy, alongside a revised Board Assurance Framework, were under development. A communication and training plan for staff would accompany the changes, with success evaluation through internal and potential

	external reviews, ensuring the reforms supported the Trust's strategic goals and improvement trajectory. The Board of Directors received the report and approved the proposed changes to the Trust's Governance and Assurance Framework.
278	LWH Improvement Plan Update 1 The Chief Transformation Officer outlined the work undertaken to date and planned work to implement an Improvement Plan for the Trust. Lessons from implementing similar plans highlighted essential components for success, including Executive commitment, strong governance, clear scope management, effective communication, and stakeholder engagement. To operationalise these insights, a detailed Mobilisation Plan had been developed, outlined in Appendix 1 to the report. This plan aimed to establish the necessary foundations for the Improvement Plan, ensuring a structured rollout over approximately 10 weeks, culminating in early May 2024. The Chair remarked that the Improvement Plan approach had been integral to LUHFT exiting National Oversight Framework segment four within a 12-month period. The process enabled the organisation to focus on key priorities and ensure that the Board was receiving and discussing the relevant items on its agenda. The Board of Directors noted the report.
279	Review of risk impacts of items discussed The Chair identified the following risk items: • Ensuring on-going Board oversight of the actions arising from the MNSI Report • On-going financial sustainability challenges and the need for the Board to maintain a clear understanding of the financial situation. • The importance of effectively engaging with the public and stakeholders in the work of the Women's Hospital Services in Liverpool Programme Board • The importance for the Board to understand the effects of Industrial Action comprehensively, noting the substantial nature of the Trust's waiting list. • The numbers of staff who had identified though the staff survey that they had been the target of unwanted behaviour of a sexual nature.
280	Chair's Log None noted.
281	Any other business & Review of meeting None noted. Review of meeting No comments noted.
282	Jargon Buster Noted.

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
11 April 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
14 March 2024	23/24/273	Quality, Operational & Workforce Performance Report	To review benchmarking data and utilise this to help set trajectories for key performance indicators within an updated Integrated Performance Report.	CDO	May 2024	On track	
14 March 2024	23/24/272	Chief Executive Announcements	To receive a report from the Women's Service Programme Board at each public Board meeting.	CEO	May 2024	On track	
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.	CMO	April 2024	Complete	The cultural factors identified within the report have been carried forward into the Improvement Plan (Safety Culture, anti-racism and deteriorating patient projects)
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	~~April 2024~~ May 2024	Risks identified	Item 010 provides commentary on staff experience including break audits. Other issues are being reviewed as part of the workforce metrics that will form part of the updated IPR.

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.	CMO	~~November 2023~~ April 2024	Risks identified	Verbal briefing to be given at the Board meeting.
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.	CMO	April 2024	Closed	The Gynaecology Division are reviewing services that require mental health support to review the totality of need. This will be progressed via the Gynaecology Divisional Board and the ERAG structure if required.

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 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~~ May 2024	Open	Guidance published in April 2024.
Delegated	09.11.2023	To explore the potential opportunities to support the Trust's Volunteer Service.	CFC	~~January 2024~~ April 2024	Closed	Discussion underway between Volunteer team and Fundraising to explore potential funding support.

Trust Board

COVER SHEET

Agenda Item (Ref)	***24/25/005***		**Date: 11/04/2024**	
Report Title	**Chief Executive's Report**			
Prepared by	***James Sumner, Chief Executive Officer***			
Presented by	***James Sumner, Chief Executive Officer***			
Key Issues / Messages	***To provide the Board of Directors with details of key activities and issues from the Chief Executive since the last update in February 2024.***			
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 of Directors is asked to: • ***note the content of the report including the Quality, Operational and Workforce Performance appendix*** • ***Approve the Terms of Reference for the Executive Risk and Assurance Group*** • ***Approve the Terms of Reference for the Improvement Plan Portfolio Board***			
Supporting Executive:	***James Sumner, Chief Executive Officer***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The report sets out details of key issues the Board need to be appraised of, and activity which the Chief Executive has been involved in, since February 2024.

MAIN REPORT

ITEMS FOR INFORMATION

System Oversight Group

The National Oversight Framework (NOF) was established by NHS England to monitor Integrated Care Boards (ICBs) and NHS trusts. It aims to ensure quality care, access, financial stability, and effective leadership and uses five national themes for assessment: quality, access, prevention, resources, and leadership. Trusts are placed in a segment following assessment with a sliding scale of autonomy and intervention from segment one (least) to segment four (most). The Trust has been placed in segment 3 and as a result the Trust attends System Oversight Group meetings with the Cheshire & Merseyside Integrated Care Board (ICB). Work to date has been focused on developing the exit criteria for the Trust to move from segment three to segment two and this has now been finalised – please see below.

1

Finance

	Exit Criteria	Measure
1.1	Financial Recovery Plan	• Development of a recovery plan that clearly articulates and defines the key drivers of the deficit and shows sustainable improvement addressing all agreed influenceable areas of deficit drivers (as agreed with ICB) • Delivery of at least 2 quarters of the recovery plan to demonstrate sustainable improvement. • Remain on I&E plan for at least 2 quarters (I&E plan as agreed within the overall system plan and in line with recovery plan) • Compliance with national, regional and system expenditure control regimes
1.2	Cash Performance	• Production of rolling 13 week cashflow underpinning ongoing cash requirement (for scrutiny) • Internal audit review of cashflow management processes.

2

Performance

	Exit Criteria	Measure
2.1	Cancer Performance	Exit NHS E Tier 2 for Cancer Performance
2.2	Delivery	Delivery of at least 2 quarters of locally agreed planning requirements 2024/25

3 Quality

	Exit Criteria	Measure
3.1	No Outstanding CQC & MSSP Actions	Trust Board & SOG sign-off of delivered Action Plan

4 Workforce

	Exit Criteria	Measure
4.1	Agency Spend	Agency spend no more than 3.2%* of total pay for 3 quarters in succession
	Turnover	Turnover under Trust ceiling (13%) for 3 quarters in succession
4.3	Actively Anti-Racist Programme	On track delivery of Actively Anti racist Programme learning sets (within Inclusion Training Programme): • delivered to 20% of workforce in each of Q1 and Q2 (24/25) • demonstrating consistent progress towards target to achieve 80% of workforce trained within 24/25

A key mechanism for the Trust to deliver the necessary actions is through the improvement programme – an update on the mobilisation of this programme and the actions taken to date against the underpinning programmes is detailed in item 007.

To provide effective oversight of the Improvement Plan, there will be a fortnightly Improvement Plan Portfolio Board meeting chaired by myself. Outputs from this meeting will report to future Board meetings via a dashboard. A draft Terms of Reference have been produced and these are tabled in Appendix C for consideration by the Board.

Women's Hospital Services in Liverpool Programme

I'd like to provide an update on our ongoing efforts to envision the future of women's services, previously known as the Future Generations Strategy. As Chair of the Women's Hospital Services in Liverpool Programme Board, I oversee the progress of this initiative, which operates under the oversight of the Women's Services Committee, a subsidiary of the NHS Cheshire and Merseyside Integrated Care Board (ICB). Our main objective is to address and resolve the challenges currently faced by hospital maternity and gynaecology services in Liverpool, aiming for a comprehensive improvement in both quality and safety for these critical services.

The services in question, specifically maternity and gynaecology, are primarily provided at the Liverpool Women's Hospital but remain physically and operationally separate from other essential specialist adult services located across the city. This separation has led to notable clinical risks, including delays in care and the need for vulnerable women to be transferred between facilities during critical times. Recognising these significant challenges, our board is dedicated to devising a

sustainable, long-term solution that will bring about substantial enhancements to the care and safety of the services provided to women in Liverpool.

As part of our roadmap, we have outlined the initial phase of the programme, emphasising the importance of openness, transparency, and continuous engagement with the public. The development of a clinical case for change is scheduled for the spring and summer of 2024, with publication expected later in the same year. Feedback from this engagement phase, gathered during the winter of 2024/25, will inform our approach to designing future services, with further development of potential options anticipated to commence in early 2025. While these timelines are subject to adjustments based on external factors such as the forthcoming general election, which might necessitate pausing our work temporarily, no definitive decisions regarding the future of women's services have been made yet. Concurrently, collaborative efforts between Liverpool Women's and Liverpool University Hospitals NHS Foundation Trusts are ensuring that, in the interim, services remain as safe and effective as possible through shared clinical expertise.

The Women's Hospital Services in Liverpool Programme Board will produce a report following each of its meetings and this will be received by the Board of each of the trusts involved to ensure consistent communication of the key messages.

Executive Risk and Assurance Group

The March 2024 Board meeting approved changes to the Trust's governance and assurance processes. These changes included delineating operational management from assurance activities, optimising meeting frequencies for strategic focus, and introducing an Executive Risk and Assurance Group (ERAG) for effective operational oversight. It is the intention that the ERAG will report directly to the Board (from May 2024 onwards) and therefore the Terms of Reference (included in Appendix B) are tabled for consideration by the Board.

Fit and Proper Person Test Compliance

The Trust Board operates within the framework of the NHS England Fit and Proper Person Test (FPPT) Framework, introduced in September 2023. This framework ensures all board members possess the necessary skills, experience, and commitment to effectively govern the Trust.

We are pleased to report that the Trust has submitted a position of compliance for all current Board members following a comprehensive assessment against the FPPT criteria.

Register of Sealings

In line with paragraph 118 of the Trust's Standing Orders, there is a requirement to report all sealings to the Board of Directors on an annual basis. The report should contain details of the seal number, the description of the document and date of sealing. The seal was utilised twice during 2023/24:

- 175 – 14 April 2023 – Community Health Partnerships Ltd & LWH – Renova Development Ltd LIFT Underlease for part of St. Chad's Centre, St Chad's Drive, Kirkby, L32 8RE
- 176 – 19 August 2023 – NHS Procure 22 ECC NEC3 Stage 4 Contract Agreement incorporating templates A&B for a scheme for a single project for LWH Crown St enhancements (Ref: P22-0057).

Liverpool Women's NHS FT Menopause Primary Care Collaboration Pilot

To bring menopause care closer to people's homes, Liverpool Women's Hospital has collaborated with the Central Liverpool Primary Care Network for a 3 month pilot to provide menopause clinics in the community. Clinical Leads from Liverpool Women's have been training and sharing their expert knowledge with GP's and Nurses at CLPCN to allow women to access specialist menopause care quicker and closer to home. This will also help to reduce waiting times and it will provide better care for complex menopause cases. We really look forward to seeing how this pilot develops over the next few months and well done to the team involved in setting this up.

PERFORMANCE SUMMARY

Quality, Operational and Workforce Performance Report is included at Appendix A.

Elective Waiting Times

- At the end of March the Trust is still reporting a number of patients waiting over 65 weeks for routine elective treatment (140). This is above the year end trajectory (85) due to the effects of industrial action earlier in the year and short-term loss of locum capacity in March. With additional resource from April the Trust is confident that it will eliminate the over 65 week waits by the end Q1 24/25 which is earlier that the national ask of September 2024. We will then move to eliminate waits of over 52 weeks through 2024/25.

- Improving waiting times for our longest waiting patients is a priority. The Quality Committee received an update on how we ensure that those patients waiting the longest have regular contact from the Trust to help prioritization. In addition, they received information on schemes whereby working collaboratively with Primary Care is beginning to reduce waiting times.

- In March the FPBD received information on a number of productivity schemes in place through the outpatient transformation group that are starting to deliver a reduction in the overall Gynaecology list size and this reduction will continue with additional resource from April.

Cancer and Diagnostic Waiting Times

- Our Cancer 28 day Faster Diagnostic target has seen sustained improvements for a full quarter and as of March 24 is within the national average for Gynaecology (62%) despite a sustained increase in referrals. There are more improvement schemes that are still to deliver and therefore we are confident of continuing this improvement. As we improve our Faster Diagnostic Performance we expect our other Cancer targets to improve and we have started to see that through the 62 day % for February.
- Our routine 6-week Diagnostic performance continues to deliver in line with national requirements.
- The 31-day cancer standard is showing statistical deterioration. The 31 Day DTT performance for February demonstrates an unvalidated position of 53%. Ongoing validation has identified patients that are not breaches and therefore the position will improve to 60% once finalised. The unvalidated position for March is currently 65%, with potential further improvement once fully validated. 12 patients breached in February, of which 1 was patient choice and 7 related to fitness for surgery and complex diagnostics. Work is underway as part of the Cancer Improvement Plan to review the MRI diagnostics cancer pathway to improve access for patients and reduce unnecessary delays.

Urgent Care

- Urgent Care waiting times (Maternity Assessment Unit and Emergency Department) continue to deliver in line with or above national requirements.

Quality Metrics

- Never Events – There were no new Never Events declared in February 2024
- Complaint actions overdue – work continues to reduce out-of-date actions across Gynaecology/Hewitt and Maternity, with a small deterioration noted (4 more than last month) out of date equating a total of 11 out of date actions remaining. Improvement required is addressed at the weekly complaint meeting.
- Friends and Family test – Maternity is showing month on month incremental improvement in the percentage of positive feedback (now 91.34%), Gynaecology ED continue to perform below threshold with current performance of 73.12%. Themes of feedback for Gynae ED include time to be seen by a doctor and availability of Ultrasound scan on attendance. The division are taking several actions, with some expected to have an immediate benefit such as moving EPAU service out of Gynaecology ED. The GED improvement plan will draw together and monitor progress on actions required.

Workforce metrics

- Mandatory Training metrics are showing a static position (following statistically significant improvements over the last 12 months). In the development of the new Trust Integrated Performance Report there need to be consideration of the benchmark the Trust wishes to set in this regard.
- Sickness is in normal variation having been statistically reduced in the last 18 months. Consideration needs to be given to a benchmarked standard for this going forward

- In March 2023 PDR rates were at 69%. They reached a peak of 86% in September 23 and rates have remained stable since this point with February 24 data at 83.67%. The PDR rates reflect the greater emphasis on delivery of mandatory training in clinical areas and some challenges with scheduling. Staff survey results reflected that although most staff stated they have had a PDR, the majority were dissatisfied with the quality. In response, a review is currently underway to move to a model of group PDRS for many clinical staff groups, supplemented by optional career conversations.

RECOMMENDATION

The Board of Directors is asked to:

- note the content of the report including the Quality, Operational and Workforce Performance appendix.
- Approve the Terms of Reference for the Executive Risk and Assurance Group
- Approve the Terms of Reference for the Improvement Plan Portfolio Board

Appendices

Appendix A - Quality, Operational and Workforce Performance Report

Appendix B - Terms of Reference for the Executive Risk and Assurance Group

Appendix C - Terms of Reference for the Improvement Plan Portfolio Board

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report

April 2024

Integrated Performance Report

Contents

Section 1: Assurance Radar Charts by Trust Values

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

KPIs Passing Target for Six Months	9
KPIs Failing Target	13
KPIs Hit and Miss	4
KPIs No Target	1

KPIs Improving Variation	7
KPIs Concerning Variation	4
KPIs Common Cause Variation	16

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
Diagnostic Tests: 6 Week Wait	>=	>= 99%	94.06%	P	H
MAU - Face to face Maternity Triage within 30 Mins	>=	>= 95%	100.00 %	P	H
Proportion of patient activity with an ethnicity code	>=	>=96%	97.38%	P	H

Good - Celebrate & Understand

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 78 Weeks	<=	0	0	?	L
Complaints: Number Received	<=	<= 15	6	P	
Infection Control: Clostridium Difficile	<=	0	0	P	
Infection Control: MRSA	<=	0	0	P	
NHSE / NHSI Safety Alerts Outstanding	<=	0	0	P	
Total Number of Patient Safety Incident Investigations (Rolling)	<=	30	18	P	
Turnover Rate	<=	<= 13%	11.12%	P	
Venous Thromboembolism (VTE)	>=	>= 95%	94.73%	?	H

Average - Investigate & Understand

KPI	Target < or >	Target	P	A	V
Number of Open Patient Safety Incident Investigations	<=	8	18		
18 Week RTT: Incomplete Pathway > 65 Weeks	<=	0	140	?	
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	>=	>= 90%	90.47%	?	

Integrated Performance Metrics

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

Concerning - Investigate

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 52 Weeks	<=	0	1600		
Cancer: 62 Day referral to Treatment	>=	>=85%	30.95%		
Friends & Family Test: A&E % positive	>=	95%	73.12%		
Friends & Family Test: In-patient/Daycase % positive	>=	95%	85.88%		
Friends & Family Test: Maternity % positive	>=	95%	91.34%		
Mandatory Training	>=	>= 95%	92.97%		
Mandatory Training (Clinical)	>=	>= 95%	88.08%		
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	>=	>= 80%	40.88%		
Sickness Absence Rate	<=	<= 4.5%	5.93%		

Very Concerning - Investigate & Take Action

KPI	Target < or >	Target	P	A	V
Cancer: 28 Day Faster Diagnosis	>=	>= 75%	53.94%		
Cancer: 31 Day decision to treat to treatment	>=	>=96%	52.94%		
Never Events (Rolling 12 Months)	<=	0	2		
Overall size of active patient waiting list	<=	<= 16500	18887		

Investigate & Understand

KPI	Target < or >	Target	P	A	V

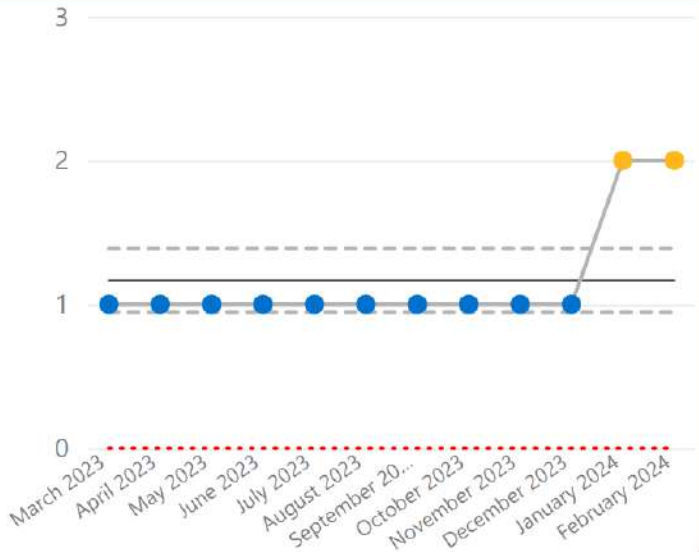
Section 3: To deliver **Safe** Services

KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Infection Control: Clostridium Difficile	Good	February 2024	0	<=	0			
Infection Control: MRSA	Good	February 2024	0	<=	0			
MAU - Face to face Maternity Triage within 30 Mins	Excellent	February 2024	>= 95%	>=	100.00%			
Never Events (Rolling 12 Months)	Very Concerning	February 2024	0	<=	2			
NHSE / NHSI Safety Alerts Outstanding	Good	February 2024	0	<=	0			
Number of Open Patient Safety Incident Investigations	Average	February 2024	8	<=	18			
Total Number of Patient Safety Incident Investigations (Rolling)	Good	February 2024	30	<=	18			
Venous Thromboembolism (VTE)	Good	March 2024	>= 95%	>=	94.73%			

To deliver **Safe** Services - Exceptions

Never Events (Rolling 12 Months) - Medical Director

Assurance Category	Very Concerning
Date	February 2024
Target	0
Target < or >	<=
Performance	2
Assurance	
Variation	



Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

To deliver Safe services - Safer Staffing

February 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	84.48%	77.01%	148.28%	98.28%	*/**February 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 38.87% in the inpatient area. The bed occupancy on HDU was recorded as 53.64% which provided the ability to flexibly rotate staff from the HDU which is based on the inpatient ward when there are no patients. The fill rate of 148.28% RN on nights remains above the 100% and is reflective of senior RN cover rotating between GED and inpatient area.
Induction & Delivery Suites	80.00%	82.76%	84.02%	96.55%	*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 our workforce developing and maintaining skills until review in Q3 24/25. Within this clinical area there has been a requirement to deploy Registered Midwives to non-clinical duties to support remaining in work and therefore vacant shifts are requested to be filled with bank up to planned staffing numbers.
Maternity & Jeffcoate	80.29%	106.03%	83.62%	96.55%	*/**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	80.17%	79.31%	81.90%	75.86%	*/**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)	90.93%	81.03%	88.20%	94.83%	*Fill rates reflect the neonatal unit occupancy in February. Total occupancy over the month was 79.5%, an increase in total occupancy from January of 11.5%. Occupancy in ITU areas was at the expected 80% with the number and acuity of the babies on the unit reflected in the RN and care staff fill rates throughout the month. Safe staffing was maintained and CHPPD (Care Hours Per Patient Day) was as expected.
Transitional Care	51.72%	131.03%	62.07%	117.24%	*/**Fill rates reflect the transitional care occupancy in February, with most of the care 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 51.3% 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) was as expected.

To deliver Safe services - Safer Staffing

Gynaecology: February Fill Rate

Fill rate – The underfilled staffing rate for February 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 for the rotation of staff from the HDU to support the inpatient area. The high fill rate of 148.28% RN on nights remains above the 100% and is reflective of senior RN cover rotating between GED and inpatient area to provide continuing senior clinical leadership support and maintain safety out of hours.

Attendance/ Absence – sickness and absence for the month of February was recorded as 9.10% a reduction from January which was recorded 10.04%. Long term sickness accounted for 59.42% which has decreased compared to the previous month recorded as 69.87%, conversely short-term sickness has increased to 40.58%. Maternity leave in February accounted for 1.61% WTE staff.

Red Flags – No red flags reported in February.

Bed Occupancy – In February bed occupancy for the Gynaecology inpatient unit is recorded as 38.87%, with the High Dependency Unit recorded as 53.64%.

CHPPD - February CHPPD overall was reported to be 7.8, a decrease on the previous month, which was 8.0. The split between registered and unregistered care staff was 4.6 for Registered Nurses and 3.1 for Health Care Assistants.

Neonates: February Fill Rate

Fill rate – Occupancy increased across the acute area of the neonatal unit in February with occupancy in all areas being at 79.5%. 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. There were 3 incidents reported of a delay in repatriation of a baby to their local neonatal unit, which was escalated appropriately to the Northwest Neonatal ODN, and one incident where there was a delay in transferring a baby requiring a time critical transfer for surgery, as transport team could not be contacted.

These incidents have been escalated to the ODN and reported appropriately.

Attendance/ Absence – Sickness was reported at 5.84% which is a reduction from the previous month, with the top reason for sickness in February reflecting anxiety, stress, and depression. Long term sickness has reduced from to 44.7 %. 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 reduced to 11.5% with no leavers in February. There were 6.45wte band 6 vacancies, and 22wte band 5 vacancies on the neonatal unit in January which were approved at vacancy panel for recruitment in February. Most of the vacancy was due to 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 4wte band 5 vacancies on Transitional care and 2.9wte band 2 support workers which were approved at vacancy panel in January with interviews taking place in early March 2024. There have been ongoing challenges recruiting to 7wte 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. 3 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. The are out for advert on Trac currently.

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

Bed Occupancy –The total unit occupancy was marginally below the expected 80% at 79.5% in February, however occupancy in the acute ITU and HDU areas were both over 80% at 80.7% and 94.8% respectively. Occupancy rates for February per area were; ITU 80.7%, HDU 94.8%, LDU 69.7% and TC 51.3%.

CHPPD – Within the critical care areas the care hours provided in February are as would be expected for babies being nursed in ITU with 12.3 Care hours per patient day (CHPPD) overall. The breakdown shows higher hours of registered nurse care and lower non- registered care. This split of 11.2 hrs of registered nurses and 1.3 healthcare support workers, is 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 February shows higher hours of care provided by non-registered carers than registered nurses with total care hours per patient day of 10.1 hours, the split is 7.0 care hours provided by the care staff and 3.1 hours provided by registered nurses which is reflective of the care model in transitional care.

To deliver Safe services - Safer Staffing

Maternity: February 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. This has been strengthened with the initiation of the Maternity Bleepholder maintaining supernumerary status 24/7 to support clinical leadership. Additional care staff were requested to mitigate unfilled shifts and contribute to postnatal care.

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 7.09%, from 7.91 in January. 44% 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 56% which represents 20 cases, of which 5 have resolutions scheduled for March. 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 are in the 0–3-month timescale. Maternity leave equates to 16.92wte (20 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 who commenced on 26th February to a period of induction and orientation, and the final arrival of Internationally Educated Midwife recruitment programme. A proactive approach to recruitment continues with an Open Day planned for March to showcase services and employment opportunities at LWH for NQM and Experienced Midwives in Maternity and Neonatal services. 120 bookings have been registered.

Red Flags – During 55 Midwifery Red Flags was a significant increase from previous months. 1:1 Care in Labour was maintained at 100%. Reported red flags include 45 delays of >12hrs for ongoing IOL (regional red flag), which affected patient experience, and 9 delays of >2hrs between admission and commencement of IOL. A service improvement project led by IOL coordinator which also includes estate works expected to complete in April will increase capacity for IOLs. 1 delay of >1hr to commence suturing due to midwife requiring support to undertake this. MAU did not report any delays in triage of >30mins and achieved performance of 97.87% of women triaged within 15mins of attendance, of which the average time was 7mins.

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 3.5 for February which is consistent with the previous months. The BirthRate Plus Ward Based Acuity Tool was launched on 29 January which provides real time evidence-based data to support staffing deployment decisions on Maternity Ward. Analysis from the initial data on the data reliability and completion rates on Maternity Base highlight that there is confidence in the assurance of the BirthRate Plus Ward Based Acuity 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
18 Week RTT: Incomplete Pathway > 52 Weeks	Concerning	March 2024	0	<=	1600			
18 Week RTT: Incomplete Pathway > 65 Weeks	Average	March 2024	0	<=	140			
18 Week RTT: Incomplete Pathway > 78 Weeks	Good	March 2024	0	<=	0			
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Average	March 2024	>= 90%	>=	90.47%			
Cancer: 28 Day Faster Diagnosis	Very Concerning	February 2024	>= 75%	>=	53.94%			
Cancer: 31 Day decision to treat to treatment	Very Concerning	February 2024	>=96%	>=	52.94%			
Cancer: 62 Day referral to Treatment	Concerning	February 2024	>=85%	>=	30.95%			
Diagnostic Tests: 6 Week Wait	Excellent	February 2024	>= 99%	>=	94.06%			
Overall size of active patient waiting list	Very Concerning	March 2024	<= 16500	<=	18887			
Proportion of patient activity with an ethnicity code	Excellent	February 2024	>=96%	>=	97.38%			

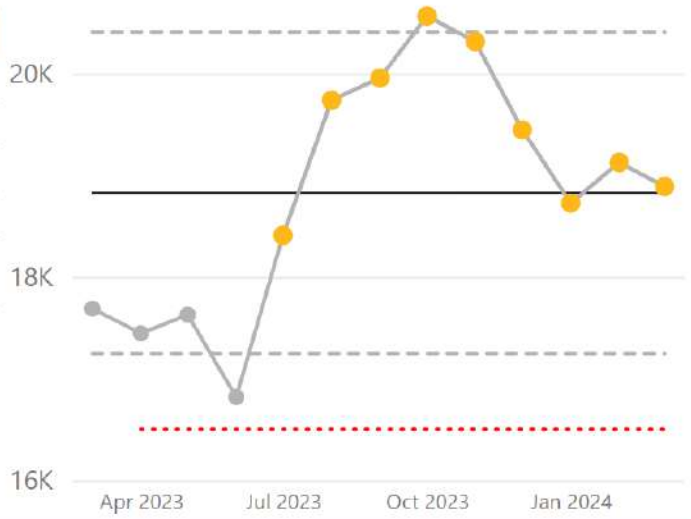
*Following KPI's have nationally set targets as part of Operational Planning Guidance for 23/24:

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	March 2024
Target	<= 16500
Target < or >	<=
Performance	18887
Assurance	
Variation	

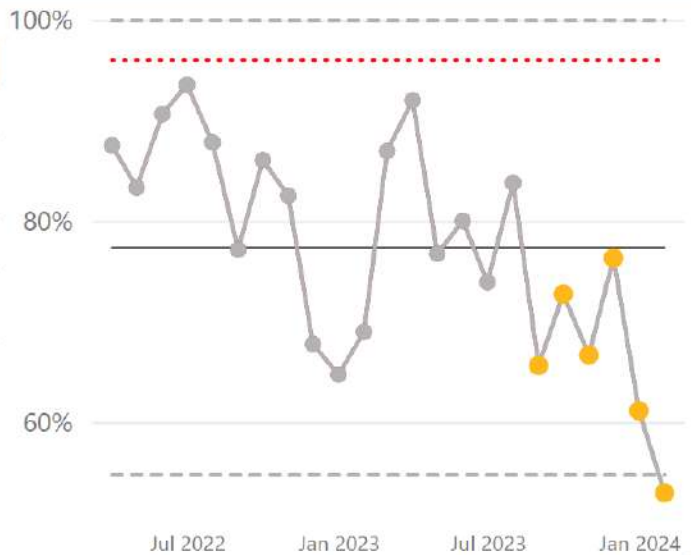


Cancer: 62 Day referral to Treatment - Chief Operating Officer

Assurance Category	Concerning
Date	February 2024
Target	>=85%
Target < or >	>=
Performance	30.95%
Assurance	
Variation	

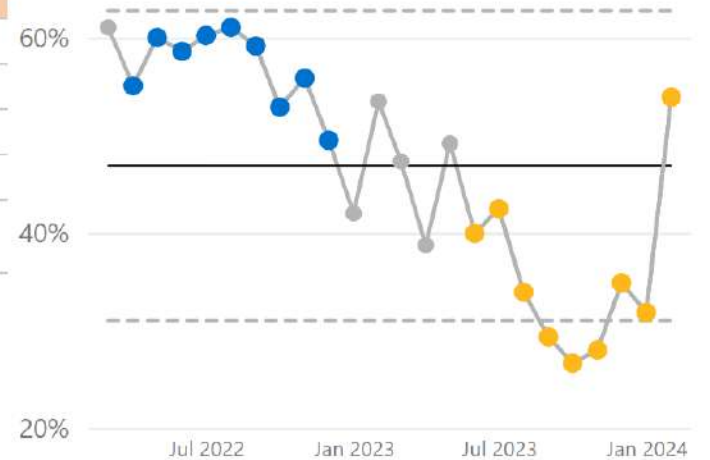
Cancer: 31 Day decision to treat to treatment - Chief Operating Officer

Assurance Category	Very Concerning
Date	February 2024
Target	>=96%
Target < or >	>=
Performance	52.94%
Assurance	
Variation	



Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

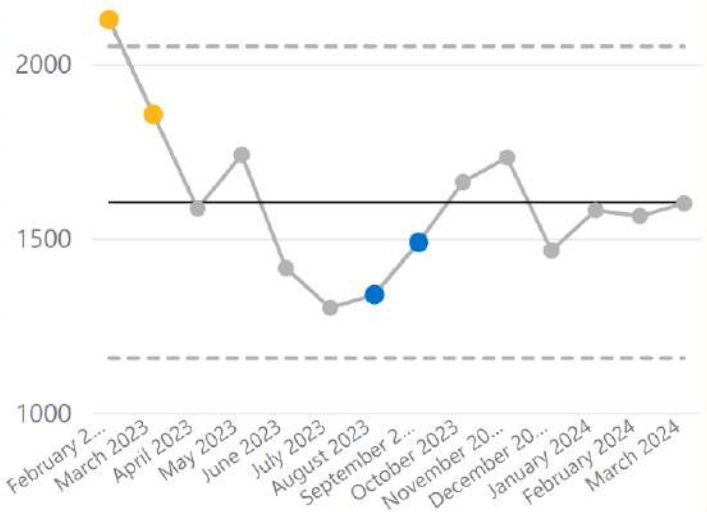
Assurance Category	Very Concerning
Date	February 2024
Target	>= 75%
Target < or >	>=
Performance	53.94%
Assurance	
Variation	



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

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

Assurance Category	Concerning
Date	March 2024
Target	0
Target < or >	<=
Performance	1600
Assurance	
Variation	



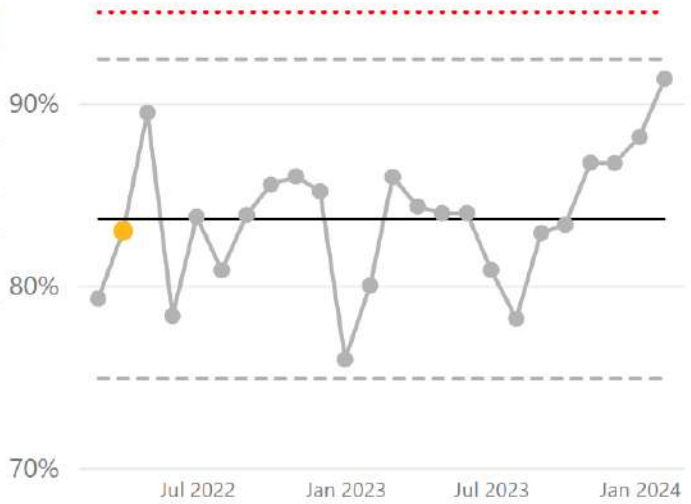
Section 5: To deliver the best possible **Experience** for patients and staff

KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Complaints: Number Received	Good	February 2024	<= 15	<=	6	P		
Friends & Family Test: A&E % positive	Concerning	February 2024	95%	>=	73.12%	F		
Friends & Family Test: In-patient/Daycase % positive	Concerning	February 2024	95%	>=	85.88%	F		
Friends & Family Test: Maternity % positive	Concerning	February 2024	95%	>=	91.34%	F		

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

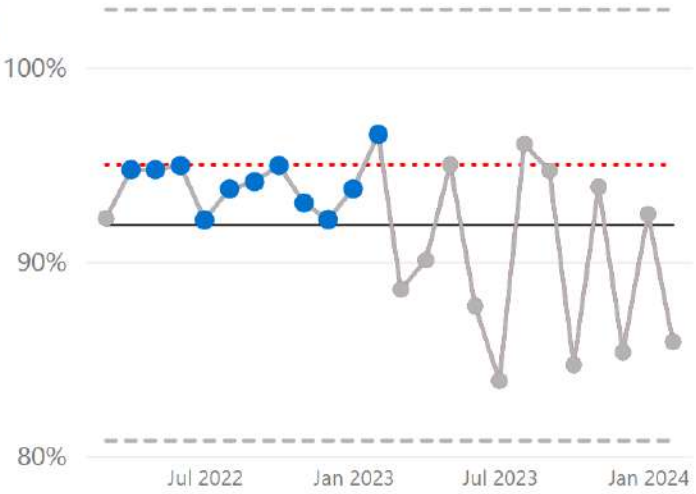
Friends & Family Test: Maternity % positive - Chief Nurse

Assurance Category	Concerning
Date	February 2024
Target	95%
Target < or >	>=
Performance	91.34%
Assurance	
Variation	



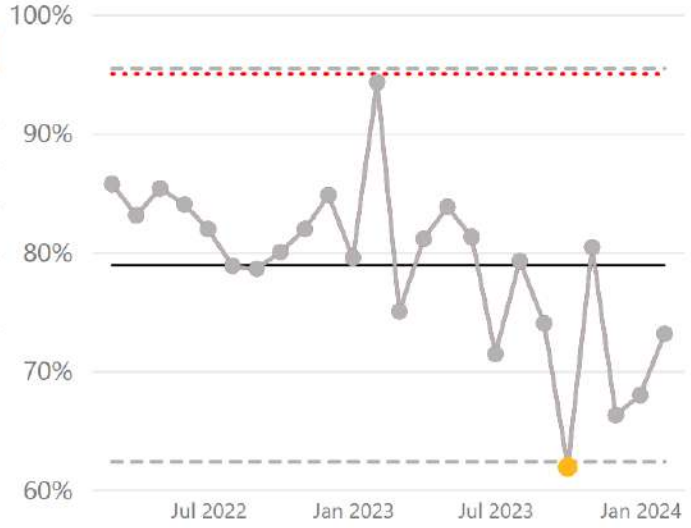
Friends & Family Test: In-patient/Daycase % positive - Chief Nurse

Assurance Category	Concerning
Date	February 2024
Target	95%
Target < or >	>=
Performance	85.88%
Assurance	
Variation	



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

Assurance Category	Concerning
Date	February 2024
Target	95%
Target < or >	>=
Performance	73.12%
Assurance	
Variation	



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

KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Mandatory Training	Concerning	February 2024	>= 95%	>=	92.97%	F	H	
Mandatory Training (Clinical)	Concerning	February 2024	>= 95%	>=	88.08%	F	H	
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Concerning	February 2024	>= 80%	>=	40.88%	F		
Sickness Absence Rate	Concerning	February 2024	<= 4.5%	<=	5.93%	F		
Turnover Rate	Good	February 2024	<= 13%	<=	11.12%	P		

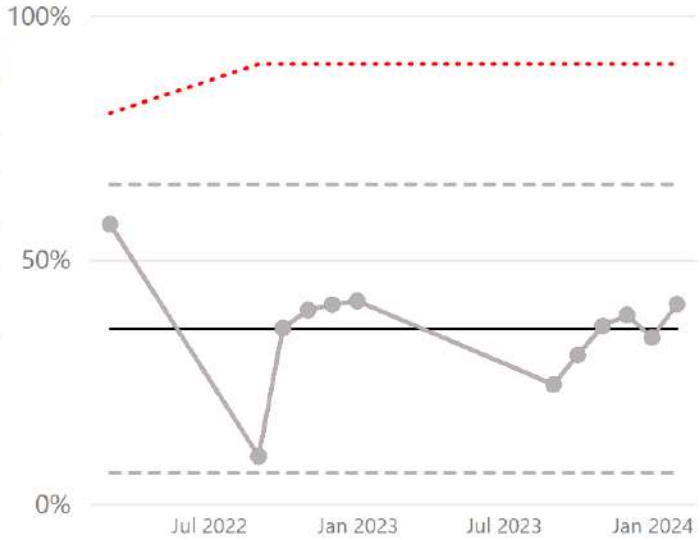
To develop a well led, capable, motivated and entrepreneurial **Workforce** - Exceptions

Sickness - Chief People Officer

Assurance Category	Concerning
Date	February 2024
Target	<= 4.5%
Target < or >	<=
Performance	5.93%
Assurance	
Variation	

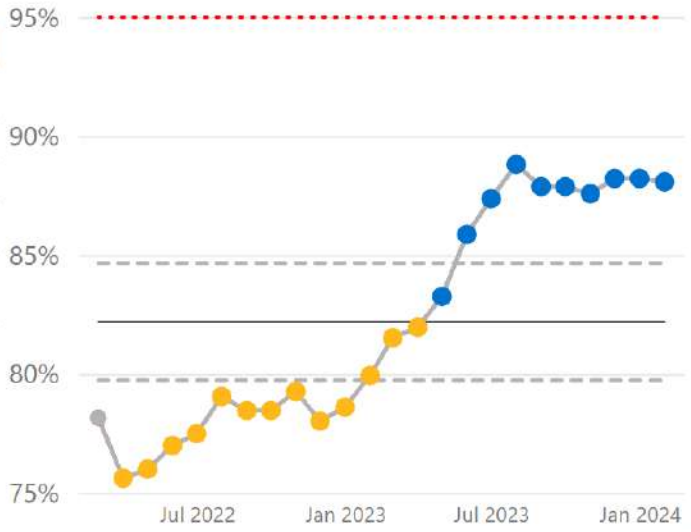
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff - Chief People Officer

Assurance Category	Concerning
Date	February 2024
Target	>= 80%
Target < or >	>=
Performance	40.88%
Assurance	
Variation	



Mandatory Training (Clinical) - Chief People Officer

Assurance Category	Concerning
Date	February 2024
Target	>= 95%
Target < or >	>=
Performance	88.08%
Assurance	
Variation	



Mandatory Training - Chief People Officer

Assurance Category	Concerning
Date	February 2024
Target	>= 95%
Target < or >	>=
Performance	92.97%
Assurance	
Variation	

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: (none)
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

Liverpool Women's
NHS Foundation Trust

EXECUTIVE RISK & ASSURANCE GROUP
TERMS OF REFERENCE

Authority

1. The Executive Risk & Assurance Group (ERAG) is authorised by the Board of Directors, to act within its terms of reference as the senior operational group of Liverpool Women's NHS FT.

2. The ERAG has no executive powers other than those specifically delegated in these Terms of Reference.

3. The ERAG has the authority to oversee and take decisions relating to the day-to-day management across the whole organisation's activities (both clinical and non-clinical), which also supports the achievement of the organisation's objectives. It also has the authority to make recommendations to the Audit Committee about changes to the Trust's Risk Management Framework.

4. It is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

5. The ERAG is authorised to create operational management, advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The ERAG may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the ERAG who will oversee their work.

Purpose

6. The ERAG provides 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.

7. The ERAG will also provide a corporate view on Trust-wide issues of current concern ensuring co-ordination between Divisions.

8. The ERAG provides the formal mechanism to support the Chief Executive in effectively discharging his responsibilities as Accountable Officer.

Duties

9. In order to fulfil its role effectively, the ERAG will:

- monitor the delivery of the Trust's strategic objectives and oversee the management of risks to that delivery, focusing on the Trust's strategic risks set out in the BAF via:
    - monitoring timely completion of actions relating to control and assurance gaps
    - sense-check the rationale for changes in risk scores
    - consideration of the strategic risks with reference to the key operational risks
- support delivery of the Risk Management Strategic Plan by using information, predominantly drawn from the Trust's risk registers and the Board Assurance Framework (BAF), to check the appropriateness and effectiveness of risk treatment plans and key controls, ensuring that good risk management principles are applied consistently across the Trust
- use operational performance data to monitor key areas of risk for the Trust and, where necessary, put in place and monitor corrective measures
- lead the Trust to make appropriate operational management decisions to deliver high quality integrated services for patients ensuring all groups deliver the strategic and in-year performance requirements
- shape the Trust's future plans and oversee the development and publication of the Trust's Annual Plan, ensuring it is robust in relation to its objectives, performance measures, investment priorities and affordability, and the resultant dialogue with its key stakeholders
- ensure that governance and assurance systems operate effectively and thereby underpin clinical care
- provide a forum for constructive challenge for the Trust and its Executive
- receive feedback from Executive Groups effectiveness review
- approve Executive Groups Terms of Reference (TOR)

10. The Executive Risk & Assurance Group is committed to protecting and respecting data privacy. The Group will have regard to UK General Data Protection (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 2018 (DPA).

Membership

11. The ERAG shall be comprised of the following members:

- Chief Executive (Chair)
- Executive Directors
- Divisional Senior Leadership Teams i.e., Divisional Managers, Clinical Directors and Head of Nursing/Midwifery from clinical divisions
- Deputy Chief Operating Officer
- Deputy Director of Nursing
- Deputy Medical Director
- Deputy Chief Finance Officer
- Deputy Director of Workforce
- Head of Communications
- Trust Secretary
- Associate Director of Quality & Governance

12. The ERAG will be deemed quorate when the Chief Executive or Chief Finance Officer / Deputy Chief Executive, plus three other Executive Directors and one senior representative from each Divisional SLT are present. Deputies must attend in the absence of any Executive Director; however, this should only be in exceptional circumstances.

13. The members in Paragraph 11 above may nominate a deputy to attend on their behalf if they are unable to attend in person. However, this should only be in exceptional circumstances. Deputies will count towards the quorum.

14. Other management or clinical staff may be co-opted or requested to attend for specific agenda items as necessary.

Requirements of Membership

15. Members of the ERAG must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings.

16. Attendance at the ERAG will be recorded and monitored.

Equality, Diversity & Inclusion

17. In conducting its business, the Group will at all times seek to promote its commitment to equality, diversity and inclusion by the creation of an environment that is inclusive for both our workforce, patients and service users including those who have protected characteristics and vulnerable members of our community.

Conflicts of Interest

18. 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

19.. The ERAG will be accountable to the Chief Executive and the Executive Team. The Board of Directors will be advised of the ERAG's work through meeting via an assurance report which will provide key assurances and any identified exceptions/risks in relation to the delivery of the priorities set out in the Trust's Strategy and annual business planning objectives. In reporting to the Board of Directors, details should include any associated action plans to mitigate the level of risk to the Trust.

20. The ERAG will receive assurance reports from the Groups falling under the remit of its responsibilities which set out all new or escalated risks (residual risk ≥12 or warrant inclusion due to impact) together with assurance on the effectiveness of risk management arrangements. The Groups include:

- Quality, Safety & Risk Executive Group
- Research Executive Group
- Finance and Operational Performance Executive Group
- People and Organisational Development Executive Group
- Divisional Boards

Administration of Meetings

21. Meetings shall be held monthly with additional meetings held on an exception basis at the request of the Chair or any three members of the ERAG.

22. The Trust Secretary will make arrangements to ensure that the ERAG is supported administratively by a Committee Secretary. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chair and Group members.

23. Agendas and papers will be circulated at least 4 days in advance of the meeting.

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

Review

25. The Terms of Reference shall be reviewed annually.

26. The ERAG will undertake an annual review of its performance against its terms of reference and work plan in order to evaluate the achievement of its duties. This review will be considered by the Executive Team.

Version Control Schedule

Date	Version no	Main changes proposed	Date approved by ERAG	Date ratified by Executive Team (thereby come into force)
March 2024	1	New Terms of Reference		N/A

Liverpool Women's
NHS Foundation Trust

IMPROVEMENT PLAN PORTFOLIO BOARD

TERMS OF REFERENCE

Authority/Constitution

1. The Improvement Plan Portfolio Board (the Board) is authorised by the Trust Board of Directors and shall report to the Trust Board of Directors to undertake any activity within these Terms of Reference.

Purpose

2. The Board will ensure delivery of the outputs and benefits of the Improvement Plan in line with meeting National Oversight Framework (NOF) 3 exit criteria.

3. The Board is accountable for the effective delivery of the Liverpool Women's NHS Foundation Trust (LWH) Improvement Plan and for managing risks and issues that are impacting programme delivery.

4. The Board reports to the Trust Board of Directors and informs key decisions, risks and mitigations associated with the delivery and outputs of the LWH Improvement Plan.

Duties

Approval of Portfolio Scope and Assurance of Robust Governance

5. To ensure that the content of the Portfolio is aligned to the Strategic objectives of the Trust and Improvement Plan.

6. To seek assurance that the scope of the projects and programmes will deliver the Strategic objectives of the Trust and Improvement Plan.

7. To seek assurance that projects and programmes have the appropriate governance to ensure decision making is clear and within the appropriate and correct delegated responsibility of the Chair.

8. To seek assurance that projects and programmes have undertaken detailed stakeholder analysis and have developed a robust communications plan.

9. To seek assurance that projects and programmes have been fully scoped and that stakeholders have been consulted with.

Controlling and Managing Projects

10. To seek assurance regarding the delivery of the plans described in the Improvement Plan project initiation documents/Project Charters.

11. To seek assurance regarding the translation of plan delivery into measurable benefits or desired outputs.

12. To seek assurance that the Improvement Plan is appropriately resourced and documented through an integrated Resource Plan and that Resource Plan is periodically reviewed and re-prioritised as required.

13. To seek assurance on the realisation of project and programme benefits through periodic review of the Improvement Plan Performance Dashboard and/or other benefits/KPIs as required.

14. To be aware of serious and significant risks and issues and seek assurance regarding adequate control and proactive management.

15. Where there is not adequate control, Portfolio Board is responsible for undertaking, or directing, activity to support and strengthen controls.

16. To check and challenge key outputs of projects and programmes against pre-agreed quality criteria.

17. To function as a gateway at go/no-go points within a project and provide approval for a project to progress.

Providing Assurance

18. To inform Trust Board of Directors of the Improvement Plan objectives, scope, deliverables, and targeted benefits.

19. To inform Trust Board of Directors of and external parties of progress made against planned delivery timescales.

20. To assure Trust Board of Directors that risks and issues are adequately controlled.

21. To assure Trust Board of Directors of delivery against benefit realisation plans and/or planned outputs.

22. To review and seek assurance for any deliverables/papers going to the System Oversight Group (SOG) prior to submission.

Membership

23. The Improvement Plan Portfolio Board shall include the following members:

- Chief Executive (Chair)
- Senior Responsible Owners from Improvement Plan Programmes
- LWH Executives
- Head of Improvement Plan Delivery Unit
- Nominated Deputies for Members

24. A quorum shall be of:

- Chief Executive Officer or nominated deputy.
- Three or more SROs or nominated deputies.
- Chief Transformation Officer or nominated deputy.

Requirements of Membership

25. Cascade of key messages to Programme/Projects

26. Supporting and Performance Managing Projects Leads as required

27. Prioritise time to attend and prepare for the Board and Chair Programme Huddles and Programme Boards on behalf of the Board.

28. Resolving risks and issues relevant to areas.

29. Attendance will be recorded at each meeting.

30. The members of the Board must nominate a deputy to attend on their behalf if they are unable to attend in person.

31. All members will undertake work requested by the Board within the identified timescales.

32. All members must feedback on issues raised within the meeting to their areas of responsibility, as appropriate.

33. Members of the Board must attend at least 75% of all meetings but should aim to attend all scheduled meetings.

Equality Diversity & Inclusion

34. The Improvement Plan is a critical vehicle for LWH to improve existing services and performance and in some cases design new services and ways of working. As a Board, we will ensure that in Improvement Plan delivery, quality improvement work and in service redesign we are demonstrating that we are working to advance EDI and for it to become second nature to everyone working in the Trust, underpinning everything that we do.

35. We will use our Project Initiation and Project Closedown processes to seek assurance on whether EDI has been appropriately considered throughout the project lifecycle.

Conflicts of Interest

36. 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

37. The Board will formally report to the Trust Board of Directors and also provide regular delivery updates to System Oversight Group.

Administration of Meetings

38. Meetings shall be held fortnightly. The duration of each meeting shall be approximately 1.5 hours.

39. Agendas and papers shall be circulated 2 working days prior to the meeting.

Review

40. The Terms of Reference of the Board 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)
April 2024	1	Development of the Terms of Reference – alignment with updated template		

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**24/25/006**		**Date: 11/04/2024**	
Report Title	**Finance Report & Financial Planning**			
Prepared by	***Jen Huyton, Deputy Chief Finance Officer / Deputy Director of Strategy***			
Presented by	***Jenny Hannon, Chief Finance Officer / Executive Director of Strategy and Partnerships***			
Key Issues / Messages	***To note the Month 11 financial position.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☒**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – If no – please outline the reasons for deviation.			
	The Board is asked to note the Month 11 Financial Position.			
Supporting Executive:	***Jenny Hannon, Chief Finance Officer / Executive Director of Strategy and Partnerships***			

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Finance, Performance, and Business Development Committee	27/03/24	Chief Finance Officer	Report noted.

EXECUTIVE SUMMARY

The Trust has a challenging financial plan for 2023/24 of £15.5m deficit. Following review of the position at Month 8, as part of the national re-forecasting exercise, the Trust revised its forecast deficit to £22.6m.

At Month 11 the Trust reported a £19.3m deficit which represents a £4.9m adverse variance to plan year to date (YTD). This position is supported by £3.0m of non-recurrent items. The forecast outturn reported at Month 11 was a £22.6m deficit, which represents a £7.2m adverse variance to plan.

Cost Improvement Programme (CIP) delivery is behind the YTD target of £6.2m by £1.2m and is forecast to be £1.0m behind the full year target by Month 12.

The cash balance (£4.5m at the end of Month 11) was below the minimum level set out in the Treasury Management policy (current policy states 15 days expenditure or c£6m minimum cash level). This includes £12.0m of national cash support received with a further £8.1m received in March.

MAIN REPORT

1. Summary Financial Position

	Plan	Actual	Variance	RAG	*R*	*A*	*G*
Surplus/(Deficit) YTD	-£14.4m	-£19.3m	-£4.9m	6	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast M11	-£15.5m	-£22.6m	-£7.2m	5	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	1	*4*	*3*	*2+*
Cash	£4.1m	£4.5m	£0.4m	6	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£7.3m	£6.2m	-£1.2m	5	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£7.3m	£3.1m	-£4.2m	1	*>10% off plan*	*Plan*	*Plan or better*
Aligned Payment Incentive (ICB)	102%	101%	-1%	6	*>10% off plan*	*<10% off plan - plan*	*Plan or better*
Non-Recurrent Items YTD	£1.0m	£3.0m	£2.0m	5	*>£0*		*<£0*
Capital Spend YTD	£5.1m	£3.7m	-£1.4m	5	*>10% off plan*	*Plan*	*Plan or better*

At Month 11 the Trust is reporting a £19.3m deficit, which represents a £4.9m adverse variance to plan year to date (YTD). This is supported by £3.0m of non-recurrent items (net position), of which £2.0m is unplanned. The reported forecast outturn at Month 11 was £22.6m deficit, which represents a £7.2m adverse variance to the full year submitted plan. This is an improvement of £0.8m from the forecast reported at Month 10 (see below) and is in line with the Trust's revised 'H2' forecast outturn submitted in November. This position 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. Forecast Outturn and Industrial Action

During the autumn re-forecasting exercise, the Trust's revised forecast was a deficit of £22.6m, or £7.2m adverse variance to plan. This *excluded* the impact of any further industrial action taking place after Month 8, in line with national instruction. At Month 9, providers were asked by NHS England (NHSE) to estimate costs of industrial action in Months 9 and 10 and include in forecasts. This was estimated to be £0.8m for Liverpool Women's Hospital, and therefore the revised forecast position for the Trust, formally approved by the Trust Board on 11 January and reported at Month 9, was a deficit of £23.4m, equating to an £8.0m adverse variance to plan.

In early February further industrial action (to take place in Month 11) was announced, however providers and systems were instructed to exclude this impact from Month 10 forecasts, as this was announced after initial Month 10 reporting was complete.

On 5 March the Trust was notified that it would receive £0.5m in additional income to mitigate the costs of industrial action in Months 9, 10, and 11, and that there was an expectation that Trusts would manage any remaining impact. The Trust has been able to successfully manage the impact and has therefore reported a forecast deficit position of £22.6m, which is in line with the original, Board approved re-forecast submitted in November 2023. This is primarily due to:

- Actual impact of industrial action in Month 9 and 10 was lower than projected impact (£0.6m vs £0.8m)
- Impact in Month 11 was lower than in Month 9 and 10 (fewer doctors participating in industrial action)
- Additional out of area income (above forecast) received in Month 11.

During March, £0.3m of additional income was received in respect of the CNST Maternity Incentive Scheme (additional non-recurrent share of premium from non-delivering Trusts). Due to timing of the receipt, this value was not included in the forecast position at Month 11, however should it have been included, the forecast deficit would have been reduced by a further £0.3m. This will be included in reporting at Month 12.

3. Financial Position

Underlying Position
As noted above, the YTD position is supported by £3.0m of non-recurrent items, of which £2.0m was unplanned. The adjusted position in Month 11 (following removal of key non-recurrent items) is a deficit of £22.3m.

The key drivers of the underlying year to date position remain consistent with prior months:

- Undelivered CIP.
- Inability to unwind prior year pay investment.
- Investment in maternity post CQC inspection.
- Operational pressures; including medical staffing, unfunded cost pressures in corporate areas and estates non-pay related pressures, off-set by anaesthetic consultant vacancies and interest receivable above plan.
- API underperformance excluding industrial action impact, offset by impact of reduction in activity targets by 4%.
- Impact of pay award.

Workforce

Whole Time Equivalents (WTEs) are shown in Appendix 1. At Month 11 WTEs total 1,674, compared to 1,688 at M12 2022/23, with an overall shift away from temporary (bank and agency) towards substantive staff. Between Month 10 and Month 11, WTEs have decreased by 30. This is driven by a reduction in nursing and healthcare assistant bank spend.

Enhanced controls have been implemented regarding agency spend including Divisional oversight and enhanced senior approvals required, resulting in an agency spend of 0.7% 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 11, the Trust has a favourable variance of £1.5m 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 11, 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 high-risk income scheme of £1.0m (relating to out of area low volume activity). At Month 11, there is an adverse variance of £1.2m against the £7.3m target.

4. 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 Payment by Results regime), is provided to Divisions to indicate financial performance linked to activity. Key highlights by Division are as follows:

- Gynaecology - activity is £0.2m behind plan YTD. This is an improvement on the previous month due 'catch up' in clinical coding enabling more timely reporting, and lesser impact of industrial action than previously anticipated. 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 £0.2m ahead plan YTD, driven by transfer of activity from Cheshire West.
- Maternity – activity is £0.7m behind plan YTD. The highest impact continues to be within deliveries, which fall under fixed payment, therefore there is no adverse financial impact to the Trust in-year.
- Neonates – activity remains £0.5m ahead of plan YTD, consistent with previous months. 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 11, the Trust has delivered 96% (in terms of £s) and 95% (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 £0.7m at Month 11. 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.

5. Cash and Borrowings

The Trust's cash and bank balance at the end of Month 11 was £4.5m. The Trust forecasts cashflow on a rolling 13-week basis and cash levels are monitored daily. The average cash balance in Month 11 was £9.2m (£11.9m YTD).

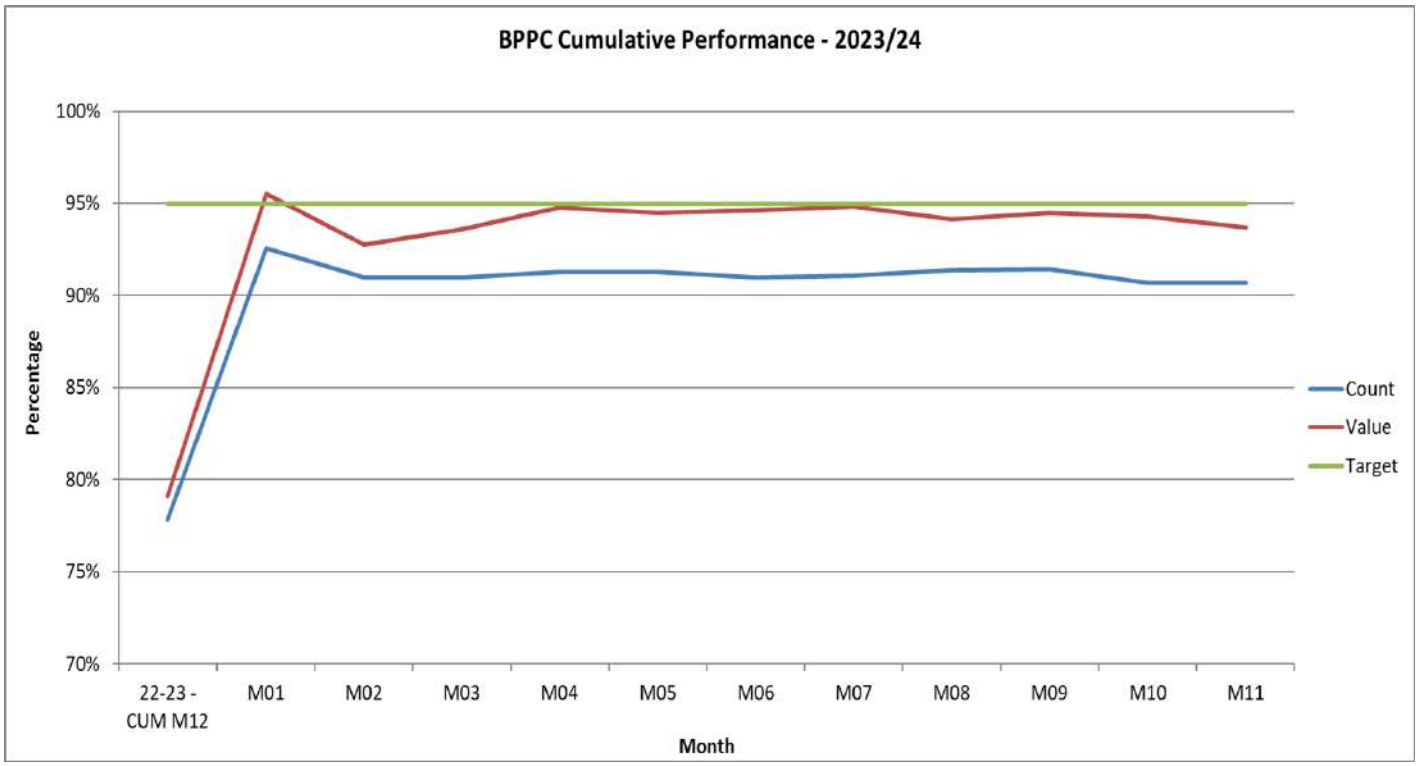
The Trust has now repaid all cash advances to the C&M ICB, with the final £7.8m paid on 1 March. The Trust has received £20.1m of national revenue support payments in total (£12.0m received in each of January and February, and £8.1m received in March).

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.

6. 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.



7. Balance Sheet

In Month 11 debtors reduced by £0.8m as many NHS debtors invoiced for quarter 3 have now been paid. Payables reduced by £0.9m and should reduce further by year end. Other areas of the balance sheet are consistent with the previous month.

8. 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 netted off 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. At Month 11, the programme was £1.4m behind plan.

9. Board Assurance Framework (BAF) Risk

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

10. Conclusion & Recommendation

The Board is asked to note the Month 11 position.

Appendices

Appendix 1 – Board Finance Pack, Month 11

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M11

YEAR ENDING 31 MARCH 2024

Liverpool Women's
NHS Foundation Trust

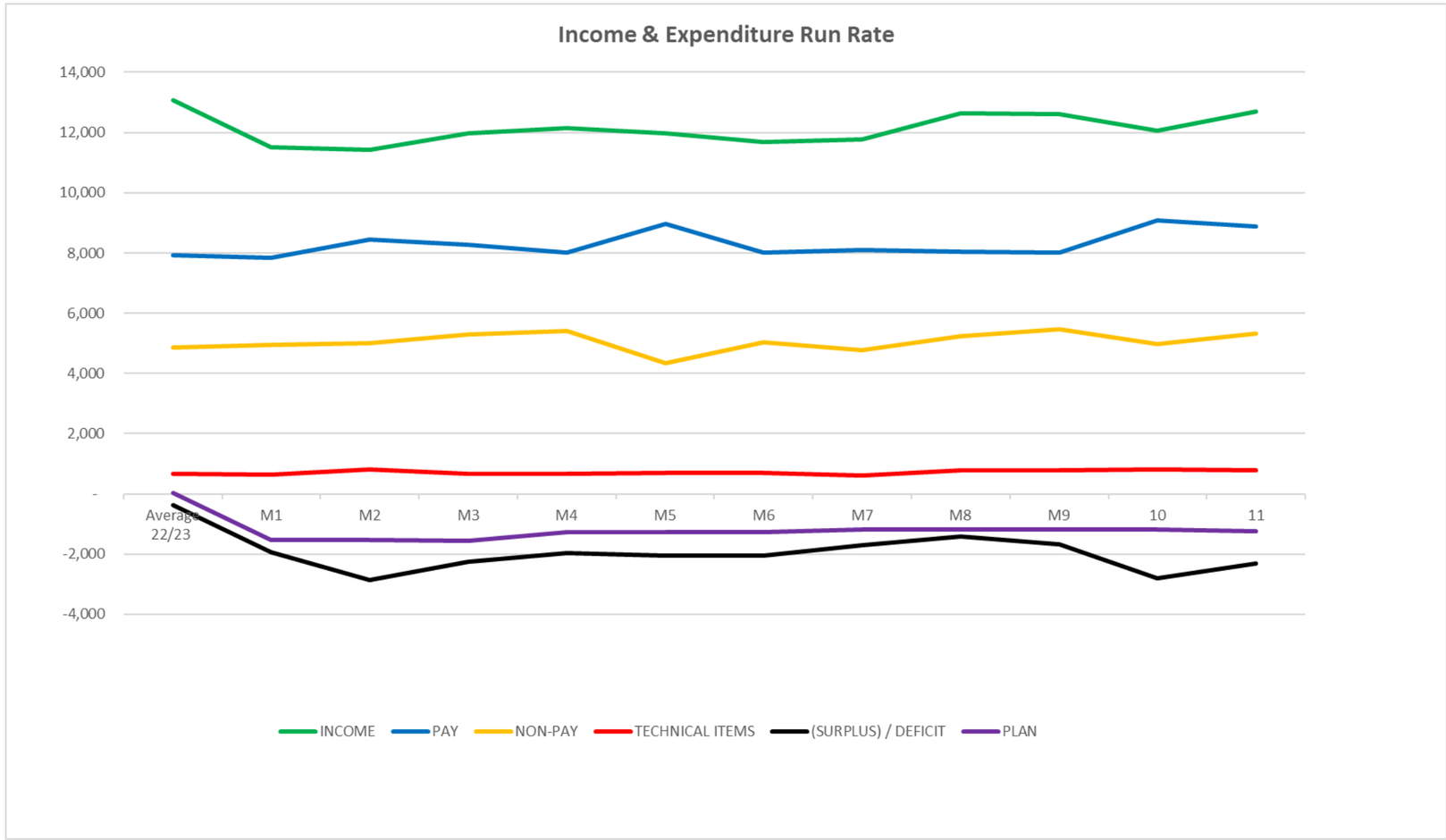
Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M11
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	Month 11 Budget	 Actual	 Variance	YTD Budget	 Actual	 Variance	YEAR Budget	 Forecast	 Variance
Income									
Clinical Income	(11,502)	(12,203)	701	(126,022)	(126,142)	121	(137,517)	(137,327)	(190)
Non-Clinical Income	(636)	(502)	(135)	(6,779)	(6,811)	31	(7,416)	(7,344)	(71)
Total Income	**(12,139)**	**(12,705)**	**566**	**(132,801)**	**(132,953)**	**152**	**(144,933)**	**(144,672)**	**(261)**
Expenditure									
Pay Costs	7,607	8,787	(1,180)	83,689	91,099	(7,410)	91,102	99,643	(8,541)
Non-Pay Costs	3,217	3,436	(219)	35,411	34,320	1,091	38,631	38,253	378
CNST	1,800	1,800	0	19,803	18,949	854	21,603	20,749	854
Total Expenditure	**12,625**	**14,023**	**(1,399)**	**138,903**	**144,367**	**(5,465)**	**151,337**	**158,645**	**(7,308)**
EBITDA	**486**	**1,319**	**(833)**	**6,102**	**11,414**	**(5,313)**	**6,404**	**13,973**	**(7,569)**
Technical Items									
Depreciation	548	579	(31)	6,031	5,886	145	6,579	6,466	113
Interest Payable	2	1	1	20	14	6	21	16	5
Interest Receivable	(17)	(38)	21	(184)	(530)	346	(200)	(560)	360
PDC Dividend	220	246	(26)	2,425	2,555	(130)	2,645	2,801	(156)
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	(69)	69	0	(69)	69
Total Technical Items	**753**	**788**	**(35)**	**8,292**	**7,856**	**436**	**9,045**	**8,654**	**391**
(Surplus) / Deficit	**1,239**	**2,107**	**(867)**	**14,394**	**19,270**	**(4,876)**	**15,450**	**22,627**	**(7,178)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
WTE: M11
YEAR ENDING 31 MARCH 2024

TYPE	DESCRIPTION	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	Movement M10 - M11	Movement M12 - M11
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	648.06	(6.78)	16.12
	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	82.91	(1.77)	0.87
	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	12.81	(0.50)	1.03
	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	63.87	(1.56)	14.65
	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	230.10	(3.43)	(4.41)
	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	65.09	2.50	5.17
	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	14.00	(1.00)	1.00
	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	280.35	4.98	(7.77)
	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	194.47	0.50	9.38
	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	14.50	1.50	0.50
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	1,606.16	(5.56)	36.54
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	26.92	(16.27)	(20.41)
	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	9.93	(6.91)	(7.49)
	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	0.39	0.17	0.11
	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	13.40	(11.68)	(17.82)
	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	0.07	0.07
	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	11.35	7.56	5.10
	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	1.44	(0.71)	(0.56)
	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	63.50	(27.77)	(41.00)
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	3.10	2.05	(0.94)
	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	-	-	0.89	0.89	0.79
	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	3.99	2.94	(9.38)
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	1,673.65	(30.39)	(13.84)



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

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
CIP: M11
YEAR ENDING 31 MARCH 2024

	MONTH 11			YTD			FULL YEAR		
	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Income	250	78	(173)	2,462	994	(1,468)	2,965	1,160	(1,805)
Pay	301	0	(301)	2,815	89	(2,726)	3,082	258	(2,824)
Non-Pay	267	208	(59)	2,036	2,045	9	2,289	2,882	593
Total Recurrent	**818**	**286**	**(532)**	**7,313**	**3,128**	**(4,185)**	**8,336**	**4,300**	**(4,036)**
Income	0	2	2	0	322	322	0	325	325
Pay	0	128	128	0	1,206	1,206	0	1,212	1,212
Non-Pay	0	3	3	0	1,496	1,496	0	1,499	1,499
Total Non-Recurrent	**0**	**133**	**133**	**0**	**3,024**	**3,024**	**0**	**3,036**	**3,036**
TOTAL CIP DELIVERY	**818**	**418**	**(400)**	**7,313**	**6,152**	**(1,161)**	**8,336**	**7,336**	**(1,000)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M11
YEAR ENDING 31 MARCH 2024

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	(17,295)
Depreciation and amortisation	5,886
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	258
Net cash generated from / (used in) operations	**(11,151)**
Interest received	547
Purchase of property, plant and equipment, ROU and intangible assets	(5,124)
Proceeds from sales of property, plant and equipment and intangible assets	245
Net cash generated from/(used in) investing activities	**(4,332)**
PDC distressed funding received	12,000
PDC Capital Programme Funding - received	0
Loans from Department of Health - repaid	(306)
Capital element of lease liability repayments	(116)
Interest paid	(10)
PDC dividend (paid)/refunded	(1,373)
Net cash generated from/(used in) financing activities	**10,195**
Increase/(decrease) in cash and cash equivalents	**(5,288)**
Cash and cash equivalents at start of period	9,790
Cash and cash equivalents at end of period	**4,502**

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 ACTUAL £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
CASHFLOW ROLLING FORECAST: M11
YEAR ENDING 31 MARCH 2024

5b

	Actual Feb-24 £000	Forecast Mar-24 £000	Plan Apr-24 £000	Plan May-24 £000	Plan Jun-24 £000	Plan Jul-24 £000	Plan Aug-24 £000	Plan Sep-24 £000	Plan Oct-24 £000	Plan Nov-24 £000	Plan Dec-24 £000	Plan Jan-25 £000	Plan Feb-25 £000	Plan Mar-25 £000
Opening cash	**7,083**	**4,465**	**994**	**4,207**	**2,859**	**1,516**	**970**	**1,029**	**975**	**1,003**	**1,052**	**1,015**	**1,010**	**1,077**
Income flows														
ICB income	8,461	8,456	2,279	2,279	2,279	2,279	2,279	2,279	2,279	2,279	2,279	2,277	2,277	2,277
NHS England	3,025	2,826	8,308	8,308	8,308	8,308	8,308	8,308	8,308	8,308	8,308	8,308	8,308	8,308
NHS Trust/FT	712	650	529	530	529	530	529	530	529	530	529	530	529	528
Private patients	280	320	391	391	391	391	391	391	391	391	391	391	391	392
Overseas	23	20	10	10	10	10	10	10	10	10	10	10	10	10
ICR/RTA scheme	5	5	3	4	4	4	4	4	4	4	4	4	4	4
Non-NHS (Wales/Man)	101	450	257	257	257	257	257	257	257	258	258	257	257	257
R&D	71	332	133	133	133	133	133	133	133	133	133	133	133	133
HEE/other E&T - paid via NHSE	0	0	377	378	377	378	378	378	378	378	378	378	378	379
Other	135	742	100	99	100	99	99	100	101	101	101	101	101	101
Bank interest	51	33	17	17	17	17	17	17	17	17	17	17	17	16
Total operating inflows	**12,864**	**13,834**	**12,404**	**12,406**	**12,405**	**12,406**	**12,405**	**12,407**	**12,407**	**12,409**	**12,408**	**12,406**	**12,405**	**12,405**
Expenditure flows														
Wages and salaries	(4,293)	(4,100)	(5,676)	(5,742)	(5,722)	(5,720)	(5,750)	(5,752)	(5,820)	(5,819)	(5,820)	(5,822)	(5,819)	(5,823)
HMRC	(1,855)	(1,960)	(1,980)	(1,980)	(1,980)	(1,980)	(1,980)	(1,980)	(1,980)	(1,980)	(1,980)	(1,980)	(1,980)	(1,980)
Pensions	(1,257)	(1,250)	(1,300)	(1,300)	(1,300)	(1,300)	(1,300)	(1,300)	(1,300)	(1,300)	(1,300)	(1,300)	(1,300)	(1,300)
CNST - cash movement	0	0	(2,276)	(2,276)	(2,276)	(2,276)	(2,276)	(2,276)	(2,276)	(2,276)	(2,276)	(2,276)	0	0
Other expenditure (ex depn)	(3,143)	(5,013)	(3,316)	(3,365)	(3,364)	(3,339)	(3,644)	(3,668)	(3,488)	(3,461)	(3,499)	(3,508)	(3,331)	(3,316)
VAT recovery	143	152	50	100	100	75	80	120	100	80	100	90	110	110
PDC/Loan	0	(1,815)	250	500	500	1,000	700	(1,013)	500	500	101			(1,351)
Interest payable	(2)	(1)	(2)	(2)	(2)	(2)	(2)	(2)	(1)	(1)	(1)	(2)	(2)	(2)
Capital plan	(800)	(653)	(641)	(981)	(1,210)	(1,297)	(966)	(1,381)	(1,006)	(594)	(694)	(604)	(308)	(159)
Total operating outflows	**(11,207)**	**(14,640)**	**(14,891)**	**(15,046)**	**(15,254)**	**(14,839)**	**(15,138)**	**(17,252)**	**(15,271)**	**(14,851)**	**(15,369)**	**(15,402)**	**(12,630)**	**(13,821)**
Other cash in/outflows														
Local cash support	(7,775)	(7,775)	6,000	2,000	2,200	(4,200)								
National/local distressed finance sup	6,000	8,100	0	0	0	6,800	3,200	5,200	3,300	2,900	1,400	3,400	700	1,700
National payroll	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Accrued/Deferred income	0	(1,000)	0	(408)	(408)	(408)	(408)	(408)	(408)	(408)	(408)	(408)	(408)	(408)
Capital creditors	0	0	(300)	(300)	(285)	(305)	0	0	0	0	0	0	0	0
LUHFT payment	(2,500)	(2,000)	0	0	0	0	0	0	0	0	0	0	0	0
NHS Resolution MIS	0	0	0	0	0	0	0	0	0	0	1,932	0	0	0
TOTAL CASH IN GBS ACCOUNT	**4,465**	**984**	**4,207**	**2,859**	**1,516**	**970**	**1,029**	**975**	**1,003**	**1,052**	**1,015**	**1,010**	**1,077**	**953**
Barclays, bank rec and cash in hand	10	10												
TOTAL CASH HOLDING	**4,475**	**994**												

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
CAPITAL EXPENDITURE: M11
YEAR ENDING 31 MARCH 2024

Area	Capital Scheme	YTD			FULL YEAR - ORIGINAL PLAN			FULL YEAR - REVISED PLAN		
		YTD PLAN	YTD ACTUAL	VARIANCE	PLAN	FOT	VARIANCE	PLAN	FOT	VARIANCE
IT	EPR frontline digitisation	560	844	(284)	560	874	(314)	910	874	36
IT	IT/digital investment - Infrastructure Investment	660	1,309	(649)	1,290	1,411	(121)	1,238	1,411	(173)
IT	IT/digital investment - Hardware	280	143	137	354	151	203	140	151	(11)
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	111	839	950	364	586	350	364	(14)
Estates	Building works/refurbishment - Neonatal	180	0	180	180	75	105	80	75	5
Estates	Building works/refurbishment - Gynaecology	244	0	244	300	0	300	0	0	0
Estates	Estates programme	560	516	44	560	869	(309)	714	869	(155)
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	768	(30)	1,041	1,490	(449)	1,257	1,490	(233)
Medical Equipment	Medical equipment - leased blood gas analysers	139	113	26	139	113	26	139	113	26
F&F	Furniture & Fittings	0	0	0	0	80	(80)	57	80	(23)
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
Accounting	Contingency/VAT savings/slippage	0	(100)	100	(905)	0	(905)	0	0	0
Accounting	Capital to revenue adjustment for digital staffing	0	0	0	0	(341)	341	0	(341)	341
Accounting	Disposals at Net Book Value	0	(176)	176	0	(176)	176	(5)	(176)	171
CDEL ALLOCATION		**4,933**	**3,611**	**1,322**	**5,035**	**5,035**	**(0)**	**5,035**	**5,035**	**(0)**
Other funding sources										
CSE	Ambulatory Scheme	0	39	(39)	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	49	0	49	49	0	49	49	0
TOTAL CAPITAL PLAN		**5,052**	**3,699**	**1,353**	**5,154**	**5,404**	**(250)**	**5,404**	**5,404**	**(0)**

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*24/25/007*		Date: 11/04/2024	
Report Title	LWH Improvement Plan Mobilisation Update 2			
Prepared by	***Tim Gold; Chief Transformation Officer LUHFT & LWH***			
Presented by	***Tim Gold; Chief Transformation Officer LUHFT & LWH***			
Key Issues / Messages	***To provide a delivery progress update on the Trust's 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/**N*** *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
N/A			

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

- The 10 Week Improvement Plan Mobilisation Plan is in week 5 and on track
- 7 "NOF 3" Exit Criteria have been agreed with the Integrated Care Board (ICB) which the Trust will need to deliver against to move out of segment 3 and the ICB's additional oversight
- Significant work has been undertaken to define a Vision, Strategic Objectives and the 16 constituent projects of the Improvement Plan

3. Solutions / Actions

- Formal reporting of the Improvement Plan Highlight Report will begin from May, however a summary of progress to date is included in the paper below

4. Recommendations

The Board is asked to note the progress made on mobilising LWH Improvement Plan, the NOF 3 Exit Criteria and the work undertaken to date on the 6 Improvement Programmes.

INTRODUCTION

In March 2024, Liverpool Women's Hospitals Foundation Trust (LWH) defined a 10 week Mobilisation Plan (see Appendix 1) to embed a Trust-wide Improvement Plan. The Improvement Plan is intended to bring a robust delivery framework to allow the Trust to progress a number of 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.

ANALYSIS

1. Mobilising the LWH Improvement Plan

The Mobilisation Plan remains on track to have the Improvement Plan fully mobilised in May 2024. The Mobilisation Plan is set out in Appendix 1 and a summary of progress is set out below.

Vision & Strategic Objectives

Following the March Board Development session and subsequent work by the Executive Team, the Vision and Strategic Objectives for the LWH Improvement Plan have been defined – see Figure 1.1 below.

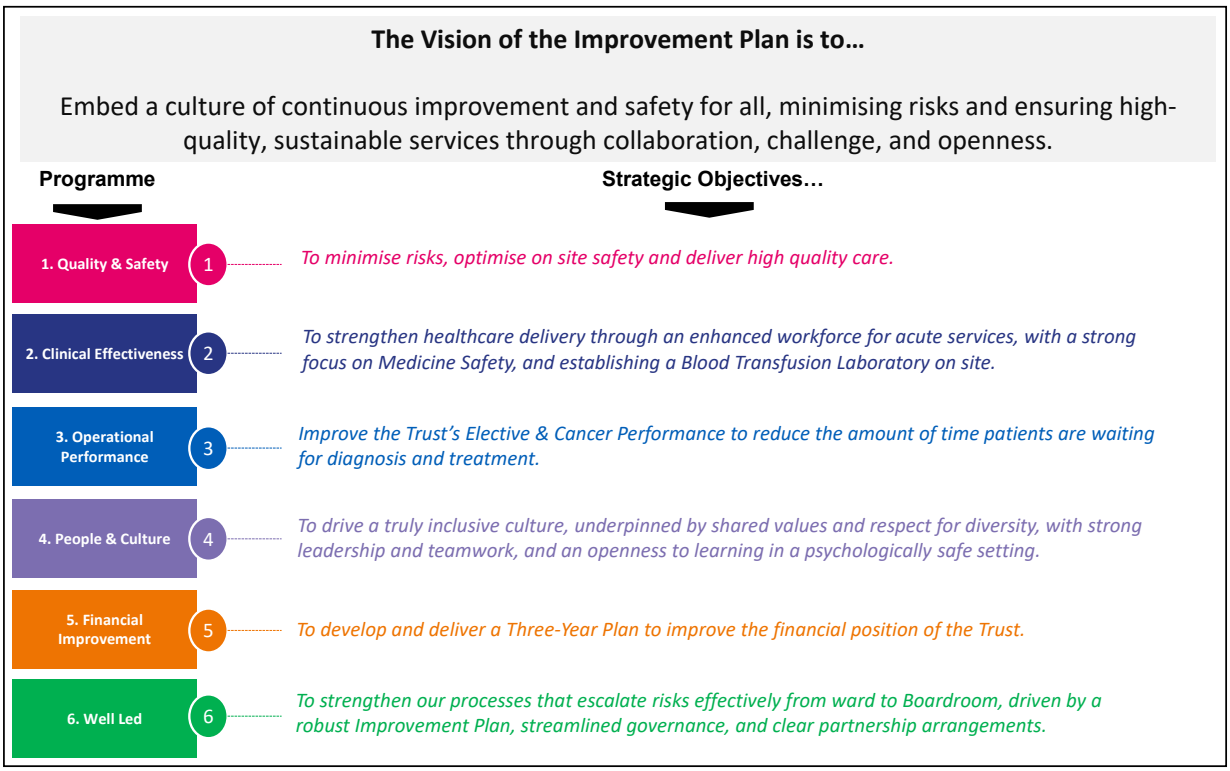


Figure 1.1 LWH Improvement Plan Vision & Strategic Objectives

The 16 projects and programmes that make up the LWH Improvement Plan Portfolio have now been defined (see figure 1.2 below) and a Project Initiation Document (PID) or Project Charter is being

produced for each project. The PIDs and Project Charters are planned to be approved at the first Improvement Plan Portfolio Board on the 23rd April.

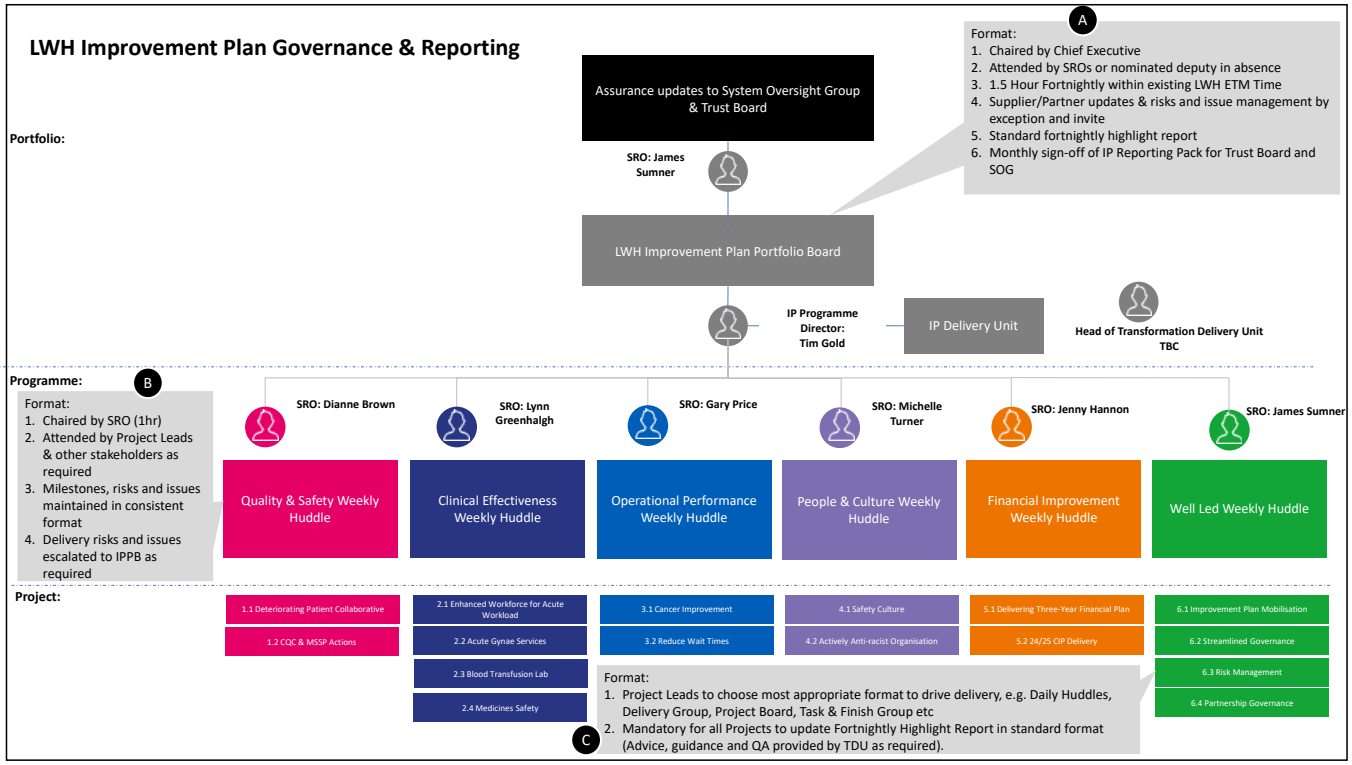


Figure 1.2: Improvement Plan Governance & Reporting

Governance & Reporting

The governance and reporting framework has been agreed for the Improvement Plan which will include a CEO-chaired LWH Improvement Plan Portfolio Board (IPPB). The Portfolio Board is a Board with delegated authority from the Trust Board and will be accountable for the overall delivery of the Improvement Plan. The Terms of Reference (ToR) for the IPPB are planned to be approved by Trust Board in April 2024.

The Senior Responsible Owners (SROs) for the six Improvement Plan Programmes will also run weekly Delivery Huddles, supported by the Transformation Delivery Unit (TDU) and will escalate delivery risks and issues by exception to the Portfolio Board.

An Improvement Plan Highlight Report will be produced as a standing item for Trust Board moving forwards to provide full transparency on the delivery of the Improvement Plan and will include escalation of the most significant issues and risks.

The second System Oversight Group (SOG), was held in March 2024, chaired by the Integrated Care Board (ICB). The Trust shared the draft Improvement Plan structure and 10 week Mobilisation Plan which was well received. The meeting also agreed the NOF 3 Exit Criteria set out below in figure 1.3 which the trust will need to provide assurance on to the SOG in order to return to segment 2 of the National Oversight Framework.

Figure 1.3 LWH National Oversight Framework Exit Criteria

NOF 3 Domain	#	Exit Criteria	Measure
1. Finance	**1.1**	**Financial Recovery Plan**	• Development of a recovery plan that clearly articulates and defines the key drivers of the deficit and shows sustainable improvement addressing all agreed influenceable areas of deficit drivers (as agreed with ICB) • Delivery of at least 2 quarters of the recovery plan to demonstrate sustainable improvement. • Remain on I&E plan for at least 2 quarters (I&E plan as agreed within the overall system plan and in line with recovery plan) • Compliance with national, regional and system expenditure control regimes
	1.2	**Cash Performance**	• Production of rolling 13 week cashflow underpinning ongoing cash requirement (for scrutiny) • Internal audit review of cashflow management processes
2. Performance	**2.1**	**Cancer Performance**	• Exit NHS E Tier 2 Oversight for cancer
3. Quality	**3.1**	**No Outstanding CQC & MSSP Actions**	• Trust Board and System Oversight Group sign-off of delivered Action Plan
4. Workforce	**4.1**	**Agency Spend**	• Agency spend no more than 3.2% of total pay for 3 quarters in succession (3.2% is the agreed national threshold from April 24)
	4.2	**Turnover**	• Turnover under Trust ceiling (13%) for 3 quarters in succession
	4.3	**Actively Anti-racist Programme**	On track delivery of Actively Anti racist Programme learning sets (within Inclusion Training Programme): • delivered to 20% of workforce in each of Q1 and Q2 (24/25) • demonstrating consistent progress towards target to achieve 80% of workforce trained within 24/25

Team & Delivery Resources

An internal recruitment exercise is being undertaken to appoint a Head of the Transformation Delivery Unit (TDU). The purpose of the role will be to programme manage the Improvement Plan and ensure effective and consistent delivery across the constituent projects and programmes. The role is planned to be appointed to by May 2024. The Head of the Transformation Delivery and Executive SROs will also receive transformation delivery support which will be provided by Liverpool University Hospitals Foundation Trust (LUHFT's) Improvement Plan Delivery Unit.

2. Work Undertaken to Date

The Improvement Plan Highlight Report is being developed in MS Project and Power BI and will be available from May 2024. An interim progress update is provided in figure 1.4 below:

Figure 1.4 Progress Update

Programme	Progress Update
1. Quality & Safety Programme	**Deterioriating Patient Collaborative** being mobilised and Project Initiation Document created **CQC & MSSP Actions** - Weekly MEWS completion audits continue by department managers - BirthRate Plus Ward Based Acuity Tool was launched - Revised daily equipment checking process implemented in clinical areas - Family Health Division reviewing KPI's and amend data collection processes
2. Clinical Effectiveness Programme	**Enhanced Workforce for Acute Workload** - 12 ACP places secured; 2 WTE clinical fellows appointed to start in August 2024 - 8 WTE clinical posts advertised - Report taken to JLNC proposing consultant obstetricians moving to resident cover at night. Enabling negotiations to begin. **Acute Gynae ED** - Recruitment of acute gynae clinical lead advertised and soon to interview - Safety huddles in place and Out of Hours escalation embedded - Project Management Support from Ambulatory Project Manager secured **Blood Transfusion Laboratory** - Following Germany site visit in Feb 24, initial quote received - Task & Finish Group and Project Initiation Document (PID) established **Medicines Safety** - Subject matter expert (0.4WTE) identified to provide additional support for six months
3. Operational Performance Programme	**Cancer Improvement** - Tier 2 monthly meetings with NHSE progressing - Cancer Improvement PID in development **Reduced Waiting List** - Trust is aiming to achieve the clearance of 65+ by the end of Q1 24/25. - Productivity stretch within Theatres, transformation of outpatient pathways and additional capacity will be required
4. People & Culture Programme	**Safety Culture** PID in development **Actively Anti-racist Organisation** - Draft PID produced - Potential external partner agreed to undertake cultural baseline survey - Recruited to anti-racism hub posts - Date confirmed for first community engagement event regarding anti-racism work
5. Financial Improvement Programme	**3YFP** - Developed 3 year financial recovery plan (supported by LTFM) in sept 23 and submitted to ICB - Stringent financial grip and control measures implanted as part of financial recovery - Productivity stretch embedded in 24/25 financial plan focused on day case activity - Outpatient productivity work continues **24/25 Cost Improvement Programme (CIP)** - Identified c. £1m recurrent CIP and £0.5 non-recurrent CIP - Divisions set targets and are working internally to develop plans - Divisional workshops held
6. Well Led Programme	- **Improvement Plan** Mobilisation Plan on track - Principle for the Trust's revised **governance structure** agreed in March Board and new meetings scheduled - **Risk Management** Strategy updated and submitted to the Board for approval. - Risk management system being updated to enable change to scoring methodology. - Divisions reviewing risks under the new scoring methodology.

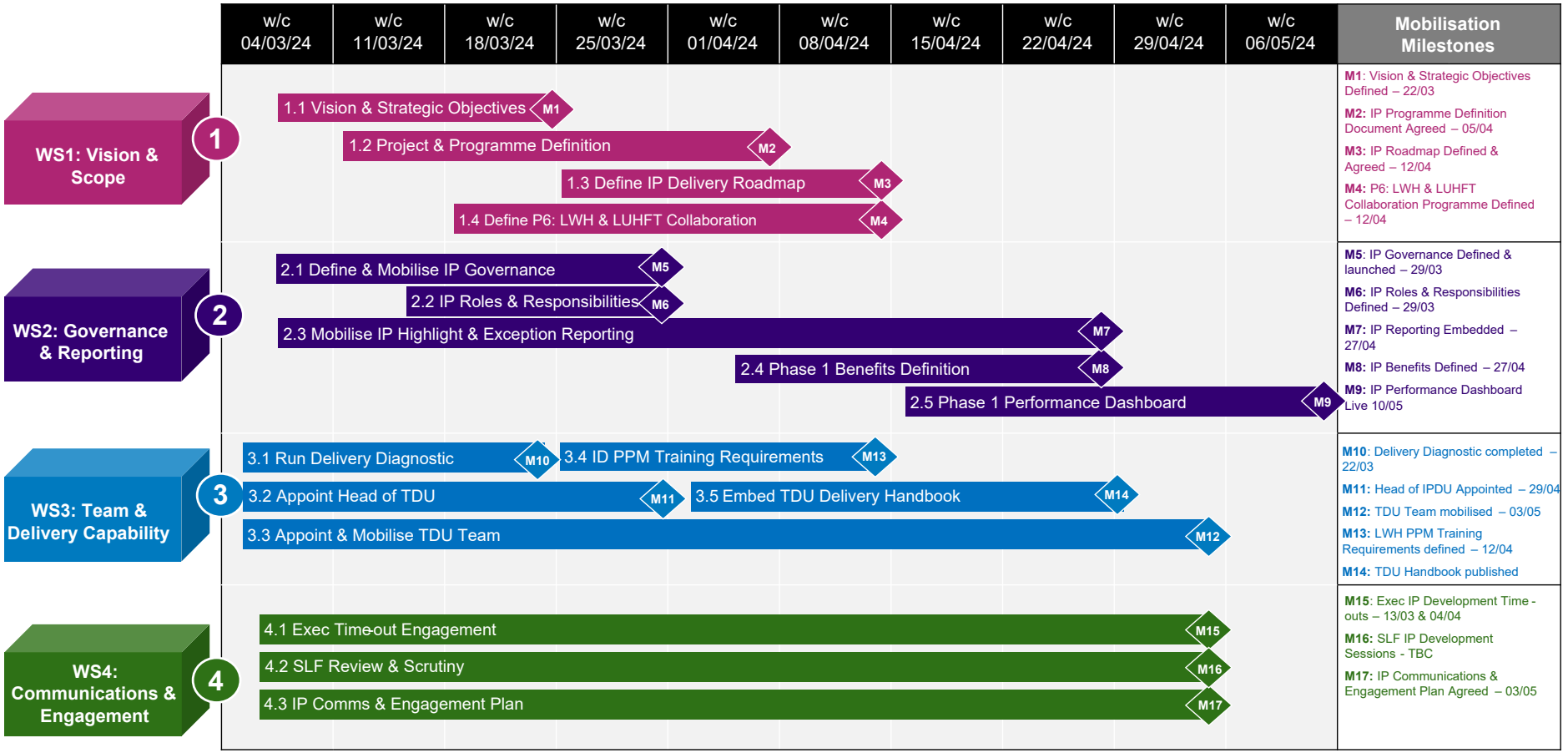
RECOMMENDATION

The Board is asked to note the progress made on mobilising LWH Improvement Plan, the NOF 3 Exit Criteria and the work undertaken to date on the 6 Improvement Programmes.

Appendices

Appendix A – LWH Improvement Plan Mobilisation Plan

Mobilising the LWH Improvement Plan – 10 Week Plan



Trust Board

COVER SHEET

Agenda Item (Ref)	*24/25/008*	Date: 11/04/2024
Report Title	Mortality and Learning from Deaths Report Quarter 3, 2023/24	
Prepared by	**Chris Dewhurst, Deputy Chief Medical Officer.** Lidia Kwasnicka, Gynaecologist; Ai-Wei Tang, Consultant Obstetrician; Rebecca Kettle, Consultant Neonatologist	
Presented by	**Lynn Greenhalgh, Chief Medical Officer**	
Key Issues / Messages	The Committee members are asked to review the contents of the paper and take assurance that there are adequate processes and progress against the requirements laid out by the National Quality Board. This paper has been reviewed and approved AT Quality Committee.	

Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	It is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths. *As per the Learning from Deaths framework requirements, the Board is requested to note:* • *number of deaths in our care* • *number of deaths subject to case record review* • *number of deaths investigated under the Serious Incident framework* • *number of deaths that were reviewed/investigated and as a result considered due to problems in care* • *themes and issues identified from review and investigation* • *actions taken in response, actions planned and an assessment of the impact of actions taken.* *The Board is also asked to approve the recommendations relating to improving the clarity of reporting for neonatal deaths.*			
Supporting Executive:	**Lynn Greenhalgh, Chief Medical 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: N/A
Link to the Corporate Risk Register (CRR) – CR Number:	Comment: No

EXECUTIVE SUMMARY

This 'Mortality and Learning from Deaths' paper presents the mortality data for Q3 2023/24. The learning from review of deaths will be from deaths that occurred in Q2 2023/24 or earlier.

As per The Learning from Deaths framework requirements the Board is requested to note:

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.

In Quarter 3 there were the following deaths:

Adult Deaths	**0**
Direct Maternal Deaths	**0**
Stillbirths	**6 (excluding ToP, rate 3.3/1000births)**
Neonatal Deaths (inborn)	**15 (5.0/1000 live births)**

There were no maternal or gynaecology deaths in Q3 2023/24.

The PMRT review of stillbirths from Q2 23/24 (n=5) identified one case where antenatal care was graded C (care issues identified which may have made a difference to the outcome). This case was subject to a PSII with capacity within antenatal diabetes clinic being the root cause. Further learning is included in the paper.

The PMRT review of neonatal deaths from Q2 23/24 (n=7) identified two babies with neonatal care issues that may have impacted upon the outcome. These issues were not being co-located with paediatric surgical services and the neonatal team not being aware of maternal microbiology results.

Of the 27 stillbirths (including TOPs) and neonatal deaths (including all deaths where babies were cared for at LWH) **11 (41%) were in non-white British mothers/babies**. This is higher than the birthing population for 2021-22 (c 15.5%). This is the first time an excess of deaths in the non-white population has been observed and caution must be used when interpreting one quarters data. As per the QC recommendation, a longer term will be reviewed in next quarters paper.

There were 23 cases whereby IMD scores for deprivation were available. Of these, **15/23 (65%) resided in the most deprived decile** for Index of Multiple Deprivation. This is higher than the booking population of c 50% residing in the most deprived decile, and is also the first time this has been seen.

Recommendation: It is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths.

As per the Learning from Deaths framework requirements, the Board is requested to note:

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.

The Board is also asked to approve the recommendations relating to improving the clarity of reporting for neonatal deaths.

MAIN REPORT

This is the Quarter 3 2023/24 mortality report for adults, stillbirths and neonates. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust. This is in accordance with recommendations by the National Quality Board 'National Guidance on Learning from Deaths' and the Care Quality Commission. It outlines the work taking place operationally and being overseen by the Safety and Effectiveness Sub-Committee and Quality Committee.

The data presented in this report relates to Q3 2023-24. The learning relates to deaths in Q2 22/23 or earlier. This is due to the multi-disciplinary review of deaths not occurring in the quarter when the death occurred.

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

1. Adult Mortality

1.1 Obstetric Mortality Data Q3 2023/24

There were **0 maternal deaths in Q3 2023/24**.

1.2 Learning from Obstetric Mortality Data

There was no new learning from the historic maternal deaths in this quarter.

1.3 Gynaecology Mortality data Q3 2023/24

There were 0 expected deaths within Gynaecology Oncology in Q3 2023/24.
There was 0 unexpected death within Gynaecology services in Q3 2023/24.

1.4 Learning from Gynaecology Mortality Q2 23/24

There were no deaths in Q2 2023/24 for learning to be gained from.

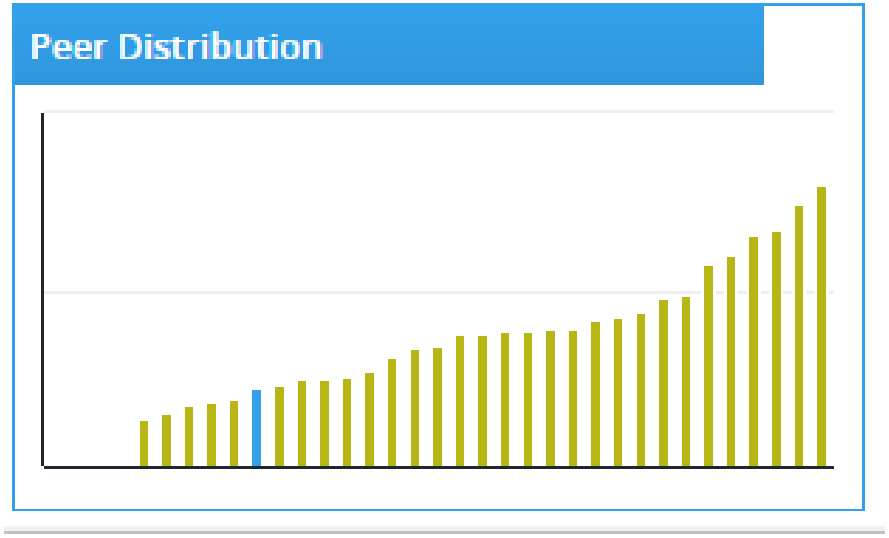
2. Stillbirths

2.1 Stillbirth data

There were seven stillbirths, excluding terminations of pregnancy (TOP) in Q3 2023/2024. This has resulted in an adjusted stillbirth rate of 3.3/1000 live births for Q3 23/24. There were 3 late fetal losses at 22 – 23+6 weeks gestational age.

Quarter	Rate 2019/20	Rate 2020/21	Rate 2021/22	Rate 2022/23	Rate 2022/23
Q1	4.0	5.5	4.0	3.7	1.7
Q2	4.1	2.5	5.3	3.6	2.2
Q3	1.5	2.7	5.1	4.3	3.3
Q4	1.7	3.2	5.0	2.3	
ANNUAL	2.9	3.4	4.9	3.5	2.6

Table 2: Quarter and Annual Stillbirth rate/1000 births since 2019/20 (excluding terminations). The stillbirth rate for the three quarters of 23/24 so far is 2.6/1000 births.



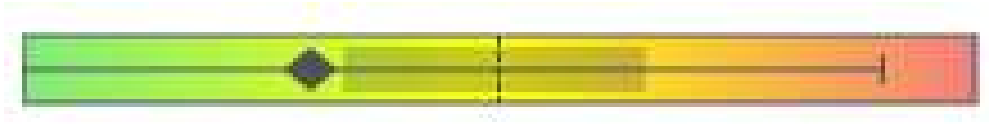


Figure 1 and 2. Stillbirth data with LWH benchmarked against other large maternity services (>7000 deliveries) Q2 2023-24. The blue bar is LWH data demonstrating the observed rate is within the lowest quartile for stillbirths. The diamond is LWH demonstrating we are within the lowest quartile for stillbirth rates.

Demographic information for the 10 stillbirths (including ToPs)

- 5/10 (50%) women were of non-white British ethnicity. This is in excess of the booking population non-white population. Booking population = c. 18%
- 8/9 (89%) women with information available live in the lowest decile for deprivation. Booking population = c 50%

In this quarter there is an increased representation of non-white women in the stillbirth population compared with the overall booking population. These data include TOPs. The absolute numbers are small and caution must be made when interpreting these data. Full year information will be included in Q4 report.

2.1 Learning from Stillbirth and PMRT reviews of stillbirths from Q2 23/24

All eligible cases (n=5) underwent a full multi-disciplinary team PMRT review with external clinician presence.

The PMRT review grades care in the antenatal, neonatal (for neonatal deaths) and post-bereavement care, assigning a grade for each aspect:

- A. No issues with care identified.
- B. Care issues that would have made no difference to the outcome.
- C. Care issues which may have made a different to the outcome.
- D. Care issues which were likely to have made a difference to the outcome.

There was one case (20%) where antenatal care issues were identified that may have made a difference to the outcome. This related to non-attendance at diabetes and antenatal clinics as well as a scan appointment. This case was subject to a PSII (STEIS 2023/15842) which concluded in December 2023. The care issue centred around the woman not being seen in a consultant gestational diabetes clinic within the required timescale. This report identified the root cause being a lack of capacity in gestational diabetes mellitus clinics with additional lessons learned around improving the management of capacity and demand in GDM clinics as well as improving SOPs for referral into specialist clinics.

Two (40%) case had antenatal care issues which would not have changed the outcome of the pregnancy. This related to midwifery reviews when patients are under the care of the FMU service.

3. Neonatal Mortality

3.1 Neonatal mortality Data Q3 2022/23

Neonatal deaths can be reported in several ways. The table below presents the total number of deaths at LWH, the mortality for babies born at LWH, the number of deaths eligible to report to MBRRACE and the number of deaths of inborn babies born at between 24 to 31+6 weeks gestational age.

Reporting of Neonatal Mortality

The author recognises the complexity in reporting of mortality and in turn clarifying assurance around neonatal mortality data. There is work ongoing nationally regarding what data to report for assurance to boards and externally around neonatal mortality. Whilst these recommendations are awaited, it is proposed from next quarter that the data is presented in the following format:

1. Time trended data for mortality on NICU and Delivery Room deaths. This will provide a measure of 'safety' identifying any spikes in neonatal deaths.
2. Time-trended data for the number of deaths within 28 days for babies born alive from 24+0 weeks gestational age. These are the deaths included in MBRRACE data and will provide early information and assurance regarding neonatal mortality. The data will not be adjusted for socio-demographic and other variables but will be compared against the most recent MBRACCE data for LWH.
3. Mortality data for the preterm cohort of infants admitted to LWH neonatal unit at 24 – 31+6 weeks gestational age.

	Apr-23	*May-23*	*Jun-23*	*Jul-23*	*Aug-23*	*Sep-23*	*Oct-23*	*Nov-23*	*Dec-23*	*Jan-24*	*Feb-24*	*March-24*	*Total*
Births	613	599	554	629	612	587	619	594	591				5398
INBORN Neonatal Mortality (all live births)	2	1	9*	3*	4	1	6*	6*	3				35
Total mortality on NICU	3	1	6	3	4	1	6	5	2				31
INBORN + DIED LWH Neonatal mortality	2	1	6	2	4	1	4	4	1				25
IUT Mortality	0	0	5*	0	4	0	2	3	1				15
PNT Mortality	1	0	0	1	0	0	2	1	1				6

INBORN (+died LWH) Neonatal Mortality Rate/1000LB	3.2	1.7	10.8	4.8	6.5	1.7	6.5	6.7	1.7				4.6
MBRRACE eligible deaths *Excl. congenital anomaly*	*0* *0*	*1* *1*	*3* *2*	*1* *0*	*4* *2*	*1* *1*	*6* *4*	*3* *2*	*1* *0*				*20* *12*
Benchmark: MBRRACE data 2021 ***3.36/1000LBs*** ***(excl. congenital anomaly)*** ***1.44/1000LBs***	*0* *0*	*1.7* *1.7*	*5.4* *3.6*	*1.6* *0*	*6.5* *3.3*	*1.7* *1.7*	*9.7* *6.5*	*5.1* *3.4*	*1.7* *0*				*3.7* *2.2*
NWNODN benchmark INBORN 24-31 w	*0*	*1*	*2*	*0*	*3*	*1*	*3*	*3*	*1*				*14*
Benchmark (NNAP >6.3% of admissions)	*0*	*5.3*	*14.2*	*0*	*25*	*10*	*37.5*	*23*	*10*				*15%*
NWNODN benchmark INBORN 24-27 w	*0*	*1*	*1*	*0*	*1*	*1*	*3*	*2*	*1*				*10*
Benchmark (NNAP >15% of admissions)	*0*	*20*	*50*	*0*	*25*	*25*	*60*	*50*	*33.3*				*29%*

**Includes babies inborn at LWH then transferred to another hospital who died in the neonatal period prior discharge*

Table 4: NICU Mortality by month for the past 12 months. Red indicates breaching the NWODN threshold. This threshold however is being challenged as not appropriate for level 3 NICUs.

Quarter	NMR *in born*
Q1 (23_24)	5.1
Q2 (23_24)	3.8
Q3 (23_24)	5.0
Q4 (23_24)	

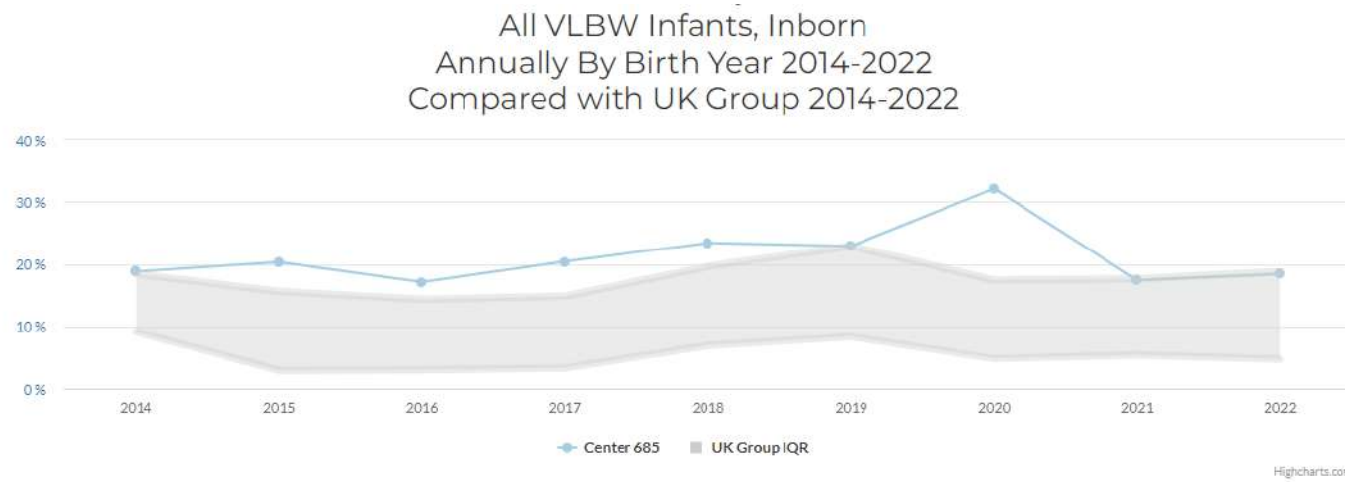
Table 5: Neonatal Mortality Rate per quarter (born and died at LWH)

Demographic data (n = 17 babies cared for at LWH)

- 11/17 (65%) babies were born to mothers of white-British background,
- 3 babies born to mothers of black-African or black-other ethnicity
- 1 described as white other
- 1 mother of Polish origin,
- 1 mother of mixed white / Asian origin.

Benchmarking via Vermont Oxford Network

The VON benchmark international neonatal outcomes for babies weighing <1500g and/or < 30 weeks gestational age. It includes >1400 neonatal units, including 33 units in the UK. The chart below shows LWH inborn mortality compared against the interquartile range for UK hospitals. The mortality is higher than the IQR as LWH is a tertiary neonatal unit with both surgical and cardiac services and is comparing against neonatal units who do not care for the most at-risk infants.



3.3. Learning from neonatal mortality reviews for neonatal deaths from Q2 23/24

There were 7 deaths in Q2 23/24 subject to a PMRT review.

There were 2/7 case where a care issue was identified that may have impacted upon the outcome. One related to non-colocation with paediatric surgical services. The second related to communication of maternal microbiology results to the neonatal team. Clarifying the process, roles and responsibilities through the Intrapartum Working Group will occur.

4. Recommendations

It is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths.

As per the Learning from Deaths framework requirements, the Board is requested to note:

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.

The Board is also asked to approve the recommendations relating to improving the clarity of reporting for neonatal deaths.

A larger data set relating to the demographic data for stillbirths and neonatal deaths will be presented with the next Quarters report.

5. Appendices

- Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report
  - Q3 (Oct – Dec 2023)

- Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report Template

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Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report – *Q3 (Oct – Dec 2023)*

REPORT ON DEATHS IN CURRENT QUARTER AND REVIEWS OF DEATHS IN QUARTER BEFORE

Contents

PROVIDER:	**LIVERPOOL WOMEN'S HOSPITAL**
COMPLETED BY:	**AI-WEI TANG**
DATE COMPLETED:	**JANUARY 2024**

1. EXECUTIVE SUMMARY:

a. There were 6 stillbirths, excluding terminations of pregnancy (TOP), in the 3rd Quartile (October – December 2023) of 2023/2024. This results to an adjusted stillbirth rate of 3.3/1000 for this Quartile.

b. In this quartile, there were 4 pregnancy loss (excluding TOP) born between 22-24 weeks gestation.

c. All stillbirths and pregnancy loss between 22-24 weeks in Q2 of 2023/24 (N=5) have been subject to a full multidisciplinary review panel meeting utilising the PMRT tool with external clinician presence.

d. All bereaved parents were invited to be involved in the review process by submitting comments and questions via the Honeysuckle Team for discussion at the MDT Review. 4 of 5 families in Q2 submitted questions and comments which were discussed by the MDT panel.

e. The MDT reviews of 4 Stillbirths and 1 pregnancy loss between 22-24 weeks gestation in Q2 have found no antenatal care issues identified (Grade A) in 2 cases, and 2 cases were Graded B (*care issues identified which would have made no difference to the outcome of the baby).* The one case graded C was investigated via the PSIII process with learning identified and shared.

f. In the reviews of postnatal care, all women received good bereavement support, but care issues were identified in the clinical care provided, where care were Graded C (*care issues identified which may have made a difference to the outcome of the mother*) in 3 of the cases in accordance with the MBBRACE Grading system. Details of the care issues identified are explained in Table 5.

g. There were no Grade D (*care issues identified which were likely to have made a difference to the outcome of the pregnancy*) in the reviews of Q2 cases.

2. DASHBOARD AND BENCHMARKING

Table. 1 Stillbirths (>24 weeks) dashboard for 2023/24

STILLBIRTHS	Jan-23	Feb-23	Mar-23	Apr-23	May -23	June -23	July - 23	Aug - 23	Sept – 23	Oct - 24	Nov - 24	Dec – 24	TOTAL 2023/24
Total Stillbirths	2	4	1	5	4	10	5	3	3	4	3	3	37
Stillbirths (excluding TOP)	**1**	**3**	**0**	**0**	**2**	**1**	**3**	**1**	**0**	**2**	**3**	**1**	**13**
Births	630	519	613	613	599	554	629	612	587	619	594	591	5398
Overall Rate /1000	3.2	7.7	1.6	8.2	6.7	18.1	7.9	4.9	5.1	6.4	5.1	5.1	6.9
Rate (excluding TOP)/1000	**1.6**	**5.8**	**0**	**0**	**3.3**	**1.8**	**4.8**	**1.6**	**0**	**3.2**	**5.1**	**1.7**	**2.4**
Pregnancy loss 22-24 weeks (excluding TOP)	1	0	0	1	0	2 (twins)	0	1	0	2	0	2	4

Table 2: Stillbirths (>24 weeks, excluding terminations)

Quarter	Rate 2019/20	Rate 2020/21	Rate 2021/22	Rate 2022/23	Rate 2022/23
Q1	4.0	5.5	4.0	3.7	1.7
Q2	4.1	2.5	5.3	3.6	2.2
Q3	1.5	2.7	5.1	4.3	3.3
Q4	1.7	3.2	5.0	2.3	
ANNUAL	2.9	3.4	4.9	3.5	

Table 3: Stillbirth (>24 weeks) by Cause (Q2, 2023/24)

Reported cause of death (based on CESDI 2018)	No.	Transferred care for delivery in LWH
Termination of pregnancy for fetal abnormality	7	
Fetal/chromosomal abnormality	1	
Pre-eclampsia	0	
Antepartum haemorrhage (abruption)	0	
Medical disorder	0	
Multiple pregnancy	0	
SGA (<10th centile)	1	
Mechanical	1	
Infection	0	
Specific placental condition	1	
Unclassified	0	

In Q2, the 1 case of pregnancy loss between 22-24 weeks was reviewed through the PMRT process, and the cause of death was:

- Placental abruption

3. MORTALITY REVIEWS AND KEY THEMES (Q2 cases, including 1x pregnancy loss 22-24 weeks)

Table 4. PMRT review panel grading of care provided in cases of Stillbirth (N=5)

Grade	Care in antenatal period	Percentage (%)	Care provided after Stillbirth	Percentage (%)
A	2	40	1	20
B	2	40	1	20
C	1	20	3	60
D	0	0	0	0

Table 5. Reasons for review panel grading B,C&D

Antenatal Care

Review panel grading	Reason for grading	Level of investigation (PSIII/AAR/PMRT with external)	HSIB (yes/ no)	Learning	Actions / QI plan aligned to theme
B	Lack of CMW as lives out of area	PMRT	No	Unclear pathway for CMW FU for women who live OOA	Development of SOP for MW reviews for women who live OOA choosing to deliver in LWH
B	Lack of clarity on PTL FU	PMRT	No	To arrange for timely FU in PTL clinic as required	Discussion with clinician involved for reflection *(completed)*
C	Missed GDM ANC and DNA scan and appropriate FU not arranged	PSIII	No	Please refer to PSIII report	Please refer to PSIII report *(completed)*

Postnatal/Bereavement Care

Review panel grading	Reason for grading	Level of investigation (PSIII/AAR/PMRT with external)	HSIB (yes/no)	Learning	Action / QI plan aligned to theme
B	Lack of drug testing as part of PN Ix	PMRT	No	Need to discuss consent for drug testing in relevant cases	EPR Stillbirth pathway updated to include drug testing as an investigation *(completed)*
C	Inadequate counselling on PN Ix	PMRT	No	Need for consultant review prior to discharge	LOTW and communication sent out to all consultants *(completed)*
C	Incomplete PN Ix Comments on treatment as woman of ethnic minority	PMRT	No	Utility of EPR Stillbirth pathway and training on type of PN SB Ix Awareness on Equality and Diversity	Training on utility of EPR pathways and LOTW reminder on importance of complete SB Ix *(completed)* Mandatory training on Equality and Diversity for all staff Appointment of lead MW for health and equality *(in post)*
C	Suboptimal management of anaemia Experience in PN period	PMRT	No	PN management plan to be followed Review of comments by DS manager/matron and offer of joint debrief appt	Discussion with clinician involved for reflection *(completed)* Joint debrief to address parental comments

a. PMRT PANEL ATTENDANCE and PARENTAL ENGAGEMENT

There was 1 PMRT panel without the presence of either an external Obstetrician or Midwife in reviewing 2 of 5 Q2 cases

4. INTRAPARTUM & TERM STILLBIRTHS (Q3 cases)

There was 1 case of intrapartum preterm labour stillbirth at 22+1 weeks gestation and 3 term stillbirths (2 at 41+2 weeks, 1 at 37+6 weeks).
72hr review and MDT PMRT review of the intrapartum stillbirth showed no care issues. One of the term stillbirth case at 41+2 weeks have been escalated to be reviewed through the PSIII process, and the other 2 cases have had learning identified with actions in progress

Gestational age at delivery of Stillbirths and pregnancy loss 22-24 weeks gestation

Gestation at Stillbirth	Number (N=10)
<24 weeks	4
<28 weeks	1
28-31 weeks	1
32-36 weeks	1
> 37 weeks	3

5. SAFEGUARDING/UNBOOKED AND LATE BOOKERS (Q3 cases)

In Q3, there was 1 case referred to safeguarding, who was under care of enhanced MW and mental health team for additional support as has learning difficulties and a history of significant mental health

6. SOCIO-DEMOGRAPHICAL (Q3 cases)

Half (5 women) of these women were not of White British ethnicity, but all communicated in English apart from 1 woman.

Of these 10 women, 2 reported to smoke at booking and was referred for smoking cessation services, although 1 declined. All women had their CO monitored.

8 (89%) of 9 women live in the lowest decile IMD score for residential address (1 case had no IMD as resides in Wales).

7. SMALL FOR GESTATIONAL AGE <10th centile (Q3 cases)

There were 6 cases of SGA (4 were FGR <3rd centile).

FGR (<3rd Centile) at birth	SGA (3-10th Centile) at Birth
35/40, 2nd centile *(Undiagnosed)* - Smoker - 3x Growth USS undertaken - 15th centile at 34+0	41+2/40, 3.4th Centile *(Undiagnosed)* - 3x Growth USS undertaken - 81st centile on USS at 38+4 - Considered as part of PSII into 2 cases of Post dates IUD.
38/40, 0.8th Centile *(Undiagnosed)* - SFH slow growth at 31+5, no referral for Growth USS - After Action Review and thematic review of growth chart incidents in relation to Digital issues.	23+4/40, 9th centile *(Undiagnosed)* - Low PAPP-A - UAD USS booked but IUD before scan
23+6/40, 0th Centile (*Diagnosed)* - known Fetal Abnormality of T21 - under FMU from 20 weeks	
26+6/40 (DCDA twins), 0.3rd centile (*Diagnosed)* - IUD Twin 1 @ 21+6 - Smoker, growth USS under MPC.	

A PSIII investigation is taking place taking into consideration both the cases of SB at 41 weeks, which include the . CMW and patients need to be provided with adequate information on counselling for IOL by 41 weeks to allow patients to make an informed decision, and is work in progress as part of the QI project on IOL. The other case relates to a missed opportunity to arrange for growth scans, relating to not contemporaneously documentating and reviewing SFH measurements, and discussions are in progress on improving K2 connectivity in the community.

8. FETAL ABNORMALITIES DEATHS (known and unknown)

In Q3 of 2023/24, there was a case of SCT diagnosed antenatally.

9. LEARNING FROM DEATHS from Q2 of 2022/23

Areas for learning in the antenatal period are as summarised in Table 5 in the report, and some of the actions have been completed, others in progress

10. SAVING BABIES' LIVES ELEMENTS (Q3 cases, N=10)

ELEMENTS	CASES	NARRATIVE
Reducing Smoking	2	Both referred to smoking cessation, 1 declined
Fetal Growth Restriction	6	4 undiagnosed SGA
Awareness of RFM		
Fetal monitoring in labour	1	Misinterpretation of CTG at MAU presentation
Reducing PTB	1	Spontaneous labour 22/40, no PTL risks
Management of DM	0	

11. LEARNING / GOOD PRACTICE / COMPLETED ACTIONS

There are completed actions from recommendations from reviews in the last quartile as detailed in Table 5.

Ongoing actions that are in progress, and discussed in various working groups include:

- Development of pathway for CMW review in women who are booked to deliver in LWH but live out of area, and the need for this pathway to be reviewed, and has been transferred for tracking and action on the MRC log

- Ongoing training of bereavement support champions to provide additional support to Honeysuckle team, utility of 2nd and 3rd trimester pregnancy loss pathways on K2 EPR, which acts as checklists to ensure stillbirth investigations, including genetic tests have been appropriately requested for

12. Benchmarking and CNST Compliance

As part of intelligence gathering the following sources were used for horizon scanning:
CQC, NCEPOD,NHS Digital, NHSE/I (includes LMS), NHSR, PHE, RCOG, RCM, MBRRACE-UK, HSIB, Ockenden, CNST Maternity Incentive Scheme

CNST submission for Year 5 has completed

NHS
North West Coast
Clinical Networks

Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report Template

(includes Perinatal Mortality Review Tool summary – see Appendix)

REPORT ALL DEATHS IN THAT QUARTER NOT THE REVIEWS COMPLETED IN THAT QUARTER

Contents

PROVIDER:	**LWH**
COMPLETED BY:	**DR REBECCA KETTLE**
DATE COMPLETED:	**19TH JANUARY 2024**

NHS
North West Coast
Clinical Networks

1. EXECUTIVE SUMMARY: Key findings section at the start of report to include

- Quarter 3 neonatal mortality rate is 4.8 /1000 LB for inborn births
- There were 2 cases in which neonatal care issues identified were considered may have made a difference to the outcome (grade C) but 0 where care issues were likely to have made a difference to the outcome (grade D)
- LWH preterm mortality is above the NWNODN benchmarking flags for the year to date – there is ongoing work to further understand this
- 2 highest causes of death are this quarter are congenital anomalies and respiratory complications of extreme prematurity.

NHS North West Coast Clinical Networks

2. DASHBOARD AND BENCHMARKING

Table. 1 Neonatal mortality dashboard with benchmarking data

	Apr-23	*May-23*	*Jun-23*	*Jul-23*	*Aug-23*	*Sep-23*	*Oct-23*	*Nov-23*	*Dec-23*	*Jan-24*	*Feb-24*	*March-24*	*Total*
Births	613	599	554	629	612	587	619	594	591				5398
INBORN Neonatal Mortality (all live births)	2	1	9*	3*	4	1	6*	6*	3				35
Total mortality on NICU	3	1	6	3	4	1	6	5	2				31
INBORN + DIED LWH Neonatal mortality	2	1	6	2	4	1	4	4	1				25
IUT Mortality	0	0	5*	0	4	0	2	3	1				15
PNT Mortality	1	0	0	1	0	0	2	1	1				6
INBORN (+died LWH) Neonatal Mortality Rate/1000LB	3.2	1.7	10.8	4.8	6.5	1.7	6.5	6.7	1.7				4.6
MBRRACE eligible deaths	*0*	*1*	*3*	*1*	*4*	*1*	*6*	*3*	*1*				*20*
Excl. congenital anomaly	*0*	*1*	*2*	*0*	*2*	*1*	*4*	*2*	*0*				*12*
Benchmark: MBRRACE data 2021													
3.36/1000LBs	*0*	*1.7*	*5.4*	*1.6*	*6.5*	*1.7*	*9.7*	*5.1*	*1.7*				*3.7*
(excl. congenital anomaly) 1.44/1000LBs	*0*	*1.7*	*3.6*	*0*	*3.3*	*1.7*	*6.5*	*3.4*	*0*				*2.2*
NWNODN benchmark INBORN 24-31 w	*0*	*1*	*2*	*0*	*3*	*1*	*3*	*3*	*1*				*14*
Benchmark (NNAP >6.3% of admissions)	*0*	*5.3*	*14.2*	*0*	*25*	*10*	*37.5*	*23*	*10*				*15%*
NWNODN benchmark INBORN 24-27 w	*0*	*1*	*1*	*0*	*1*	*1*	*3*	*2*	*1*				*10*
Benchmark (NNAP >15% of admissions)	*0*	*20*	*50*	*0*	*25*	*25*	*60*	*50*	*33.3*				*29%*

**Includes babies inborn at LWH then transferred to another hospital who died in the neonatal period prior discharge*

Table 2: Neonatal Death Rate per quarter

Quarter	NMR *in born*
Q1 (23_24)	5.1
Q2 (23_24)	3.8
Q3 (23_24)	5.0
Q4 (23_24)	

Table 3: Neonatal Mortality by MCCD A. cause Q3 23_24 (all deaths)

Reported cause of death (based on CESDI 2018)	No.	IUT / PNT	Other information
Prematurity	3	1 IUT	24, 25 and 26 weeks
Respiratory	4	2 IUT 1 PNT	All born extremely prematurely <26 weeks
Congenital anomaly	5	2 IUT 1 PNT	Dilated cardiomyopathy, Renal agenesis Non-immune hydrops Pyruvate dehydrogenase alpha 1 deficiency, Trisomy 13+18
Neurological	2	2 PNT	Hypoxic ischaemic encephalopathy
Infection	1		Gram negative sepsis
Abdominal	1	1 PNT	Necrotising enterocolitis
Other	1		Coroners case – under review

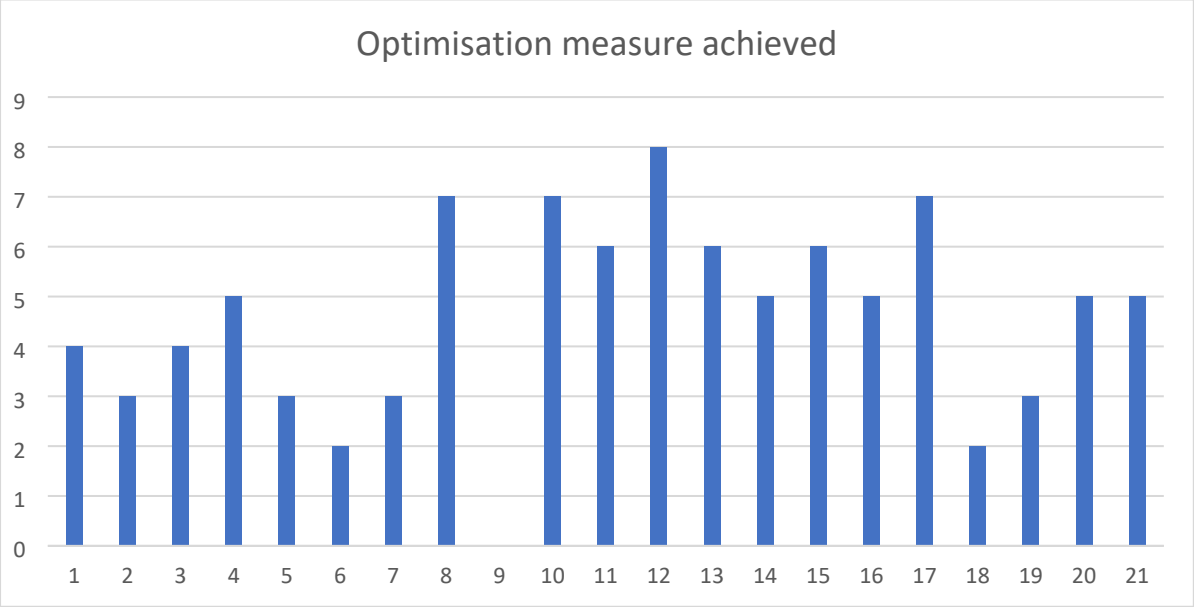
Coroners Cases 23_24:

Month	Case	Updates
June	AR	Referred to coroner, raised as SUDI PM found bacterial meningitis closed by coroner as natural causes
August	EM	Hydrops fetalis, cervical dislocation – Coroners investigation ongoing, update due mid Feb.
October	KH	SUDI declared by coroner; Police and social aspects stepped down PM report pending, coroners investigation open

Preterm optimisation data:

In 23_24 Q1,2 and 3 there have been 21 inborn babies <32 weeks eligible for optimisation measures, 1 with missing data. 9 optimisation interventions include:

- Birth in appropriate setting
- Maternal Steroids (24 hours – 7 days prior to birth)
- Maternal magnesium sulphate
- Maternal IV antibiotics
- Delayed cord clamping (>1 minute)
- Admission temperature (36.5-37.5^{0}C)
- Time to maternal breast milk (within 24 hours)
- Caffeine in first 24 hours
- *Use of volume guarantee ventilation (if appropriate) * recent addition*



3. MORTALITY REVIEWS AND KEY THEMES

Table 4.1. PMRT review panel grading of care provided in cases of Neonatal Death Q2 (23_24)

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the baby up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A	5	2	6
PMRT grade B	1	3	1
PMRT grade C	0	2	0
PMRT grade D	0	0	0
Total cases	6*	7	7

*1 case of a post-natal transfer not graded as no input from birth hospital

Alder Hey Mortality after transfer of care from NICU

Babies who transfer to AH for ongoing care are also reviewed through the PMRT process up to the point of transfer of care, these are not included in the above table. These review findings feed into the AH HMRG meeting.

- In quarter 2 23_24 there were 2 babies who died at AH after a transfer of care from LWH, there were issues identified for these cases which did not affect the outcome for the baby including not achieving golden hour on admission and an unplanned extubation in the delivery room.

Table 5. Reasons for review panel grading B, C & D

(Neonatal PMRT may involve multiple service providers; learning for LWH only included in this report)

Review panel grading	Antenatal / Intrapartum Neonatal Bereavement	Reason for grading	Level of investigation(StEIS/Level 2/Level 1/PMRT with external)	HSIB (yes/no)	Learning	Actions / QI plan aligned to theme
B	Antenatal / Intrapartum	Delay in repeat CTG	PMRT with external	No		
C	Neonatal	Non-colocation with paediatric surgical services	PMRT with external	No	LNP development	AH NICU development
C	Neonatal	Lack of neonatal awareness of relevant maternal microbiology results	PMRT with external	No	Need to understand the process of the neonatal team being aware of relevant maternal results.	Discussion at intrapartum working group for process / responsibilities
B	Neonatal	Not achieving golden hour for fluids and antibiotics at birth Unplanned extubation	PMRT with external	No	 During CXR	Ongoing QI project Ongoing monitoring of rates UE following QI project
B	Neonatal	Unplanned extubation	PMRT with external	No	During CXR	Ongoing monitoring of rates UE following QI project
B	Neonatal	Hypothermia	PMRT with external	No	Occurred during line insertion	QI project on thermoregulation during admission process has commenced

a. PMRT PANEL ATTENDANCE

5 MDT Neonatal PMRT panels held for Q3 babies, all had at least 1 external representative. All meetings had an external neonatologist,1 of the 4 meetings had an obstetric, midwife and neonatal external panel member, 2 meetings had an external neonatologist and midwife and 1 meeting had an external obstetrician and neonatologist.

Panel meeting	External Neonatologist	External Obstetrician	External Midwife
October	✓		
October	✓	✓	✓
November	✓	✓	✓
January	✓	✓	✓
January			

4. TERM NEONATAL DEATHS (in-hospital deaths – for Level 3 units add deaths in Alder Hey)

There were 3 term neonatal deaths in LWH, 1 baby who died in the delivery room had renal agenesis, 1 baby was a post-natal transfer with severe hypoxic ischaemic encephalopathy. There was a third baby who was known to have congenital cardiac anomaly who deteriorated unexpectedly and is currently an open coroners investigation.

5. SAFEGUARDING/UNBOOKED AND LATE BOOKERS

1 baby who died in the neonatal period during Q3 was born to a woman who had previous safeguarding issues identified, but the case had since been closed to safeguarding. No late bookers or unbooked pregnancies.

6. SOCIO-DEMOGRAPHICAL

9/17 babies were extremely premature (<28 weeks). 8/17 babies died within the first 7 days of life, 5 in the neonatal period (7-28days) and 4 in the post-neonatal period >28 days of life.

Ethnicity data available shows 11/17 babies born to mothers of white -British background, 1 mother of polish origin, 1 mother of mixed white / Asian origin, 1 described as white other and there were 2 babies born to mothers of black-African origin and 1 described as black other.

Of 17 babies, 8 died within the first 7 days of life, 5 between 7 and 28 days of life in the neonatal period, and 4 in the post-natal period up to 95 days of life.

Of the 17 deaths in Q2 IMD data was available for 14 based on home postcode at booking, 7/14 families live in the lowest decile of index of multiple deprivation.

7. LANGUAGE BARRIERS

2 families did not speak English as first language and required interpretation to support communication.

8. FETAL ABNORMALITIES DEATHS (known and unknown)

5 deaths were associated congenital anomalies including 1 case of hydrops fetalis, 1 baby born with dilated cardiomyopathy, 1 baby with multiple chromosomal abnormalities, 1 baby with renal agenesis and pulmonary hypoplasia and a congenital enzyme deficiency.

9. LEARNING / GOOD PRACTICE.

Below are comments received from families through the PMRT parent feedback process.

- This was very unexpected and everything happened extremely quickly, but we felt supported and looked after both in the run up and during the birth
- We think the Neonatal Unit in Liverpool Women's Hospital is exceptional, and the care and compassion from the staff towards both ourselves and [redacted] during her time there was wonderful.
- I was provided with expressing support by the nurses on NICU which felt very caring and sensitive. I felt supported and encouraged and this was a significant positive in an overwhelmingly awful situation. I was able to confidently take this knowledge and ability forward and developed a good milk supply while at Alder Hey.
- Midwives on Maternity base at Liverpool Womens - absolutely AMAZING!
- Midwives offered amazing support throughout entire stay in hospital, including after [redacted] death and truly became like a second family. They offered support when i needed it, came for a chit-chat when i was lonely, they explained things to me in a simple way so i understood, they went above and beyond.
- excellent facilities for NICU parents at the liverpool womens hospital. it was amazing to be able to stay in a room at the hospital, especially as we didnt live local. It allowed us to be with Hope as much as we wanted and be close in case of an emergency. it had cooking facilities available and food. It was a real comfort in a difficult time to have this available. This also extends to free parking, allowing us to come and go to shops etc without the concern for money. Excellent nurses, doctors and facilities within the NICU.
- Excellent team - offered so much support. Met us rather soon after Hope was born and became a familiar face quickly. Was very understanding and compassionate. Listened when we needed to talk in the hospital and offered support afterwards.

Trust Board

COVER SHEET

Agenda Item (Ref)	***24/25/009***	**Date: 11/04/2024**
Report Title	**Integrated Governance Report Quarter 3 2023/24**	
Prepared by	***Allan Hawksey, Head of Risk and Safety***	
Presented by	***Allan Hawksey, Head of Risk and Safety***	
Key Issues / Messages	This report provides information of oversight and assurance monitoring of Integrated Governance and highlights key risks to the Trust evidencing any embedded learning divisionally and cross divisionally. The reports provide a detailed overview of Qtr. 3 2023/24 in relation to Integrated Governance. The report provides assurance in relation to the oversight and control of risk and demonstrates appropriate learning and improvement across the Trust.	

Action required	Approve ☐	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to receive the report, note the contents and take assurance from the systems of control and learning evidenced across the Trust			
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*		Comment:					

more BAF risks 3.1 Failure to deliver an excellent patient and family experience to all our service users 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

EXECUTIVE SUMMARY

The Integrated Governance Report Quarter 3 2023/24 forms part of the regular reports received by the Board to provide oversight and assurance in relation to Quality, Safety and Risk Management

The Trust is actively addressing challenges, promoting a positive reporting culture, and implementing initiatives to enhance patient safety, health and safety, and overall quality of care, all detailed within the appendices of the report. Ongoing monitoring and collaboration are key elements of the organisation's strategy for continuous improvement.

Pending Board approval of the reviewed Risk Management Strategy, this report will become increasingly risk and less data focussed. The data currently within the report will be used to drive the risk profiles of the Trust and focussed on key actions within those risks, to manage, mitigate and drive quality and safety improvements, and will align more with the Trust improvement plan for 24/25 and beyond.

The Board are requested to note the contents of the paper and take assurance that there are sufficient governance processes in place consisting of divisional and corporate oversight to mitigate and manage risks. The Board are asked to take note that feedback from the previous reports has been acted upon, and the additional information requested has been incorporated into the latest report.

MAIN REPORT

The report highlights the following key areas to the Board:

1. **Incident Reporting and Patient Safety:** There is a slight decrease in incident reporting, particularly in blood sampling errors. The report outlines the types and severity of incidents, including a never event that is now under a Patient Safety Incident investigation (PSII). The integration of blood sampling errors with the Pathology Steering Group is emphasised.
2. **Controlled Drugs Management:** The report highlights concern around the administration and documentation of controlled drugs within maternity & neonates. There are no themes identified which were subject to divisional review.
3. **Health and Safety:** The organization has made efforts to enhance health and safety awareness, evidenced by an increased reporting in non-clinical incidents.
4. **Complaints and Patient Communication:** There was a decrease of 11 complaints. 78% of the complaints received relate Gynaecology Services. A Task and Finish group is established to address appointment issues and improve patient communication in Gynaecology. Initiatives like text reminders for appointments are implemented. We would expect to see an improvement within the reporting for Q4.

5. **Clinical Audits and Quality Improvement:** Compliance with clinical audits is emphasized, with specific achievements in areas like 100% of ultrasound examinations being reported in one day. The report underscores the importance of ongoing improvement projects, collaboration, and the development of a quality statements.
6. **Legal Claims and Scorecard:** The report mentions the number of active claims, and a current Trust position.
7. **Incident Investigations:** The report provides insights into serious incidents, Patient Safety Incident Investigations, levels of patient harm and challenges related to submission delays.

Risks:

1. **Blood Sampling Errors:** The continued high level of blood sampling errors poses a key risk to patient safety although there were no identified delays to patient safety care.
2. **Controlled Drugs Management:** Issues around the administration and documentation of controlled drugs pose potential risks, requiring robust management of improvement strategies.
3. **Overdue Serious Incident Investigation Actions:** Identified as a risk to the Trust being able to demonstrate robust responses to learning and embedding change as a result of findings identified as a risk.

Positive Assurances:

1. **Positive Reporting Culture:** The Ulysses data reflects a continuous positive reporting culture with more incidents of no harm, low harm and near misses. The levels of harm have also decreased.
2. **Learning and Improvement:** The report highlights embedded learning from incidents, divisional plans to manage risks, and evidence of positive changes in practice and culture.
3. **Quality Improvement Initiatives:** The commitment to ongoing quality improvement initiatives and collaboration through networks are aligned to the trust's improvement priorities.

CONCLUSION & RECOMMENDATION

This report seeks to provide assurance as to the Governance Systems in place in LWH and that staff are being open by reporting incidents, clinical and non-clinical, to ensure patients and staff safety is maintained. The Ulysses data clearly demonstrates a continuous positive reporting culture across all Clinical Divisions and Corporate Services

There remains ongoing work across all Divisions via their integrated governance reports but triangulation has significantly improved since the last quarter. The divisions have been able to demonstrate:

- Key areas of risk affecting patient safety and quality of services
- Divisional plans to manage and mitigate those risks.
- Evidence of embedded learning Divisionally and cross Divisionally
- Plans for audit of embedded learning within 6 months of learning being identified (As per Ockenden within Maternity but that expectation is across all Divisions) and how assurance is gained, 6 months, 12 months and beyond that learning is embedded, practice and culture has changed and there is clear tangible evidence of improved patient safety outcomes.

It is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place with ongoing support from the Corporate Team and that there is positive progress in managing risk across the Divisions with Senior Management having oversight of such risk.

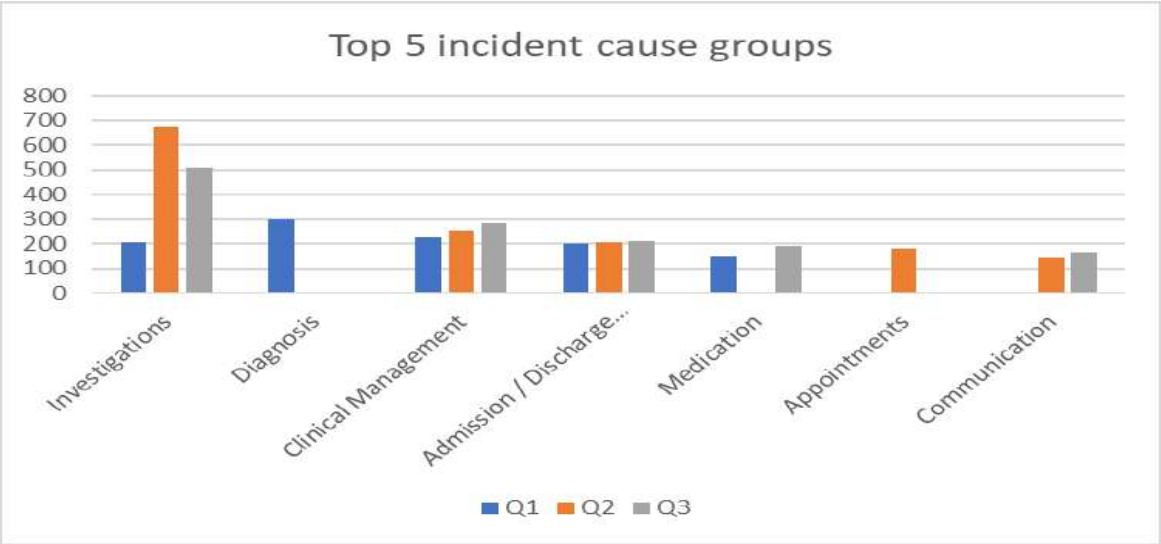
APPENDICES

1. Incidents

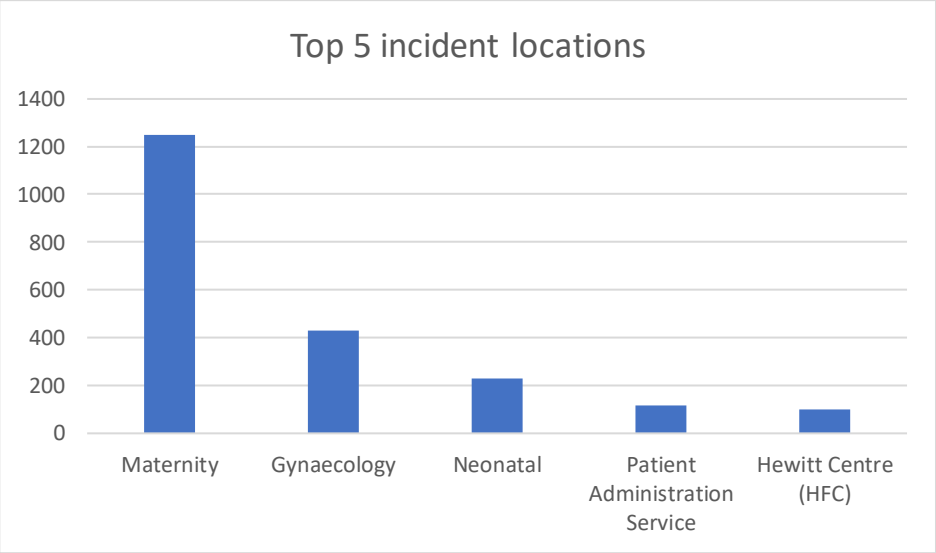
HEADLINE - A continued key area of risk for Q3 was within the investigations cause group (508 – a slight reduction from 671 in Q2) relating to:

1. **Inadequately Labelled Sample (258) of which 203 relate to Maternity (Community 99, Delivery Suite 45) and 42 to Gynaecology (GED 23 and Gynaecology Unit 15)**
2. **Incorrect details on report – Investigations (77) of which 47 relate to Maternity (Community 17, Delivery Suite 12) and 23 to Gynaecology (Gynaecology Unit 11 and GED 9)**

- 2506 incidents reported in total.
- Decrease of 42 incidents compared to Quarter 2 23/24



Cause Group	Q1	Q2	Q3
Investigations	204	672	508
Diagnosis	298		
Clinical Management	225	256	285
Admission / Discharge / Transfer	201	208	209
Medication	145		193
Appointments		180	
Communication		141	165



Maternity	1251
Gynaecology	428
Neonatal	230
Patient Administration Service	116
Hewitt Centre (RMU)	98
Total	2123

Total number of incidents reported across Q3 for 2023/24 compared to 2022/23 and 2021/22.

2021-22	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total	557	636	498	510	468	835	597	718	577	686	657	657	**7396**
Quarterly	**1691(>279)**			**1813 (>122)**			**1892 (>79)**			**2000 (>108)**			**(>2626)**
2022-23	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**total**
Total	641	693	500	700	658	627	849	665	509	616	653	735	**7846**
Quarterly	**1834 (<166)**			**1985 (>151)**			**2023 (>38)**			**2004 (<19)**			**(>450)**
2023-24	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**total**
Total	502	658	777	726	898	928	885	931	690				**6995 to date**
Quarterly	**1937 (<67)**			**2552 (>615)**			**2506 (<46)**						

The tables above indicate the key areas of risk for the trust and the numbers of incidents reported since 2022/23 for comparison. The top risk is still a concern despite improvement with actions to address outlined below.

Patient Safety Incidents (PSI's)

2225 total PSI for Q3 (Trust wide) and a decrease of 136 when compared to Q2 in 2023/24

Family health (1387)	Gynae (Inc HFC) (559)	CSS (170)
Investigations 385	Investigations 95	Patient Records / Identification 22
Clinical Management 213	Appointments 72	Clinical Management 22

Medication 136	Diagnosis 70	Investigations 21
Admission / Discharge / Transfer 133	Communication 66	Medication 19
Midwifery Red Flag 98	Admission / Discharge / Transfer 52	Equipment 18

This gives the key themes for the incidents across the divisions who review the incidents for themes, patterns, and trends, acting as appropriate. These are reviewed cross divisionally to provide any particular focus of trust wide actions. The are detailed within the divisional updates towards the end of this report.

Actual impact of Patient Safety Incidents

Row Labels	Count of Actual Impact
2 No Harm	1797
3 Low Harm / Minor	287
1 Near Miss	43
4 Moderate Harm - Moderate	19
7 Death (NOT Caused By A Patient Safety Incident)	9
5 Severe Harm / Major (Serious)	1
(blank)	To be finalised

Improvements and actions

The Trust has merged the blood sampling errors group with Pathology Steering Group who have overall accountability of the work that is led by Joe Downie (DCOO), meeting monthly. Liverpool Clinical Laboratories are reviewing the processes within Digicare. This includes ordering, results and mobile phlebotomy. This work has progressed well with data reflecting improvements seen with training and education delivered. It is anticipated that this will have an impact moving forward and a reduction in repeat blood sampling errors reported from Q3.

2. Medicines Safety

HEADLINE: Medication incident reporting increased during Q3 with Maternity (50 to 76) and Neonates (50 to 67) showing the largest increases (see graph below). The governance teams across Family Health have started to review these incidents as part of a thematic review. No significant themes have yet to be identified. It is considered likely that the increase is aligned with the general rise in reporting of medication incidents which signals an improving safety culture.

Medication Safety Week (#MedSafetyWeek) was promoted in early November and focused on sharing learning from recent medication incidents around Controlled Drugs (CDs) that had occurred across the Trust.

A stocktake paper was presented to Safety & Effectiveness Sub Committee in December that described the gaps identified during an initial review of the Medicines Management and Pharmacy Service provision in the Trust. Initial work will focus on placing individual risks resulting from service deficiencies on the appropriate risk registers.

Actions & Improvements

Division	Area noted for improvement	What are we doing to improve the position both short and long term
Family Health	Administration of IV antibiotics	QI project to increase the number of IV antibiotics that are administered within the "golden hour" following sepsis screening for neonates.
All areas	digiCare training	Refresher training has been delivered as part of an on-going plan to clinical staff regarding the MAR module on digiCare to aid the correct and safe administration of medicines. Current training take up is being collated and monitored by Medicines Safety Group reporting in Medicines Management Group.
Gynaecology	VRII (Variable Rate Insulin Infusion)	The management of diabetes patients in gynaecology guideline has been updated to include the VRII pathway and rolled out across the gynaecology ward. This is so diabetic patients will get the correct does of insulin in a timely manner.
Theatres	Expiry date checking	The My Kit Check module has been amended in theatres to facilitate an improved process for checking the expiry dates of medication. These actions were identified by CQC in January 2024 with an action plan in place as a result. This action is now completed with continuing monitoring to ensure it's embedded.
Maternity	TTO communication	A digital board has been employed on Matbase which demonstrates the processing of TTO prescriptions for staff and improves communication between the ward and pharmacy.
All areas	Learning from medication incidents across the Trust	LOTW shared with senior staff across all areas for dissemination across teams; *#MedSafetyWeek, World Antimicrobial Awareness Week, Labelling medicines for IV administration, Processing TTOs out of hours, Administering medication via the wrong route.*
All areas	Learning from medication incidents across the Trust	Safety Check In covering topics including; *World Thrombosis Day, Fridge monitoring & Monika, Nicotine Replacement Therapy (Stoptober), World Antimicrobial Awareness Week, Patient concordance, NHS Never Events relating to medicines.*

3. Health & Safety

HEADLINE – In Q3, there were 33 non-clinical health and safety related incidents reported, an increase of 12 incidents from the previous quarter. Family Health and Gynaecology Divisions reported the highest number of incidents of 12 per division; Clinical Support Services reported 3 incidents and the Corporate Function reporting 5 incidents. All incidents were appropriately managed, and all processes were followed. There was 1 RIDDOR

reportable staff incident involving exposure to a corrosive substance, which was declared a serious incident. A thorough investigation was undertaken with prompt actions taken to reduce further risks of similar incidents occurring.

A breakdown of all non-clinical health and safety incidents, reported in quarter 3, are detailed in the table below:

	FAMILY HEALTH	GYNAECOLOGY & RMU	CSS	CORPORATE FUNCTION	TOTAL
PERSONAL INJURY/ILL HEALTH	5	2	1	1	9
NEEDLESTICK INCIDENTS	4	3	1	1	9
SLIPS, TRIPS & FALLS	1	3		3	7
COSHH	3	2			5
ENVIRONMENT			1		1
COLLAPSE/COLLISION	1				1
TOTAL	14	10	3	5	32

Improvements and actions:

Work remains ongoing to increasingly raise the profile of the Health and Safety Team, making Health and Safety everyone's business and growing the Trust network of health and safety advocates. The Health and Safety Group meeting, chaired by the Head of Risk and Safety, continues to be well attended by all Divisions. Planning continues in readiness to conduct a quality improvement exercise and relaunch of Health and Safety matters.

Residual actions remained following the Mersey Fire and Rescue Service fire inspection. These have now been completed.

MHRA central patient safety alerts continued to be well managed, and alerts actioned within defined deadlines. A CAS Leads and Deputies revalidation exercise commenced towards the end of the quarter.

4. Patient Experience

a. Complaints, PALS, and PALS+

HEADLINE - Complaints in Q4 23/24 saw a decrease of 11 complaints compared to the previous quarter, and a decrease of 2 compared to the same quarter in 22/23. Gynaecology Services division, which incorporates Gynaecology and the Hewitt Fertility Centre services, accounted for 78% of the received volume, the Trust are working hard with patients and families to address concerns raised at source to achieve local resolutions.

The number of PALS + cases dealt with this quarter has decreased by 18, with the Gynaecology Division still conducting the majority of these, with the hope that these address concerns at an earlier stage. Work continues to promote the PALS + process provisions to achieve early resolution of concerns and provide more timely outcomes for people raising concerns. The trends show that this has a positive impact on reducing the number of complaints needing to be raised when it is consistently used.

591 PALS cases were received in this quarter which is a decrease of 124 cases overall. Initial end of quarter review has highlighted areas which have been highlighted as main concerns raised:

- Communication with patient and Information requests are the top concerns raised in this category.
- Appointment availability

The main issues are:

- The extended waiting time for initial appointments following referral and follow up appointments.
- Difficulties getting surgery dates and surgery being cancelled, sometimes having 2 or 3 pre op appointments (as they had expired) whilst they wait for their surgery date.
- The most cases received by a division was 329 (56%) PALS cases which were received this quarter by Gynaecology. With the busiest month being noted as October 23.
- The PALS service is continuing to see an additional increase of contacts with patients who, after speaking to other staff in the hospital, both clinical and non-clinical, were advised to contact PALS to get their delayed appointment issues addressed. We are working to resolve this alongside local leaders to drive further improvements.
- Patients are all aware nationally of the waiting lists across the NHS and that fear of not getting their own appointment is leading to an increase in more forceful queries being raised to try and expedite their own case. We are having open and honest conversations with patients about this to manage their expectations.

In January 24 LWH have started to send our validation texts to patients on the follow-up waiting lists- sending to patients that are overdue their follow-up appointment or have been on the follow up WL for over 12 weeks.

This will help to decrease the concerns raised regarding appointments and the impact will be seen in the Q4 report.

Improvements and actions:

Face to face availability for the PALS service continues to be provided and utilised by our patients and a Help Hub at the main entrance has been created that is more open and more interactive by reducing the barriers of doors and windows. The feedback has been positive and both staff and patients are enjoying using the new facility. There is also the opportunity for patients to access the help hub to access help and support from visiting charity leads to discuss concerns with charities who are working with the Patient Experience Team who are great support for staff and patients.

b. <u>Patient Experience</u>

HEADLINE – Divisional FFT "you said, we did" reports are now a standing item on the Patient Involvement and Experience Subcommittee. This enables greater visibility and promotion of the improvements being implemented from the FFT and allows this learning to be shared across the various divisions who attend this meeting.

Friends and Family Test (FFT) – overview

FFT reports are scheduled and sent to all divisions on a weekly basis highlighting the comments that need reviewing and addressing, both positive and negative. Divisions have been encouraged to consult with the patient experience team if there are any specific reports that they need creating to assist with this review. F&F review is included in the Divisional reports required to be presented. KPI has been introduced to monitor the response initially to the displeased responses provided.

FFT results for Q3 2023/24

Total	Maternity	Gynaecology	Genetics	Reproductive Medicine (RMU)
2611 ↑	357 ↑	1530 ↑	59 ↑	217 ↑

Overall experience score (satisfaction report) – this score is based on the responses to the question "Please rate your overall experience (Poor=1 to Good=10)"

Trust score %	Maternity %	Gynaecology %	Genetics %	Reproductive Medicine (RMU) %
89 ↑	84 ↑	88 ←	91 ←	90 ↓

Recommendation score - this score is based on the responses to the question "*Thinking about the service we provided, overall, how was your experience of our service*?"

Trust score %	Maternity %	Gynaecology %	Genetics %	Reproductive Medicine (RMU) %
91 ←	88 ↑	90 ↓	92 ↓	93 ↓

The FFT ask patients some equality monitoring questions to enable us to monitor if any of these characteristics are having a detrimental impact on their experience by comparing both overall experience and recommendation scores. These are reviewed under three categories:

- **Age**
- **Ethnicity**
- **Disability**

Please note all respondents are allowed to leave these sections blank when completing the FFT. These blank responses are still stored but are not reported in these figures.

Improvements and actions:

Divisional FFT "you said, we did" reports are a standing item on the Patient Involvement and Experience Subcommittee (PIESC). This enables greater visibility and promotion of the improvements being implemented from the FFT and allows this learning to be shared across the various divisions who attend this meeting.

These are also displayed in the patient and public areas of the relevant area. This is to promote the work done and also encourage more responses and patients see how we have acted on their feedback providing assurance to patient's that raising their concern can make a difference to patient care.

Below are some examples shared at the PIESC covering Q3 23/24.

CLINICAL SUPPORT SERVICES		
Department	**What we heard**	**What we did**
Genetics	There are national guidelines for who, and in what clinical situation, genetic testing is possible and so any patients who are eligible will be offered testing. If a patient is not eligible this is explained by the clinician during their appointment, but this has obviously not been satisfactory for some patients.	We regularly remind staff to mention F&F to patients during their appointment. We now have the QR code for the F&F message that Genomic Medicine patients receive and this has been displayed on the notice boards in the patient waiting area. We have asked that all patients attending Genomic Medicine appointments be sent F&F but we are still awaiting a response from IT to clarify if this is the case for patients attending peripheral clinics.
GYNAECOLOGY		
GED / EPAU	All displeased responses relate to the waiting time to see Doctor following triage	A review of the escalation policy has been completed and with increased scrutiny and application in times of increased activity.
	Access to USS scan	Plans have been made to increase clinics in the Early pregnancy assessment unit on a demand-based schedule to avoid any women waiting longer than 72 hours for their early pregnancy scan. From a workforce perspective sufficient resilience in terms of those staff with the right skills and experience to build on scanning capacity has been highlighted with in the division as a risk, participation and engagement in the Ultrasound Improvement group has also highlighted this trust wide deficit.
OPD	Waiting time for appointment	A daily review of all waiting times is a core component of activity management within the division. Increased demand for RAC appointments due referral volume has led to cancellations on occasion of general Gynae. In addition, lost days due to industrial

		action has seen a loss of 620 patient appointments. This continues to be a focus for Gynae Division and an overview report of the contributory factors/ Challenges is being prepared by the admissions team manager.
OPD	Waiting time once in the Department	Communication with the outpatient Department in the event of an unplanned cancellation is of paramount importance and allows the Nursing team to inform patient immediately, the communication process is being reviewed by the Divisional Clinical Lead and Operational Manager. With regards to Reception staff support has been given by Digital Nursing who have worked closely with the admissions team manager to support competence use of the new EPR system.
OPD	Interaction with Dr 'dismissive' 'didn't listen'.	Specific feedback has been shared with the Clinical leads and shared at sup speciality meetings.
FAMILY HEALTH		
Matbase	Service users requested that we increase support person visiting including overnight.	Maternity ward has piloted the 24-hour visiting in response to our service users, the pilot was extended and remains in place. Matron is currently working with MNVP, and patient experience midwife and a report will be presented at the PIESC with the outcomes from both patient and staff feedback.
Matbase	Lack of information upon discharge for the transition from hospital to home.	The manager and matron are working with the MNVP and other agencies to produce a discharge booklet that will provide all the required information for service users to feel confident when they are discharged from the hospital.
Delivery Suite	Birth rooms on the delivery suite were allocated to increase IOL beds, this as impacted on the flow through	As part of the improvement project qualitative and quantitive data will be collected, maternity is currently undergoing extensive work to provide an area for low-risk inductions to enable a reduction in delays for both high risk and low risk IOL. As part of the IOL improvement group a six-month post for a senior midwife as an IOL

	the delivery suite and caused delays in the IOL process. Feedback through complaints, PALS' and FFT from our service users highlighted this as a concern.	coordinator has been appointed, with priorities to review the IOL process, expanding use of IOL agents, and ongoing information provision. Plans include providing a window of time to be managed as an outpatient and called in when IOL to be commenced. The current estate has been reviewed and funding agreed to move low risk IOL to a new area to increase capacity for the delivery suite, with a view to reduce waiting times and increase patient experience.
Midwifery Led Unit	Service users have reported they have been unhappy with having to leave the pool to go to another room where a bed is available, they have stated lack of dignity with having to walk through a corridor to get to another room.	Estates work has commenced on the midwifery led unit making the rooms larger to enable all the required equipment as well as a pool is available for all service users.
Maternity Assessment Unit	Postnatal service users have requested a private area where they can breast feed their babies privately.	Ward manager and matron have now identified a private room where service users who return to the MAU can feed their babies with privacy and dignity.
Community	Women informed the midwifery managers that they were unaware that they were required to book their own 15-week GP appointment following Dating Scan. A simple intervention of	Midwifery staff now provide a reminder to all service users to ensure 15-week appointment is booked. This information is captured within power BI team leader awaiting response from data team to review compliance. The community matron reports that they are in the process of collecting data to ascertain if compliance has improved.

	Midwifery staff now providing a reminder to all to ensure 15-week appointment is booked has improved timely attendance.	

5. Continuous Improvement

a. CLINICAL AUDIT AND EFFECTIVENESS

HEADLINE – The Trust received 8 Clinical Audit Reports including Action Plans in Quarter 3.

Key successes from Clinical Audits completed Quarter 3

- As part of the provision of routine childhood immunisations and Hepatitis B vaccination at LWH there was written consent gained in all babies, the vaccination was given at correct time in all babies eligible/suitable, and rotavirus was given before day 104 in all babies as recommended.
- 90.1% patients were screened within the recommended time window during retinopathy of prematurity screening and treatment.
- Amendments made to the approval checklist on Patient leaflets has shown to have greatly improved results overall.
- There were no incidents of Wrong Blood in Tube (WBIT) at LWH detected as part of the National Comparative Audit of Blood Sample Collection and Labelling for the specified data collection time frame despite this incident being on the rise nationally.
- As part of the Image Quality of Posterior-Anterior Chest X-rays audit there was 95% compliance of images being of diagnostic quality with no need to repeat any examinations.
- All recorded Dose area products (DAPs) were compliant with the local diagnostic reference level (LDRL) for the Ionising Radiation Regulations re-audit.
- 100% of ultrasound examinations were reported in one day and overall improvement in time taken for reports to be completed.
- There is clear evidence that staff are routinely asking about Early Help, recognising additional needs, and are appropriately referring families for support. There are also positive examples of interagency/collaborative working.

Key themes to be actioned as a result of Clinical Audit reports received in Quarter 3 which are monitored via the Clinical Audit & Effectiveness Team and Quality Improvement Group (QIG).

- As part of the provision of routine childhood immunisations and Hepatitis B vaccination at LWH, not all patients were prescribed paracetamol following routine vaccination, very few babies had a swab alert completed on Badgernet, and not all babies had documented barrier nursing on Badgernet. Work is ongoing within the trust on e-consent for vaccinations that will improve these issues and work is ongoing with the NICE low dependency nurses regarding swab alerts and documented barrier nursing to be placed on BadgerNET.
- As part of the retinopathy prematurity screening and treatment it was identified that 4 babies had a poor structural outcome, further analysis as well as an MDT will be performed to reflect on those cases.
- Approval form to be amended to include if patient leaflets have been reviewed by patients with additional needs, and if it is likely that the leaflet will be read by patients under the age of 18, that they been consulted also.
- Training compliance for Blood sampling collection and labelling remains low in Family Health therefore direct training was completed within the clinical areas to improve compliance and an accurate sample error reporting database is now accessible to identify staff involved in incidents.
- As part of the Image Quality of Posterior-Anterior Chest X-rays audit rotation was the area with the most scope for improvement and will be targeted as a priority by the radiographic team. This audit has been disseminated at Imaging team meeting as well as to all radiographic staff via email.
- It was identified as part of the Ionising Radiation Regulations that last menstrual period (LMP) guidance was not followed for all patients of childbearing potential. LMP forms are now scanned on to CRIS for each female of childbearing age.

- The digital reporting log for X-rays will be spot checked monthly to ensure daily checks are being carried out to ensure we improve in compliance levels on the next audit cycle.
- The plan is to implement neglect/risk screening toolkits for staff to improve identification of concerns and professional decision making.

Improvements and actions:

Where audits have determined that the level of expected standards have not been met, there are significant Divisional action plans formulated to address issues highlighted. All audits are reviewed by the Quality Improvement Group (QIG) and actions either approved or amended and updated where required. These are divisionally led and monitored by the Clinical Audit and Effectiveness (CAE) Department. The outcome of such action plans is subsequently reported back in to QIG where a further audit may be required. There is considerable oversight of all audits by QIG and the Continuous Improvement Team Department.

b. QUALITY IMPROVEMENT

HEADLINE – The Trust has improved capacity and capability to deliver and support improvement activity through provision of structured learning.

Key areas of activity from Q3 2023/24

- 9 staff in key positions within the Trust completed their QI Evolve (practitioner) learning with AQuA in Q3.
- 5 staff started the AQuA QI Excel (leadership) which concluded in March 2024.
- Learning is being provided at an introductory basic/level via the AQuA Hub (on-line platform), and the Trust's leadership programme.
- 15 additional improvement projects were registered in Q3.
-

Plans for Q4 and beyond – incorporating improvement in every Trust process

The work with AQUA will continue throughout Q4 to ensure we have the capacity and capability to support an embedded culture of improvement across the Trust. AQuA has agreed to the next cohort for QI Evolve being co-facilitated. This will mean we have our own staff accredited to deliver the learning which will in turn increase our control and capacity. Processes to register and manage improvement projects will be further reviewed and simplified to facilitate rapid improvement activities.

Platforms have been identified and secured to recognise and celebrate improvement projects. A main reception notice board and a revised structure for outcome posters will be used to share information. The Trust will explore the potential for closer working with improvement specialists from the Cheshire and Merseyside Improvement Network, and in particular, colleagues at LUHFT.

Priorities to make this happen continue to be:

- Completion of the AQUA QI learning at basic, practitioner and leadership level
- Development of a shared language and approach to improvement
- An improved focus on safety and health inequalities within projects
- Clearer evidence of embedded learning as a requirement for all improvement projects
- Fuelling staff motivation through the communication of success stories, positive feedback, and actions
- Being data driven, being clear about post benefit analysis
- Creation of digital platforms to support our continuous improvement work

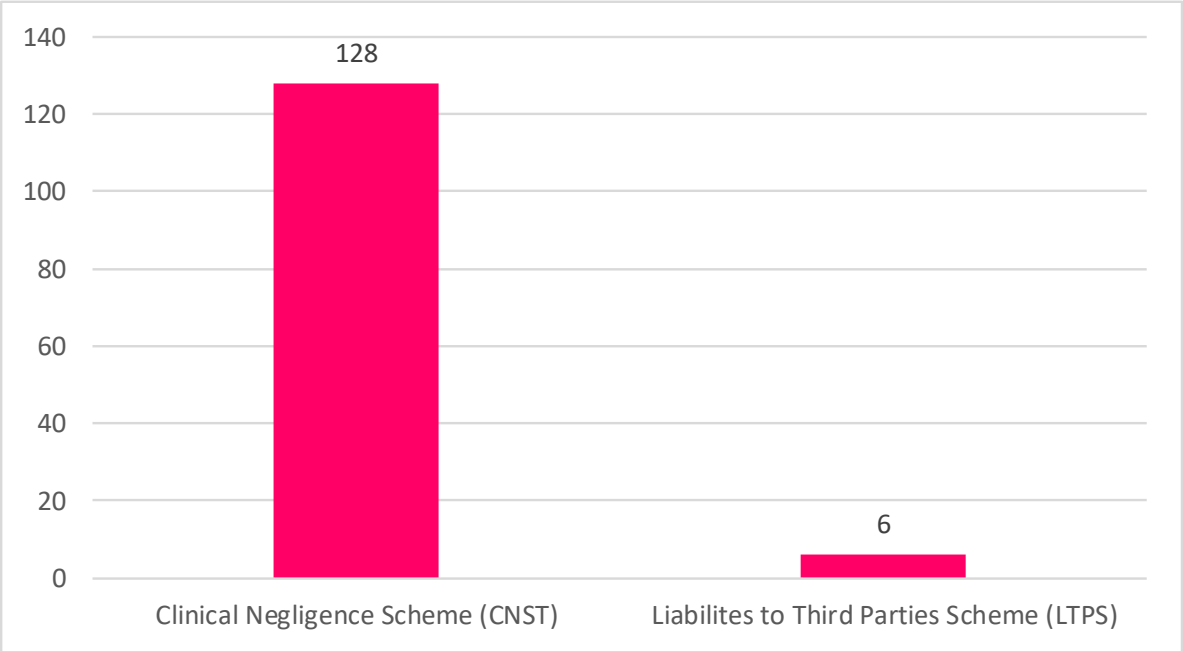
- Learning from other organisations, locally & nationally

Improvements and actions:

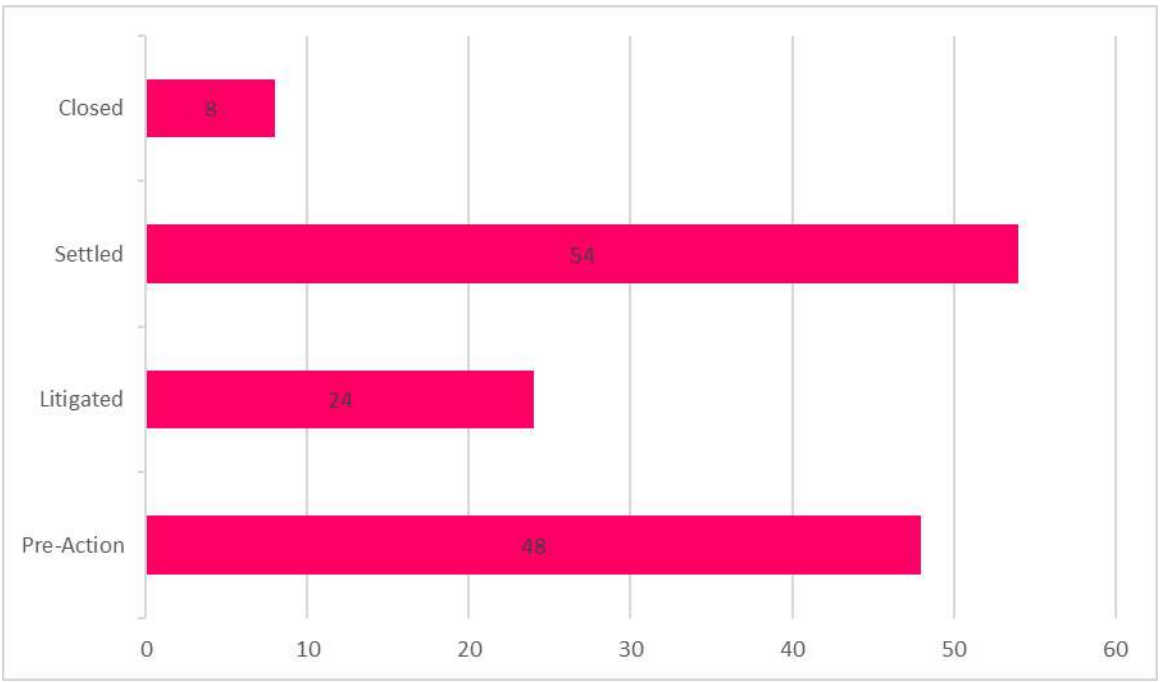
The team will maximise the opportunities for learning and efficiencies afforded by engagement with local networks. They will continue to make more efficient use of the limited resources available through a further review of key processes, the development of skills and knowledge within the team, and an increasingly flexible approach to the work of the Governance and Quality Team.

6. Legal Services

HEADLINE: As of 31 December 2023, there were 134 active, 'open' claims: 128 Clinical claims and 6 non-clinical claims.



The current procedural position of these claims are as follows:



The following table shows all new and settled Clinical Negligence Scheme for Trusts (CNST), Liabilities to Third Parties Scheme (LTPS), Early Notification Scheme (EN) and Inquest cases between 1 October to 31 December 2023.

Month	CNST		LTPS		EN		Inquest	
	New	*Closed*	*New*	*Closed*	*New*	*Closed*	*New*	*Closed*
October	4	6	0	1	0	3	1	0
November	2	8	0	0	1	2	1	0
December	2	6	2	0	1	0	0	0

Improvements and actions:

The Legal Services team continue to circulate claims data to the divisions on a monthly basis, incorporating both new and closed claims data. Upon receipt of a Letter of Claim, Legal Services will notify the relevant division providing a copy of the Letter of Claim, NHS Resolution's initial financial reserves and any incident or complaint documentation, if any, to ensure triangulation and learning.

7. Serious Incidents, Patient Safety Incident Investigations and identified learning

***HEADLINE* – There were 11 Patient Safety Incident Investigations declared to the Integrated Care Board (ICB) during Q3 (an increase of 1 incident investigations from Q2) – 5 in October 4 in November and 2 Patient Safety Incident Investigations (PSII) in December.**

Serious Incidents / Patient Safety Incident Investigations declared, and final reports submitted to the ICB

All Serious Incidents / Patient Safety Incident Investigations had full duty of candour completed accordance with the current Trust policy.

Although deadlines to complete investigations are not nationally mandated, the Trust has set itself a target of concluding its investigation within 60 working days. This was not achieved in Q3 due to competing priorities for the investigators who front line colleagues delivering patient care. There has been a request from the chief nurse and medical director to factor this work in as part of job planning for 24/25. All extensions/delays have been discussed and agreed with the patients with the ICB no longer required to approve them. This process will be reviewed further as part of our first PSIRG review in April 2024.

Of the incident investigations declared, and in addition to any future generation's cases, there was a never event declared regarding a catheter being cut by a clinician, being retained by the patient and subsequently passed. The never event is currently under investigation and part of an ongoing thematic review. (NOTE: There has been a paper submitted to the March 2024 Quality Committee by the chair of the LocSSIPS group and DCMO, providing an overview of recent never events, themes and actions to be taken).

Overdue actions from previous submitted SI's / Serious Incidents

There were 2 overdue serious incident submissions due with the ICB from Gynaecology. Appropriate extensions were agreed with the ICB.

There was 1 Serious Incidents Submitted October 23, 5 in November 2023 and 1 in December 2023. 1 maternity PSII was subsequently considered for de-escalation to the ICB and formally approved.

Whilst the Trust ongoing action plans are not currently externally reportable, the Ulysses System is now being used more effectively to manage divisional action plans. All action plans are updated on to the system following SI submission to the ICB and are monitored Divisionally and Corporately for compliance and reported to the Safety and Effectiveness Sub Committee monthly.

As of 01 January 2024, there were 20 ongoing action plans that had actions overdue. These were subsequently escalated to all Heads, Divisional Managers and Safety Leads to action and all Divisions agreed to have a plan in place to resolve overdue actions which will be monitored via Divisional Governance meetings in addition to the Safety and Effective Sub Committee.

Dissemination of learning from serious incidents

The Trust communicates learning from serious incidents via a few ways such as the following:

- Learning and engagement teams events held online Trust wide for all services to present and discuss learning.
- The weekly safety check in for all services to present and discuss learning
- Governance Boards within the divisions to share learning.
- Trust wide shared learning portal to upload all divisional learning such as 7-minute briefings accessible to all staff
- The Safety and Effectiveness Sub Committee serious incident report
- Staff communications via secure social media
- SBARS

Improvements and actions:

Learning from all incidents is key to being able to demonstrate that the Trust is a Learning Organisation. The Corporate Team continues to work in detail with the divisions to recognise how learning from incidents is captured and evidenced, how it is disseminated to new and existing colleagues, that is becomes embedded as part of practice and culture and that there is tangible evidence that learning has been addressed immediately, embedded after 6, 12 months and beyond and that learning continually evolves from current intelligence and is used to mitigate recurrences as much as practicable.

This has been an area of concern for the trust. As such, a new divisional governance structure was being proposed towards the end of Q3 (this went live in early Q4). It was agreed for governance to managed centrally with the focus to be on demonstrating evidence of embedded learning for incidents in line with our PSIRF plan. It is expected improvements will be clear within the Q4 report.

8. Divisional Triangulation and Integrated Governance Reports Q1

Key learning / assurance / messages identified.

Maternity

- The drive to reduce the Web Holding File continues, this has been impacted by staff shortages and an increase has been seen. This has been escalated within the division. In the interim all new incidents are reviewed daily by the maternity governance team to flag areas of concern. Investigations remains the top cause group with 368 incidents. The maternity sample QI is being reinstated and regular meetings are taking place with maternity governance and transfusion to monitor the transfusion incidents.
- The monthly maternity base multi-disciplinary team working collaboratively with Pharmacy continues and is being developed into a quality improvement project. The meeting takes place on the ward and ward staff input is welcomed. During the reviews, learning and themes are identified. Following the meeting feedback is given to the Matron and actions assigned to address any issues identified. Monthly meetings will continue.
- The learning from claims report is share at maternity risk meeting. A settled claims report is also shared from the safety matron and Risk Consultant with all shift leaders with a request to cascade. The reports provide information on the cases that have been settled by the legal team. They include a summary of the case and the learning that was identified. It also shows what changes have been made following the cases to reduce harm to our patients.
- October saw the last inclusion of Midwifery Red Flag (MRF) events in relation to delays of induction of labour more than four hours. In November this reporting matrix changed to reflect introduction of delays >12 hours to align with national and regional reporting.
- The new Maternity and neonatal voices partnership (MNVP) Vice Chair, Megan Taylor, started in October. She is funded to work one day a week.
- There were 218 FFT tests received in October and November of Q3.191 pleased comments and 27 displeased comments were received, 2 of the displeased comments had no narrative therefore it was not possible to respond. The remaining displeased comments were reviewed, and comments were added to Power BI. This is an improvement from the previous reporting period following training for new managers in post.

Neonates

- There is a shared risk register for all risks within the Liverpool Neonatal Partnership which is reviewed monthly at the LNP Integrated Governance Meeting, to ensure the risks are mitigated and remain on track. There are 7 risks arising out of the Liverpool Women's Neonatal unit which are open and on track.
- Due to the consistent levels of high reporting medication incidents, a thematic analysis is in progress which is reviewing retrospective incident data and staff reflection feedback. To support this analysis, flip charts have been displayed within staff areas within the unit for comments and ideas from staff regarding medication issues with a view to supporting the team's engagement in in the process. An update detailing the outcome of the thematic analysis will be presented in the next quarterly report (Q4 2023/24).
- An emerging risk has been identified regarding the provision of cooling equipment. The risk is in the process of being developed and will report to LNP Integrated Governance Meeting Additionally, the provision of EBME servicing has been escalated trust wide regarding event equipment failures. Mitigations have been identified with regards to onsite cover and training / competencies for those staff based at Neonatal LWH.
- Most of these incidents relate to blood sampling including labelling, minimum dataset not complete and delays in scans/x-rays. The neonatal blood sampling working group are addressing all blood sampling errors within the neonatal unit. This group is led by a neonatal consultant and a member of the neonatal education team. A QI project is in progress to address these errors. A blood sampling paper is in progress and will be submitted to Safety & Effectiveness. The neonatal blood sampling task and finish group address all blood sampling errors. This group meets monthly and is a MDT approach with doctors and nurses in the group. All staff within the department are completing a blood sampling workbook and competency which will be completed annually.
- Liverpool Maternity and Neonatal Voices completed the Fifteen Steps for Maternity visit in December. Feedback was positive specifically relating to the clean ward environment and welcoming staff full of smiles. Display boards were up to date, a special mention was noted for the NICU graduation board and artwork emphasised a co-created inclusive space. Some friendly and personal recommendations were identified to improve patient feedback and work is ongoing to implement the recommendations detailed as follows: Consider what appliances could be added to the family room so there is more choice for parents. Consider some more furniture in the quiet rooms with additional entertainment options of a radio or TV. Consider a small questionnaire that could be distributed once a week or fortnightly to gain more patient feedback that is relevant to specific moments of their stay not just a reflective piece towards the end.
- The neonatal team continue to work closely with maternity services around PMRT which ensure that there is a clear line of sight on neonatal mortality (Risk 2430) throughout the division, working together to see how we can improve care delivery, outcomes, and family experience.
- The neonatal digital team continue to work closely with the maternity digital team with regards to K2 (risk 2419) to ensure that all mother and baby information is accessible to the right person at the right time in the right location. This is not completely resolved but is significantly improved with joint working.

Gynaecology

- There were 98 Investigation incidents reported within Q3. 66 of these incidents relate to blood sampling issues, e.g., Inadequately labelled samples and Haemolysed samples. There have been several actions implemented across the division to support with blood sampling issues.

Attendance at Task and finish group. Divisional action plan co-ordinated by Quality and Safety Matron. Clinical Walkabout completed by Quality and Safety Matron delivering on the job training, ensuring mobility phlebotomy is connected and operational.

- Matrons have met with and listened to the experiences of three women who recently accessed care at the Gynaecology Emergency Department, specific experiences have been shared wider across the Nursing and Medical Team. We have recognised that improvement both environmentally and form a pathway perspective is required for women who attend with either miscarriage or fearful of miscarriage. As a result, our patients experience alongside recent DoH publications regarding Miscarriage care in Early pregnancy are providing us with foundations for relocating the Early Pregnancy Assessment Unit as well as the improving the continuity of care for these women. Additional actions regarding information to patients as well as the provision of compassionate care kits is also being completed.
- The Gynaecology ward have improved the experience for patients requiring Iron and blood transfusions by changing to later appointment times, which allows time for prescriptions to be completed, and treatment can commence on arrival this is following feedback from the patients who were previously having to wait for treatment to commence.
- The Division continue to place patient experience as an important quality measure and the additional workstreams are ongoing that contribute to this. Continue to build upon provision of care for under 18-year-old patients against KSF standards. Stakeholder engagement in Ultrasound improvement group. Lead in Menopause special interest group. Second Trimester Miscarriage training project role out in conjunction with Trust Honeysuckle Team. Gynaecology Consultants are leading on system wide improvement projects for the Women's Health strategy, Menopause, Under 18's Gynaecology, Endometriosis, Colposcopy all of which will improve patient experience

Clinical Support Services

- There has been a reduction in incidents in some of the re-occurring themes across CSS since the previous quarter. This is evidenced by the reduction of Admin Clinical Genetics incidents (-27%) and blood sampling incidents in Gynae Pre-Op this quarter (-60%), indicating that mitigations and actions which have been taken to make improvements are proving to be successful. A new theme which was seen in a high number of incidents relating to issues with Anaesthetics documentation in October / November 23, was managed swiftly and effectively, which was again evidenced by there being no further incidents of this kind reported in December 23.

What happened	Lessons Learnt
Controlled drugs not managed/ stored in accordance with policy	Importance of following CD policy highlighted at Theatre Huddles. Issues highlighted regarding emergency theatre access to drugs to be further explored/ agreed.
Loss of connection with national server for Monika system	Communication with clinical areas during downtime period
Running out of medications in clinical areas overnight	Importance of reviewing datasheets in a timely manner and ensuring these are kept up to date

Fridge items not labelled correctly for delivery	New labels procured and staff reminders issued
Supply of expired medicines to clinical areas	Review of expiry date checking processes and pharmacy staff reminded of responsibilities

Trust Board

COVER SHEET

Agenda Item (Ref)	*24/25/010*		**Date: 11/04/2024**	
Report Title	Bi-annual staffing paper update, July 2023-December 2023 (Q2 &Q3)			
Prepared by	Nashaba Ellahi, Deputy Director of Nursing and Midwifery			
Presented by	Nashaba Ellahi, Deputy Director of Nursing and Midwifery			
Key Issues / Messages	*The Board is asked to note the contents of the paper and take assurance of the actions undertaken to effectively manage and provide safe staffing within Nursing, Midwifery and AHP to support the delivery of safe care.*			
Action required	Approve ☐	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): NA			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board of Directors are asked to recognise and take assurance from the oversight in place to support safe staffing and deliver safe patient care and to agree and support the actions and recommendations within Section 9.0 of the report.			
Supporting Executive:	Dianne Brown, Chief Nurse			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1. Inability to recruit and maintain a highly skilled and engaged workforce that is representative of our local communities	Comment: Risk score of 16 has reduced to 12 in Q3; target 12
Link to the Corporate Risk Register (CRR) – CR Number: The below are service level risks, however for context are highlighted. **Gynaecology** Risk number: 2256 – Risk to staff the Telephone Triage Line (GED). Risk score of 12 has reduced to 8 during reporting period reflecting EPAU pathway review and fewer phone line incidents; target 3. **CSS** Risk number: 2549 – Staff shortages in the Imaging Dept. Initial risk score of 20, however risk score of 12 remains the same as previous reporting period with risk merging with 2048 & 2724 reflecting wider Imaging and US workforce challenges; target 12. **Neonates** Risk number: 2161 – Lack of access to AHP support services. Risk score of 6 remains the same with all staff in post and currently monitoring effectiveness; target 2.	Since the previous reporting period the following risk scores have reduced or closed: **FH (Maternity)** - Risk number: 1705 – midwifery staffing "insufficient midwifery staffing levels as recognised by birth rate plus. Risk score of 12; target 6. **Risk closed in November 2023 as all vacancies filled.** **Gynaecology** - Risk number: 2395 - OPD ambulatory staffing Risk score of 15; target 12. **Risk closed November 2023 as duplicated, and risk merged with 2728.** **CSS** - Risk number: 2579 – Staffing for CDC. Risk score of 12; target 5. **Risk closed as duplicate.** Risk number: 2519 – Risk to staffing the X-Ray on call rota. Risk score of 12; target 10. **Risk closed as residential x-ray on call rota covered, with additional second on call for any short notice absence in plan.** Risk number: 2546 – Reduction of staff in genetic counselling. Risk score of 12; target 4. **Risk closed as posts have been appointed to.**

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
NA			

EXECUTIVE SUMMARY

The bi-annual Nursing, Midwifery and Allied Health Professional (AHP) staffing report is provided to the Board of Directors through the Putting People First (PPF) Committee. The report sets out the Liverpool Women's NHS Foundation Trust (LWH) position in the context of the National Nursing, Midwifery and AHP workforce challenges. This report covers the period from July 2023 to December 2023 (Quarter 2 and Quarter 3). The report provides assurance that there are robust systems and processes in place throughout the year to monitor and manage Nursing, Midwifery and AHP staffing requirements. The report will demonstrate the adoption of a triangulated approach to the bi-annual staffing report and therefore includes discussion of evidence-based tools, professional judgement, and outcomes (e.g., complaints, incidents) to support understanding.

The report was previously presented at Putting People First (PPF) Committee in March 2023. The PPF Committee were assured with the triangulation of information presented provided a Trust wide overview and noted the available divisional level detail. Furthermore PPF, were assured of the divisional actions being taken to address and improve safe staffing.

The summarised report highlights the following main points:

- Demand for Bank and Agency has reduced by 14% throughout Q2/Q3 2023 with demand for the six-month period compared to year on year decreasing by 21% (24,000 hours) which is likely due to substantive staff in post and lower sickness rates than seen in previous years. Bank fill rates have increased by 6% year on year with agency fill rates decreasing significantly (94% reduction year on year) due to tighter controls in place and overall low maternity vacancy rates.
- Vacancy rate (December 2023) remains reduced reflecting 4.87% (wte 50.67) a similar reporting position from previous reporting period (4.66% with 48.00wte, June 2023), with Family Health Division combined reflecting the greatest vacancies (Neonatal, 34.07wte and Maternity, 8.31wte).
- Maternity leave fluctuates between 43.83-49.12wte on maternity leave per month. Maternity leave in December 2023 is 49.12wte across all NMAHP staff groups which reflects 5.03% of total NMAHP staff and an increase from previously reported period where June 2023 saw 40.00wte on maternity leave.
- Sickness has been above target of 4.5% with a combined NMAHP sickness position of 8.64% in December 2023 which coincides with winter when sickness rises. This is above threshold and reflects a deterioration from previous reporting period where sickness for NMAHP groups in June 2023 was at 6.97%.
- Long-term sickness (LTS) rates (28 calendar days or more) continue to remain the greatest challenge with high levels of LTS noted across all staff groups over the last 12 months.
- Turnover in December 2023 for NMAHP staff groups remains under the Trust threshold of 13% with one exception, that of HCA group. December 2023 reflects HCA turnover at 13.65%.
- Age profile has marginally shifted due to recruitment activity in divisions. There remains a risk in Nursing and Midwifery (NMC/HCA) to those who may retire now or in the next five years. As a percentage of the NMAHP workforce this is represented as 6.68% within 56-60 age bands and 3.74% within 61-65 age bands in NMC in December 2023. Both age bands reflect a reduction in percentage of staff when compared to June 2023.
- Staff Training and Personal Development Review performance measures reflect HCA and AHP groups achieved MT and NMC group achieved PDR compliance in December 2023. However, none of the staff groups achieved LMT or CMT.
- 245 clinical incidents related to staffing or staff sickness were noted compared to 227 in previous reporting period, with highest seen in Maternity Services (151) closely followed by Gynaecology (67). Maternity reflected a small reduction in incidents reported, whereas gynaecology has seen an increase in reporting with majority occurring in Gynaecology ED (37) and Medical staffing (12).
- Red Flag events (212) were all reported from Maternity services and reflect an increase of 119 red flags, majority relating to >4-hour delay in ongoing induction of labour. In line with C&M reporting this local red flag has ceased and moved to >12 hours from November 2023. There were 23 Serious Incidents and Patient Safety Incident Investigations combined (previously 15 SI's only) with 11 in Maternity; 9 in Gynaecology; 2 in Neonatal and 1 in CSS.
- Friends and Family Test – 27 comments received (from 4027) saw an increase from previous reporting period (23 comments from 5361 responses) in Friends and Family Test (FFT) that mentioned staffing numbers or staffing shortages in the patients' experience. 16 of these were in Maternity and 11 in Gynaecology/HFC. The common theme continues to be a lack of support on the ward which the patients attributed to being understaffed. 40

comments (from 2500) relating to the Trust question "please tell us anything we could have done better" also related to staffing numbers or staff shortages, a reduction from previous reporting (79 comments from 3460 responses). Most of the comments related to Maternity services (21), followed by Gynaecology (18) and CDC (1). Themes such as waiting for pain relief, answering call bells and waiting times in GED are already known with divisions undertaking Quality Improvements to address the themes noted.

- Complaints – 36 formal complaints received highlighting an increase of 10 from previous reporting period. No PALS+ recorded (from the 35 recorded) noted staffing in the issue raised, same as in previous reporting period. No PALS cases (from 1307) noted staff shortages in issues raised. 51 Compliments were received, which reflect a decrease of 28 from previous reporting.
- Staff experience – 29 reported violence and aggression incidents (previously 13), all relating to non-physical violence or aggression towards staff. No themes or trends identified across incidents.
- Recruitment and Retention – ongoing recruitment across the Trust continued with successful recruitment and commencement of Midwives within Maternity filling all existing vacancies in October 2023. LWH completed International Recruitment (IR) in Theatres and Midwifery successfully with onboarding and pastoral care.

In summary, the Board of Directors are asked to recognise and take assurance from the oversight in place to support safe staffing and deliver safe patient care and to agree and support the actions and next steps within Section 9.0 of the report.

MAIN REPORT

1.0 Introduction

To provide the Putting People First Committee with a six-monthly update of the 2023/2024 staffing establishment reviews in relation to the Nursing, Midwifery and Allied Health Professional (AHP) workforce requirements. To report against the workforce requirements identified in 2023/2024 to achieve safe staffing across services within the Trust.

2.0 Background

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

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

The annual comprehensive Nursing and Midwifery workforce planning skill mix review is undertaken in Quarter 4 each year, ahead of budget setting to effectively inform any changes which are divisionally led and signed off as agreed by Ward Manager, Matrons and Heads of Nursing, Midwifery and AHP. All staffing establishments are reviewed and signed off by the Chief Nurse and Trust Board each year.

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

The Trust Board via the Putting People First Committee receives twice-yearly staffing review papers; one which confirms a complete Nursing and Midwifery establishment review was undertaken reported through Divisional overviews and a further comprehensive staffing report to ensure workforce plans are still appropriate across the clinical workforce, allowing for seasonal variance to be captured and reviewed appropriately.

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

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

Developing Workforce Safeguards (NHSI, 2018) additionally recommends:

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

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

Table 1: National Quality Board (2016)

3.0 Workforce planning - Setting evidenced based establishments

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

The Safer Nursing Care Tool within Gynaecology in-patient areas is adopted for use. In October 2023 a repeat audit was undertaken with the results reflecting that ward level care was mostly level 0 (recognising patients require hospitalisation and ward level care) with High Dependency unit acuity noted as level 1B (patients who are in a stable condition but are dependent on nursing care to meet most or all activities of daily living). The Nursing workforce workstream is reviewing the model of HDU care across Gynaecology and Maternity with a lead identified to undertake this work and implement any recommendations following a diagnostic, which is supported by LUHFT colleagues.

A refreshed version of SNCT: Adult Inpatient Wards in Acute Hospitals has been received by the Trust with LWH being active contributors during beta-testing phase. The license agreement was received in October 2023; however, the gynaecology division had already commenced an establishment review utilising previous version. This was appropriate given the division have not been trained and assessed by the Deputy Director of Nursing and Midwifery in its use. This was due to the planned training for Safer Staffing Fellows in Trusts from Imperial College being scheduled at the end of November 2023. The new SNCT will be used from June 2024 by Gynaecology to inform the 6 monthly staffing reviews.

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

Maternity Services are assessed using Birthrate Plus®. The Birthrate Plus® methodology is based on an assessment of clinical risk and the needs of women and their babies during labour, delivery, and the immediate post-delivery period. Birthrate Plus® utilises the accepted standards of one midwife to one woman to determine the total midwife hours and therefore the staffing required to deliver midwifery care to women across the whole maternity pathway using NICE guidance (2015) and acknowledged best practice (RCM, 2018). A Birthrate Plus® refresh audit was completed in April 2023 with report received in May 2023 and reflected that the Maternity budgeted establishment in 2023/24 was 5.35wte below the audit recommendation which Maternity addressed and are now fully compliant with current Birthrate Plus® establishment.

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

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

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

From April 2016, following the Carter Review all Trusts were required to publish staffing fill rates of RN/RM and Care Staff by hours and percentages (Actual versus Planned) and CHPPD via the Strategic Data Collection Service (SDCS), run by NHS Digital. A summary of the submission is uploaded onto the Trust website each month. Appendix 1 highlights data submitted from July 2023-December 2023.

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

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

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

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

Trustwide CHPPD in Q2 and Q3 (Appendix 1) has shown slightly lower rates when compared to that in Q4 and Q1, and although on its own is not a cause for concern it can when triangulated indicate a potential patient safety risk. When CHPPD is reviewed on Model Hospital (December 2023 latest published data) it reflects LWH provider value is 8.6 (Quartile 3), and most likely reflects effective rosters and productive wards. When LWH CHPPD is compared, it highlights that 'My Region' peer median average is 8.8 (Quartile 3). When compared further to Birmingham Womens and Children's NHS Foundation Trust (My Peer) it highlights that LWH CHPPD value of 8.6 is lower than 'My Peer' with Birmingham Womens and Children's having a peer median of 12.7 (Quartile 4). Although it can be worthwhile comparing data on Model Hospital as very high rates of CHPPD may suggest an organisation has several unproductive wards or inefficient staff rostering processes, it is important to be mindful of comparing different types of wards and trusts.

4.0 Operational oversight of staffing and acuity-based care

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

- Monthly rosters sign off meetings undertaken by Heads of Nursing, Midwifery and AHP (NMAHPS) across all divisions, where roster effectiveness is challenged against roster compliance KPIs. Final roster approvals are signed off by Heads of NMAHPs.
- Weekly forward view of staffing overseen by Heads of NMAHP and Matrons.

- Maternity and Neonatal services provide information for staffing on a weekly basis to NHS Gold command.
- Staffing reported to Bronze (staffing meetings) twice daily (Mon-Fri) and recorded on Power BI (RAG rated). Any identification of risk is addressed and where not resolved escalated to Silver (daily huddle) for resolution. First on call manages staffing at weekends and bank holidays with support from site managers.
- RAG rated staffing matrix in place for Neonatal and Maternity. Acuity and activity review is undertaken at 10am/10pm and 12am/12pm each day with MDT jointly in NNU and Maternity; focusing on staffing, activity, dependency, and ability to take women and babies recorded.
- Maternity operational oversight (104 bleep holder) completes 4 hourly oversight reviews of acuity, dependency and staffing to determine appropriate midwifery care across all areas. Helicopter role oversees and supports staff moves, staff breaks and care ratios.
- Neonatal services adhere to national reporting to Cot Bureau three times daily.
- Silver (daily huddle) informed of staffing position forecasted as they arise, into the following shift and ahead of a weekend.

4.1 Temporary Staffing

NHS Professionals (NHSP) service is contracted and used within the Trust. Operational oversight on a weekly basis continues and allows early resolution to issues arising. Early commencement of actions to reduce agency expenditure are in place.

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

- NHSP attendance at twice daily staffing meetings to support priority shift allocation.
- NHSP team proactively manage agencies and cancellations and source more cost-effective agencies where possible, adhering to framework and caps.
- Review and agree competitive incentives through NHSP Operational Group to support increase in fill rate.
- Facilitating block booking requirements with bank
- NHSP Recruitment Team who will support with Bank Only recruitment.

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

- Weekly updates on agency spend provided to directorates/divisions.
- Weekly engagement ward walks from NHSP local team including seasonal promotional events to reward bank workers and encourage substantive staff sign up, ongoing with additional drop-in sessions held in departments to facilitate joining process.
- National campaigns to engage and reward bank- Going the Extra Mile Awards, promoted in November with winner announcement in February 2024 and Bank member of the month.
- Engagement with ward managers and matrons to maximise positive booking behaviours (encouraging high lead time and minimising bank member cancellations)
- Continued support with health roster compliance – 99%
- Continued within Northwest region to promote LWH to current bank staff registered with NHSP.
- Bank adverts out for key roles and ad hoc for roles as requested.
- Central team providing support to fill AHP placements.
- Review of payrates to ensure in line with AFC.
- Agency migration in Theatres – 1 person came away from an agency onto NHSP in Q2/3

All new starters broken down by role and recruitment type from July 2023-December 2023 are noted in Table 2. The figures reflect the new starters in the reporting period who have joined the bank, which equates to 79 new bank staff, of which 38 are substantive staff in LWH (multi-post holders) and 41 are bank only or bank exclusive (so may have joined for another Trust but added LWH as a place to work OR joined primarily to work at LWH).

Roles	Bank	Multi-post Holder (MPH)	Total
HCAs Band 2&3	36	6	42
Midwives	0	17	17
Nurses	4	14	18
Theatres	1	0	1
Radiographers	0	1	1
Total	41	38	79

Table 2: Number of individuals added new to NHSP Bank between July-December 2023

The performance of bank and agency demand and fill rate by directorate/division is reflected in Appendix 2.

The graphs (Appendix 2, Trustwide graph) reflect that overall demand has decreased throughout Q2/3 by 14% within July-December 2023. Demand for the 6-month period compared to year on year has decreased by 21% (24,000 hours).

Bank fill year on year has increased by 6%. This has led to an average bank fill for Q2/Q3 of 65.5% compared to 49% for the same period in the previous year (2022). Agency fill has reduced significantly by 94% year on year with average usage at 0.8% for the July- December period (a cost saving of £481,314).

5.0 Trustwide Nursing, Midwifery and AHP Workforce Measures (January 2023-June 2023 data; Q4 & Q1 position)

5.1 Vacancy position

The data highlights the vacancy position in December 2023 (Table 3) for Nursing, Midwifery and AHP of 50.67wte, a slight increase from the previous reporting period (48.00wte in June 2023). This demonstrates a vacancy rate of 4.87%. Reassuringly, the vacancy rate is like that in previous reporting period where it was 4.66% (June 2023).

The vacancy position of 50.67wte is largest in Family Health Division combined with 42.38wte (Neonatal, 34.07wte and Maternity, 8.31wte), followed by CSS Division (5.54wte) and Gynaecology Division including Hewitt Fertility Centre (2.75wte).

All divisions are actively recruiting to their vacancy positions.

Sum of Wte Budget	Sum of Wte Contracted	Sum of Vacancy
1,039.40	988.73	50.67

Table 3: December 2023 Trustwide NMAHP vacancy position

5.2 Maternity Leave

Table 4 highlights the rolling position of staff on maternity leave across each staff group and Trustwide. The group of staff with the largest maternity leave are those who are registered midwifes or nurses, however December 2023 saw a rise in HCAs on maternity leave at 9.85wte. The overall maternity leave in December 2023 is 49.12wte, an increase from the previous reporting period (June 2023, 40wte) which is likely a reflection of changes to the age profile. The 49.12wte combined across all NMAHP staff groups reflects 5.03% of staff.

Figures based on 3 staff groups within clinical areas	Jul-23			Aug-23			Sep-23			Oct-23			Nov-23			Dec-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Overall Maternity of All 3 Staff Group WTE	6.00	32.28	5.55	6.00	32.77	5.55	5.92	36.05	4.71	6.56	34.26	5.71	6.56	33.41	4.71	9.85	34.56	4.71
		43.83			44.32			46.68			46.53			44.68			49.12	

Table 4: Maternity leave

5.3 Sickness absence

The combined sickness absence of NMAHP staff groups over the reported six-month period (Table 5) has remained high and above the Trust threshold of 4.50%, currently at 8.64% in December 2023. However, when compared with the previous six months, sickness has risen with the largest peak in sickness seen in December 2023 compared to that in the previous reporting period where peak sickness was at 8.88% (January 2023), with both months coinciding with winter when sickness in staff can rise.

The lowest combined overall sickness rate was seen in September 2023 (6.66%) in the last six months, which is below the lowest reported period of sickness in the previous reporting period.

Covid-19 related sickness remains very low and under 1% with September 2023 reflecting the lowest reported at 0.06% and much improved overall from previous reporting period, although still under 1%.

The overall percentage of sickness across the 3 staff groups in December 2023 is 8.64% with further breakdown of this illustrating the following:

- 8.56% was all non-covid related sickness.
- 0.08% was covid-19 related sickness.
- 0% was covid -19 special leave (this is not calculated in the sickness recorded).

		Jun-23			Jul-23			Aug-23			Sep-23			Oct-23			Nov-23			Dec-23		
	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Sickness	7.00%	10.12%	5.78%	8.21%	9.90%	5.60%	9.18%	9.39%	9.39%	6.11%	10.08%	5.33%	8.04%	12.60%	5.53%	6.69%	12.27%	7.01%	9.62%	13.40%	7.22%	6.99%
Overall Absence of All 3 Staff Group		6.97%			6.83%			7.08%			6.66%			7.27%			8.39%			8.64%		
COVID Sickness	0.00%	0.71%	0.08%	0.09%	0.49%	0.13%	0.00%	0.29%	0.15%	0.00%	0.07%	0.07%	0.00%	0.48%	0.31%	0.03%	0.27%	0.01%	0.05%	0.10%	0.08%	0.00%
Overall Absence of All 3 Staff Group		0.23%			0.21%			0.18%			0.06%			0.34%			0.08%			0.08%		
Sickness WITHOUT COVID Sickness	7.00%	9.41%	5.70%	8.12%	9.41%	5.47%	9.18%	9.10%	9.24%	6.11%	10.01%	5.26%	8.04%	12.12%	5.21%	6.66%	11.99%	6.99%	9.57%	13.30%	7.13%	6.99%
Overall Absence of All 3 Staff Group		6.74%			6.62%			6.90%			6.60%			6.93%			8.31%			8.56%		
COVID Special Leave	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Overall Absence of All 3 Staff Group		0.00%			0.00%			0.00%			0.00%			0.00%			0.00%			0.00%		
Trust Target 4.50%																						

Table 5: All sickness absence

5.4 Long-term and short-term sickness

Sickness over the reporting period reflects that long-term sickness continues to remain the greatest challenge across all staff groups and has been for over 12 months. July 2023 (Table 6) shows the lowest long-term sickness rate at 61.41% for NMC staff group with November 2023 reflecting the highest levels of long-term sickness at 71.69%. The HCA group reflects the lowest long-term sickness recorded in December 2023 at 59.18% with the highest rate recorded at 77.55% in November 2023. AHPs reflect significantly higher levels of long-term sickness when compared to other professional groups which is reflective of AHP's being a relatively small cohort of staff, which skews the data to appear disproportionately elevated when reviewing. December 2023 saw long-term sickness at its highest in the reporting period at 88.35%, this is marginally higher than the highest long-term sickness reported in previous six months (87.11% in August 2022).

The Deputy Director of Nursing and Midwifery, alongside the Deputy Director of People have undertaken divisional long term sickness review meetings to ensure actions are in line with policy and appetite for alternative considerations to support earlier returns.

	Jul-23		Aug-23		Sep-23		Oct-23		Nov-23		Dec-23	
	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
NMC Staff Group Trust Total	50.32%	49.68%	39.86%	60.14%	46.31%	53.69%	37.63%	62.37%	28.31%	71.69%	30.62%	69.38%
HCA Staff Group Trust Total	32.92%	67.08%	37.31%	62.69%	40.48%	59.52%	29.74%	70.26%	22.45%	77.55%	40.82%	59.18%
AHP Staff Group Trust Total	16.79%	83.21%	28.19%	71.81%	17.11%	82.89%	27.06%	72.94%	43.05%	56.95%	11.65%	88.35%

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

5.5 Turnover

The Trust turnover threshold is 13%. The position over the last six months (Table 7) reflects that all groups have remained under the Trust threshold with one exception, that of HCA group. In December 2023 the turnover position for HCA reflects 13.65%. NMC staff groups have remained under threshold for the past 12 months, with AHP staff group remaining under threshold for the past 8 months.

	Jul-23			Aug-23			Sep-23			Oct-23			Nov-23			Dec-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Staff Group Trust Total	12.86%	8.81%	9.21%	12.99%	8.04%	9.23%	11.18%	8.75%	5.34%	12.24%	8.10%	3.63%	12.69%	8.67%	4.95%	13.65%	9.04%	6.71%
Trust Target 13%																		

Table 7: Turnover

5.6 Age profile

Table 8 reflects the position overall across all NMAHP staff groups. The age profile in the staff groups overall have marginally shifted over most of the age bands, with recruitment having seen an increase in NMC filled posts within 21-25; 26-30 and 31-35 age bands. There remains a risk in Nursing and Midwifery (NMC/HCA) to those who may retire now or in the next five years. As a percentage of the NMAHP workforce this is represented as 6.68% within 56-60 age bands and 3.74% within 61-65 age bands in December 2023.

Headcount	Jul-23			Aug-23			Sep-23			Oct-23			Nov-23			Dec-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
<=20 Years	4	0	0	4	0	0	6	0	0	6	0	0	5	0	0	5	0	0
21-25	29	64	3	28	61	3	29	2	69	29	78	2	28	76	3	28	73	3
26-30	34	100	4	34	102	5	33	6	99	34	103	6	30	105	6	31	104	6
31-35	30	143	15	32	143	13	33	14	145	32	150	15	30	147	18	29	147	18
36-40	38	88	9	38	88	10	38	9	90	35	94	10	30	94	10	30	93	8
41-45	30	94	10	30	98	10	34	11	98	34	97	11	37	99	12	35	99	11
46-50	22	67	8	21	67	8	23	8	69	23	69	7	23	68	7	23	67	8
51-55	35	79	10	34	79	10	35	9	79	35	78	9	32	77	9	31	78	10
56-60	24	79	2	23	79	2	22	3	73	21	74	3	24	75	3	25	75	3
61-65	25	47	3	24	44	3	25	3	42	25	42	3	24	43	3	24	42	3
66-70	6	4	0	7	6	0	8	0	4	8	4	0	9	4	0	9	3	0
>=71 Years	1	1	0	1	1	0	1	0	1	1	1	0	1	1	0	1	1	0
Total	278	766	64	276	768	64	287	65	769	283	790	66	273	789	71	271	782	70
Total of all 3 Staff Groups	1108			1108			1121			1139			1133			1123		

Table 8: NMAHP age profile data

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

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

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

Over the reporting period it is evident that compliance is like the previous reporting period when comparing December 2023 with June 2023 positions. Noting not all staff groups have not met the thresholds for all indicators.

In December 2023 the following indicators have been achieved:

- MT – in HCA and AHP staff group
- PDR – NMC staff group

When comparing December 2023 position across all four indicators and across all staff groups with previous reporting position (June 2023) the below is established:

- 3 areas of compliance (as above)

- 7 individual indicators have improved since June 2023
- 4 indicators are performing worse than June 2023, all are within the AHP staff group, however one indicator meets threshold, yet reduced marginally from previous position

The below data does not reflect where small teams in divisions may have met all targets within the reported periods. Divisional updates included (Appendix 4-7) reflect compliance within division and continued actions being taken to support a focus on improvement.

		Jul-23				Aug-23				Sep-23				Oct-23				Nov-23				Dec-23			
	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
NMC Staff Group Trust Total	90.00%	86.53%	84.49%	92.83%	92.26%	88.47%	87.46%	92.50%	92.61%	87.98%	86.55%	92.37%	93.32%	88.69%	89.27%	93.47%	93.84%	88.22%	90.56%	93.14%	91.50%	88.22%	90.56%	93.14%	91.50%
HCA Staff Group Trust Total	79.75%	89.12%	78.12%	95.47%	81.86%	89.87%	84.24%	95.69%	86.19%	90.13%	81.63%	95.64%	85.66%	90.40%	89.05%	96.69%	88.24%	90.21%	82.62%	95.34%	86.73%	90.21%	82.62%	95.34%	86.73%
AHP Staff Group Trust Total	86.27%	97.27%	96.10%	99.56%	94.00%	95.61%	96.43%	99.37%	88.46%	97.95%	97.53%	99.29%	88.46%	94.32%	96.23%	98.53%	86.54%	86.36%	84.73%	97.33%	80.70%	86.36%	84.73%	97.33%	80.70%

Table 9: Training and PDR data

7.0 Measurement of Quality of Care

7.1 Clinical Incident Reporting

The Trust has a local incident reporting system (Ulysses) that staff access to report any patient safety incident that is unintended or unexpected which could have (near miss) or did lead to harm, allowing the organisation to investigate, learn and take action to prevent re-occurrence. Incidents related to staffing levels are an example of incidents reported. The caveat to all incidents exists that validation and possible re-categorisation of cause groups may alter from when an incident was initially reported. This occurs following the review and closing of the incident by the division and merging subsequent upload to the National Reporting and Learning System (NRLS) by the Corporate Governance Team, therefore the data presented is still subject to potential minor changes, however, reflects an accurate record when downloaded.

The number of Trustwide clinical incidents reported within the last six months (July 2023-December 2023) can be seen in Table 10. The data highlights the incidents related to staffing levels and/or staff sickness affecting staffing levels and is drawn from the overall incidents reported within the timeframe.

Since previous reporting period (January 2023 – June 2023) an increase of clinical incidents related to staffing has been seen with 245 incidents reported in this reporting period across divisions compared to 227 previously.

Of the total clinical incidents related to staffing, Family Health Division had the largest volume of 152; (Maternity, 151; Neonatal, 1), Clinical Support Services (CSS) Division reported 22 and Gynaecology Division reported 67. All areas have seen a reduction in staffing related clinical incidents except for Gynaecology who have seen an increase from previous reporting period. On closer analysis of Gynaecology Division, it is noted that the highest reported incidents are from the Gynaecology Emergency Department (37) and Medical Staffing (12) with the greatest cause being staffing problem/staffing problem (levels).

Reporting Period July 2023- December 2023
Total clinical incidents reported = 4718 (previous reporting period = 3655)
Total staffing levels/staff sickness incidents reported related to clinical incidents (combined divisions) = 245 (previous reporting period = 227)

Table 10**:** Trustwide overview of incidents

7.2 Red Flag Events

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

There were no nursing red flags reported in the reporting period, therefore all red flags reported are midwifery red flags within Maternity services. Table 11 reflects the 12-month position of midwifery red flags and is included to highlight the peaks of when reporting across a 12-month period is seen and the specific red flags that contribute to this. There were 212 red flags reported between July 2023–December 2023 which is an increase of 119 from previous reporting period (January 2023 – June 2023) where 93 red flags were reported.

On closer analysis of reported red flags in Maternity between July 2023- December 2023, the 3 highest reported red flags following appropriate review and validation are related to > 4hour delay in ongoing induction of labour (local LWH Maternity red flag) which has moved to >12 hours from November 2023 in line with Cheshire and Mersey reporting (195, previously 40), >2 hour delay in admission to induction of labour (30, previously 7) and delay of 30 minutes or more between presentation and triage (12, which has reduced from previous reporting of 28).

To ensure patient safety, all women waiting for a bed on delivery suite or for an available midwife to provide 1:1 care in labour receive care as per Induction of Labour Guidelines (v10). This means that women are cared for in an induction of labour bay with care overseen by a midwife. Women waiting for transfer to delivery suite for ongoing induction of labour are subject to a twice daily multi-disciplinary review to prioritise case-based need. The Maternity bleep holder and the Multi-Disciplinary Team review inductions of labour women who are scheduled to come in the following day to identify and pre-empt any areas of challenge. All red flags are reviewed in Maternity Clinical Risk meeting.

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

Midwifery Red Flag Event - Validated	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Year End
1:1: Care in Labour Not Supported	5	2	2	2	1	0	0	5	0	3	2	0	22
>30 min Delay in Presentation to Triage	6	2	5	12	1	2	1	5	0	6	0	0	40
>2 hour delay in admission to IOL	5	2	0	0	0	0	2	12	5	6	3	2	37
>4 hour delay in ongoing IOL (LWH MRF) > 12hrs from Nov 23	0	10	6	14	9	1	18	36	28	31	25	17	195
Delay in time critical activity	0	0	1	0	0	0	0	3	0	0	0	0	4
Delay in pain relief > 30 mins	0	0	1	0	0	1	1	0	0	0	0	0	3
Missed medication during hospital admission	0	0	0	0	0	0	0	0	0	0	0	0	0
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	0	0	0	0	0	0	0
Full clinical examination - presenting in labour	0	0	0	0	0	0	0	0	0	0	0	0	0
Missed or Delay Care (Suturing)	0	0	1	2	0	0	0	0	0	0	0	1	4
Total	16	16	16	30	11	4	22	61	33	46	30	20	305

Table 11: Midwifery red flags over a 12-month period

7.3 Serious Incidents/Patient Safety Incident Investigations

As highlighted by the Serious Incident Framework (NHSE, 2015) serious incidents in health care are events where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant that they warrant attention to ensure these incidents are identified correctly, investigated thoroughly and trigger actions that will prevent them from happening again. From September 2023 the Trust launched the Patient Safety Incident Response Framework (PSIRF) under the NHS Standard Contract. As part of the NHS Patient Safety Strategy (NHSE/I, 2019) the Trust is now seeing PSIRF replace the Serious Incident Framework (NHSE, 2015). Current reporting reflects a hybrid of reporting via both approaches, until such time when only PSIRF reporting will be in place.

There was a total of twenty-three serious incidents (SIs) and/or Patient Safety Incident Investigations (PSII) in the Trust and an additional two reportable HSIB/MNSI cases between July 2023-December 2023. This is an increase from previous reporting period where the Trust had fifteen SIs and is likely as a reflection of PSIRF criteria for triggering a PSII threshold when the Trust initially went live with PSIRF in September. However, anticipated is a reduction of PSIIs and an increase in After Action Reviews (AARs) as PSIRF is embedded. Of the twenty-three SIs/PSIIs, the following is the breakdown: Eleven incidents occurred in Maternity services with five SI's; five PSIIs; one Never Event (passed

possible indwelling catheter tubing); Of the two externally reportable cases, 1 was a HSIB case (expected death within 10 days following elective c-section) and 1 MNSI case (deteriorating patient with sepsis/transfer to LUHFT). Three of the cases required transfer to external Trust.

Neonates had two PSIIs, one related to a Sudden Unexpected Death in Infant and one relating to cooling devices incorrectly connected. Neither was impacted by staffing or single site risk.

Gynaecology Division had nine SIs/PSIIS with the breakdown as follows: four SIs, with two related to clinical care and two related to cancer breach/delayed diagnosis; five PSIIs related to clinical care, clinical practice, delayed diagnosis, and communication.

CSS division had one PSII reported and relating to incorrect patient with similar name receiving a CT scan in error.

Actions from all the Serious Incidents/PSIIs will be implemented and shared for lessons learned when completed.

7.4 Patient Experience - Friends and Family Test (FFT)

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

A total of **4027** "Overall Experience" comments were received during the period July 2023 to December 2023 from the overall **4055** FFT responses received. The 4055 FFT responses reflects a reduction of 1715 FFT responses overall when compared to the previous reporting period.

274 (7%) of these comments were received by patients noting themselves as "displeased". Of these displeased comments **27** (10%) mentioned staffing numbers/shortages in the description of their experience (Maternity, 16; Gynaecology/HFC, 11). These mainly related to Maternity but did cover other areas as well. The common theme of these continues to be a lack of support on the ward which the patients attributed to being understaffed.

The FFT asks patients "please tell us anything we could have done better". In the reporting period, **2500** comments were left in this section covering both Pleased and Displeased results. Of these **40** (1.6%) identified staffing numbers/shortages as something that needed to be improved, this is a reduced volume to that reported in the previous reporting period. Most of the comments related to Maternity services (21), followed by Gynaecology (18) and CDC (1).

Maternity mainly attributed to Maternity Base with common themes such as:

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

Gynaecology themes were:

- Struggling to contact GED/appointment phonelines.
- Waiting times in GED

Maternity and Gynaecology have Quality Improvement projects underway to support the improvement work to address the themes noted.

7.5 Complaints, Concerns and Compliments

There were **36** formal complaints received in the Trust during July 2023 – December 2023 which was an increase of ten from the previous six months (26). The breakdown reflects: Gynaecology 24 (8 of these were Hewitt), Maternity

11 and CSS (Theatres and Anaesthetic) 1. These contained 218 individual categories of concerns that required investigation within the 36 complaints, reflecting an increase of 74 individual concerns from the previous reporting period. An average of 5 categories of concerns were raised per complaint (previously 4). Response rates for complaints answered in timeframe during this reporting period reflects 100% compliance (previously 36%). There is 1 complaint category where staffing levels were raised specifically.

There were **35** PALS+ recorded during the reporting timeframe (an increase of 12 from previous reporting) with no cases noting staffing in the issue raised. There were **1307** PALS cases noted within July 2023-December 2023, which is a decrease from the previous reporting period (1362 reported). There were no PALS cases noted where shortages of staff were highlighted as the issue raised (none in previous reporting period also).

There was a total of **51** compliments Trustwide received (via PALS) within the timeframe which broadly covered general satisfaction of the service provided, which includes staff groups and individuals. Compared to the previous reporting period this is a decrease of 28 compliments. Of the 51 compliments the clinical divisions breakdown is: Gynaecology, 26; Maternity, 20; and CSS, 4; Patient Experience, 1. All compliments, where possible when individuals are identified, are shared with the individual and their manager/leaders.

7.6 Staff Experience

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

Health and Wellbeing – The LWH Staff Support Service is now established, led by a Consultant Psychologist, and supported by two externally funded wellbeing coaches and an Assistant Psychologist. Additionally, the decision to bring counselling provision back in house, recognising that the single biggest reason for absence is mental health. The team have supported the delivery of wellbeing conversations, which reflects 71% compliance in December 2023 (previously 54% at June 2023). The roll out of trauma-prevention workshops for clinical staff has been agreed and a plan for delivery has been devised with 2 sessions per month for the next 18 months. The overall demand for the service remains high with an average of 25 referrals per month. They will work closely with PNAs and PMAs to ensure there is a joined-up offer of support for the NMAHP workforce. Physical health will be a focus for the next 12 months, with the health and wellbeing coach offering tailored programmes to staff to support weight management and nutrition.

Leadership and Management - Every NMAAHP leader (alongside other professionals) are invited to undertake one of 3 programmes, which are accredited by the Chartered Management Institute. Over 100 staff have either completed or are currently engaged on a programme.

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

Flexible Working – Unlimited requests are now in place and working well in several departments including maternity and gynaecology and 'later career' registrants are benefiting from changes to pension rules meaning they can reduce their hours without having a break in service.

Breaks Audits - Breaks continue to be closely monitored, with a programme of ongoing audits and feedback on progress at Professional Forum. The update received in July and August 2023 by all divisions highlighted the following:

- Gynaecology – most areas received planned breaks, however occasionally unforeseen circumstances resulted in some breaks missed, however no concerns of any patterns emerging.

- CSS – assurance that all areas are taking breaks, however clinics overrunning have caused shorter breaks to be taken within imaging/ultrasound. The Head of AHP is reviewing to support this issue improves.
- Maternity – 227/240 break audited over all areas, midwives only were affected by not receiving a full break, as they only received 30minutes.
- Neonatal – insufficient data collected to evaluate well. Of the information received nurses and neonatal assistances mostly had breaks, however room leaders and shift leaders often had shorter breaks. To improve future audit Head of Nursing will assign data collection to Team leaders.

The next breaks audit update at Professional Forum is due to be received in February 2024.

Communications and engagement - The Trust continues to facilitate *Trust forums* designed to support staff or enable them to share their views including the *Great Place to Work Group* and *Schwartz Rounds,* however there is a continued need to achieve greater presence from NMAHP groups. A focus on improved internal communication has taken place with the launch of '*3 key messages'*, a mix of Trust, divisional and local communications which is disseminated to staff through huddles and handover. Staff Survey action plans focus on 3 key areas of improvement and are tracked through Divisional Boards. 'Big Conversations' take place 2 or 3 times a year and is an opportunity for colleagues in all areas to have a voice and be part of making positive changes. Local newsletters, walkarounds and drop ins with managers are all in place to foster good channels of internal communication.

7.7 Staff reported incidents (Violence and Aggression)

During July 2023–December 2023 the number of reported incidents related to verbal or physical acts of violence or aggression against NMAHP staff is recorded as **29** (previously 13 reported). This is broken down further as Maternity 11, Neonatal 1 and Gynaecology 17. No incidents occurred in CSS. There were no themes or trends as all related to individual circumstances.

There is continued emphasis on hearing staff views to make improvements on the experience of health and wellbeing as we recognise the relatively low reporting may reflect under-reporting rather than simply limited violence and aggression incidents in the Trust.

8.0 Attraction, Recruitment and Retention

The Learning and Development Facilitator in the Trust supports the Trust attraction, recruitment, and retention plans. They do this through Widening Participation, Acorns and Cadets, Work Experience, Apprenticeships, Recruitment Fairs and Careers Events.

The Trust also engages through wider teams an ambition to increasing diversity of new entrants across roles and salary bands as a priority. LWH has recently introduced a positive recruitment scheme based on race. It has been agreed that volunteers on the Volunteer to Career (VtC) programme will be guaranteed interviews for support worker roles within clinical services. Discussions have begun to emulate this scheme for vacancies advertised by NHS Professionals.

LWH has completed its International Theatre Nurse recruitment, through Cheshire International Recruitment Collaborative (CIRC). A total of 22 Internationally educated recruits arrived to LWH since recruitment commenced (11 in Theatre, with one leaver; 10 in Midwifery with one further arriving in 2024). The current position reflects that during July – December 2023, five IRs arrived (1 nurse, 4 midwives) and commenced in the Trust, with the final nursing recruit arriving in the UK on 7th September 2023. The Trust also implemented an applicant landing page, to support new recruits with access to training and pastoral support materials, prior to their UK Arrival. On arrival to LWH all IRs received a full onboarding programme and take part in an internal Mentoring and Coaching programme, as part of a development initiative.

Theatres are hosting a 1-year celebration event taking place on the Great Day, to mark 12 months of welcoming the Internationally Educated Nurses.

Ongoing recruitment of newly qualified nurses and midwives continues as students qualify and in line with vacancy position across all divisions. With successful international recruitment within theatres and midwifery supported by a programme of onboarding and pastoral care with consideration to vacancy levels and skill mix, no further international recruitment is being undertaken at this juncture. Maternity filled all existing vacancies in October 2023.

9.0 Actions and next steps:

The following actions are proposed during next six months (January 2024-June 2024):

- Succession planning across all divisions in line with business planning cycle.
- Continued focus to recruiting to vacancy position.
- Divisions to continue to review trajectories of improvement in Training and PDRs to be reviewed through monthly Divisional Performance Reviews
- Several actions related to ongoing work with NHSP such as:
    - Rolling adverts with focus on full bank recruitment and increase substantive staff registration.
    - Attendance at future jobs fairs in region and attend any relevant LWH recruitment events.
- Continued focus on the nursing and midwifery self-assessment tool/retention improvement and action plan.
- Ongoing focus within the NMAHP workstream commenced in September 2023 to support the Trust's Strategic Objective in relation to maximising the potential of our workforce, understanding investments and leadership requirements of the future.
- Apply for charitable funds to support Cavell Nurses fund

10.0 Conclusions and Recommendation

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

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

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

Appendix 1 – CHPPD and Actual versus Planned Fill Rates

The NHS Digital Return via Strategic Data Collection Service (SDCS) - Safe Staffing Fill Rate each month are noted as per below from July 2023–December 2023. The data is presented monthly to Trust Board via the Integrated Performance Report, supported by a detailed narrative and triangulation of information from the Heads of Nursing and Midwifery.

July 2023

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	80.6%	73.1%	130.6%	101.6%
Induction & Delivery Suites	78.7%	86.0%	83.7%	96.8%
Maternity & Jeffcoate	85.5%	100.0%	94.9%	114.5%
MLU	85.5%	48.4%	89.5%	64.5%
Neonates (ExTC)	89.6%	114.5%	94.1%	79.0%
Transitional Care	64.5%	112.9%	64.5%	103.2%

August 2023

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	83.9%	76.3%	141.9%	98.4%
Induction & Delivery Suites	77.0%	89.2%	78.9%	96.8%
Maternity & Jeffcoate	82.3%	111.3%	84.3%	108.9%
MLU	79.8%	80.6%	87.1%	71.0%
Neonates (ExTC)	89.3%	101.6%	95.1%	61.3%
Transitional Care	64.5%	112.9%	83.9%	83.9%

September 2023

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	86.7%	75.6%	143.3%	100.0%
Induction & Delivery Suites	80.2%	88.9%	77.8%	103.3%
Maternity & Jeffcoate	79.6%	109.2%	84.3%	105.8%
MLU	72.5%	83.3%	65.8%	60.0%
Neonates (ExTC)	91.6%	110.0%	94.7%	78.3%
Transitional Care	86.7%	93.3%	53.3%	113.3%

October 2023

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	95.2%	78.5%	146.8%	95.2%
Induction & Delivery Suites	77.6%	87.1%	80.0%	96.8%
Maternity & Jeffcoate	94.4%	101.6%	87.5%	98.4%
MLU	83.9%	67.7%	81.5%	83.9%
Neonates (ExTC)	88.3%	114.5%	91.9%	69.4%
Transitional Care	80.6%	100.0%	80.6%	93.5%

November 2023

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	93.3%	73.3%	150.0%	100.0%
Induction & Delivery Suites	87.8%	87.8%	84.9%	103.3%
Maternity & Jeffcoate	85.9%	106.7%	94.2%	116.7%
MLU	92.5%	90.0%	91.7%	86.7%
Neonates (ExTC)	90.4%	98.3%	91.2%	95.0%
Transitional Care	50.0%	103.3%	73.3%	86.7%

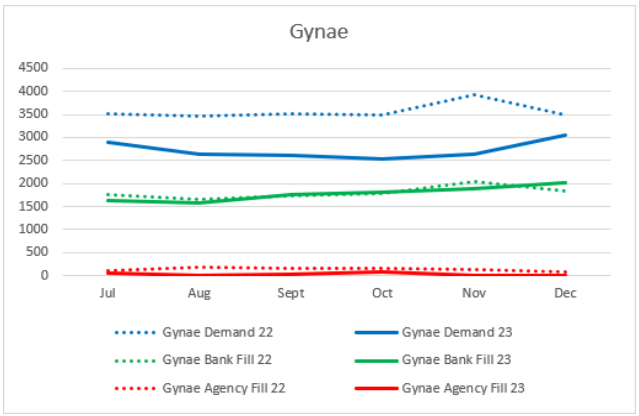
December 2023

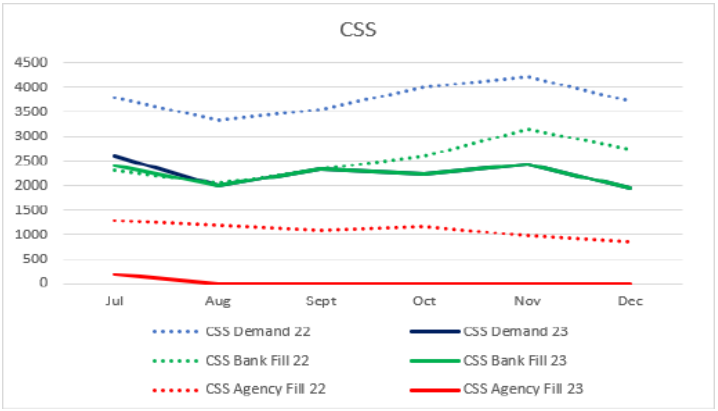
WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	83.1%	61.3%	145.2%	100.0%
Induction & Delivery Suites	86.2%	81.7%	81.9%	96.8%
Maternity & Jeffcoate	87.2%	84.7%	88.3%	93.5%
MLU	81.5%	80.6%	84.7%	64.5%
Neonates (ExTC)	95.1%	101.6%	92.0%	95.2%
Transitional Care	64.5%	87.1%	83.9%	64.5%

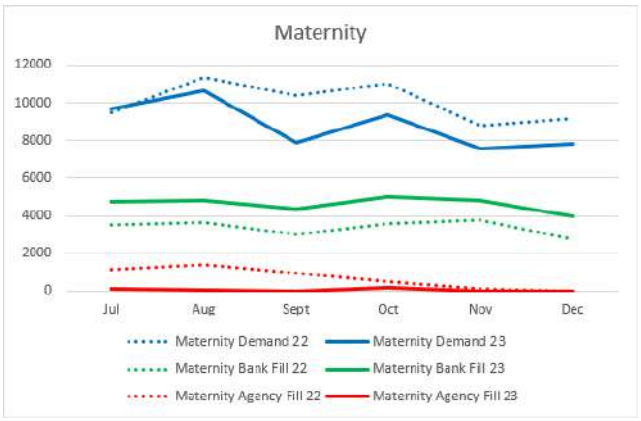
Trustwide CHPPD

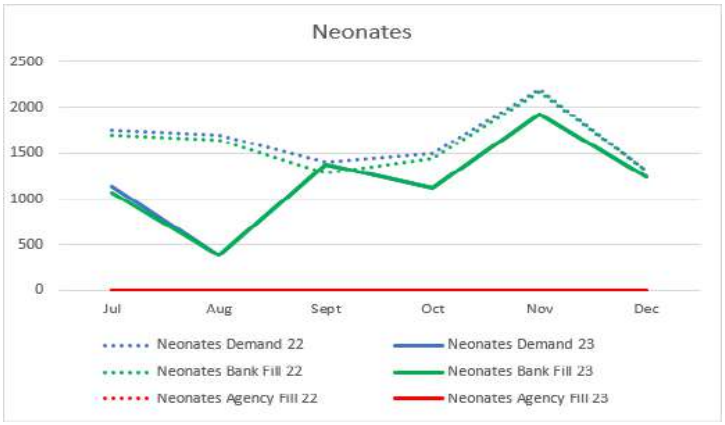
CHPPD	July 23	August 23	September 23	October 23	November 23	December 23
Trust wide	8.8	8.7	8.8	8.6	8.8	8.6

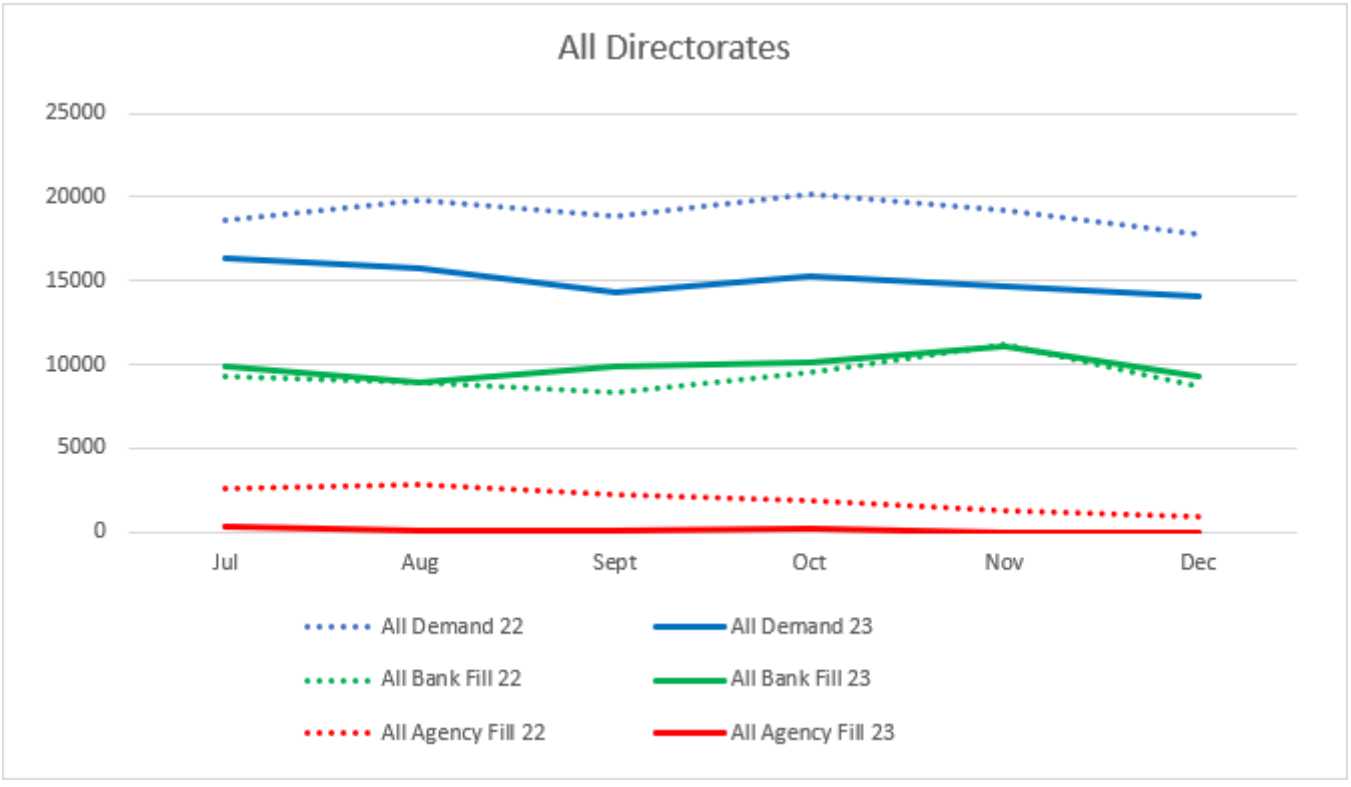
Appendix 2: NHSP July 2023- December 2023 Bank and Agency demand and fill rates by Division and Trustwide











Appendix 3: NICE Guidance on Red Flag Events

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

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

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

Other midwifery red flags may be agreed locally.

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

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

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
    - Pain: asking patients to describe their level of pain level using the local pain assessment tool.
    - Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
    - Placement: making sure that the items a patient needs are within easy reach.
    - Positioning: making sure that the patient is comfortable, and the risk of pressure ulcers is assessed and minimised.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).
- Less than 2 registered nurses present on a ward during any shift.

Other nursing red flag events may be agreed locally.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***24/25/011***		**Date: 11/04/2023**	
Report Title	**Equality & Diversity Reports**			
Prepared by	**Lisa Shoko, ED&I Lead** **Rachel London, Deputy Chief People Officer**			
Presented by	**Michelle Turner, Chief People Officer**			
Key Issues / Messages	As a public sector body, we are governed by the Equality Act 2010 and the Public Sector Equality Duty (PSED) in relation to our equality duties. As part of the PSED the Trust is required to publish reports for EDS 2022, EDI Annual Report and Equality Objectives. The Trust is also required to publish Gender Pay Gap report on the website, to meet the Government requirements for Gender Pay Gap reporting. The purpose of this report is to demonstrate the Trust's achievements in 2022/23 in relation to EDI and the plans for 2023/24. In addition, the required reports are included as appendices for approval for publication on the Trust website. Progress against the Actively Anti Racist programme of work will be regularly to Board as one of the pillars of the Trust Improvement Programme.			
Action required	**Approve ☒**	**Receive ☒**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): n/a			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	The reports included as appendix 1-4 of this report have been received and commented on by the EDI Committee and PPF Committee, all required amendments to papers have been made. The Trust Board is asked for approval of the reports for publication on the website.			
Supporting Executive:	**Michelle Turner, Chief People Officer**			

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

Strategy ☐ Policy ☒ Service Change ☐ Not Applicable ☐

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1.1 Failure to be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: no suitable matching risks reported	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
People Committee (PPF)	March 24	CPO	Committee supported content of reports. The Chair made some recommendations for the content of the reports going forward. The Chief Nurse noted that for EDS going forward, it would be helpful to see a baseline report for *all* services

EXECUTIVE SUMMARY

As a public sector body, there are several mandatory reports the Trust is required to publish as stipulated by the Equality Act 2010 and the Public Sector Equality Duty (PSED).

This paper provides an overview of the key issues in each report, and provides broader strategic context and priorities for Equality, Diversity & Inclusion (EDI) at LWH.

The Board are asked to receive and approve 3 reports which are appended to this summary paper.

- Equality Delivery System (EDS) 2022
- EDI Annual Report
- Gender Pay Gap Report

Following Trust Board approval, the reports will be published on the Trust website.

REPORT

1. Introduction

Liverpool Women's has a strategic aim to be one of the most inclusive organisations in the NHS with zero discrimination for staff and patients. To support this our corporate objectives state we will:

- Move closer to our aim of 25% of leaders (Band 7 or above) being from a racially minoritized background, by increasing to 13% in 2023/24. (Current position 9.09%, on a positive upward trajectory)
- Increasing the number of employees from a racially marginalised background by 5%, moving to 13% in 2023/24. (Current position 11.6%, on a positive upward trajectory)

In addition, we have declared our commitment to anti-racism at LWH and this has been identified as an improvement priority for the Trust and will be managed as a project within the new improvement governance structure. The overarching aim of the Actively Anti Racist improvement programme is to shape and embed an organisational culture which is Actively Anti Racist, and where the care we deliver and the employment we offer is welcoming, inclusive, and culturally competent.

As an NHS Trust, whilst our agreed priority is the focus on anti-racism, we are required to maintain our commitment to reducing discrimination and fostering equality; as well as our statutory and mandatory reporting requirements across the whole ED&I agenda.

2. Reporting Requirements

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

- EDS 2023 (appendix 1)
- EDI Annual Report (appendix 2)
- Gender Pay Gap (appendix 3)

3. Summary of the reports

EDS 2023/24

The main purpose of the EDS was, and remains, to help local NHS systems and organisations, in discussion with local partners and local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

There are 3 domains within the EDS assessment, 1) clinical service 2) workforce health and wellbeing and 3) inclusive leadership.

We identified one clinical service to be assessed against this year, which was Endometriosis, this was based on patient feedback data.

There is a defined scoring criteria and scores can be *undeveloped, developing, achieving, excelling.*

Our services were assessed in February 2024 by a range of external and internal stakeholders. Our overall score across the 3 domains was *developing.* Detailed scores can be seen in the attached paper.

ED&I l Annual Report 2023/24

The ED&I Annual Report provides the opportunity to showcase our achievements around equality, diversity and inclusion across both patient and staff groups. We are required to publish demographic data for our staff and patient population. It also includes our WRES and WDES metrics for workforce race and disability.

The report outlines some key achievements over the last 12 months, including:

- Top 50 'Most Inclusive Employers' list for 3rd year running.
- Guaranteed interview scheme (2 ticks) for race
- Diverse interview panels for senior roles
- Board and Senior Leadership Diversity coaching and training including participation in an external programme.
- Access to specialist Menopause support for staff
- Access to specialist support on Endometriosis for staff
- Supported internships for young people with additional needs
- Launched face to face ED&I training.
- Launched Anti Racism and Inclusive Recruitment training for leaders
- Gained Armed forces Silver accreditation
- Launch of racial trauma psychology offer
- Launch of the bi-lingual volunteers
- Changing Place facility opened
- Expansion of community engagement programme to meet more diverse groups

Gender Pay Gap 2023

The gender pay gap is a measure of labour market or workplace disadvantage, expressed in terms of a comparison between men's and women's average (median) hourly rates of pay. As a public sector body, LWH is required to publish our gender pay gap in March each year. The report published in March 2024 contains data as at 31st March 2023.

The gender pay gap has seen a positive reduction between 2022 and 2023:

- Mean gender pay gap 20.99% (compared to 23.7% in 2022)
- Median gender pay gap 8.60% (compared to 12.4% in 2022)

Although the percentage of men working at LWH has remained static for some years at around 10%, the pay gap at LWH remains higher than the national average of 7%. For the previous 3 years it is clear that male staff are predominantly represented in the upper quartile, followed by the lower quartile. This is explained by the number of males in medical posts and senior management / operational posts. The lower quartile is explained by the number of men in roles such as estates and facilities.

Supporting women to succeed in leadership roles is a key focus for the Trust and our two leadership programmes have been accessed by more than 100 staff. Our next area of focus is our 'mid-career' nurses, midwives and AHPs, offering bespoke development opportunities for those staff who wish to develop in their careers either through linear progression or career enrichment.

We recognise that a diverse board and executive team has a positive effect on organisational performance and our board selection processes reflect this commitment.

We recognise that flexible working is a critical part of enabling women to maintain their careers and offer a wide range of flexible working options for clinical and non-clinical staff.

We will continue to listen to our female colleagues through our variety of listening mechanisms and be open to considering any proposals to further gender equality in the workplace.

4. Recommendations

The Trust Board are asked to approve the three attached reports for publication on the Trust website in order to meet statutory requirement to publish these three reports.

5. Appendices

Appendix 1 – EDS 2023 Report

Appendix 2 – EDI 2023 Annual Report

Appendix 3 – Gender Pay Gap Report

Liverpool Women's NHS Foundation Trust

Putting People First Committee

COVER SHEET

Agenda Item (Ref)	***Secretary to complete***	**Date: 18/03/2024**		
Report Title	**Equality Delivery System**			
Prepared by	**Lisa Shoko, EDI Lead. Rachel London Deputy Chief People Officer**			
Presented by	**Lisa Shoko, EDI Lead**			
Key Issues / Messages	The Equality Delivery System (EDS) is designed to encourage the collection and use of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and so to help NHS organisations meet the public sector equality duty (PSED) and to set their equality objectives. This report includes the summary for the EDS implementation including the gaps identified in each of the domains. In the appendix, the full report is provided for the approval and ratification of the committee. It also outlines the process for Domains 2 and 3, including engagement and scoring of all three Domains with the EDI Lead at the ICB. The report details the rationale behind a holding statement being published on the Trust website for the deadline date of 28 February 2024 and provides a report for consideration by the PPF Committee in advance of Trust Board approval on 11 April 2024. The approved report will then replace the holding statement on the website, this is following guidance from the ICB EDI Leads.			
Action required	**Approve ☒**	**Receive ☐**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): n/a			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	The Committee are asked to approve the EDS report.			
Supporting Executive:	**Michelle Turner, Chief People Officer**			

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

Strategy ☒ Policy ☐ Service Change ☐ Not Applicable ☐

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks*	Comment: Whilst this is a national NHS reporting requirement (EDS 2022) there is a link to

1.1 Failure to be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	our Trusts Strategic ambition and BAF risk in relation to being one of the most inclusive NHS organisations.
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

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EXECUTIVE SUMMARY

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

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

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

Government guidance was for all Trusts to publish a version of their EDS report by 28 February 2023. However, due committees being streamlined, and limited capacity within the EDI Team, there have been delays in completion and reporting within the timescales. As the EDI Team is due to expand in the upcoming financial year, there will be more capacity in the team to ensure that this does not happen. Additionally, there will be a clear schedule for committee and Trust Board dates to ensure timely approval and ratification.

This report includes the summary for the EDS implementation including the gaps identified in each of the domains. In the appendix, the full report is provided for the approval and ratification of the committee.

The report details the rationale behind a holding statement being published on the Trust website for the deadline date of 28 February 2023 and provides a report for consideration by the EDI Committee in advance of Trust Board approval on 11 April 2024. The approved and ratified report will then replace the holding statement on the website, this is following guidance from the ICB EDI Leads.

REPORT

Introduction

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

A review of the EDS2 was undertaken to incorporate system changes and take account of the new system architecture. Through collaboration and co-production and taking into account the impact of COVID-19, the EDS has been updated and EDS 2022 (also referred to as EDS) is now available, including revisions from the live test in 2022.

The main purpose of the EDS was, and remains, to help local NHS systems and organisations, in discussion with local partners and local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

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

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

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

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

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

MAIN REPORT

EDS Ratings and Score 2024

See below the Rating and Score Care supporting guidance document:

Liverpool Women's NHS Foundation Trust

EDS Rating and Score Card

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

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

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

This year, the Trust reviewed a third service in addition to the two services that we reviewed last year, as advised by the ICB and nationally.

In 2022, during the live test of EDS, the scores reflected that we were **Developing with a score of 15 (Maternity and Gynaecology). This year the scores reveal that we have an average score of 16 (Endometriosis).** See the simplified version of the EDS data collection and assessment.

Better than last year, we engaged key stakeholders *(see domain 1 on page 20*) such as Patient Experience and Equality, Diversity, and Inclusion (EDI) leads at Liverpool Women's and in the Cheshire and Merseyside ICB. This approach aimed to capture both quantitative data and qualitative insights, painting a complete picture of our organisation's landscape. Additionally, the Endometriosis Team were supportive of providing information about Endometriosis, ongoing work, and limitations within the service to informed EDS.

Throughout the process, we identified gaps in our statistical data. These were carefully reviewed in collaboration with the Information Team to ensure our data was complete and accurate.

Equality Delivery System (EDS) – Summary Results for Liverpool Women's NHS Foundation Trust, February 2024.

Our 2023 submission was assessed by internal and external stakeholders.

EDS 2022 Outcome:	Score	Assessor Comments/Discussion Points
Domain 1: Commissioned or Provided Services		**Date of Assessment: 16 February 2024**
1a - Service users have required levels of access to the service.	1 - Developing	Service users consistently report good when asked about accessing services. The team is quite small with 2 staff being, a consultant and a specialist nurse. There are 15 supporting champions. The team demonstrates awareness of barriers to accessing services for marginalised groups. Engagement feedback reflects that the service needs to focus on transgender, refugee and asylum seeker, migrant, global majority communities and people with disabilities (particularly, those who

		are profoundly deaf, have learning disabilities and/or have a low reading age) to understand their challenges when accessing the service in an accessible way to them
1b - Individual service user's health needs are met.	1-Developing	The Service takes a patient centred and personalised care approach to the work that they do focussing on supporting each individual case that attends the service, and supporting their individual needs, including looking at hormone therapy, surgery, diet, pain management, physio support and where needed, they can find mental health support. However, this is the sort of service that would benefit from having internal mental health support due to the inherent nature of endometriosis, where it can significantly impact on a person's quality of life and in some cases fertility. The Service are working effortlessly to engage with service users from diverse backgrounds with the support of Equality, Diversity and Inclusion and Patient Experience and Engagement Teams.

		The service works to address health inequalities with local GPS to improve triage and referrals.
1c - When service users use the service, they are free from harm	1-Developing	The Trust has procedures in place to enhance safety in services for service users in protected characteristic groups where there is known risk. Colleagues and service users feel confident to report incidents and near misses. Additionally, the Service did not have any complaints. All concerns were mitigated at the earliest stage. The Trust encourages an improvement culture which considers equality and health inequality themes regarding safety incidents and near misses.
1d - Service users report positive experiences of the service.	1-Developing	The Trust collates data from service users from some protected characteristics about their experience of the service. The Trust creates action plans, and monitor's progress. The Trust and the Service will need to build on its engagement plans in 2024-2025.

		It was the view of the assessor that for the Trust to be achieving or excelling in all the above categories it would need to provide good quality evidence in each of the domains.
Total Score	4/12	
EDS 2022 Outcome:	**Score**	**Assessor Comments/Discussion Points**
Domain 2: Workforce Health and Wellbeing		**Date of Assessment: 4 March 2024**
2a - 'When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions' (response to Covid-19)	2 - Achieving	The Trust has a Trauma Informed Service, which is staff with a Consultant Psychologist, Clinical Psychologist, Assistant Psychologist, Counsellor and two Health and Wellbeing Officers. Each of these people play a key role in ensuring that the mental, physical health of all of the staff is well looked after. We offer specific care for staff inhouse through the Menopause Café which is led by Menopause Specialists in the Trust and an Endometriosis pathway specifically designed for the staff.

		Additionally, there are annual health checks available for all staff as a drop in facility from our occupational health physicians. These allow opportunity for blood pressure tests, cholesterol tests, general well-being conversation and health promotion materials e.g., asthma, diabetes, nutrition, physical wellbeing, mental wellbeing, prostate care and women's health care. Annual health and well-being conversations take place for each member of staff with their line manager to support staff to remain healthy at work and consider any reasonable adjustments that may be required.
2b – 'When at work, staff are free from abuse, harassment, bullying and physical violence from any source'	1 - Developing	Internal Policies - Equality and Human Rights Policy - Equality Impact Assessment Policy - Reasonable Adjustments Policy and Reasonable Adjustments Passport - Violence and Aggression Policy - Transitioning in the Workplace Policy - Resolution policy - Anti-Racist Approach

		- Fair and Just Culture - Zero Tolerance to Bullying and Harassment The NHS Survey, WRES and WDES reflects that there been an increase in staff reporting experiencing discrimination on the basis of ethnic background and disability (although a reduction on the basis of gender and religion). In addition, more staff have experienced physical violence (2%) and fewer are reporting it. Freedom to Speak Up and HR report low cases of abuse, harassment, bullying and physical violence. Staff are regularly encouraged to report instances of abuse, harassment, bullying and physical violence through staff networks, listening events, HR, EDI, FTSU and Ulysses reporting.
2c – Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source'	1- Developing	Internal Policies - Equality and Human Rights Policy - Equality Impact Assessment Policy

		- Reasonable Adjustments Policy and Reasonable Adjustments Passport - Violence and Aggression Policy - Transitioning in the Workplace Policy - Resolution policy - Anti-Racist Approach - Fair and Just Culture - Zero Tolerance to Bullying and Harassment Staff Networks are invited to contribute to all EDI action plans following national reporting criteria e.g., WRES, WDES. All EDI policies and procedures are equality impact assessed and staff networks have the ability to comment on these. Freedom to Speak Up Month run an annual campaign inviting colleagues to speak up. There are two Freedom to Speak Up Guardians, one of whom is from the global majority. The FTSUGs are embedded within the organisation and are members of relevant committees e.g., EDI Committee. The Trust works closely to Staff Side Chair and supports the Union Representatives to be impartial

		and where required, to work with partner organisations. The Great Place to Work Group is a platform for staff voices and lived experiences to be heard, there is a staff representative from each team in attendance. We will upskill the Great Place to work representatives to become champions for ensuring that staff have another avenue to raise concerns relating to behaviours. The Trust Board and other Committees have agenda items for lived experiences of staff and patients from protected characteristics. This is an opportunity to listen and learn, making improvements and positive change to practice.
2d – 'Staff recommend the organisation as a place to work and receive treatment'.	1 - Developing	The Trust NHS Staff Survey, WRES and WDES all demonstrate an improvement compared to last years data. 62.46% of staff report that they would recommend the organisation as a place work. 73.88% of staff report that if a friend or relative needed treatment they would be happy with the standard of care provided by Liverpool Women's NHS FT

		There are ongoing plans to deliver on EDI reporting mechanisms through listening events, surveys and Ulysses reporting. There is planned work to investigate the staff turnover, including the turnover of staff from the global majority. We have The Big Conversation, twice annually. This includes Executive Directors, Non-Executive Directors and senior leaders visiting each department/team in addition to this, focus groups are held for the following: - Medics - Nurses - Midwives - HCAs - Admin Staff - Racially Minoritised Staff - Staff with Disabilities and long-term - conditions In The Big Conversation, staff make suggestions for how we can improve. Following this, actions are developed and fed into divisional staff survey plans

Total Score	5/12	
EDS 2022 Outcome:	**Score**	**Assessor Comments/Discussion Points**
Domain 3: Inclusive Leadership		**Date of Assessment: 4 March 2024**
3a – 'Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities'.	1- Developing	Executive Leaders are continuously engaged about race, racism with the support of the EDI Lead. They also engage with the Anti-Racism Resource Hub on the staff intranet. Executive Leaders have focussed EDI objectives that have a focus on anti-racism and inclusion. Executive Leaders share widely with the Trust their 'anti-racism journey' for their senior leadership team (including our medical staff) and organisation wide. Equality, Core20Plus5, Health inequalities and EDS are standing items in internal meetings including Trust Board and Executive Board including workforce EDI and patient EDI.

		A key area that we are working on as an organisation is reducing health inequalities for people from the global majority in Maternal and Women's Health. Currently a key topic being worked on is reducing health inequalities in Maternity. Some of the ongoing at the Trust focusses on supporting staff to expand their understanding and knowledge through cascading of information and learning from our senior leaders and Executive Directors. The aim of the above pieces of work has been with a focus to the organisation becoming an anti-racist organisation
3b – 'Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed'.	3-Achieving	Both Equalities and Health Inequalities are discussed at Trust Board and other internal meetings on a regular basis. Actions are recorded in the minutes and/or action trackers. These are reported on and followed up at subsequent meetings. The Equality Impact Assessments are signed off at senior level through internal committees and any identified risks are highlighted directly to the Trust Board for

		consideration, mitigation and future monitoring. Accessible Information Standard is included in an action tracker along with Reasonable Adjustments which is monitored and reported on through internal committees where senior leaders ensure actions are implemented and embedded into everyday practice. The Trust acknowledge that the Equality Impact Assessments for projects and policies, whilst signed off at senior level are not normally reported through Trust Board or other formal committees and this is an area for consideration in the upcoming year to ensure clear and consistent EIA completion.
3c – 'Board members, system, and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients (response to Covid-19)'	3-Achieving	Trust Board and Senior Leaders monitor and ensure implementation of actions relating to the following: WRES, WDES, Gender Pay Gap and Equality Delivery System. These are all reported through senior leadership committees, discussed with staff inclusion networks and then ratified at Trust Board before publication on the Trust website.

		There is ongoing work in Divisions to review data in relation to leavers from the Trust and the reasons for them leaving. This will inform an action plan to improve the retention of staff particularly those from protected characteristic groups. Additionally, the Trust commissioned the EDI Mandatory Training and 'Being and Anti-Racist Leader' on the leadership programme to complement the Executives Facilitated Discussions on race, racism, and anti-racism. The Trust has signed up to: - Northwest Anti-Racism Framework - Smallest Things, Employer with a Heart Charter - Endometriosis Friendly Employer, - Miscarriage Association, Pregnancy Loss Pledge - These commitments are supported through local action plans which are monitored through internal committees. The Executive Leadership have shown commitment and accountability

		throughout, even in the face of challenging situations.
Total Score	7/9	
Final Score	16 - Developing	

EDS 2024 – Identified Gaps and Limitations.

Domain 1: Commissioned or Provided Services
The main gaps that were identified (which are articulated as limitations from hereon) when doing the assessment was around evidence provided being lean – the challenge is to prove that in this service, marginalised groups (as listed below) are being considered, and having a way of proving that this is happening through feedback, care pathways, engagement events, literature etc.
Many of the attendees spoke specifically about the need for improved engagement with the following groups:

- People with disabilities including Merseyside Society for Deaf People
- People from migrant backgrounds, refugees and asylum seekers
- People from Black, Asian and other ethnic minority groups
- Transgender people

The assessors justified the score of 1-developing in each of the outcomes in domain 1 as they felt that these groups face challenges when it comes to access to services, and a lack of information around Endometriosis for these groups and they identified a great need for inclusive engagement activity. They also thought that the Endometriosis Event held in September with the support of the Patient Experience Team was good, and that more work like that was needed.

Stakeholders for domain 1 included the following:

- Liverpool Women's NHS FT

- Integrated Care Board
- Health Watch
- Liverpool Primary Care Network
- BHA for Equality
- Liverpool Heart and Chest
- Merseyside Police
- LGBTQ Foundation

Domain 2: Workforce Health and Wellbeing

Whilst there was evidence that the organisation considers the health of staff, there was no evidence that this was analysed based on protected characteristics and that there were interventions for staff from marginalised groups e.g., monitoring sickness and absence data by protected characteristics 'to reduce negative impact of the working environment' as required for the achieving and excelling criteria of EDS. There was no evidence that the organisation promotes self-management of conditions to all staff including work-life balance, healthy lifestyles, and signposting to national and VSCE support.

Though the Trust has zero tolerance to verbal and physical abuse, there were some limitations around Trust responses to closed cultures. There is ongoing work to understand 'closed cultures' in the organisation related to protected characteristics and otherwise. The Trust is currently recruiting for a People Promise Manager and an Employee Experience Manager to support this work around Culture. The EDI Lead will work alongside these individuals.

In the NHS Staff Survey 62.46 of the respondents reported that they would recommend Liverpool Women's as a place to work. This was 1.15% more people than the previous year and 8.18% less than the national average. 19.8% of respondents with disabilities reported harassment, bullying and abuse from other colleagues in the last month. This is 2.54% less than the previous year and 2.03% better than the national average. 23.71% of respondents from the global majority reported experiencing harassment, bullying or abuse from staff in the last 12 months, a decline of 7.46% compared to the last year and 0.52% less than the national average.

Domain3: Inclusive Leadership

For the developing criteria in Outcome 3A Board members and senior leaders would be required to meet with staff networks 3 or more times a year and each staff network would require an Executive sponsor. The Chief People Officer is the Executive Sponsor for Equality, Diversity, Inclusion and Anti-Racism. However, we would need to identify Executive sponsors with staff networks in their EDI objectives.

In Outcomes 3B and 3C the Inclusive Leadership domain has been assessed as 'Achieving' as both equality and health inequalities are standing agenda items in board and committee meetings. Equality Impact Assessments are completed for projects and policies. To maintain this the Trust and

the Board need to ensure that this is consistent in the organisational business plans to help shape work to address needs. Additionally, the Trust need to ensure that 'those holding roles at AFC Band 7 and above are reflective of the population served'. There are 34 staff from the global majority who are Band 7 and above which is 16.1% of the overall staff population. This is representative of the Liverpool population which is 6.1% (excluding Gypsy and Irish Traveller, Irish, Roma and Other white communities 7.6%). Although Trusts are required to show consistent improvements in WRES and WDES metrics, the ongoing work and investment in EDI and anti-racism shows that the Trust and the Board are committed to inclusion and making improvements to reflect ongoing work and future work with the Anti-Racism Hub.

EDS 2022 – proposed report for ratification and publication on 7 April 2024 following EDI Committee comment and Trust Board approval.

Government guidance was for all Trusts to publish a version of their EDS report by 28 February 2024. Due to internal committees being streamlined and limited capacity within the EDI Team, there have been delays in completion and reporting within the timescales. As the EDI Team is due to expand in the upcoming financial year, there will be more capacity in the team to ensure that this does not happen. Additionally, there will be a clear schedule for committee and Trust Board dates to ensure timely approval and ratification.

This report includes the summary for the EDS implementation including the gaps identified in each of the domains. In the appendix, the full report is provided for the approval and ratification of the committee.

Summary / Actions

Domain 1: Commissioned or Provided Services the following actions are recommended:

- Enhance evidence provision – The Patient Involvement and Experience Sub-Committee along with the assessors recognised that whilst the Endometriosis Service provide an exemplary service, the evidence provided was lean. This was largely attributed to the limited capacity of the team. The first recommendation is to develop mechanisms to gather comprehensive evidence demonstrating consideration for marginalised groups. This could involve feedback mechanisms, care pathways, engagement events, and relevant literature.
- Improved engagement with marginalised groups – As a Trust, there has been improved engagement as reflected in the full EDS report through Patient Experience, particularly, the 'Listen, Learn, Act' method. However, it was identified by the assessors that there were limitations in the engagement and involvement of patients from marginalised groups. It is recommended that services engage with the Patient Experience and EDI Teams to facilitate engagement with marginalised groups and VCSE for opportunities to co-design, co-produce and collaborate. This could involve organizing inclusive events like the Endometriosis Event held in September organised and delivered by the Patient Experience Team.

- Trust to continue working collaboratively with the ICB Business Intelligence Team to deliver Equality and Health Inequalities Dashboards.

Domain 2: Workforce Health and Wellbeing, the following actions are recommended:

- Analyse workforce health data by protected characteristics to ensure that health analysis of staff considers protected characteristics to identify any disparities and implement targeted interventions for marginalised groups.
- Address closed cultures by continuing ongoing efforts to understand and address 'closed cultures' within the Trust, especially related to protected characteristics. Recruitment for positions such as People Promise Manager and Employee Experience Manager can support this work.
- Promote self-management and support for staff by implementing measures to promote self-management of conditions and overall wellbeing among staff, including work-life balance, healthy lifestyles, and access to support resources alongside the support provide by the Trauma Informed Care Service, Health and Wellbeing and Occupational Health Teams.

In Domain 3: Inclusive Leadership, the following actions should be taken:

- Enhance engagement with staff networks by ensuring that board members and senior leaders meet with staff networks regularly and assign executive sponsors to each network to support inclusion efforts.
- Maintain focus on equality and health inequalities by ensuring that equality and health inequalities remain standing agenda items in board and committee meetings. Consistently completing and conducting audits for Equality Impact Assessments related to projects and policies.
- Ensure representation in leadership roles by ensuring that leadership roles reflect the diversity of the population served, particularly at AFC Band 7 and above. Continuously monitor and improve representation metrics, demonstrating commitment to inclusion and anti-racism efforts.
- Showing consistent improvements in WRES and WDES metrics.

Recommendations

The Committee are asked to consider, approve and ratify the Equality Delivery System Report attached, pending approval from Trust Board before publication of finalised version on the Trust's website.

Appendix 1: Proposed Equality Delivery System report for ratification and publication on 11 April 2024

Liverpool Women's NHS Foundation Trust

Equality Delivery System 2024

Scoring

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

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

EDS assessment programme and results

The Trust held multiple engagement and assessment events on:

- July 2023 – Engagement
- August 2023 – Approval
- September 2023 – Engagement
- January 2024 – Assessment
- March 2024 - Assessment

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

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

Service Selected for Domain 1: Gynaecology – Endometriosis (Trust Score)

Classification: Official

Publication approval reference: PAR1262

NHS Equality Delivery System
EDS Reporting Template

Version 1, 15 August 2022

Contents

Equality Delivery System for the NHS

The EDS Reporting Template

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

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

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

NHS Equality Delivery System (EDS)

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

EDS Lead	Lisa Shoko, EDI Manager		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	6 July 2023 – Engagement 31 August 2023 – Approval 1 September 2023 – Engagement January 2024 – Assessment March 2024 - Assessment		**Individual organisation**	Liverpool Women's NHS Foundation Trust
			Partnership* (two or more organisations)	
			Integrated Care System-wide*	NHS and Cheshire Integrated Care Board

Date completed	February 2024	**Month and year published**	February 2024

Date authorised	February 2024	Revision date	February 2025

Completed actions from previous year	
Action/activity	**Related equality objectives**
• Working with DigiCare to improve the information that we get about patients protected characteristics – EDI Manager working collaboratively with the ICB to influence the development of ethnicity data collection. • Access Audit was conducted to help promote equality for people with protected characteristics in ensuring the environment is fit for purpose. Access Audit was completed at the end of November 2023 with the help of Izzy Garnell – awaiting the full report which should be in by the end of January. • The Trust has developed a local Accessible Information plan monitored by the Patient Experience and Involvement Facilitator – the initial plan was agreed by digital and patient experience senior leaders. • The Trust will continue to review the interpretation policy and follow through on any gaps that are identified. Additionally, there is ongoing work with the Trust volunteers to provide support for people accessing service when they are waiting for a qualified interpreter to attend. There is work being piloted with the Non-English-Speaking Team (NEST) who attend to people requiring maternal services who do not have English as a first language. The Trust will monitor and review the experiences of people using these services including translations provided by Signalise and Language Line.	We will improve access to all services for the population that we serve
• The Trust will continue building positive and enduring relationships with communities to improve services, support and outcomes for people. The Trust has developed a stakeholder map and an inclusion	We will work in Partnership with People and Communities

and engagement calendar which includes both internal and external events. Actions from the events are monitored through Patient Experience Sub-Committee.	
Revie the process for reasonable adjustments to support staff including educating managers and staff on resources available through Access to work – these have been included in the Employee Attendance and Wellbeing Toolkit developed by HR and readily available on the intranet	
Development of health and wellbeing plan in relation to self-management of conditions with the Trust Physical Health and Wellbeing Coach – programme being rolled out in 2024	

EDS Rating and Score Card

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

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

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

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Liverpool Women's NHS FT Trust Website https://www.liverpoolwomens.nhs.uk/about-us/ **Services Provided at Liverpool Womens:** Our services - Liverpool Womens NHS Foundation Trust **Endometriosis Clinic** **Locations:** Liverpool Women's NHS FT, Crown Street, Liverpool, L8 7SS (Main Site); Aintree University Hospital, Aintree Lower lane, Liverpool, L9 7AL 0151 525 5980 **Clinic Times:** Endometriosis Clinics are held each Wednesday and Thursday between 9:00am and 11:30am **Contact us** • If you need to rearrange or cancel your appointment, please contact Gynaecology	1	Gynaecology Outpatient Specialist Nurse (Endometriosis), Denise Carter; Equality, Diversity and Inclusion Lead, Lisa Shoko

		Access Centre on 0151 702 4328 (option 1), between 8.30am and 4.30pm, Monday to Friday. An answer machine is available out of hours. If you require any clinical information about your outpatients' appointment, please ring 0151 708 9988 ext.: 4617. **How to be seen** • To be seen in our Endometriosis Clinic please request a referral from your GP to the Liverpool Women's Endometriosis Clinic **Accredited Endometriosis Site** • Accredited Endometriosis Site - Liverpool Womens NHS Foundation Trust **Endometriosis Information Video** • This video is delivered by Ilyas Arshad, Consultant in Endometriosis, Manou Manpreet Kaur, Specialist in Endometriosis and Denise Carter, Endometriosis Nurse Specialist. **Click Link:** https://vimeo.com/694056513 • What Is Endometriosis and How Does It Develop? • Do You Have a Specialist Endometriosis Team?		

		• Can Endometriosis Affect Fertility? • How Long Is the Waiting Time for Treatment with Laparoscopic Surgery? • Do You Have to Have an MRI Scan for The Precise Localisation of Endometriosis? • Is Endometriosis on The Bowel Likely to Cause Digestion Issues Around the Time of Ovulation? • Can You Give Us the Words to Explain Why It Causes So Much Pain? **Endometriosis Easy Read Leaflet**  endometriosis easy read.pdf **Website Accessibility Information** • Liverpool Women's NHS FT is developing key goals around accessibility – the Trust will be implementing the action plan from the access audit last year, in 2024 quarter 2, additionally there is ongoing work focussing on local accessible information standard actions plans and digital inclusion.		
	1B: Individual patients (service users) health needs are met	• The service reports strong relationships with other services where people are being referred the Endometriosis Pelvic Pain Clinic, the Pelvic Pain Programme,	1	

		Physiotherapy, Psychosexual Therapists, Occupational Therapists. • In brief, respectively, these areas could help the patient understand pelvic pain, pelvic pain management, how movement can help with pain and mobility, how endometriosis can affect sexual intercourse and what different methods people could use to work more effectively, or to support their team members who are affected by endometriosis. • However, there has been an identified need for some support to be in-house for example mental health professionals to support with the condition which can be quite debilitating. This will help the service to assess the mental health of the patient at different stages of their treatment. • Patients are supported by the Endometriosis Specialist Nurse, who also provides signposting for example to Reasonable Adjustments, ACAS, Personal Independence Payment (PIP), Citizens Advice Bureau. • Due to the service being quite small, the Endometriosis Specialist Nurse		

	1C: When patients (service users) use the service, they are free from harm	• The service is led by a Consultant, a specialist nurse and supported by 15 Endometriosis Champions. • The service has a patient centred approach, and they encourage staff and patients to report any concerns to Ulysses, Freedom to Speak Up and PALS. A pathway has been developed to support staff with Endometriosis working at Liverpool Women's •  NSS23 Benchmark Reports_REP.pdf	1	
	1D: Patients (service users) report positive experiences of the service	• The service identified the need to share more broadly, the importance of making flexible working available to staff who are usually accessing services as patients as well. • To make a focussed and outcome-based effort in engagement the Patient Experience Team developed an Inclusion and Engagement Calendar which identifies awareness/celebration days, internal and external engagement events.	1	

		• The service, and the Trust are working collaboratively with voluntary sector organisations and partners to broader their reach and impact – engaging with patients on site and off site. • We make sure to give patients every opportunity to feedback on the care that they receive from this team through different methods including emails, phone calls, friends and family tests, complaints, British Society Gynaecology Endoscopy databases and lived experience stories. •  Final Board development slides  Engagement & Involvement Calend		
Domain 1: Commissioned or provided services overall rating			4	

Domain 1: Commissioned or provided services

Domain 2: Workforce health and well-being

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• The Trust has a Trauma Informed Service, which is staff with a Consultant Psychologist, Clinical Psychologist, Assistant Psychologist, Counsellor and two Health and Wellbeing Officers. Each of these people play a key role in ensuring that the mental, physical health of all of the staff is well looked after. • The two health and wellbeing officers have split responsibilities, with one health and wellbeing officer looking after and promoting Mental Health Wellbeing whereas the other is looking after Physical Health and Wellbeing. • We offer specific care for staff inhouse through the Menopause Café which is led by Menopause Specialists in the Trust and an Endometriosis pathway specifically designed for the staff. • Additionally, there are annual health check s available for all staff as a drop in facility from our occupational health physicians. These allow opportunity for blood pressure tests, cholesterol tests, general well-being conversation and health promotion materials e.g., asthma, diabetes, nutrition, physical wellbeing, mental wellbeing, prostate care and women's health care. • Annual health and well-being conversations take place for each	2	

		member of staff with their line manager to support staff to remain healthy at work and consider any reasonable adjustments that may be required.		

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• Internal Policies & Culture - Equality and Human Rights Policy - Equality Impact Assessment Policy - Reasonable Adjustments Policy and Reasonable Adjustments Passport - Violence and Aggression Policy - Transitioning in the Workplace Policy - Resolution policy - Anti-Racist Approach - Fair and Just Culture - Zero Tolerance to Bullying and Harassment The NHS Survey, WRES and WDES reflects that there been an increase in staff reporting experiencing discrimination on the basis of ethnic background and disability (although a reduction on the basis of gender and religion). In addition, more staff have experienced physical violence (2%) and fewer are reporting it. • Freedom to Speak Up and HR report low cases of abuse, harassment, bullying and physical violence. • Staff are regularly encouraged to report instances of abuse, harassment, bullying and physical violence through staff	1	

		networks, listening events, HR, EDI, FTSU and Ulysses reporting.		

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	• Internal Policies
		  ○ Equality and Human Rights Policy
		  ○ Equality Impact Assessment Policy
		  ○ Reasonable Adjustments Policy and Reasonable Adjustments Passport
		  ○ Violence and Aggression Policy
		  ○ Transitioning in the Workplace Policy
		  ○ Resolution policy
		
		• Zero tolerance approach to bullying,
		• harassment and abuse with a new policy written in a fair and just culture approach.
		• Staff Networks are invited to contribute to all EDI action plans following national reporting criteria e.g., WRES, WDES. All EDI policies and procedures are equality impact assessed and staff networks have the ability to comment on these.
		• Freedom to Speak Up Month with alternative options where they can access support and safely raise concerns. There are two Freedom to Speak Up Guardians, one of whom is from a racially minoritised background and is from a clinical background. The FTSUGs are embedded within the organisation and are members of
			1	

		relevant committees e.g., EDI Committee. FTSUGs have a slot on corporate introduction to explain their role and introduce themselves to new starters. The organisation works closely to Staff Side Chair and supports the Union Representatives to be impartial and where required, to work with partner organisations. Promotion ran during Anti-Bullying Week with a launch of the newly developed Values to Behaviours guidelines. This has been developed by staff through various focus groups and engagement events following the National Staff Survey results. • The Great Place to Work Group is a platform for staff voices and lived experiences to be heard, there is a staff representative from each team in attendance. We will upskill the Great Place to work representatives to become champions for ensuring that staff have another avenue to raise concerns relating to behaviours. The Trust Board and other Committees have agenda items for lived experiences of staff and patients from protected characteristics. This is an opportunity to listen and learn, making improvements and positive change to practice.		

	2D: Staff recommend the organisation as a place to work and receive treatment	• The Trust NHS Staff Survey, WRES and WDES all demonstrate an improvement compared to last years data.
		• 62.46% of staff report that they would recommend the organisation as a place work.
		• 73.88% of staff report that if a friend or relative needed treatment they would be happy with the standard of care provided by Liverpool Women's NHS FT
		• There are ongoing plans to deliver on EDI reporting mechanisms through listening events, surveys and Ulysses reporting.
		• There is planned work to investigate the staff turnover, including the turnover of staff from the global majority.
		• We have The Big Conversation, twice annually. This includes Executive Directors, Non-Executive Directors and senior leaders visiting each department/team in addition to this, focus groups are held for the following:
		  ○ Medics
		  ○ Nurses
		  ○ Midwives
		  ○ HCAs
		  ○ Admin Staff
		  ○ Racially Minoritised Staff
		  ○ Staff with Disabilities and long-term
			1	

		○ conditions • In The Big Conversation, staff make suggestions for how we can improve. Following this, actions are developed and fed into divisional staff survey plans		
Domain 2: Workforce health and well-being overall rating			5	

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• Executive Leaders are continuously engaged about race, racism with the support of the EDI Lead. • They also engage with the Anti-Racism Resource Hub on the staff intranet. • Executive Leaders have focussed EDI objectives that have a focus on anti-racism and inclusion. • Executive Leaders share widely with the Trust their 'anti-racism journey' for their senior leadership team (including our medical staff) and organisation wide. • Equality, Core20Plus5, Health inequalities and EDS are standing items in internal meetings including Trust Board and Executive Board including workforce EDI and patient EDI. • A key area that we are working on as an organisation is reducing health inequalities for people from the global majority in Maternal and Women's Health. • Currently a key topic being worked on is reducing health inequalities in Maternity. • Staff Network Chairs are in attendance at EDI Committee and have recently been	1	

		• Some of the ongoing at the Trust focusses on supporting staff to expand their understanding and knowledge through cascading of information and learning from our senior leaders and Executive Directors. The aim of the above pieces of work has been with a focus to the organisation becoming an anti-racist organisation		

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	• Both Equalities and Health Inequalities are discussed at Trust Board and other internal meetings on a regular basis. • Actions are recorded in the minutes and/or action trackers. These are reported on and followed up at subsequent meetings. • The Equality Impact Assessments are signed off at senior level through internal committees and any identified risks are highlighted directly to the Trust Board for consideration, mitigation and future monitoring. • Accessible Information Standard is included in an action tracker along with Reasonable Adjustments which is monitored and reported on through internal committees where senior leaders ensure actions are implemented and embedded into everyday practice. • The Trust acknowledge that the Equality Impact Assessments for projects and policies, whilst signed off at senior level are not normally reported through Trust Board or other formal committees and this is an area for consideration in the upcoming year to ensure clear and consistent EIA completion.	3	

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	• Trust Board and Senior Leaders monitor and ensure implementation of actions relating to the following: WRES, WDES, Gender Pay Gap and Equality Delivery System. These are all reported through senior leadership committees, discussed with staff inclusion networks and then ratified at Trust Board before publication on the Trust website.
		• There is ongoing work in Divisions to review data in relation to leavers from the Trust and the reasons for them leaving. This will inform an action plan to improve the retention of staff particularly those from protected characteristic groups.
		• Additionally, the Trust commissioned the EDI Mandatory Training and 'Being and Anti-Racist Leader' on the leadership programme to complement the Executives Facilitated Discussions on race, racism and anti-racism
		• The Trust has signed up to:
		  ○ Northwest Anti-Racism Framework
		  ○ Smallest Things, Employer with a Heart Charter
		  ○ Endometriosis Friendly Employer,
			3	

		○ Miscarriage Association, Pregnancy Loss Pledge • These commitments are supported through local action plans which are monitored through internal committees. • The Executive Leadership have shown commitment and accountability throughout, even in the face of challenging situations.		
Domain 3: Inclusive leadership overall rating			7	
Total Score			16	
Third-party involvement in Domain 3 rating and review				
Trade Union Rep(s):		**Independent Evaluator(s)/Peer Reviewer(s):**		

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

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

Domain	Objective	Action	Completion date

Domain 1: Commissioned or provided services	• Enhance evidence provision – The Patient Involvement and Experience Sub-Committee along with the assessors recognised that whilst the Endometriosis Service provide an exemplary service, the evidence provided was lean. This was largely attributed to the limited capacity of the team. The first recommendation is to develop mechanisms to gather comprehensive evidence demonstrating consideration for marginalised groups. This could involve feedback mechanisms, care pathways, engagement events, and relevant literature. • Improved engagement with marginalised groups – As a Trust, there has been improved engagement as reflected in the full EDS report through Patient Experience, particularly, the 'Listen, Learn, Act' method. However, it was identified by the assessors that there were limitations in the engagement and involvement of patients from marginalised groups. It is recommended that services engage with the Patient Experience and EDI Teams to facilitate engagement with marginalised groups and VCSE for opportunities to co-design, co-		

	produce and collaborate. This could involve organizing inclusive events like the Endometriosis Event held in September organised and delivered by the Patient Experience Team. • Trust to continue working collaboratively with the ICB Business Intelligence Team to deliver Equality and Health Inequalities Dashboards.		

Domain	Objective	Action	Completion date

Domain 2: Workforce health and well-being	• Analyse workforce health data by protected characteristics to ensure that health analysis of staff considers protected characteristics to identify any disparities and implement targeted interventions for marginalised groups. • Address closed cultures by continuing ongoing efforts to understand and address 'closed cultures' within the Trust, especially related to protected characteristics. Recruitment for positions such as People Promise Manager and Employee Experience Manager can support this work. • Promote self-management and support for staff by implementing measures to promote self-management of conditions and overall wellbeing among staff, including work-life balance, healthy lifestyles, and access to support resources alongside the		

	support provide by the Trauma Informed Care Service, Health and Wellbeing and Occupational Health Teams.		

Domain	Objective	Action	Completion date
Domain 3: Inclusive leadership	• Enhance engagement with staff networks by ensuring that board members and senior leaders meet with staff networks regularly and assign executive sponsors to each network to support inclusion efforts. • Maintain focus on equality and health inequalities by ensuring that equality and health inequalities remain standing agenda items in board and committee meetings. Consistently completing and conducting audits for Equality Impact Assessments related to projects and policies. • Ensure representation in leadership roles by ensuring that leadership roles reflect the diversity of the population served, particularly at AFC Band 7 and above. Continuously monitor and improve representation metrics,		

	demonstrating commitment to inclusion and anti-racism efforts. • Showing consistent improvements in WRES and WDES metrics.		

Appendix:

Liverpool Women's Diversity and inclusion

https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights

Liverpool Women's Commitment to Anti-Racism

https://www.liverpoolwomens.nhs.uk/about-us/diversity-inclusion-human-rights/race-equity-declaration-of-intent/

Anti-Racism Resources Hub

LWH Intranet - Anti-Racism Hub (liverpoolwomens.nhs.uk)

Staff Engagement Survey

https://forms.office.com/e/kRxU6iYMkC

Equality Delivery System 2023 Presentation

EDS 2023
Presentation Feb 24.p

Endometriosis Engagement & Assessment 2023

Endometriosis
Engagement 16 Febru

Diversity in Health Care Programme

Diversity in Health and Care Partners Programme 2023 2024 brochure.pdf (nhsemployers.org)

North West Anti-Racism Framework:

The-North-West-BAME-Assembly-Anti-racist-Framework-FINAL.pdf (england.nhs.uk)

Liverpool Women's Trauma Informed Care Support Service

Staff Support and Trauma Informed Care

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

Gender Pay Gap Report 2023

Gender Pay Gap Report _ 31 March 20

WRES and WDES Report 2023

WRES WDES report 2023 Trust Board (002

NHS Staff Survey

NSS23 Benchmark Reports_REP.pptx

'How We Listen' Patient Experience Presentation 2023

Listening - Patient Experience July 23.pd

Great Place to Work

Great Place to Work.pdf

Attendance Manager Toolkit

Attendance Management Toolkit.p

Liverpool Women's NHS Foundation Trust

Putting People First Committee

COVER SHEET

Agenda Item (Ref)	*Secretary to complete*		Date: 18/03/2024	
Report Title	Equality and Diversity Annual Report			
Prepared by	*Lisa Shoko, EDI Lead & Rachel London, Deputy Chief People Officer*			
Presented by	*Lisa Shoko, EDI Lead*			
Key Issues / Messages	The report highlights the Trust's commitment to becoming one of the most inclusive organisations in the NHS, particularly focussing on anti-racism The report outlines ongoing evaluation and improvement plans dedicated to inclusion and anti-racism The report sets ambitious goals for increasing representation of global majority staff in leadership roles, and developing a culture of inclusion through the Anti-Racism Hub			
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.*			
	For the committee to receive the report and be informed of EDI actions in 2023 For the committee to be cited on EDI plans for 2024			
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* Choose an item.	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

EXECUTIVE SUMMARY

1. Define the issue

In a concerted effort to address racial inequalities and develop a more inclusive workplace environment, Liverpool Women's NHS Foundation Trust has embarked on a transformative journey. At the heart of this endeavour lies the establishment of an Anti-Racism Hub, a pivotal initiative aimed at driving change over the course of a comprehensive three-year program.

Central to the success of this initiative is the recruitment of key roles, including the appointment of a Head of Culture and Inclusion, Practice Education Facilitator, Assistant Psychologist, and an EDI Officer. These individuals will spearhead efforts to embed anti-racism principles throughout the organisation, ensuring that every aspect of the Trust's operations reflects a commitment to diversity and equity.

Recognising the importance of continuous learning and development, the Trust has also prioritised enhanced EDI Learning & Development learning. Mandatory training programs and leadership coaching sessions are now integral components of staff development, supporting individuals at all levels to champion inclusion and anti-racism within their respective roles.

Furthermore, the Trust has actively engaged staff through different workstreams designed to develop an open and supportive culture. Anonymous surveys provide a platform for candid feedback, while the "Call It Out, Stamp It Out" campaign encourages individuals to report instances of discrimination or bias, reinforcing a zero-tolerance approach to racism.

The Trust's dedication to inclusion has not gone unnoticed, with the Trust earning recognition among the Top 50 Most Inclusive Employers (positioned 41st). Such accolades serve as a testament to the ongoing efforts to create a workplace where every individual feels valued and respected.

Moreover, the Trust has prioritised the well-being of its staff through the establishment of support services such as the Staff Support and Trauma Informed Care service. This resource provides confidential assistance to staff members facing difficulties related to their work, ensuring they have access to the support they need to thrive.

Additionally, the Trust is committed to widening participation within the community. Through programs offering internships and apprenticeships, individuals from diverse backgrounds are provided with opportunities to explore careers within healthcare, promoting greater representation and diversity within the workforce.

Equally important is the Trust's engagement with patients and carers to enhance service accessibility and inclusion. By actively seeking feedback and implementing improvements, the hospital aims to ensure that all individuals receive high-quality care tailored to their unique needs.

Looking ahead, the Trust remains steadfast in its commitment to advancing EDI and anti-racism initiatives. Plans for the upcoming year include the launch of the Anti-Racism hub, the delivery of a cultural survey to further inform efforts, and ongoing work to promote inclusion at every level of the organisation. Through these collective endeavours, Liverpool Women's Hospital continues to strive towards a future where equity, diversity, and inclusion are the cornerstones of its operations.

2. Key Findings

To meet the ambitious goal that the Trust has set to become on of the most inclusive organisations in the NHS. These are some of the key issues that are highlighted in the report.

Central to this mission is the Trust's Commitment to Anti-Racism and EDI and Anti-Racism workstreams. Recognising the pervasive impact of systemic racism, the Trust has declared its intent to become an anti-racist organisation. Through proactive measures aimed at identifying, discussing, and challenging racism within its systems, the Trust is laying the groundwork for meaningful and lasting change.

Diverse workforce representation and leadership diversity is a cornerstone of the Trust's agenda. With a bold ambition to triple the number of staff from global majority backgrounds in leadership roles by 2025, the organisation is dedicated to dismantling barriers to career progression and creating pathways for underrepresented individuals to succeed.

Supporting staff on their journey towards equity and inclusion is paramount, and the Trust is committed to providing comprehensive Staff Support and Training programs. From the introduction of guaranteed interviews for global majority staff to the establishment of an Anti-Racism Hub and ongoing anti-racism and leadership training, the organisation is empowering its workforce to drive positive change from within.

Furthermore, the Trust is dedicated to enhancing Patient and Carer Experience, recognising that every interaction is an opportunity to develop inclusion and address systemic barriers. Initiatives such as the Help and Advice Hub and the Secret Shopper program are just a few examples of the Trust's commitment to ensuring that every individual receives high-quality care tailored to their unique needs.

Engagement with the Volunteer Service and Widening Participation are also key pillars of the Trust's strategy. By actively involving volunteers in its endeavours and launching programs like Bi-lingual volunteers, the organisation is creating opportunities for individuals from all walks of life to contribute meaningfully to its mission.

As the Trust moves forward, it remains dedicated to EDI inclusion in policies, monitoring and evaluation processes, ensuring that inclusion and anti-racism principles are embedded throughout every aspect of its operations. Additionally, the organisation is committed to awareness and celebrating events, recognising the importance of commemorating key culture days and fostering a culture of learning and growth.

Finally, through collaboration and partnerships with community stakeholders, the Trust is amplifying its impact and driving collective action towards a more equitable and inclusive future. By co-designing initiatives aimed at addressing health inequalities and improving staff and patient experiences, Liverpool Women's Hospital is leading the charge towards a brighter tomorrow for all.

Solutions / Actions

3. Recommendations

To review the full report which is attached and for the Putting People First Committee to approve the EDI Annual Report

Liverpool Women's NHS Foundation Trust

Equality & Diversity Annual Report 2024

Contents

1.0 Our Aims, Vision & Values

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

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

1.1 Our Aims – We See

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

1.2 Our Vision

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

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

1.3 Our Values

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

1.4 Our Commitment to Anti-Racism

Liverpool Women's has a strategic objective to drive towards becoming one of the most inclusive organisations in the NHS. The Board has previously agreed that the initial area of focus within our wider inclusion agenda is racial equity.

At a time where statements are no longer enough, here at Liverpool Women's we want to proactively confront all forms of systemic racism as part of an ongoing commitment to being an anti-racist organisation.

Fundamental to this commitment is to foster an environment where colleagues, patients, their friends and families, from all backgrounds, can thrive - free from discrimination, inequity, unfairness and prejudice. To enable this, we will strive to remove bias – unconscious or otherwise – from our policies and processes and root out bullying, harassment and other unacceptable behaviours.

Being actively anti-racist at LWH means opposing racism through positive actions that purposefully identify, discuss, then challenge racism and the impact it has on our organisation, our systems and our people.

There is no room for neutrality. LWH is committed to an equitable approach where our people are enriched by their differences ensuring fairness. We can and must do better.

LWH being antiracist is fundamental to ensuring we have the best, talented and diverse people to maintain our longstanding reputation for providing the safest care and outstanding experiences.

Click here to read Liverpool Women's anti-racism commitment in full.

Additionally, we maintain the ambition of becoming on of the most inclusive organisations in the NHS. We have aspire to treble the number of staff from racially minoritised backgrounds in leadership roles (band 7 and above) and ensure that our workforce matches the ward of Riverside in terms of the percentage (%) of staff from racially minorities backgrounds by 2025.

1.5 Reasons to be Proud.

Liverpool Women's has made great strides in Equality, Diversity and Inclusion, and continues to progress across the Trust. See below our infographic with some of our 2023 highlights and 'Reasons to be Proud'.

Inclusion @ LWH
Reasons to be Proud 2024

NHS
Liverpool Women's
NHS Foundation Trust

Our Strategic Ambition: We will be recognised as one of the most inclusive organisations in the NHS with zero discrimination for staff and patients (zero complaints from patients, zero investigations)

We will:

- Treble number of staff from ethnic minority backgrounds in leadership roles (Band 7 and above) by 2024
- Ensure our workforce matches the ward of Riverside in terms of % of staff from ethnic minority backgrounds by 2025

Introduced EDI **Mandatory Training**

Launched the **Help Hub**

Launched the Annual EDI Conference

Delivered **'Championing Change'** webinar to Inclusive Companies Membership

Launched Volunteers to Careers and Bi-Lingual Volunteers Programmes

Recognised for 3rd year running as the **41st Most Inclusive Employer** in the 2023 Inclusive Top 50

Completed the **Environmental Access Audit**

Launched an **Anti-Racism Leadership** module for the Leadership Development Programme

Patient Experience Team developed relations with marginalised groups in the local community

We 'Listen', 'Learn' and 'Act' when we engage with **Patient and Staff Lived Experience Stories**

Liverpool Women's ran its first **pre-employment programme** post-pandemic

Signed the **Armed Forces Covenant** achieved Silver accreditation

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

2.0 Context

2.1 Equality Objectives

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

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

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

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

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

3.0 Activity in 2022/23

3.1 Our EDI Ambition and Achievements in 2023/24

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

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

As outlined within the Trust Strategy 2021-25 LWH is

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

With ambitions to achieve this including:

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

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

In 2022, we commenced our anti-racism programme, and this will continue to be further shaped by learning from events and from the feedback we receive from our workforce, our patients and families and our communities. This programme includes Trust Board development, Executive Team Coaching, Anti-Racism and Leadership Training, reviewing recruitment processes and HR policies.

At Liverpool Women's we recognise that racism, including that which might present as unconscious bias, exists in our society, in our city and therefore exists within our organisation. We do not shy away from this, and we are committed to learning and improving in partnership with our workforce, our patients, and our communities.

As part of our Trust Improvement Programme, we are setting up an Anti-Racism Hub to deliver a 3 year actively anti racist programme. This is currently being developed ready for launch of activities shortly. To make sure we are delivering the correct activities over the next 3 years we intend to commission an independent cultural survey of staff, service users, leavers, partners, volunteers & students to better understand our current baseline and through a process of engagement and analysis inform the next stages of the programme.

3.2 Current Equality, Diversity and Inclusion Team

The Core EDI Team is the EDI Lead who works in the team 50:50 split patients and workforce and a Practice Education Facilitator who works in the team one day a week, mainly focussing on workforce EDI.

In the delivery of EDI priorities, the team is supported by the Communications Team, HR Team, L&OD Team, Trauma Informed Service and Health and Wellbeing Service regularly.

Through the recently introduced Trust Improvement Plan, anti-racism has been identified as an area of focus, which has brought resources into the Team. To deliver anti-racism there have been resources identified to recruit the following roles: Head of Culture and Inclusion, EDI Officer, Practice Education Facilitator, Assistant Psychologist. Alongside the current EDI Lead and Practice Education Facilitator, this will be the core team in the Anti-Racism Hub. The Head of Culture and Inclusion with the support of the Team will be responsible for launching the hub, and deliverables related to race inclusion and anti-racism. All of these roles are funded for 12 months.

3.3 EDI Learning & Development

In 2023/4 the Trust enhanced the EDI Learning Offer to include the EDI Mandatory Training, 'Being an Anti-Racist Leader' and Executive Leadership Coaching. The EDI Lead provides bespoke support for teams in collaboration with other teams, including the L&OD, Trauma Informed Service. Additionally, the EDI Lead with the support of L&OD and Communications have ensure that there are race inclusion and anti-racism resources on the intranet. This is referred to as the Anti-Racism Resources Hub. Available here: LWH Intranet - Anti-Racism Hub (liverpoolwomens.nhs.uk)

The EDI Lead is working collaboratively with the ICB on two main projects. The first looks at ethnicity data recording and collection and responding the need in the system for improved data recording, including training staff to ask the right questions, engaging with communities to socialise the importance of data, creating opportunities for patients to self-declare their protected characteristics for example. The second project looks at creating EDI Dashboards for Cheshire and Merseyside on capturing protected characteristics and health inclusion groups. Liverpool Women's already have a Patient EDI Dashboard available for use across the Trust. The Patient EDI Dashboard is available on Power BI and helps the Trust, teams and individuals to help them to understand who their patients are and identify areas where there might be inherent health challenges or social determinants of health. The Cheshire and Merseyside dashboards which are currently under development will tell Trusts more information about their patient profiles e.g., which patients fall within particular health groups like people experiencing homelessness as an example.

3.4 Staff Engagement

From an EDI perspective, there is a drive towards finding different ways of supporting colleagues to speak up about issues that have to do with discrimination as defined by the Equality Act of 2010.

The Team has developed a survey for wider distribution which is due to be launched by the Communications team in coming weeks. The survey is a pathway for staff, patients and others to share their concerns with the organisation anonymously. For example, a patient who might not want to be identified, might have information about an incident that they observed, and wish for it to be investigated, or recorded. Another example is where a colleague might want guidance on how to be more inclusive in their team because of challenges and growing tensions. The EDI Team on the responding side of that communication will be able to advise and support appropriately.

Here is the survey link: https://forms.office.com/e/kRxU6iYMkC

Additionally, there is an ongoing communications campaign 'Call It Out, Stamp It Out' for people who witness or experience racism to report directly to freedom to speak up or the EDI Lead. This campaign has been staff facing and patient facing to ensure that people have every opportunity to let us know if they experience racism or discrimination.

Furthermore, the EDI Team and Trauma Informed Care Service are working collaboratively to develop a psychological support offer for the anti-racism programme. The Trust recognises that conversations about race can be challenging for different people, regardless of their ethnic background for different reasons. As such, it is responsible to ensure that we are able to support individuals and teams throughout the delivery of the programme.

3.5 Our EDI and Anti-Racism Journey

- **Inclusive Companies** - Top 50 Most Inclusive Employers List for the third year running. 7 place fall from 34th to 41st most inclusive employer in the Inclusive Top 50 list for 2023. February 2024, the Trust was invited to deliver a webinar for Inclusive Companies Membership to talk about 'Championing Change: Liverpool Women's Journey Towards Anti-Racism'. This included the highlights of work undertaken over the last couple of years to establish a good foundation for the work of anti-racism.
- **Guaranteed Interviews** –In recruitment we have implemented the two ticks model that is also available for candidates with a disability. This ensures that candidates meeting the essential criteria are shortlisted for interviewing. This has been successful and led to the design and development of the 'Licence to Hire' training.

- **Board And Senior Leaders Development**- The Board and Senior leaders are engaged in Diversity in Health and Care Partners Programme. See more about the programme here: Diversity in Health and Care Partners Programme 2023 2024 brochure.pdf (nhsemployers.org)

- **North West Anti-Racism Framework** – The Trust is currently in the process of conducting a self-assessment to obtain the Bronze accreditation. At the end of the year, the Trust will make a submission for the Silver accreditation after completing the required criteria. See more about the North West Anti-Racism Framework here: The-North-West-BAME-Assembly-Anti-racist-Framework-FINAL.pdf (england.nhs.uk)

- **EDI Mapping** - Alongside the Anti-Racism Framework mentioned above, the Trust is mapping EDI and anti-racism work to ensure comprehensive capture of all best practice activities including NHSE EDI Improvement Framework this will also include any actions developed from the Cultural Survey of all clinical services (staff, patients, volunteers and students) which will be conducted by an external organisation
- **Patient and Staff Lived Experience Stories – The Trust** continued learning shared at our Equality, Diversity & Inclusion Committee, Putting People First Committee and Trust Board meetings. The Trust has developed a model which informs how we listen. 'We Listen, We Learn, We Act'
- **Continued to Deliver the Menopause Club in 2023/4 –** for our staff who are experiencing symptoms. The club is run by in-house specialists in menopause and offers support around 'hot topics' followed by brief consultations and treatment plans on headed paper that can be shared with GP's
- **Endometriosis Support for Staff** – The Endometriosis Service developed a pathway for colleagues to prioritised for Endometriosis care, to ensure that Liverpool Women's staff receive care at the earliest opportunity.

3.6 Staff Support Service

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

The service is led by Dr Emma Evans, Consultant Clinical Psychologist. The Trauma Informed Care Team includes a Trainee Clinical Psychologist, Assistant Psychologist, Clinical Psychologist, Counsellor, CBT Therapist, Health and Wellbeing Coaches who will be offering support i.e. workshops signposting, listening ear sessions from our health and wellbeing coaches, and psychological therapies.

This service is available to support staff with the emotional and psychological demands of their role, recognising the potential impact these demands may have on both

personal and professional lives. The support will be confidential and is available face to face, by telephone or remotely.

3.7 Widening Participation

The Trust supports pre-employment programmes with the purpose of providing an opportunity to those within the community to experience what it is like to work both at the Trust and within the NHS. The programme also aims to enable those on the programme to be employment ready. The Widening Participation programme is aimed at people who may not possess academic qualifications yet have the attitude and values congruent to the NHS by supporting people and providing opportunities for development.

In 2023/24, successful programmes include;

- Supported Internships - The Trust has supported internship schemes for young people with additional needs. In the reporting period 6 interns have been supported to complete an 8-month placement with LWH in June 2023. All interns identified as neurodiverse with one individual also identifying as having physical disabilities. The interns worked in areas of reception, kitchen stores, ward hostess, portering and estates. Of the 6 interns one is returning to LWH to undertake a supported apprenticeship, one has obtained a job as a maintenance assistant in a care home whilst studying at college. A further intern is going to college to learn carpentry, and another is going to undertake a catering course with the final student joining the step into work programme for 18- to 25-year-olds with learning difficulties, which combines work and education placements to ensure trainees are truly work ready.
- Acorns/Cadets - providing placements to 16–19-year-old college students studying a Level 3 Extended BTEC Diploma in Healthcare considering a career in the NHS. The Trust accommodated 3 learner placements during the reporting period in Neonatal Unit, MatBase Ward and Maternity Assessment Unit. It is too soon to measure the success of where the learners may go on to gain places in courses within Health.
- Work Experience – During this reporting period work experience has slowly re-opened further to work directly with those schools where students have shown an interest in a career in health. We have provided one-week placements to 25 students, in areas such as Neonatal, Maternity, Gynaecology, Pharmacy and Corporate services. In addition, a group of Year 10 students visited the Trust and met professionals including those within HR, Finance, Pharmacy, Theatre (ODPs), Neonatal (nurses).
- Apprenticeships – 3 places filled with staff working in the areas of Finance, Digital and Clinical Advanced Practitioner from Gynaecology.

- Recruitment Fairs and Careers Events – the Trust actively attends and participates in fairs to share opportunities to communities on job availabilities. During January 2023-June 2023 the Trust attended a Careers event at Archbishop Beck where approximately 1,000 individuals attended to learn about the different careers available within Health. LWH attended with staff from the areas of Neonatal, Theatres, Pharmacy, HR, and Genetics. An additional careers event at St John Bosco was attended by LWH that involved approximately 800 students and included representation across divisions and corporate services also.
- Supporting schools – three staff from LWH attended Archbishop Blanch High School to take part in providing mock interviews for year 11 students.

3.8 Volunteers Service

The infographic below details some of the achievements that the Volunteers have had in the past year.

The volunteer service has had done tremendous work, in 2023/4 they have been successful in championing inclusion across different protected characteristics and engaging and supporting different areas across the Trust.

In 2024, the service launched the Bi-lingual volunteers which has been established to improve our patient experience and engagement through pastoral support. This will not include any clinical interpretations in accordance with national guidance. There are twenty-one volunteers who speak more than one language in the team. We are currently in the process of recruiting more volunteers from our local communities, who can speak additional languages to enhance our support offer. This includes volunteers from our deaf community supported by their own interpreter.

Our Bi-Lingual volunteers are identified by badges that identify the language that they speak by the flag and is written in English and the additional language.

A request has been made by our local Bangladesh community to translate some of our written information into audio translation. Volunteer manager is working with their link person to make this happen.

Additionally, one of our Bi-lingual volunteers has been shortlisted for the National Heroes award for Volunteering. This is in recognition of supporting patients on Maternity Base whose first language is not English. The award ceremony is taking place in April 2024.

"I have enjoyed making friends with the staff and cueing over the newborn babies and children I see while pushing my post trolley around the corridors of the ground floor. Not only am I the post person, but I often support patients and visitors by giving directions and assistance.

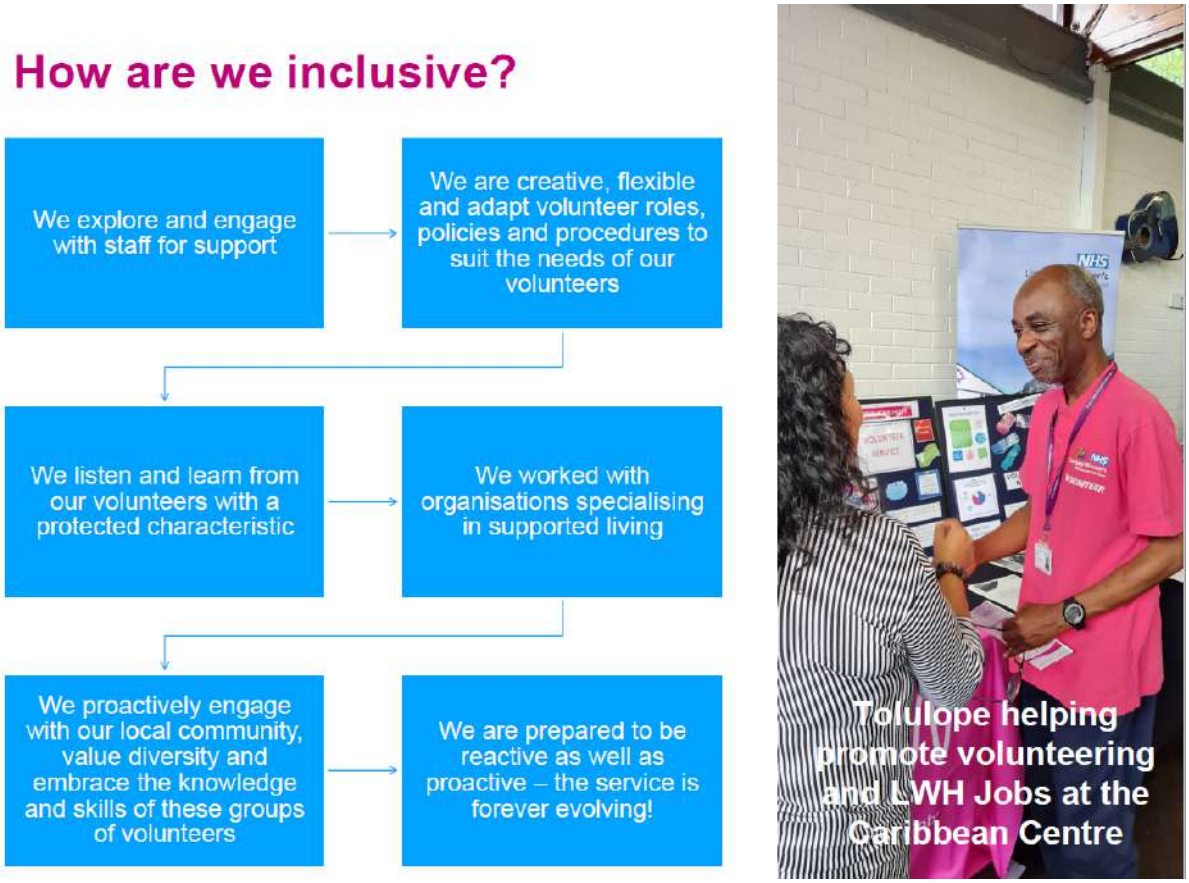
This role has helped build my confidence and improve my communication skills. I look forward to coming in each week. Some of the highlights of volunteering include receiving recognition for my 20 years of service and Volunteer of the Year, for the good work and support I give to the hospital." Michael, Liverpool Women's Volunteer

In addition, the Volunteers Service provided:

- 1:1 support with the onboarding process, and or provide a personal experience with the support of the volunteer service instead of TRAC with the Recruitment Team
- Mandatory training for volunteers who do not have capacity to understand or complete the training do not have to do it, instead their support worker completes the training on their behalf. Volunteers with mild SEN are given support by the Volunteer. Team to complete the training. Aim is to convert training to Easy Read & Questions

- Buddying – extra support during shifts from another volunteer or member of staff, maintain that support until the disabled volunteer feels comfortable.

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



3.9 Staff Inclusion Networks

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

REACH network colleagues from racially and ethnically diverse communities, and in the past year, notably delivered a report led by the Vice Chair during Black History about the experiences of race/racism by staff in the organisation. This resulted in an organisational response to actively engage with learning about race/racism including considerations of how to staff, service users and families accessing our services.

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

PRIDE@LWH, established their network in 2023. The group was successful in delivering its first Pride in Liverpool stall last year and will be working towards another

appearance at the celebratory event this year supporting LGBTQ+ service users and staff. The groups include LGBTQ+ staff and allies.

Additionally, there is the Menopause Café, where in-house Menopause Specialists advise colleagues at different stages i.e., perimenopause, menopause and post menopause to manage their symptoms and keep healthy. At the Menopause Cafes specialists provide rapid consultations and information about managing Menopause.

Another staff support offer in Women's Health has developed this year. This is the Endometriosis Staff Support The service have developed a staff pathway for colleagues to prioritised for Endometriosis care, to ensure that Liverpool Women's staff receive care at the earliest opportunity. Additionally, in this year's annual Equality Delivery System (EDS) review, the Endometriosis service achieved the score of 8 out of a possible 12. The EDI Lead made not of the engagement work that the service is doing with different marginalised groups and primary care services e.g., GP services in Kensington where the Team are working in partnership with primary care to develop an improvement of access to Endometriosis services and the quality of referrals they receive.

4.0 Patient and Carer Experience and Service Improvement related to EDI

The Patient Experience Team and EDI Team have been successful in working collaboratively and cohesively to develop EDI focussed plans for the benefit of patients receiving care at Liverpool Women's. Additionally, there have been marked improvements in listening and engaging including the newly adopted, listen, learn and act model.

- Changing place facility has now been opened and it is being registered on the national data base to highlight that LWH now has this facility . A staff member used their lived experience in helping to design the area. In addition, a remodelled 'anyone' toilet facilty has now been opened.
- Enviromental Access audit has been completed during the week of 27th November 2023. Estates and facilities manager is in the process of completing an action plan and securing funding for any remedial works that need to be undertaken. The action plan will was shared at Patient Involvment and Experience Sub Committee in February 2024.
- In relation to Accessible Standards information, the Trust established a task and finish group led by PEIO and sponsored by Chief information Officer. A baseline assessment has been completed and this is being aligned to the digital platforms work being progressed within the Trust. (more detail is at the end of this paper)
- Antenatal Link clinic is supported by face to face interpreters for the patients. There is also access to lanaguage line. There are seven interpreter on wheels within the Trust.

Engagement for Service Users

4.1Secret Shopper

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

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

As a result, an environmental access audit of the premises, and the actions from the audit will inform workstreams across the Trust for an inclusive physical environment.

4.2 Help and Advice Hub

Patient Expereince Matron (PEM) and Patient Experience and Involvement Officer (PEIO) have worked with Patient Experience Officers (PEO) to establish an area in the main reception as a Help and Advice Hub. PEM secured funding and adaptations were made to the room to make the front of the room open and accessible. PEO team man this area Monday to Friday 08-30 hrs to 16-00hrs.The area is also supported at times by PEM and PEIO.

One day a week a representative from the Brain Charity is based in there. They provide help, advice, support to patients , service users and staff. PEM is currently scoping other charities and organisations who have requested to spend time in the Help Hub.

Contact has been made with Mary Seacole House in Liverpool 8 to enquire if they would like to utilise the Help Hub in relation to Black and Vulnerable Communities. HSBC bank are also scheduled to come in to support patients, service users and staff with advice in the current cost of living crisis as this is one of the main issues raised when out and about in the communities.

Bi-lingual volunteers have translated "Happy to Help" into different lanaguages and these are positioned in front of the Help Hub. An interpreter on wheels has been procured to be based in the Help Hub for any patients and service users whose first lnaguage is not english , including Briitsh sign lanaguge and can be utilised to assist with translation.

Situated on the Help Hub counter is a copy of the Trust Inclusion and Wellbeing Events Calendar. This calendar was commissioned by our Deputy Chief Nurse and the information collected and collated by PEIO. The calandar is a resource that details cultural, religeous and national equality and health and wellbeing events and it seeks

to equip staff with the knowledge to respond to the diverse needs of patients and staff leading to personalised centred care and a supportive and inclusive work place.

PEIO has distributed a total of 250, calendars internally and externally to our stakeholders across the city.

5.0 Measures & Objectives

5.1 Gender Pay Gap Report (2023)

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

The full 2023 Gender Pay Gap Report will be published on the Trust website by the end of March (https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/). See full report in appendix.

5.2 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard

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

The WRES and WDES data is collated as of 31st March 2023 for all data with the exception of data taken from the 2022 National Staff Survey. We are statutorily required to report and publish this data and action plans, however the Board are asked to recognise that these are one set of metrics which are included in and underpinned by our Equality Objectives 2023-2027 and our annual EDI workplans. See full report in appendix.

The WRES data is measured against the following metrics:

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

- Board member and non-Executive Director data – decrease in position from previous year.
- Likelihood of being appointed from interview – decrease in position from previous year.
- Likelihood of entering formal disciplinary process – minor decrease in position from previous year however same number of white staff also entering formal process.
- Number of staff experiencing harassment, bullying or abuse from staff – decrease in position from previous year.
- Equal opportunities for career progression –decrease in position from previous year.

Further information can be found in the appendices. Find WRES and WDES Report 2023 at the end of the report.

The WDES data is measured against the following metrics:

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

Further information can be found in the appendices. Find WRES and WDES Report 2023 at the end of the report.

The WRES and WDES report and action plans will be published on the Trust website by the end of March. (https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/).

6.0 Policies

In 2023/4 there have not been any changes to EDI policies. However, there has been a policy that was Attendance and Management Toolkit.

Key Features of the Upgraded Toolkit:

- Return-to-Work Guidance: To facilitate a smooth transition for employees returning from leave, we have included comprehensive guidelines outlining the steps to be followed (including ESR & E-Roster guidance).
- Wellbeing Conversations: Recognising the importance of employee well-being, we have included additional resources to help support you with annual wellbeing conversations.
- Short Term & Long-Term Sickness Processes: There is a comprehensive suite of letter templates and tools to support the management of long- and short-term sickness.
- Reasonable Adjustments: The toolkit features helpful and practical guidance on how to support your staff with workplace adjustments.

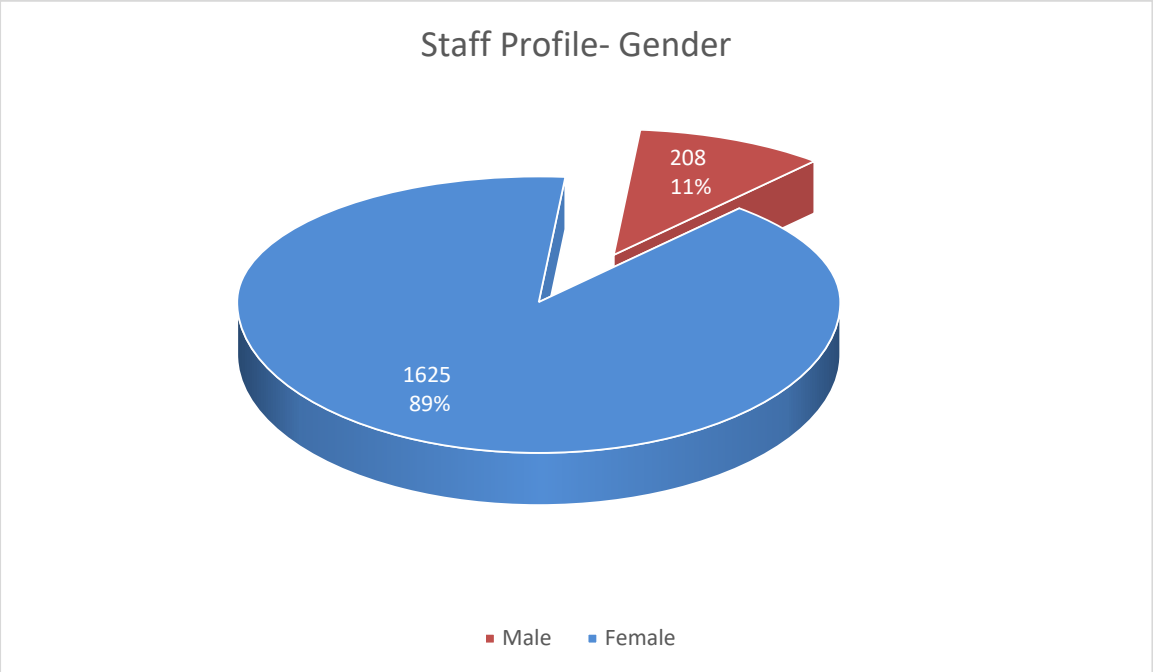
Additionally, there are policies and procedures that the EDI Team would like to audit in the upcoming year to ensure that policies and processes are inclusive and steeped in anti-racist principles, as a reflection of the Trust's commitment to anti-racism.

7.0 Staff Profiles

Headcount for the workforce as of February 2024 stood at 1833 which is an increase of 77 staff from the figure reported in 2023.

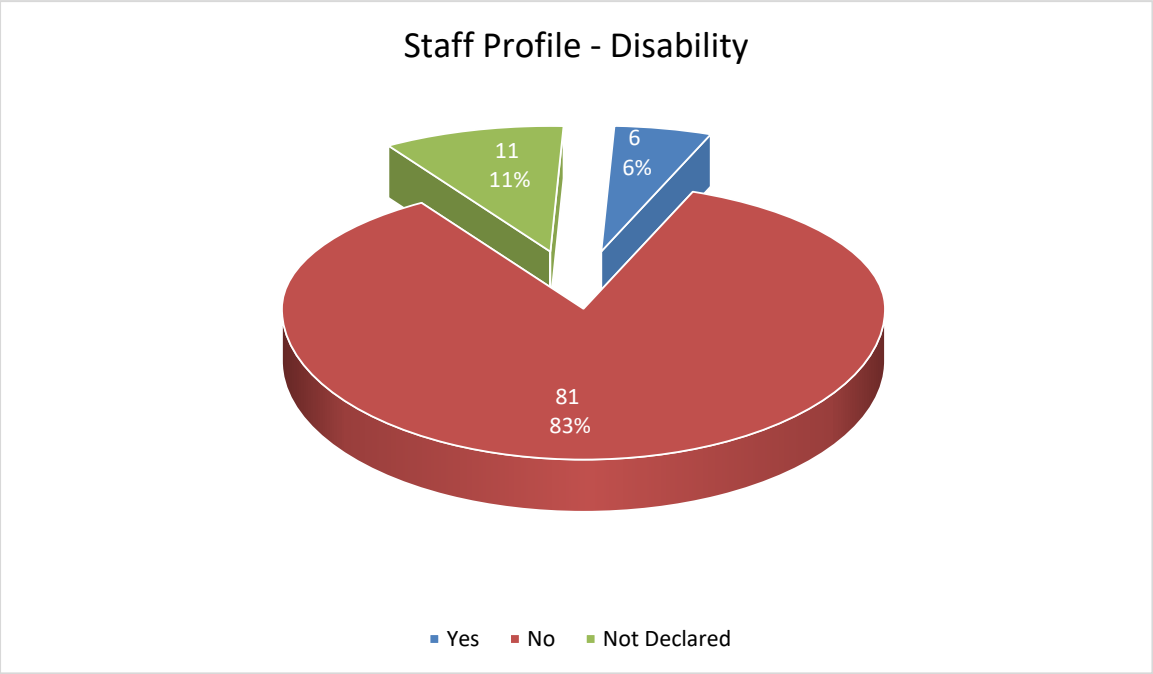
7.1 Staff Profile – Gender

Liverpool Women's NHS Foundation Trust has an 89% female workforce which equates to 1625 colleagues. The male workforce which is 208 colleagues is 11% of the overall workforce.



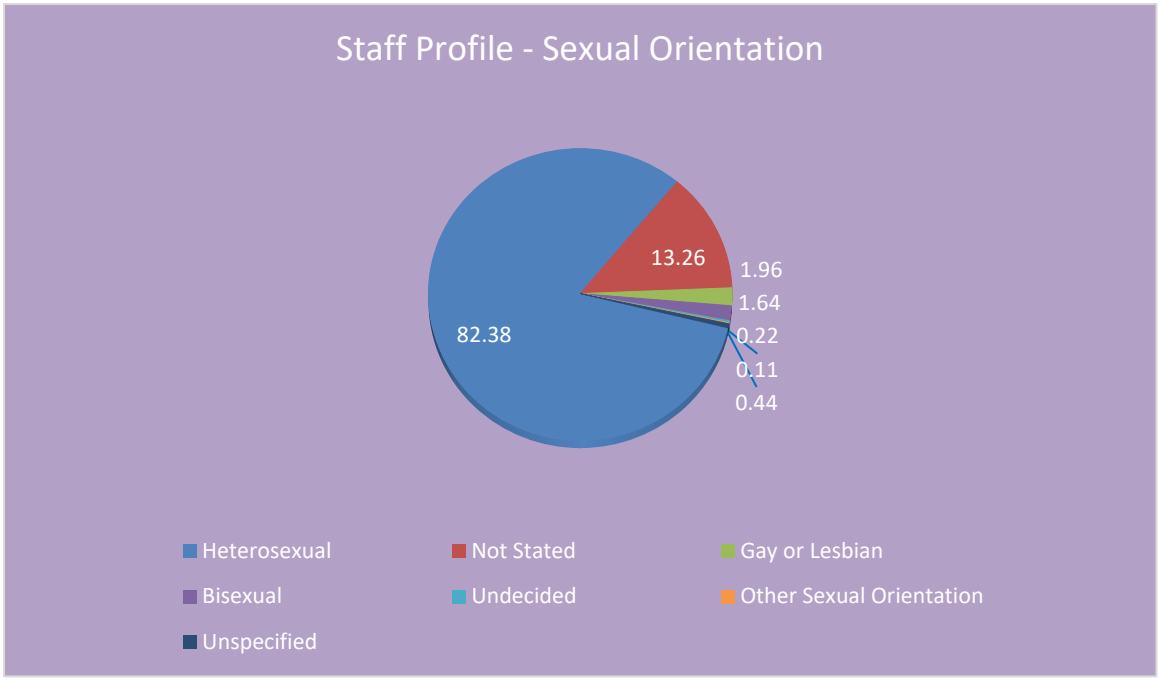
825 staff are in the Nursing and Midwifery staff group; 99% of this group are female.

7.2 Staff profile – Disability



The figures relating to disability declarations 80.74% of colleagues state they do not have a disability and 6.44% state that they do. 11.46% of colleagues declined to provide an answer to the question and therefore not providing a full representation of disability within our colleague base. Further information can be found in the Trust WDES report which can be found via https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/

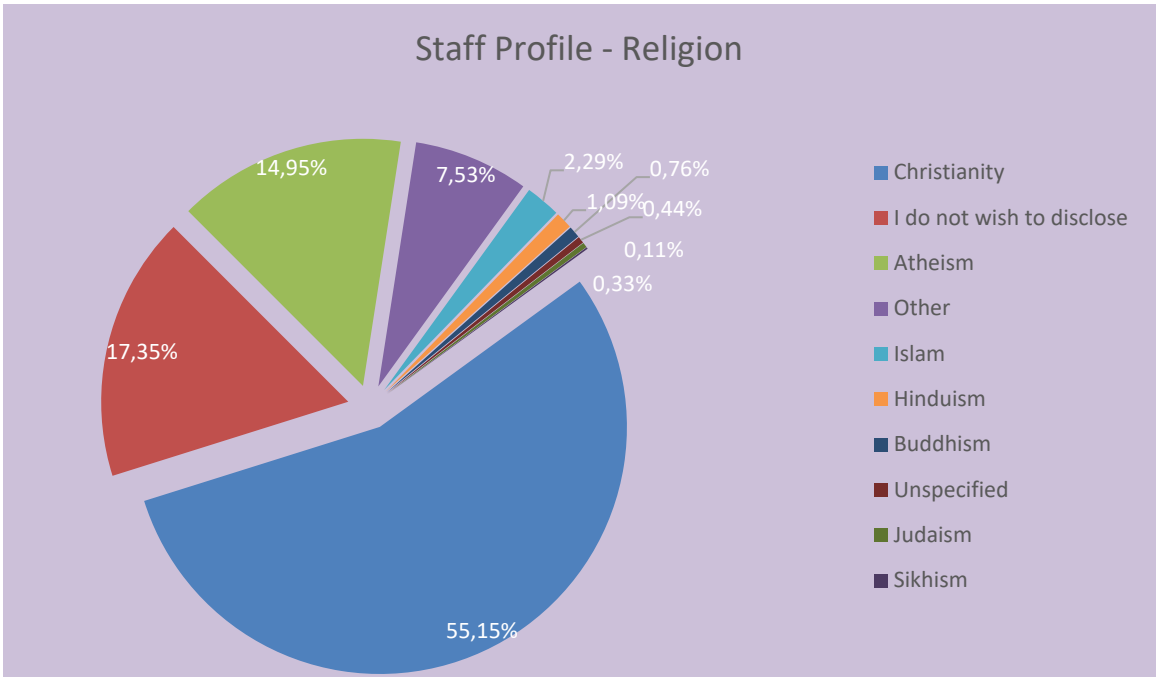
7.3 Staff profile – Sexual Orientation



82.38% of colleagues define their sexual orientation as Heterosexual; this is a reduction compared to last year in which 84.6% of colleagues reported the same. Those identifying as Gay or Lesbian account for 1.96 compared to 2.06% of the staff group in the previous year.

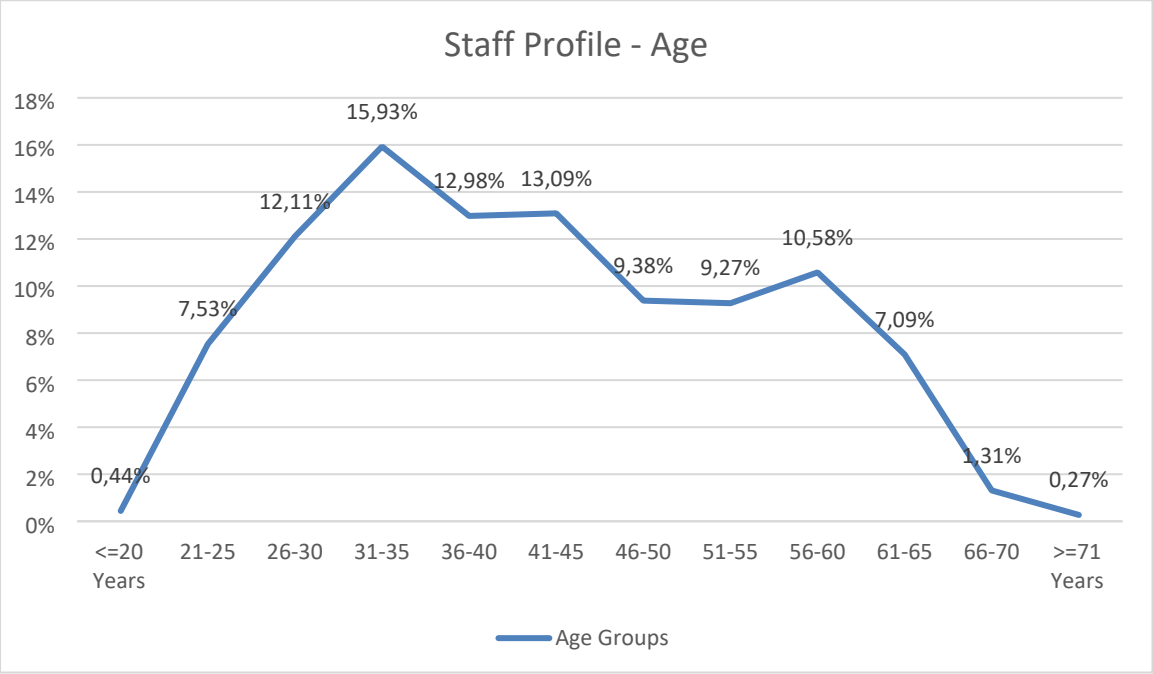
As with disability declarations, the above does not provide a full representation of colleagues' orientation as 13.26 declined to provide an answer, whereas last year this figure was 11.8%.

8.4 Staff profile – Religion



1101 or 55.16% of colleagues define their religious beliefs as Christian, followed by Atheism equating for 14.95%. As with previous declarations this does not provide a full representation of colleagues' orientation as 17.35% declined to provide an answer.

7.5 Staff profile – Age



The graph above shows that there are highest age groups represented at Liverpool Women's are ranges 31-35 (15.93%), followed by 36-40 (12.98%) and 41-45 (13.09%).

The other age groups represented show lower figures. The lowest represented groups are age ranges <=20-25. When combined, this represents 7.97% of the overall staff population. The other group which has low figures is between 61->=71. When these groups are combined, this represents 8.67 of the overall staff population.

8.0 Plans for 2023/24

This report has provided an update on many of the activities and actions that have taken place in 2023/24 across the Trust. In the upcoming year, the Trust looks forward to:

- Launching the anti-racism hub, which will include the roles of Head of Culture and Inclusion, EDI Officer, Practice Education Facilitator, Assistant Psychologist. These roles are funded for 12 months.
- Launching the Cultural Survey which has been commissioned to an external organisation to understand the underlying challenges for the Trust, staff and service users relating to race inclusion.
- Recruitment of another Clinical Psychologist in the Trauma Informed Care Service to support the demand for Health and Wellbeing Support, People Promise Manager and Employee Experience Manager in the HR Team.
- EDI Audit of Trust Policies and Processes
- The design, development and delivery of 'Licence to Hire', the inclusive recruitment training, including EDI related questions to ask candidates at interviews.
- The second EDI Annual Conference to be hosted at Liverpool Women's NHS FT
- Delivering actions from the recently completed Environmental Access Audit
- Listening events and 1:1s delivered by the EDI Team and the Trauma Informed Service for staff from the global majority
- Making a submission to the North West BAME Assembly to obtain the Bronze (first quarter) and Silver (third quarter) accreditation on the North West Anti-Racism Framework
- Providing an informal channel for people to report experiences that they have had or witnessed relating to discrimination, bullying and harassment, for staff and for service users, with the option of reporting this anonymously
- Continuing to work at regional level to support the delivery of EDI Dashboard which allow filtering of protected characteristics and health inclusion groups
- Education and celebration of the key EDI events: Black History Month, Disability History Month, LGBT+ History Month and key faith observance days/festivals, which will be supported by new roles.
- Exploring the disability pay gap and the Social Model for Disability
- Exploring the potential for adopting gender inclusive language across the Trust
- Monitor the use of the guaranteed interview scheme for racially minoritised groups and diverse interview panels

- Developing relationships with key community stakeholders, exploring opportunities for co-design, co-production and collaboration
- Establish an Anti-Racism working group taking a multi-disciplinary approach across the Trust to make improvements with regards to health inequalities and staff experience.

9.0 Summary

In conclusion, Liverpool Women's Hospital's steadfast commitment to inclusion and anti-racism is evident throughout Trust strategies and collaborative efforts with volunteers, initiatives for widening participation, and developments in patient experience. Through strategic initiatives outlined in the Trust Strategy 2021-25 and the Trust Commitment to Anti-Racism, the organisation has taken concrete steps to address racial disparities in leadership roles, workforce representation, and patient care.

The involvement of volunteers, including the launch of the Bi-lingual volunteers program, showcases the Trust's dedication to championing inclusion and engaging diverse communities. Through initiatives like supported internships, work experience placements, and apprenticeships, the Trust actively promotes widening participation, providing opportunities for individuals from different marginalised backgrounds to explore careers in healthcare.

Moreover, the Trust's focus on patient experience, as demonstrated through initiatives like the Help and Advice Hub and the Secret Shoppers, underscores its commitment to listening to and addressing the needs of its patients. By involving patients in the audit of facilities and services and actively seeking feedback, Liverpool Women's Hospital ensures that its care delivery is responsive, inclusive, and patient-centred.

The development of an Anti-Racism Hub, recruitment of specialist staff, implementation of anti-racism training programs, and engagement with community stakeholders highlight the Trust's dedication to delivering on its commitment to equity and diversity. Furthermore, initiatives such as guaranteed interviews for global majority staff and the development of EDI dashboards reflect ongoing efforts to monitor progress and drive accountability.

Looking ahead, Liverpool Women's Hospital is poised to continue its journey towards becoming one of the most inclusive organisations in the NHS with plans for policy audits, recruitment drives, educational events, and partnerships with community organisations. By prioritising the voices and experiences of global majority groups, the Trust aims to reinforce a culture of care, respect, ambition, engagement, development, and learning, for both its staff and patients. Through these concerted efforts, the Trust continues to advance its mission of fostering an environment of equity, respect, and empowerment for all.

Appendix

Liverpool Women's Diversity and inclusion

https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights

Liverpool Women's Commitment to Anti-Racism

https://www.liverpoolwomens.nhs.uk/about-us/diversity-inclusion-human-rights/race-equity-declaration-of-intent/

Anti-Racism Resources Hub

LWH Intranet - Anti-Racism Hub (liverpoolwomens.nhs.uk)

Staff Engagement Survey

https://forms.office.com/e/kRxU6iYMkC

Inclusive Companies 'Championing Change' Presentation

Inclusive Companies Presentation Feburary

Diversity in Health Care Programme

Diversity in Health and Care Partners Programme 2023 2024 brochure.pdf (nhsemployers.org)

North West Anti-Racism Framework:

The-North-West-BAME-Assembly-Anti-racist-Framework-FINAL.pdf (england.nhs.uk)

Liverpool Women's Trauma Informed Care Support Service

Staff Support and Trauma Informed Care

Gender Pay Gap Report 2023

Gender Pay Gap Report _ 31 March 20

WRES and WDES Report 2023

WRES WDES report 2023 Trust Board (002

Patient Engagement Activities 2023/24

*Patient Experience Matron (PEM)

**Patient Experience and Involvement Officer (PEIO)

Where did we go/Who Did we meet	What did we learn	What did we do
Chinese New Year Celebrations Pagoda Centre of 100 Harmonies and Chinatown Sunday 22/1/23	Local leaders, residents and communities did not know about some of the Liverpool Women's Hospital (LWH) services, roles, and issues. They wanted face to face conversations to help reduce anxiety and communication issues.	Introduction of patient experiences and the support roles. Worked with women to understand hospital services, confidentiality, and GP registration. We showed and explained with our leaflets and website about communication and confidentiality.
Merseyside Police Windsor Street Thursday 2/2/23	That LWH need to be linked up to more women support groups	Patient Engagement & Experience Officer (PEIO) met and introduced the role with the support groups recommended. It was explained how to contact PEIO
Health & Wellbeing Chinese New Year Celebrations Palm House. Monday 6/2/23	LWH and Honeysuckle are providing an excellent service supporting families in the Chinese community that have suffered the death of a baby as the result of a baby dying due to early/late miscarriage, stillbirth or just after birth.	Governors reported back to LWH about the positive feedback. Via their engagement/communications meeting.
WHISC Thursday 23/2/23	WHISC wanted to work in partnership with LWH services. Many of their clients are facing severe cost of living impact and poverty.	LWH midwives are facilitating health sessions and supporting women groups and families.
Experiencing Menopause Central Library Thursday 23/2/23	People wanted information about diagnosis, sexual health, and relationships	Dr Paula Briggs explained clearly and respectfully with models, presentations, patient stories, and her own personal experiences.
Great Day- Subject was: Equality, Diversity, and Inclusion. (ED&I) Blair Bell Friday 24/2/23	LWH are not communicating effectively with marginalised groups	Used workshops and drama to facilitate patient stories between staff, patients, and communities.

International Woman's Day Pakistan Centre Wednesday 8/3/23	Women wanted to know about what happens when births go wrong and wanted to know more about pelvic health and the role of Governors.	One of our Governors explained her role. Physio lead used a pelvis working model to explain and make women feel comfortable. Shared QR codes and multiple translated leaflets.
Rotunda Kirkdale Friday 17/3/23	LWH needs to work closer and co-produce health sessions and events. LWH need to build relationships and closer ties with the local communities in the North End of the city.	Gave leaflets on menopause and other women's health topics. Information provided on how to become a volunteer at LWH and also what current job opportunities were available. PEIO agreed to attend future Events
Ahmadiyya Muslim Women's Association. Bait – Ul Lateef Mosque. Anfield 18/3/23	We learnt that this community wanted to celebrate their 100-year anniversary and for LWH to embrace Diversity, Equity and understand social determinants to health. (This was a female only event)	Colleagues attended to explain different roles and inclusion. The community GP of the Mosque and LWH Governor explained their roles to make more younger women involved. Trust Learning and Development Facilitator explained about the number of services that our Trust provides. Head of fund raising explained how donated monies to the hospital charity were spent.
Porchfield Centre Croxteth Tuesday 4/4/23	Centre manager and a woman wanted to know about financial aid for fertility	Linked them up to Hewitt Fertility and NHS websites. Centre user understood the criteria.
The Bridge Community Centre Norris Green Wednesday 19/4/23	The centre wanted to share the work of foodbanks and services to families with LWH	LWH shared what services we provide and planned a future health event.
Croxteth Family Matters Croxteth Wednesday 19/4/23	The centre wanted to share that they offer a food pantry, a community health hub for family issues and day trips, with LWH	LWH explained that local women find it difficult to access the hospital. The centre said they would help on one off basis and will work closer with LWH.
Baby Well- refugee group Blair Bell Lecture Theatre Wednesday 19/4/23	Director of Midwifery (DOM) and senior colleagues learnt the barriers that pregnant refugees faced on their journey	DOM agreed to invite the group to facilitate their learning and work in partnership with LWH

Liverpool Global Health (Liverpool Medical Institute) Blair Bell 2/5/23	Partners wanted to share FGM and poverty issues.	LINK team showcased LWH services and their good work for partners understanding. CAB also discussed social prescribing that can help healthy lives.
Whitechapel Homeless, Everton Valley Wednesday 3/5/23	Vulnerable girls and women become exploited, abused, and homeless. That women who had suffered a miscarriage or removal of a baby at birth had no tangible keepsake.	PEM and PEIO invited case workers to LWH and Honeysuckle. Better understanding of poverty and real issues women faced. PEM worked with Honeysuckle Team to produce small keepsake bags that included wild flower seeds that could be planted any way they wanted as a special place for an individual.
Merseyside Society for Deaf People Deaf awareness week Thursday 4/5/23	Members of Liverpool Deaf Society brought a selection of the latest technology aids to assist people with hearing loss and profound deafness.	Staff were able to access the equipment to help with communication issues. MSDP, BSL interpreters shared equipment and adjustments for staff, patients and public, at the foyer.
Honeysuckle FC Jeffrey Humble Football Hub. Every two weeks Thursday 4/5/23	Dads and men grieve differently.	Developed a partnership between LFC foundation and LWH and using the power of sports like football to help and support them. Future men and dads have a complimentary and active way to support themselves and peers
Young Persons Advisory Service (YPAS) Central Hub Team Lead Tuesday 9/5/23	YPAS wanted to share that they had a focus group and to look at developing strong partnership working with LWH. To gain an understand of LWH services and how they support young children.	Informed Trust Lead for Children/young persons and Trust ED&I manager. So that we now have a direct contact for future planning of Participation groups, consisting of young people, if we want to share or consult with our service provision.
Irish Community Care 151 Dale Street Liverpool Tuesday 16/5/23	CEO wants to set up a meeting for LWH to discuss and meet travellers, with support from community health champions	PEIO met with CEO and provided information regarding C Gull research study. Genomic service including counsellors. PEIO feedback to lead genetic counsellor about meeting with CEO and how to make contact.

		How we can work together to establish links with the travelling community.
LCVS and Healthwatch Liverpool and South Sefton, Joint meeting at LWH board room 25/5/23	Meeting arranged by PEM and PEIO. Claire Stevens Health watch the aim was to discuss future partnership, service improvements and events	PEM and PEIO agreed for Healthwatch to visit, meet, and engage with Trust and patients on the wards. This was to encompass Healthwatch first listen Event in the Trust since COVID-19.
Pagoda Community Centre Chinese Health Day Wednesday 7 June	A health event was arranged to close any gaps on misunderstandings about primary/secondary care services and LWH was represented by PEIO The community had fears on access, confidentiality, and language issues regarding LWH.	Members of the local and wider community got health checks and registered to a GP. PEIO was able to explain to the local community and public understood more about confidentiality and how to access LWH services.
Visits to the African Caribbean Centre, Mosque & Pakistan Centre Monday 19/6/23	Car parking is used by all three communities at different times of the week. This is with regard to the overflow car park situated in Mulgrave Street. PEIO and Trust lead for car parking/security went to visit the community near to Mulgrave Street.	It was explained to the local communities how the car parking site was managed by the Trust. Why there was a need for additional space as an overflow car park was explained, how we had a security presence that supported the car park.
Liverpool Charity and Voluntary Services. Health and Wellbeing Network. Quarterly meeting Wednesday 21/6/23 via Zoom	LCVS and Healthwatch wanted to ask how we can improve patient & carers experiences and make our services more accessible?	PEIO attended explained his role and how he can help support capturing the lived experience of patients and services users to improve our services.
Summer Health Fair Dingle Park Practice Park Street, L8 6QP Friday 23/6/ 23	PEIO asked to attend a Women's and Maternity Day as they feel Women and Families are isolated and have low health outcomes in the Dingle area for the local diverse communities.	PEIO shared information about LWH services, how to become a volunteer, and current job vacancies, Community midwives/Health visitors explained their roles.
Cancer Awareness Day Everton Football Club 24/6/23	Cancer Partnership asked LWH to have a stall and present on topics- endometrial, vulval, ovarian, cervix and vaginal cancers. To target local residents who have poor health and high cancer rates in the local area	Cancer team explained to the public about therapies, managing fatigue, the importance of diet and exercise with a cancer diagnosis. They guided people to welfare benefits and the other 25 cancer stall holders.

Women's and Family Health Day Rotunda Kirkdale Monday 17/7/23	Rotunda explained that they had East European residents who worked anti-social hours but did not know how to or had difficulty accessing the NHS and LWH services	PEIO explained how to access primary services and LWH services. Discussion about a future NHS Outdoor event with East European communities, centre's nursery, and family/women's group. Multilingual leaflets were given out on Physio, Menopause and Endometriosis. How to become a volunteer information was provided and current job vacancies.
Summer Health Event The Bridge Community Centre Liverpool 4 Tuesday 29/8/23	The Bridge community wanted to co-produce with LWH a Health Event for the local residents. Pandemic had stopped everything. They asked for LWH services to help inform and engage with residents.	CGULL research team representative, Governor and community midwife were brought in to discuss their roles to improve patient experience and knowledge. Insights on poverty, transport issues and cost of living
Endometriosis Health Event Blair Bell Friday 1/9/23	LWH was asked by many communities and individuals to explain endometriosis so they could cascade the information back to the community	Over 45 representatives from community groups came to a planned Health Event at LWH to listen, understand and discuss Endometriosis. Patient and staff stories were shared, with support from expert clinicians. Feedback about the event were overwhelmingly positive.
May Logan Health Centre Bootle Wednesday 4/9/23	The centre's management team wanted to discuss and share about their services and find out more about LWH for closer working relationships	On the next visit, the PEIO will invite governors to listen to the experiences of patients who use LWH services. The aim is also to reach out to residents in the north of the city and scope out the possibility of co-producing a future menopause event in the community.
Volunteer and Job Fair African Caribbean Centre Friday 8/9/23	The community has asked LWH to attend with other organisations to showcase their jobs and volunteer roles. Information provided on how to become a volunteer.	PEIO and a volunteer, showcased the many LWH roles on offer.The Volunteer discussed the satisfaction and experiences he gained from his role.

Family Hubs Croxteth Hall Croxteth Park Tuesday 19/9/23	Liverpool will have 5 family hubs. Two are ready in Clubmoor & Ellergreen and Speke. The other three will be ready for 2024/5	DOM, Childrens/Young people's lead, Community Non-English-Speaking Team leader and PEIO discussed their roles and what they could offer and discussed future opportunities for the 5 family Hubs
Refugee Women Connect (Ex- MRANG) St Brides Church Tuesday 24/10/23	The group wanted to know more about pelvic therapy and the issues of Women Health that could provide a safe place	The Physiotherapy Lead met the group and sensitively engaged and explained about women's pelvic health. Exercises were shown. Further sessions are planned.
Ibijoke Children Foundation Sanfex African Hotspot Fairfield Tuesday 31/10/23	West African communities explained that they faced unemployment; racism from society; barriers to health due to language and cultural differences	Working with the Police and their funding LWH helped facilitate a health event with Picton PCN. Promoting LWH diversity, CGULL, employment, governor, and volunteer roles. Supported by four staff and two governors.
Association of Congolese de Merseyside. (Congolese Community) Bootle Thursday 16/11/23	The leader, wanted to discuss why some of the community's appointments at LWH were cancelled/missed. Also discussed was the racism they faced in housing and employment. Recently a young Congo family were racially assaulted in Norris Green. 500 members registered with the community.	PEIO linked them up to May Logan and vice versa. The lead speaks all 4 dialects spoken by the Congolese Community. The lead was asked if they would like to sign up to go back on Language Line to help with the lack of interpreters available in the different dialects with the aim to reduce cancellations. Gave job vacancy information out and how to become a volunteer. Information was also provided on how to report hate crimes.
New Parents Kensington Children's Centre (Life Bank) Thursday 30/11/23	Picton PCN have a Perinatal Mental Health project, and they wanted LWH to highlight and signpost services to new and expecting parents, covering topics such as mental health and wellbeing, breast	NEST Team, Perinatal Mental Health team and community midwife engaged with registered PCN parents to discuss their health issues and link them up with primary care colleagues.

	feeding, parent support and more.	PEIO also attended and provided information become a volunteer.
May Logan Centre Bootle Monday 4/12/23	Locality, costs, and availability of transport were priorities in choosing the centre. Housing owns the building but wishes it to be a multi functioning health hub	Three governors listened to patients in the waiting room and learnt how well LWH services are received in the centre. They publicised a governor's vacancy for the area.
L8 Community Wellbeing Day African Caribbean Centre Wednesday 17/1/24	Cost of living and heating is high which in turns affects wellbeing. Higher priorities than health.	Shared job and volunteer roles to the local communities. Linked those in need to PCN and local authority colleagues.

Liverpool Women's
NHS Foundation Trust

Gender Pay Gap Report

Data at March 2023
Published March 2024

1. What is the Gender Pay Gap?

The gender pay gap is a measure of labour market or workplace disadvantage, expressed in terms of a comparison between men's and women's average (median) hourly rates of pay.

Gender pay gap reporting doesn't specifically ask who earns what, but what women earn compared with men. It provides a framework within which gender pay gaps can be surfaced, enabling organisations to constructively consider why they exist and what to do about them.

Gender pay gap reporting regulations require UK employers with 250+ employees to disclose their gender pay gap. The gender pay gap gives a snapshot of the gender balance within an organisation. It measures the difference between the average earnings of all male and female employees, irrespective of their role or seniority.

The gender pay gap measures the difference between average hourly earnings (excluding overtime) of men and women as a proportion of men's average hourly earnings (excluding overtime).

A gender pay gap can be expressed as:

- A positive measure, for example, a gap of 13.9% – this indicates the extent to which women earn, on average, less per hour than their male counterparts.
- A negative measure, for example, a gap of −9.2% – this indicates the extent to which women earn, on average, more per hour than their male counterparts. This may happen, for example, if you employ a high proportion of men in low-paid, part-time work, and/or your senior and higher-paid employees are women.

The gender pay gap is often confused with equal pay. However, whilst both deal with the disparity of pay that women receive in the workplace compared to men, they tackle two different issues:

1. Equal pay means that men and women must be paid the same for carrying out work of equal value for the same employer, as set out in the Equality Act 2010.
2. The gender pay gap gives a snapshot of the gender balance within a hierarchy. It measures the difference between the average earnings of all men and women across an organisation or the labour market, irrespective of their role. It is expressed as a percentage of men's average earnings.

2. The National Picture on the Gender Pay Gap (Source- Office of National Statistics)

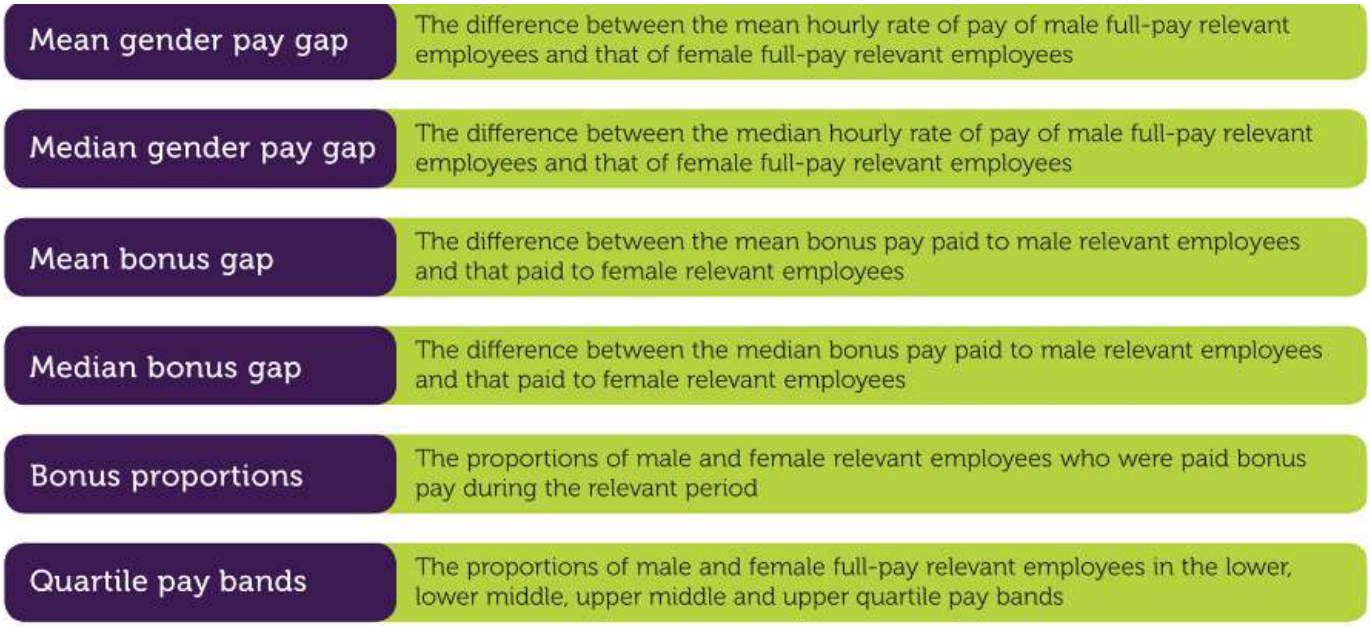
- The gender pay gap has been declining slowly over time; over the last decade it has fallen by approximately a quarter among full-time employees, and in April 2023 it stands at 7.7%.
- There remains a large difference in the gender pay gap between employees aged 40 years and over and those aged under 40 years.
- Compared with lower-paid employees, the gender pay gap among higher earners is much larger, however this difference has decreased in recent years.
- The gender pay gap has decreased across all major occupational groups between 2022 and 2023.

- The gender pay gap in skilled trades occupations remains the largest of the major occupational groups, however, it has also decreased by the largest amount over the past years.
- The gender pay gap among full-time employees is higher in every English region than in Wales, Scotland or Northern Ireland.

3. The Gender Pay Gap Indicators

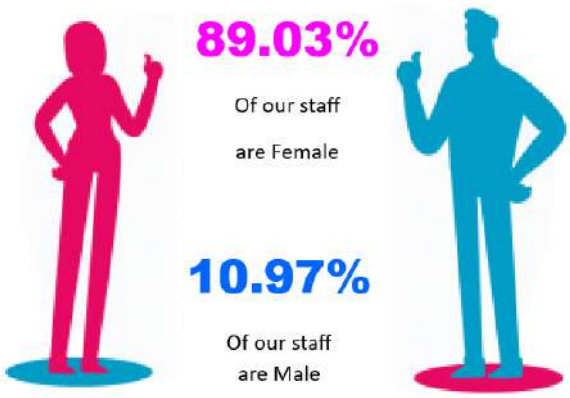
The legislation requires LWH as a public sector employer to publish six calculations:

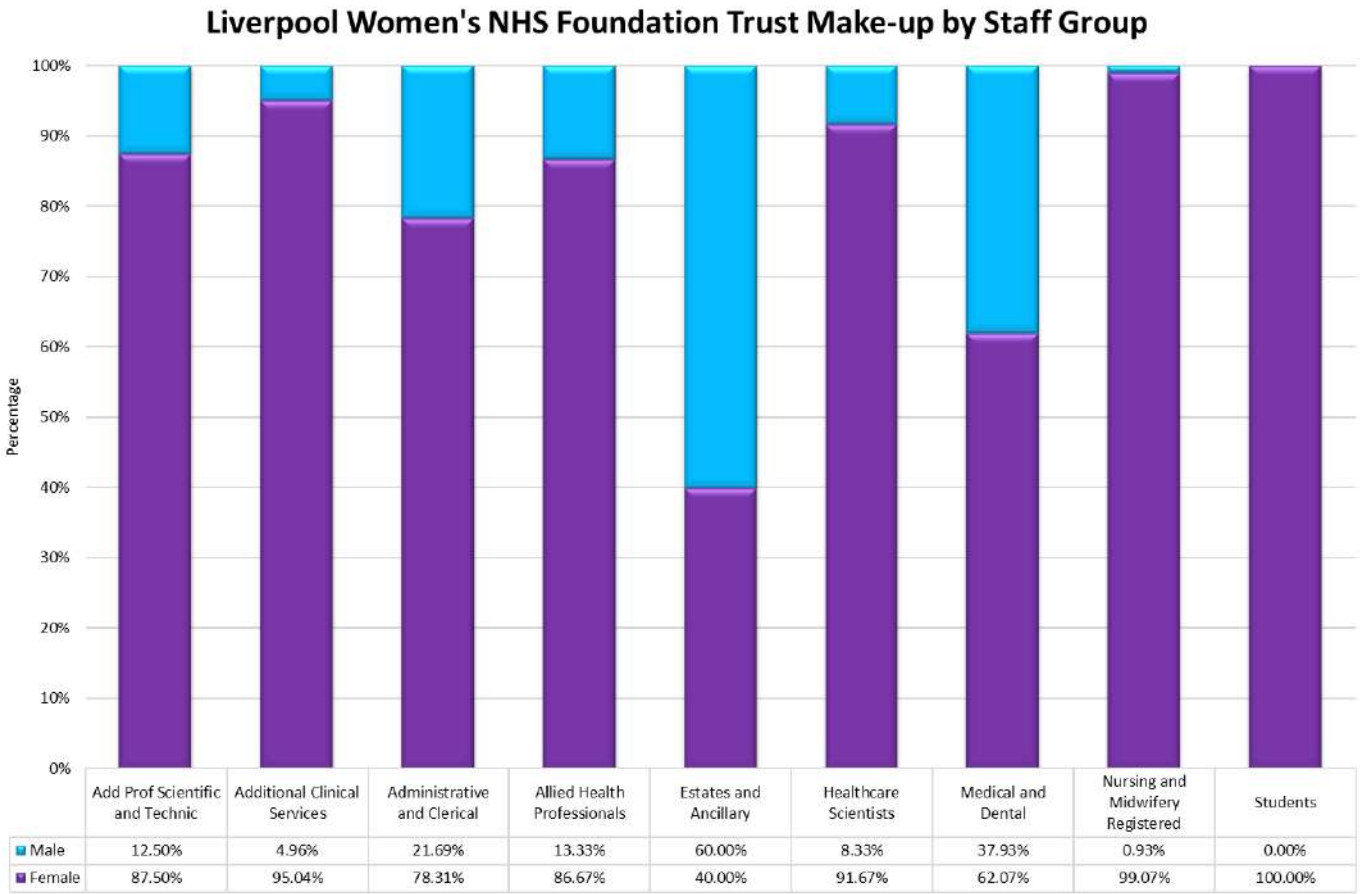
- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males receiving a bonus payment and potation of females receiving a bonus payment
- Proportion or males and females divided into four groups ordered from lowest to highest pay



(Source: CIPD)

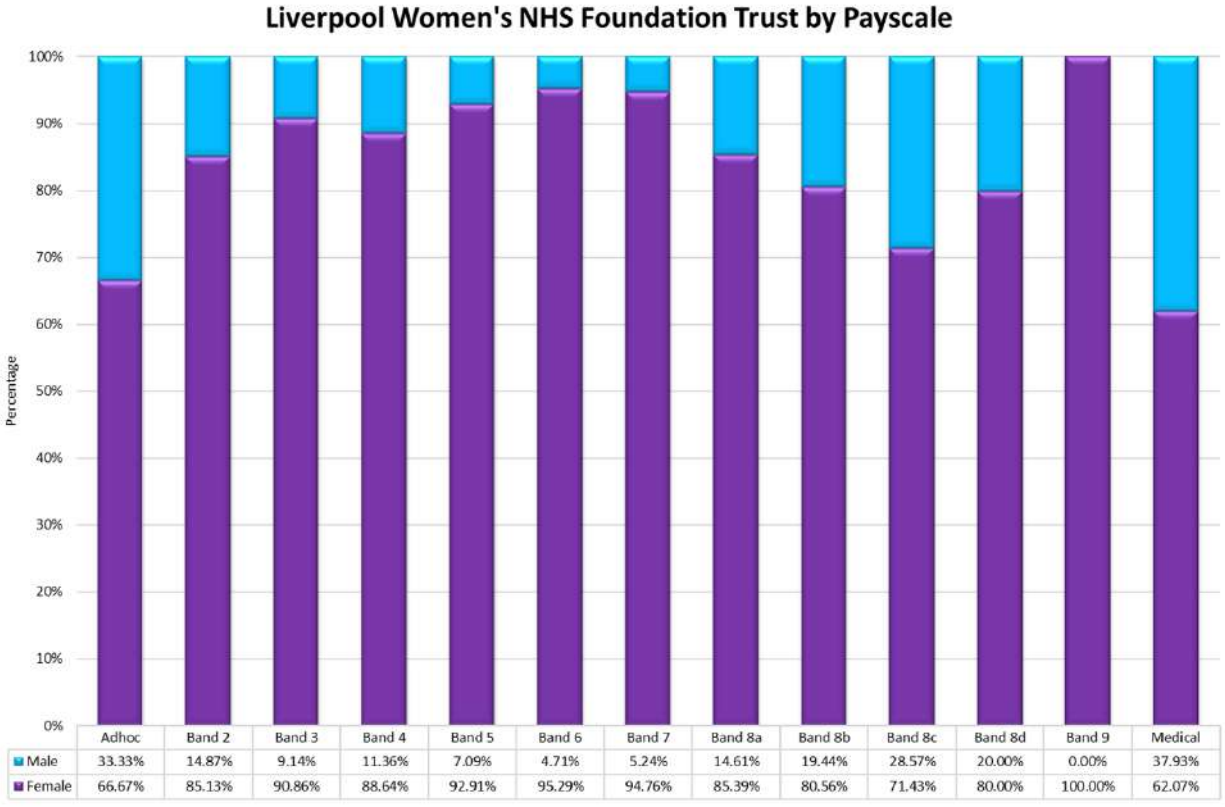
4.Gender Pay at Liverpool Women's





	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Students
Male	12.50%	4.96%	21.69%	13.33%	60.00%	8.33%	37.93%	0.93%	0.00%
Female	87.50%	95.04%	78.31%	86.67%	40.00%	91.67%	62.07%	99.07%	100.00%

	Female		Male		Total
Grouped by Payscale	Headcount	%	Headcount	%	Headcount
Adhoc	10	66.67%	5	33.33%	15
Band 2	166	85.13%	29	14.87%	195
Band 3	169	90.86%	17	9.14%	186
Band 4	117	88.64%	15	11.36%	132
Band 5	262	92.91%	20	7.09%	282
Band 6	384	95.29%	19	4.71%	403
Band 7	199	94.76%	11	5.24%	210
Band 8a	76	85.39%	13	14.61%	89
Band 8b	29	80.56%	7	19.44%	36
Band 8c	10	71.43%	4	28.57%	14
Band 8d	4	80.00%	1	20.00%	5
Band 9	4	100.00%	0	0.00%	4
Medical	72	62.07%	44	37.93%	116
Grand Total	**1502**	**89.03%**	**185**	**10.97%**	**1687**



Key Points:

- Liverpool Women's NHS Foundation Trust staff comprise 89.73% Women and 10.27% Men
- The trust has 751 Nursing and Midwifery Registered staff of which 54.59% are Midwives.
- The staffing of Liverpool Women's is reflective of the small numbers of men working as midwives, Gynaecology or neonatal nurses at a national level.

- Women make up the majority of staff in every single pay band. A higher number of men can be seen in medical, ad-hoc and Band 8c groups, although women remain in the majority.

Average Hourly Rates

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	£25.20	£19.94
Female	£19.91	£18.23
Difference	£5.29	£1.72

Average Hourly Rate of Gender Pay as a Mean Average

20.99% Mean Gender Pay Gap

Average Hourly Rate of Gender Pay as a Median Average

8.60% Median Gender Pay Gap

Key Points:

- The average hourly rate is calculated for each employee based on 'ordinary pay' which includes basic pay, allowances and shift premium pay.
- The median rate is calculated by selecting the hourly rate at the mid-point for each gender group.
- The percentage variance for the average hourly (mean) rate of pay is 20.99%. This calculation is based on the average (mean) hourly rate of female staff compared to male staff.
- The percentage variance for the median hourly rate of pay is 8.60%. This calculation is based on the average hourly rate at the mid-point for each gender group.

- The fact the median percentage is lower than the mean percentage, indicates there is likely to be some higher banded male staff which impacts on the average pay differential but not the median.

Average Bonus Rates

Bonuses payments at LWH only relate to Clinical Excellence Awards for Consultant Medical Staff. Depending on the outcome of consultant contract negotiations they may be ceased in future years. CEA awards are based on consultants delivering contribution over and above their job plan across a range of categories. Looking at this in the context of gender pay it may be the case that female consultants have additional childcare responsibilities and are therefore less able to take on extra-curricular work.

Gender	Avg. Pay	Median Pay
Male	£9,498.30	£4,660.58
Female	£6,734.46	£4,660.58
Difference	**£2,763.84**	**£0.00**

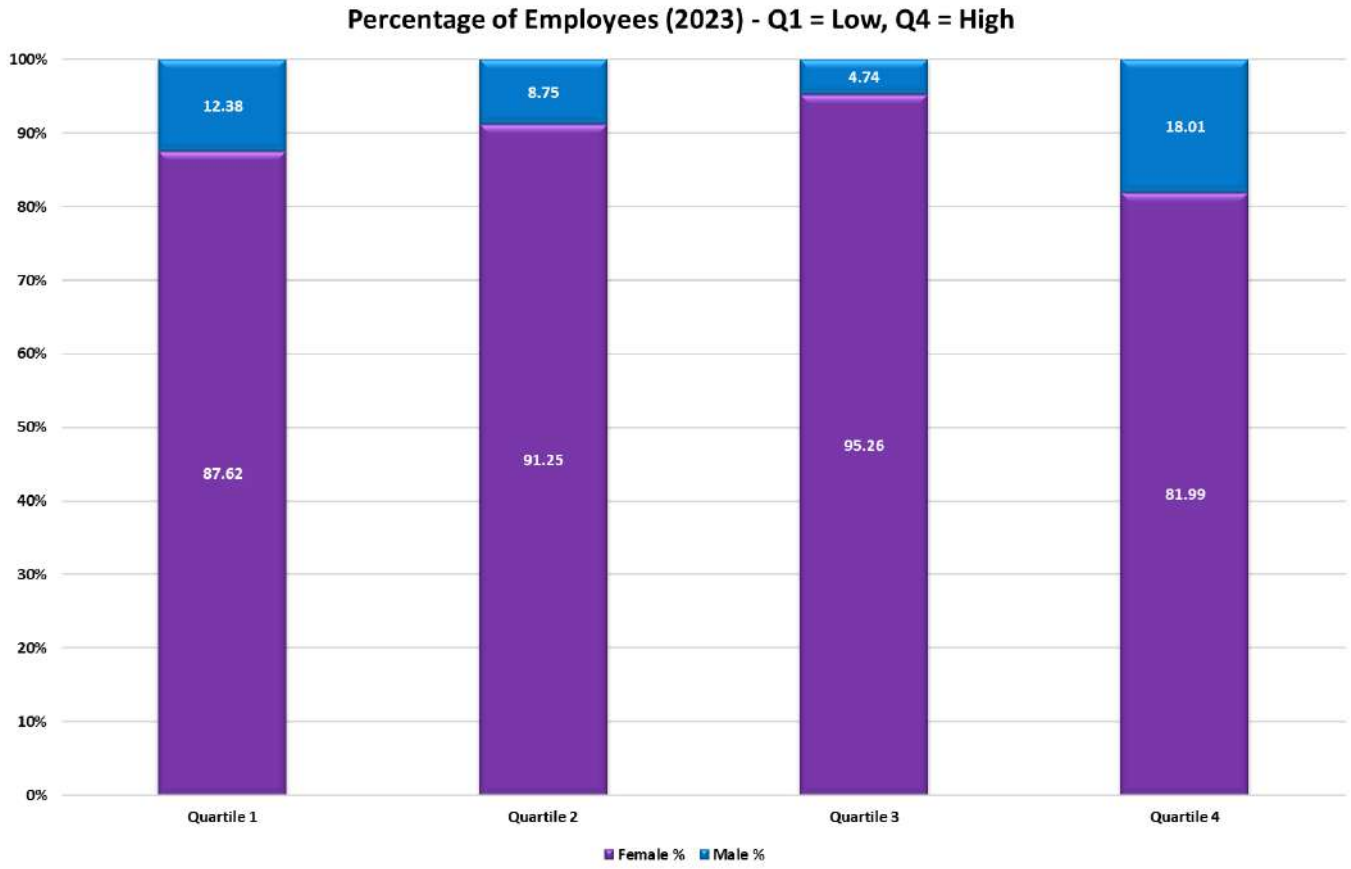
Proportion of Males & Females receiving a bonus payment

Proporation Receiving Bonus	
Female	Male
2.62% (44 Staff)	13.39% (30 Staff)
3.88% of Total Employees	

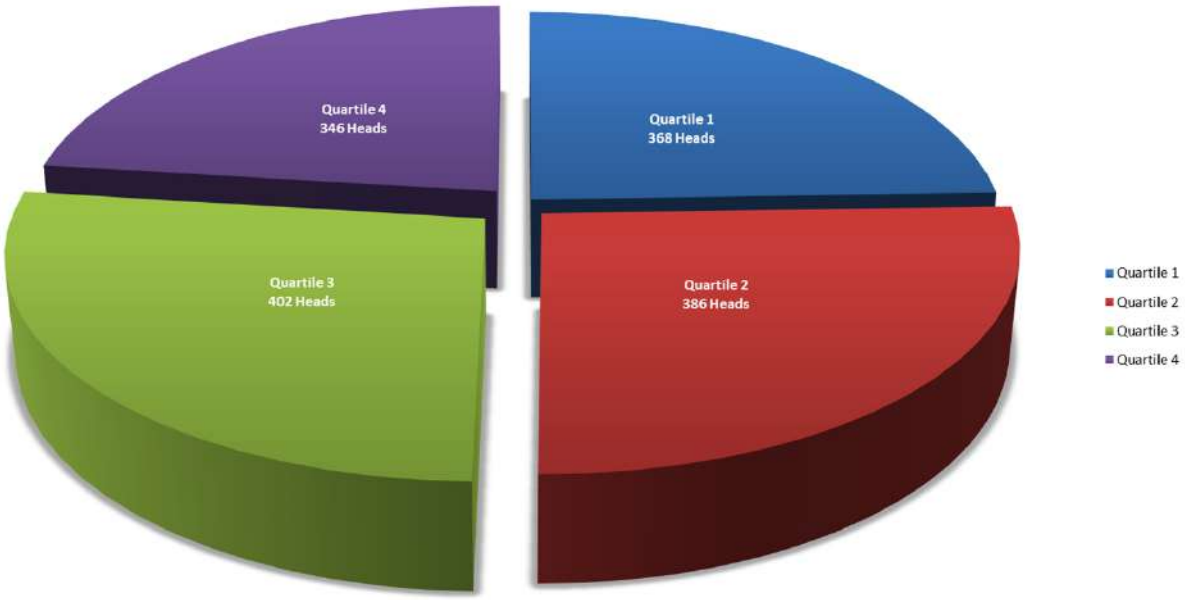
Mean Gender Bonus		Median Gender Bonus	
Female	Male	Female	Male
£6,734.46	£9,498.30	£4,660.58	£4,660.58
Pay Gap		**Pay Gap**	
29.10%		0.00%	
£2,763.84		£0.00	

Proportion of Males and Females divided into four groups ordered from lowest to highest pay.

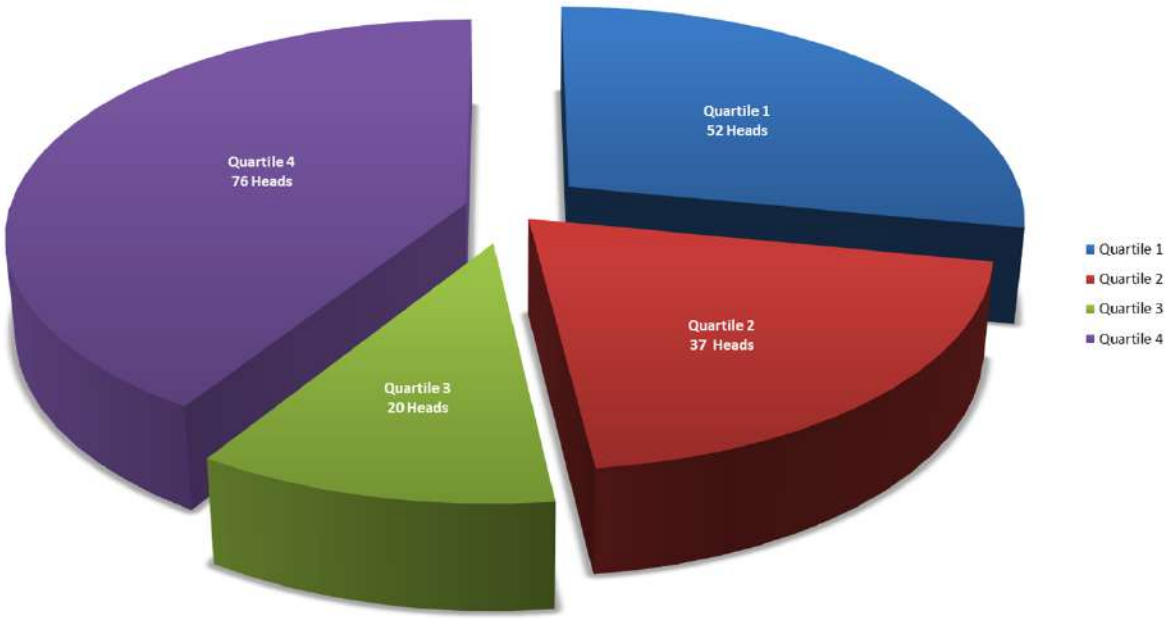
	2021		2022		2023	
	Female	Male	Female	Male	Female	Male
Upper Quartile	84.87%	15.13%	87.50%	12.50%	81.99%	18.01%
Upper Middle Quartile	95.13%	4.87%	93.43%	6.57%	95.26%	4.74%
Lower Middle Quartile	93.81%	6.19%	94.76%	5.24%	91.25%	8.75%
Lower Quartile	87.53%	12.47%	82.98%	17.02%	87.62%	12.38%



Number of Female Employees
Q1 = Low, Q4 = High



Number of Male Employees
Q1 = Low, Q4 = High



Key Points:

- In order to create the quartile information all staff are sorted by their hourly rate of pay, this list is then split into 4 equal parts

- The middle quartiles are occupied primarily by nursing and midwifery, AHP and scientific female staff, the largest proportion of our workforce

- For the previous 3 years it is clear that male staff are predominantly represented in the upper quartile, followed by the lower quartile. This is explained by the number of males in medical posts and senior management / operational posts. The lower quartile is explained by the number of men in roles such as estates and facilities.

5. Conclusion and Recommendations

There are societal and structural factors which go some way to explaining the gender pay gap at Liverpool Women's. Over-representation of women in the traditionally care-giving professions of nursing and midwifery is a major factor common to all NHS Trusts and given the number of males entering nursing / midwifery training, LWH as an employer has a limited influence in this regard.

Supporting women to succeed in leadership roles is a key focus for the Trust and our two leadership programmes have been attended for more than 100 staff. Our next area of focus is our 'mid-career' nurses, midwives and AHPs, offering bespoke development opportunities for those staff who wish to develop in their careers either through linear progression or career enrichment.

We recognise that a diverse board and executive team has a positive effect on organisational performance and our board selection processes reflect this commitment.

We recognise that flexible working is a critical part of enabling women to maintain their careers and offer a wide range of flexible working options for clinical and non-clinical staff.

We will continue to listen to our female colleagues through our variety of listening mechanisms and be open to considering any proposals to further gender equality in the workplace.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*24/25/012*		Date: 11/04/2024	
Report Title	Corporate Governance Manual			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	To propose and seek approval for amendments to the Corporate Governance Manual in order to ensure it is aligned with the recently approved Governance changes and to support effective communication to staff.			
Action required	Approve ☒	Receive ☐	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): n/a			
	*For Decisions - in line with Risk Appetite Statement – Y/**N*** *If no – please outline the reasons for deviation.*			
	The Board is asked to • ***approve the proposed amendments to the Trust's Corporate Governance Manual*** • ***approve the close of the Governance and Performance Framework***			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* All	
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's Corporate Governance Manual, a key resource since 2005, alongside the 2022 Governance and Performance Framework, are undergoing significant updates following Board-approved changes in March 2024. These updates aim to consolidate governance documentation into a singular, comprehensive manual to avoid confusion and streamline access to governance information for staff. The revision enhances sections on corporate governance, integrates all codes of conduct, and introduces new guidelines for conducting Trust business. The updated manual, expected to enhance clarity and accessibility, requires Board approval for its amendments and the discontinuation of the separate Governance and Performance Framework.

RECOMMENDATIONS

The Board of Directors is asked to:

- approve the proposed amendments to the Trust's Corporate Governance Manual
- approve the close of the Governance and Performance Framework

MAIN REPORT

INTRODUCTION

Since its establishment in 2005, the Trust's Corporate Governance Manual has been a cornerstone for compiling critical internal control documents, such as the Schedule of Matters Reserved to the Board of Directors, Scheme of Delegation, and Standing Financial Instructions. This manual also encompasses various Codes of Conduct and offers a broad overview of the Trust's governance frameworks and processes. However, its lack of contextual information has rendered it more of a technical reference than a practical guide for staff.

In response to the need for a more user-friendly resource that clearly communicates the relevance of these governance documents to staff roles, the Trust developed the Governance and Performance Framework in 2022. This comprehensive framework delineates the structure, responsibilities, and processes critical to governance and performance management, ensuring clarity and accessibility for all staff members.

These documents have been made available in the 'supporting documents' section of Admin Control for Board members.

DRIVERS FOR CHANGE

Significant amendments to the Trust's Governance and Assurance Framework, ratified by the Board in March 2024, have rendered both the Corporate Governance Manual and the Governance and Performance Framework outdated. Recognising the importance of effectively communicating these updates, there is a proposal to consolidate these documents into a singular, cohesive reference to streamline access to information on corporate governance for all staff members across the Trust.

SUMMARY OF CHANGES

Version control			
Version	**Section**	**Changes made**	**Date**

13.0	**Foreword**	**The foreword has been expanded to provide additional context and outline of each of the respective sections of the document.**	**April 2024**
13.0	**Version Control**	**Moved from the front of the document to be an appendix**	**April 2024**
13.0	**Schedule of matters reserved to the Board of Directors**	**Moved to be an appendix. No changes have been made to the content.**	**April 2024**
13.0	**Corporate Governance (section 3)**	**This section has been strengthened by adding in context regarding the Trust's regulatory framework (taken from the Governance and Performance Framework).** **Additional narrative on the Corporate Governance functions added.** **Brief description of the Board's Committees added.** **Outline of the updated operational management processes added.** **Description of the Trust's internal and external control environment added**	**April 2024**
13.0	**Scheme of Delegation (including the NHS Foundation Trust Accounting Officer Memorandum)**	**Moved to be an appendix. No changes have been made to the content.**	**April 2024**
13.0	**Standing Financial Instructions**	**Moved to be an appendix. No changes have been made to the content.**	**April 2024**
13.0	**Code of Conduct for the Board of Directors** **Code of Conduct for the Council of Governors – found in the Trust Constitution** **Code of Conduct for NHS Managers**	**These have been collated into a single section (4) and the public sector equality duties have been added.**	**April 2024**

	Standards of Business Conduct for NHS Staff **Standing Orders for the Council of Governors**		
13.0	**Section 5**	**New section added from the Governance and Performance Framework called 'How we conduct Trust Business'. This is to provide staff with advice, guidance and templates for the effective management of meetings. This will support a consistent approach across the Trust.**	**April 2024**
13.0	**Appendix G**	**Meeting templates added to the document.**	**April 2024**

PROCEDURE FOR AMENDING THE CORPORATE GOVERNANCE MANUAL

Typically subjected to an annual review in July by the Audit Committee, the Manual's revisions are approved by the Board based on the Committee's recommendations. Although the Audit Committee was briefed in March 2024 on the Governance and Assurance Framework changes, timing constraints precluded a formal review of the Manual. However, it is important to note that the significant alterations pertain mainly to document formatting rather than the substance of internal control documents, like the Scheme of Delegation or Standing Financial Instructions.

There are no suggested amendments that impact the Trust Constitution – something that would require the views and approval of the Council of Governors.

The forthcoming annual review scheduled for July 2024 will entail a thorough examination of these key documents by the Corporate Governance, Finance, and Procurement teams, with the Audit Committee and Board receiving detailed recommendations.

Should the changes to the Corporate Governance Manual be accepted, the Governance and Performance Framework document would be stood down.

RECOMMENDATION

The Board of Directors is asked to:

- approve the proposed amendments to the Trust's Corporate Governance Manual
- approve the close of the Governance and Performance Framework

Liverpool Women's
NHS Foundation Trust

This is how we do it ….

Corporate Governance Manual

April 2024
V13.0

Contents

1. Foreword

1.1 Corporate governance is the system by which an organisation is directed and controlled at its most senior levels, to achieve its objectives and meet the necessary standards of accountability and probity. Effective corporate governance, along with clinical governance, is essential for a Foundation Trust to achieve its clinical, quality, and financial objectives. Fundamental to effective corporate governance is having the means to verify the effectiveness of this direction and control which is achieved through independent review and assurance.

1.2 NHS Foundation Trusts (FT) are created as legal entities in the form of public benefit corporations by the NHS Act 2006. The legislation constitutes NHS FTs with a governance regime that enables the NHS FT boards of directors to have autonomy to make financial and strategic decisions. They also have a framework of local accountability to members through a Council of Governors. Externally, whilst remaining part of the NHS, FTs are authorised by, and accountable for the operation of their licence to NHS England, rather than the Secretary of State for Health & Social Care. FTs are free to decide locally how to meet their obligations. They have specified powers to enter contracts in their own name and to act as Corporate Trustees, in which role they are accountable to the Charity Commission for those funds deemed to be charitable.

1.3 Effective corporate governance is a fundamental cornerstone for the success of Liverpool Women's NHS Foundation Trust (the Trust). The autonomy that the Trust enjoys, its public service purpose and the fact it is entrusted with public funds demands that the Board of Directors, the Council of Governors, and all Trust employees operate according to the highest standards of corporate governance. It is essential, therefore, that all employees, especially those operating at a senior level clearly understand the key principles of good governance and how to apply them. To this end, this Manual is available on the Trust's intranet with directors and relevant senior managers required to ensure that all staff for whom they are responsible are advised of its existence.

1.4 *The Corporate Governance Manual*

1.5 The Corporate Governance Manual serves as a comprehensive guide for outlining the control framework essential for achieving the Trust's objectives, operating within a legal and regulatory framework as defined by the Trust's Constitution and Provider License. This Manual is aligned with the revised Code of Governance for Provider Trusts (October 2022), as published by NHS England, providing an overarching governance and assurance framework for NHS foundation trusts. It emphasises the importance of statutory and regulatory compliance, incorporating key documents like the Accountable Officer Memorandum, Standards of Business Conduct, and Standing Orders and Financial Instructions for robust internal and financial governance.

1.6 This framework is enriched by integrating best practices in governance and performance management, drawing from both within and outside the NHS Foundation Trust sector. It focuses on utilising strategic and operational information and intelligence to enhance service delivery and manage delivery risks. This is complemented by detailed documentation of the governance and performance management processes established by the Board and Executive. These processes are designed to ensure that the Trust is well-led, operates efficiently, achieves its strategic objectives, and delivers optimal care to its patients.

1.7 The Manual aims to not only adhere to the existing legal and regulatory obligations but also encapsulates a clear explanation of governance, performance management, and delivery mechanisms.

1.8 *How to get the most from the Corporate Governance Manual (and how it is structured)*

1.9 This document will provide a comprehensive overview of governance and performance management structures and mechanisms in the Trust and the contents page will allow navigation through the relevant sections. It is structured in four sections:

1) *Definitions and Interpretations* – **Section 2** outlines common terms used throughout the document in order to provide clarity on meaning and references.

2) *Corporate Governance* - The Board of Directors leads the Corporate Governance oversight within the organisation, providing both internal and external assurance about our work. It achieves that by oversight of the Trust's management and operational processes. **Section 3** of this document describes the Trust's Corporate Governance processes, the context within which the Trust operates and how it identifies and manages risk.

3) *Behaviours and Standards* - Behaviours and standards are pivotal elements of corporate governance as they establish the ethical foundation and operational integrity within an organisation. These principles guide the conduct of individuals at all levels, from the boardroom to the front lines, ensuring decisions and actions align with the organisation's values and regulatory requirements. They serve as a benchmark for accountability, fostering a culture of transparency, responsibility, and ethical decision-making. By embedding high standards of behaviour into the corporate governance framework, organisations can enhance trust among stakeholders, mitigate risks, and optimise performance. **Section 4** of this document outlines the Trust's approach to managing conflicts of interest, the Code of Conduct for Board members, managers and Governors and standards expected in all Trust meetings.

4) *How we conduct Trust business* - To support the Trust's Governance and Performance Frameworks, it is vital to ensure that meetings are: effective (carry out actions); timely; attended by the right people; and recorded. **Section 5** of this document outlines a standardised approach to Trust meeting and provides templates to be used across the organisation.

1.10 It is essential that all Directors, Governors, officers and employees know of the existence of these documents and are aware of their responsibilities include within. A copy of this manual is available on the Trust's website and intranet and has been explicitly brought to the attention of key staff within the organisation and to all staff via the internal communication routes.

1.11 Any queries relating to the contents of these documents should be directed to the Chief Finance Officer, Trust Secretary or myself who will be pleased to provide clarification.

James Sumner
Chief Executive
April 2024

2. Definition and interpretation

2.1. Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this corporate governance manual bear the same meaning as in the NHS Act 2006 and the Constitution. References to legislation include all amendments, replacements, or re-enactments made.

2.2. Headings are for ease of reference only and are not to affect interpretation. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

2.3. In this corporate governance manual, the following definitions apply:

	Definition
The 2022 Act	The Health and Care Act 2022
The 2012 Act	The Health and Social Care Act 2012
The 2006 Act	The National Health Service Act 2006
The 1977 Act	The National Health Service Act 1977
Accounting Officer	The person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act; they shall be the Officer responsible and accountable for funds entrusted to the Foundation Trust in accordance with the NHS Foundation Trust Accounting Officer Memorandum. They are responsible for ensuring the proper stewardship of public funds and assets. The NHS Act 2006 designates the Chief Executive of the NHS Foundation Trust as the Accounting Officer
Agenda Item	• Board of Directors - an item from a Board member (notice of which has been given) about a matter over which the Board has powers or duties or which affects the services provided by the Foundation Trust • Council of Governors – an item from a Governor or Governors (notice of which has been given) about a matter over which the Council has powers or duties or which affects the services provided by the Foundation Trust
Appointing organisations	Those organisations named in the constitution who are entitled to appoint governors
Authorisation	An authorisation given by NHS England under Section 35 of the 2006 Act
The Board	The Board of Directors of the Foundation Trust as constituted in accordance with the Trust's constitution
Bribery Act	The Bribery Act 2010
Budget	A resource, expressed in financial or workforce terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Foundation Trust
Budget holder	The Director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation
The Chair	Is the person appointed by the Council of Governors to lead the Board and ensure it successfully discharges its overall responsibility for the Foundation Trust as a whole. It means the Chair of the Foundation Trust, or, in relation to the function of presiding at or chairing a meeting where another person is

	Definition
	carrying out that role as required by the Constitution, such person
Chief Executive	The chief officer of the Foundation Trust
Committee	A committee or subcommittee created and appointed by the Foundation Trust
Constitution	The constitution of the Foundation Trust as amended from time to time. Describes the type of organisation, its primary purpose, governance arrangements and membership
Contracting and procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets
Council of Governors	The Council of Governors of the Foundation Trust as constituted in accordance with the Trust's constitution
Director	A member of the Board of Directors
Chief Finance Officer	The chief finance officer of the Foundation Trust
External auditor	The person appointed to audit the accounts of the Foundation Trust, who is called the auditor in the 2006 Act
Financial year	Successive periods of twelve months beginning with 1 April
Foundation Trust	Liverpool Women's NHS Foundation Trust
Foundation Trust contract	Agreement between the Foundation Trust and Clinical Commissioning Groups and/or others for the provision and commissioning of health services
Funds held on Trust	Those trust funds which the Foundation Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under the 2006 Act. Such funds may or may not be charitable
Governor	An elected or appointed member of the Council of Governors
Legal advisor	A properly qualified person appointed by the Foundation Trust to provide legal advice
Licence	The document issued by the sector regulator setting out the conditions of operation for a Foundation Trust
NHS England(previously known as NHS Improvement and/or Monitor)	The independent regulator (NHS Improvement) took over the responsibilities of its predecessors responsibilities from [1 April 2016] NHS Improvement became part of NHS England in July 2022.
Meeting	• Board of Directors – a duly convened meeting of the Board of Directors • Council of Governors - a duly convened meeting of the Council of Governors
Member	A member of the Foundation Trust
Motion	A formal proposition to be discussed and voted on during the course of a meeting
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions
Non commissioner contract	Agreements with non Clinical Commissioning Group to organisations covering the variety of services that the Foundation Trust provides and charges for
Officer	An employee of the Foundation Trust

	Definition
Partner	In relation to another person, a member of the same household living together as a family unit
Protected property	Property identified in the Licence as being protected. This will generally be property that is required for the purposes of providing the mandatory goods and services and mandatory training and education
Registered medical practitioner	A fully registered person within the meaning of the Medicines Act 1983 who holds a licence to practice under that Act
Registered nurse or midwife	A nurse, midwife or health visitor registered in accordance with the Nurses, Midwives and Health Visitors Act 1997
Secretary	The Secretary appointed under the constitution, the Secretary of the Foundation Trust or any other person appointed to perform the duties of the Secretary, including a joint, assistant or deputy secretary
Standing Financial Instructions	(SFIs) regulate the conduct of the Trust's financial matters
Standing Orders	(SOs) incorporate the Constitution and regulate the business conduct of the Foundation Trust

3. Corporate Governance

3.1 Regulatory Framework

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

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

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

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

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

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

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

3.1.7 Good governance of the organisation ensures that the Board can give an account to stakeholders of its strategic and operational management of the organisation. Our improvement plan, strategic objectives and performance measures are therefore aligned to this framework.

3.2 Integrated Care Board and Provider Collaboratives

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

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

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

3.2.4 What does this mean for the Trust?

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

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

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

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

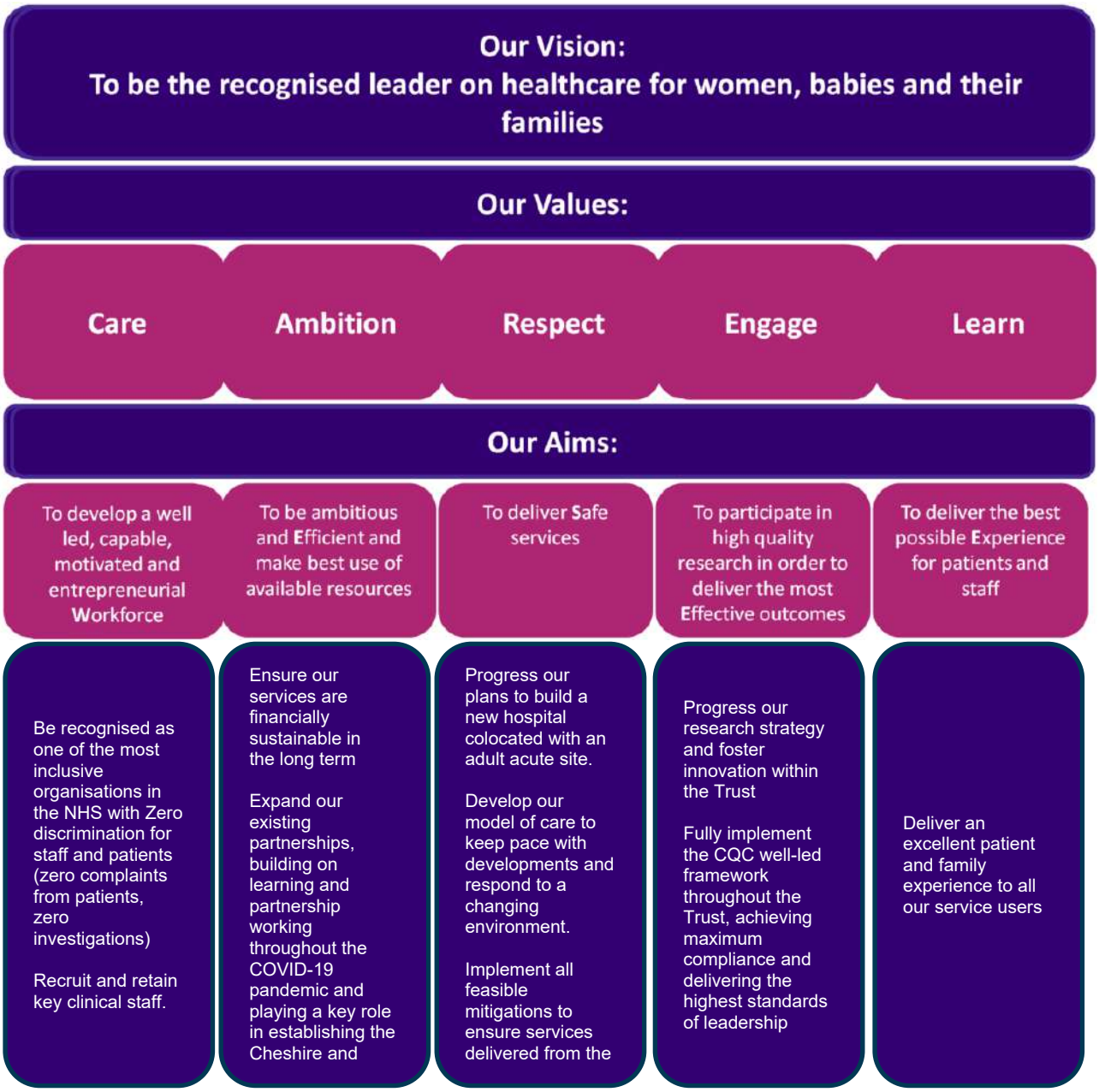
3.2.8 ** A Committee in Common (CiC) in the NHS is a joint committee that is made up of representatives from two or more NHS organisations, usually NHS Trusts or NHS Foundation Trusts. The purpose of a CiC is to provide a forum for collaboration and decision-making between the participating organizations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

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

3.3 Our Vision and Strategic Objectives

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

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



3.4 Authoritative Bodies

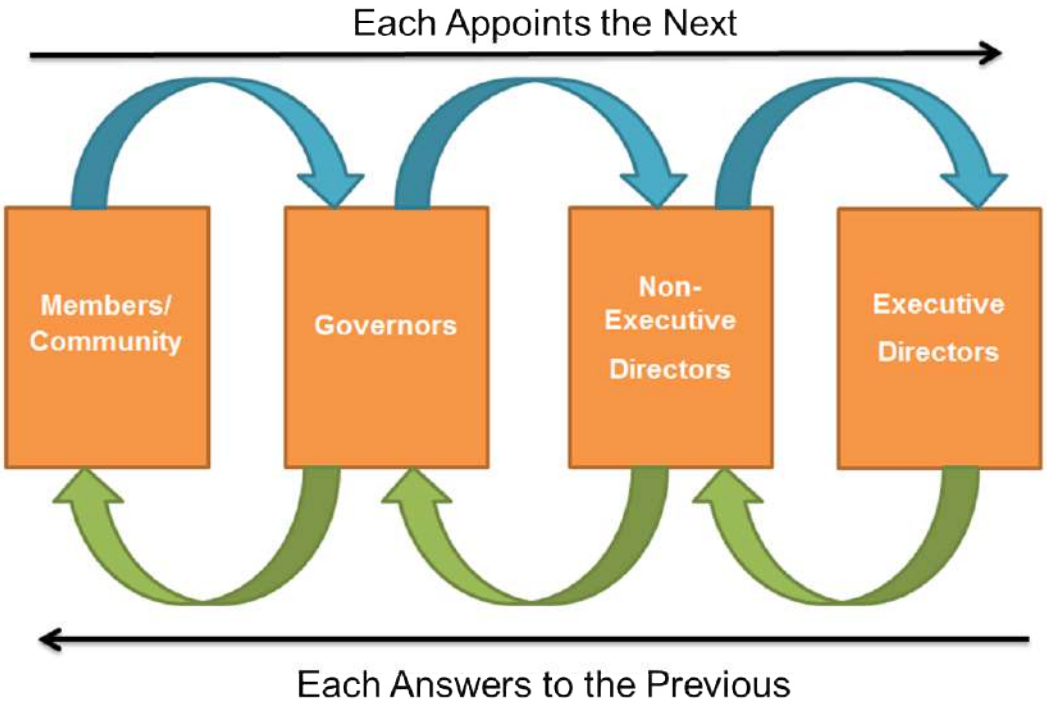
3.4.1 Foundation Trust Governance Structure

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

3.4.1.2 Governors have key statutory duties to hold the non-executives, individually and collectively, to account for the performance of the Board of Directors and to represent the interests of the Members and the public. Governors therefore need to understand how the Board of Directors uses information and intelligence to understand and be assured that the Trust provides high

quality sustainable services. This depends on a good flow of information between the Board of Directors and Council of Governors in order to support effective and informed dialogue and debate.

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



3.4.3 The Board of Directors

3.4.3.1 <u>The Role</u>

3.4.3.2 The Board takes corporate responsibility for all activities of the Trust considering the new general duties on Directors as identified in the Health & Social Care Act 2022 (referenced in the Trust Constitution).

3.4.3.3 The Board's main duties are:

- Setting the organisations strategic aims, taking into consideration the views of the Council of Governors, ensuring the necessary financial and human resources are in place for it to meet its objectives, and reviewing management performance
- Collective responsibility for ensuring the quality and safety of healthcare services, education, training, and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health & Social Care, the Care Quality Commission and other relevant NHS bodies.
- Collective responsibility for adding value to the organisation by promoting its success through the direction and supervision of its affairs.
- Providing proactive leadership within a framework of prudent and effective controls which enable risk to be assessed and managed.

- Setting and maintaining the organisation's vision, values, and standards of conduct, whilst ensuring its obligations to members, patients and other stakeholders including the local community and the Secretary of State are understood and met.

3.4.3.4 The Board is expected to bring about change by making best use of all its resources – financial, staffing, physical infrastructure, and knowledge – and working with staff and partner organisations to meet the publics and patient's expectations. As leaders, board members are expected to understand opportunities for improving services and motivate others to bring them about.

3.4.3.5 The Board makes plans to achieve the Government's objectives for healthcare, guided by the targets and delivery dates set out in the NHS System Oversight Framework. The Board also signs off an annual plan, setting out the year's objectives, and it is the function of the Board to ensure progress.

3.4.3.6 Membership

3.4.3.7 The Board consists of Executives, Non-Executive Directors, and a Chair. The Chair and Non-Executive Directors include lay people drawn from the local community and are selected with a view to ensuring a balance of skills and experience. They are accountable to the Council of Governors.

3.4.3.8 The Chair and Chief Executive - There is a clear division of responsibility between the chairing of the Board of Directors and Council of Governors on the one hand and the executive responsibility for the running of the Trust's business on the other.

3.4.3.9 The overall role of the Chair is one of enabling and leading so that the attributes and specific roles of the Executive team and the Non-Executives are brought together in a constructive way.

The Chair is responsible for:

- providing leadership of the Board of Directors and the Council of Governors, ensuring their effectiveness on all aspects of their role, and setting their agenda
- ensuring that the Board and the Council work together effectively
- ensuring that directors and governors receive accurate, timely and clear information that is appropriate for their respective duties
- ensuring that there is effective communication with patients, members, staff, and other stakeholders
- facilitating the effective contribution of all executive and non-executive directors to the Board's affairs and ensuring that the Board acts as a team
- appraising the performance of the Chief Executive and the Non-Executive Directors.

3.4.3.10 The Chief Executive is accountable to the Chair and Non-Executive Directors for ensuring that the Board is empowered to govern the Trust and that the objectives it sets are accomplished through effective and properly controlled executive action. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board.

The Chief Executive is responsible for:

- performing the duties of 'Accountable Officer' as set out in the NHS Act 2006
- overseeing risk management within the Trust and signing the Annual Governance Statement
- organising, managing, and staffing the Trust

- developing and maintaining procedures for the Trust
- protecting the Trust's reputation and integrity locally and nationally, by ensuring the Trust is open and honest in its communications and through the development of strong partnerships with all stakeholders
- ensuring the quality-of-service provision.

3.4.3.11 Non-Executive Directors - As members of a unitary board, Non-Executive Directors have a duty to ensure that there is constructive challenge of the decisions of the Board. Non-Executive Directors are responsible for:

- bringing independent judgement to bear on issues of strategy, performance, risk management and key appointments
- satisfying themselves as to the integrity and robustness of financial, clinical, and other information
- determining appropriate levels of remuneration of Executive Directors (through the Nominations & Remuneration Committee)
- appointing and where necessary removing Executive Directors, and succession planning
- ensuring that 'the Board acts in the best interests of the public and is fully accountable to the public for the services provided by the Trust and the public funds its uses'
- undertaking the work of the Audit Committee
- providing the Council of Governors with accurate, timely and clear information on the Trust's key quality, performance, and financial indicators.

3.4.3.12 A Non-Executive Director will be appointed Chair of the Audit Committee. Other appointments include the Senior Independent Director and Deputy Chair.

3.4.3.13 <u>Enhancing Board Oversight</u>

3.4.3.14 The Board of Directors may designate lead responsibility to a Non-Executive Director where there is a specific requirement for an individual Non-Executives to be identified or where the Trust has determined that this would provide additional assurance as specified within the Trust's governance arrangements. This designation does not contradict the overall, collective responsibility of the Board to discharge its duties and function as a unitary board; and does not require that the Non-Executive assumes operational matters.

3.4.3.15 In December 2021, NHS England issued guidance which set out a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some Non-Executive 'Champion Roles', through committee structures. Roles and responsibilities have been aligned to Non-Executives where required, and within the Trust's Corporate Governance structure.

3.4.3.16 The list of current Board Champions/ Nominated Leads roles are:

- Whistleblowing (Freedom to Speak Up)
- Safeguarding
- Board Maternity Safety Champion
- Wellbeing

3.4.3.17 <u>Executive Directors</u>

3.4.3.18 The Trust's Executive Directors are:

- Chief Executive Officer

- Chief Finance Officer
- Chief Nurse
- Chief Medical Officer
- Chief Operating Officer
- Chief People Officer

3.4.3.19 The above Executive Directors hold voting rights on the Board of Directors.

- Chief Digital Information Officer
- Chief Transformation Officer

3.4.3.20 The above Executive Directors do not hold voting rights on the Board of Directors.

3.4.3.21 Each Executive Director has responsibilities as a member of the Board of Directors and as one of the most senior managers of the operations of the Trust.

3.4.3.22 The Standing Orders of the Board of Directors are in the Trust's Constitution. This can be located via https://www.liverpoolwomens.nhs.uk/media/5250/constitution-september-2023-final.pdf

3.4.3.23 The Code of Conduct for Board Members can be found in Section 4.

3.4.4 Council of Governors

3.4.4.1 The Council of Governors comprises elected and appointed governors. Elected governors represent two main groups: staff and members of the public. The staff group is divided into constituencies as detailed within the Constitution. Appointed governors represent key stakeholders of the Trust.

3.4.4.2 In broad terms, the Council of Governors is responsible for representing the interests of the Trust's members and the partner organisations in the communities served by the Trust. To this end, it prepares and, from time to time, reviews the Trust's Membership and Engagement Strategy.

3.4.4.3 Governors provide their views to the Board on the Trust's forward plans and are presented with the Annual Report and Accounts, and the Quality Account. Responsibilities of the Council are:

- appoint or remove the Chair and the other Non-Executive Directors
- decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors
- approve the appointment of the Chief Executive
- hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors
- approve 'significant transactions' and any application by the Trust to enter into a merger, acquisition, separation or dissolution
- approve any proposed increases in private patient income of 5% or more (in proportion to the Trust's total income) in any financial year
- approve amendments to the Trust's Constitution
- appoint or remove the Trust's auditor
- receive the FT's annual accounts, any report of the auditor on them and the annual report
- represent the interests of the members of the Trust as a whole and the interests of the public.

3.4.4.4 Further details on the Council of Governors are to be found in the Trust's Constitution, including additional provisions in Annex 5 and within the Standing Orders located in Annex 7.

3.4.4.5 The Code of Conduct for Governors can be found in section 4.

3.5 **Corporate Governance Structure**

3.5.1 Board Committees

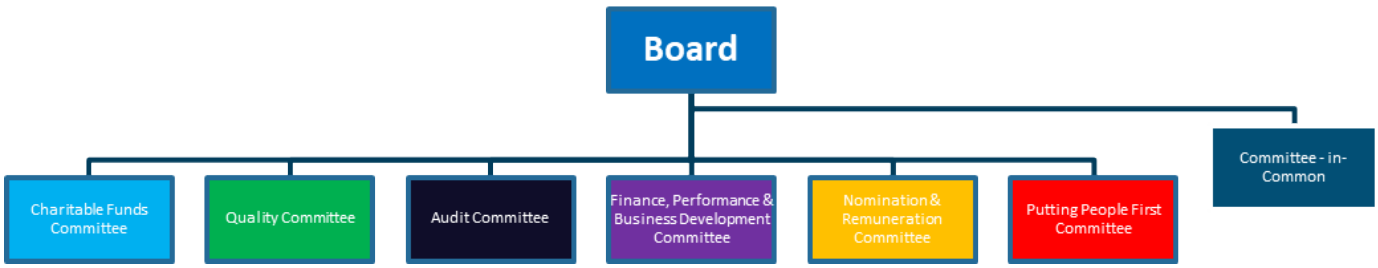
3.5.2 The Trust has governance structures across the Trust to ensure that decisions are made in the right place and that risks and issues can be escalated and managed effectively from line of sight (ward) to Board.

3.5.3 The governance structures create a clear and standardised reporting process and give us greater assurances about the decisions that are being made – that they are made at the correct level, that they align with our strategy and that they enable us to progress on our improvement journey.

3.5.4 The Board has established the following committees:

- Audit Committee
- Nomination & Remuneration Committee
- Charitable Funds Committee
- Finance, Performance & Business Development Committee
- Quality Committee
- Putting People First Committee

3.5.5 The diagram below outlines the Board's Committee structure:



3.5.6 The terms of reference of these committees are approved by the Board on an annual basis, and can be found in Appendix D.

3.5.7 A brief description of their role follows:

3.5.8 Audit Committee

3.5.9 The Audit Committee serves a crucial oversight role, primarily focused on enhancing the Trust's governance, risk management, and internal control frameworks. Its core purpose includes overseeing the integrity of financial statements, ensuring the effectiveness of the internal audit function, monitoring compliance with legal and regulatory requirements, and assessing the independence and performance of external auditors. By scrutinizing financial

reporting processes, internal controls, and the management of financial and operational risks, the Audit Committee helps to ensure that the Trust operates in a transparent, efficient, and accountable manner, thereby contributing to the Trust's overall integrity and public confidence in its operations.

3.5.10 Nomination & Remuneration Committee

3.5.11 The Nomination & Remuneration Committee's primary responsibilities include overseeing the processes for recruiting and appointing senior leadership positions within the Trust, ensuring there is a transparent and merit-based selection process. Additionally, the committee is tasked with developing and reviewing policies related to the remuneration, incentives, and terms of service for the executive directors and senior management, ensuring these are fair, competitive, and capable of attracting and retaining the high-calibre talent necessary for the Trust's success.

3.5.12 Charitable Funds Committee

3.5.13 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.

3.5.14 Finance, Performance & Business Development Committee

3.5.15 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.

3.5.16 Quality Committee

3.5.17 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.

3.5.18 Putting People First Committee

3.5.19 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.

3.5.20 Trust Wide Governance

3.5.21 In a review of Board and Committee Effectiveness in March 2024, it was agreed that the structure of providing the Board with oversight and comprehension of essential operational issues would be strengthened. The development of an Executive Risk and Assurance Group (ERAG) is a fundamental element of this process.

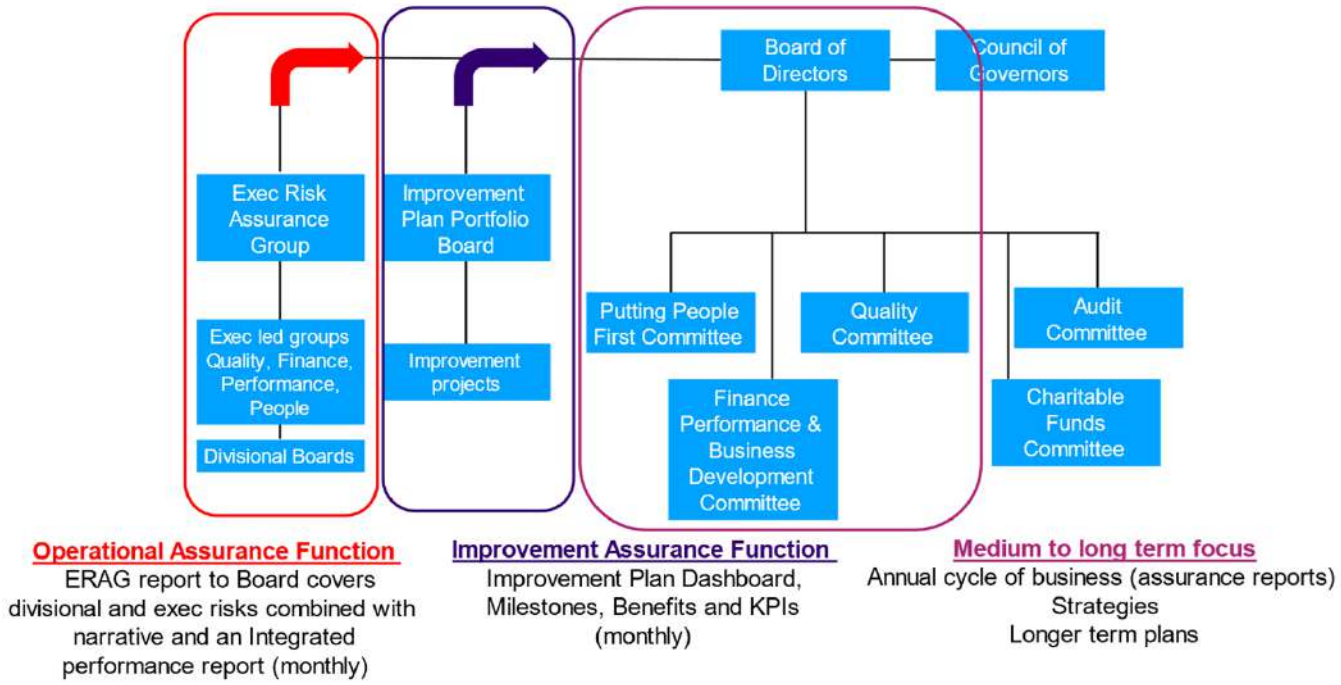
3.5.22 Executive Risk and Assurance Group (ERAG)

3.5.23 The ERAG provides 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 takes 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 also provides a corporate view on Trust-wide issues of current concern ensuring co-ordination between Divisions. Ultimately, the ERAG provides the formal mechanism to support the Chief Executive in effectively discharging his responsibilities as Accountable Officer. To fulfil this role, the ERAG has an underpinning reporting structure, led thematically by Executives.

3.5.24 Improvement Portfolio Governance

3.5.25 Improvements across the Trust are made via a series of agreed improvement projects that are led by a Senior Responsible Officer and will report into the Improvement Programme Portfolio Board. Updates the Improvement Plan are monitored via the Board of Directors.

3.5.26 The overall governance and assurance framework can be summarised in the diagram below:



3.5.27 Executive and Senior Management Meetings

3.5.28 Executive Directors Group (EDG)

3.5.29 Chaired by the Chief Executive and made up of the Executive Directors of the Board of Directors, meeting weekly. The EDG is the approval forum for all issues that cannot be delegated to Divisions. It triages key issues to (and from) the Trust Management Group and Senior Leadership Forum. Key issues from EDG are reported to the Board through Board Chief Executive's report. The EDG takes decisions on strategic communications, regulatory management, and reportable issues.

3.5.30 Trust Management Group (TMG)

3.5.31 Chaired by the Chief Executive and made up of the Executive Directors, Deputies, Divisional Senior Leadership Teams and the Heads of Service. Meeting bi-monthly, the TMG is a key place for the discussion of issues that cannot be decided by a single Division or service. It will consider Trust-wide corporate business cases and/or proposals, policies and procedures, and receive key updates from meetings which have a Trust-wide focus.

3.5.32 Senior Leadership Forum (SLF)

3.5.33 The SLF Is a development forum made up of the most senior leaders in the Trust. It is the platform for strategic communications to be delivered in the first instance for onward communication across the Trust, protected development time for key elements of Learning Enhancement Frameworks and an engagement group to discuss new ideas and proposals.

3.6 **Internal Control**

3.6.1 Internal control entails having in place processes and procedures which together ensure that the Trust is meeting the terms of its authorisation, running effectively, smoothly, and safely, and keeping risks to a minimum. Internal control also entails the Trust having clearly identifiable objectives and identifying the risks to achieving those.

3.6.2 Board Assurance Framework

3.6.3 The Board needs to be confident that the systems, policies, and people it has put in place are operating in a way that is effective in driving the delivery of strategic objectives. This needs an overarching focus on understanding key factors involved and minimising risk. The Board has a key role in needing to demonstrate that it has been properly informed about the totality of its risks, both clinical and non-clinical.

3.6.4 To do this, the Board needs to be able to provide evidence that it has systematically identified its objectives and managed the principal risks to achieving them. The Board Assurance Framework (BAF) fulfils this purpose. The BAF provides the Trust with a simple but comprehensive method for the effective and focused management of the principal risks to meeting its objectives. It also provides a structure for the evidence to support the Annual Governance Statement.

3.6.5 The Board must:

- establish key goals (strategic & directorate)
- identify the principal risks that may threaten the achievement of these objectives
- identify and evaluate the design of key controls intended to manage these principal risks
- set out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk
- evaluate the assurance across all areas of principal risk (assurances can be internal or external)
- identify positive assurances and areas where there are gaps in controls and/or assurances
- put in place plans to take corrective action where gaps have been identified in relation to principal risks
- maintain dynamic risk management arrangements including a well-founded risk register.

3.6.6 For the BAF to be effective, the Executive Directors take the lead for risks assigned to them and ensure that the relevant information is kept up to date and available for reporting to the Board. Each Executive Director has assigned an appropriate risk lead officer from their senior staff to co-ordinate on their behalf. This is a senior individual who is well- placed to access and interpret relevant risk information and assurance evidence. At the end of each financial year, the Chief Executive considers the BAF and other sources of assurance to complete the Annual Governance Statement. This document is contained within the Trust's Annual Report and is made available to the public.

3.6.7 Processes and Procedures

3.6.8 There are two broad categories of internal processes and procedures which ensure the proper running of the Trust. First, there are those which provide a comprehensive framework for the proper conduct of business:

- Standing Orders of the Board of Directors including the Matters Reserved to the Board (Appendix A) and the Scheme of Delegation (Appendix B).
- Standing Orders of the Council of Governors (outlined within the Trust's Constitution)
- Standing Financial Instructions (Appendix C).

3.6.9 All Board members and managers should be aware of the existence of these documents and, where appropriate, should be familiar with the detailed provisions. Staff should pay attention to the detailed scheme of delegation as any action that they take which is outside of their delegated authority could have serious consequences for both the Trust and the individual.

3.6.10 Secondly, there are the internal risk management processes and procedures which together constitute the Board Assurance Framework.

3.6.11 Risk Management

3.6.12 Risk management is the key system through which clinical, organisational, and financial risks are managed by all staff to the benefit of patients, visitors, staff, and other stakeholders.

3.6.13 The Trust has a Risk Management Strategy and an associated Policy which:

- Is approved by the Board
- Sets out the approach to setting the Trust's risk appetite
- Defines the structures for the management, ownership, and oversight of risk defines the management of situations in which the failure of controls leads to material realisation of risks
- Specifies how both new and existing activities are assessed for risk and incorporated into risk management structures
- Ensures common understanding of terminology used in relation to risk
- Defines the processes and considerations which inform the assessment of risk
- Defines the way in which the risk register is regularly reviewed.

3.6.14 The Trust's Risk Register is a database of all the risks which are recorded within the Trust, from individual site, divisional and support service risk register. This includes individual departments and ward risks. It identifies which staff member is leading on the management of that risk and identifies the risk grading. It is the totality of all risks recorded on Ulysses. The Register also includes details of action plans to mitigate the risks and identify progress against these plans.

3.6.15 Performance

3.6.16 The Board will review an Integrated Performance Report (IPR) covering financial, activity and quality performance data including workforce, operational, and research and innovation activity. These will include key relevant national priority and regulatory indicators. More detailed reports on performance will be considered by relevant Board committees to ensure corporate oversight across key functions to include all metrics.

3.6.17 Annual Governance Statement (AGS)

3.6.18 The Board needs to demonstrate that it has reviewed and been properly informed about the totality of its risks. The Chief Executive is required to sign an Annual Governance Statement, as part of the statutory Annual Report & Accounts, confirming that the Board and the Chief

Executive have reviewed the system of internal control within the Trust and have received assurance on that system.

3.6.19 The AGS is submitted annually to NHS England and covers the following:

- the scope of the responsibility of the Accountable Officer (Chief Executive)
- the purpose of the system of internal control
- the Trust's capacity to handle risk
- the risk and control framework
- the process used to ensure that resources are used economically, efficiently, and effectively
- confirmation that a review of effectiveness has been undertaken and that a plan is in place to address any weaknesses
- the process for maintaining the system of internal control and details of actions planned or taken to deal with any significant internal control issues. These might include:
    - an issue which seriously prejudiced or prevented achievement of a principal objective
    - an issue which resulted in a need to seek additional funding, or in a significant diversion of resources
    - an issue which the External Auditor or the Head of Internal Audit or the Audit Committee considers to be significant
- an issue which attracted significant adverse public interest or seriously damaged the reputation of the Trust.

3.6.20 The AGS is signed off by the Chief Executive, as Accountable Officer, on behalf of the Board of Directors. The Head of Internal Audit provides an annual opinion on the adequacy and effectiveness of the risk management, control, and governance processes to support the AGS.

3.6.21 The full AGS can be found in the Annual Report & Accounts.

3.6.22 Custody of Seal and Sealing of Documents

3.6.23 Custody of Seal - The Common Seal of the Trust shall be kept by the Chief Executive or the Trust Secretary in a secure place.

3.6.24 Sealing of Documents - The seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a Committee, where the Board has delegated its powers. Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Finance Officer (or an Officer named by them) and authorised and countersigned by the Chief Executive (or an Officer nominated by them who shall not be within the originating directorate).'

3.6.25 Register of Sealing - An entry of every sealing shall be made and numbered consecutively in a register provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. The register shall contain details of the seal number, the description of the document and date of sealing.

3.7 Independent Control and Regulation

3.7.1 Internal Audit

3.7.2 The Internal Audit Terms of Reference provide the Trust with the framework for the provision and conduct of an Internal Audit service, in accordance with the requirements of the NHS Internal Audit Standards, the NHS Audit Committee Handbook (2018) and the Trust's Standing Financial Instructions.

3.7.3 Internal Audit is an independent and objective assurance service which has no executive responsibilities within the line management structure. It has an annual plan focused on key aspects of risk management, control or governance agreed by the Trust's Audit Committee which is kept under review to consider any significant changes to the Trust's risk profile.

3.7.4 Internal Audit embraces two key areas:

- The annual provision of an independent and objective opinion to the Accountable Officer, the Board, and the Audit Committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives
- The provision of an independent and objective advisory service specifically to help line management improve the Trust's risk management, control, and governance arrangements.

3.7.5 The Head of Internal Audit's annual report presents the opinion on the overall adequacy and effectiveness of the Trust's risk management, control, and governance processes. This encompasses an opinion on the Trust's Assurance Framework and other mandated work alongside the conclusions arising from the risk based internal audit assignments within the plan. The degree to which previous audit recommendations have been acted on also forms part of the opinion.

3.7.6 In addition to the formal annual report, the Head of Internal Audit reports interim progress to the Audit Committee and Accountable Officer in the year. Such interim reports detail objectives, findings, and performance against plan. Additionally, progress against the implementation of agreed recommendations is followed up and reported to the Audit Committee on a regular basis.

3.7.7 Head of Internal Audit

3.7.8 The Head of Internal Audit reports to the Audit Committee, with the Chief Finance Officer taking executive oversight for the provision of the Internal Audit service (except when this may impinge on the objectivity of the audit).

3.7.9 The Head of Internal Audit, or an appropriate representative of the internal audit team, attends meetings of the Audit Committee unless, exceptionally, the Audit Committee decides that they should be excluded from either the whole meeting or for agenda items.

3.7.10 The Head of Internal Audit has an independent right of access to the Chair of the Audit Committee. In exceptional circumstances, where normal reporting channels may be seen to impinge on the objectivity of the audit, he/she may report directly to the Chair of the Trust.

3.7.11 If the Head of Internal Audit considers that the level of audit resources or the terms of reference in any way limit the scope of internal audit, or prejudice the ability to deliver a satisfactory service, he/she will advise the Audit Committee accordingly.

3.7.12 Fraud and Probity

3.7.13 Managing the risk of fraud is the responsibility of Trust management. To support this endeavour, the Trust has in place a comprehensive Anti-Fraud & Bribery Policy, and a nominated Local Counter Fraud Specialist who raises awareness, undertakes preventative

work, and investigates allegations of fraud. Key information resources to support staff are available on the Trust's intranet and website.

3.7.14 The relationship between the Trust's Local Counter Fraud Specialist, the Head of Internal Audit and the Trust's Chief Finance Officer are conducted in accordance with the requirements of the Government Functional Standard GovS 013: Counter Fraud.

3.7.15 External Audit

3.7.16 All foundation trusts must have their accounts audited by independent external auditors who are appointed by the Council of Governors. The audited annual accounts must be laid before Parliament.

3.7.17 The External Auditor's opinion on the annual accounts reports on whether:

- the financial statements give a true and fair view, in accordance with the accounting policies directed by NHS England of the state of the Trust's affairs and of its income and expenditure for the year as then ended.
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by NHS England.
- information included within the Annual Report is consistent with the financial statements.

4 Behaviours and Standards

4.1 Overview

4.1.1 Behaviours and standards are pivotal elements of corporate governance as they establish the ethical foundation and operational integrity within an organisation. These principles guide the conduct of individuals at all levels, from the boardroom to the front lines, ensuring decisions and actions align with the organisation's values and regulatory requirements. They serve as a benchmark for accountability, fostering a culture of transparency, responsibility, and ethical decision-making. By embedding high standards of behaviour into the corporate governance framework, organisations can enhance trust among stakeholders, mitigate risks, and optimise performance. This section outlines the public sector equality duties, the Trust's approach to managing conflicts of interest, the Code of Conduct for Board members, managers and Governors and standards expected in all Trust meetings.

4.2 Public Sector Equality Duties

4.2.1 The Public Sector Equality Duty was created by the Equality Act 2010. The duty covers age, disability, sex, gender reassignment, pregnancy and maternity, race, religion or belief and sexual orientation. It applies in England, Scotland and in Wales. The general equality duty is set out in section 149 of the Equality Act 2010.

4.2.2 The aim of the general equality duty is to integrate considerations of the advancement of equality into the day-to-day business of public authorities. In summary, those subject to the equality duty, must in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Act.

- Advance equality of opportunity between people who share a characteristic and those who don't
- Foster good relations between people who share a characteristic and those who don't

4.2.3 Liverpool Women's NHS Foundation Trust, as a public authority, is also subject to specific duties which help meet the general duty. This requires us to publish information to demonstrate our compliance with the general equality duty. This information must include information relating to people who share a protected characteristic who are its employees or affected by its policies and practices.

4.2.4 The Board of Directors, its Board Committees and operational groups are all required to take the equality duties into consideration to ensure they comply with relevant legislation and best practice in the conduct of their duties. The hyperlink to the Public Sector Equality Duty can be found below.

Public Sector Equality Duty | Equality and Human Rights Commission

4.3 Managing Conflicts of Interest

4.3.1 Liverpool Women's NHS Foundation Trust (the 'Trust') and the people who work with and for the Trust, collaborate closely with other organisations in the delivery of high-quality care to our patients. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. However, there is a risk that conflicts of interest may arise because of these collaborative activities. Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles on the NHS Constitution. The Trust is committed to maximising its resources for the benefit of the whole community. As an organisation, and as individuals, the Trust has a duty to ensure that all its dealings are conducted with the highest standards of integrity and that NHS monies are used wisely so that the Trust is using its finite resources in the best interests of patients.

4.3.2 In 2017, NHS England produced national policy and guidance in relation to Managing Conflicts of Interests in the NHS. The national policy required all NHS organisations to adopt a consistent approach to local policy content and, in 2019/20, NHS Foundation Trusts were required to publish a statement of compliance in the Annual Governance Statement confirming that a policy consistent with national guidance and that a register of interests for 'decision making staff' was available to members of the public. The Trust has made positive declarations of compliance in the Annual Governance Statement from 2019/20 onwards.

4.3.3 Work has continued to strengthen the Trust's approach to managing conflicts of interest in two main areas. Firstly, by attempting to ensure that all relevant information is being made available in a transparent way i.e., declarations are being made and secondly by looking to take effective action to improve the probity and transparency of decision-making utilising the available information. These actions were collated into a Standard Operating Procedure – agreed by the Audit Committee in July 2021. Both the policy and Standard Operating Procedure are available on the Trust's intranet.

4.4 Code of Conduct for Board Members

4.4.1 Introduction

4.4.2 High standards of corporate and personal conduct are an essential component of public services. As an NHS foundation trust, Liverpool Women's NHS Foundation Trust is required to comply with the principles of best practice applicable to corporate governance in the

NHS/health sector and with any relevant code of practice. The purpose of this code is to provide clear guidance on the standards of conduct and behaviour expected of all directors.

4.4.3 This code, with the Trust's Constitution, Corporate Governance Framework and Code of Conduct for Governors forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the foundation trust. The code is intended to operate in conjunction with the principles of the NHS Foundation Trust Code of Governance, the NHS Constitution, requirements set out within the 2006 Health and Social Care Act, and all subsequent amendments, and Regulation 5 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Fit and Proper Persons: Directors. The code applies at all times when directors are carrying out the business of the foundation trust or representing the foundation trust.

4.4.4 Principles of public life

4.4.5 All directors are expected to abide by the Nolan principles of: selflessness, integrity, objectivity, accountability, honesty, transparency and leadership:

4.4.6 Selflessness - Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.

4.4.7 Integrity - Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

4.4.8 Objectivity - In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

4.4.9 Accountability - Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

4.4.10 Openness - Holders of public office should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

4.4.11 Honesty - Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

4.4.12 General principles

4.4.13 Foundation Trust Boards of Directors have a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public. The Board of Directors therefore undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct. The Board of Directors will lead in ensuring that the provisions of the Constitution, the Standing Orders, Standing Financial Instructions and accompanying Scheme of Delegation conform to best practice and serve to enhance

standards of conduct. The Board of Directors expects that this Code will inform and govern the decisions and conduct of all directors.

4.4.14 Confidentiality & access to information

4.4.15 Directors must comply with the Foundation Trust's confidentiality policies and procedures. Directors must not disclose any confidential information, except in specified lawful circumstances.

4.4.16 Information on decisions made by the Board of Directors and information supporting those decisions should be made available in a way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation and directors must not seek to prevent a person from gaining access to information to which they are legally entitled.

4.4.17 The Foundation Trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation which will be followed at all times by directors.

4.4.18 Register of interests

4.4.19 Directors are required to register all relevant interests on the Board of Directors' Register of Interests in accordance with the provisions of the Trust's Constitution. It is the responsibility of each director to update their register entry if their interests change. The register is held by the Trust Secretary. Directors must send notification of any updates to the Trust Secretary and request confirmation that the register has been updated. Failure to register a relevant interest in a timely manner may constitute a breach of this Code.

4.4.20 Conflicts of interest

4.4.21 Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Foundation Trust. Directors have a further statutory duty not to accept a benefit from a third party by reason of being a director or for doing (or not doing) anything in that capacity.

4.4.22 If a director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the Chairman or Trust Secretary. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before the Trust enters into the transaction or arrangement.

4.4.23 The Chairman will advise directors in respect of any conflicts of interest that arise during Board of Directors meetings, including whether the interest is such that the director should withdraw from the meeting for the period of the discussion. In the event of disagreement, it is for the Board of Directors to decide whether a director must withdraw from the meeting. The Trust Secretary will provide advice on any conflicts that arise between meetings.

4.4.24 Bribery

4.4.25 The Bribery Act 2010 introduces a new, clearer regime for tackling bribery that applies to all businesses (including NHS organisations) based or operating in the UK. It covers all sorts of bribery, the offering and receiving of a bribe, directly or indirectly, whether or not it involves a public official, in the UK or abroad.

4.4.26 The Board of Directors has a responsibility to protect both the Trust and the wider NHS from bribery or corruption. Directors shall at all times comply with the Bribery Act 2010 and with the Trust's policy. Directors will not request or receive a bribe from anybody, nor imply that such an act might be considered. This means not agreeing to receive or accept a financial or other advantage from any source as an incentive or reward to perform improperly the function or activities of the Liverpool Women's NHS Foundation Trust.

4.4.27 Gifts & hospitality

4.4.28 The Board of Directors will set an example in the use of public funds and the need for good value in incurring public expenditure. The use of the Foundation Trust for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Board of Directors is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Foundation Trust in the eyes of the community.

4.4.29 The Board of Directors has adopted a policy on gifts and hospitality, within its Standards of Business Conduct, which will be followed at all times by directors. Directors must not accept gifts or hospitality other than in compliance with this policy.

4.4.30 Whistleblowing

4.4.31 The Board of Directors acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this Code and other concerns of an ethical nature. The Trust has adopted a whistle-blowing policy (concerns reporting procedure) that is available for staff.

4.4.32 This policy reflects the provisions of the Public Interest Disclosure Act 1998, which gives protection from dismissal, harassment, fear of reprisal or other detrimental treatment to "workers" (this term means Trust employees, agency or bank staff, the staff of one of our contractors, or volunteers) who wish to report information, which they reasonably believe, is in the patient or public interest. This enables staff to express concerns safely, so that issues are raised at an early stage and in the right way. Directors will understand and fulfil their responsibilities in respect of the Trust's Whistleblowing Policy and the Public Interest Disclosure Act 1998.

4.4.33 Personal conduct

4.4.34 Directors are expected to conduct themselves in a manner that reflects positively on the Foundation Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Foundation Trust into disrepute.

4.4.35 Specifically directors must:

- Act in the best interests of the Foundation Trust and adhere to its Values, expected Behaviours and this Code of Conduct.
- Respect others and treat them with dignity and fairness.
- Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion.
- Be honest and act with integrity and probity.
- Contribute to the workings of the Board of Directors as a Board of Directors member in order for it to fulfil its role and functions.

- Recognise that the Board of Directors is collectively responsible for the exercise of its powers and the performance of the foundation trust
- Raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate.
- Recognise the differing roles of the Chairman, Vice-Chairman, Senior Independent Director, Chief Executive, Executive Directors and Non-Executive Directors.
- Make every effort to attend statutory meetings.
- Adhere to good practice in respect of the conduct of meetings and respect the views of others.
- Take and consider advice on issues where appropriate.
- Acknowledge the responsibility of the Council of Governors to represent the interests of the Foundation Trust's members and partner organisations in the governance and performance of the Foundation Trust and to hold Non-Executive Directors to account for the performance of the Board of Directors, and to have regard to the views of the Council of Governors.
- Not use their position for personal advantage or seek to gain preferential treatment; nor seek improperly to confer an advantage or disadvantage on any other person.
- Accept responsibility for their performance, learning and development.

4.4.36 Eligibility Criteria

4.4.37 The Trust's Provider Licence requires that the Trust will not appoint as a director any person who is an unfit person, and shall ensure termination is enforced promptly on discovering any director to be an unfit person, except with the approval in writing of Monitor (NHS England).

4.4.38 The Trust's Constitution also sets the approved criteria, which deem a person to be an unfit person to become or continue as a Director of the Foundation Trust, as follows:

- s/he is a member of the Council of Governors, or a Governor of an NHS body or another NHS Foundation Trust;
- s/he is a member of a Local Involvement Network, its successor organisation, Local Healthwatch, or any of its successor organisations;
- s/he is the spouse, partner, parent or child of a member of the Board of Directors of the Trust;
- s/he is a member of a Local Authority's committee which scrutinises health matters.;
- s/he is a Director or member of a Clinical Commissioning Group with whom the Trust contracts;
- s/he been adjudged bankrupt or her estate has been sequestrated and in either case s/he has not been discharged;
- s/he has made a composition or arrangement with, or granted a Trust deed for, her creditors and has not been discharged in respect of it;
- s/he is the subject to a sex offender order;
- s/he has within the preceding five years been convicted in the British Islands of any offence:
- against a woman or child; or
- any other offence for which a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed
- s/he is the subject of a disqualification order made under the Company Directors Disqualification Act 1986;
- in the case of a non-executive Director, s/he is no longer a member of one of the public constituencies or an individual exercising functions for a University providing a medical or dental school to a hospital of the Trust;

- s/he is a person whose tenure of office as a Chair or as a member or Director of a health service body has been terminated on the grounds that her appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
- s/he has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;
- in the case of a non-executive Director s/he has refused without reasonable cause to fulfil any training requirement established by the Board of Directors; or
- s/he has refused to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors.

4.4.39 In addition, Regulation 5 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Fit and Proper Persons Directors states that Directors should be of good character, have the required skills, experience and knowledge and as such that their health enables them to fulfil the management function.

4.4.40 Furthermore, Directors would be excluded from office if they have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying out a regulated activity, or discharging any functions relation to any office or employment with a service provider.

4.4.41 Directors will notify the Trust Secretary immediately if any of the above criteria apply to their personal or professional circumstances.

4.4.42 Removal of a Director under the Fit and Proper Person Test

4.4.43 In addition to the Trust Disciplinary Rules which apply to all staff there is a requirement for Directors to be Fit and Proper Persons and to meet the Care Quality Commission Fit and Proper Person Test (FPPT) on an ongoing basis under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

4.4.44 Where a Director fails to meet the FPPT then consideration will be given to removing that person from their role of Director.

4.4.45 Directors should be of good character, have the required skills, experience and knowledge and as such that their health enables them to fulfil the management function. To pass the FPPT none of the criteria of unfitness should apply, which include bankruptcy, sequestration and insolvency, appearing on a barred list and being prohibited from holding Directorships under other laws. Directors should not have been involved or complicit in any serious misconduct, mismanagement of failure of care in carrying on a regulated activity.

4.4.46 An individual can be appointed as a Director with the expectation that they develop specific competence to undertake the role within specified timescales. Failure to do so may result in the FFPT not being met.

4.4.47 Where information is discovered that suggests an individual is not of good character after appointment to a role (e.g. through annual checks or through information provided to, or discovered by, the Trust) then appropriate and timely action will be taken to investigate and rectify the matter. Immediate action will be taken to protect people receiving services from risk or potential risk.

4.4.48 In such cases the Chair or Deputy Chairman may suspend a Non-Executive Director or the Chief Executive where this is deemed appropriate. The Chief Executive may suspend an

Executive Director and he/she, will notify the Chair of the reasons for this decision and the Chair shall forthwith call a meeting of the Board Nominations and Remuneration Committee to consider what actions should be taken. All concerns will be investigated quickly and due diligence in all such investigations demonstrated.

4.4.49 For concerns regarding a Non-Executive Director the Council of Governors Nominations and Remuneration Committee, supported by the Chief People Officer or other nominated person, will investigate the concerns and make a recommendation to the Chair and to the Council of Governors on the continued fitness of the Director where concerns are substantiated. Where the Director is deemed not to be a fit and proper person then action, as is proportionate, up to and including the termination of their engagement with immediate effect will be considered.

4.4.50 For concerns regarding an Executive Director or other Director level appointment, then an investigating officer will be appointed by the Chief Executive or Chief People Officer. The Investigating Officer may be an employee or Director of the Trust or may be a person or organisation engaged to undertake this role. They will investigate and present a case to a Director or Chief Executive of the Trust who will determine an outcome to be recommended in the first instance to the Board Nominations and Remuneration Committee and thereafter to the Board of Directors. Proportionate action up to summary dismissal will be taken as appropriate.

4.4.51 Where concerns are substantiated but an individual is retained as a Director, the rationale for this will be recorded and made available to those that need to be aware of this.

4.4.52 Where an individual appointment is terminated because they no longer meet the FPPT then this will be reported to the Regulator and to any appropriate professional body.

4.4.53 Compliance

4.4.54 All Directors will be required to:

4.4.55 prior to appointment, and annually thereafter, give an undertaking to abide by the provisions of this Code of Conduct by signing the declaration below.

4.5 Code of Conduct for the Council of Governors

4.5.1 This Code seeks to outline appropriate conduct for the Council of Governors and addresses both the requirements of office and the personal behaviour of individual Governors. Ideally any sanctions for non-compliance would never need to be applied, however a Code is considered an essential guide for Foundation Trust (FT) Governors. The Code is intended to operate in conjunction with the Code of Governance, the constitution, with standing orders and 'Your Statutory Duties, A reference guide for Foundation Trust Governors', Monitor August 2013.

4.5.2 As a member of the Council of Governors sometimes dealing with difficult and confidential issues, Governors are required to act with discretion and care in the performance of their role. They will be required to maintain confidentiality with regard to information gained via their involvement with the Trust.

4.5.3 Qualifications for Office

4.5.4 Governors must continue to comply with the qualifications required to hold office throughout their period of tenure. The Trust Secretary should be advised of any changes in

circumstances which disqualify the Governor from continuing in office. An example of this would be if a public Governor joined the Trust as an employee, at which point they would no longer be able to hold office as a public Governor.

4.5.5 All Governors will be expected to understand, agree and promote the Trust's Equal Opportunities policy in every area of their work.

4.5.6 One of the key objectives of the governing body is to promote social inclusion through its activities and as such the development and delivery of initiatives should not prejudice any part of the community on the grounds of age, race, disability, marital status, sexual orientation or religious belief.

4.5.7 Role of Governors and the Council of Governors

- To hold the Non-Executive Directors (NEDs) individually and collectively to account for the performance of the Board of Directors
- To represent the interests of the members of the Foundation Trust as a whole and the interests of the public, bringing a fair and open-minded view on all issues
- To appoint and, if appropriate, remove the Chair
- To appoint and, if appropriate, remove the other Non-Executive Directors
- To decide the remuneration and allowances and other terms and conditions of office of the Chair and the other Non-Executive Directors
- To approve the appointment of the Chief Executive
- To appoint and, if appropriate, remove the NHS Foundation Trust's auditor
- To receive the NHS Foundation Trust's annual accounts, any report of the auditor on them, and the annual report.
- Put forward views on the Foundation Trust's forward plan and communicate the Trust's plans to members
- To adhere to the seven principles of public life, as defined by the Nolan Committee (further information at www.public-standards.org.uk). The seven principles are:
    - Selflessness
    - Integrity
    - Objectivity
    - Accountability
    - Openness
    - Honesty
    - Leadership
- To actively support and promote the principles of the Foundation Trust and contribute to its success
- To adhere to the Trust's policies and procedures and support its objectives
- To lead the Trust's membership strategy, including membership recruitment
- To engage and consult with the membership of the Trust
- To encourage members to become future Governors
- To recognise that their role is a collective one whereby Governors exercise collective decision making in the meeting room which is recorded in the minutes. Outside the meeting room a Governor has no more rights and privileges than any other member.
- To undertake an advisory role to the Board of Directors.

4.5.8 In addition, individual Governors are required:

- To attend Council of Governor meetings
- To contribute to the workings of the Council, ensuring that it fulfils its role and functions.

4.5.9 It should be noted that the functions allotted to the Council of Governors are not of a managerial nature.

4.5.10 Confidentiality

4.5.11 In the course of their duties Governors may receive information which is confidential. All Governors are required to respect the sensitivity of the information they are made privy to as a result of their position and to adhere to the Trust's policy in this regard. Information made available to Governors in confidence must remain confidential. Failure to maintain confidentiality may result in removal from the Council of Governors.

4.5.12 Conflicts of Interest

4.5.13 Governors should act with the utmost integrity and objectivity and in the best interests of the Trust in performing their duties. They should not use their position for personal advantage or seek to gain preferential treatment. They should declare any conflicts of interest which may arise at the earliest opportunity. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. It is then for the Chair to advise whether it is necessary for the governor to refrain from participating in discussion of the item or withdraw from the meeting. If in any doubt they should seek advice from the Trust Secretary. It is important that conflicts of interest are addressed and are seen to be actioned in the interests of the Trust and all individuals concerned.

4.5.14 Register of Interests

4.5.15 There is a Register of Interests which records any pecuniary and non-pecuniary interests declared by Governors that might create a conflict of interest. It also records 'nil' returns. It is the responsibility of each governor to update their register entry if their interests change following initial completion at induction and on an annual basis. A pro forma is available from the Trust Secretary. Failure to declare interests may result in removal from the Council of Governors.

4.5.16 Council of Governor meetings

4.5.17 Governors have a responsibility to attend meetings of the Council of Governors. When this is not possible they should submit an apology to the Trust Secretary in advance of the meeting.

4.5.18 Absence from the Council of Governor meetings without good reason established to the satisfaction of the Council of Governors is grounds for disqualification. Absence from three consecutive meetings will result in the member being deemed to have resigned their position unless the grounds for absence are deemed to be satisfactory by the Council of Governors.

4.5.19 Governors are expected to attend for the duration of each meeting.

4.5.20 Personal Conduct

4.5.21 Governors are required to adhere to the highest standards of conduct in the performance of their duties. In respect of their interaction with others they are required to:

- Adhere to good practice in respect of the conduct of the meetings and respect the views of their fellow members, both elected and appointed
- Be mindful of conduct which could be deemed to be unfair or discriminatory

- Treat the Trust's employees and fellow members with respect and in accordance with the Trust's policies
- Recognise that the Council of Governors and the Board of Directors and its management team have a common purpose, i.e. the success of the Trust, and to work together as a team to this end

4.5.22 Governors should conduct themselves in such a manner as to reflect positively on the Trust and in accordance with the seven principles of public life (see above). When attending external meetings or any other events at which they are present, it is important for Governors to be ambassadors for the Trust.

4.5.23 Fit and Proper Person

4.5.24 In order to comply with the Trust's Provider Licence, Governors are asked to confirm the following:

4.5.25 I have not been adjudged bankrupt or my estate has not been sequestrated and (in either case) has not been discharged

4.5.26 I have not made a composition or arrangement with, or granted a trust deed for, my creditors and have not been discharged in respect of it

4.5.27 I have not within the preceding five years been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on me

4.5.28 I am not subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986

4.5.29 Accountability

4.5.30 Governors are accountable to the membership and should demonstrate this by attending members' meetings and other key events which provide opportunities to interface with their electorate in order to best understand their views.

4.5.31 Training and Development

4.5.32 Training and development are essential for the Council of Governors in respect of the effective performance of their role and Governors will be expected to both contribute to the formulation of a training programme for the Council and to actively participate in training events which are arranged for them. Governors may be removed from the Council of Governors if they have refused without reasonable cause to undertake any training which the Council of Governors requires all Governors to undertake.

4.5.33 Visits to Trust premises

4.5.34 Where the Governors wish to visit the premises of the Trust in a formal capacity as opposed to individuals in a personal capacity, the Council of Governors should liaise with the Trust Secretary to make the necessary arrangements. When attending Trust premises in the formal capacity of Governor, Governors must wear their identity badge which clearly indicates that they are a Governor of Liverpool Women's NHS Foundation Trust.

4.5.35 Non-compliance with the Code of Conduct

4.5.36 Non-compliance with this Code may result in action being taken as follows:

- Where misconduct takes place, the Chair shall be authorised to take such action as may be immediately required, including the exclusion of the person concerned from a meeting.
- Where such misconduct is alleged, it shall be open to the Council of Governors to decide by simple majority of those in attendance, to lay a formal charge of misconduct
- The individual will be notified in writing of the charge/s, detailing the specific behaviour which is considered to be detrimental to the Trust and inviting their response for consideration by the Council of Governors within a defined timescale
- The Governor will be invited to address the Council in person if the matter cannot be resolved satisfactorily through correspondence
- The Council of Governors will decide by simple majority of those present and voting whether to uphold the charge of conduct detrimental to the Trust
- The Council of Governors may impose such sanctions as shall be deemed appropriate, ranging from the issuing of a written warning as to the member's future conduct, to the removal of the individual from office.

4.5.37 In order to aid participation by all parties it is imperative that all Governors observe the points of view of others and conduct likely to give offence will not be permitted. The Chair will reserve the right to ask any member of the Council who, in his or her opinion, fails to observe the Code to leave the meeting.

4.5.38 This Code of Conduct does not limit or invalidate the right of the Council of Governors or the Trust to act under the Constitution.

4.5.39 All Governors will be required to prior to appointment, and upon reappointment, give an undertaking to abide by the provisions of this Code of Conduct by signing the declaration below.

4.5.40 Acceptance and Declaration

I, _____ (print name) confirm that I have received, read and understood the Code of Conduct of Liverpool Women's NHS Foundation Trust.

I confirm that I agree to abide by the Code of Conduct of Liverpool Women's NHS Foundation Trust and understand that failure to do so may result in removal from the Council of Governors.

Position: _____

Signature: _____

Date: _____

4.6 Code of Conduct for NHS Managers

4.6.1 Introduction

4.6.2 The Code of Conduct for NHS Managers sets out the standards of conduct expected of NHS Managers. It serves two purposes:

- to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make
- to reassure the public that these important decisions are being made against a background of professional standards and accountability.

4.6.3 The Code

4.6.4 As an NHS manager, I will observe the following principles:

- make the care and safety of patients my first concern and act to protect them from risk;
- respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- be honest and act with integrity;
- accept responsibility for my own work and the proper performance of the people I manage;
- show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community;
- take responsibility for my own learning and development.

4.6.5 This means in particular that I will:

- respect patient confidentiality;
- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of the public and patients;
- be guided by the interests of the patients while ensuring a safe working environment;
- act to protect patients from risk by putting into practice appropriate support and disciplinary procedures for staff; and
- seek to ensure that anyone with a genuine concern is treated reasonably and fairly.

4.6.6 I will respect and treat with dignity and fairness, the public, patients, relatives, carers, NHS staff and partners in other agencies. In my capacity as a senior manager within the NHS I will seek to ensure that no one is unlawfully discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin. I will also seek to ensure that:

- the public are properly informed and are able to influence services;
- patients are involved in and informed about their own care, their experience is valued, and they are involved in decisions;
- relatives and carers are, with the informed consent of patients, involved in the care of patients;
- partners in other agencies are invited to make their contribution to improving health and health services; and
- NHS staff are:
    - valued as colleagues;
    - properly informed about the management of the NHS;
    - given appropriate opportunities to take part in decision making.
    - given all reasonable protection from harassment and bullying;

- provided with a safe working environment;
- helped to maintain and improve their knowledge and skills and achieve their potential; and
- helped to achieve a reasonable balance between their working and personal lives.

4.6.7 I will be honest and will act with integrity and probity at all times. I will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to my own duties or the functions of my employer.

4.6.8 I will seek to ensure that:

- the best interests of the public and patients/clients are upheld in decision-making and that decisions are not improperly influenced by gifts or inducements;
- NHS resources are protected from fraud, bribery and corruption and that any incident of this kind is reported to the NHS Protect;
- judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and are properly founded; and
- open and learning organisations are created in which concerns about people breaking the Code can be raised without fear.

4.6.9 I will accept responsibility for my own work and the proper performance of the people I manage. I will seek to ensure that those I manage accept that they are responsible for their actions to:

- the public and their representatives by providing a reasonable and reasoned explanation of the use of resources and performance;
- patients, relatives and carers by answering questions and complaints in an open, honest and well researched way and in a manner which provides a full explanation of what has happened, and of what will be done to deal with any poor performance and, where appropriate giving an apology; and
- NHS staff and partners in other agencies by explaining and justifying decisions on the use of resources and give due and proper consideration to suggestions for improving performance, the use of resources and service delivery.

4.6.10 I will support and assist the Accountable Officer of my organisation in his or her responsibility to answer to Parliament, Ministers, the Department of Health and the Independent Regulator of Foundation Trusts in terms of fully and faithfully declaring and explaining the use of resources and the performance of the local NHS in putting national policy into practice and delivering targets.

4.6.11 For the avoidance of doubt, nothing in this Code requires or authorises an NHS manager to whom this Code applies to:

- make, commit or knowingly allow to be made any unlawful disclosure;
- make, permit or knowingly allow to be made any disclosure in breach of his or her duties and obligations to his or her employer, save as permitted by law.

4.6.12 If there is any conflict between the above duties and obligations and this Code, the former shall prevail.

4.6.13 I will show my commitment to working as a team by working to create an environment in which:

- teams of frontline staff are able to work together in the best interests of patients;
- leadership is encouraged and developed at all levels and in all staff groups; and

the NHS plays its full part in community development.

4.6.14 I will take responsibility for my own learning and development. I will seek to:

- take full advantage of the opportunities provided;
- keep up to date with best practice; and
- share my learning and development with others.

4.6.15 I will also uphold the seven principles of public life as outlined by the Nolan Committee:

- Selflessness – holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family or their friends
- Integrity – holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties
- Objectivity – in carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on meri
- Accountability – holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office
- Openness – holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demand
- Honesty – holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interes
- Leadership – holders of public office should promote and support these principles by leadership and example

4.6.16 Implementing the Code

4.6.17 The Code should be seen in a wider context that NHS managers must follow the 'Nolan Principles on Conduct in Public Life' (see paragraph 8.2.11 above), the 'Corporate Governance Codes of Conduct and Accountability', the 'Standards of Business Conduct', the 'Code of Practice on Openness in the NHS' and standards of good employment practice.

4.6.18 In addition many NHS managers come from professional backgrounds and must follow the code of conduct of their own professions as well as this Code.

4.6.19 In order to maintain consistent standards, the Trust will consider suitable measures to ensure that managers who are not their employees but who:

- manage their staff or services; or
- manage units which are primarily providing services to their patients also observe the Code.

4.6.20 It is important to respect both the rights and responsibilities of managers. To help managers to carry out the requirements of the Code, the Trust will provide reasonable learning and development opportunities and seek to establish and maintain an organisational culture that values the role of managers. NHS managers have the right to be:

- treated with respect and not be unlawfully discriminated against for any reason;
- given clear, achievable targets;
- judged consistently and fairly through appraisal;

- given reasonable assistance to maintain and improve their knowledge and skills and achieve their potential through learning and development; and
- reasonably protected from harassment and bullying and helped to achieve a reasonable balance between their working and personal lives.

4.6.21 Breaching the Code

4.6.22 Alleged breaches of the Code of Conduct will be promptly considered and fairly and reasonably investigated. Individuals must be held to account for their own performance, responsibilities and conduct where employers form a reasonable and genuinely held judgement that the allegations have foundation. Investigators should consider whether there are wider system failures and organisational issues that have contributed to the problems. In order to learn from and prevent future breaches of the Code, it is necessary to look at the wider causes of alleged breaches.

4.6.23 Local employers should decide whether to investigate alleged breaches informally or under the terms of local disciplinary procedures. It is essential however that both forms of investigation should be, and be seen to be, reasonable, fair and impartial. If Chief Executives or Directors are to be investigated, the employing authority should use individuals who are employed elsewhere to conduct the investigation. The NHS Confederation, the Institute of Healthcare Management and the Healthcare Financial Management Association are among the organisations who maintain lists of people who are willing to undertake such a role.

4.6.24 Application of the Code

4.6.25 The Code codifies and articulates certain important contractual obligations that apply to everyone holding management positions. These include Chief Executives and Directors who as part of their duties are personally accountable for achieving high quality patient care.

4.6.26 The Trust will:

- incorporate the Code into the employment contracts of Chief Executives and Directors and include the Code in the employment contracts of new appointments to that group
- identify any other senior managerial posts, i.e. with levels of responsibility and accountability similar to those of Director-level posts, to which they consider the Code should apply
- include the Code in new employment contracts as appropriate
- incorporate the Code into the employment contracts of existing postholders as appropriate.
- investigate alleged breaches of the Code by those to whom the Code applies promptly and reasonably as at paragraphs four to five
- provide a supportive environment to managers.

4.6.27 See also Standards of Business Conduct for NHS Staff, included in this manual

4.7 **Standards of Business Conduct for NHS Staff**

4.7.1 Introduction

4.7.2 These guidelines are based on recommendations by the NHS Management Executive to assist NHS employers and staff in maintaining strict ethical standards in the conduct of NHS business. They cover:

- the standards of conduct expected of all NHS staff where their private interests may conflict with their public duties; and
- the steps which NHS employers should take to safeguard themselves and the NHS against conflict of interest
- Action checklist for NHS Managers - Part C (omitted from this extract)
- Short guide for staff - Part D
- Ethical Code of the Chartered Institute of Purchasing and Supply (CIPS) (reproduced courtesy of IPS) - Part E.

4.7.3 The guidance is in four parts:
Part A - brief summary of the main provisions of the Bribery Act 2010
Part B - general policy guidelines
Part C – Short guide for staff
Part D - Ethical Code of the Chartered Institute of Purchasing and Supply (CIPS).

4.7.4 Part A

4.7.5 Bribery Act 2010

4.7.6 Bribery is generally defined as an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage, on behalf of oneself or another.

4.7.7 The Act repeals the UK's existing anti-corruption legislation – the Public Bodies Corrupt Practices Act 1889, the Prevention of Corruption Acts of 1906 and 1916 and the common law offence of bribery – and provides an updated and extended framework of offences to cover bribery both in the UK and abroad.

4.7.8 Zero Tolerance

4.7.9 Bribery is a criminal offence. Liverpool Women's NHS Foundation Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor do we or will we, accept bribes or improper inducements. This approach applies to everyone who works for us, or with us. To use a third party as a conduit to channel bribes to others is a criminal offence. We do not, and will not, engage indirectly in, or otherwise encourage, bribery.

4.7.10 Proactively combatting bribery has clear benefits for this Trust and the wider NHS. It helps prevent:
- adverse damage to or criticism of the organisation's reputation and funding
- the potential diversion and/or loss of resources from NHS care;
- unforeseen and unbudgeted costs of investigations and/or defence of any legal action; and,
- a negative impact on patient/stakeholder perceptions.

4.7.11 Part B

4.7.12 General policy guidelines

4.7.13 Responsibility of the Trust

4.7.14 The Trust is responsible for ensuring that these guidelines are brought to the attention of all employees; also that machinery is put in place for ensuring that they are effectively implemented.

4.7.15 Responsibility of NHS staff

4.7.16 It is the responsibility of staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. This primary responsibility applies to all NHS staff, i.e. those who commit NHS resources directly (e.g. by the ordering of goods) or those who do so indirectly (e.g. by the prescribing of medicines). A further example would be staff who may have an interest in a private nursing home and who are involved with the discharge of patients to residential facilities.

4.7.17 Guiding principle in conduct of public business

4.7.18 It is a long established principle that public sector bodies, which include the NHS, must be impartial and honest in the conduct of their business, and that their employees should remain beyond suspicion. It is also an offence under the Bribery Act 2010 for an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage, on behalf of oneself or another (see Part A).

4.7.19 A breach of the provisions of the Act renders employees liable to prosecution and may also lead to loss of their employment and superannuation rights in the NHS.

4.7.20 NHS staff are expected to:

- ensure that the interest of patients remains paramount at all times;
- be impartial and honest in the conduct of their official business;
- use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.

4.7.21 It is also the responsibility of staff to ensure that they do not:

- abuse their official position for personal gain or to benefit their family or friends;
- seek to advantage or further private business or other interests, in the course of their official duties.

4.7.22 Implementing the guiding principles

4.7.23 Casual gifts

4.7.24 Casual gifts offered by contractors or others, e.g. at Christmas time should be politely but firmly declined.

4.7.25 Any gifts received from or offer of gifts by a contractor or potential contractor must be reported immediately to the Chief Executive. In the context of these instructions contractor means any supplier of goods and/or services to the Trust. Exception may be made only for items of a trivial nature, otherwise staff should decline all offers of gifts.

4.7.26 Articles of low intrinsic value such as diaries or calendars, or small tokens of gratitude from patients or their relatives, need not necessarily be refused. In cases of doubt staff should either consult their line manager or politely decline acceptance.

4.7.27 Hospitality

4.7.28 Modest hospitality provided it is normal and reasonable in the circumstances, e.g. lunches in the course of working visits, may be acceptable, though it should be similar to the scale of hospitality which the NHS as an employer would be likely to offer.

4.7.29 Visits to contractors or potential contractors or to another site to inspect their installations must be made at the Trust's expense and not the contractor's. Exception to this rule may be granted by the Chief Executive where reasonable. Otherwise only minimal hospitality should be accepted from a contractor or potential contractor and an immediate explanation must be given to the Chief Executive if a breach of the rules occurs. As with gifts, unless of a minor nature hospitality and entertainment should be declined.

4.7.30 Staff should decline all other offers of gifts, hospitality or entertainment. If in doubt they should seek advice from their line manager.

4.7.31 Any item/s of gifts and hospitality accepted, which are over the value of £25.00, should be entered into the gifts and hospitality register held in the Chief Executive's office.

4.7.32 Declaration of interests

4.7.33 For conflict of interests please refer to the Trust policy 'Managing Conflicts of interest' which sets out the requirement for staff to disclose any conflict or perceived conflict with the Trust's activities.

4.7.34 All NHS staff should therefore declare such interests to their employer, either on starting employment or on acquisition of the interest, in order that it may be known to and in no way promoted to the detriment of either the employing authority or the patients whom it serves.

4.7.35 One particular area of potential conflict of interest, which may directly affect patients, is when NHS staff hold a self-beneficial interest in private care homes or hostels. While it is for staff to declare such interests to their employing authority, the employing authority has a responsibility to introduce whatever measures it considers necessary to ensure that its interests and those of patients are adequately safeguarded. This may for example take the form of a contractual obligation on staff to declare any such interests. Advice on professional conduct issued by the General Medical Council recommends that when a doctor refers a patient to a private care home or hostel in which he or she has an interest, the patient must be informed of that interest before referral is made.

4.7.36 In determining what needs to be declared, employers and employees will wish to be guided by the policy referred to above and to the following documents that can be found on NHS England's website at https://www.england.nhs.uk/ourwork/coi/.

4.7.37 The Trust will:

- ensure that staff are aware of their responsibility to declare relevant interests
- keep a register of all such interests and make them available for inspection by the public
- develop a local policy, in consultation with staff and local staff interests, for implementing this guidance. This may include the disciplinary action to be taken if an employee fails to declare a relevant interest or is found to have abused his or her official position, or knowledge, for the purpose of self-benefit, or that of family or friends.

4.7.38 Preferential treatment in private transactions

4.7.39 Individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official

dealings on behalf of their NHS employer. (This does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interest, on behalf of all staff - for example, NHS staff benefits schemes.)

4.7.40 Contracts

4.7.41 All staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign purchase orders, or place contracts for goods, materials or services, are expected to adhere to professional standards of the kind set out in the Ethical Code of the CIPS, reproduced at Part D.

4.7.42 Favouritism in awarding contracts

4.7.43 Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of NHS Standing Orders and of EC Directives on Public Purchasing for Works and Supplies. This means that:

- no private, public or voluntary organisation or company which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the NHS employer, such as a long-running series of previous contracts
- each new contract should be awarded solely on merit, taking into account the requirements of the NHS and the ability of the contractors to fulfil them.

4.7.44 The Trust will ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

4.7.45 Warnings to potential contractors - Trust bribery statement

4.7.46 NHS employers will wish to ensure that all invitations to potential contractors to tender for NHS business include a notice warning tenderers of the consequences of engaging in any corrupt practices involving employees of public bodies.

4.7.47 Liverpool Women's NHS Foundation Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor do we or will we, accept bribes or improper inducements. This approach applies to everyone who works for us, or with us. To use a third party as a conduit to channel bribes to others is a criminal offence. We do not, and will not, engage indirectly in, or otherwise encourage, bribery.

4.7.48 Outside employment

4.7.49 NHS employees are advised not to engage in outside employment which may conflict with their NHS work, or be detrimental to it. They are advised to tell the Trust if they think they may be risking a conflict of interest in this area: the Trust will be responsible for judging whether the interests of patients could be harmed, in line with the principles in 'Implementing the guiding principles' above.

4.7.50 Second employments must also be considered carefully. These activities should neither take precedence over an officer's main employment with the Trust nor should engagement in these activities in any way affect an officer's efficient discharge of duties under his or her main employment. Where an officer has reason to believe that this or her second employer

has any business dealings whatsoever with the Trust the fact must be reported to the Chief Executive.

4.7.51 For full time staff, the main employment of officers necessarily takes precedence over any other paid or voluntary activities undertaken. Employees should not engage in any second or spare time job which affects in any way their performance or discharge of their duties with this Trust.

4.7.52 Second or spare time jobs are permissible without the need for registration or authorisation where the activity is not with a supplier or contractor to the Trust or not with any other NHS organisation.

4.7.53 Extra jobs, whether regular or occasional, should not be with a supplier to the Trust unless specifically approved by the Chief Executive who will keep a register detailing the personnel, the activity, the employer, and any other such details as deemed desirable.

4.7.54 Details of such situations must be submitted as and when these arise and confirmed on an annual basis.

4.7.55 Particular care must be taken to disclose any employment, even if only on a temporary or supply basis, with another NHS or private health care body.

4.7.56 Private practice

4.7.57 Consultants (and associate specialists) employed under the Consultant Contract are permitted to carry out private practice in NHS hospitals subject to the conditions outlined in the handbook and in accordance with the Code of Conduct for Private Practice

4.7.58 Other grades may undertake private practice or work for outside agencies, providing they do not do so within the time they are contracted to the NHS, and they observe the conditions in the paragraph above. All hospital doctors are entitled to fees for other work outside their NHS contractual duties (paragraph 41 of the TCS of Hospital Medical and Dental staff) e.g. examinations and reports for life insurance purposes. Hospital doctors and dentists in training should not undertake locum work outside their contracts where such work would be in breach of their contracted hours. Career grade medical and dental staff employed by NHS Trusts may agree terms and conditions different from the National Terms and Conditions of Service.

4.7.59 Rewards for Initiative

4.7.60 The Trust will identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that it receives any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by their employees in the course of their NHS duties. Most IPR are protected by statute e.g. patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. To achieve this, the Trust will build appropriate specifications and provisions into the contractual arrangements which they enter into before the work is commissioned, or begins. They should always seek legal advice if in any doubt in specific cases.

4.7.61 With regard to patents and inventions, in certain defined circumstances the Patents Act gives employees a right to obtain some reward for their efforts, and employers should see that this is effected. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar

rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

4.7.62 In the case of collaborative research and evaluative exercises with manufacturers, NHS employers should see that they obtain a fair reward for the input they provide. If such an exercise involves additional work for an NHS employee outside that paid for by the NHS employer under his or her contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should however be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

4.7.63 Commercial sponsorship for attendance at courses and conferences

4.7.64 Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where the employee seeks permission in advance and the employer is satisfied that acceptance will not compromise purchasing decisions in any way.

4.7.65 On occasions when NHS employers consider it necessary for staff advising on the purchase of equipment to inspect such equipment in operation in other parts of the country (or exceptionally, overseas), employing authorities will themselves want to consider meeting the cost, so as to avoid putting in jeopardy the integrity of subsequent purchasing decisions.

4.7.66 Commercial sponsorship of posts - “linked deals”

4.7.67 Pharmaceutical companies, for example, may offer to sponsor, wholly or partially, a post for the Trust. The Trust will not enter into such arrangements, unless it has been made abundantly clear to the company concerned that the sponsorship will have no effect on purchasing decisions by the Trust. Where such sponsorship is accepted, monitoring arrangements will be established to ensure that purchasing decisions are not, in fact, being influenced by the sponsorship agreement.

4.7.68 Under no circumstances should employers agree to “linked deals” whereby sponsorship is linked to the purchase of particular products, or to supply from particular sources.

4.7.69 “Commercial in-confidence”

4.7.70 Staff should be particularly careful of using, or making public, internal information of a “commercial in-confidence” nature, particularly if its disclosure would prejudice the principle of a purchasing system based on fair competition. This principle applies whether private competitors or other NHS providers are concerned, and whether or not disclosure is prompted by the expectation of personal gain (see the paragraphs above and Part D).

4.7.71 However, NHS employers should be careful about adopting a too restrictive view on this matter. It should certainly not be a cause of excessive secrecy on matters which are not strictly commercial per se. For example, the term “commercial in confidence” should not be taken to include information about service delivery and activity levels, which should be publicly available. Nor should it inhibit the free exchange of data for medical audit purposes, for example, subject to the normal rules governing patient confidentiality and data protection. In all circumstances the overriding consideration must be the best interests of patients.

4.7.72 Disciplinary action

4.7.73 Failure to follow the principles and the guidance in this Code may result in disciplinary action and possibly prosecution under the Bribery Act 2010.

4.7.74 Officers should take action to report as soon as possible any instance where they feel the guidelines have been broken, accidentally or otherwise, by themselves or others. It should be emphasised that the crime occurs when any money, gift or consideration has been offered, requested or received and the recipient then shows favour or partiality to the donor. The recipient should be prepared to, and be able to demonstrate that any gift or hospitality was not received corruptly. Money should never be accepted. Prompt disclosure and registration are important acts to refute the charge of corruption.

4.7.75 Part C

4.7.76 Short guide for staff

4.7.77 Do:

- make sure you understand the guidelines on standards of business conduct, and consult your line managers if you are not sure make sure you are not in a position where your private interests and NHS duties may conflict (3)
- declare to your employer any relevant interests. If in doubt, ask yourself: am I, or might I be, in a position where I (or my family/friends) could gain from the connection between my private interests and my employment? Do I have access to information which could influence purchasing decisions? Could my outside interest be in any way detrimental to the NHS or to patients' interests? Do I have any other reasons to think I may be risking a conflict of interest? If still unsure - declare it!
- adhere to the ethical code of the Chartered Institute of Purchasing and Supply if you are involved in any way with the acquisition of goods and services
- seek your employer's permission before taking on outside work, if there is any question of it adversely affecting your NHS duties (special guidance applies to doctors)
- obtain your employer's permission before accepting any commercial sponsorship.

4.7.78 Do not:

- accept any gifts, inducements or inappropriate hospitality
- abuse your past or present official position to obtain preferential rates for private deals
- unfairly advantage one competitor over another or show favouritism in awarding contracts
- misuse or make available official "commercial in confidence" information.

4.7.79 If in doubt seek advice from the Trust Secretary on 0151 702 4033 or if you wish to report any concerns in relation to fraud or corruption contact the Trust's LCFS on 07800 617 012, the Fraud and Corruption Reporting Line 0800 028 4060 or www.reportnhsfraud.nhs.uk.

4.7.80 Part D

4.7.81 Chartered Institute of Purchasing and Supply - Ethical Code (Reproduced by kind permission of CIPS)

4.7.82 Introduction

4.7.83 The code set out below was approved by the CIPS Council on 11 March 2009 and is building on CIPS members.

- maintain the highest standard of integrity in all my business relationships
- reject any business practice which might reasonably be deemed improper
- never use my authority or position for my own personal gain
- enhance the proficiency and stature of the profession by acquiring and applying knowledge in the most appropriate way
- foster the highest standards of professional competence amongst those for whom I am responsible
- optimise the use of resources which I have influence over for the benefit of my organisation
- comply with both the letter and the intent of:
    - the law of countries in which I practise
    - agreed contractual obligations
    - CIPS guidance on professional practice
- declare any personal interest that might affect, or be seen by others to affect, my impartiality or decision making
- ensure that the information I give in the course of my work is accurat
- respect the confidentiality of information I receive and never use it for personal gain
- strive for genuine, fair and transparent competition
- not accept inducements or gifts, other than items of small value such as business diaries or calendars
- always declare the offer or acceptance of hospitality and never allow hospitality to influence a business decision
- remain impartial in all business dealing and not be influenced by those with vested interests.

5 How we Conduct Trust Business

5.1 Introduction

5.1.1 It is important to ensure that Trust meetings are:

- effective (carry out actions)
- timely
- attended by the right people; and recorded.

5.1.2 Paperwork that supports meetings, whether it's an action log, reports, action notes or full minutes are often requested for review by external bodies such as the CQC, and the external auditors.

5.1.3 A suite of supporting templates has been produced to provide help and support for all meetings that take place in our meeting structure (within the Assurance and Performance Management Framework).

5.1.4 It covers the 'architecture' or framework for meetings; the agreed standards of practice and provides the templates to be used.

5.1.5 Also covered are the behaviours expected of members in meetings. This outlines how members and those attending should always act in accordance with the Trust's values and seek to create a safe space to challenge and feel comfortable to be challenged with the aim of achieving the right outcome for our service users and patients.

5.1.6 Whilst this framework has been written for all meetings in the formal meeting structure, staff involved in local meetings (for example team meetings) should apply the good practice set out in the framework and use those templates that are applicable to ensure risks, decisions and actions are appropriately evidenced, recorded and progressed.

5.2 Roles and Responsibilities

5.2.1 *The Role of the Chair*

5.2.2 The role and contribution of the chair is pivotal in ensuring that boards/committees/groups/task and finish groups are effective in their operation. Key points are summarised as follows:

- To agree the committee/group cycle of business with the executive / senior lead and the administrative secretary in advance of the forthcoming financial year ensuring this aligns with the terms of reference.
- The chair will review and confirm the agenda with the executive / senior lead and the administrative secretary in advance of the meeting to ensure all items are relevant to the duties of the committee and aligned against the cycle of business.
- The chair will sign off the minutes within the agreed timeframe to enable draft minutes to be circulated to committee/meeting members.
- The chair is responsible for leading members in establishing effective decision-making processes and act as the guardian of due process.
- The chair is responsible for ensuring that constructive relationships based on candour, trust and mutual respect exist between members.
- The chair will assume that all members come prepared to discuss agenda items having read through supporting papers, this obviates the need for leads to take up valuable time presenting their papers
- The chair will allow a free ranging debate and steer discussions to keep members on track whilst at the same time not being seen to overly influence the outcome of the debate
- The chair will provide a brief summary following presentation and discussion of the paper, confirming any key risks and / or assurances identified and whether there are any matters for the chair's log
- The chair will question leads when reports have not been submitted within the Trust's standard template or within the required timeframe
- Ensure that correct people are in the room to 'form the meeting' with other attendees invited to attend only when presenting their item.

5.2.3 The Role of the Executive / Senior Lead

5.2.4 The role of the executive / senior lead is to ensure that relevant and appropriate information is provided to the committee / group to enable them to provide assurance to the Board or parent meeting. Specific responsibilities include:

- To agree the cycle of business with the chair and the administrative secretary in advance of the forthcoming financial year
- To agree the agenda with the chair/secretary in advance of the meeting to ensure that all items are relevant to the duties of the committee / group and aligned against the cycle of business
- To reinforce with operational teams/individuals the requirement to ensure papers are submitted to the secretary within the agreed deadline dates.

- To sign off the final set of papers prior to circulation to committee / group members.
- Agreeing the final wording of the assurance report prior to submission to the chair of the committee / group and/or the Board, ensuring they reflect the key issues discussed.
- Agree the final minutes prior to submission to the committee / group chair for final approval.

5.2.5 The Role of the Administrative Secretary

5.2.6 The role of the secretary is to provide administrative support to the meetings and ensure they are managed effectively. Key responsibilities of a secretary include:

- To arrange dates (for the coming year), times and venues for meetings and circulate to all members.
- To develop and maintain the cycle of business in conjunction with the chair and executive / senior lead.
- To draft the agenda, collate papers and circulate them within the required timeframe.
- To reinforce with report authors with regard to the submission of papers according to the agreed deadline dates.
- Work with the chair to identify actions during the meeting and record them on the action tracker.
- To transcribe the minutes and actions from the meeting. Minutes should be drawn up within five working days of the meeting and approved by the chair and the executive / senior lead for the committee meetings. The minutes and action tracker should then be circulated to members.
- To manage the action and chair's log tracker and follow up on outstanding actions/actions arising from the chair's log.

5.2.7 The Role of Meeting Attendees

5.2.8 The meeting members play a major role during the discussion and decision-making process. It is their role to ensure they have received sufficient information to inform their decision-making.

5.2.9 The Corporate Governance Team

5.2.10 The role of the Corporate Governance Team is to provide senior level support to the Board and its Committees to ensure that meetings are managed effectively and appropriately; to be the key contact point for those reporting in. They are responsible for complete, objective record keeping which identifies items requiring follow-up and actions taken. This record evidence the discussions held and the outcomes arising from those discussions in a professional way that can be audited. (NB. all minutes, not just those of the Board and its Committees are externally assessed and can also be released under Freedom of Information). They are also responsible for ensuring the Committees remain consistent with their terms of reference and do not operate ultra vires.

5.2.11 The Corporate Governance Team also provides administrative advice regarding the functioning of the Trust's meetings and must be informed if a meeting within either the performance or assurance framework is cancelled. The establishment of a committee / sub-committee / group must be discussed with the Corporate Governance Team.

5.2.12 Meeting Guidance notes

5.2.13 The Trust's Meeting Guidance notes should be appended to every meeting pack and serve as a reminder of the expected meeting processes and behaviours.

5.3 Meeting Documentation

5.3.1 Style Guide

5.3.2 Documentation must follow a standard format (which will be set out in the Trust's style guide - https://drive.google.com/file/d/1lw_aMuLATcf_Jv60UESpc9kxzq31xVUN/view). Documents must be written in predominantly Arial size 11 font and have page numbers in the footer. You can set your version of Word to default to Arial 11 through the font drop down box using the "set as default" button. The Trust logo must also be applied in accordance with the style guide. Further information can be obtained from the Trust's Communications Team.

5.3.3 All templates referenced within this document can be found in – Appendix G

5.3.4 Front Sheet

5.3.5 The Front Sheet will include the following information:

- Title of the meeting
- Date and time of the meeting
- Location of the meeting

5.3.6 Agenda

5.3.7 The agenda is the notice to members of the items that are to be discussed at the meeting. Individual agendas are built from the meetings' work schedule, action logs and any other items notified to the administrator in the period between meetings. For the Board and Board Committees, it also important that the BAF is reviewed and used to drive the agenda content i.e. by ensuring that gaps in controls and assurances receive explanations via reports.

5.3.8 All agendas must, as a minimum, include the following standing items: apologies; declaration of any conflicts of interest in any agenda items to be discussed; minutes of the last meeting; the action log; and a concluding item considering everything that has been discussed at the meeting and whether there is anything to escalate to the 'parent' committee / meeting.

5.3.9 The number of items on an agenda shouldn't be so big that they can't all be reasonably discussed in the time allotted for the meeting. Shorter agendas will ensure that all items are properly considered with well thought out conclusions.

5.3.10 The agenda is:

- drafted by the administrator of the meeting in sufficient time to allow it to be agreed by the chair of the meeting and circulated to paper authors
- required to show the date, time and venue for the meeting
- circulated to document authors in sufficient time (who may or may not be members of the committee / meeting) indicating which papers they are required to write

- sent out as part of the final meeting paperwork.

5.3.11 Minutes

5.3.12 Minutes are an official summary record of what happened at the meeting. It is important that the right type of record is made of the meeting and the chair of the meeting is accountable for deciding what the style of minute is made and ensuring they provide an accurate record.

5.3.13 Minute numbers should be expressed in a clear format that allows the reader to move between the minute document, the action log, and any other supporting paperwork that is linked to that minute. This should show the year and corresponding item number e.g. 2024/25/001.

5.3.14 Some minutes are internal facing, some are public facing but the quality of minutes should always be of the highest standard as they may be called on as evidence for external inspections, audits, fact finds, inquests, Freedom of Information requests etc. Their importance should not be underestimated.

5.3.15 Minutes of meetings are not line-for-line reporting, but they must:

- be written by the person administering the meeting within five working days of the meeting taking place, unless the meeting is weekly then it is within two working days
- be written in the past tense (it is a record of what happened at a meeting that took place in the past)
- use professional, formal language
- include a brief outline of the context of the item / discussion so the reader understands something about the item that was discussed
- the important points of discussion
- record any risks / benefits highlighted and what was being done in relation to these
- capture any challenge to the proposals / decisions and the responses to the challenge
- record any actions agreed ensuring they include who is responsible for the action and when it must be completed by
- be checked by the chair of the meeting
- be circulated to members of the committee as part of the meeting paperwork for the next meeting.

5.3.16 It is the responsibility of the chair to check the minutes before they are presented at the next meeting. It is during the course of the next meeting that they are checked for accuracy.

5.3.17 Action notes template

5.3.18 Action notes are far less detailed than minutes. They do not capture any discussion but record only the agreed actions. These can be used for those meetings where it is not necessary to make a formal record of the discussion / challenge. It will be for the chair of the meeting to decide if formal minutes or action notes are required.

5.3.19 Action notes are a record of the meeting. Any actions agreed at the meeting will need to be transferred to and managed through the 'Action Log' to ensure that actions can be effectively managed, especially those with distant future dates are not lost sight of.

5.3.20 **Action log**

5.3.21 Action logs are an important tool and source of evidence for committees and meetings, and those being assured of the work of the committee/meeting. Actions are captured in the minutes of the meeting; however, the action log is in a different format to the minute. The log also provides a mechanism for ensuring the committee / meeting doesn't lose sight of those actions with completion dates set in the future.

5.3.22 Actions in the log may need to be brought to the attention of people who don't normally attend the meeting. The administrative support for the meeting is usually the person who will circulate the log to members and if necessary, to others outside of the meeting who are named as action leads.

5.3.23 It is also the administrative support person who will capture comments from action leads between meetings and prepare the most up to date log so it can be reviewed at the next meeting. The cumulative action log should be a standing item at each meeting, so it is reviewed regularly by the committee / meeting.

5.3.24 As good practice, where a particular minute has a number of actions these should be split up and each given a separate log number so each separate action can be tracked individually (this is particularly important if they have different completion dates and different leads) e.g. 2020/21/001(a) and 2020/21/001 (b).

5.3.25 **Terms of reference**

5.3.26 'Terms of Reference' is the name of the document that formally establishes a committee / sub-committee / group. Every Committee / sub-committee / group in the Trust's meeting structure must have this document in place. The Terms of Reference:

- clearly set out information about the Committee / sub-committee / group including: membership and anyone in attendance; its position in the meeting structure; which committee it reports to and any subordinate committee that reports into it; its duties and its powers of decision making; and the minimum number of members required at the meeting to be quorate
- must be agreed by the committee itself and then ratified by the committee which acts as 'parent' in the meeting structure
- must be reviewed on an annual basis (at the least) by the committee to ensure the information still reflects what it was set up to do
- must be ratified by the 'parent' committee if there any changes or revisions.

5.3.27 **Annual work plan**

5.3.28 All meetings must have a work schedule in place. Once the Terms of Reference have been agreed a work schedule should be drawn up. This is a document which assists with the development of future agendas. It:

- plots the duties set out in the Terms of Reference across the meetings that will take place over a period of time (usually a year)
- shows both standing items that must be taken at each meeting and those that occur at particular points in the period
- should be agreed by the committee each year or if there are any significant changes to the committee's duties during the period.

- maintains a record of items that were not scheduled but were received to assist with the end of year review.
- for the Board and the Board Committees, the work plan should be reviewed quarterly against the Board Assurance Framework to ensure that the assurances being received are helping to close out gaps in controls and assurances.

5.3.29 **Reports**

5.3.30 Requirements for reports

5.3.31 The primary reason for the use of formal reports is to ensure that the meeting is fully informed of the circumstances relating to the subject in question. Having the complete picture will enable the meeting to take informed decisions on the basis of the information presented. For this reason, written reports should always be used in preference to verbal briefings. The availability of reports prior to meetings allows subjects to be considered prior to decisions being made. There is an inherent risk that verbal briefings will not cover all the salient points, and this can lead to ill-informed decisions being taken.

5.3.32 The use of reports enables the Trust to demonstrate its commitment to observe the principles of good governance and provides evidence of openness and transparency in decision making. Reports also result in a robust governance audit trail which provides the Trust with the ability to evidence decision-taking and demonstrate compliance with the requirements of external authorities e.g. NHS Improvement or the Care Quality Commission (CQC).

5.3.33 In view of the above, formal reports are the means by which items are presented to the meetings within the Trust's assurance and performance frameworks and any papers submitted to these meetings for consideration must be accompanied by an appropriate covering report.

5.3.34 Content of reports

5.3.35 There are many different types of report and content will vary dependent on the subject matter and purpose of the report. However, in general, reports will be used to give an account of something, to address a particular issue or to propose solutions for a specific problem. Whatever the nature or purpose of the report, there are a number of standard headings which will always need to be included. Use of these headings should lead to the production of a logical report covering all key aspects of the subject matter. A standard report template is available and must be used (see below). If you do not have a copy, it is available from the corporate governance team. Individual report headings are covered in more detail later in this guide.

5.3.36 It is imperative that, regardless of the subject matter, reports are used to provide assurance to the group considering the report. This assurance may be positive or negative, depending on the prevailing circumstances, but all reports should include an appropriate assurance statement.

5.3.37 Report authors should be aware of their target audience when preparing reports and be mindful that different groups will require different levels of details. In some cases, the approval process will necessitate the consideration of matters at Executive Team, Committee and Board level. Use of the same report at each of these levels would not be appropriate as each group will be interested in a differing level of detail and content to inform their decision-making.

5.3.38 The Trust observes a principle of 'no surprises' in the conduct of business at formal meetings. Authors should note that the preparation of reports does not eliminate the need for engagement with key stakeholders on the subject matter covered in reports. Prior engagement and involvement will help to engender support for proposals, promote understanding amongst key stakeholders and will reduce the risk of avoidable delays in the decision-making process.

5.3.39 Preparation

5.3.40 Authors should ensure that they have sufficient time to write their reports having taken into account the relevant deadline for submission. Prior to writing reports, authors should ask themselves (and answer!) the following questions:

- Why am I writing this report?
- What is the report intended to achieve?
- What is the desired outcome of the report?
- Do I have all the relevant information to write the report?
- Do I need to consult with others in preparing the report?
- What is my audience?

5.3.41 Having answered the above questions, authors can commence writing their reports but should bear in mind the following – 'Content is King'. You may produce an attractive, colourful report in the correct style and format which will be meaningless unless the content is correct.

5.3.42 Report template

5.3.43 The Trust has adopted a single report template for the submission of reports to all Trust forums. A single template encourages adoption of a corporate style and will result in consistency of presentation. The template incorporates a header page which, in addition to standard entries such as subject and author, enables references to elements such as strategic objectives, Equality Impact Assessments and the Board Assurance Framework. These references facilitate the identification and retrieval of documentary evidence to demonstrate compliance with a range of internal and external assessments. It is important that these are given full consideration by the author and if unsure, contact should be made with the corporate governance team.

5.3.44 With the implementation of the Integrated Care Board and the Health and Social Care Act 2022, report templates now include a section to reference to the impact on system working and collaboration.

5.3.45 There is an increasing understanding of the interrelatedness of financial, quality, performance and workforce issues. Authors are encouraged by the report template to outline these considerations if not already covered in the report content.

5.3.46 The standard template must be used for the production of reports to all Trust forums. Pointers and reminders are included for the sections of the report template.

5.3.47 **Assurance / escalation process and report to 'parent' committee / meeting**

5.3.48 The Chair's Report is a high-level report designed go to the 'parent' Committee / meeting. In providing the report the Chair will be acting on behalf of the group, though the content of which will probably have been discussed at the meeting.

5.3.49 The Chair's Report is not intended to simply be a summarised version of the minutes, but rather identify issues that require escalation, report key risks and provide a view on the strength of the assurances received.

5.3.50 **Committee effectiveness**

5.3.51 All committees / sub-committees /groups must take time to consider if they are still effective and what, if any, changes need to be made to the way they operate or to their duties. Any changes made will need to be reflected in the Terms of Reference which will then need to be agreed by the committee and approved by the 'parent' committee.

5.3.52 All those listed on the Terms of Reference (members and regular attendees) must be offered the opportunity to review the effectiveness of the committee. The review must be carried out on an annual basis. A survey should be circulated to core members and regular attendees for feedback.

5.3.53 This will be set out in the Terms of Reference. The outcome should be reported to the committee itself so it can evaluate the results, consider comments and ideas and take action to address any weaknesses found. The outcome should also be reported to the 'parent' committee via the assurance / escalation process.

5.3.54 **Committee Annual Report**

5.3.55 Board committees are required to provide an annual report summarising their work over the course of the year.

Appendices

Appendix A - Schedule of matters reserved to the Board of Directors

Appendix B - Appendix B - Scheme of Delegation (including the NHS Foundation Trust Accounting Officer Memorandum)

Appendix C - Standing Financial Instructions

Appendix D – Board and Board Committee Terms of Reference

Appendix E - Procedure for amending the Corporate Governance Manual

Appendix F – Corporate Governance Manual Change Schedule

Appendix G – Meeting templates

Appendix A - Schedule of matters reserved to the Board of Directors

General enabling provisions.

The Board of Directors may determine any matter it wishes, for which it has authority, in full session within its statutory powers. In accordance with the Code of Conduct and Accountability adopted, the Board explicitly reserves that it shall itself approve or appraise, as appropriate, the following matters detailed below. All Board members share corporate responsibility for all decisions of the Board and the Board remains accountable for all of its functions, even those delegated to individual committees, subcommittees, directors or officers.

Duties

It is the Board's duty to:

- Act within statutory financial and other constraints
- Be clear what decisions and information are appropriate to the Board of Directors and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these
- Ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account
- Establish performance and quality measures that maintain the effective use of resources and provide value for money;
- Specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities;
- Establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.

a. Reserved matters

i. Standing Orders
Approval of and changes to Board standing orders.

ii. Matters of Governance

- Approval of and changes to the schedule of matters reserved to the Board of Directors
- Approval of and changes to the standing financial instructions
- Suspension of Board standing orders
- Ratify or otherwise instances of failure to comply with standing orders brought to the Chief Executive's attention in accordance with Standing Orders
- Ratification of any urgent decisions taken by the Chair and Chief Executive, in accordance with the standing orders
- Approval of and changes to codes of conduct
- Approval of the Trust's risk assurance framework
- Approval of the Board's scheme of reservation and delegation
- Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Foundation Trust and approval of any changes
- Approval of the remit and membership of Board committees, including
- Approval of terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board of Directors

- To confirm the recommendations of committees where they do not have executive powers
- To receive reports from committees including those which the Foundation Trust is required by the National Health Service Act 2006 or other regulation to establish and to take appropriate action thereon
- Audit arrangements
- Clinical audit arrangements
- The annual audit letter
- Annual report (including quality report/accounts) and statutory financial accounts of the Trust
- Annual report and accounts for funds held on trust (charitable funds)
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a corporate trustee for funds held on trust
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a bailer for patients' property
- Disciplining Board members or employees who are in breach of statutory requirements or Standing Orders.

iii. Important regulatory matters

- Compliance with the Trust's Licence or any document which replaces it, its constitution, and all statutory and regulatory obligations
- Directors' and officers' declaration of interests and determination of action if required
- Arrangements for dealing with complaints
- Disciplinary procedures for officers of the Trust.

iv. Appointments and dismissals

- Appointment and dismissal of committees (and individual members) that are directly accountable to the Board of Directors excluding the Audit Committee, the Nomination & Remuneration Committee. This does not imply that individual members of all Committees can be dismissed
- Appointment, appraisal, disciplining and dismissal of Executive Directors
- Confirm the appointment of members of any committee of the Foundation Trust as representatives on outside bodies
- Appoint, appraise, discipline and dismiss the Trust Secretary
- Approve proposals received from the Nomination & Remuneration Committee regarding the Chief Executive, Directors and senior employees.

v. Strategic direction

- Strategic aims, direction and objectives of the Foundation Trust
- Financial plans and forecasts
- Approval of the Trust's annual plan, strategic developments and associated business plans
- Approval of annual revenue and capital budgets
- Approval of all Trust strategies to include, but not be limited to the risk management strategy and human resources strategy
- Approval of capital plans including:
    - Proposals for acquisition, disposal or change of use of land and/or buildings
    - Private finance initiative (PFI) proposals

- Individual contracts, including purchase orders of a capital or revenue nature in accordance with Delegated Financial Limits, Table B, section 2.

- Approve proposals for action on litigation against or on behalf of the Foundation Trust where the likely financial impact is as shown in the Delegated Financial Limits, Table B, section 2 or contentious or likely to lead to extreme adverse publicity, excluding claims covered by the NHS risk pooling schemes.

vi. Monitoring performance

- Operational and financial performance arrangements at intervals that it shall determine.

vii. Other matters

- Appointment of bankers
- Approve the opening of bank accounts.
- Approve individual compensation payments.

Appendix B - Scheme of Delegation (including the NHS Foundation Trust Accounting Officer Memorandum)

1 Introduction

1.1 Reservation of powers

1.2 The Trust's Standing Orders (for its Board of Directors) provide that "Subject to the scheme of reservation and delegation, and such directions as may be given by statute, the independent regulator or the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Foundation Trust, of any of its functions by a committee or subcommittee, or by a Director or an officer of the Trust in each case subject to such restrictions and conditions as the Board things fit." The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Foundation Trust Board of Directors.

1.3 The purpose of this document is to detail how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Foundation Trust policies and procedures. The Board of Directors remains accountable for all of its functions, even those delegated to committees, subcommittees, individual directors or officers. A formal structure is in place for monitoring the functions delegated to committees and subcommittees enabling the Board to receive information and to maintain its monitoring role

1.4 Role of the Chief Executive

1.5 All powers of the Foundation Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions they shall perform personally and which functions have been delegated to other directors and officers for operational responsibility.

1.6 All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

1.7 Caution over the Use of Delegated Powers

1.8 Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

1.9 Absence of Directors or Officer to whom Powers have been Delegated.

1.10 In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

1.11 Further details about situations where the Accounting Officer is unable to fully discharge their responsibilities are available in the Accounting Officers' Memorandum, sections of which are reproduced below and which is available separately from NHS England.

2 Delegation of powers

2.1 Delegation to committees

2.2 The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors. The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with Standing Order 74 committees may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors.

2.3 In exercising any delegated power a committee or director must comply with the Foundation Trust's Standing Orders, Standing Financial Instructions and written procedures and with any statutory provisions or requirements. They must not incur expenditure over and above the Foundation Trust's annual budget (excluding the Chief Executive in conjunction with the Chief Finance Officer).

2.4 In cases of doubt or difficulty and/or where no policy guidelines exist, decisions should be referred to the Board of Directors.

2.5 Delegation to Officers

2.6 Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive, the Chief Finance Officer and other directors.

2.7 The Accounting Officer Memorandum

2.8 The responsibilities of the Accounting Officer are set out in the NHS Foundation Trust Accounting Officer Memorandum[1], relevant sections of which are reproduced below:

2.9 Introduction

2.10 The National Health Service Act 2006 (the Act) designates the chief executive of an NHS foundation trust as the accounting officer.

2.11 The principal purpose of the NHS foundation trust is the provision of goods and services for the purposes of the health service in England. The NHS foundation trust has a general duty to exercise its functions effectively, efficiently and economically.

2.12 The Act specifies that the accounting officer has a duty to prepare the accounts in accordance with the Act. An accounting officer has the personal duty of signing the NHS foundation trust's accounts. By virtue of this duty, the accounting officer has the further duty of being a witness before the Public Accounts Committee (PAC) to deal with questions arising from those accounts or, more commonly, from reports made to Parliament by the Comptroller and Auditor General (C&AG) under the National Audit Act 1983.

2.13 Associated with these duties are the further responsibilities that are the subject of this memorandum. It is incumbent on the accounting officer to combine these duties with their duties to the board of directors of the NHS foundation trust.

[1] NHS Foundation Trust Accounting Officer Memorandum, NHS Improvement (2015)

2.14 It is an important principle that, regardless of the source of the funding, accounting officers are responsible to Parliament for the resources under their control.

2.15 General responsibilities

2.16 The accounting officer has responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matters. The accounting officer must ensure that:

- there is a high standard of financial management in the NHS foundation trust as a whole
- the NHS foundation trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation
- financial considerations are fully taken into account in decisions by the NHS foundation trust.

2.17 Specific responsibilities

2.18 The essence of the accounting officer's role is a personal responsibility for:

- the propriety and regularity of the public finances for which he or she is answerable
- the keeping of proper accounts
- prudent and economical administration in line with the principles set out in *Managing public money*
- the avoidance of waste and extravagance
- the efficient and effective use of all the resources in their charge.

As accounting officer you must:

- personally sign the accounts and, in doing, so accept personal responsibility for ensuring their proper form and content as prescribed by Monitor (now NHSI/E) in accordance with the Act
- comply with the financial requirements of the NHS provider licence
- ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS foundation trust)
- ensure that the resources for which you are responsible as accounting officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official
- ensure that assets for which you are responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate
- ensure that any protected property (or interest in) is not disposed of without the consent of Monitor
- ensure that conflicts of interest are avoided, whether in the proceedings of the board of directors, or council of governors or in the actions or advice of the NHS foundation trust's staff, including yourself
- ensure that, in the consideration of policy proposals relating to the expenditure for which you are responsible as accounting officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the board of directors.

2.19 An accounting officer should ensure that effective management systems appropriate for the achievement of the NHS foundation trust's objectives, including financial monitoring and control systems, have been put in place. An accounting officer should also ensure that managers at all levels:

- have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives
- are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS foundation trust), including a critical scrutiny of output and value for money
- have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

2.20 Accounting officers must make sure that their arrangements for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in the *Public Sector Internal Audit Standards*.

2.21 Absence of an accounting officer

2.22 An accounting officer should ensure that he or she is generally available for consultation, and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, there will be a senior officer in the NHS foundation trust who can act on his or her behalf if required.

2.23 If it becomes clear to the board of directors that an accounting officer is so incapacitated that he or she will be unable to discharge these responsibilities over a period of four weeks or more, the board of directors should appoint an acting accounting officer, usually the Chief Finance Officer, pending the accounting officer's return. The same applies if, exceptionally, the accounting officer plans an absence of more than four weeks during which he or she cannot be contacted.

2.24 The PAC may be expected to postpone a hearing if the relevant accounting officer is temporarily indisposed. Where the accounting officer is unable by reason of incapacity or absence to sign the accounts in time for submission, the NHS foundation trust may submit unsigned copies pending the accounting officer's return. If the accounting officer is unable to sign the accounts in time for printing, the acting accounting officer should sign instead.

2.25 **Schedule of Delegated Authority**

2.26 Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The **'Delegated to'** authority is in accordance with the Standing Orders and Standing Financial Instructions. The **'Operational Responsibility'** shown below is the lowest level to which authority is delegated.

- Table A - Delegated Authority
- Table B - Delegated Financial Limits

2.27 Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Managers as appropriate.

Table A – Delegated Authority

Delegated matter	Delegated to[2]	Operational responsibility
1. Standing Orders (SOs) and Standing Financial Instructions (SFIs)		
a. Final authority in interpretation of Standing Orders	Chair	Chair
b. Notifying Directors, employees and governors of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Chief Executive	All Line Managers
c. Responsibility for security of the Foundation Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions and financial procedures	Chief Executive	All Directors and Employees
d. Suspension of Standing Orders	Board of Directors	Board of Directors
e. Review suspension of Standing Orders	Audit Committee	Audit Committee
f. Variation or amendment to Standing Orders	Board of Directors	Audit Committee
g. Emergency powers relating to the authorities retained by the Board of Directors	Chair and Chief Executive with two non-executives	Chair and Chief Executive with two non-executives
h. Disclosure of non-compliance with Standing Orders to the Chief Executive (report to the Board of Directors)	All staff	All staff
i. Disclosure of non-compliance with SFIs to the Chief Finance Officer (report to the Audit Committee)	All staff	All staff
j. Advice on interpretation or application of SFIs and this Scheme of Delegation	Chief Finance Officer	Chief Finance Officer with input from Internal Audit
2. Audit arrangements		
a. Ensure an adequate internal audit service is provided	Audit Committee	Chief Finance Officer
b. To make recommendations to the Council of Governors in respect of the appointment, re-appointment and removal of the external auditor and to approve the remuneration in respect of the external auditor	Audit Committee (for recommendation to the Council of Governors for approval)	Chief Finance Officer
c. Monitor and review the effectiveness of the internal audit function	Audit Committee	Chief Finance Officer
d. Review, appraise and report in accordance with Public Sector Internal Audit Standards (PSIAS) and best practice	Audit Committee	Head of Internal Audit

[2] If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

Delegated matter	Delegated to[2]	Operational responsibility
e. Provide an independent and objective view on internal control and probity	Audit Committee	Internal Audit / External Audit
f. Ensure cost-effective audit service(s)	Audit Committee	Chief Finance Officer
g. Implement agreed recommendations	Chief Executive	Relevant Officers
3. Authorisation of Clinical Trials & Research Projects	Chief Executive	Director of Research and Development through the Research and Development committee
4. Authorisation of New Drugs	Chief Executive	Medical Director through the Medicines Management committee
5. Bank Accounts/Cash (including on Trust (Charitable / Non Charitable))		
a. Operation: Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements)	Chief Finance Officer	Deputy Chief Finance Officer
b. Opening bank accounts as approved by the Board of Directors	Chief Finance Officer	Deputy Chief Finance Officer
c. Authorisation of transfers between bank accounts	Chief Finance Officer	In accordance with bank mandate / internal procedures
d. Approve and apply arrangements for the electronic transfer of funds	Chief Finance Officer	In accordance with bank mandate / internal procedures
e. Authorisation of: • BACS schedules • Automated payment schedules • Manual cheques	Chief Finance Officer	In accordance with bank mandate / internal procedures
f. Investments: • Investment of surplus funds in accordance with Treasury Management Investment Policy • Preparation of investment procedures	Chief Finance Officer Chief Finance Officer	Deputy Chief Finance Officer Deputy Chief Finance Officer
g. Petty Cash	Chief Finance Officer	See Delegated Limits Table B (section 2(a))
6. Capital Investment		
a. Programme: Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on Business Plans	Chief Executive	Chief Finance Officer
b. Preparation of Capital Investment Programme	Chief Executive	Chief Finance Officer / Deputy Chief Finance Officer
c. Preparation of a business case for expenditure over £100,000	Chief Executive	Divisional Manager with advice from Chief Finance Officer or Deputy Chief Finance Officer or Divisional Accountant
d. Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Chief Finance Officer	Deputy Chief Finance Officer / Estates and Facilities Manager

Delegated matter	Delegated to[2]	Operational responsibility
e. Authorisation of capital requisitions	Chief Executive	See Delegated Limits Table B (Section 5)
f. Construction industry tax scheme	Chief Executive	Chief Finance Officer
g. Assessing the requirements for the operation of the construction industry taxation deduction scheme	Chief Finance Officer	Financial Controller
h. Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost	Chief Executive	Chief Finance Officer and Estates and Facilities Manager
i. Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences	Chief Executive	Chief Finance Officer
j. Issue procedures to support: • Capital investment • Staged payments	Chief Executive	Chief Finance Officer
k. Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes	Chief Finance Officer	Deputy Chief Finance Officer
l. Issuing the capital scheme project manager with specific authority to commit capital, proceed / accept tenders in accordance with the standing orders and SFIs	Chief Executive	Chief Finance Officer
m. Private Finance: • Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector • Proposal to use PFI must be specifically agreed by the Board of Directors.	Chief Executive Board of Directors	Chief Finance Officer
n. Leases (property and equipment) in accordance Delegated Limits Table B (Section 4)	Chief Executive	Chief Executive or Chief Finance Officer
7. Clinical Audit	Chief Executive	Medical Director
8. Commercial Sponsorship		
Agreement to proposal	Chief Executive	Chief Finance Officer
9. Complaints		
a. Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Executive	Chief Nurse
b. Responsibility for ensuring complaints relating to a clinical division are investigated thoroughly	Chief Nurse	Chief Operating Officer and Associate Director of Quality and Governance
c. Coordination of the management of medico-legal complaints	Chief Executive	Chief Nurse and Head of Quality & Governance
10. Confidential Information		
a. Review of the Trust's compliance with the Caldicott report on protecting patients' confidentiality in the NHS	Chief Executive	Caldicott Guardian (Medical Director)
b. Freedom of Information Act compliance code	Chief Executive	Chief People Officer & Trust Secretary

Delegated matter	Delegated to[2]	Operational responsibility
11. Controlled drugs accountable officer	Medical Director	Head of Pharmacy
12. Data Protection Act		
Review of Trust's compliance	Chief Executive	Chief Information Officer
13. Declaration of Interests		
a. Maintaining a register of interests	Chief Executive	Trust Secretary
b. Declaring relevant and material interests	Board of Directors and Council of Governors	Board of Directors, Council of Governors, Senior Managers, Clinical consultants and all decision-making staff as defined in the Trust policy 'Managing Conflicts of interest'
14. Disposals and Condemnations		
a. Items obsolete, redundant, irreparable or cannot be repaired cost effectively	Chief Finance Officer	(Clinical Director or Divisional Manager or Department Heads) – Approved in accordance with Delegated Limits, Table B Section 8 Head of Procurement or Deputy Chief Finance Officer
b. Develop arrangements for the sale of assets	Chief Finance Officer	(Clinical Director/ Divisional Manager / Department Heads) – Approved in accordance with Delegated Limits Table B Section 8 Head of Procurement or Deputy Chief Finance Officer
c. Disposal of Protected Property (as defined in the Licence	Chief Executive (with authorisation of the Independent Regulator)	Chief Executive
15. Environmental Regulations		
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Finance Officer	Estates & Facilities Manager
16. External Borrowing		
a. Advise Board of Directors of the requirements to repay / draw down Public Dividend Capital	Chief Finance Officer	Deputy Chief Finance Officer
b. Approve a list of employees authorised to make short term borrowings for the Trust	Board of Directors	Chief Executive / Chief Finance Officer
c. Application for draw down of Public Dividend Capital, overdrafts and other forms of external borrowing in accordance with approved mandates	Chief Executive	Chief Finance Officer and Deputy Chief Finance Officer
d. Preparation of procedural instructions concerning applications for loans and overdrafts	Chief Finance Officer	Deputy Chief Finance Officer
17. Financial Planning / Budgetary Responsibility		
• **Budget setting**		
a. Submit budgets to the Board of Directors	Chief Finance Officer	Deputy Chief Finance Officer

Delegated matter	Delegated to[2]	Operational responsibility
b. Submit to the Board of Directors financial estimates and forecasts	Chief Finance Officer	Deputy Chief Finance Officer
c. Compile and submit to the Board of Directors an Operational Plan which takes into account financial targets and forecast limits of available resources. The Business Plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan	Chief Executive	Chief Operating Officer and Chief Finance Officer
• **Budget monitoring**		
d. Devise and maintain systems of budgetary control	Chief Finance Officer	Deputy Chief Finance Officer
e. Delegate budgets to budget holders	Chief Executive	Chief Finance Officer
f. Monitor performance against budget	Chief Finance Officer	Deputy Chief Finance Officer and Divisional Accountants
g. Ensuring adequate training is delivered on an ongoing basis to budget holders to facilitate their management of the allocated budget	Chief Finance Officer	Deputy Chief Finance Officer
h. Submit financial monitoring returns in accordance with NHS England's requirements	Chief Executive	Chief Finance Officer
i. Identify and implement cost improvements and income generation activities in line with the Operational Plan	Chief Executive	All budget holders
j. Preparation of annual accounts	Chief Finance Officer	Deputy Chief Finance Officer / Financial Controller
k. Preparation of annual report	Chief Executive	Trust Secretary
• **Budget responsibilities**		
l. Ensure that: • no overspend or reduction of income that cannot be met from virement is incurred; • approved budget is not used for any other than specified purpose subject to rules of virement; • no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment	Chief Finance Officer	Budget Holders All corporate posts are reviewed by the Vacancy Control Panel and all clinical posts by the Executive team
• **Virement**		
m. It is not possible for any officer to vire from non-recurring budgets to recurring, budgets or from capital to revenue / revenue to capital. Virement between	Chief Executive	Refer To Delegated Limits Table B Section 1

Delegated matter	Delegated to[2]	Operational responsibility
different budget holders requires the agreement of both parties		
• **Financial procedures and systems**		
n. Maintenance and updating of Trust Financial Procedures	Chief Finance Officer	Deputy Chief Finance Officer
o. Accountability for financial control	Chief Executive / Chief Finance Officer	All budget holders
p. Responsibility for: • Implementing the Trust's financial policies and co-ordinate corrective action • Ensuring that adequate records are maintained to explain the Trust's transactions and financial position. • Providing financial advice to members of the Board of Directors and staff • Maintaining such accounts certificates, records, etc to meet statutory requirements • Designing and maintaining compliance with all financial systems	Chief Finance Officer	Deputy Chief Finance Officer
• **Financial systems Information Management & Technology (IM&T)**		
q. Developing financial systems in line with the Trust's IM&T strategy	Chief Finance Officer	Deputy Chief Finance Officer
r. Implementing new systems to ensure they are developed in a controlled manner and thoroughly tested	Chief Finance Officer	Deputy Chief Finance Officer and Chief Information Officer
s. Seeking third party assurances regarding financial systems operated externally	Chief Finance Officer	Deputy Chief Finance Officer
t. Responsibility for the accuracy and security of computerised financial data	Chief Finance Officer	Deputy Chief Finance Officer
u. Ensure that contracts for computer services for financial applications define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage	Chief Finance Officer	Chief Information Officer
v. Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place	Chief Finance Officer	Chief Information Officer
18. Fire precautions		
Ensure that the Fire Precaution and Prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact	Chief Executive	Estates and Facilities Manager in conjunction with Head of Resilience, Health and Safety
19. Fixed assets		
a. Maintenance of asset register including asset identification and monitoring	Chief Executive	Deputy Chief Finance Officer in conjunction with Financial Controller

Delegated matter	Delegated to[2]	Operational responsibility
b. Approving procedures for reconciling balances on fixed asset accounts in ledgers against balances on fixed asset registers	Chief Finance Officer	Deputy Chief Finance Officer in conjunction with Financial Controller
c. Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with relevant legislation	Chief Finance Officer	Financial Controller in conjunction with Director of Estates
d. Calculate and pay capital charges in accordance with the requirements of the Department of Health / independent regulator	Chief Finance Officer	Deputy Chief Finance Officer
e. Responsibility for security of Trust's assets including notifying discrepancies to the Chief Finance Officer and reporting losses in accordance with Trust procedures	Chief Executive	All staff
20. Fraud (See also 26 & 37)		
a. Monitor and ensure compliance with Secretary of State Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist	Audit Committee	Local Counter Fraud Specialist
b. Notify NHS Protect and External Audit of all suspected Frauds	Chief Finance Officer	Local Counter Fraud Specialist
21. Funds Held on Trust (Charitable and Non Charitable Funds)		
a. Appropriate management of funds held on trust	Charitable Funds Committee	Chief Finance Officer
b. Maintenance of authorised signatory list of nominated fundholders	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
c. Expenditure Limits	Chief Finance Officer	See Delegated Limits Table B Section 7
d. Developing systems for receiving donations	Chief Finance Officer	Deputy Chief Finance Officer
e. Dealing with legacies	Chief Finance Officer	Deputy Chief Finance Officer
f. Fundraising appeals • Preparation and monitoring of budget • Reporting progress and performance against budget	Charitable Funds Committee Chief Finance Officer	Deputy Chief Finance Officer in conjunction with Financial Controller Deputy Chief Finance Officer in conjunction with Financial Controller
g. Operation of Bank Accounts - managing banking arrangements and operation of bank accounts	Chief Finance Officer in conjunction with the Charitable Funds Committee	Deputy Chief Finance Officer
h. Opening bank accounts	Chief Finance Officer in conjunction with Charitable Funds Committee	Deputy Chief Finance Officer

Delegated matter	Delegated to[2]	Operational responsibility
i. Appointing Investment Manager	Charitable Funds Committee	Deputy Chief Finance Officer through Charitable Funds Committee
j. Nominated deposit taker	Charitable Funds Committee	Chief Finance Officer
k. Placing investment transactions.	Chief Finance Officer	Deputy Chief Finance Officer in conjunction with Financial Controller
l. Registration of funds with Charities Commission	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
22. Gifts and hospitality		
a. Keeping of gifts and hospitality register	Chief Executive	Trust Secretary
b. Declaration and registration of all individual and collective items in excess of £50.00 per item	Chief Executive	All staff
23. Health and Safety		
Review of all statutory compliance with legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Chief Executive	Chief Nurse with Head of Governance and Head of Resilience, Health & Safety
24. Infectious Diseases and Notifiable Outbreaks	Chief Nurse	Director of Infection Prevention & Control
25. Legal Proceedings		
a. Engagement of Trust's Solicitors / Legal Advisors	Chief Executive	Executive Directors
b. Approve and sign all documents which will be necessary in legal proceedings, i.e. executed as a deed	Chief Executive	Executive Directors
c. Sign on behalf of the Trust any agreement or document not requested to be executed as a deed	Chief Executive	Executive Directors
26. Losses, write-offs and special payments		
a. Prepare procedures for recording and accounting for losses and special payments including preparation of a Fraud Response Plan and informing Local Counter Fraud Specialist of frauds	Chief Executive	Chief Finance Officer
b. Setting financial limits	Chief Executive	See Delegated Limits Table B Section 9
b. Losses of cash due to theft, fraud, overpayment and others	Chief Executive	Chief Finance Officer
c. Fruitless payments (including abandoned Capital Schemes)	Chief Executive	Chief Finance Officer
d. Bad debts and claims abandoned	Chief Executive	Chief Finance Officer
e. Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson)	Chief Executive	Chief Finance Officer

Delegated matter	Delegated to[2]	Operational responsibility
f. Reviewing appropriate requirement for insurance claims	Chief Finance Officer	Deputy Chief Finance Officer
g. Compensation payments by court order	Chief Executive	Chief Executive
h. Clinical negligence, covered by membership of CNST/NHSLA scheme	Chief Executive	Chief Nurse and Midwife
i. Ex-gratia payments • Setting financial limits • Other	Chief Finance Officer Chief Executive	See Delegated Limits Table B Section 9 See Delegated Limits Table B Section 9
j. A register of all losses and special payments should be maintained by the Finance Department and made available for inspection	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
k. A report of all losses and special payments should be presented to the Audit committee	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
27. Medical		
a. Clinical Governance arrangements	Medical Director	Associate Director of Quality and Governance
b. Medical Leadership	Medical Director	Medical Director
c. Programmes of medical education	Medical Director	Medical Director
d. Medical staffing plans	Medical Director	Medical Director
e. Medical Research	Medical Director	Director of Research & Development
28. Medicines inspectorate regulations		
• Review regulations	Chief Executive	Medical Director / Head of Pharmacy
29. Meetings		
a. Calling meetings of the Board of Directors	Chair / Trust Secretary	Chair / Trust Secretary
b. Chair all Board of Director meetings and associated responsibilities	Chair	Chair
30. Non pay expenditure		
a. Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Delegated Limits Table B Section 4	Chief Executive	Financial Controller in conjunction with Deputy Chief Finance Officer
b. Obtain the best value for money when requisitioning goods / services	Chief Executive	Chief Operating Officer, Clinical Directors, Department Heads and Head of Procurement
c. Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement (subject to Delegated Limits Table B Section 4)	Chief Executive	Chief Finance Officer
d. Develop systems for the payment of accounts	Chief Finance Officer	Deputy Chief Finance Officer and Financial Controller
e. Prompt payment of accounts in line with national requirements	Chief Finance Officer	Deputy Chief Finance Officer and Financial Controller

Delegated matter	Delegated to[2]	Operational responsibility
f. Financial Limits for budgetary expenditure and ordering / requisitioning goods and services (including invoice authorisation without orders)	Chief Executive	See Delegated Limits Table B Section 4
g. Approve prepayment arrangements	Chief Finance Officer	Chief Finance Officer
31. Nursing		
a. Compliance with statutory and regulatory arrangements relating to professional nursing and midwifery practice	Chief Nurse	Professional nursing and midwifery leads
b. Matters involving individual professional competence of nursing and midwifery staff	Chief Nurse	Professional nursing and midwifery leads
c. Compliance with professional training and development of nursing and midwifery staff	Chief Nurse	Professional nursing and midwifery leads
d. Quality assurance of nursing and midwifery processes	Chief Nurse	Professional nursing and midwifery leads
32. Patient Services Agreements		
a. Negotiation of Foundation Trust Contract and Non Commercial Contracts	Chief Executive	Chief Finance Officer and Chief Operating Officer
b. Quantifying and monitoring out of area treatments	Chief Finance Officer	Director Operations and Deputy Chief Finance Officer
c. Reporting actual and forecast income including payment by results	Chief Finance Officer	Chief Operating Officer and Deputy Chief Finance Officer
d. Costing Foundation Trust Agency Purchase Contracts and Non Commercial Contracts	Chief Finance Officer	Chief Operating Officer and Deputy Chief Finance Officer
e. National Cost Collection Exercise	Chief Finance Officer	Deputy Chief Finance Officer
f. Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Chief Finance Officer	Chief Operating Officer and Deputy Chief Finance Officer
33. Patients' property (in conjunction with financial advice)		
a. Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Chief Executive	Chief Nurse
b. Prepare detailed written instructions for the administration of patients' property	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller
c. Informing staff of their duties in respect of patients' property	Chief Finance Officer	Divisional Managers, Clinical Managers and Legal Services Manager
d. Issuing property of deceased patients (See SFI 6.25). In accordance with Delegated Limits Table B Section 4	Chief Finance Officer	Deputy Chief Finance Officer or Financial Controller in conjunction with nominated Divisional Lead
34. Human Resources		
a. Develop Human resource policies and strategies for approval by the Board of Directors including training, industrial relations	Chief People Officer	Chief People Officer

Delegated matter	Delegated to[2]	Operational responsibility
b. Nomination of officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts	Chief People Officer	Divisional Managers or Heads of Departments
c. Ensure that all employees are issued with a contract of employment in a form approved by the Board of Directors and which complies with employment legislation	Chief People Officer	Chief People Officer
• **Staff establishment (including engagement of staff not on the establishment) and re-gradings**		
d. Authority to fill funded post on the establishment with permanent staff	Chief People Officer	Clinical Directors, Divisional Managers or Heads of Departments
e. Additional staff to the agreed establishment with specifically allocated finance	Chief People Officer	Clinical Directors, Divisional Managers or Heads of Departments
f. Additional staff to the agreed establishment without specifically allocated finance	Chief Executive	Chief Finance Officer
g. Self-financing changes to an establishment	Chief People Officer	Human Resources Business Partner and Divisional Accountant
h. Nominate officers to enter into contracts of employment regarding staff, agency staff or non-medical consultancy service contracts	Chief Executive	Chief People Officer
i. Booking of bank staff • Nursing and midwifery • Other	Chief Nurse Divisional Manager	Deputy Chief Nurse and Midwife or Matron. Chief Operating Officer
j. Booking of agency staff • Nursing and midwifery • Other	Chief Nurse Divisional Manager	Chief Operating Officer, Matron or Heads of Nursing / Midwifery. Chief Operating Officer or Heads of Departments
k. The granting of additional increments at recruitment stage to staff within budget (other than automatic increments)	Chief People Officer	Clinical Directors, Chief Operating Officer or Heads of Departments
l. Re-grading requests / major skill mix changes (all requests shall be dealt with in accordance with Trust procedure)	Chief People Officer	Clinical Directors, Chief Operating Officer or Heads of Departments
m. Waiting list payments (approval of rates of pay and variations to agreed rates)	Chief Executive	Chief Operating Officer, Chief People Officer or Chief Finance Officer
• **Grievance and disciplinary procedures**		
n. Operation of grievance procedure (all grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Chief Operating Officer must be sought when the	Chief People Officer	As per Trust procedure

Delegated matter	Delegated to[2]	Operational responsibility
grievance reaches the level of Clinical Director / Divisional Managers / Heads of Department)		
o. Operation of the disciplinary procedure (excluding Executive Directors)	Chief People Officer	To be applied in accordance with the Trust's Disciplinary Procedure
• **Terms and conditions of employment**		
p. Renewal of fixed term contract	Chief People Officer	Chief Operating Officer on advice from Vacancy Control Panel
q. Authorise mobile phone use / issue	Chief People Officer	Executive Directors, Chief Operating Officer or Heads of Departments
r. Authorisation of payment of removal expenses, excess rent and house purchases (all staff in accordance with Trust policy and as agreed at interview)	Chief People Officer	Executive Directors, Chief Operating Officer or Heads of Departments
• **Pay**		
s. Presentation of proposals to the Board of Directors for the setting of remuneration and conditions of service for those staff not covered by the Nominations committee	Chief Executive	Chief People Officer
t. Authority to complete standing data forms affecting pay, new starters, variations and leavers	Chief People Officer	Clinical Directors, Chief Operating Officer, Heads of Departments or line or departmental managers
u. Authority to complete and authorise staff attendance record / positive reporting forms	Chief People Officer	Clinical Directors, Chief Operating Officer, professional Heads of Service, Heads of Departments or ward or departmental managers
v. Authority to authorise overtime	Chief People Officer	Clinical Directors & Chief Operating Officer
w. Authority to authorise travel and subsistence expenses	Chief People Officer	Executive Directors, Clinical Directors, Chief Operating Officer, Heads of Departments or authorised approvers.
• **Annual and special leave (refer to leave policies)**		
x. Approval of annual leave	Chief People Officer	Departmental Manager (as per Trust policy)
z. Approval of annual leave carry forward (up to maximum of 5 days)	Chief People Officer	Departmental Manager (as per Trust policy)
aa. Approval of annual leave carry forward of 6 to 10 days (to occur in exceptional circumstances only)	Chief People Officer	Executive Directors, Chief Operating Officer, or Heads of Department
bb. Approval of annual leave carry forward in excess of 10 days	Chief People Officer	Executive Directors
cc. Special leave arrangements for personal, domestic and family reasons including compassionate / bereavement leave, parental leave, paternity leave, carers leave and adoption leave (to be applied in accordance with Trust Policy)	Chief People Officer	Line or Departmental Managers

Delegated matter	Delegated to[2]	Operational responsibility
dd. Special Leave for non-domestic / personal / family reasons including jury service and armed services (to be applied in accordance with Trust Policy)	Chief People Officer	Chief Operating Officer or Heads of Departments
ee. Leave without pay (including short-term unpaid leave and career break)	Chief People Officer	Chief Operating Officer, Heads of Departments or line or departmental managers
ff. Medical Staff leave of absence – paid and unpaid	Chief People Officer	Clinical Director with advice from Medical Director
gg. Time off in lieu	Chief People Officer	Divisional Managers or Line Managers
hh. Maternity Leave - paid and unpaid	Chief People Officer	Automatic approval with guidance
• **Sick leave**		
ii. Extension of sick leave on pay	Chief People Officer	Divisional Managers or Human Resources staff, as per Trust policy
jj. Return to work part-time on full pay to assist recovery	Chief People Officer	Deputy Director of Workforce or Divisional Managers
• **Study leave**		
kk. Study leave outside the UK	Chief Executive	Relevant Executive Director
ll. Medical staff study leave (UK): • Consultant • Career Grade • Non Career Grade	 Medical Director Medical Director Post Graduate Tutor	 Clinical Director Clinical Director Clinical Director
mm. All other study leave (UK)	Chief People Officer	Executive Directors, Clinical Directors, Divisional Managers or Department Heads
• **Retirement (including ill-health retirement)**		
nn. Authorisation of return to work in part time capacity under the flexible retirement scheme	Chief People Officer	Divisional Manager
oo. Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department	Chief People Officer	Divisional Manager
• **Redundancy (as approved by Board of Directors)**	Chief Executive	Chief People Officer
35. Quotation, tendering and contracting procedures		
a. Entering into contracts on behalf of the Trust, regardless of value	Chief Executive	Executive Directors or nominated Deputy
b. Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Chief Finance Officer, Chief Operating Officer and Head of Procurement
c. Nominate officers to oversee and manage contracts on behalf of the Trust	Chief Executive	Chief Finance Officer, Chief Operating Officer ,Head of Procurement or Divisional Managers

Delegated matter	Delegated to[2]	Operational responsibility
d. Set competitive tender authorisation limits (see Delegated Limits Table B, section 6)	Chief Executive	Chief Finance Officer
e. Maintain a register to show each set of competitive tender invitations despatched	Chief Executive	Financial Controller or Head of Procurement
f. Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote	Chief Executive	Chief Finance Officer or Head of Procurement
g. Receipt and custody of tenders prior to opening	Chief Executive	Chief Finance Officer or Head of Procurement
i. Waiving the requirement to request tenders (subject to SFI 6.26.11.6, reported to the Audit Committee)	Chief Executive	Chief Executive or Chief Finance Officer
j. Waiving the requirement to request quotes (subject to SFI 6.26.11.6)	Chief Executive / Chief Finance Officer	Chief Executive or Chief Finance Officer
36. Records		
a. Review Trust's compliance with the Retention of Records Act	Chief Executive	Executive Directors
b. Review the Trust's compliance with the Records Management Code of Practice	Chief Executive	Chief Nurse, Chief Information Officer, Chief Operating Officer and Heads of Departments
c. Ensuring the form and adequacy of the financial records of all departments	Chief Finance Officer	Deputy Chief Finance Officer
37. Reporting of Incidents to the Police		
a. Where a criminal offence is suspected: • Criminal offence of a violent nature • Arson or theft • Other	Chief Operating Officer	Executive Director on call
b. Where a fraud is involved (reporting to NHS Protect and external audit)	Chief Finance Officer	Local Counter Fraud Specialist in conjunction with Chief Finance Officer
c. Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption	Chief Finance Officer	Local Counter Fraud Specialist in conjunction with Chief Finance Officer
38. Risk Management		
a. Ensuring the Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Chief Operating Officer
b. Developing systems for the management of risk	Chief Operating Officer	Associate Director of Quality and Governance
c. Developing incident and accident reporting systems	Chief Operating Officer	Associate Director of Quality and Governance
d. Compliance with the reporting of incidents and accidents	Chief Operating Officer	All staff
39. Seal		

Delegated matter	Delegated to[2]	Operational responsibility
a. The keeping of a register of seal and safekeeping of the seal	Chief Executive	Trust Secretary
b. Attestation of seal in accordance with Standing Orders	Chief Executive	Chief Executive and Chief Finance Officer (report to Board of Directors)
c. Property transactions and any other legal requirement for the use of the seal	Chair and Chief Executive	Chair or Non-Executive Director and the Chief Executive or their nominated Executive Director
40. Security Management		
Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist	Chief Executive	Chief Operating Officer and Local Security Management Specialist
41. Setting of Fees and Charges (Income)		
a. Private Patient, Overseas Visitors, Income Generation and other patient related services	Chief Finance Officer	Deputy Chief Finance Officer and budget holders
b. Non patient care income	Chief Finance Officer	Divisional Managers, Heads of Departments or Divisional Accountants
c. Informing the Chief Finance Officer of monies due to the Trust	Chief Finance Officer	All Staff
d. Recovery of debt	Chief Finance Officer	Deputy Chief Finance Officer
e. Security of cash and other negotiable instruments	Chief Finance Officer	Deputy Chief Finance Officer
42. Stores and Receipt of Goods		
a. Responsibility for systems of control over stores and receipt of goods, issues and returns	Chief Finance Officer	Clinical Directors, Divisional Managers, Heads of Departments or Head of Procurement
b. Stocktaking arrangements	Chief Finance Officer	Clinical Directors / Divisional Managers, Heads of Departments or Head of Procurement
c. Responsibility for controls over pharmaceutical stock	Head of Pharmacy	Head of Pharmacy and Ward Managers
d. Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items	Chief Finance Officer	Clinical Directors, Divisional Managers, Heads of Departments or Head of Procurement

Table B – Delegated Financial Limits

Delegated matter	Delegated limit	Delegated to[3]
1. Virement		
Authorisation of virement	£100,000 and above	Chief Executive or Chief Finance Officer and reported to Board of Directors
	£50,001 up to £100,000	Chief Finance Officer or Deputy Chief Finance Officer
	Up to £50,000	Divisional Managers, Hewitt Centre Managing Director,, Head of Management Accounts and relevant budget holder, subject to virement signed off by Divisional Accountant
2. Cash and banking		
a. Petty cash disbursements	Up to £50	Petty cash imprest holder
b. Sundry exchequer items	£100 up to £5,000	Deputy Chief Finance Officer or Financial Controller
c. Patient monies	£5,000 and above	Chief Finance Officer or another Executive Director
d. Acceptance of cash transactions	Up to £10,000	Chief Finance Officer, Deputy Chief Finance Officer or Financial Controller
3.Non-establishment pay expenditure		
Nominated officer entering into contracts or agreements with staff not on the establishment:		
a. Where aggregate commitment in any one year (or total commitment) is less than £20,000	Chief Executive	Executive Directors or Divisional Managers
b. Where aggregate commitment in any one year is more than £20,000	Chief Executive	Chief Finance Officer
4. Non-pay expenditure (including invoice authorisation without orders)		
Approving requisitions, authorising invoices and recommending contract awards.	£500,000 and above	Board Approval
	£250,000 up to £500,000	Two Executive Directors – one of which must be the Chief Executive or Chief Finance Officer
	£138,760 (inclusive of VAT) up to £250,000	Chief Executive or Chief Finance Officer
	£40,000 up to £138,760 (inclusive of VAT)	Executive Director with advice from Deputy Chief Finance Officer and/or Head of Procurement
	£5,000 up to £40,000	Divisional Manager or Head of Department

[3] If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

Delegated matter	Delegated limit	Delegated to[3]
	Up to £5,000	Budget holder
5. Capital expenditure		
Requisitioning items / services against capital budget	Over £500,000	Board of Directors (minute approval)
	£250,000 up to £500,000	Chief Executive and Chief Finance Officer
	£25,000 up to £250,000	Chief Finance Officer or Chief Operating Officer
	Up to £25,000	Chief Finance Officer or project sponsor or delegated nominee
6. Quotation, tendering and contract procedures		
a. Quotations: *Obtaining* a minimum of 3 written quotations for goods / services	£10,000 up to £40,000 including VAT	Head of Procurement & Contracts
b. Competitive tenders: *Obtaining* a minimum of 3 written competitive tenders for goods / services (in compliance with EC directives as appropriate)	£40,000 - Prevailing OJEU Limit(s) Currently £213,477 including VAT	Head of Procurement & Contracts
c. Competitive Tenders: OJEU Tender process or use of compliant framework where applicable	> £213,477 including VAT	Head of Procurement & Contracts
d. Waiving requirements for tenders, subject to full compliance with standing orders: Tenders	£5,000 up to £213,477 (including VAT)	The Chief Finance Officer in the first instance. Should the Chief Finance Officer be absent for an extended period of time; or absent when an urgent requirement occurs relating to either service continuity or patient care Deputy Chief Finance Officer or any Executive Director will have delegated authority to authorise the use of a waiver.
7. Funds held on trust		
a. Expenditure authorisation (per request) – General Purpose Fund	£40,001 and above	Chief Nurse or Deputy Chief Finance Officer plus Chief Finance Officer plus Charitable Funds Committee
	£20,001 up to £40,000	Chief Nurse or Deputy Chief Finance Officer plus Chief Finance Officer
	Up to £20,000	Chief Nurse or Deputy Chief Finance Officer
b. Expenditure authorisation (per request) – Funds other than the General Purpose Fund	£30,000 and above	Nominated fund holder(s) plus Deputy Chief Finance Officer plus Chief Finance Officer and NED plus Charitable Funds Committee
	£10,001 up to £29,999	Nominated fund holder(s) plus Deputy Chief Finance Officer plus Chief Finance Officer and NED

Delegated matter	Delegated limit	Delegated to[3]
	Up to £10,000	Nominated fund holder(s) plus Deputy Chief Finance Officer
8. Disposals and condemnations		
With current / estimated purchase price	£5,000 and above	Divisional Manager or Deputy Chief Finance Officer with advice of relevant professional lead where appropriate
	Up to £5,000	Divisional Manager or Head of Department with advice of relevant professional lead where appropriate
9. Losses and special payments		
Losses a. Fruitless payments (including abandoned capital schemes)	£250,000 and above	Board of Directors
	£5,000 up to £250,000	Chief Executive or Chief Finance Officer and reported to Audit Committee
	Up to £5,000	Chief Executive or Chief Finance Officer
b. Losses of cash due to theft, fraud, overpayment and others	£50,000 and above	Board of Directors
c. Bad debts and claims abandoned	£1,000 up to £50,000	Chief Executive or Chief Finance Officer and reported to Audit Committee
	Up to £1,000	Deputy Chief Finance Officer
d. Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson)	Up to £1,000	Chief Executive or Chief Finance Officer
Special payments	£50,000 and above	Board of Directors
e. Compensation payments by court order	£2,000 up to £50,000	Chief Executive or Chief Finance Officer
	Up to £2,000	Legal Services Manager
f. Ex-gratia payments to patients / staff for loss of personal effects	£50,000 and above	Board of Directors
	£2,000 to £50,000	Chief Executive or Chief Finance Officer
	Up to £2,000	Legal Services Manager
	£50,000 and above	Board of Directors
g. Other ex-gratia payments	Up to £50,000	Chief Executive or Chief Finance Officer
10. Legally binding contracts for clinical service provision or purchase of clinical support services under Foundation Trust contracts		
	£1million annual value and above	Chief Executive or Chief Finance Officer or Chief Operating Officer
	Up to £1million annual value	Chief Finance Officer or Chief Operating Officer

Appendix C - Standing Financial Instructions

6.1 Introduction

6.1.1 The independent regulator sets the Licence for the Foundation Trust that require compliance with the principles of best practice applicable to corporate Governance within the NHS/ Health Sector with any relevant code of proactive ad guidance issued by the independent regulator.

6.1.2 The Code of Conduct and Accountability in the NHS4 requires that each NHS Foundation Trust shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code. They shall have effect as if incorporated in the Standing Orders (SOs) of the Foundation Trust.

6.1.3 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Foundation Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board of Directors and the Scheme of Delegation adopted by the Foundation Trust.

6.1.4 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust and its constituent organisations, including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. The Chief Finance Officer must approve all financial procedures.

6.1.5 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Chief Finance Officer MUST BE SOUGHT BEFORE ACTING. The user of these SFIs should also be familiar with and comply with the provisions of the Foundation Trust's SOs.

FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER, WHICH COULD RESULT IN DISMISSAL.

6.1.6 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.

6.2 Terminology

6.2.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in the constitution and these instructions bear the same meaning as in the National Health Service Act 2006. References in the Constitution to legislation include all amendments, replacements, or re-enactments made.

[4] Code of Conduct, Code of Accountability, Department of Health (1994 & 2004)

6.2.2 Wherever the title Chief Executive, Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other directors or employees who have been duly authorised to represent them. Wherever the term "employee" is used, and where the context permits, it shall be deemed to include employees of third parties contracted to the Foundation Trust when acting on behalf of the Foundation Trust, including nursing and medical staff and consultants practising on the Foundation Trust premises and members of staff of private contractors or trust staff working for private contractors under retention of employment model.

6.3 Responsibilities and Delegation

6.3.1 The Foundation Trust shall at all times remain a going concern as defined by the relevant accounting standards in force. The Board of Directors exercises financial supervision and control by:

(a) Formulating the financial strategy;
(b) Requiring the submission and approval of budgets within overall income;
(c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money) and by ensuring appropriate audit provision; and
(d) Defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

6.3.2 The constitution dictates that the Council of Governors may not delegate any of its powers to a committee or sub-committee. The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the “Reservation of Powers to the Board of Directors” document, published within the Scheme of Delegation. The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Foundation Trust.

6.3.3 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors and as the Accounting Officer for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Foundation Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Foundation Trust’s system of internal control.

6.3.4 The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

6.3.5 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions. All staff shall be responsible for ensuring conformity with the Standing Orders, Standing Financial Instructions and financial procedures of the Foundation Trust.

6.3.6 The Chief Finance Officer is responsible for:

(a) Implementing the Foundation Trust’s financial policies and for co-ordinating any corrective action necessary to further these policies (the SFIs themselves do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes);
(b) Maintaining an effective system of internal financial control, including ensuring that detailed financial procedures and systems incorporating the principles of separation

of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) Ensuring that sufficient records are maintained to show and explain the Foundation Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Foundation Trust at any time and, without prejudice to any other functions of directors and employees to the Foundation Trust, the duties of the Chief Finance Officer include:

(d) The provision of financial advice to other members of the Board of Directors, Council of Governors and employees;

(e) The design, implementation and supervision of systems of internal financial control; and

(f) The preparation and maintenance of such accounts, certificates, estimates, records and financial reports as the Foundation Trust may require for the purpose of carrying out its statutory duties.

6.3.7 All directors and employees, severally and collectively, are responsible for:

(a) The security of the property of the Foundation Trust;

(b) Avoiding loss;

(c) Exercising economy and efficiency in the use of resources; and

(d) Conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

6.3.8 Any contractor or employee of a contractor who is empowered by the Foundation Trust to commit the Foundation Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

6.3.9 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

6.4 Audit

6.4.1 Audit Committee

6.4.1.1 In accordance with Standing Orders, the Board of Directors shall formally establish an Audit Committee with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

(a) Overseeing internal and external audit services;

- Internal audit
  - to monitor and review the effectiveness of the internal audit function

- External audit
  - to assess the external auditor's work and fees on an annual basis to ensure that the work is of sufficiently high standard and that the fees are reasonable
  - to ensure a market testing exercise for the appointment of the external auditor is undertaken at least once every five years
  - to make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the external auditor and to approve the remuneration and terms of engagement of the external auditor
  - to review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements.

(b) Reviewing financial and information systems and monitoring the integrity of the financial statements and any formal announcements relating to the Trust's financial performance and reviewing of significant financial reporting judgements;
(c) Reviewing the effective implementation of corporate governance measures to enable the Foundation Trust to implement best practice as set out in appropriate guidance. This will include the Assurance Framework and control related disclosure statements, for example the Statement on Internal Control and supporting assurance processes, together with any accompanying audit statement, prior to endorsement by the Board of Directors
(d) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical, operational, compliance controls and risk management systems) that support the achievement of the organisation's objectives
(e) Monitoring compliance with Standing Orders and Standing Financial Instructions;
(f) Reviewing schedules of losses and compensations and making recommendations to the Board of Directors.

6.4.1.2 The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

6.4.1.3 Where the Audit Committee feels there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chair of the Audit Committee should raise the matter at a full meeting of the Board of Directors (to the Chief Finance Officer in the first instance).

6.4.1.4 It is the responsibility of the Chief Finance Officer to ensure an adequate internal audit service is provided, and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

6.5 Chief Finance Officer

6.5.1 The Chief Finance Officer is responsible for:
(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control, including the establishment of an effective internal audit function and the coordination of other assurance arrangements;
(b) Ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;
(c) Deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities not involving fraud or corruption;
(d) Ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:
  (i) An opinion to support the statement on the effectiveness of internal controls in accordance with current guidance issued by the Department of Health;
  (ii) Major internal financial control weaknesses discovered;
  (iii) Progress on the implementation of internal audit recommendations;
  (iv) Progress against plan over the previous year;
  (v) Strategic audit plan covering the coming three years;
  (vi) A detailed plan for the coming year.

6.5.2 The Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:
(a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
(b) Access at all reasonable times to any land, premises, members of the Board of Directors and Council of Governors or employee of the Foundation Trust;

(c) The production of any cash, stores or other property of the Foundation Trust under a member of the Board of Directors or employee's control; and
(d) Explanations concerning any matter under investigation.

6.6 Role of Internal Audit

6.6.1 The NHS Foundation Trust Accounting Officer Memorandum requires the Foundation Trust to have an internal audit function.

6.6.2 The role of internal audit embraces two key areas:

- The provision of an independent and objective opinion to the Accounting Officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives
- The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

6.6.3 Internal Audit will review, appraise and report upon:

(a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
(b) The adequacy and application of financial and other related management controls;
(c) The suitability of financial and other related management data;
(d) The extent to which the Foundation Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
    i) fraud and other offences
    ii) waste, extravagance, inefficient administration
    iii) poor value for money or other causes.
(e) Internal Audit shall also independently verify the assurance statements in accordance with guidance from NHS England and the Department of Health.

6.6.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

6.6.5 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Foundation Trust.

6.6.6 The Head of Internal Audit shall be accountable to the Audit Committee. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Auditing Standards (PSIAS). The reporting system shall be reviewed at least every three years. Where, in exceptional circumstances, the use of normal reporting channels is thought to limit the objectivity of the audit, the Head of Internal Audit shall have access to report direct to the Chair or a non-executive member of the Foundation Trust's Audit Committee.

6.6.7 Managers in receipt of audit reports referred to them have a duty to take appropriate remedial action within the agreed timescales specified within the report. The Chief Finance Officer shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate remedial action has failed

to take place within a reasonable period, the matter shall be reported to the Chief Finance Officer.

6.7 External Audit

6.7.1 Duties

6.7.1.1 The Foundation Trust is to have an external auditor and is to provide the external auditor with every facility and all information which they may reasonably require.

6.7.1.2 The external auditor is to carry out their duties in accordance with Schedule 10 of the 2006 Act and in accordance with any directions given by the Independent Regulator on standards, procedures and techniques to be adopted.

6.7.1.3 In auditing the accounts the financial auditor must, by examination of the accounts and otherwise, satisfy themselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

6.7.1.4 The Foundation Trust is required to include an annual governance statement within its annual report and financial accounts which include the quality report. The external auditors have a responsibility to:

- consider the completeness of the disclosures in meeting the relevant requirements; and
- identify any inconsistencies between the disclosures and the information that they are aware of from their work on the financial statements, quality report and other work.

6.7.2 Appointment of External Auditor

6.7.2.1 The external auditor is appointed by the Council of Governors following recommendation from the Audit Committee. 5The Audit Code for NHS Foundation Trusts ("the Audit Code") contains the directions of NHS England with respect of those eligible to be appointed under the National Health Service Act 2006, and with respect to the standards, procedures and techniques to be adopted by the external auditor.

6.7.2.2 A person may only be appointed as the external auditor if they (or in the case of a firm of each of its members) are a member of one or more of the bodies referred to in Schedule 10 of the 2006 Act.

6.7.2.3 The Council of Governors at a general meeting shall appoint or remove the Foundation Trust's external auditor.

6.7.2.4 The Board of Directors may, upon taking the advice of the Audit Committee, resolve that external auditors be appointed to review and publish a report on any other aspect of the Foundation Trust's performance. Approval of the engagement of external auditors on non-audit work will take into account relevant ethical guidance regarding the provision of such services. Any such auditors are to be appointed by the Council of Governors.

6.7.3 Undertaking Work

6.7.3.1 NHS England may require auditors to undertake work on its behalf at the Foundation Trust. In this situation, a tripartite agreement between the Independent Regulator, the auditor and the Foundation Trust will be agreed. This agreement, which will include

[5] Audit Code for NHS Foundation Trust, NHS Improvement (2011)

details of the subsequent work and reporting arrangements, will be in accordance with the principles established in the guidance issued by the Institute of Chartered Accountants in England and Wales in audit 05/03: Reporting to Regulators or Regulated Entities.

6.7.3.2 The auditor may, with the approval of the Council of Governors, provide the Foundation Trust with services which are outside of the scope as defined in the code (additional services). The Foundation Trust shall adopt and implement a policy for considering and approving any additional services to be provided by the auditor.

6.7.4 Liaison with Internal Audit

6.7.4.1 It is expected that the external auditors will liaise with the internal audit function in order to obtain a sufficient understanding of internal audit activities to assist in planning the audit and developing an effective audit approach. The auditors may also wish to place reliance upon certain aspects of the work of internal audit in satisfying their statutory responsibilities as set out in the 2006 Act and the Audit Code. In particular the financial auditor may wish to consider the work of internal audit when undertaking their procedures in relation to the statement on internal control.

6.7.5 Access To Documents

6.7.5.1 The Auditors of the Foundation Trust have a right of access at all reasonable times to every document relating to the Foundation Trust which appears to them necessary for the purpose of their functions under Schedule 10 of the 2006 Act.

6.7.6 Public Interest Report

6.7.6.1 In the event of the External Auditor issuing a Public Interest report the Foundation Trust shall:

- Send the public interest report to the Council of Governors, the Board of Directors and NHS England:
  - At once if it is an immediate report; or
  - Not later than 14 days after conclusion of the audit.
- Forward a report to NHS England within 30 days (or such shorter period as the Independent Regulator may specify) of the report being issued. The report shall include details of the Foundation Trust's response to the issues raised within the Public Interest report.

References in 6.6.5 and 6.6.7 relate equally to internal and external audit.

6.8 Fraud and Bribery

6.8.1 Fraud applies to any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006. Bribery applies in the giving (or offering) or receiving (or requesting) a financial or other advantage in connection with the improper performance of a position of trust, or a function that is expected to be performed impartially or in good faith.

6.8.2 The Foundation Trust shall take all necessary steps to counter fraud and bribery affecting NHS funded services in accordance with Clause 47 of the "Foundation Trust Agency Purchase Contract" (FTAPC) including Schedule 11 and in accordance with:

(a) The NHS Fraud and Corruption Manual published by NHS Counter Fraud Authority;
(b) The policy statement "Applying Appropriate Sanctions Consistently" published by NHS Counter Fraud Authority;
(c) Any other reasonable guidance or advice issued by CFSMS that affects efficiency, systemic and/or procedural matters

(d) The Fraud Act 2006;
(e) The Bribery Act 2010.

The Chief Executive and Chief Finance Officer shall monitor and ensure compliance with the above.

6.8.3 The Foundation Trust shall nominate a suitable, independent person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

6.8.4 The Local Counter Fraud Specialist shall report to the Foundation Trust Chief Finance Officer and shall work with the staff of NHS Counter Fraud Authority in accordance with the Department of Health Fraud and Corruption Manual.

6.8.5 All allegations of fraud and bribery will be reported and if necessary investigated by the Local Counter Fraud Specialist. All accountable officers should also be aware of their obligation to pass any referrals onto the Local Counter Fraud Specialist at their earliest convenience.

6.8.6 The Local Counter Fraud Specialist will provide a written plan and report, at least annually, on counter fraud work within the Foundation Trust.

6.9 Security Management

6.9.1 The Foundation Trust shall promote and protect the security of people engaged in activities for the purposes of the health service functions of that body, its property and its information in accordance with the requirements of the 'Foundation Trust Contract', having regard to any other reasonable guidance or advice issued by NHS Protect.

6.9.2 The Foundation Trust shall nominate and appoint a local security management specialist as per the Foundation Trust contract.

6.9.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

6.10 Allocations/Payment by Results, Business Planning, Budgets, Budgetary Control, and Monitoring

6.10.1 Preparation and approval of Business Plans and Budget

6.10.1.1 The Chief Executive will compile and submit to the Board of Directors an annual plan that takes into account financial targets and forecast limits of available resources. The annual plan will contain:
(a) A statement of the significant assumptions on which the plan is based;
(b) Details of major changes in workload, delivery of services or resources required to achieve the plan.

6.10.1.2 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets relating to income and expenditure for approval by the Board of Directors. Such budgets will:
(a) Be in accordance with the aims and objectives set out in the annual plan, and the commissioners' local delivery plans;
(b) Accord with workload and workforce plans;
(c) Be produced following discussion with appropriate budget holders;
(d) Be prepared within the limits of available funds;
(e) Identify potential risks;

(f) Be based on reasonable and realistic assumptions; and

6.10.1.3 The Chief Finance Officer shall monitor financial performance against budgets, periodically review it and report to the Board of Directors. Any significant variances should be reported by the Chief Finance Officer to the Board of Directors as soon as they come to light, and the Board of Directors shall be advised of action to be taken in respect of such variances.

6.10.1.4 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled.

6.10.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

6.10.1.6 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders and budget managers to help them manage successfully.

6.10.2 Budgetary Delegation

6.10.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Section 31 of the Health Act 1999. This delegation must be in writing and be accompanied by a clear definition of:

(a) The amount of the budget;
(b) The purpose(s) of each budget heading;
(c) Individual and group responsibilities;
(d) Authority to exercise virement (which cannot be from a non-pay heading into a pay heading) (see also sections 6.10.2.2 and 6.10.2.3 below);
(e) Achievement of planned levels of service; and
(f) The provision of regular reports.

6.10.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

6.10.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

6.10.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive as advised by the Chief Finance Officer.

6.10.3 Budgetary Control and Reporting

6.10.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

(a) Regular financial reports to the Board of Directors in a form approved by the Board of Directors containing:
    i) Income and expenditure to date showing trends and forecast year-end position;
    ii) Balance sheet, including movements in working capital;
    iii) Capital project spend and projected outturn against plan;
    iv) Explanations of any material variances from plan/budget;
    v) Details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation;

(b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder and budget manager, covering the areas for which they are responsible;
(c) Investigation and reporting of variances from financial, and workload budgets;
(d) Monitoring of management action to correct variances;
(e) Arrangements for the authorisation of budget transfers;
(f) Advising the Chief Executive and Board of Directors of the consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the economic and financial impact of future plans and projects; and
(g) Review of the bases and assumptions used to prepare the budgets.

In the performance of these duties the Chief Finance Officer will have access to all budget holders and budget managers on budgetary matters and shall be provided with such financial and statistical information as is necessary.

6.10.3.2 Each budget holder is responsible for ensuring that:
(a) Any planned or known overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors;
(b) Officers shall not exceed the budget limit set;
(c) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and
(d) No permanent employees are appointed without the approval of the Chief Executive or Chief Finance Officer other than those provided for in the budgeted establishment as approved by the Board of Directors.

6.10.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

6.10.4 Capital Expenditure

6.10.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure (the particular applications relating to capital are contained in Section 6.18). A project sponsor will be identified who will assume responsibility for the budget relating to the scheme.

6.10.5 Monitoring Returns

6.10.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation within specified timescales.

6.11 Annual Accounts and Reports

6.11.1 Accounts

6.11.1.1 The Foundation Trust shall keep accounts in such form as NHS England may with the approval of HM Treasury direct. The accounts are to be audited by the Foundation Trust's external auditor. The following documents will be made available to the Comptroller and Auditor General for examination at their request:
- the accounts;
- any records relating to them; and
- any report of the financial auditor on them.

6.11.1.2 The functions of the Foundation Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

6.11.1.3 In preparing its annual accounts, the accounting officer shall cause the Foundation Trust to comply with any directions given by the Independent Regulator with the approval of the Treasury as to:

- the methods and principles according to which the accounts are to be prepared;
- the information to be given in the accounts;

and shall be responsible for the functions of the Foundation Trust as set out in Schedule 10 to the 2006 Act.

6.11.1.4 The annual accounts, any report of the external auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting. The Accounting Officer shall cause the Foundation Trust to:

- lay a copy of the annual accounts, and any report of the financial auditor on them, before Parliament; and
- once it has done so, send copies of those documents to NHS England.

6.11.1.5 Responsibility for complying with the requirements relating to the form, preparation and presentation of the accounts shall be delegated to the Accounting Officer.

6.11.2 Annual Reports

6.11.2.1 The Foundation Trust is to prepare annual reports and send them to the independent regulator, NHS England. The reports are to give:

- information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual membership of its public constituencies and of the classes of the staff constituency is representative of those eligible for such membership; and
- any other information NHS England requires.

6.11.2.2 The Foundation Trust is to comply with any decision NHS England makes as to:

- the form of the reports;
- when the reports are to be sent to them;
- the periods to which the reports are to relate.

6.11.2.3 The external auditors of the Foundation Trust have a responsibility to read the information contained within the Annual Report and consider the implications for the audit opinion and/or certificate if there are apparent misstatements or material inconsistencies with the financial statements.

6.11.2.4 Annual Plans

6.11.2.5 The Foundation Trust is to give information as to its forward planning in respect of each financial year to be submitted in accordance with requirements and timescales set by NHS England. The document containing this information is to be prepared by the Directors, and in preparing the document, the Board of Directors must have regard to the views of the Council of Governors. The Annual Plan must be approved by the Board of Directors.

6.11.3 Other Reports

6.11.3.1 The Foundation Trust is required to publish a separate Quality Account each year as required by the NHS Act 2009 and in the terms set out in the NHS (Quality Accounts) Regulations 2010 and any guidance issued by NHS England.

6.12 Bank and OPG Accounts

6.12.1 General

6.12.1.1 The Chief Finance Officer is responsible for managing the Foundation Trust banking arrangements and for advising the Foundation Trust on the provision of banking services and operation of accounts.

6.12.1.2 The Board of Directors shall approve the banking arrangements.

6.12.2 Bank and OPG Accounts

6.12.2.1 The Chief Finance Officer is responsible for:

(a) Bank accounts including those provided by the Government Banking Service (GBS), and other forms of working capital financing;
(b) Establishing separate bank accounts for the Foundation Trust's non-exchequer funds;
(c) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;
(d) Reporting to the Board of Directors all arrangements made with the Foundation Trust's bankers for accounts to be overdrawn (together with the remedial action taken).

6.12.2.2 All accounts should be held in the name of the Foundation Trust. No officer other than the Chief Finance Officer shall open any account in the name of the Foundation Trust or for the purpose of furthering Foundation Trust activities.

6.12.3 Banking Procedures

6.12.3.1 The Chief Finance Officer will prepare detailed instructions on the operation of bank accounts which must include:

(a) The conditions under which each bank is to be operated;
(b) The limit to be applied to any overdraft; and
(c) Those authorised to sign cheques or other orders drawn on the Foundation Trust's accounts.

6.12.3.2 The Chief Finance Officer must advise the Foundation Trust's bankers in writing of the conditions under which each account will be operated.

6.12.3.3 The Chief Finance Officer shall approve security procedures for any cheques issued without a handwritten signature e.g. lithographed. Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate. All cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

6.12.3.4 Acceptance of cash will be limited to a maximum of £10,000.

6.12.4 Tendering and Review

6.12.4.1 The Chief Finance Officer will review the banking arrangements of the Foundation Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Foundation Trust's business banking.

6.12.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board of Directors. This review is not applicable to GBS accounts.

6.13 Income, Fees and Charges and Security of Cash, Cheques and other Negotiable Instruments

6.13.1 Income Systems

6.13.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.13.1.2 All such systems shall incorporate, where practicable, in full the principles of internal check and separation of duties.

6.13.1.3 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

6.13.2 Fees and Charges other than Foundation Trust Agency Purchase Contract

6.13.2.1 The Foundation Trust shall follow the Department of Health advice in the NHS Costing Manual in setting prices for non-commercial contracts with NHS organisations other than those covered by the Foundation Trust Agency Purchase Contract and non-NHS organisations.

6.13.2.2 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the guidance in the Department of Health's [6]'Commercial sponsorship: Ethical standards in the NHS' shall be followed.

6.13.2.3 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.13.3 Non-NHS Income

6.13.3.1 In accordance with Part 4 of the Health and Social Care Act 2012 the Foundation Trust shall ensure that the income it receives from providing goods and services for the NHS is greater that its income from other sources.

6.13.3.2 Where the Foundation Trust proposed to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the health service, it will seek approval from the Council of Governors.

6.13.4 Debt Recovery

6.13.4.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts, including a formal follow up procedure for all debtor accounts.

6.13.4.2 Income not received should be dealt with in accordance with losses procedures (see paragraph 6.21 below).

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[6] Commercial sponsorship: Ethical standards for the NHS, Department of Health (2000)

6.13.4.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.13.5 Security of Cash, Cheques and Other Negotiable Instruments

6.13.5.1 The Chief Finance Officer is responsible for:

(a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable (no form of receipt which has not been specifically authorised by the Chief Finance Officer should be issued);

(b) Ordering and securely controlling any such stationery;

(c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Foundation Trust.

6.13.5.2 Official money shall not under any circumstances be used for the encashment of private cheques, nor IOUs.

6.13.5.3 Staff shall be informed in writing on appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques etc.

6.13.5.4 All cheques, postal orders, cash or other negotiable instruments shall be banked promptly intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

6.13.5.5 The Foundation Trust will not accept a cash payment for a single transaction which is in excess of the current limit (€15,000 as at October 2010 or sterling equivalent or £10,000, whichever is lower.) This exempts the Trust from the requirement to register under the 2007 Money Laundering Regulations that came into effect on 15 December 2007.

6.13.5.6 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Foundation Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Foundation Trust from responsibility for any loss.

6.13.5.7 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be monitored and recorded within the Finance Department. Any significant trends should be reported to the Chief Finance Officer and internal audit via the incident reporting system. Where there is prima facie evidence of fraud or corruption, this should follow the form of the Foundation Trust's Fraud and Corruption Response Plan and the guidance provided by NHS Protect .

6.13.5.8 Where there is no evidence of fraud or corruption, the loss should be dealt with in line with the Foundation Trust's Losses and Compensations Procedures (see section 6.20 below).

6.14 Foundation Trust Contracts

6.14.1 Provision of Services

6.14.1.1 The Board of Directors shall regularly review and shall at all times maintain and ensure the capacity and capability of the Foundation Trust to provide Commissioner Requested Services in accordance with the Trust's Licence.

6.14.2 Foundation Trust Contract

6.14.2.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Foundation Trust enters into suitable Foundation Trust Contracts (FTCs) with commissioners for the provision of NHS services. The Foundation Trust will follow the priorities contained within the schedules of the contract, and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- The standards of service quality expected;
- The relevant national service framework (if any);
- The provision of reliable information on cost and volume of services;
- The Performance Assessment Framework contained within the FT;
- That FTC builds where appropriate on existing partnership arrangements.

6.14.3 A good FTC will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Foundation Trust works with all partner agencies involved in both the delivery and the commissioning of the service required.

6.14.4 The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from FTCs. This will include appropriate payment by results performance information.

6.14.5 Non Commissioner Contracts

6.14.5.1 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services – clinical or non-clinical, the responsible executive director should ensure that an appropriate non-commercial contract is present and signed by both parties. This should incorporate:

- A description of the service and indicative activity levels
- The term of the agreement
- The value of the agreement
- The lead officer
- Performance and dispute resolution procedures
- Risk management and clinical governance agreements.

6.14.5.2 Non-commissioner contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement so as to ensure value for money and to minimise the potential loss of income.

6.15 Terms of Service, Allowances and Payment of Members of the Board of Directors and Employees

6.15.1 Nominations and Remuneration Committee (Executive Directors)

6.15.1.1 In accordance with Standing Orders, the Board of Directors has established a Nominations and Remuneration Committee which is responsible for the appointment of Executive Directors and for agreeing the terms of service of Executive Directors. It has clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

6.15.1.2 The terms of reference for the Nominations and Remuneration Committee (Executive Directors) can be found in this Corporate Governance Manual.

6.15.1.3 The Remuneration and Nomination Committee will be accountable to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it or require executive action.

6.15.1.4 The Board of Directors will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

6.15.1.5 **Nominations and Remuneration Committee (Non-Executive Directors)**

6.15.1.6 In accordance with Standing Orders, the Council of Governors have established a Nominations and Remuneration Committee which is responsible for the appointment and setting the terms of appointment of Non-Executive Directors. It will make recommendations to a general meeting of the Council of Governors on the appointment of Non-Executive Directors. It has clearly defined terms of reference, specifying its area of responsibility, its composition and the arrangements for reporting.

6.15.1.7 The terms of reference of the Nominations and Remuneration Committee (Non-Executive Directors) can be requested from the Trust Secretary.

6.15.2 **Funded Establishment**

6.15.2.1 The workforce plans incorporated within the annual budget will form the funded establishment. The establishment of the Foundation Trust will be identified and monitored by the Chief People Officer under delegation from the Chief Executive.

6.15.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or individual nominated within the relevant section of the Scheme of Reservation and Delegation. The Chief Finance Officer is responsible for verifying that funding is available.

6.15.3 **Staff Appointments**

6.15.3.1 No Executive Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

i. Unless authorised to do so by the Chief Executive; and
ii. Within the limit of his approved budget and funded establishment as defined in the Scheme of Reservation and Delegation.

6.15.3.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

6.15.3.3 **Processing of the Payroll**

6.15.3.4 The Chief People Officer in conjunction with the Chief Finance Officer is responsible for:

(a) Specifying timetables for submission of properly authorised time records and other notifications;
(b) The final determination of pay and allowances; including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;
(c) Making payment on agreed dates; and
(d) Agreeing method of payment.

6.15.3.5 The Chief People Officer will issue instructions, taking into account the advice of the Chief Finance Officer and provider of payroll services regarding:

a) Verification and documentation of data;
b) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;

c) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
d) Security and confidentiality of payroll information;
e) Checks to be applied to completed payroll before and after payment;
f) Authority to release payroll data under the provisions of the Data Protection Act;
g) Methods of payment available to various categories of employee;
h) Procedures for payment by cheque, bank credit, or cash to employees;
i) Procedures for the recall of cheques and bank credits;
j) Pay advances and their recovery;
k) Maintenance of regular and independent reconciliation of pay control accounts;
l) Separation of duties of preparing records and handling cash; and
m) A system to ensure the recovery from leavers of sums of money and property due by them to the Foundation Trust.

6.15.3.6 Appropriately nominated managers have delegated responsibility for:
(a) Processing a signed copy of the contract/appointment form and such other documentation as may be required immediately upon an employee commencing duty;
(b) Submitting time records, and other notifications in accordance with agreed timetables;
(c) Completing time records and other notifications in accordance with the Chief People Officer's instructions and in the form prescribed by the Chief People Officer; and
(d) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Chief People Officer must be informed immediately. In circumstances where fraud might be expected this must be reported to the Chief Finance Officer.

6.15.3.7 Regardless of the arrangements for providing the payroll service, the Chief People Officer, in conjunction with the Chief Finance Officer, shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

6.15.4 Contracts of Employment

6.15.4.1 The Board of Directors shall delegate responsibility to a manager for:
(a) Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment and Health and Safety legislation; and
(b) Dealing with variations to, or termination of, contracts of employment.

6.16 Non Pay Expenditure

6.16.1 Delegation of Authority

6.16.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

6.16.1.2 The Chief Executive will set out:
(a) The list of managers who are authorised to place requisitions for the supply of goods and services (see Table B Delegated Financial Limits Section 4) which should be updated and reviewed on an ongoing basis and annually by the Finance Department in conjunction with departmental officers;

(b) Where the authorisation system is computerised, the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system; and
(c) The maximum level of each requisition and the system for authorisation above that level.

6.16.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

6.16.2 **Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services**

6.16.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Foundation Trust with particular reference to the requirements for quotations and tenders detailed in Table B delegated limits of the Scheme of Reservation and Delegation. In so doing, the advice of the Foundation Trust's Procurement Department and advisor on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Executive) shall be consulted.

6.16.2.2 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall only commit expenditure within delegated approval limits with the raising of an official Trust Purchase Order (PO). Invoices received by the Trust without an official PO number quoted will be returned unpaid to the supplier.

6.16.2.3 The Chief Finance Officer shall be responsible for the prompt payment of properly authorised accounts and claims in accordance with the Better Payment Practice Code (BPPC). Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

6.16.2.4 The Chief Finance Officer will:

(a) Advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained and, once approved, the thresholds should be incorporated in the Scheme of Reservation and Delegation and regularly reviewed;
(b) Prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;
(c) Be responsible for the prompt payment of all properly authorised accounts and claims;
(d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
    i) A list of directors/employees (including specimens of their signatures) authorised to approve or incur expenditure. Where the authorisation system is computerised, the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system.
    ii) Certification that:
        - Goods have been duly received, examined and are in accordance with specification and the prices are correct;
        - Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- The account is arithmetically correct;
- The account is in order for payment.

iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment. Provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department

v) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as below).

6.16.2.5 Prepayments outside of normal commercial arrangements, for example fully comprehensive maintenance contracts and rental insurance, are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate);

(b) The appropriate officer in conjunction with the Procurement Department must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Foundation Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

6.16.2.6 Official Orders must, where not generated by the Trust's computerised procurement system:

(a) Be consecutively numbered;

(b) Be in a form approved by the Chief Finance Officer;

(c) State the Foundation Trust terms and conditions of trade; and

(d) Only be issued to, and used by, those duly authorised by the Chief Executive.

6.16.2.7 Managers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

(a) All contracts other than for a simple purchase permitted within the Scheme of Delegation or delegated budget, leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

(b) Contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement;

(c) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health. Where an officer certifying accounts relies upon other officers to do preliminary checking, he/she shall wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms;

(d) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
- Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars
- Conventional hospitality, such as lunches in the course of working visits

(e) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(f) All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or on purchasing cards;

(g) Verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order, and clearly marked "Confirmation Order";

(h) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) Goods are not taken on trial or loan in circumstances that could commit the Foundation Trust to a future uncompetitive purchase;

(j) Changes to the list of directors/employees authorised to certify invoices are notified to the Chief Finance Officer;

(k) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

(l) Petty cash records are maintained in a form as determined by the Chief Finance Officer; and

(m) Orders are not required to be raised for utility bills, NHS recharges and ad hoc services such as private hospital fees. Payments must be authorised in accordance with the delegated limits set for non pay.

6.16.2.8 The Chief Executive and Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the Capital Investment Manual and any other relevant guidance issued by NHS England. The technical audit of these contracts shall be the responsibility of the relevant Director.

6.16.2.9 Under no circumstances should goods be ordered through the Foundation Trust for personal or private use.

6.16.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

6.16.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with these Acts.

6.17 External Borrowing and Investments

6.17.1 Public Dividend Capital

6.17.1.1 On authorisation as a Foundation Trust, the Public Dividend Capital held immediately prior to authorisation continues to be held on the same conditions.

6.17.1.2 Additional Public Dividend Capital may be made available on such terms the Secretary of State (with the consent of the Treasury) decides.

6.17.1.3 Draw down of Public Dividend Capital should be authorised in accordance with the mandate held by the Department of Health Cash Funding Team, and is subject to approval by the Secretary of State.

6.17.1.4 The Foundation Trust shall be required to pay annually to the Department of Health a dividend on its Public Dividend Capital at a rate to be determined from time to time, by the Secretary of State.

6.17.2 Working Capital Loan Facility

6.17.2.1 The Foundation Trust may be required by NHS Improvement to have a working capital facility. This will be provided by the Trust's banker or other commercial provider if available and cost effective. Such a facility may be of variable term.

6.17.2.2 The Foundation Trust must only draw down against this facility in respect of true working capital needs, and in accordance with the terms and conditions of the facility.

6.17.3 Commercial Borrowing and Investment

6.17.3.1 The Foundation Trust may borrow money from any commercial source for the purposes of or in connection with its functions.

6.17.3.2 The Foundation Trust may invest money (other than money held by it as charitable trustee) for the purposes of or in connection with its functions. Such investment may include forming, or participating in forming, or otherwise acquiring membership of bodies corporate.

6.17.3.3 The Foundation Trust may also give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.

6.17.4 Investment of Temporary Cash Surpluses

6.17.4.1 Temporary cash surpluses must be held only in such public and private sector investments as authorised by the Board of Directors.

6.17.4.2 The Finance, Performance and Business Development committee is responsible for establishing and monitoring an appropriate investment strategy.

6.17.4.3 The Chief Finance Officer is responsible for advising the Board of Directors on investments and shall report periodically to the Board of Directors concerning the performance of investments held.

6.17.4.4 The Chief Finance Officer will prepare detailed procedural instructions on investment operations and on the records to be maintained. The Foundation Trust's Treasury Management Policy will include instructions on funding and investing, safe harbour investments, risk management, borrowing, controls, reporting and performance management. It will also incorporate guidance from NHS England as appropriate.

6.18 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

6.18.1 Capital Investment

6.18.1.1 The Chief Executive:

(a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
(b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and
(c) Shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

6.18.1.2 For capital expenditure proposals, the Chief Executive shall ensure (in accordance with the limits outlined in the Scheme of Delegation):
(a) That a business case is produced, setting out:
    i) An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and
    ii) Appropriate project management and control arrangements; and
    iii) The involvement of appropriate Foundation Trust personnel and external agencies; and
(b) That the Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case.

6.18.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the capital investment manual and any other relevant guidance issued by NHS England.

6.18.1.4 The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme, in accordance with Inland Revenue guidance.

6.18.1.5 The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised budgets.

6.18.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:

(a) Specific authority to commit expenditure
(b) Authority to proceed to tender
(c) Approval to accept a successful tender.

6.18.1.7 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the capital investment manual guidance and any other relevant guidance issued by NHS England, and the Foundation Trust's Standing Orders.

6.18.1.8 The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

6.18.2 Private Finance

6.18.2.1 The Foundation Trust should normally test for PFI when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector, the following should apply:
(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;
(b) A business case must be referred to NHS England for approval or treated as per current guidelines;

(c) The proposal must be specifically agreed by the Foundation Trust, in the light of such professional advice as should reasonably be sought, in particular with regard to vires;
(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

6.18.3 Asset Registers

6.18.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

6.18.3.2 The Foundation Trust shall maintain an asset register recording fixed assets. As a minimum, the minimum data set to be held within these registers shall be as specified in the NHS Foundation Trust Annual Reporting Manual as issued by NHS England.

6.18.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder, and be validated by reference to:
(a) Properly authorised and approved agreements, architects' certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;
(b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and
(c) Lease agreements in respect of assets held under a finance lease and capitalised.

6.18.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

6.18.3.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on the Asset Register.

6.18.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the NHS Foundation Trust Annual Reporting Manual issued by NHS England.

6.18.3.7 The value of each asset shall be depreciated using methods and rates as specified in the NHS Foundation Trust Annual Reporting Manual issued by NHS England.

6.18.3.8 The Chief Finance Officer shall calculate and pay capital charges as specified by the Department of Health.

6.18.4 Protected Property

6.18.4.1 A register of protected property is required to be maintained in accordance with requirements issued by NHS England. The property referred to in Condition 9(1) of the Licence, which is to be protected, is limited to land and buildings owned or leased by the Foundation Trust (assets such as equipment, financial assets, cash or intellectual property will not be regarded as protected assets).

6.18.4.2 No protected property may be disposed of (including disposing of part of it or granting an interest in it) without the approval of NHS England.

6.18.4.3 This will be achieved through the annual planning process. The annual plan will include proposed changes in the treatment of assets that are protected and proposed disposals and acquisitions.

6.18.4.4 The Foundation Trust is required to notify relevant bodies of the publication date of their plans to allow them to lodge any objections. Twenty-one days is allowed before the plans are then approved.

6.18.4.5 During the year when the proposed changes are made the Asset Register must be updated accordingly. The relevant bodies should then be notified that an updated Asset Register is available.

6.18.4.6 As required by its Licence the Foundation Trust must make the Asset Register available for inspection by the public. The Foundation Trust may charge a reasonable fee for access to this information.

6.18.5 Security of Assets

6.18.5.1 The overall control of fixed assets is the responsibility of the Chief Executive advised by the Chief Finance Officer. Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) Recording managerial responsibility for each asset;
(b) Identification of additions and disposals;
(c) Identification of all repairs and maintenance expenses;
(d) Physical security of assets;
(e) Periodic verification of the existence of, condition of, and title to, assets recorded;
(f) Identification and reporting of all costs associated with the retention of an asset; and
(g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

6.18.5.2 All significant discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

6.18.5.3 Whilst each employee has a responsibility for the security of property of the Foundation Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

6.18.5.4 Any damage to the Foundation Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

6.18.5.5 Where practical, assets should be marked as Foundation Trust property.

6.19 Stock, Stores and Receipt of Goods

6.19.1 Stocks are defined as those goods normally utilised in day to day activity, but which at a given point in time have not been used or consumed. There are three broad types of store:

(a) Controlled stores – specific areas designated for the holding and control of goods;
(b) Wards and departments – goods required for immediate usage to support operational services;
(c) Manufactured Items – where goods and consumables are being made or processes are being applied which add to the raw material cost of the goods.

6.19.2 Such stocks should be kept to a minimum and for:

(a) Controlled stores and other significant stores (as determined by the Chief Finance Officer) should be subjected to an annual stock take or perpetual inventory procedures; and
(b) Valued at the lower of cost and net realisable value.

6.19.3 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any pharmaceutical stocks shall be the responsibility of the Head of Pharmacy. The control of any fuel oil shall be the responsibility of the Estates and Facilities Manager.

6.19.4 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager.

6.19.5 Wherever practicable, stocks should be marked as NHS property.

6.19.6 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

6.19.7 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

6.19.8 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

6.19.9 The designated manager shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also 6.20, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

6.19.10 Receipt of Goods

6.19.10.1 All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification. A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available.

6.19.10.2 All goods received shall be entered onto an appropriate goods received/stock record (whether a computer or manual system) on the day of receipt. If goods received are unsatisfactory, the records shall be marked accordingly. Further, where the goods received are found to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately.

6.19.10.3 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note to satisfy themselves that the goods have been received. The Finance Department will make payment on receipt of an invoice. This may also apply for high-level low volume items such as stationery.

6.19.11 Issue of Stocks

6.19.11.1 The issue of stocks shall be supplied by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer. Where a 'topping up' system is used, a record shall be maintained as approved by the Chief Finance Officer. Regular comparisons shall be made of the quantities issued to wards/departments etc, and explanations recorded of significant variations.

6.19.11.2 All transfers and returns shall be recorded on forms/systems provided for the purpose and approved by the Chief Finance Officer.

6.20 Disposals and Condemnations, Insurance, Losses and Special Payments

6.20.1 Disposals and Condemnations

6.20.1.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

6.20.1.2 When it is decided to dispose of a Foundation Trust asset, the head of department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

6.20.1.3 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;

(b) Recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

6.20.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

6.21 Losses and Special Payments

6.21.1 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Chief Finance Officer must also prepare a fraud response plan that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

6.21.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their directorate manager or head of department, who must immediately inform the Chief Finance Officer who will liaise with the Chief Executive or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Chief Finance Officer who will liaise with the Chief Executive.

6.21.3 Where a criminal offence such as theft or arson is suspected, the Divisional Manager or departmental head must immediately inform the police and obtain a crime number, which should be forwarded to the Chief Finance Officer. In cases of fraud, bribery or corruption, or of anomalies which may indicate fraud, bribery or corruption, the Chief Finance Officer must inform their Local Counter Fraud Officer, who will inform NHS Counter Fraud Authority before any action is taken and reach agreement on how the case is to be handled.

6.21.4 The Chief Finance Officer must notify NHS Counter Fraud Authority and the external auditor of all frauds.

6.21.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:
(a) The Board of Directors, and
(b) The external auditor, and
(c) NHS Protect (through LSMS).

6.21.6 The Board of Directors shall approve the writing-off of all losses and special payments in accordance with the Scheme of Delegation.

6.21.7 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Foundation Trust's interests in bankruptcies and company liquidations.

6.21.8 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

6.21.9 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

6.22 Insurance

6.22.1 The Chief Finance Officer shall ensure that insurance arrangements exist in accordance with the risk management programme.

6.23 Compensation Claims

6.23.1 The Foundation Trust is committed to effective and timely investigation and response to any claim which includes allegations of clinical negligence, employee and other compensation claims. The Foundation Trust will follow the requirements and note the recommendations of the Department of Health, and the NHS Resolution in the management of claims. Where appropriate external insurance has been contracted, this will be within the above mentioned requirements and recommendations. Every member of staff is expected to co-operate fully, as required, in assessment and management of each claim.

6.23.2 The Foundation Trust will seek to reduce the incidence and adverse impact of clinical negligence, employee and other litigation by:

- Adopting prudent risk management strategies including continuous review
- Implementing in full the NHS Complaints Procedure, thus providing an alternative remedy for some potential litigants
- Adopting a systematic approach to claims handling in line with the best current and cost effective practice
- Following guidance issued by the NHS Resolution relating to clinical negligence
- Achieving compliance with the relevant core Care Quality Commission standards
- Implementing an effective system of clinical governance.

6.23.3 The Chief Nurse in association with the Medical Director is responsible for clinical negligence, for managing the claims process and informing the Board of Directors of any major developments on claims related issues.

6.24 Information Technology

6.24.1 Responsibilities and duties of the Chief Finance Officer

6.24.1.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Foundation Trust, shall:

(a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Foundation Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (updated 2000) and the Computer Misuse Act 1990;
(b) Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
(c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
(d) Ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks;
(e) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

6.24.1.2 The Chief Finance Officer shall satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

6.24.1.3 The Foundation Trust has published and maintains a Freedom of Information (FoI) Publication Scheme as approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

6.24.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

6.24.2.1 In the case of computer systems which are proposed General Applications (i.e. those applications which a number of NHS organisations wish to sponsor jointly), all responsible directors and employees will send to the Chief Finance Officer:
(a) Details of the outline design of the system;
(b) In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

6.24.3 Contracts for Computer Services with other health bodies or outside agencies

6.24.3.1 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation, or any other agency, shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

6.24.3.2 Where another health organisation, or any other agency, provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

6.24.4 Requirement for Computer Systems which have an impact on corporate financial systems

6.24.4.1 Where computer systems have an impact on corporate financial systems, the Chief Finance Officer shall satisfy themselves that:

(a) Systems acquisition, development and maintenance are in line with corporate policies, such as an Information Management and Technology Strategy
(b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
(c) Chief Finance Officer staff have access to such data; and
(d) Such computer audit reviews as are considered necessary are being carried out.

6.24.5 Risk Assessment

6.24.5.1 The Chief Finance Officer shall ensure that risks to the Trust arising from the use of information technology are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

6.24.5.2 The Foundation Trust shall disclose to NHS England and directly to any third parties, as may be specified by the Secretary of State, information, if any, as specified in the Licence. Other information, as requested, shall be provided to NHS England.

6.24.5.3 The Foundation Trust shall participate in the national programme for information technology, in accordance with any guidance issued by NHS England.

6.25 Patients' Property

6.25.1 The Foundation Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

6.25.2 The Chief Executive is responsible for ensuring that patients, or their guardians as appropriate, are informed before or at admission by

- Notices and information booklets
- Hospital admission documentation and property records
- The oral advice of administrative and nursing staff responsible for admissions

that the Foundation Trust will not accept responsibility or liability for patients' property brought into its premises, unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt.

6.25.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. The said instructions shall cover the necessary arrangements for withdrawal of cash or disbursement of money held in accounts of patients who are incapable of handling their own financial affairs. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

6.25.4 A patient's property record, in a form determined by the Chief Finance Officer, shall be completed in respect of the following:
(a) Property handed in for safe custody by any patient (or guardian as appropriate); and
(b) Property taken into safe custody, having been found in the possessions of:
    - Mentally disordered patients
    - Confused and/or disorientated patients
    - Unconscious patients
    - Patients dying in hospital
    - Patients found dead on arrival at hospital (property removed by police).

A record shall be completed in respect of all persons in category (b), including a nil return if no property is taken into safe custody.

6.25.5 The record shall be completed by a member of the hospital staff, in the presence of a second member of staff and the patient (or representative) where practicable. It shall then be signed by both members of staff and by the patient, except where the latter is restricted by physical or mental incapacity. Any alterations shall be validated by signatures as requested for the original entry on the record.

6.25.6 Where Department of Health instructions require the opening of separate accounts for patients' monies (separate from those containing Foundation Trust monies), these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

6.25.7 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Works and Pensions. For long stay patients, the Chief Executive shall ensure that positive action is taken to use their funds effectively and so reduce balances accruing.

6.25.8 Refunds of cash handed in for safe custody will be dealt with in accordance with current Department of Works and Pensions guidance. Property other than cash, which has been handed in for safe custody, shall be returned to the patient as required by the officer who has been responsible for its security. The return shall be receipted by the patient, or guardian as appropriate, and witnessed.

6.25.9 The disposal of property of deceased patients shall be effected by the officer who has been responsible for its security. Such disposal shall be in accordance with written instructions issued by the Chief Finance Officer. In particular, where cash or valuables have been deposited for safe custody, they shall only be released after written authority has been given by the Chief Finance Officer. Such authority shall include details of the lawful kin or other person entitled to the cash and valuables in question.

6.25.10 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

6.25.11 Property handed over for safe custody shall be placed into the care of the appropriate administrative staff. Where there are no administrative staff present, the property shall be placed into the care of the most senior member of nursing staff on duty.

6.25.12 In respect of deceased patients, if there is no will and no lawful next of kin the property vests in the Crown and particulars shall, therefore, be notified to the Treasury Solicitor.

6.25.13 Any funeral expenses necessarily borne by the Foundation Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any element of the estate held by the Foundation Trust may be appropriated towards funeral expenses, upon the authorisation of the Chief Finance Officer.

6.25.14 Staff should be informed, on appointment, by the appropriate departmental or senior manager, of their responsibilities and duties for the administration of the property of patients.

6.25.15 Where patients' property or income is received for specific purposes and held for safekeeping, the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

6.26 Funds held on Trust

6.26.1 General

6.26.1.1 The Foundation Trust has a responsibility as a corporate trustee for the management of funds it holds on trust. The management processes may overlap with those of the organisation of the Foundation Trust. The trustee responsibilities must be discharged separately, and full recognition given to its dual accountabilities, to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

6.26.1.2 The reserved powers of the Board of Directors and the Scheme of Delegation make clear where decisions where discretion must be exercised are to be taken and by whom.

6.26.1.3 As management processes overlap, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

6.26.1.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

6.26.1.5 Charitable Funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the Trust and the objectives of which are for the benefit of the NHS in England. They are administered by the Foundation Trust Board of Directors acting as the Charitable Funds Committee (the trustees).

6.26.1.6 The Chief Finance Officer shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Foundation Trust as trustees of non-exchequer funds, including an Investment Register.

6.26.2 Existing Charitable Funds

6.26.2.1 The Chief Finance Officer shall arrange for the administration of all existing funds. A Deed of Establishment must exist for every fund, and detailed codes of procedure shall be produced covering every aspect of the financial management of charitable funds, for the guidance of fund managers. The Deed of Establishment shall identify the restricted nature of certain funds, and it is the responsibility of fund managers, within their delegated authority, and the Charitable Funds Committee, to ensure that funds are utilised in accordance with the terms of the Deed.

6.26.2.2 The Chief Finance Officer shall periodically review the funds in existence, and shall make recommendations to the Charitable Funds Committee regarding the potential for rationalisation of such funds within statutory guidelines.

6.26.2.3 The Chief Finance Officer shall ensure that all funds are currently registered with the Charities Commission in accordance with the Charities Act 1993 or subsequent legislation.

6.26.3 New Charitable Funds

6.26.3.1 The Chief Finance Officer shall recommend the creation of a new fund where funds and/or other assets received for charitable purposes cannot adequately be managed as part of an existing fund. All new funds must be covered by a Deed of Establishment, and must be formally approved by the Charitable Funds Committee.

6.26.3.2 The Deed of Establishment for any new fund shall clearly identify, inter alia, the objects of the new fund, the nominated fund manager, the estimated annual income and, where

applicable, the Charitable Funds Committee's power to assign the residue of the fund to another fund contingent upon certain conditions e.g. discharge of original objects.

6.26.4 Sources of New Funds

6.26.4.1 All gifts accepted shall be received and held in the name of the Charity and administered in accordance with the Charity's policy, subject to the terms of specific funds. As the Charity can accept gifts only for all or any purposes relating to the NHS, officers shall, in cases of doubt, consult the Chief Finance Officer before accepting any gift. Advice to the Board of Directors on the financial implications of fund raising activities by outside bodies or organisations shall be given by the Chief Finance Officer.

6.26.4.2 All gifts, donations and proceeds of fund-raising activities which are intended for the Charity's use must be handed immediately to the Chief Finance Officer via the Finance Department to be banked directly to the Charitable Funds Bank Account.

6.26.4.3 In respect of donations, the Chief Finance Officer shall:

(a) Provide guidelines to Officers of the Foundation Trust as to how to proceed when offered funds. These will include:
- The identification of the donors intentions;
- Where possible, the avoidance of creating excessive numbers of funds;
- The avoidance of impossible, undesirable or administratively difficult objects;
- Sources of immediate further advice; and
- Treatment of offers for personal gifts.

(b) Provide secure and appropriate receipting arrangements, which will indicate that donations have been accepted directly into the appropriate fund and that the donor's intentions have been noted and accepted.

6.26.4.4 In respect of Legacies and Bequests, the Chief Finance Officer shall be kept informed of and record all enquiries regarding legacies and bequests. Where required, the Chief Finance Officer shall:

(a) Provide advice covering any approach regarding:
- The wording of wills;
- The receipt of funds/other assets from executors.

(b) After the death of a testator, all correspondence concerning a legacy shall be dealt with on behalf of the Charity by the Chief Finance Officer who alone shall be empowered to give an executor a good discharge;

(c) Where necessary, obtain grant of probate, or make application for grant of letters of administration;

(d) Be empowered to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and

(e) Be directly responsible, in conjunction with the Charitable Funds Committee, for the appropriate treatment of all legacies and bequests.

6.26.4.5 In respect of fund-raising, the final approval for major appeals will be given by the Board of Directors. Final approval for smaller appeals will be given by the Charitable Funds Committee. The Chief Finance Officer shall:

(a) Advise on the financial implications of any proposal for fund-raising activities;

(b) Deal with all arrangements for fund-raising by and/or on behalf of the Charity, and ensure compliance with all statutes and regulations;

(c) Be empowered to liaise with other organisations/persons raising funds for the Charity, and provide them with an adequate discharge;

(d) Be responsible for alerting the Charitable Funds Committee and the Board of Directors to any irregularities regarding the use of the Charity's name or its registration numbers; and
(e) Be responsible for the appropriate treatment of all funds received from this source.

6.26.4.6 In respect of Trading Income (see also NHS Charitable Funds Guidance Chapter 6), the Chief Finance Officer shall:
(a) Be primarily responsible, along with designated fund managers, for any trading undertaken by the Charity; and
(b) Be primarily responsible for the appropriate treatment of all funds received from this source.

6.26.4.7 In respect of Investment Income, the Chief Finance Officer shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

6.26.5 Investment Management

6.26.5.1 The Charitable Funds Committee shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the approved investment policy. The issues on which the Chief Finance Officer shall be required to provide advice to the Charitable Funds Committee shall include:
(a) The formulation of investment policy which meets statutory requirements (Trustee Investment Act 1961) with regard to income generation and the enhancement of capital value;
(b) The appointment of advisers, brokers and, where appropriate, investment fund managers and:
- The Chief Finance Officer shall recommend the terms of such appointments, and for which
- Written agreements shall be signed by the Chief Executive

(c) Pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;
(d) The participation by the Charity in common investment funds and the agreement of terms of entry and withdrawal from such funds;
(e) That the use of assets shall be appropriately authorised in writing and charges raised within policy guidelines;
(f) The review of the performance of brokers and fund managers;
(g) The reporting of investment performance.

6.26.5.2 The Chief Finance Officer shall prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for Charitable Funds.

6.26.6 Expenditure from Charitable Funds

6.26.6.1 Expenditure from Charitable Funds shall be managed on a day to day basis by the Financial Accountant and by the Charitable Funds Committee in accordance with delegated limits on behalf of the Corporate Trustee. In so doing, the committee shall be aware of the following:
(a) The objects of various funds and the designated objectives;
(b) The availability of liquid funds within each trust;
(c) The powers of delegation available to commit resources;
(d) The avoidance of the use of exchequer funds to discharge endowment fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;
(e) That funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Foundation Trust; and

(f) The definitions of “charitable purposes” as agreed by the Department of Health with the Charity Commission.

6.26.6.2 Delegated authority to incur expenditure which meets the purpose of the funds is set out in the Scheme of Delegations. Exceptions are as follows:
(a) Any staff salaries/wages costs require Charitable Funds Committee approval;
(b) No funds are to be “overdrawn” except in the exceptional circumstance that Charitable Funds Committee approval is granted.

6.26.7 Banking Services

6.26.7.1 The Chief Finance Officer shall advise the Charitable Funds Committee and, with its approval, shall ensure that appropriate banking services are available in respect of administering the Charitable Funds. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

6.26.7.2 Asset Management

6.26.7.2.1 Assets in the ownership of or used by the Charitable Fund shall be maintained along with the general estate and inventory of assets of the Foundation Trust. The Chief Finance Officer shall ensure:
(a) That appropriate records of all donated assets owned by the Charitable Fund are maintained, and that all assets, at agreed valuations are brought to account;
(b) That appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;
(c) That donated assets received on trust shall be accounted for appropriately;
(d) That all assets acquired from Charitable Funds which are intended to be retained within the funds are appropriately accounted for.

6.26.8 Reporting

6.26.8.1 The Chief Finance Officer shall ensure that regular reports are made to the Charitable Funds Committee and Board of Directors with regard to, inter alia, the receipt of funds, investments and expenditure.

6.26.8.2 The Chief Finance Officer shall prepare annual accounts in the required manner, which shall be submitted to the Board of Directors within agreed timescales.

6.26.8.3 The Chief Finance Officer shall prepare an annual trustees’ report and the required returns to the Charity Commission for adoption by Charitable Funds Committee and subsequently the Board of Directors as Corporate Trustee.

6.26.9 Accounting and Audit

6.26.9.1 The Chief Finance Officer shall maintain all financial records to enable the production of reports as above, and to the satisfaction of internal and external audit.

6.26.9.2 Distribution of investment income to the charitable funds and the recovery of administration costs shall performed on a basis determined by the Chief Finance Officer.

6.26.9.3 The Chief Finance Officer shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He/she will liaise with external audit, and provide them with all necessary information.

6.26.9.4 The Charitable Funds Committee and subsequently the Board of Directors shall be advised by the Chief Finance Officer on the outcome of the annual audit.

6.26.10 Taxation and Excise Duty

6.26.10.1 The Chief Finance Officer shall ensure that the Charity's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

6.27 Tendering, Quotation and Contracting Procedures

6.27.1.1 Duty to comply with Standing Orders and Standing Financial Instructions

6.27.1.1.1 The procedure for making all contracts by or on behalf of the Foundation Trust shall comply with the Trust's Standing Orders and Standing Financial Instructions (except where Suspension of Standing Orders is applied). In particular reference should be made to the Trust Delegated Authorities Table A Section 35 and Table B Section 6 Delegated Financial Limits of this Corporate Governance Manual.

6.27.1.2 EU Directives Governing Public Procurement

6.27.1.2.1 Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions. Details of EU thresholds and the differing procedures to be adopted can be obtained from the Supplies Departments (see paragraph 6.27.1.4.1).

6.27.1.2.2 NHS ProCure22 was launched in 2016 as a standardised approach to the procurement of healthcare facilities. It is based upon long term relationships with selected supply chains that have the ability to work with NHS bodies across the whole life cycle of a capital scheme. For further details see the ProCure22 website at www.procure22.nhs.uk

6.27.1.3 Formal Competitive Tendering

6.27.1.3.1 The Foundation Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

6.27.1.3.2 Where the Foundation Trust elects to invite tenders for the supply of healthcare these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

6.27.1.3.3 Formal tendering procedures are not required where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the limit set in the Scheme of Reservation and Delegation; or
(b) the supply is proposed under special arrangements negotiated by the Department of Health in which event the said special arrangements must be complied with; or
(c) regarding disposals as set out in Standing Financial Instruction 'Disposals and Condemnations'.

6.27.1.4 Fair and Adequate Competition

6.27.1.4.1 No company must be given any advantage over its competitors, which might hinder fair competition between prospective contractors or suppliers. In this context see also the section on awarding contracts in the section below containing Standards of Business Conduct for NHS Staff.

6.27.1.4.2 The Foundation Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

6.27.1.5 Items which subsequently breach thresholds after original approval

6.27.1.5.1 Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Foundation Trust record.

6.27.1.6 Waiving of Formal Tendering / Quotation Procedures

6.27.1.6.1 There is no exemption from formal procedures if the total financial value exceeds the threshold. In this instance, and in accordance with the Public Contract Regulations 2015, tendering/quotation procedures cannot be waived.

6.27.1.6.2 Formal tendering procedures may be waived in the following circumstances:

(a) In very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures;
(b) Where the requirement is covered by an existing contract;
(c) Where national or other framework agreements are in place and have been approved by the Board of Directors;
(d) Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
(e) Where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;
(f) Where specialist expertise is required and is available from only one source;
(g) When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
(h) Where there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
(i) For the provision of legal advice and services providing that any legal firm or partnership commissioned by the Foundation Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Chief Finance Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

6.27.1.6.3 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

6.27.1.6.4 Competitive tendering cannot be waived for building and engineering construction works and maintenance without Departmental of Health approval.

6.27.1.6.5 Where it is decided that competitive tendering or quotation is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded on the Trust's standard Waiver Request Form. The originating department should submit the completed Waiver Request Form for approval in advance of any requisitioning activity to the Chief Finance Officer / Chief Executive.

6.27.1.6.6 All requests to waive tenders should be reported to the Audit Committee on a quarterly basis.

6.27.1.6.7 Exceptionally a single tender action may be permitted. However it should not be used retrospectively i.e. after a contract has been awarded nor should it be used for administrative convenience or to avoid competition. In all cases the reasons should be documented and reported by the Chief Finance Officer to Audit Committee and through to the Board via the Chair's Report.

6.27.1.7 Competitive Tenders and Quotations

6.27.1.7.1 Wherever practicable, at least three competitive tenders or quotations shall be obtained for the supply of goods or services in accordance with the Trust Delegated Financial Limits Table B Section 6.

6.27.1.7.2 In respect of any formal procurement exercises to be undertaken over the £5,000 threshold, the Head of Procurement's advice must be sought prior to commencement of the exercise. The Head of Procurement will lead any procurement exercises which exceed the Find a Tender Service procurement threshold.

6.27.1.8 Contracting / Tendering Procedure

6.27.1.8.1 Invitation to Tender

6.27.1.8.1.1 All invitations to tender on a formal competitive basis shall state the date and time as being the latest time for the receipt of tenders and no tender will be considered for acceptance unless submitted via the Trust's accepted method of receiving completed tender responses. All tenders must be received in this way and no exceptions will be made.

6.27.1.8.1.2 Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

6.27.1.8.1.3 Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

6.27.1.8.1.4 Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Contract conditions as are applicable. Every tenderer must give a written undertaking not to engage in collusive tendering or other restrictive practice.

6.27.1.8.1.5 Selection and award criterion must always be established in advance of tender selection taking place. Subsequent decisions to vary these criteria will be closely scrutinised before final approval is given. Further to Procurement Policy Note 06/20's application to NHS Trusts from April 2022, a minimum weighting of 10% must be given to Social Value in any tender award criteria.

6.27.1.8.1.6 Before the due date of the tender, the electronic tendering portal will issue an automatic notification to the directors responsible for receiving and the releasing of electronic tenders.

6.27.1.8.2 Receipt and safe custody of tenders

6.27.1.8.2.1 Formal competitive tender documents will be received electronically via the Trust's electronic tendering portal.

6.27.1.8.2.2 The Chief Executive or their nominated representative will be responsible for ensuring a secure system is in place for the safe custody of tenders. Electronic tenders received will be kept 'locked' in a secure electronic tender box within the electronic portal until the tender deadline for receipt of completed tender responses.

6.27.1.8.2.3 The electronic tenders will remained sealed until the electronic seal is removed by the Chief Executive's designated receiving officer. The date and time of receipt of each tender will be recorded on the electronic tender portal along with any tenders that have been received after the tender deadline, which will include details of the date and time the late tender(s) was/were received.

6.27.1.8.2.4 The Chief Executive shall designate a Releasing Officer, not from the originating Department, to release the electronic tenders which have had the seal removed by the receiving officer. Appropriate records will be provided by the electronic portal, as below.

6.27.1.8.2.5 Tenders will be held by the electronic tender portal under electronic seal until the closing date and time have been reached.

6.27.1.8.3 Opening tenders and Register of tenders

6.27.1.8.3.1 The rules relating to the opening of tenders should be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

6.27.1.8.3.2 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened (i.e. the electronic seal will be removed) at one time in the presence of the Chief Executive or his/her nominated Executive Director together with one other Executive Director who is not from the originating Department (i.e. the department sponsoring or commissioning the tender).

6.27.1.8.3.3 The involvement of Finance Department staff in the preparation of a tender proposal will not preclude the Chief Finance Officer from serving as one of the two Executives to open and release tenders. All Executive Directors are authorised to open and release tenders and for this purpose the Foundation Trust Secretary will count as a Director for the purposes of opening tenders.

6.27.1.8.3.4 Should a tender be procured directly by an Executive Director, that officer should not be present at the opening or releasing of tenders.

6.27.1.8.3.5 The electronic tender portal will provide an extensive audit trail of the time of the tenders being opened and the time they are released to the evaluation team.

6.27.1.8.3.6 No tender shall be amended after it has been received except to correct bona fide errors endorsed as such by the Chief Executive or his nominated Executive Director. Any corrections shall be recorded.

6.27.1.8.3.7 On completion of the opening and releasing arrangements, all accepted tenders will be made available to the issuing department via the electronic tender portal.

6.27.1.8.3.8 Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e. those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (See 6.27.1.8.4.2 below).

6.27.1.8.4 Admissibility

6.27.1.8.4.1 In considering which tender to accept, the designated Officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Executive.

6.27.1.8.4.2 Tenders received after the due time and date may be considered only if the Chief Executive or nominated Executive Director decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Executive or nominated Executive Director shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted, the late arrival of the tender should be reported to the Board of Directors at its next meeting.

6.27.1.8.4.3 Incomplete tenders i.e. those from which information necessary for the adjudication of the tender is missing and amended tenders i.e. those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt should be dealt with in the same way as late tenders under Section 6.26.11.9.4.2 above.

6.27.1.8.4.4 Where examination of tenders reveals errors that would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their offer.

6.27.1.8.4.5 Necessary discussions with a tenderer of the contents of their tender, in order to elucidate technical points etc, before the award of a contract, need not disqualify the tender.

6.27.1.8.4.6 Formal pre-contract discussions must have the written consent of the Chief Executive and at least two Officers must be present and all details must be confirmed in writing.

6.27.1.8.4.7 If for any reason the designated officers are of the opinion that the tender received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

6.27.1.8.4.8 Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

6.27.1.8.4.9 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or if the process of evaluation and adjudication has not started.

6.27.1.8.4.10 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or their nominated officer.

6.27.1.8.5 Acceptance of formal tenders

6.27.1.8.5.1 Where only one tender is sought and/or received, the Chief Executive and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Foundation Trust, obtaining an independent assessment if required.

6.27.1.8.5.2 A tender other than the lowest (if payment is to be made by the Trust), or other than the highest (if payment is to be received by the Trust) shall not be accepted unless there are good reasons to the contrary. Such reasons shall be set out in a permanent record and be reported to the Board.

6.27.1.8.5.3 A financial appraisal should be undertaken by the Chief Finance Officer of successful tenderers who bid for contracts in excess of £50,000 and for all contractors bidding for financial services.

6.27.1.8.5.4 All tender documentation should be treated as confidential and should be retained for inspection / audit.

6.27.1.8.5.5 Note, unsuccessful bidders will be debriefed by the Head of Procurement involved, as required.

6.27.1.8.5.6 A contract cannot be concluded until the expiry of a period of at least 10 calendar days with effect from the day following the date on which the contract award decision is sent to the tenderers concerned if fax or electronic means are used; or, if other means of communication are used, before the expiry of a period of either at least 15 calendar days with effect from the day following the date on which the contract award decision is sent to the tenderers and candidates concerned.

6.27.1.8.5.7 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender (see also 6.27.1.8.4.6 above).

6.27.1.8.5.8 The lowest tender, if payment is to be made by the Foundation Trust, or the highest, if payment is to be received by the Foundation Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

6.27.1.8.5.9 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

6.27.1.8.5.10 The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

6.27.11.9.5.11 All tenders must be treated as confidential and will be retained within the secure electronic tender portal for inspection.

6.27.11.9.6 Tender reports to the Board of Directors

6.27.11.9.6.1 Reports to the Board of Directors will be made for spend above £500,000 to be approved in line with delegated limits.

6.27.11.9.7.1 **Responsibility for maintaining list**

6.27.11.9.7.1.1A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Foundation Trust is satisfied. All suppliers must be made aware of the Foundation Trust's terms and conditions of contract.

6.27.11.9.7.1.2 **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

6.27.11.9.7.1.3 **Financial Standing and Technical Competence of Contractors**

The Chief Finance Officer may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

6.27.11.9.7.1.4 **Exceptions to using approved contractors**

6.27.11.9.7.1.4.1 If in the opinion of the Chief Executive and the Chief Finance Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example

where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

6.27.11.9.7.1.4.2 An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

6.27.11.10 **Quotations: Competitive and non-competitive**

6.27.11.10.7 **Quotation Procedures**

6.27.11.10.7.1 Quotations must be obtained in writing as specified in the Delegated Financial Limits Table B Section 6 of this Corporate Governance Manual.

6.27.11.10.7.2 Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Foundation Trust.

6.27.11.10.7.3 Quotations should be in writing unless the Chief Finance Officer or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

6.27.11.10.7.4 Wherever practicable, requests for quotations and quotation responses should be provided via the electronic tendering portal. This electronic tendering portal will allow for all quotations to be received electronically and will record the time and date of receipt.

6.27.11.10.7.5 If quotations are to be received outside of the electronic tendering portal they should be opened by the nominated Receiving Officer.

6.27.11.10.7.6 Where only one quotation is received the Foundation Trust shall, as far as practicable, ensure that the price to be paid is fair and reasonable, obtaining an independent assessment if required.

6.27.11.10.7.7 A quotation other than the lowest (if payment is to be made by the Foundation Trust), or other than the highest (if payment is to be received by the Foundation Trust) shall not be accepted unless there are good reasons to the contrary. Such reasons shall be set out in a permanent record and be reported to the Board.

6.27.11.10.7.8 All quotation documentation should be treated as confidential and should be retained either via the electronic tendering portal of in hard copy format for inspection / audit.

6.27.11.10.8 **Non-Competitive Quotations**

6.27.11.10.8.1 Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.(i) and (ii) of this SFI) apply.

6.27.11.10.8.2 **Quotations to be within Financial Limits**

6.27.11.10.8.

2.1 No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Finance Officer.

6.27.11.10.9 Instances where formal competitive tendering or competitive quotation is not required

6.27.11.10.9.1 Where competitive tendering or a competitive quotation is not required the Foundation Trust should adopt one of the following alternatives:

(a) The Foundation Trust shall use the NHS Supply Chain or nominated procurement partner for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate.

(b) If the Foundation Trust does not use the NHS Supply Chain - where tenders or quotations are not required, because expenditure is below the levels defined in the Scheme of Reservation and Delegation, the Foundation Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.

6.27.11.11 Private Finance for capital procurement

6.27.11.11.1 The Foundation Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the independent regulator, NHS England, for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Foundation Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

6.27.11.12 Compliance requirements for all contracts

6.27.11.12.1 The Board may only enter into contracts on behalf of the Foundation Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Foundation Trust's Standing Orders and Standing Financial Instructions;

(b) Public Contracts Regulations 2015and other statutory provisions;

(c) Any relevant directions including the NHS FREM, Estate code and guidance on the Procurement and Management of Consultants;

(d) Such of the NHS Standard Contract Conditions as are applicable.

(e) Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Foundation Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Foundation Trust.

6.27.11.13 Foundation Trust Contracts / Healthcare Services Agreements

6.27.11.13.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the requirements of the law. A contract with a Foundation Trust, being a Public Benefits Corporation, is a legal document and is enforceable in law.

6.27.11.13.2 The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board of Directors (refer to Scheme of Reservation and Delegation).

6.27.11.14 Disposals (See also Section 6.20 Condemnations and Disposals)

6.27.11.14.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;

(b) Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Foundation Trust;

(c) items to be disposed of with an estimated sale value of less than that defined on the Scheme of Delegation, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

6.27.11.15 In-house Services

6.27.11.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Foundation Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

6.27.11.15.2 In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Finance Officer representative.

6.27.11.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

6.27.11.15.4 The evaluation team shall make recommendations to the Board of Directors.

6.27.11.15.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Foundation Trust.

6.27.11.16 Applicability of SFIs on Tendering and Contracting to funds held in trust

6.27.11.16.1 These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Foundation Trust's trust funds and private resources.

6.27.12 Acceptance of Gifts and Hospitality by Staff

6.27.12.1 The Chief Finance Officer shall ensure that all staff are made aware of the Foundation Trust policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the [7]Department of Health Standards of Business Conduct for NHS Staff.

6.27.13 Retention of documents

6.27.13.1 **Context**

6.27.13.1.1 All NHS records are public records under the terms of the Public Records Act 1958 section 3 (1) – (2). The Secretary of State for Health and all NHS organisations have a duty under this Act to make arrangements for the safe keeping and eventual disposal of all types of records. In addition, the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 must be achieved.

6.27.13.1.2 Accountability

6.27.13.1.2.1 The Chief Executive and senior managers are personally accountable for records management within the organisation. Additionally, the organisation is required to take positive ownership of, and responsibility for, the records legacy of predecessor organisations and /or obsolete services. Under the Public Records Act 1958 all NHS employees are responsibility for any records that they create or use in the course of their duties. Thus any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations.

6.27.13.1.2.2 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in the [8]Department of Health guidance, Records Management: NHS Code of Practice.

6.27.13.1.3 **Types of Record Covered by The Code of Practice**

6.27.13.1.3.2 The guidelines apply to NHS records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the media on which they are held:

- Patient health records (electronic or paper based)
- Records of private patients seen on NHS premises;
- Accident and emergency, birth and all other registers;
- Theatre registers and minor operations (and other related) registers;
- Administrative records (including e.g. personnel, estates, financial and accounting records, notes associated with complaint handling);
- X-ray and imaging reports, output and other images;
- Photographs, slides and other images;
- Microform (i.e. fiche / film)
- Audio and video tapes, cassettes, CD-ROM etc.
- Emails;
- Computerised records;
- Scanned records;

[7]Standards of business conduct for NHS staff (HSG(93)5), NHS Management Executive, 1993
[8]Records Management: NHS Code of Practice, Department of Health 2006 & 2009

- Text messages (both outgoing from the NHS and incoming responses from the patient).

6.27.13.1.3.3 The documents held in archives shall be capable of retrieval by authorised persons.

6.27.13.1.3.4 Documents held in accordance with the Records Management Code of Practice shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

6.27.14 Risk Management

6.27.14.1 The Chief Executive shall ensure that the Foundation Trust has a programme of risk management which must be approved Board of Directors and monitored by the Quality committee.

6.27.14.2 The programme of risk management shall include:

(a) A process for identifying and quantifying risks and potential liabilities;
(b) Engendering among all levels of staff a positive attitude towards the control of risk;
(c) Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
(d) Contingency plans to offset the impact of adverse events;
(e) Audit arrangements, including internal audit, clinical audit, health and safety review;
(f) Decisions on which risks shall be insured;
(g) Arrangements to review the risk management programme.

6.27.14.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of internal control within the Annual Report and Accounts, as required by current guidance.

6.27.15 Insurance arrangements

6.27.15.1 The Board shall decide if the Foundation Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

6.27.15.2 Arrangements to be followed by the Board of Directors in agreeing Insurance cover:

(a) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.
(b) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.
(c) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

6.27.15.3 **Standard Areas for Commercial Insurance Cover**

(a) Foundation Trust's may enter commercial arrangements for insuring motor vehicles owned by the Foundation Trust including insuring third party liability arising from their use;

(b) Where the Foundation Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and

(c) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Foundation Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Foundation Trust's powers to enter into commercial insurance arrangements the Finance Director should consult NHS England or the Department of Health as appropriate.

6.27.15.4 Consideration for Other Areas of Insurance Cover

6.27.15.4.1 As a Foundation Trust the Board need to consider the adequacy of insurance cover recognising the Public Benefit Corporation status. Key areas to consider include:

(a) Directors and Officers Liability – Recognising the cover available through the NHSLA, consideration is required to the adequacy of the cover in respect of selling assets, entering into contracts and insolvency indemnity cover

(b) Property Damage – consider the provision for underwriting claims.

(c) Business interruption resulting from property damage-consider the provision to cover for loss of income.

BOARD OF DIRECTORS

TERMS OF REFERENCE

Authority/Constitution

1. The Board is constituted as the principal governing body of the NHS Foundation Trust, operating under the guidance of the Trust's Governance Framework. Its constitution and terms of reference are as detailed below, with the provision for amendments at future Board meetings or as required by changes in legislation, governance guidelines, or the Trust's operational needs.

2. The Board is empowered by the Trust's Constitution and the relevant NHS statutory frameworks to act within its prescribed terms of reference. All employees and members of the Trust are required to comply with directives and requests made by the Board, ensuring full cooperation in the execution of its governance, oversight, and strategic functions.

Purpose

3. The Terms of Reference describe the role and working of the Board of Directors (hereafter referred to as the Board) and are for the guidance of the Board, for the information of the Trust as a whole and serve as the basis of the Terms of Reference for the Board's own Committees.

4. The Trust exists to 'provide goods and services for any purposes related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.'

5. The Trust has a Board which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a Committee of directors or to the Chief Executive. The Board consists of Executive Directors, one of whom is the Chief Executive, and Non-Executive Directors, one of whom is the Trust Chair. The nominated deputy for the Chief Executive and Trust Chair, upon appointment to a substantive or acting up role, must be formally recorded in the minutes.

Duties

6. The Board leads the trust by undertaking four key roles:
    - setting strategy;
    - supervising the work of the executive in the delivery of the strategy and through seeking assurance that systems of control are robust and reliable;

- setting and leading a positive culture for the Board and the organisation;
- giving account and answering to key stakeholders, particularly the Council of Governors.

7. The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public. Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust).

8. The practice and procedure of the meetings of the Board, and of its committees, are not set out here but are described in the Board's Standing Orders.

9. GENERAL RESPONSIBILITIES:

10. The general responsibilities of the Board are:
    - to maintain and improve quality of care;
    - to work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, effective, accessible, and well governed services for patients, service users and carers;
    - to ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity;
    - to ensure relationships are maintained with the Trust's stakeholders, regulators, public, governors, staff and patients, such that the trust can discharge its wider duties;
    - to exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner;
    - to ensure compliance with all applicable law, regulation and statutory guidance.

11. In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of non-executive and executive directors.

12. LEADERSHIP

13. The Board provides active leadership to the organisation by:
    - ensuring there is a clear vision and strategy for the Trust that is well known and understood by stakeholders and is being implemented within a framework of prudent and effective controls which enable risk to be assessed and managed;
    - ensuring the Trust is a good employer by the development of a workforce strategy and its appropriate implementation and operation;
    - implementing effective Board and Committee structures and clear lines of reporting and accountability throughout the organisation.

14. STRATEGY

15. The Board:
    - sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
    - determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;

- monitors and reviews management performance to ensure the Trust's objectives are met;
- oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- develops and maintains an annual business plan, with due regard to the views of the council of governors, and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders;
- ensures that national policies and strategies are effectively addressed and implemented within the Trust.

16. CULTURE, ETHICS AND INTEGRITY

17. The Board:
    - is responsible for setting values, ensuring they are widely communicated and adhered to and that the behaviour of the Board is entirely consistent with those values;
    - promotes a patient-centred culture of openness, transparency and candour;
    - ensures that high standards of corporate governance and personal integrity are maintained in the conduct of foundation trust business.

18. GOVERNANCE

19. The Board:
    - ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance and appropriate codes of conduct, accountability and openness applicable to NHS provider organisations;
    - ensures that all licence conditions relating to the Trust's governance arrangements are complied with;
    - ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
    - ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective and safe services taking account of patient and carer experiences and maintaining the dignity of those cared for;
    - ensures that all the required returns and disclosures are made to the regulators;
    - formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation trust business;
    - agrees the schedule of matters reserved for decision by the Board of Directors;
    - ensures that the statutory duties of the Trust are effectively discharged;
    - Acts as corporate trustee for the Trust's charitable funds.

20. RISK

21. The Board:
    - ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;

- ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement in the development of care plans, the review of quality of services provided and the development of new services;
- ensures there are appropriately constituted appointment and evaluation arrangements for senior positions such as consultant medical staff and those reporting to executive directors.

22. COMMUNICATION

23. The Board:
    - Ensures an effective communication channel exists between the Trust, its governors, members, staff and the local community.
    - Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback.
    - Ensures that those Board proceedings and outcomes that are not confidential are communicated publicly through Board meetings in public and also via the Trust's website.

24. FINANCIAL AND QUALITY SUCCESS

25. The Board:
    - Ensures that an effective system of finance and quality is embedded within the Trust.
    - Ensures that the Trust operates effectively, efficiently and economically.
    - Ensures the continuing financial viability of the organisation.
    - Ensures the proper management of resources and that financial and quality of service responsibilities are achieved.
    - Ensures that the Trust achieves the quality targets and requirements of stakeholders within the available resources.
    - Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

26. RESPONSIBILITIES OF BOARD MEMBERS

27. All Members of the Board:
    - Have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not impact upon the particular responsibilities of the Chief Executive as the Accounting Officer.
    - Have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

28. Role of the Trust Chair:

29. The Trust Chair is the guardian of the Board's decision-making processes and provides general leadership of the Board and the Council of Governors.
    - Responsible for leading the Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.
    - Reports to the Board and is responsible for the effective operation of the Board and the Council of Governors.

- Responsible for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives.

30. Role of the Chief Executive

- The Chief Executive reports to the Trust Chair and to the Board directly. All members of the management structure report either directly or indirectly to the Chief Executive.
- The Chief Executive is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.
- The Chief Executive is responsible for implementing the decisions of the Board and its Committees, providing information and support to the Board and Council of Governors.

31. Role of Executive Directors (EDs)

- Share collective responsibility with the Non-Executive Directors as part of a unified Board.
- Shape and deliver the strategy and operational performance in line with the Trust's strategic aims.

32. Role of Non-Executive Directors (NEDs)

- Bring a range of varied perspectives and experiences to strategy development and decision making.
- Ensure that effective management arrangements and an effective management team are in place.
- Hold the Executive Directors to account for performance of the operational responsibilities.
- Scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. NEDs should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.
- To take an active role in providing advice, support and encouragement to Executive Directors.

33. Role of the Senior Independent Director (SID)

- Is a Non-Executive Director appointed by the Board in consultation with the Council of Governors to undertake the role. Normally the SID will not be the Vice Trust Chair although this may be the case if the Board deems it necessary.
- Will be available to members of the Foundation Trust and to Governors if they have concerns which, contact through the usual channels of the Trust Chair, Chief Executive, Deputy Chief Executive, Director of Finance and Trust Secretary, has failed to resolve or where it would be inappropriate to use such channels.
- Has a key role in supporting the Trust Chair in leading the Board and acting as a sounding board and source of advice for the Trust Chair. The SID has a role in supporting the Trust Chair in his/her role as Trust Chair of the Council of Governors.

34. In addition to the duties described here, the SID has the same duties as the other Non-Executive Directors.

35. Role of the Trust Secretary

The Trust Board shall be supported by the Trust Secretary whose duties in this respect will include:

- agreement of the agenda, for Board and Board committee meetings, with the relevant Chair, in consultation with the Chief Executive;
- collation of reports and papers for Board and committee meetings;
- ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward;
- ensuring that board procedures are complied with;
- supporting the Chair in ensuring good information flows within and between the Board, its committees, the Council of Governors and senior management;
- advising the Board and Board committees on governance matters;
- supporting the chair on matters relating to induction, development and training for directors

Membership

36. The composition of the Board shall be:

- A Non-Executive Chair
- Not more than seven other non-executive Directors
- Not more than seven executive Directors including:
    - The Chief Executive (who is the Accounting Officer)
    - Chief Finance Officer
    - A registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984)
    - A registered nurse or registered midwife.

37. Six Directors including not less than three executive Directors (one of whom must be the Chief Executive or another Executive Director nominated by the Chief Executive) and not less than three non-executive Directors (one of whom must be the Chair or the Vice Chair of the Board of Directors) shall form a quorum.

38. An officer in attendance for an executive Director but without formal acting up status may not count towards the quorum.

39. If a Director has been disqualified from participating in a discussion on any matter and/or from voting on any resolution by reason of declaration of a conflict of interest, that Director shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minute of the meeting. The meeting must then proceed to the next business.

40. Voting

41. All questions put to the vote shall, at the discretion of the Chair, be decided by a show of hands save that no resolution of the Board of Directors shall be passed if it is opposed by all of the non-executive Directors present or by all of the executive Directors present. A paper ballot may be used if a majority of the Directors present so request.

42. In case of an equality of votes the Chair shall have a second and casting vote.

43. If at least one third of the Board members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot). If a Board member so requests, her vote shall be recorded by name.

44. In no circumstances may an absent Director vote by proxy. Subject to Standing Order 59, absence is defined as being absent at the time of the vote.

45. An officer who has been appointed formally by the Board to act up for an executive Director during a period of incapacity or temporarily to fill an executive Director vacancy, shall be entitled to exercise the voting rights of the executive Director. An officer attending the Board to represent an executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive Director. An officer's status when attending the meeting shall be recorded in the minutes.

46. Where an executive Director post is shared by more than one person:
    - Each person shall be entitled to attend meetings of the Board
    - Each of those persons shall be eligible to vote in the case of agreement between them
    - In the case of disagreement between them no vote should be case
    - The presence of those persons shall count as one person.

Requirements of Membership

47. The Board of Directors may agree that Directors can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

48. Directors who are unable to attend a meeting shall notify the Secretary in writing in advance of the meeting in question so that their apologies may be submitted.

Equality Diversity & Inclusion

49. 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

50. 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

51. The minutes of all meetings of the Board of Directors shall be formally recorded and submitted to the following meeting for approval.

52. The Council of Governors is responsible for holding the Board to account, for example by attending Board meetings in public and meeting with the Trust Chair, Chief Executive and Committee Chairs on the day of Board meetings / Council of Governors' meeting. The agenda and minutes of Board meetings will be shared with the Council of Governors.

53. The Trust Chair will be responsible for ensuring the Board of Directors adheres to its Terms of Reference and Annual Work Plan. The Board shall self-assess its performance following each board meeting.

Administration of Meetings

54. Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Secretary will publish the dates, times and locations of meetings of the Board in advance.

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

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

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

Review

58. The Terms of Reference of the Board of Directors shall be reviewed and submitted for approval at least annually.

Version Control Schedule

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

QUALITY COMMITTEE

TERMS OF REFERENCE

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 are being undertaken; 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

*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, diversity & inclusion 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 for assurance. 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 Audit 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	Date ratified by Board of

			Audit Committee	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

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, diversity and inclusion 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

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, diversity and inclusion 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 four 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		

AUDIT COMMITTEE

TERMS OF REFERENCE

Authority/Constitution

1. The Committee is established by the Board of Directors and will be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

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 Audit Committee serves a crucial oversight role, primarily focused on enhancing the Trust's governance, risk management, and internal control frameworks. Its core purpose includes overseeing the integrity of financial statements, ensuring the effectiveness of the internal audit function, monitoring compliance with legal and regulatory requirements, and assessing the independence and performance of external auditors. By scrutinizing financial reporting processes, internal controls, and the management of financial and operational risks, the Audit Committee helps to ensure that the Trust operates in a transparent, efficient, and accountable manner, thereby contributing to the Trust's overall integrity and public confidence in its operations.

Duties

5. The Committee is responsible for:

6. **Governance, risk management and internal control**

7. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievements of the Trust's objectives. It will provide an independent and objective view on internal control and probity. In addition, the committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance, reviewing significant financial reports and the judgements contained in them.

8. In particular, the Committee will review the adequacy of:
    - All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance to external bodies), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
    - The process of preparing the Trust's returns to NHS England (which returns are approved by the Board's Finance and Performance Committee)
    - The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
    - The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
    - The Trust's standing orders, standing financial instructions and scheme of delegation
    - The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State directions and as required by the NHS Counter Fraud Authority
    - The arrangements by which Trust staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In so doing the Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

9. In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

10. The Committee will undertake an annual training needs assessment for its own members.

11. Internal audit

12. The Committee will ensure that there is an effective internal audit function established by management that meets mandatory government and Public Sector Internal Auditing Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:
    - Consideration of the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal
    - Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
    - Reviewing the internal audit programme, considering the major findings of internal audit investigations (and management's response), and ensuring coordination between internal and external auditors

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- Annual review of the effectiveness of internal audit.

13. External audit

14. The Committee shall review the independence, objectivity and work of the external auditor appointed by the Council of Governors and consider the implications and management's response to this work. This will be achieved by:
    - Consideration of the appointment and performance of the external auditor, including making recommendations to the Council of Governors regarding the former
    - Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure coordination with internal auditors and with other external auditors
    - Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
    - Reviewing all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any audit work performed outside the annual audit plan, together with the appropriateness of management's response
    - Recommending to the Council of Governors the engagement of the external auditor in respect of non-audit work, taking into account relevant ethical guidance regarding the provision of such services
    - Annual review of the effectiveness of external audit.

15. Other assurance functions

16. The Committee will review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. These will include, but will not be limited to, reviews and reports by the Department of Health, arms length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Resolution, etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc) or the Local Anti-Fraud Specialist.

17. In addition the Committee will review the work of other Committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality Committee, Finance, Performance & Business Development Committee and Putting People First Committee, and include a review of an annual report of each of the Committees against their terms of reference. In reviewing the work of the Quality Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

18. The Committee will also review all suspensions of standing orders and variation or amendment to standing orders.

19. The Audit Committee will report to the Board and to the Council of Governors any matters in respect of which it considers action or improvement is needed.

20. Counter fraud

21. The Audit Committee will satisfy itself that the Trust has adequate arrangements in place for countering fraud and will approve the appointment of the Local Anti-Fraud Specialist. The Committee will review the outcomes of counter fraud work.

22. Management

23. The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

24. The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

25. Financial reporting

26. The Audit Committee shall monitor the integrity of the Annual financial statements of the Trust.

27. The Audit Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

28. The Audit Committee will review the Trust's annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies and practices
- Unadjusted mis-statements in the financial statements
- Major judgemental areas, and
- Significant adjustments resulting from the audit
- Letter of representation
- Qualitative aspects of financial reporting.

Membership

29. The Committee membership will be appointed by the Board of Directors from amongst its Non-Executive members and will consist of not less than three members.

30. 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.

31. 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.

32. Voting

33. 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

34. Members

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

36. Officers

37. The Chief Finance Officer, Deputy Chief Finance Officer, Financial Controller and Deputy Chief Nurse & Midwife shall normally attend meetings. At least once a year the Committee will meet privately with external and internal auditors.

38. The Chief Executive and other executive directors will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are within the responsibility of that director.

39. The Chief Executive will also be required to attend when the Audit Committee discusses the process for assurance that supports the Annual Governance Statement.

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

Equality Diversity & Inclusion

41. In conducting its business, members must demonstrably consider the equality, diversity and inclusion 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

42. 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

43. The Audit Committee will be accountable to the Board of Directors.

44. 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.

45. The Committee will report to the Board annually on its work and performance in the preceding year and, as part of this report, will provide commentary in support of the Annual Governance Statement (AGS), specifically dealing with the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts. In providing this commentary in support of the AGS the Committee will seek relevant assurance from the Chair of the Board's Quality Committee.

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

Administration of Meetings

47. Meetings shall be held at least four times per year.

48. The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

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

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

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

Review

52. The Terms of Reference of the Audit 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

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	Date ratified by Board of

			Audit Committee	Directors (thereby come into force)
March 2024	1	Development of the Terms of Reference – alignment with updated template		

NOMINATION & REMUNERATION COMMITTEE

TERMS OF REFERENCE

Authority/Constitution

1. The Committee is established by the Board of Directors and will be known as the Nomination and Remuneration Committee (the Committee).

2. The Committee is authorised by the Board to investigate any activity within its Terms of Reference.

3. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

Purpose

4. The Nomination & Remuneration Committee's primary responsibilities include overseeing the processes for recruiting and appointing senior leadership positions within the Trust, ensuring there is a transparent and merit-based selection process. Additionally, the committee is tasked with developing and reviewing policies related to the remuneration, incentives, and terms of service for the executive directors and senior management, ensuring these are fair, competitive, and capable of attracting and retaining the high-calibre talent necessary for the Trust's success.

Duties

5. The Committee is responsible for:

    a. Overseeing the recruitment and selection process for the posts of Chief Executive[9] and Executive Directors

    b. Preparing a description of the role and capabilities required for the Chief Executive and Executive Director posts to reflect the balance of skills, knowledge and experience required

    c. Succession planning Executive appointments taking into account the challenges and opportunities facing the Trust and the skills and expertise required on the Board

    d. Reviewing the structure, size and composition of the Executive Director composition of the Board of Directors

[9] Note that Chief Executive appointments are subject to approval by the Council of Governors

e. Reviewing Executive Directors' performance.

f. Determining the remuneration and terms of service of the Chief Executive and the Executive Management Team

g. Determining the annual cost of living award for senior managers (excluding those paid under Agenda for Change arrangements)

h. Succession planning for Executive Director appointments

i. Overseeing agreement of appropriate contractual arrangements relating to the Chief Executive and Executive Management Team

j. Scrutinising any termination payments relating to the Chief Executive or the Executive Management Team, ensuring that they have been properly calculated and take account of any relevant guidance

k. To be responsible for any disciplinary issue relating to the Chief Executive or member of the Executive Management Team which may result in their dismissal. The Committee will not be responsible for any disciplinary issue which is short of dismissal

l. Such other duties as the Board of Directors may delegate.

Membership

6. The Committee membership will be appointed by the Board of Directors and will consist of:
    - Trust Chair
    - All Non-Executive Directors

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 Chair of the Board of Directors will be the Chair of the Committee. The Vice Chair of the Board will be the Vice Chair of the Committee from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent.

9. A quorum shall be three members including the Chair or Vice Chair and at least two Non-Executive Directors.

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 Chief Executive and Chief People Officer (or equivalent executive lead for the Trust with responsibility for the human resources functions of the Trust) will be in attendance at its meetings, as and when appropriate and necessary.

16. The Trust Secretary will act as Secretary to the Committee.

Equality Diversity & Inclusion

17. 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

18. 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

19. The Nomination and Remuneration Committee will be accountable to the Board of Directors.

20. The minutes of the Nomination & Remuneration Committee will be formally recorded and submitted to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it or require executive action

21. Summary minutes will also be circulated to members of the Audit Committee.

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

23. Trust standing orders and standing financial instructions apply to the operation of the Remuneration and Nomination Committee.

Administration of Meetings

24. Meetings shall be held at least once per year or as required to fill Executive Director vacancies. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.

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

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

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

Review

28. The Terms of Reference of the 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 Nomination & Remuneration Committee	Date ratified by Board of Directors (thereby come into force)
March 2024	1	Development of the Terms of Reference – alignment with updated template		

Appendix E - Procedure for amending the Corporate Governance Manual

Procedure for Reviewing and Updating

1. Background

1.1 This manual sets out how the Trust operates and regulates itself. This is of vital importance in the public sector where the use of public funds and the performance and conduct of the organisation is under constant scrutiny.

2 Annual Review

2.1 The manual will be reviewed annually. It will be reviewed by the Trust Audit Committee in July. Thereafter it will be presented to the Board of Directors for formal approval and adoption at the next available meeting.

2.2 All changes[10] to the manual will be reviewed by the Audit Committee. These changes will be clearly highlighted in the updated Manual which is presented for subsequent adoption to the Board of Directors.

2.3 Following adoption, the Chief Executive and the Trust Secretary are responsible for ensuring that all directors, governors and trust staff are made aware of the manual and their responsibilities in respect of it. An up-to-date version of the manual will at all times be available on the Trust's intranet and website.

2.4 Where there are proposed changes to the manual that require initial review and approval by the Council of Governors, this will be done prior to consideration by the Audit Committee and the Board of Directors.

2.5 Care should be taken to ensure that all changes are consistent with the Trust's Constitution. Any proposed changes to the Constitution must first be approved by the Trust's members and NHS England as per paragraph 23 of the Constitution.

2.6 Changes to Standing Financial Instructions, Scheme of Delegation of Board powers and associated section or which have financial implications or impact must always be routed through the Trust's Finance Department, where the Deputy Chief Finance Officer will ensure all financial aspects of the change are given due consideration and approval. These changes must be subsequently approved by the Finance, Performance and Business Development Committee ahead of consideration by the Audit Committee and Board of Directors.

2.7 The Trust Secretary will co-ordinate the submission of Corporate Governance Manual changes for approval to the Audit Committee, the Board of Directors and the Council of Governors as required.

3 Periodic Updating

3.1 The manual will be reviewed annually, when necessary, changes will be made. However, it is recognised that changes may need to be made in-year to reflect legislative, constitutional, operational, or other requirements i.e., periodic updating.

3.2 In such circumstances the same procedures must be followed, in due order, as specified above in respect of the annual review.

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[10] With the exception of minor changes such as an organisational name change which will be reported for noting to the next available Audit Committee

Appendix F – Corporate Governance Manual Change Schedule

Version control			
Version	**Section**	**Changes made**	**Date**
13.0	Foreword	The foreword has been expanded to provide additional context and outline of each of the respective sections of the document.	April 2024
13.0	Version Control	Moved from the front of the document to be an appendix	April 2024
13.0	Schedule of matters reserved to the Board of Directors	Moved to be an appendix. No changes have been made to the content.	April 2024
13.0	Corporate Governance (section 3)	This section has been strengthened by adding in context regarding the Trust's regulatory framework (taken from the Governance and Performance Framework). Additional narrative on the Corporate Governance functions added. Brief description of the Board's Committees added. Outline of the updated operational management processes added. Description of the Trust's internal and external control environment added	April 2024
13.0	Scheme of Delegation (including the NHS Foundation Trust Accounting Officer Memorandum)	Moved to be an appendix. No changes have been made to the content.	April 2024
13.0	Standing Financial Instructions	Moved to be an appendix. No changes have been made to the content.	April 2024
13.0	Code of Conduct for the Board of Directors Code of Conduct for the Council of Governors – found in the	These have been collated into a single section (4) and the public sector equality duties have been added.	April 2024

	Trust Constitution **Code of Conduct for NHS Managers** **Standards of Business Conduct for NHS Staff** **Standing Orders for the Council of Governors**		
13.0	**Section 5**	**New section added from the Governance and Performance Framework called 'How we conduct Trust Business'. This is to provide staff with advice, guidance and templates for the effective management of meetings. This will support a consistent approach across the Trust.**	**April 2024**
13.0	**Appendix G**	**Meeting templates added to the document.**	**April 2024**
11.0	**Throughout**	**Updates post exit from the EU reflected throughout the document**	**July 2022**
11.0	**4.0**	**Approved committee membership and terms of reference added.**	**July 2022**
11.0	**6.27.11.10.9**	**Instances where formal competitive tendering or competitive quotation is not required updated**	**July 2022**
10.0	**Throughout**	**Public Contracts Regulations 2015 to the procurement of services and supplies threshold changed to £122,976 rather than £189,330.**	**August 2021**
10.0	**Throughout**	**Removal of references to 'OJEU'**	**August 2021**
10.0	**5.0, Table A**	**TABLE A – Delegated Authority** • **Removal of Head of Estates – replaced where appropriate with Director of Estates** • **19c – removal of references to outdated legislation** • **35a – inclusion of the ability of Executives to nominate a Deputy to enter the Trust into contracts.** • **35c – addition of Divisional Managers as having operational responsibility to nominate officers to oversee and manage contracts on behalf of the Trust**	**July 2021**

		• **35h – removed – duplication with 35g**	
10.0	**Throughout**	**References to 'CONCODE' removed throughout the document.**	**July 2021**
10.0	**4.1**	**Updated Committee Structures**	**July 2021**
10.0	**3.3.4**	**References to Nominations Committee (Executive Directors) and the Remuneration and Terms of Service Committee and replaced by Nomination & Remuneration Committee**	**July 2021**
10.0	**Throughout**	**Alignment with new Corporate branding**	**July 2021**
10.0	**Throughout**	**Change of job titles:** • **Director of Finance changed to Chief Finance Officer** • **Director of Nursing & Midwifery to Chief Nurse & Midwife**	**July 2021**
10.0	**4.0**	**Approved committee membership, Committee Structure and terms of reference added.**	**July 2021**
9.0	**6.15.1.3**	**Reference to Nomination & Remuneration Committee updated to align with updated Nomination & Remuneration Committee Terms of Reference.**	**September 2020**
9.0	**8.0**	**Board Code of Conduct Updated**	**September 2020**
8.0	**6.0 (6.27.1.6.6)**	**Reasons for a single tender action to be reported to the Audit Committee and through the Board of Directors in the Chair's Report.**	
8.0	**6.0 (6.27.1.6.6)**	**All requests to waive tenders to the Audit Committee quarterly and not directly to the Board of Directors**	**July 2020**
8.0	**5.0, Table B**	**OJEU threshold updated from £181,302 to &189,330**	**July 2020**
8.0	**5.0, Table B (4)**	**Provision 'Requisitioning stock and non-stock items / services against a budget, in line with EU procurements thresholds (subject to periodic review) and quotation and tendering procedures set out under Section 6' amended to 'Approving requisitions, authorising invoices and recommending contract awards'.**	**July 2020**
8.0	**5.0, Table A (35, h)**	**Removal of the provision - 'Decide if late tenders should be considered'.**	**July 2020**
8.0	**5.0, Table A (35, a)**	**Provision added – 'Entering into contracts on behalf of the Trust, regardless of value'**	**July 2020**
8.0	**5.0, Table A (35, b)**	**Removal of Head of Estates from Operational Responsibility**	**July 2020**
8.0	**5.0, Table A (30, e)**	**Insertion of '…in line with national requirements' following the 'prompt payment of accounts' section**	**July 2020**

8.0	**5.0, Table A (34, w)**	**Authority to authorise overtime – limited to Clinical Directors and Chief Operating Officer. To encourage preferred option of utilising the Bank rather than overtime.**	**July 2020**
8.0	**5.0, Table A (34, nn)**	**Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances – provision removed.**	**July 2020**
8.0	**5.0, Table A (34, x)**	**Reference 'authorised approvers' in place of budget holders.**	**July 2020**
8.0	**5.0, Table A (34, k)**	**Addition of '…at recruitment stage' to the provision of the granting of additional increments.**	**July 2020**
8.0	**5.0, Table A (34, q)**	**Remove section on 'Authorise car users' – Trust no longer has a car lease scheme.**	**July 2020**
8.0	**5.0, Table A (34, p)**	**Renewal of fixed term contract – role of Vacancy Control Panel stated.**	**July 2020**
8.0	**5.0, Table A (17, l)**	**Reference to 'All corporate posts to be reviewed by the Vacancy Control Panel and all clinical posts by the Executive team' added to operational responsibility.**	**July 2020**
8.0	**5.0, Table A (33, c)**	**Operational responsibility for Informing staff of their duties in respect of patients' property noted as being Head of Governance and Quality rather than Head of Legal Services.**	**July 2020**
8.0	**5.0, Table A (34, i)**	**Removal of line managers from being authorised to book agency staff. In relation to Nursing and Midwifery agency staff, line managers to be replaced with Heads of Nursing / Midwifery.**	**July 2020**
8.0	**5.0, Table A (34, i)**	**Deputy Chief Nurse and Midwife or Matron listed as having operational responsibility for approving bank usage.**	**July 2020**
8.0	**5.0, Table A (17, i)**	**Responsibility to Identify and implement cost improvements and income generation activities in line with the Operational Plan identified as being all budget holders.**	**July 2020**
8.0	**5.0, Table A (throughout)**	**References to 'business plan' removed from budget section and replaced with operational plan.**	**July 2020**
8.0	**5.0, Table A (17, b)**	**Operational responsibility for budget submissions to the Board identified as Deputy Chief Finance Officer (from Chief Finance Officer)**	**July 2020**
8.0	**5.0, Table A (throughout)**	**Removal of reference to Corporate Administration Manager**	**July 2020**
8.0	**5.0, Table A**	**Caldicott Guardian changed from Chief Nurse and Midwife to Medical Director**	**July 2020**

8.0	**5.0, Table A (throughout)**	**Removal of references to Hewitt Centre Managing Director**	**July 2020**
8.0	**Throughout**	**Change of job titles:** • **Director of Operations changed to Chief Operating Officer** • **Director of Workforce & Marketing to Chief People Officer**	**July 2020**
8.0	**4.2**	**Trust Board Terms of Reference added**	**July 2020**
8.0	**4.0**	**Approved committee membership, Committee Structure and terms of reference added.**	**July 2020**
7.0	**4.0**	**Approved committee membership, Committee Structure and terms of reference added.**	**July 2019**
7.0	**5.0, Table A**	**Section 13 - Conflicts of interest definition of decision-making staff in compliance of the Trust's policy 'Managing conflicts of Interest'**	**July 2019**
7.0	**5.0, Table A**	**Section 22 – Gifts and Hospitality- Threshold increased in line with the Trust Policy 'Managing conflict of Interest' from £25 to £50.**	**July 2019**
6.0	**4.0**	**Approved committee membership and terms of reference added.**	**05.07.18**
5.2	**5.0** **Table B**	**OJEU threshold has changed and been updated. Threshold value amended from £164,176 (ex VAT) to £181,302 (ex VAT).**	**09.01.2018**
5.1	**4.0**	**Change of name of Governance and Clinical Assurance Committee to the Quality Committee** **Amended Terms of Reference of the Quality Committee and Remuneration and Nominations Committee** **Amended Integrated Structure Charts**	**08.01.2018**
4.1	**4.0**	**Board approved Terms of reference added**	**07.07.17**
	Table B – Delegated Financial Limits	**Threshold value amended from £172,514 ex VAT when in fact it should be £164,176 ex VAT.**	**15.06.17**
4.0	**4.0**	**Board approved Terms of reference added**	**30.01.17**
	5.0	**Table B – Delegated Financial Limits**	**30.01.17**
	6.0	**Amendments to Standing Financial Instructions.**	**30.01.17**
	All	**Changes to names throughout the document, i.e. Trust regulator name, job titles of directors, heads of departments.** **Full reformat required to provide consistency.**	**30.01.17**
3.0	**4.0 Terms of reference**	**Board approved Terms of reference added**	**27.07.15**

	Table A	**Amended job titles of Directors.** **Amended waiving requirements to include delegated authority to authorise the use of a waiver.** **Amended thresholds to reflect the revised EU threshold.**	**27.07.15**
	6.0	**Prudential Borrowing Code removed as is no longer a requirement** **The approval limits for Charitable Expenditure updated.**	**27.07.15**
2.0	**4.0 Terms of reference**	**Board approved Terms of reference added**	**03.10.14**
1.1	**6.12.3** **6.13.3.2** **Table A** **Table B**	**Minor amendments approved by Board of Directors in April 2014.**	**05.04.14**

Appendix G – Meeting Templates

NHS
Liverpool Women's
NHS Foundation Trust

Name of Meeting

x Month Year, xx.xxa/pm
Location

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

Liverpool Women's
NHS Foundation Trust

Name of Meeting

Location	
Date	
Time	

AGENDA					
Item no. 23/24/	**Title of item**	**Objectives / desired outcome**	**Process**	**Item presenter**	**Time**
PRELIMINARY BUSINESS					
	Introduction, Apologies & Declaration of Interest		Verbal	Chair	xx:xx (xx mins)
	Minutes of (title of meeting) held on (date of minutes)		Written	Chair	
	Action Log and matters arising		Written	Chair	
	Chair's announcements		Verbal	Chair	
Headings to be used as appropriate.					
CONCLUDING BUSINESS					
	Review of risk impacts of items discussed and key messages		Verbal	Chair	
	Chair's Log		Verbal	Chair	
	Any other business & Review of meeting		Verbal	Chair	
Finish Time: xx					

Date of Next Meeting:

Liverpool Women's
NHS Foundation Trust

Name of Meeting

Action Notes of the [Meeting]
held [location] at [time] on [date]

PRESENT
Name of Core Member Job Title

IN ATTENDANCE
Name of attendee Job Title

APOLOGIES:
Name Job Title

Core members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Present (✓) **Apologies (A)** **Representative (R)** **Non attendance (NA)**												

23/24/	Summary of item	Action(s)	Assigned to	Timeframe
Item number	*Only one or two sentences*			

Liverpool Women's
NHS Foundation Trust

Name of Meeting

Minutes of the [Meeting]
held [location] at [time] on [date]

PRESENT
Name of Core Member Job Title

IN ATTENDANCE
Name of attendee Job Title

APOLOGIES:
Name Job Title

Core members only	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Present (✓) **Apologies (A)** **Representative (R)** **Non attendance (NA)**												

23/24/	
Item number	**Title** Body of the minute **Action:** *Note action, owner and timeframe* **Resolved:** *The Committee/ Sub-Committee/Group agreed/recommended/noted etc. If more than one resolution, utilise bullet points.*

Liverpool Women's
NHS Foundation Trust

Action Log

Name of Meeting
Date of Meeting

Key	Complete	On track	Risks identified but on track	Off Track

Meeting Date	Agenda Item	Action Point	Owner	Action Deadline	RAG Open/Closed	Comments / Update

Name of Meeting 2024/25 - Cycle of Business

Item	Frequency	Action	Item Purpose	Outline Areas to be considered within the report	Lead	Report Authors/ (Personal Assistant)	Trust Board	Transferred from EAG	April	May	June	July	August	September	October	November	December	January	February	March
STANDARD AGENDA ITEMS																				
Introduction, Apologies and Declaration of Interest	Monthly	For Noting	N/A	N/A				N/A												
Minutes of the previous meeting	Monthly	For Approval	N/A	N/A				N/A												
Action Tracker and matters arising	Monthly	For Noting		N/A				N/A												
ITEMS FOR CONSIDERATION																				
	Monthly	For Assurance	Assurance on key matters discussed at reporting groups, providing a mechanism by which to escalate any concerns.	•Agenda Items Covered •Matters for Escalation •Key Issues •Decisions Made •Recommendations				N/A												
CONCLUDING BUSINESS																				
Key Decisions (within the site limit)	Monthly	For noting	To note any key decisions made during the meeting	N/A	Chair	N/A					P									
Items for escalation to ARC	Monthly	For Assurance	To ensure strong vertical lines of reporting between all levels of the governance structure.	N/A				N/A												
Any Other Business	Monthly	For Noting	To note any other business the HMB members may wish to raise	N/A				N/A												

Liverpool Women's
NHS Foundation Trust

NAME OF MEETING

TERMS OF REFERENCE

Authority

1. The xxx is established as a xxx reporting to the xxx. Its terms of reference shall be as set out below, subject to amendment at future xxx meetings.

2. The xxx is authorised by the xxx to act within its terms of reference. All members of staff are directed to cooperate with any request made by the xxx.

3. The xxx is authorised by the xxx to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions. This should be undertaken in line with the Trust's Scheme of Delegation and Standing Financial Instructions.

4. The xxx is authorised to obtain such internal information as is necessary and beneficial to the fulfilment of its functions.

Purpose

5. Define the purpose of the meeting (two or three paragraphs max)

Duties

6. In order to fulfil its role and obtain the necessary assurance, the xxx will provide the following assurances to the xxx:

    - List the key areas of focus

Membership

9. The xxx shall be composed of the following members:

    - List the core members – maximum should be 10

Other members will be co-opted onto the group to provide updates

- List other regular attendees but not core members of the meeting

10. The xxx will be deemed quorate when at least xxx of the core members (including the Chair or Deputy Chair) and xxx are in attendance.

Requirements of Membership

11. Members of the xxx must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Any meetings members are unable to attend must be covered by a nominated representative. Attendance at the xxx will be recorded and monitored.

Equality Diversity & Inclusion

12. 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

13. 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

13. The minutes of all meetings of the xxx shall be formally recorded and submitted to the following meeting for approval.

14. Outline reporting arrangements

15. The xxx will report annually to the xxxx in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its performance according to a standardised framework and process.

16. The following xxx shall report to the xxx:
    - List any reporting groups

The above groups will report as per the xxx's cycle of business, and also at times when requested by the xxx.

Administration of Meetings

17. Meetings shall be held monthly with additional meetings held on an exceptional basis at the request of the Chair or any three members of the xxx.

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

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

20. Minutes and actions will be circulated to Group members as soon as is reasonably practicable.

Review

21. The Terms of Reference of the xxx shall be reviewed by the Group and submitted to the xxx for review and approval at least annually.

Version Control Schedule

Date	Version no	Main changes proposed	Date approved by ERAG	Date ratified by Executive Team (thereby come into force)
March 2024	1	New Terms of Reference		N/A

Liverpool Women's NHS Foundation Trust

Name of Meeting

COVER SHEET

Meeting Date	Click or tap to enter a date.	**Item Reference**	
Report Title			
Author	[First Name-Surname, Job Title]		
Responsible Director	[First Name-Surname, Job Title]		

Purpose of Report	*[Brief summary of why the report is being presented to the meeting]*
Executive Summary	Key Issues, Recommendations and Areas of Concern *[2/3 headline issues to be highlighted for the Committee's attention and presented at the meeting. (Include concerns/implications for care/staff/finance and operational performance)]*
Key Areas of Concern	*[Brief summary of any current potential areas of concern or risk requiring escalation to the meeting]*
Trust Strategy and System Impact	*Outline how the report links to / supports elements of the Trust's strategy **and** the 'triple aim'* / other NHS Cheshire and Merseyside system priorities* **a legal duty on NHS bodies which requires them to consider the effects of their decisions on:* • *the health and wellbeing of the people of England (including inequalities in that health and wellbeing)* • *the quality of services provided or arranged by both the Trust and other relevant bodies (including inequalities in benefits from those services)* • *the sustainable and efficient use of resources by both the Trust and other relevant bodies.*

Links to Board Assurance Framework		***Risk Score to be inputted***
Links to Corporate Risk Register (scoring 10+)		***Risk Score to be inputted***

Assurance Level	1. HIGH - Strong system of internal control applied to meet existing objectives

Action Required by the Committee *(ensure that this is consistent with purpose and recommendation in the report)*	The xxx is asked to *[e.g. note, approve, receive assurance, recommend, ratify etc.]*

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

*For most papers, the Cover sheet should be supported by a main report. The body of the report should be completed in Arial 11 font and should aim not to exceed **2000** words. Where you need to use additional evidence to support the recommendation, consider using these are appendices for information purposes.*

The structure of the main report should include the following sections: -

- *Introduction – why is this report being presented*
- *Analysis – what are the issues, where is the evidence and how are we going to improve*
- *Recommendations – what do we need the Board and Group to consider before the end of the meeting*

Some prompts to help you and set out below.

MAIN REPORT

INTRODUCTION

Type over these prompts:

- *Context, background, and purpose.*
- *Define the issue / problem and ensure that the report is contextualised:*
  - *At a macro level with the Trust's Corporate Strategic Priorities and Objectives*
  - *At a micro level to ensure that the paper addresses its purpose.*

ANALYSIS

Type over these prompts:

What are the key findings and how were they reached?

- *Use information that is meaningful and relevant – graphs and tables do not require describing. The use of graphs, tables, graphics, and RAG ratings focus the reader's attention but make sure the information is as up to date as possible*
- *Try to ensure that the report is forward looking / trend based wherever appropriate – not 'snapshot' or two data point reporting. The use of revised trajectories alongside existing can be useful to show the expected impact of actions.*

- *How reliable is the data – is it externally or internally produced, and can you rely on the IT system that generates the information and the data that is entered into it in the first place (e.g., sickness absence data may not always be accurate because managers can forget to enter the absence on to ESR, or to record when the employee comes back to work).*
- *It is better to be exception based to direct the reader to the key issues to focus on those areas requiring greater attention.*
- *Your analysis can be enhanced by using benchmarking or comparator information where possible / appropriate.*
- *Trend data and analysis is critical, so use the most appropriate data points and range to illustrate the trend; in the same way ensure that the use of graphs/charts etc are the most appropriate for the data being presented. Use SPC charts wherever possible and appropriate and the use of comparators is important to understand the Trust's performance in comparison with other similar trusts*
- *Risks and any negative issues should be straightforward and visible. This should highlight risks and issues at corporate, divisional or both levels. This should include quality of care, safety and financial risks.*

Solutions:

- *Try to be action orientated – not just reporting performance. This is where you can provide effective assurance to the Board / Committee / Group.*
- *As a learning organisation, consider key areas of learning which can help develop continuous improvement. As a result of any changes, what will be different, what is the timescale and how will it benefit patients or staff.*
- *Outline the accountability arrangements for the proposed actions and how they are SMART.*

Equality, Diversity & Inclusion Implications – DO NOT DELETE [state N/A if necessary)

Outline how the report may impact positively or negatively, equality, diversity and/or inclusion.

If the report is introducing a new (or updated) strategy, policy or service change, and Equality Impact Assessment must be included as an appendix.

Quality, Financial or Workforce implications - DO NOT DELETE [state N/A if necessary)

Outline how the report may have quality, financial or workforce implications not already included in the main body of the report.

RECOMMENDATION

Type over these prompts:

- *Be clear on what you are asking the Board / Committee. Who will take ownership for delivery?*
- *If you are seeking to provide assurance, provide a summary of the reason for the assessed level of assurance and the evidence base to support the assurance level. Important to state if the assurance is provided on the strength of the process, the delivered outcome or both.*
- *Consider the level of assurance using the definitions given by clicking in the drop down box below:*

If you need further help or assistance, please contact the Corporate Governance Team.

SUPPORTING DOCUMENTS

*List appendices here – **PLEASE DO NOT EMBED DOCUMENTS***

Either include the additional documents as appendices or send through to Secretary with clear labels.

Liverpool Women's NHS Foundation Trust

Board / Committee / Group Assurance Report

Report to	xxx
Date	
Meeting Name	xxx
Date of Meeting	
Chair's Name & Title	

Agenda Items

The following agenda items were discussed by the meeting:

1. Agenda item 1 **(Moderate Assurance)**
2. Agenda item 2 **(Limited Assurance)**
3. Agenda item 3 **(Substantial Assurance)**

Matters for Escalation

To note the matters agreed for escalation by the meeting.

Key Issues

Summary of each agenda item

Risk Summary

Decisions Made

Recommendations

Appendix 1:

There are a total of xx risks aligned to this meeting scoring xx+

Risk escalated or received	Area	Risk ID	Risk Scoring	Risk Description	Controls in place	Discussion held (if Risk is escalated)

Appendix 2: Attendance Matrix

Core members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) ***Non-quorate meetings highlighted in greyscale***												

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

Committee Effectiveness Survey

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer	Comments/ actions
I understand the duties of the committee.						
I believe the committee receives sufficient assurance to conclude upon the its areas of responsibility						
I am confident that the committee effectively monitors and scrutinises progress against the aligned strategies.						
I am content that the committee is delivering the right level of assurance to the Board / Committee.						
I believe that the committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management.						
I feel that the committee has the right balance of experience, attendance, knowledge and skills to fulfil its role.						

The committee has structured its agenda and work plan to cover its key responsibilities.						
The committee is effectively chaired.						
All members of the committee are able to participate effectively.						
There is clarity in relation to the work of the committee and its interaction and alignment with other committees.						

Liverpool Women's NHS Foundation Trust

Liverpool Women's NHS Foundation Trust

[Name of Committee] Annual Report 2023/24

Committee Name

The Committee is responsible for …….

It completes these duties by undertaking the following:

INSERT DUTIES FROM COMMITTEE/GROUP TERMS OF REFERENCE.

This remit is achieved through the Committee being appropriately constituted, and by the Committee being effective in ensuring internal accountability and the delivery of assurance services.

This report outlines how the Committee has complied with the duties delegated by the **[PARENT COMMITTEE]** through the terms of reference.

Constitution

The **[Committee Name]** is accountable to the Board of Directors/ Division etc.

Membership during the year comprised;

- **Insert membership from Terms of Reference**
- Person A
- Person B
- Person C

Section to include:

- **Attendance other than members**
- **No. of meetings held during the year in accordance with terms of reference**
- **Terms of reference reviewed**
- **Format of meetings held, face:face/virtual**
- **Quorum achieved for % of meetings**

Key Achievements

Section to include significant achievements demonstrating that the committee had achieved its key duties.

Information drawn from agenda items considered over the course of the year.

Conclusion

In evaluating its achievements it is concluded that the **[Committee Name]** has achieved its objectives for the Financial Year **2023/24**.

Work planned for [2024/25]

- **Include forward planning**
- **New additions to the workplan for the following year**
- **Continuation of monitoring of any key issues / projects**

NAME - Chair
[Committee Name]
[DATE]

Liverpool Women's NHS Foundation Trust

APPENDIX 1: Attendance at [Committee Name] during 2023/24

MEMBERS	JOB TITLE	April 2023	May 2023	June 2023	July 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	%
NAME 1		✓	✓	✓	AP	✓	✓	✓	MTG NOT HELD				
NAME 2													
NAME 3		Non member											
NAME 4													
Represent quorum if needed													
REP NAME 1													
Invited Attendance													

The quorum shall be [INSERT QUORUM DETAILS FROM TERMS OF REFERENCE].

Liverpool Women's
NHS Foundation Trust

Business Case Template

1. Background

   - *what's the business case about, brief intro*

2. Case for change

   - *what's the reasons for a change/for the business case*

3. Risk Management

   - *should link case for change with risks trying to mitigate*

4. Options appraisal

   - *what solutions have been explored and what is the preferred option and why*

5. Benefits realisation - what benefits will be realised by the change of the business case & how it ties into *the Trust's vision, aims and values*

6. Financial impact

   - *are there any costs/savings and how will they be funded.*

7. Timetable for delivery

8. Conclusion/Recommendation

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*24/25/013*		Date: 11/04/2024	
Report Title	**Risk Management Strategy**			
Prepared by	*Allan Hawksey, Head of Risk and Safety*			
Presented by	*Allan Hawksey, Head of Risk and Safety*			
Key Issues / Messages	The Trust Board are requested to receive this report and approve the proposed updates and realignment of the Risk Management Strategy with system partners for 2024/25.			
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 of Directors is asked to review, and if deemed appropriate, approve the Risk Management Strategy.			
Supporting Executive:	***Dianne Brown, Chief Nurse***			

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

Strategy ☒ Policy ☐ Service Change ☐ Not Applicable ☐

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	26/03/2024	Head of Risk and Safety	Approved

EXECUTIVE SUMMARY

Risk management should be embedded in all the Organisation's practices and processes in a way that it is relevant, effective and efficient. The risk management process should be part of, and not separate from, those organisational processes.

In particular, risk management should be embedded into policy development, business and strategic planning and review, and the change management processes. Risk is an inherent part of the delivery of healthcare.

The risk management strategy outlines the Trust's updated approach to risk management throughout the organisation.

Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks and responding to them. Risk is defined as the uncertainty in achieving an objective.

To support and enable this process to occur the Trust has a defined Risk Management Strategy in place which is led by the Associate Director of Quality and Governance and supported through the management structure of the organisation.

The updated and realigned strategy was approved at Quality Committee in March 2024.

MAIN REPORT

The following report provides a review of the current Risk Management Strategy (last reviewed in 2024) and provides an updated proposed Risk Management Strategy for 2024/25, which identifies changes which are required to maintain it as a contemporary document.

The Risk Management Strategy has previously been developed with consideration and adoption of available guidance and consultation with the Trust Executives.

Proposed Risk Management Strategy for 2024/25

The Risk Management Strategy (version 17 proposed for 2024 onwards) has undergone several amendments and additions to reflect developments in the Trust's approach to assessment, management and mitigation of risk as follows:

- Reviewed statement of intent from the Chief Executive (subject to finalisation by the Chief Executive).
- Updates to individual and delegated responsibilities including delegated / subcommittee responsibilities for controls.
- Updates to the Governance Structure to support risk management and the removal of the Corporate Risk Register, with the introduction of Serious and Significant risks.
- More frequent meeting of the Executive Risk and Assurance Group from bimonthly to monthly
- An increased accountability on Divisional Boards' management, driving change and escalation of risks to the new Executive Risk and Assurance Group (Previously Corporate Risk Sub Committee)
- Streamlined escalation and oversight of key risks by the Trust Executives in real time as risks are added to the risk register
- Changes in risk scoring and moving from the current 5 x 5 process to 5 + 5 + 5 which will now score the effectiveness of controls and will support more effective risk management in divisions and will focus on where controls are ineffective or highlight where the risk cannot be controlled.
- Risk management will be at the forefront of everyday business to ensure the Trust becomes a risk driven Organisation.
- Greater alignment with system partners with existing joint risk registers, for example, LUHFT.

The need for change and benefits:

- Risk management processes are not embedded reliably in all areas of the Trust.
- Risks not always appropriately articulated.
- Risk scoring sometimes inconsistent and risk controls not scored.
- High number of risks (256) as a comparator to – LUHFT (751 (15 per service)) over 3 sites, LHCH (491), AHCH (255)
- Requirement to refocus Trust risk register management processes.
- Risk management will be at the forefront of everyday business to ensure the Trust becomes a risk driven Organisation.

The change journey:

Subject to Board approval, the following implementation plan has been presented to Quality Committee:

- Risk review and reconciliation process to be undertaken by Divisions with the support of the corporate Governance Team for all risks - Due to be completed by end April 2024.
- Refreshed risk management training for all staff supported by and in collaboration with LUHFT governance colleagues - Commences April 2024.
- Risk summit to be led by the Corporate Governance Team to support the transition process - To be held in April 2024.
- Exploration of a new risk management system in collaboration with LUHFT - Planned for 2024/25.

Recommendation:

The Board of Directors is asked to review, and if deemed appropriate, approve the Risk Management Strategy.

Risk Management Strategy

Liverpool Women's NHS Foundation Trust

Version 17.0
April 2024

Contents (to be re numbered once main body is finalised)

1 Foreword: Trust Risk Statement (statement to be reviewed and agreed by the Chief Executive) – minor amendments to wording

We are committed to delivering the highest quality services, which are safe and promote the wellbeing of service users, their relatives and carers, staff and stakeholders. We will ensure consistent risk management systems and processes are in place for continuous quality improvement and safer patient care. Managing risk is a key organisational responsibility and as such is seen as an integral part of the Trust's strong governance arrangements. The Trust is committed to implementing the principles of good governance, defined as:

The system by which the organisation is directed and controlled to achieve its objectives and meet the necessary standards of accountability, probity, and openness.

The Trust recognises that the principles of governance must be supported by an effective risk management system that is designed to deliver improvements in patient safety and care as well as the safety of its staff, patients and visitors. This strategy describes a consistent and integrated approach to the management of all risk across the Trust and is intended to build upon previous strategies, from which the Trust has achieved substantial assurance from external auditors over the last 2 years.

The principles of risk management apply to all staff and all areas of the Trust regardless of the type of risk. The Trust Board will ensure that risk management, quality and safety receive priority and the necessary resources within budgets, to achieve the Trust's strategic objectives. The Board recognises that the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of premises and managing finances by their nature incur risks.

The Trust is committed to having a risk management culture that underpins, supports and drives the business of the Trust. The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation. Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the Board and Executive Management is not surprised by risks that could, and should, have been reasonably foreseen and that have been escalated proactively where necessary, and in a timely manner.

Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk. Considered risk taking is encouraged, together with experimentation and innovation within authorised limits. The priority is to reduce those risks that impact on patient safety, and reduce the Trust's financial, operational and reputational risks.

James Sumner
Chief Executive

2 Introduction

Risk management should be embedded in all the organisation's practices and processes in a way that it is relevant, effective and efficient. The risk management process should be intrinsically part of, and not separate from, those organisational processes. In particular, risk management should be embedded into policy development, business and strategic planning and review, and the change management processes. Risk is an inherent part of the delivery of healthcare. The risk management strategy outlines the Trust's approach to risk management throughout the organisation.

Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks and responding to them. Risk is defined as the uncertainty in achieving an objective.

This board approved strategy (to be confirmed) for managing risk identifies accountability arrangements, resources available, and provides guidance on what may be regarded as acceptable risk within the organisation.

This strategy applies to all Trust staff, contractors and other third parties working in all areas of the Trust. Risk management is the responsibility of all staff and managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

The strategy is supported by a comprehensive 'risk assessment and process toolkit' and a programme of mandatory training, underpinning the fundamentals of the patient safety agenda 2019 and NHS England / Improvement and Care Quality Commission ambitions

2.1 Individual and Delegated Responsibilities

Risk management is the responsibility of all staff. Ultimately all who work at the Trust have a responsibility for the delivery of high quality, safe care, although this may manifest itself in various day to day to activities conducted by members of staff. The following sections define the organisational expectations of roles or groups:

Chief Executive
The Chief Executive is the responsible officer for Liverpool Women's NHS Foundation Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As the 'accountable officer', the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the annual governance statement. Operationally, the Chief Executive has designated responsibility for implementation of this strategy as outlined below.

Chief Finance Officer
The Chief Finance Officer has responsibility for financial governance and associated financial risk.

Chief Nurse
The Chief Nurse has joint authority for clinical governance and absolute delegated authority for quality improvement, risk management, and complaints, and is executive lead for safeguarding and infection control.

Chief Operating Officer
The Chief Operating Officer is executive lead for health and safety and emergency planning,

Associate Director of Quality and Governance
The Associate Director of Quality and Governance**,** working closely with the Chief Nurse and supported by key staff, will be responsible for systems and processes for risk management and for reporting risk performance to board sub-committees.

Trust Secretary
The Trust Secretary is responsible for maintaining the Board Assurance Framework and will work closely with the Associate Director of Quality and Governance in a collaborative and supportive function.

Chief Medical Officer
The Chief Medical Officer has joint responsibility for clinical governance, and responsibility for audit and clinical effectiveness.

Other Chief Officers
Chief Officers have responsibility for the management of strategic and operational risks within individual portfolios. These responsibilities include oversight and monitoring of Serious and Significant Risks (previously extreme risks / those on the Corporate Risk Register) and the promotion of risk management to staff within their directorates.

Chief Officers have responsibility for monitoring their own systems to ensure they are robust, for accountability, critical challenge, and oversight of risk.

Divisional Managers
Divisional Managers are the accountable officer for their division and take the lead on risk management within the division as the triumvirate, setting the example through visible leadership of their staff. They do this by:

- Taking personal responsibility for managing risk.
- Sending a message to staff that they can be confident that escalated risks will be acted upon.
- Ensuring risks are reviewed regularly, updated and acted upon appropriately.
- Identifying and managing risks that cut across delivery areas.
- Discussing risks on a regular basis with staff and up the line to help improve knowledge about the risk faced; increasing the visibility of risk management and moving towards an action focussed approach.
- Communicating downwards what top risks are and doing so in plain language.
- Escalating risks from the front line.
- Linking risk to discussions on finance and stopping or slowing down non-priority areas or projects to reduce risk as well as stay within budget, demonstrating a real appetite for setting priorities.
- Ensuring staff are suitably trained in risk management.
- Monitoring mitigating actions and ensuring risk and action owners are clear about their roles and what they need to achieve.
- Ensuring that people feel supported when identifying and escalating risks, and fostering a fair and just culture, which encourages them to take responsibility in helping to manage them.
- Ensuring that risk management is included in appraisals and development plans where appropriate.

Clinical Directors, Heads of Nursing/ AHP and Head of Midwifery
Clinical Directors, Heads of Nursing/ AHP and Head of Midwifery play and active role in supporting the Divisional Manager within the division as the triumvirate and set the example through visible leadership of their staff. They do this by working in partnership with the Divisional Manager as detailed in their responsibilities that are outlined above.

Heads of Corporate Services
Heads of Corporate Services will undertake the same roles and responsibilities as those outlined above for the divisional triumvirate.

Patient Safety Specialists
Patient Safety Specialists are new roles identified within the Patient Safety Strategy, of which the Trust has 3 nominated specialists. They are the patient safety experts within the Organisation to

provide leadership, visibility and expert support to patient safety work. They are expected to:

- Support the development of a patient safety culture and safety systems.
- Engage directly with the executive team.
- Lead, oversee or support patient safety improvement and ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes.
- Promote patient safety thinking beyond things going wrong to why things routinely go right healthcare and the systems approach to patient safety.
- Implement any changes and updates to the Patient Safety Incident Response Framework post implementation (since 6 September 2023)

Senior Managers (Corporate, Ward & Departmental Managers)

Senior Managers are expected to be aware of and adhere to risk management best practice to:

- Identify risks to the safety, effectiveness and quality of services, finance, delivery of objectives and reputation- drawing on the knowledge of front-line colleagues.
- Identify risk owners with the seniority to influence and be accountable should the risk materialise.
- Assess the rating of individual risks looking at the likelihood that they will happen, and the consequence if they do.
- Identify the actions needed to reduce the risk and assign action owners.
- Record risks on the risk register.
- Check frequently on action progress, especially for high severity risks.
- Apply healthy critical challenge, without blaming others for identifying and highlighting risks, or consider that they are being unduly negative in doing so.
- Implement a process to escalate the most severe risks and use it.

Head of Risk and Safety

The Head of Risk and Safety will be responsible for ensuring that the systems and processes for risk management are monitored and maintained for their effectiveness. They:

- Will lead on effective operational risk management across the Trust as the Governance Lead reporting to the Associate Director of Quality and Governance.
- Have oversight of all risk within the Trust
- Triangulate all trust risks through quarterly Integrated Governance Reports to Quality Committee
- Ensure risk is being managed proactively and effectively, ensuring escalation or de-escalation where required.
- Ensure the Ulysses Risk Management system is being fully utilised effectively
- Ensure risk and risk actions are regularly reviewed within required timescales.
- Report to the Executive Risk and Assurance Group (Previously Corporate Risk Sub Committee) any issues for escalation regarding new risks, closed risk assurance and the effectiveness of risk management across the Trust monthly by exception reporting.

Divisional Governance Managers

- Manage the Divisional risk assessment process and to ensure that the risk register is effectively populated, to analyse and identify trends and actions arising, and to monitor on a regular basis to ensure that risks are controlled.
- Review procedures and practice in relation to Governance plans, strategic developments and Risk Management (including risk assessments and risk. The best people, giving the safest care, providing outstanding experiences register maintenance) ensuring actions are developed and implemented, escalating issues as the needs arise
- Triangulate all divisional risks through quarterly Integrated Governance Reports to the Quality, Safety and Effectiveness Group.
- Ensure risk and risk actions are regularly reviewed within required timescales.
- Deliver training on key aspects of risk management, governance, and related activities to key staff.

All Staff

All staff are encouraged to use risk management processes as a mechanism to highlight areas they believe need to be improved. Where staff feel that raising issues may compromise them or may not be effective, they should be aware and encouraged to follow guidance on whistle blowing and raising concerns.

Staff side representatives also have a role in risk management including providing support and guidance to staff undertaking risk assessments where appropriate and providing advice in the event of a dispute to the validity of a risk assessment.

Delegated Responsibilities

Risk Area	Officer Responsible for co-ordination and advice	Responsible for Identification of risks	Responsible for analysis	Responsible for control (where there is a delegated Sub – Committee / Group)
Incident Reporting & Analysis, Risks.	Head of Risk and Safety and Divisional Governance Managers	Head of Risk and Safety Individual Services Divisional Governance Managers	Head of Risk and Safety All departments Divisional Governance Managers	Divisional Boards Executive Risk and Assurance Group Quality, Safety and Risk Executive Committee
Board Assurance Framework (BAF)	Trust Secretary	Trust Board Trust Executive Trust Secretary	Trust Secretary Trust Executive	Executive Risk and Assurance Group
Clinical and Non-Clinical Claims	Legal Services	Legal Services	Legal Services	Quality, Safety and Risk Executive Committee
Complaints	Head of Patient Experience	Individual Services Divisional Governance Managers Complaints Officers	All departments Divisional Governance Managers Patient Experience Team	Patient Involvement and Experience Group
Patient Safety Incident Investigations	Head of Risk and Safety and Divisional Governance Managers	Individual Services Divisional Governance Managers	All departments Divisional Governance Managers Head of Risk and Safety	Quality, Safety and Risk Executive Group
Building, land, plant, non-medical equipment – all estates	Deputy Director of Estates and Facilities	Individual services. Patient Facilities Manager Deputy Director of Estates and	Estates and Facilities Manager Deputy Director of Estates and Facilities	Safe and Sustainable Estates Group

		Facilities		
Catering and Food Hygiene	Deputy Director of Estates and Facilities	Individual services. Patient Facilities Manager Deputy Director of Estates and Facilities	Patient Facilities Manager Deputy Director of Estates and Facilities	Safe and Sustainable Estates Group
Emergency Preparedness, Resilience and Response EPRR	EPRR Lead Chief Operating Officer	Individual services EPRR Lead Chief Operating Officer	EPRR Lead Chief Operating Officer	Safe and Sustainable Estates Group
Fire Safety	Chief Operating Officer Fire Safety Officer	Individual Services Fire Safety Officer Chief Operating Officer	Fire Safety Officer Chief Operating Officer	Safe and Sustainable Estates Group
Health and Safety	Chief Operating Officer Health and Safety Manager	Individual Services Health and Safety Manager	Health and Safety Manager Chief Operating Officer	Safe and Sustainable Estates Group
Human Resources	Deputy Chief People Officer	Deputy Chief People Officer	Deputy Chief People Officer	People and OD Executive Group
Infection Prevention and Control	Director of Infection Prevention and Control	Infection Prevention and Control Team	Infection Prevention and Control Team	Infection Prevention and Control Group
Digital Services / Information Governance	Head of Information Governance	Head of Information Governance	Head of Information Governance	Digital Hospitals Group
Medical Devices	Chief Medical Officer Head of Risk and Safety	Head of Risk and Safety	Head of Risk and Safety	Quality, Safety and Risk Executive Group
Medicines Management	Chief Pharmacist Deputy Chief Pharmacist	Deputy Chief Pharmacist	Deputy Chief Pharmacist	Medicines Management Group
Security	Local Security Management Specialist	Local Security Management Specialist	Local Security Management Specialist	Safe and Sustainable Estates Group
Audit and counter Fraud	Deputy Director of Finance	Deputy Director of Finance	Deputy Director of Finance	Audit Committee

2.2 The Core Elements of the Strategy

Risk Management Process

The Trust's risk management process ensures that risks are identified, assessed, controlled, and when necessary, escalated. These main stages are carried out through:

- Clarifying objectives
- Identifying risks to the objectives
- Defining and recording risks
- Completion of risk on to the risk register and identifying actions
- Escalation and de-escalation of risks

The identification of risk is the essential element of any risk management strategy or process. There needs to be a fully identified and supported approach to this element of risk management which includes formal risk assessment generated for incidents, claims, complaints etc. the identification of any new risks as part of normal business of meetings from papers or concerns raised is beneficial. The use of horizon scanning which is in built into the agendas of a number of committees, sub-committees and groups within the Trust provides a solid foundation in supporting robust discussions within the meeting and the identification of new risk on the horizon. This key element needs to be developed and embedded further within the divisional boards and sub groups to ensure there is a Trust wide approach to identifying risks on the horizon.

Governance Structure to Support Risk Management

There are different operational levels ensuring the governance of risk in the Trust:

- Board of Directors
- Executive Management Team
- Divisional Boards

Divisional Governance Management is supported by divisional governance managers, who work as part of the senior management team within each division.

Risk management by the Board is underpinned by a number of interlocking systems of control. The Board reviews risk principally through the following three related mechanisms:

1. **The Board Assurance Framework (BAF)** sets out the strategic objectives, identifies key strategic threats in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF is cross-referenced with and contains all risks scored as serious and / or significant (previously recorded against the Corporate Risk Register). The BAF can be used to drive the board agenda.

2. **Serious and Significant Risks (Previously recorded against the Corporate Risk Register (CRR))** are the highest level of operational risks used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust.

3. **Low and Moderate Risks (Previously recorded against Divisional and Local risk registers)** are risks pertaining to the routine daily activities of each service and may become business as usual (BAU). These risks are locally managed, discussed at team meetings and will have the oversight of each Divisional Board. They will no longer report outside of the Division.

Additionally, the annual governance statement is signed by the Chief Executive. It sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the annual accounts process and brought to the board with the accounts.

2.3 Aim

The aim of this strategy is to set out the Trust's vision for managing risk. Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats and maximise opportunities.

i. The key objectives of risk management at the Trust are to:
- Reduce the level of exposure to harm for patients, colleagues, or visitors by proactively identifying and managing personal risk to a level as low as reasonably practicable.
- Promote success and protect everything of value to the Trust, such as high standards of patient care, safe working environment, the Trust's safety record, reputation, community relations, equipment or sources of income.
- Continuously improve performance by proactively adapting to mitigate risk as much as possible and remaining resilient to changing circumstances or events.

ii. The Trust will establish an effective risk management system which ensures that:
- All risks are identified that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the Trust
- Priorities are determined, continuously reviewed and managed through objectives that are owned and understood by all staff.
- Risks to the achievement of objectives are anticipated and proactively identified.
- Controls are put in place, effective in their design and application to mitigate the risk and understood by those expected to use them.
- The operation of controls is monitored by management.
- Gaps in control are rectified by management in the most appropriate manner determined.
- Management is held to account for the effective operation of controls.
- Risks that exceed timescales for completion are proactively reviewed and escalated to the appropriate management for action.
- Assurances are reviewed and acted on.
- Staff continuously learn and adapt to improve safety, quality, and performance.
- Risk management systems and processes are embedded locally across operational divisions and in corporate services including business planning, service development, financial planning, project and programme management and education.
- The risk management system effectively supports the Trust's risk management agenda, with plans to jointly procure an updated and more effective risk management system in partnership with LUHFT.
- The Trust can effectively respond to system risk with system partners, rather than manage risk as an isolated site, but work in collaboration, where risks are understood clearly across partners.

2.4 Risk Appetite and Statement

Risk Appetite

The resources available for managing risk are finite and so the aim is to achieve an optimum response to risk, prioritised in accordance with an evaluation of the risks. Risk is unavoidable, and every organisation needs to take action to manage risk in a way that it can justify to a level which is tolerable. The amount of risk that is judged to be tolerable and justifiable is the "risk appetite". (Appendix D provides a guidance template on setting the Trust risk appetite).

Risk appetite is therefore 'the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.' *(Definition from HMT Orange Book, 2005).* It can be influenced by personal experience, political factors and external events.

Risks need to be considered in terms of both opportunities and threats and are not usually confined to money - they will invariably also impact on the capability of our organisation, its performance, and its

reputation.

We need to know about risk appetite because: If we don't know what our organisation's collective appetite for risk is and the reasons for it, then this may lead to erratic or inopportune risk-taking exposing the organisation to a risk it cannot tolerate; or an overly cautious approach which may stifle growth and development. If our leaders do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised, and patient outcomes affected.

The Trust will periodically review its appetite for and attitude to risk, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk. The periodic review and arising actions will be informed by an assessment of risk maturity, which in turn enables the board to determine the organisational capacity to control risk. The review will consider:

- Risk leadership.
- People.
- Risk policy and strategy.
- Partnerships.
- Risk management process.
- Risk handling.
- Outcomes.

Risk Appetite Statement

The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept to deliver its strategy over a given time frame. In practice, an organisation's risk appetite should address several dimensions:

- The nature of the risks to be assumed.
- The amount of risk to be taken on.
- The desired balance of risk versus reward.

On an annual basis the Trust will publish its reviewed and current risk appetite statement. The statement will define the board's appetite for risk identified to the achievement of strategic objectives for the financial year in question. This will be agreed by the Executive Risk and Assurance Group as an overall risk appetite statement and will move away from the current format of several parts, informed by the reporting sub committees.

Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.

The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk and published publicly within the Trust updated risk management strategy on an annual basis.

2.5 Responsibility and Accountability

Liverpool Women's Hospital will ensure that there is accountability, authority, and appropriate competence for managing risk, including implementing the risk management process and ensuring the adequacy, effectiveness and efficiency of any controls. This will be facilitated by:

- Identifying risk owners that have the accountability and authority to manage risks.
- Identifying who is accountable for the development, implementation, and maintenance of the framework for managing risk.
- Identifying other responsibilities of people at all levels in the organisation for the risk management process.

- Establishing performance measurement and external/internal reporting and escalation processes; and
- Ensuring appropriate levels of recognition.

To enable all staff to fulfil their respective roles and responsibilities the Trust Governance Team will provide support, guidance, and training in risk management.

2.6 Executive Led Committee Duties and Responsibilities

The Board sub-committees / groups are responsible for assuring that the risks are being managed appropriately by considering the gaps, mitigation and Trust tolerance levels, and for assuring the Board where appropriate or raising any concerns to other relevant sub-committee, additionally each board sub-committee should review the board assurance framework at each of its respective meetings and the serious and significant risks which will be aligned and report in to the Executive Risk and Assurance Group.

Board of Directors

The Board is responsible for ensuring that the Trust has effective systems for identifying and managing all risks whether clinical, financial, or organisational. The risk management structure helps deliver the responsibility for implementing risk management systems throughout the Trust.

The responsibility for monitoring the management of risk across the organisation has been delegated by the board to the following inter-relating committees:

- Audit Committee
- Finance, Performance and Business Development Committee
- Quality Committee
- Putting People First Committee

The Board reviews the board assurance framework at each of its respective meetings and will together with significant risks and those risks highlighted from the Executive Risk and Assurance Group on a quarterly basis.

Specific responsibilities for the management of risk and assurance on its effectiveness are delegated as follows:

Audit Committee

The Audit Committee is responsible for providing assurance to the Trust board on the process for the Trust's system of internal control by means of independent and objective review of corporate governance and risk management arrangements, including compliance with laws, guidance, and regulations governing the NHS. In addition, it has the following responsibilities relating to risk:

> *To maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements.*

Finance, Performance and Business Development Committee

This Committee is responsible for providing information and making recommendations to the Trust board on financial and operational performance issues, and for providing assurance that these are being managed safely. The committee will consider any relevant risks within the Board Assurance Framework and significant and serious risks as they relate to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the Executive Risk and Assurance Group or the board as appropriate.

Quality Committee

The Committee is responsible for providing the Trust board with assurance on all aspects of quality of clinical care; governance systems including risks for clinical, information and research and development issues; and regulatory standards of quality and safety. The committee will consider any relevant risks within the Board Assurance Framework and significant and serious risks as they relate to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the Executive Risk and Assurance Group or the board as appropriate.

The Committee is provided with a quarterly integrated governance report which demonstrates how the systematic triangulation and analysis of aggregated data can be used to minimise the risk of a recurrence and underpin the trust's commitment to improving safety by learning and sharing lessons. Repeat causality and contributory factors within PSIRF can be used on aggregated incidents, complaints, PALS information and claims to analyse the trends and identify changes in practice.

Putting People First Committee

The Committee is responsible for providing the Trust board with assurance on all aspects of governance systems and risks related to the workforce, and regulatory standards for human resources. The committee will consider any relevant risks within the Board Assurance Framework and significant and serious risks as they relate to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the Executive Risk and Assurance Group or the board as appropriate.

Trust Executive Team

The Trust executive team is responsible for the operational management and monitoring of risk, through significant and serious risks and Board Assurance Framework, and for agreeing resourced treatment plans and ensuring delivery.

2.7 Clinical Services and Risk Management Arrangements

All service areas will put the necessary arrangements in place within their areas for good governance, safety, quality, and risk management.

Clinical services have the responsibility, through Divisional Managers as the accountable person, for the risks to their services and for the putting in place of appropriate arrangements for the identification and management of risks. Services will develop, populate and review their risks, drawing on risk processes to ensure risk registers are kept up to date through regular review.

In doing this, due account will be taken of the Trust's strategic and corporate objectives, particularly in terms of meeting regulatory standards and guidance, national performance standards and targets and relevant legislation, and of the issues and risks relevant to specific areas within the particular services

Divisional Board meetings will review risks and contribute to the development of the risk registers and ensure that they are in place and operating within the defined tolerances and escalation processes.

Executive Risk and Assurance Group

The group will consist of a quorate of new members and functions to ensure effective oversight and scrutiny of the entire business of the Trust, the relationship between the Executive Risk and Assurance Group, and the other Board Sub- Committees, is based on inclusiveness, clarity of purpose and constructive challenge. The Executive Risk and Assurance Group will oversee the management of all significant and serious risks, reviewing closed assurance and new risk reports and will provide the Audit Committee with assurance on the effective operation of internal controls. The Trust's divisions (Corporate, Family Health, Clinical Support Services and Gynaecology) will report to the Group monthly via dashboards and exception reporting.

3 Process for Managing Risk

Stage 1 – Clarifying Objectives

Whether a new risk has been identified or staff need to know what to do next; clarifying objectives is a critical stage of the risk management process. To understand whether something constitutes a risk it must first be understood what the objectives/outcomes are to be achieved.

Strategic or corporate objectives; to identify and clarify which Trust strategic or corporate objective is relevant to the division, directorate, or service. Look at the Trust business plan and the latest local business plan. If this step is missed or omitted, then the risk register will be neither relevant nor effective.

Local objectives should also be considered. By clarifying the objectives, it can be identified whether there is a risk to manage.

Stage 2 – Identifying Risks to Objectives

Once the objectives have been identified then risks can start to be identified. Consider the following questions:

- Do you know what all of the risks to the delivery of your objectives or work are, especially those that impact on delivering high quality, safe services?
- What could happen, and what could go wrong?
- How and why could this happen?
- What is depended upon for continued success?
- Is there anyone else who might provide a different perspective on your risks?
- Is it an operational risk or a risk to a strategic objective?

If possible, gather those staff together who are able to assist with the identification of risk for the area. Guidance on how to do this is available from the Corporate Governance Team (Section 6).

Stage 3 – Defining and Recording Risks

- Once the risk has been identified then:
- Undertake a comprehensive risk assessment
- Describe the risk, so that others understand what the risk is in relation to the description of condition, cause and consequence, being clear for each one.
- Complete a draft initial risk assessment score so that the risk is appropriately escalated to management for review and approval onto the risk register which should include (subject to approval)
- Assigning an owner to the risk who will oversee the risk management and review the initial score
- List the key controls (actions) being taken to reduce the likelihood of the risk happening or reduce the impact.
- If it is a significant or serious risk then consider what the contingency action plan is, i.e., what will you do should the risk happen.
- Rate the likelihood of the risk materialising.
- Rate the consequence of the risk happening.

All of these things should be recorded which will allow the risk to be recorded on to the risk register following risk assessment, if the risk assessment process has not enabled the risk to be eliminated or managed. The following sections describe in detail how to complete the risk register.

Stage 4 – Risk Register

The risk register will contain operational and strategic risks that are routinely managed within the service, and for which the service has the required resources, controls and mitigation within the parameters of risk set by the risk appetite.

Significant and Serious risks will be a collection of risks that directly impact on to the delivery of the corporate aims. These risks will be formulated from a variety of sources, i.e., risks that cannot be controlled or mitigated in the service area, external audit reports, and principal risks from the board assurance framework.

Traditionally, completing a risk can be daunting but the aim is to have a simplified process to allow the monitoring of actions and aid decision-making, electronically.

Headings on the register that need to be completed are:

1. The risk identification (ID) is the unique identifier to distinguish the risk from the other risks on the register. The ID will not change throughout the life of the risk.

The risk owner is the individual who is accountable and has overall responsibility for a risk; it may or may not be the same person as the action owner. Significant risks, for example, will be owned by a Chief Officer, but there may be many action owners. The risk owner must know, or be informed that they are the owner, and accept this.

2. Source of, how or where the risk was identified. This could include:

- Business planning.
- Clinical audit.
- Complaints/PALS.
- External audit.
- External review.
- Incident.
- Internal audit.
- Legislation.
- Litigation.
- National risks such as financial fraud
- NICE guidance.
- Regulatory standard.
- Risk Assessment.

3. Risk description as the name suggests, allows the risk to be described. It is important that risks are clearly articulated. If not, then it is difficult to put effective controls, or actions, in place to reduce the risk materialising and contingency plans. Using the following subheadings will help to clearly describe risk:

- Condition
- Cause
- Consequence

For example:

Condition: Inability to release clinical staff for mandatory training due to staffing levels.
Cause: Results in staff not receiving compulsory training in resuscitation or blood safety.
Consequence: Leading to an increased safety risk to patients.

Getting this right is important as the key controls relate directly to the description of the risk. Key controls are the measures put in place as preventative measures to lessen or reduce the likelihood or consequence of the risk happening and/or the severity if it does. You must ensure that each control (or

action where a gap in control has been identified) has an owner and target completion date.

These must describe the practical steps that need to be taken to manage and control the risk. Without this stage, risk management is no more than a paper based or bureaucratic process.

Not all risks can be dealt with in the same way. The 5T's provide an easy list of options available to anyone considering how to manage risk:

- **Tolerate** – the likelihood and consequence of a particular risk happening is accepted.
- **Treat** – work carried out to reduce the likelihood or consequence of the risk (this is the most common action).
- **Transfer** – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party.
- **Terminate** – an informed decision not to become involved in a risk situation, e.g. terminate the activity.
- **Take the opportunity** – actively taking advantage, regarding the uncertainty as an opportunity to benefit.

In most cases the chosen option will be to treat the risk. When considering the action to take remember to consider the cost associated with managing the risk, as this may have a bearing on the decision. The key questions in this instance are:

- Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.
- When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.

Stage 5 – Escalation and De-escalation of Risks

The consequence of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk by rescoring its' impact, for example from a moderate risk to a serious risk or a serious risk to a significant risk for review and oversight of the Executive Team and Executive Risk and Assurance Group, and finally the Board.

Risk will be escalated or de-escalated within the defined tolerances.

For example: a risk scoring low or moderate should only be escalated to serious or above if it is **not** manageable within the service. If the risk **is** manageable within the service, then it remains as a low or moderate risk. In a case whereby the risk is to be escalated, robust options for controls or mitigation must be offered. The risk owner should discuss and seek approval from within the division before risk escalation. Once an escalated risk is to be considered by the Executive Risk and Assurance Group, it will consider the risk control options advised and discuss recommendations for action.

It is important that risks are reviewed regularly to ensure appropriate action, including closing risks or action plans where necessary.

Stage 6 - Closure of Risk

Risk registers need to be current and up to date. It is therefore essential that risks are continually monitored and fully reviewed at least annually. They should be closed under the following circumstances:

- The Risk has materialised.
- The Risk has reached its target score and has remained stable for an acceptable period (following Senior Members authorisation)

All closed risks will be archived and not deleted.

3.1 Risk Profile

A summary risk profile is a simple visual mechanism that can be used in reporting to increase the visibility of risks; it is a graphical representation of information normally found on an existing risk register. A risk profile shows all key risks as one picture, so that managers can gain an overall impression of the total exposure to risk.

3.2 Horizon Scanning

Horizon scanning is about identifying, evaluating, and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing formal mechanisms to horizon scanning the Trust will be better able to respond to changes or emerging issues in a planned structured and co-ordinated way. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:

- Legislation.
- Government white papers.
- Government consultations.
- Socio-economic trends.
- Trends in public attitude towards health.
- International developments.
- NHS England publications.
- Local demographics.
- Seeking stakeholders' views.
- Risk assessments.

All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.

Board members have the responsibility to horizon scan and formerly communicate matters in the appropriate forum relating to their areas of accountability.

4 Proactive Risk Processes

Training

Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management.

Training required to fulfil this strategy will be provided in accordance with the Trust's training needs analysis.

All new staff undertake risk management training as part of their Corporate Induction. Training is mandated for all other staff on an annual basis. Compliance of this mandated training will be monitored by the Head of Risk and Safety monthly. Where compliance falls below 90% at any one time, the Head of

Risk and safety will escalate to Divisional / Senior Managers to address compliance issues and will report into Corporate risk Sub – Committee if compliance issues remain.

Management and monitoring of training will be in accordance with the Trust's statutory and mandatory training policy.

Specific training will be provided for the board, in respect of high-level awareness of risk management. Risk awareness sessions are included as part of the board's development programme.

Strategies, policies and procedures

There are a range of policies that support the management of risk in the Trust. These are available on the Trust's intranet site. Policies that link closely to the risk management strategy are detailed under Associated Documents at section 1.0 of this risk management strategy & policy.

Resilience Management

The Trust has in place a comprehensive Major Incident Plan, as well as a range of plans and other associated documents that are designed to ensure the resilience of the Trust in a range of scenarios that would limit the operating capacity of the organisation. These plans are tested in line with the requirements of the Civil Contingencies Act and learning from these tests is communicated back into relevant groups to ensure the processes are refined.

Implementation of clinical guidance

The Trust has mechanisms in place to implement the latest guidance and recommendations – these processes are covered by the Management of National Clinical Guidelines policy.

Standards and Accreditation

The Trust ensures that it meets (and aims to exceed) a range of standards and accreditations. Many of these are covered by the Management of external agency visits, inspections and accreditations policy.

Audit Activity (clinical, internal and external)

There is extensive audit activity within the Trust covering a range of issues. Findings from these reviews are fed back to appropriate members of staff, and reports made to the clinical and research effectiveness committee and the Board of Director's assurance committees

5 Reactive Risk Processes

Learning and potential risks are identified from adverse events or complaints and concerns reported by patients and / or their carers to the Trust. The following can be considered as reactive Risk Processes;

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Incidents

The Trust has a system for reporting adverse incidents, including serious incidents, set out in the Incident Reporting and Investigation Policy. All notified incidents are graded using a simple risk assessment matrix, consistent with that used for risk assessment.

Complaints

The Trust has a well-established complaints process, set out within the Complaints Policy which ensures that all concerns are responded to within the approved timescales. All serious complaints are the subject of a full root cause analysis. Information and action plans arising from complaints are used to develop or change the service delivery.

Claims & litigation

The Quality and Standards team works closely with the divisions to enable the early identification of potential legal claims against the Trust as set out in the Claims Policy.

Inquests

The Quality and Standards teamwork with Trust clinicians and HM Coroner to ensure the best outcomes for families and the Trust from the inquest process, as set out in the Inquest Policy. Any concerns or recommendations raised by the coroner are communicated appropriately to ensure that remedial action is taken.

Debriefing/Post Event Analysis

Potential risks and learning are identified following all reactive risk management activities as an integral part of these processes. Appropriate management action put in place to reduce or eliminate the possibility of a similar occurrence.

Incident investigation

Training has been provided by the Trust and will be revised as part of the Patient Safety Incident Response Framework (PSIRF) programme in 24/25.

6 Evidence Base

- Home Office Risk Management Policy and Guidance, Home Office (2011).
- A Risk Matrix for Risk Managers, National Patient Safety Agency (2008).
- NHS Audit Committee Handbook, Department of Health (2011).
- UK Corporate Governance Code, Financial Reporting Council (2010).
- 'Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance', Audit Commission (2009).
- The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004).
- Risk Management Assessment Framework, HM Treasury (2009).
- Understanding and Articulating Risk Appetite, KPMG (2008).
- Risk Appetite Frameworks- how to spot the genuine article, Deloitte (2013).
- Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012).
- Good Practice Guide: Managing Risks in Government, National Audit Office (2011).
- Risk Management – principles and guidelines ISO 31000 (2009).
- Patient Safety Strategy (2020)

7 Risk Management Approach

Fair and Just Culture

The Trust operates a “fair and just culture”. An open & honest approach to reporting incidents and concerns is encouraged The Trust promotes a “fair and just culture”. An open and honest approach to reporting in accordance with the principles of ‘An Organisation with a Memory’ and in accordance with the Incident reporting and investigation policy. It is recognised that whilst it is easy to promote a culture of learning and closing the loop regarding risk management, the effect on staff directly involved in an incident or enquiry should not be underestimated, and support is provided in line with the. Supporting Staff involved in a complaint, claim or incident policy. Exceptional cases will arise where there is clear evidence of wilful or gross neglect contravening the Trust’s policies and procedures and/or Professional Codes of

Conduct, or where there is repeated evidence of poor performance despite intervention/support. These will be dealt with on an individual basis in accordance with Human Resources policies.

Duty of Candour

'Duty of candour' supports a culture of openness, honesty, and transparency and includes apologising and explaining what happened. Being open with patients often defuses the situation and allows open communication and learning to avoid recurrence. Patients and/or carers should receive an apology as soon as possible, within 10 working days, after a patient safety incident has occurred. Staff should feel able to apologise, saying sorry is not an admission of liability and it is the right thing to do. This culture is promoted throughout the Trust in line with the Duty of Candour Policy

Reporting Concerns

All employees must ensure they are familiar with the Raising Concerns at Work Policy for raising concerns of matters relating to fitness to practice for reasons of conduct, health or competence.

8 Monitoring, Compliance and Audit

The Trust risk team, led by the Associate Director of Governance and Quality oversee all risks recorded on the Ulysses risk management system. The team review all new, closed, and outstanding risks and quality assures every risk assessment whether ongoing or completed. The team re-open closed risks, if necessary, where it is deemed appropriate action has not been taken and audit risks exceeding timescales, escalating to the appropriate management level where necessary,

The Trust have performed well in audits undertaken by auditor Mersey Internal Audit Agency (MIAA). In both 2022/23 and 23/24, the Trust received substantial assurance for an audit in relation to Risk Management.

To enhance what the Trust have already achieved, a series of objectives were set in the 2023 Strategy as follows:

- Reviewed and consulted with staff about the effectiveness of communication systems to ensure that both reactive and proactive messages about safety reach all areas of the Trust
- Reviewed and enhanced practice to ensure that all risks are underpinned by a risk assessment that has been approved at departmental level

- Undertaken an audit of risk assessments and risks on the Trust's risk register for each area and department, providing feedback to the relevant areas ensuring any improvements are made accordingly.
- Reviewed the feedback from training in human factors and agreed the approach needed for the future
- Reviewed the outcomes of Executive quality and safety walk rounds, including seeking feedback from staff
- Started to embed our Patient Safety Incident Response Framework (PSIRF), evaluating, and enhancing the current system for reviewing and learning from Serious Incidents, repeat causality and effective action planning to learn from investigations
- Introduced an automated process for the approval of documents such as policies and procedures
- Ensured Divisional board agendas have a case study / patient story each quarter
- Mature systems of communication of safety and risk issues, both reactive and proactive, across the organisation
- Developed a system for proactive sharing of risk with partner organisations across the patient's pathway
- Human factors methodology firmly embedded in Trust systems and processes
- Undertaken a survey about the safety culture within the trust to identify and commenced any targeted improvement initiatives based on the findings of the survey.

These key measurables will continue into for 2024 – 2025. Whilst strong foundations have been established, closer collaboration with system partners, a refreshed approach to risk management, staff training and ongoing triangulation of key risks to inform Divisional workplans will continue across 2024.

The Trust Risk Team, which includes the divisional governance managers, are always for available for operational advice / support when required and are contactable as follows:

Name	Role	Extension
Phil Bartley	Associate Director of Governance and Quality	1383
Allan Hawksey	Head of Risk and Safety	4437
Hayley Roberts	Quality, Safety and Governance Facilitator	4292
Elaine Eccles	Governance support officer	4292
Jenny Lamble	Governance support officer	4489
Paula Best	Divisional Governance Manager (maternity)	4433
Matt O'Neill	Divisional Governance Manager (Gynaecology / Hewitt Centre)	1048
Virginia Wallace / Justine Collins	Divisional Governance Manager (Neonatal)	1015
Ashleigh Henerty	Divisional Governance Manager (Clinical Support Services)	4421
Clare Murray	Lead Governance Manager (Family Health)	1333

9 Dissemination, Implementation and Access to the Document

This strategy will available on the Trust intranet. All staff will be notified via the communications team of the strategy and other amendments. This Policy will be discussed at Quality Committee in March 2024 for consideration of submission to Trust Board in April 2024 for approval.

10 Key Performance Indicators

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
All verified BAF strategic threats are reported to the Board of Directors at each formal meeting of the Board.	100%	The following mechanisms will be used to monitor compliance with the requirements of this document:	Executive Risk and Assurance Group & Trust Board (when meetings are scheduled)	Monthly	Trust Secretary
All significant risks are reported to and reviewed as a standing agenda item at each formal meeting of the Executive Risk and Assurance Group.	100%	• Evidence of reporting verified significant risk exposures to the Board of Directors at each formal meeting. • Evidence of review of significant risk exposure by the Executive Risk and Assurance Group at each formal meeting. • Periodic internal audit of any or all aspects of the Risk Management process as determined by the Audit Committee (risk identification, assessment, control, monitoring and reviews).	Executive Risk and Assurance Group	Monthly	Associate Director of Quality and Governance (Exec Lead: Chief Nurse)
The risk profiles (significant and serious risks) for all divisions are reviewed by the Corporate Risk Sub Committee at a frequency determined by the Executive Risk and Assurance Group as part of a rolling programme of reviews.	100%		Executive Risk and Assurance Group	Monthly	Associate Director of Quality and Governance (Exec Lead: Chief Nurse)
Local risk registers are in place, maintained and available for inspection.	100%		Divisional Boards	Monthly	Divisional Managers and Senior Leadership Teams
Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and all risks and risk actions are within review date, and none are overdue for review.	100%		Divisional Boards	Monthly	Divisional Managers and Senior Leadership Teams

Annual review and approval of the Trust's Risk Appetite	100%		Quality Committee	Annual Report	Associate Director of Quality and Governance (Exec Lead: Chief Nurse)
Risk management training mandatory for all staff at corporate induction	100%		Quality Committee	Annual Report	Associate Director of Quality and Governance (Exec Lead: Chief Nurse)
Risk management training mandatory for all staff as part of their mandatory training	100%		Quality Committee	Annual Report	Associate Director of Quality and Governance (Exec Lead: Chief Nurse)
Staff compliance with the risk management standard operating procedure (SOP)	100%		Quality Committee	Annual Report	Associate Director of Quality and Governance (Exec Lead: Chief Nurse)

11 Appendices

Appendix A - Risk Descriptors and Grading

Risk Descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Control Scores

1	2	3	4	5
Risk is fully under control	Risk is adequately controlled	Action to control risk adequately has started and appears to be effective	Action to control risk is agreed but no action started	No actions to controls risk identified

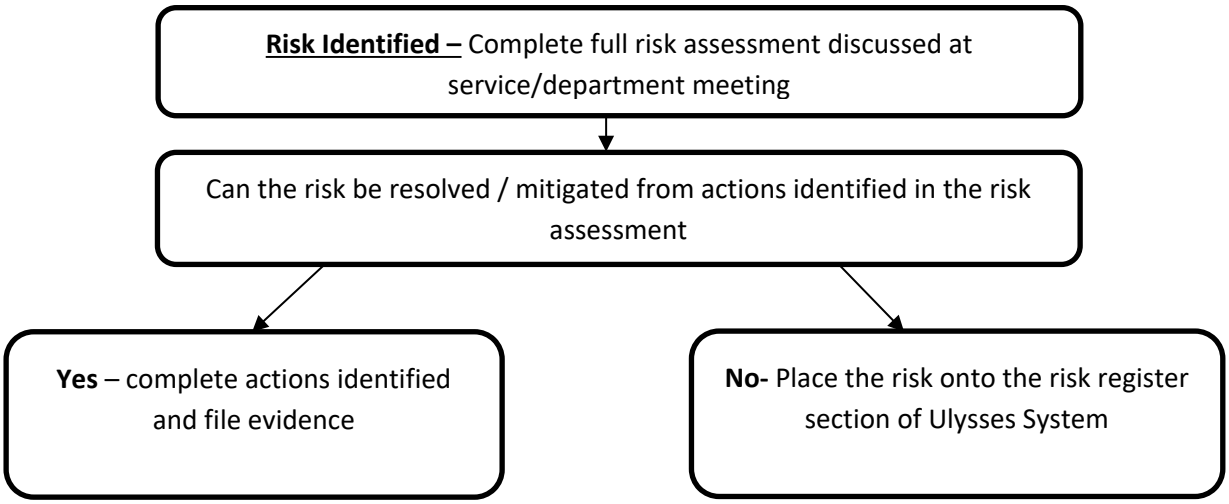
Risk scoring = Likelihood + Consequence + Control Scores

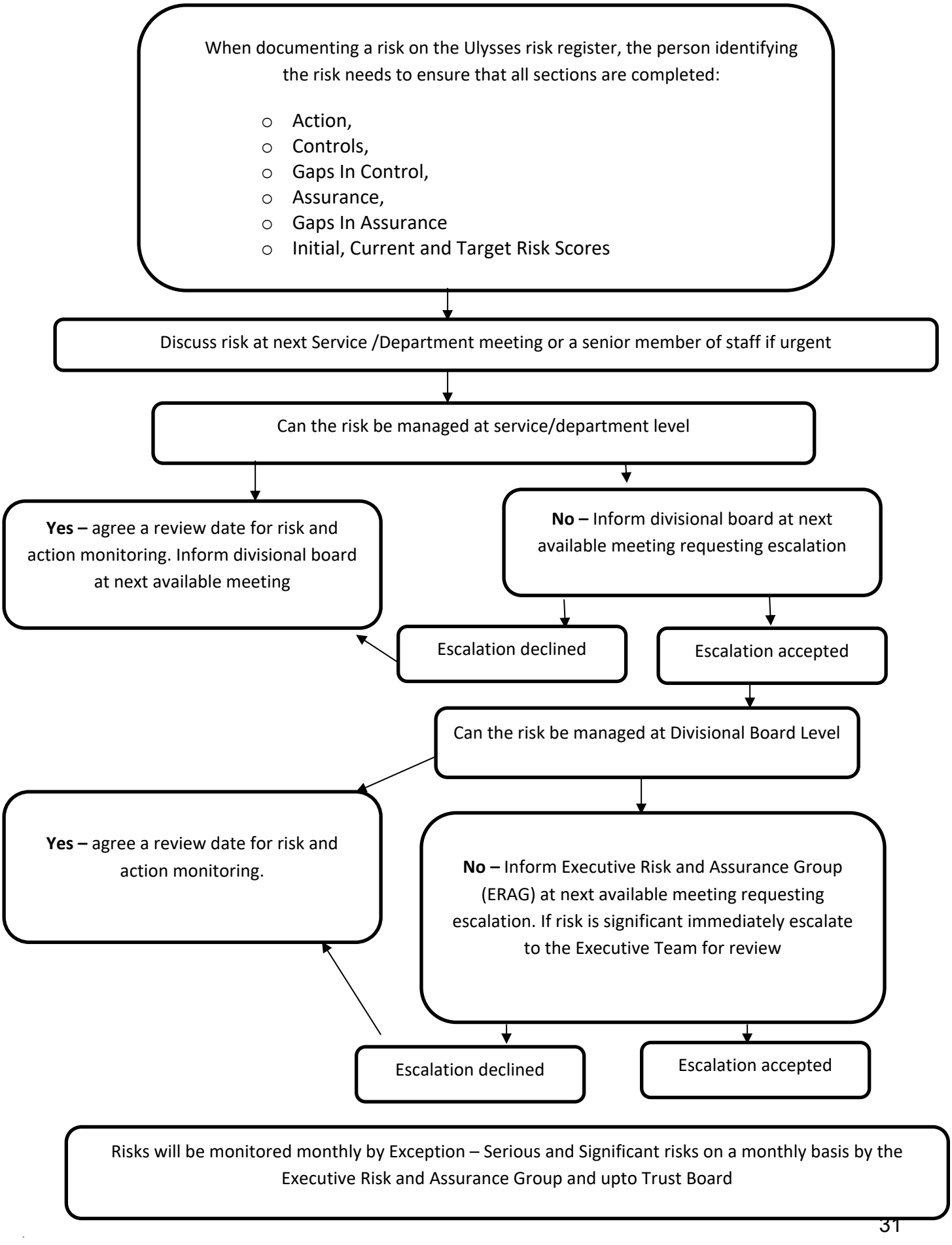
For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

3 - 5	Low risk
6 - 9	Moderate risk
10 - 11	Serious risk
12 - 15	Significant risk

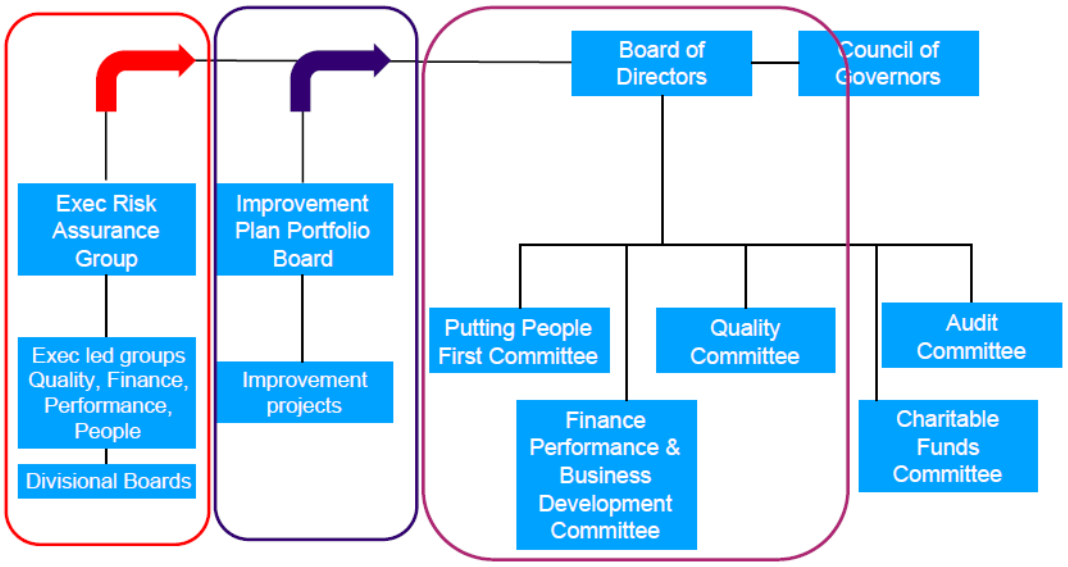
Appendix B – Risk Procedural Steps to Assessment

The following flow chart provides a visual representation of the process of managing risk registers




When documenting a risk on the Ulysses risk register, the person identifying the risk needs to ensure that all sections are completed:
Action,
Controls,
Gaps In Control,
Assurance,
Gaps In Assurance
Initial, Current and Target Risk Scores
Discuss risk at next Service /Department meeting or a senior member of staff if urgent
Can the risk be managed at service/department level
Yes – agree a review date for risk and action monitoring. Inform divisional board at next available meeting
No – Inform divisional board at next available meeting requesting escalation
Escalation declined
Escalation accepted
Can the risk be managed at Divisional Board Level
Yes – agree a review date for risk and action monitoring.
No – Inform Executive Risk and Assurance Group (ERAG) at next available meeting requesting escalation. If risk is significant immediately escalate to the Executive Team for review
Escalation declined
Escalation accepted
Risks will be monitored monthly by Exception – Serious and Significant risks on a monthly basis by the Executive Risk and Assurance Group and upto Trust Board

Appendix C – Risk Oversight



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

Appendix D - Initial Equality Impact Assessment

Name of policy/ business or strategic plans/CIP programme:	**Risk Management Strategy v 16**	
Does the proposal, service or document affect one group more or less favourable than another on the basis of:	**No**	**Justification/evidence and data source**
Age	No	No discrimination / inequality identified, the document sets out the Trust's approach and framework for Risk Management, ensuring this is systematic and objective and applied without prejudice or favour.
Disability: including learning disability, physical, sensory or mental impairment.	No	
Gender reassignment	No	
Marriage or civil partnership	No	
Pregnancy or maternity	No	
Race	No	
Religion or belief	No	
Sex	No	
Sexual orientation	No	
Human Rights – are there any issues which might affect a person's human rights?	**No**	**Justification/evidence and data source**
Right to life	No	No impact on human rights, the document sets out the Trust's approach and framework for Risk Management, ensuring this is systematic and objective and applied without prejudice or favour. The aim being to reduce risks to the organisation, its services and the safety and well-being of patients, visitors, staff and the wider public.
Right to freedom from degrading or humiliating treatment	No	
Right to privacy or family life	No	
Any other of the human rights?	No	

Assessment carried out by:

Date:

Signature and Job Title:

Appendix E – Glossary

Action	A response to control or mitigate risk.
Action Plan	A collection of actions that are specific, measurable, achievable, realistic and targeted.
Assessment	A review of evidence leading to the formulation of an opinion.
Assurance	Confidence based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved (Building the Assurance Framework: A Practical Guide for NHS Boards (2003), Department of Health. Taking it on Trust, Audit Commission (2009), Care Quality Commission, Judgement Framework, (2009).
Board Assurance Framework (BAF)	A matrix setting out the organisation's strategic objectives, the risks to achieving them, the controls in place to manage them and the assurance that is available.
Clinical Audit	'A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria the implementation of change' (Principles of Best Practice in Clinical Audit (2002), National Institute of Clinical Excellence).
Compliance	Acting in accordance with requirements.
Contingency plan	The action(s) to be taken if the risk occurs.
Consequence	The result of a threat or an opportunity.
Corporate Governance	The system by which boards of directors direct and control organisations in order to achieve their objectives.
Control	Action taken to reduce likelihood and or consequence of a risk.
Cumulative Risk	The risk involved in several related activities that may have low impact or be unlikely to happen individually, but which taken together may have significant impact and or be more likely to happen; for example, the cumulative impact of cost improvement programmes.
Escalation	Referring an issue to the next appropriate management level for resolution, action, or attention.
External Audit	An organisation appointed to fulfil the statutory functions in relation to providing an opinion on the annual accounts of the Trust.
Gap in Assurance	Failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively.
Gap in Control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risk and achieve objectives.
Hazard	A potential source of damage or harm.
Internal Audit	The team responsible for evaluating and forming an opinion of the robustness of the system of internal control.
Internal Control	A scheme of checks used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation.
Inherent/ Initial Risk	The level of risk involved in an activity before controls are applied.

Integrated Risk Management	A process through which organisations identify, assess, analyse and manage all risk and incidents for every level of the organisation and aggregate the results at a corporate level e.g., patient safety, health and safety, complaints, litigation and other risks.
Key Risk / Key Control	Risks and controls relating to strategic objectives.
Likelihood	The probability of something happening.
Mitigation / treatment of risk	Actions taken to reduce the risk or the negative consequences of the risk.
Negative Assurance	Evidence that shows risks are not being managed and/or controlled effectively e.g., poor external reviews or serious untoward incidents.
Reasonable	Based on sound judgement.
Reassurance	The process of telling others that risks are controlled without providing reliable evidence in support of this assertion.
Residual / Current Risk	The risk that is still present after controls, actions or contingency plans have been put in place.
Risk	The uncertainty of outcome of activity, described as the combination of likelihood and consequence, including perceived importance.
Risk Appetite	The level of risk that the organisation is prepared to accept, tolerate and be exposed to at any point in time.
Risk Capacity	The maximum level of risk to which the organisation should be exposed, having regard to the financial and other resources available.
Risk Management	The processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate and anticipate them, and monitoring and reviewing progress.
Risk Matrix	A grid that cross references consequences against likelihood to assist in assessing risk.
Risk Maturity	The quality of the risk management framework.
Risk Owner	The person/group responsible for the management and control of all aspects of individual risks. This is not necessarily the same as the action owner, as actions may be delegated.
Risk Profile	The overall exposure of the organisation or part of the organisational to risk.
Risk Rating	The total risk score worked out by multiplying the consequences and likelihood scores on the risk matrix.
Risk Register	The tool for recording identified risks and monitoring actions and plans against them.
Risk Tolerance	The boundaries of risk-taking that the organisation is not prepared to go beyond.
Strategy	In the NHS a document that sets out the corporate approach and policy to a particular area or work activity. This is sometimes described as a policy, particularly outside the NHS.
Sufficient	Whatever is adequate

Appendix F – Risk appetite

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Good Governance Institute

Risk levels ▶ / Key elements ▼	0 Avoid Avoidance of risk and uncertainty is a Key Organisational objective	1 Minimal (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

Trust Board

COVER SHEET

Agenda Item (Ref)	***24/25/014***		**Date: 11/04/2024**	
Report Title	**Committee Chair's Reports**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Committee Chairs***			
Key Issues / Messages	***This report highlights key matters, issues, and risks discussed at Committees since the last report in February 2024.***			
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 of Directors is asked to note the Committee Chair's Reports.			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

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

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

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The Chair reports for the following Board committees are included in this report and attached at Appendix 1.

Quality Committee

- 27 February 2024 – Chaired by Sarah Walker
- 26 March 2024 – Chaired by Jackie Bird

Finance Performance & Business Development Committee

- 28 February 2024 – Chaired by Louise Martin
- 27 March 2024 – Chaired by Louise Martin

Putting People First Committee

- 18 March 2024 – Chaired by Gloria Hyatt

Audit Committee

- 21 March 2024 – Chaired by Tracy Ellery

MAIN REPORT

Quality Committee Chair's Highlight Report to Trust Board
27 February 2024

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• A never event was reported to the Committee during January 2024. The Committee noted the immediate action taken and no theme identified.
• The Committee noted the following matters from the Quality Performance Report:
  ○ Industrial Action had impacted performance delivery for reducing 65+ weeks during December 2023 and January 2024. Recovery measures put in place during January and February 2024 had supported improvement during February 2024, however, further industrial action announced for 24 – 28 February 2024 would further impact performance. It was probable that residual 65+ week patients would remain at the end of 2023/24. NHSE had been made aware of the risk and position.
  ○ Gynaecology Emergency Department (GED) performance remained concerning, as highlighted further from responses to the friends and family test and noted a large programme of work underway to improve the leadership structure and provision of services.
  ○ 28-day faster diagnosis: referrals had been 40% higher in January 2024 compared to the previous year. In addition to the increasing volume of referrals, industrial action had also impacted on compliance against the initial trajectory. A revised trajectory had been agreed by NHSE and implemented as of October 2023 against which the Trust was performing more positively, reporting 56% in February 2024 against a target of 58%. An increasing volume of referrals and increasing waiting lists had been reflected nationally.
	• Received the analysis of adult clinical incidents attributable to the Isolation of LWH services from other specialist services for Quarter 3 2023/2024. It was noted that the report would continue to be shared with the Partnership Forum and the ICB and would not be required to be submitted to the Committee unless escalated.
	• The Committee noted work underway to review the Board Committee structure and work programmes which would reframe the direction of business in 2024/25. A report would be considered by the Trust Board in March 2024 with a view to implement changes as of April 2024. The Committee Chair noted the direction of change and identified the positive impact of the Committee to deepdive into escalated matters and influence change.
	• The Committee received a position update on the High Dependency Unit and Enhanced Maternity Care provision. The Committee noted the recommendations and actions underway in response to the Cheshire and Mersey Critical Care Network Adult Peer review and service specification process of the gynaecology High Dependency Unit (HDU) and enhanced maternal care unit (EMC) in July 2023. The Trust would continue to work collaboratively with the Critical Care Network and local critical care teams to strengthen pathways, training and support rotational posts.
	• The Committee received the Local and National Safety Standards for Invasive Procedures (LocSSIPs), Quarter 3, 2023/24 report noting that digital improvements to record data accurately had meant that the Trust could now focus on monitoring compliance. Compliance issues identified culture and human factors as issues.

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

• The Committee received the Quality and Regulatory update noting reportable key issues in month. Four patient safety incident investigations (PSII) and one never event had been reported since the last update. The Committee noted that the CQC had lifted the Warning Notice following the inspection on 15 January 2024. (ALL)
• The Committee noted the following positive matters from the Quality Performance report:
  ○ The number of out of hours procedures taking place for emergency surgery continued to remain low following a period of reduction, supported by positive steps taken to increase the number of emergency theatre sessions taking place to prevent risk to patients out of hours.
  ○ Maternity Assessment Unit (MAU) Triage performance continued to be positive and above 95% for 15-minute triage and above 99% for 30 minutes.
  ○ To support Elective Recovery, the Trust had engaged with the Royal College of Gynaecologists and had a place on the working group looking at national elective recovery and waiting lists.
	• Approved the Trust Safeguarding Sub-Committee terms of reference.

• The Committee noted positive progress against the RD&I Strategy aims and objectives, particularly in respect to professional development opportunities for Nursing, Midwifery and Allied Health Professional colleagues, project management support for researchers, and maintaining excellent performance in research delivery.	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the related BAF risks and noted no recommended changes to BAF scores.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Considered future direction of papers discussed within the new governance meeting structure

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
180.	Review of BAF risks: Quality related risks	Information	184.	Quality Performance Report Month 10 2023/24	Information
181.	Clinical incidents attributable to the isolation of LWH services from other specialist services Quarter 3	Information	185.	Review of High Dependency Unit /Enhanced Maternity Care provision	Information
182.	Sub-Committee Chair Reports	Assurance	186.	LocSSIPs Quarterly Assurance Report Quarter 3 2023/24	Assurance
183.	Quality and Regulatory Update	Information	187.	Research and Innovation Strategy Review	Information

3. 2023/24 Attendance Matrix

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

Philip Bartley, Associate Director of Quality & Governance	A	✓	✓	✓	A	A	A	A	✓	✓	
Yana Richens, Director of Midwifery	A	✓	A	✓	A	✓	✓	✓	✓	✓	
Heledd Jones, Head of Midwifery	A	✓	✓	A	✓	✓	✓	✓	A	A	

Quality Committee Chair's Highlight Report to Trust Board
26 March 2024

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• The Committee received the Quality and Regulatory update noting reportable key issues in month. Two patient safety incident investigations (PSII) and one never event had been reported since the last update, and investigations underway. The purpose and importance of the Safety Champions ward visits was noted to identify any areas of concern and share learning.
• The Committee noted the following matters from the Quality Performance Report:
  ○ Delivery against 65+ weeks continued to be impacted by Industrial Action and there would be some 65+ week patients at the end of March 2024. Operational guidance confirmed that this target to clear all 65+week wait patients had moved to the end of September 2024 however the Trust aimed to clear any outstanding patients during Quarter 1 2024/25.
  ○ The number of overdue appointments had risen slightly in month, primarily due to the impact of Industrial Action and a high number of cancer referrals which is impacting activity delivery. The Access Sub-Committee provides oversight to multiple actions that are ongoing to increase capacity and improve utilisation of clinics to reduce numbers of overdue appointments.
  ○ A Theatre Utilisation Improvement Project had identified patient experience issues to address which included wait time to go to theatre and theatre cancellations. The CSS and Gynaecology Divisions were working together to support improvements.
• The Committee received a robust review of recent Never Events which included a 6-year lookback, immediate action taken and benchmarking data. Themes identified included use of multiple systems and the recording of swab counts. The Committee noted ongoing work through the LocSSIPs and digital workstreams to improve these systems. An external observational audit of LocSSIP policy for maternity theatres had been agreed to provide an opinion on LocSIPP culture and approach at the Trust and would form part of the Trust's Developing a Safety Culture improvement work.
• The Committee remarked on the finding in the Mortality and Learning from Deaths Report Quarter 3, 2023/24 that non-white British mothers and mothers who resided in the most deprived decile were disproportionately represented in the stillbirth and neonatal deaths data. The Committee requested a 'look back' into previous data sources and requested that this metric be continued to be used in future reports.
	• The Committee received a progress update outlining immediate actions taken to address any risks to patient safety within the current service provision within the Gynaecology Emergency Department (GED) and the Early Pregnancy Assessment Unit (EPAU). The Committee noted the establishment of the Acute Gynaecology Transformation Programme which included key improvement priorities and involved multiple stakeholders, both internal and external, to ensure successful delivery against the Gynaecology Improvement Plan.
	• Safeguarding Quality Assurance Report (Quarter 3 2023/24) provided positive assurance of meeting referral targets, completing investigations and driving forward training programmes, including planning delivery of the Oliver McGowan Learning Disability and Autism Training, whilst undergoing workforce challenges within the Safeguarding Team.
	• Received an update from the Maternity Transformation and Neonatal programme workstreams and noted ongoing progress of the individual workstreams, and arrangements to accelerate progression. The Committed noted positive action underway against theme 2 - growing, retaining and supporting our workforce and a focus towards retention.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• The Committee noted the following positive matters from the Quality Performance report: ○ Continued to improve delivery against the 28 Day Faster Diagnosis Standard. Positive progress has been noted at NHSE Tier 2 performance oversight meetings.	• The Committee received and approved the revised Risk Management Strategy for 2024/25 and recommended approval to the Trust Board. • The Committee noted the year-end outturn against the Corporate Objectives aligned to its terms of reference ahead of submission to the Trust Board.

- The launch of a Menopause Community Pilot in March 2024. This would help reduce the length of time patients are waiting for a first appointment as well as supporting Primary Care to manage patients in the community. The scheme had attracted national interest with the Department of Health and was being identified as an area of innovative practice to reduce long waits for women.
- The number of out of hours procedures taking place for emergency surgery continues to remain positively low following the increase of in-hours theatre capacity for emergency procedures
- MAU Triage performance continues to be high at 98% for 15-minute triage and 100% for 30 minutes.

- The Committee received the Integrated Governance and Assurance Report for Quarter 3 2023/24 and were assured that the Trust was actively addressing challenges, promoting a positive reporting culture, and implementing initiatives to enhance patient safety, health and safety, and overall quality of care.
- The Committee received assurance from the Mortality and Learning from Deaths Report Quarter 3, 2023/24 noting that adequate governance processes were in place when learning from deaths. It was reported that there had been 0 gynaecology, 0 maternal, 6 stillbirths and 15 neonatal deaths during Quarter 3. It was noted that demographic information would be included within reporting going forward.
- The Committee received the Maternity Survey 2023- PICKER Survey Findings and Action Plan for information.

- The Committee received and recommended approval of the following documents by the Board of Directors:
  - Committee Annual Report
  - Committee Business Cycle for 2024/25
  - Committee Terms of Reference – subject to a minor amendment to the membership

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the related BAF risks and noted no recommended changes to BAF scores.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Good discussion and debate throughout the meeting with consideration towards the future direction of papers within the new governance structure. Each agenda item was captured as either going forward to operational Quality meeting or to the Assurance Quality Committee.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
196.	Review of BAF risks: Quality related risks	Information	203.	Mortality and Perinatal Report (Learning from Deaths) Quarter 3 2023/24	Assurance
197.	Sub-Committee Chair Reports	Assurance	204.	Safeguarding Quality Assurance Report Quarter 3, 2023/24	Assurance
198.	Quality and Regulatory Update	Information	205.	Maternity and Neonatal Services Transformation plan	Information
199.	Quality Performance Report Month 11, 2023/24	Information	206.	Revised Risk Management Strategy for 2024-25	Approval
200.	Gynaecology Emergency Department (GED) service progress update	Assurance	207.	Corporate Objectives year-end review	Information
201.	Never Events Update	Assurance	208.	Quality Committee Effectiveness Review	Information

202.	Integrated Governance Assurance Report Quarter 3 2023/24	Assurance	**209.**	Maternity Survey 2023- PICKER Survey Findings and Action Plan	Information

3. 2023/24 Attendance Matrix

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

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
28 February 2024

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• The Committee noted that at Month 10 2023/24 the Trust was reporting an overall net position £17.2m deficit, which represents a £4.0m adverse variance to plan year to date, 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.
• The Committee received a presentational update of 2024/25 planning position, based on draft guidance issued by NHS England. Cheshire and Merseyside System had reviewed the annual positions and had sought additional savings to be identified by trusts. This proved a significant challenge and risk to the Trust to identify.
• The Committee noted the following matters from the operational performance report:
  ○ Delivery against 65+ weeks had been impacted by Industrial Action. Improvements in Month 11 had been demonstrated due to recovery measures put in place, however, further industrial action announced for 24 – 28 February 2024 would further impact performance. There continued to be significant referral pressure on 65+ weeks within Cheshire and Merseyside and the Trust remained committed to clear the backlog by quarter 1, 2024/25.
  ○ Cancer performance continued to be a challenge; referrals were 40% higher in Month 10 than the same period the previous year. The 28 Day Faster Diagnosis Standard had plateaued in month 10 due to high referrals and industrial action although an improved position had been demonstrated in month 11 due to a significant amount of work undertaken to positively improve performance against this target.
	• The Committee received a progress update against delivery towards a Net Zero NHS and the Trust Green plans. The Committee noted the challenging national NHS target date of 2028-32 to 'reduce carbon emissions from our 'NHS Carbon Footprint' by 80%'. The difficulty to achieve these targets without substantial ambition and collaboration from the NHS system was recognised.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• The Committee noted significant positive performance demonstrated by the Community Diagnostic Centre (CDC), driven forward by Claire Butler and Tom White. Going forward into year 4, funding would be allocated as part of regional funding and would not be undertaken as a separate process. (ALL) • The Committee took positive assurance from the Digital Services Update noting that the DigiCare Programme continued to operate within the optimisation phase. The Committee also noted the positive work developing and introducing digital systems to support interpretation of information for non-English speakers. (ALL) • Successful progress against the key themes of the Digital Generations Strategy 2020-24 had been demonstrated by the annual review. (ALL)	• None
Summary of BAF Review Discussion (Board Committee level only)	
• The Committee reviewed the related BAF risks and noted no recommended changes to the risk narrative or risk scores.	

Comments on Effectiveness of the Meeting / Application of QI Methodology
• Noted positive levels of participation, debate and reflection from all members and attendees.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
174.	Review of BAF risks: FPBD related risks	Assurance	178.	Digital Services Update	Assurance
175.	Operational Performance Report Month 10, 2023/24	Information	179.	Digital Generations Strategy 2020-24 Annual Review	Assurance
176.	Finance Performance Report Month 10, 2023/24	Information	180.	Delivery a Net Zero NHS and Trust Green Plan	Information
177.	2024/25 Planning Update	Information	181.	Sub-Committee Chair Reports	Assurance

3. 2023 / 24 Attendance Matrix

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

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

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
27 March 2024

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee noted the following matters from the operational performance report: ○ Delivery against 65+ weeks continued to be impacted by Industrial Action and there would be some 65+ week patients at the end of March 2024. Operational guidance confirmed that this target to clear all 65+week wait patients had moved to the end of September 2024 however the Trust aimed to clear any outstanding patients during Quarter 1 2024/25. • The Committee noted that at Month 11 2023/24 the Trust was reporting an overall net position £19.3m deficit, which represents a £4.9m adverse variance to plan year to date, supported by £3.0m of non-recurrent items. The forecast outturn reported at Month 11 was a £22.6m deficit, which represents and £7.2m adverse variance to plan. • Cost Improvement Programme (CIP) delivery is behind the YTD target by £1.2m and is forecast to be £1.0m behind the full year target by Month 12. • The Committee received a presentational update of 2024/25 planning position. Significant work undertaken by internal teams to develop the 2024/25 plans with robust evidence to support the Trust position and what can be delivered to ensure continuation of safe services. The regional and national position was noted. Final submission of the 2024/25 plans is May 2024 with the Trust submission to the ICB in April.	• Significant work undertaken to ensure capital plan is expended by the year-end and is expected to be in line with available funding • The Committee received a progress update on Third Party Service Provider Controls and Service Level Agreements (SLA) noting continued good progress in strengthening the process and putting in place robust SLA's. The SLA workstream would continue to meet to ensure further progress and continued compliance. It was noted that the Committee should receive updates until the action has been completed as remitted from Audit Committee.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**

• Noted positive sustained improvement in Better Payment Practice Code performance during the year.
• The Committee noted significant improvement against the 28 Day Faster Diagnosis Standard (FDS) which had continued into March 2024. As improvements for the 28 Day FDS are embedded, focus is being driven towards the 62 day % standard which would be a key focus for 2024/25. The Cancer Improvement Plan was demonstrating positive results with continued focus to reduce waiting times further and maintain the increase in activity into 2024/25. Positive progress against performance and pathway changes has been noted at NHSE Tier 2 performance oversight meetings. (ALL)
• The Committee noted the launch of the Menopause Community pilot in March 2024 which had increased capacity within primary care to see new patients on the menopause pathway. The scheme had attracted national interest with the Department of Health and was being identified as an area of innovative practice to reduce long waits for women. The Trust is working on other pathways such as Endometriosis with regional NHSE colleagues to identify similar types of solutions to reduce waiting times. (ALL)
• Fire Service inspection undertaken in February 2024 and no areas of concern identified. (SAFE, WELL LED)
	• The Committee recommend to the Trust Board approval of an extension of the current Soft Facilities Management contract for an initial period to 30 September 2025 with appropriate break clauses.
	• The Committee noted the year-end outturn against the Corporate Objectives aligned to its terms of reference ahead of submission to the Trust Board.
	• The Committee received and recommended approval of the following documents by the Board of Directors:
	  ○ Committee Annual Report
	  ○ Committee Business Cycle for 2024/25
	  ○ Committee Terms of Reference

• The Committee took positive assurance from the Digital Services Update noting the following updates from the DigiCare Programme: (ALL)
  ○ Digital status boards continue to be developed and implemented, with the forecast for all areas to have digital dashboards by July 2024
  ○ Progress on the Patient Engagement Portal (PEP) project with engagement sessions being held regularly for all across the Trust
  ○ Positive external audit results of Clinical Coding work and noted the introduction of a bank workforce for Coding Staff to manage unexpected resource issues in the future and prevent a backlog of work from occurring.	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the related BAF risks and noted no recommended changes to the risk narrative or risk scores.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Noted positive levels of participation, debate and reflection from all members and attendees.
- Consideration of information flow to the Committee within the new governance structure to ensure that the Committee would continue to receive appropriate assurance.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
190.	Review of BAF risks: FPBD related risks	Assurance	**195.**	Extension to OCS Contract for Provision of Soft FM Services	Approval
191.	Operational Performance Report Month 11, 2023/24	Information	**196.**	Third Party Service Provider Controls – Service Level Agreements update	Information
192.	Finance Performance Report Month 11, 2023/24	Information	**197.**	Corporate Objectives: Year-end review	Information
193.	2024/25 Planning Update	Information	**198.**	FPBD Committee Effectiveness Review	Information
194.	Digital Services Update	Assurance			

3. 2023 / 24 Attendance Matrix

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

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

Putting People First Committee Chair's Highlight Report to Trust Board
18 March 2024

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The bi-annual safer staffing report and the annual staff survey report identified potential under-reporting of violence and aggression, for example verbal aggression. A review of tolerance levels within departments was underway to assess the position. • The Workforce KPI report identified turnover at its highest rate since February 2023, and declining PDR rates. The HR Business Partners were working with divisions to review delivery methods to improve staff experience.	• Received the Gender Pay Gap report and noted the recommendations to support women to succeed in leadership roles and reduce the gender pay gap. • The Committee received the workforce performance assurance report from the Gynaecology Division noting a number of transformation projects underway to address issues and challenges identified which would impact upon the nursing and medical workforce. The importance of robust project planning and sign-off processes at each stage of development was noted to support the workforce. • The Committee received an overview of the 2024/25 annual operational and workforce planning process at the Trust, noting the complex financial climate NHS trusts are operating in and details of the internal processes undertaken to effectively plan for a sustainable workforce. • The results and recommended actions in response to the Annual Staff Survey 2023 were noted.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**

• Received a positive staff story from a Clinical Nurse in Ultrasound from Obstetric Theatre who had joined the Gynaecology Early Pregnancy Assessment Unit team who described the initiatives undertaken to improve the patient journey and team morale. The Committee noted how the nurses when given appropriate autonomy could improve the service for their patients. (WELL LED)
• The Equality and Diversity Annual Report provided assurance of the Trust's commitment to inclusion and anti-racism, via a range of strategies and collaborative work, for example the development of an Anti-Racism Hub, and the introduction of Bi-lingual Volunteers programme. Initiatives such as guaranteed interviews for global majority staff and the development of EDI dashboards reflected ongoing efforts to monitor progress and drive accountability. (ALL)
• The Committee noted the Trust overall score as 'developing' against the Equality Delivery System (EDS) assessment. The submission had been reviewed by both internal and external stakeholders. (ALL)
• The Committee took positive assurance from the bi-annual safer staffing review, noting proposed actions for the next six-months including continued focus on succession planning, retention improvement and recruiting to vacancy positions. (ALL)
• The Workforce KPI report demonstrated a significant decrease of sickness rates across the Trust. (ALL)
• The Leadership and Talent Management workstream was delivering planned activity against the PPF strategy. Key developments included delivery of the Leadership and Management Framework to develop future leaders, access to Leadership and Management Level 7 programmes, and increased capacity of coaching and mentoring scheme. Alignment of career progression and leadership development with workforce planning was noted. (ALL)
	• The Committee received and approved the following statutory Equality, Diversity and Inclusion Reports ahead of publication: E&D Annual Report; EDS Report; and the Gender Pay Gap report.
	• The Committee approved the following policies: Supporting staff following a work-related traumatic event or serious incident policy; Temporary staffing policy; Maternity Paternity Baby Loss and Adoption Leave; Capability Policy; Disciplinary Policy and Procedure; and Resolution Policy.
	• The Committee noted the year-end outturn against the Corporate Objectives aligned to its terms of reference ahead of submission to the Trust Board.
	• The Committee received and recommended approval of the following documents by the Board of Directors:
	  ○ Committee Annual Report
	  ○ Committee Business Cycle for 2024/25
	  ○ Committee Terms of Reference

• The Committee received the Chief People Officer report which provided an overview of the key national, regional and LWH people issues. (WELL LED) • Received the Medical Revalidation quarterly update (Quarter 3) and noted that the Trust continues to fulfil NHS England reporting requirements regarding the Responsible Officer role; appraisal; and revalidation. (WELL LED) • The Committee received an end of year summary of performance against the Communications, Marketing and Engagement Strategy 2021-24. (WELL LED)	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the related BAF risks and noted no recommended changes to the risk narrative or risk scores.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- The Committee received detailed reports allowing for robust discussion

2. Summary Agenda

No.	Agenda Item	Purpose	Rating	No.	Agenda Item	Purpose	Rating
115.	Board Assurance Framework (BAF): Workforce related risks	Assurance		123.	Chief People Officer Report	Information	
116.	Staff Story – Gynaecology	Information		124.	Medical Appraisal & Revalidation Quarterly Report Q3	Information	
117.	Service Workforce Assurance Report: Gynaecology	Assurance		125.	Policies for approval	Approval	
118.	Bi-Annual Safer Staffing Review (Q2 & Q3)	Assurance		126.	Annual review of Corporate Objectives aligned to PPF	Information	
119.	Equality & Diversity Reports • E&D Annual Report • EDS Report • Gender pay gap	Information & Approval		127.	PPF Committee Effectiveness Review, Terms of Reference and Business Cycle	Information	
120.	Workforce Planning Return	Information		128.	Staff Survey Results	Information	
121.	PPF Workforce Performance Report	Information		129.	Communications, Marketing and Engagement Strategy Annual Review	Information	
122.	Talent Management & Leadership Development Review	Information		130.	Sub Committee Chair Reports	Assurance	

3. 2023 / 24 Attendance Matrix

Core members	May	Jun	September	Nov	Jan	Mar

Gloria Hyatt, Chair, Non-Executive Director	✓	✓	✓	✓	✓	✓
Louise Martin, Non-Executive Director	✓	A	A	✓	✓	A
Zia Chaudhry, Non-Executive Director	A	✓	✓	A	✓	A
Michelle Turner, Chief People Officer	✓	✓	✓	✓	✓	A
Dianne Brown, Chief Nurse	A	A	A	A	✓	✓
Gary Price, Chief Operations Officer	✓	A	✓	✓	✓	✓
Jen Huyton, Deputy Chief Finance Officer	A	A	✓	✓	✓	A
Liz Collins, Staff Side Chair	✓	✓	✓	✓	✓	✓
Dyan Dickins, MSC Chair	A	A	A	✓	✓	A
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) Non-Member (NM) *Non-quorate meetings highlighted in greyscale*						

Audit Committee Chair's Highlight Report to Trust Board
21 March 2024

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate

- Three out of the six internal audit reports received since the January 2024 meeting had resulted in Moderate and Limited Assurance outcomes:
  - 2022/23 Listening to Patient Voice [Moderate Assurance]
    - Whilst it was recognised that there were examples of listening to patient voices activities being undertaken within the Trust, the approach was unstructured due to the lack of a work plan. This finding was the key driver for the Moderate Assurance opinion.
  - 2023/24 IT Medical Devices (EBME) [Limited Assurance]
    - Whilst the review identified some areas of good practice, there was a compromised system of internal control with weakness in some key controls.
  - 2023/24 Asset Management [Moderate Assurance]
    - The moderate assurance opinion is driven by the lack of a computerised stock system to assist the inventory management of the stock categories covered by this audit.
- The Committee received the external audit plan from Grant Thornton. There had been changes to the team to ensure independence from the team undertaking the audit at Liverpool University Hospitals NHS FT. Noted that materiality had been set at 2%. Significant risks identified for the audit included; Improper revenue recognition, fraud in expenditure recognition, management override of controls, and the valuation of land and buildings.

Major Actions Commissioned / Work Underway

- In reviewing the Follow up of Internal Audit and External Audit Recommendations, the Committee noted the positive progress in closing recommendations but requested that focus be provided on finalising legacy (from previous fiscal years) recommendations ahead of the next meeting.
- Noted that the HFMA had updated their Audit Committee handbook. An action was taken to circulate to the Board.
- The Committee identified a need to increase the response rate to a MIAA anti-fraud survey.
- The Committee requested that the timings to produce the Clinical Audit plan be reviewed. A draft of the plan had been tabled to the Committee in advance of it being reviewed by the Quality Committee or Safety & Effectiveness Sub-Committee. It was agreed to raise this issue with the Quality Committee.
- The Committee noted its role to review the efficacy of the Trust's developing governance and assurance framework, particularly in relation to divisional governance arrangements.

Positive Assurances to Provide

- Six internal audit reports were received – high and substantial assurance reports listed below:
  - 2023/24 Clinical Negligence Scheme for Trusts (CNST) [Assurance Opinion N/A]
  - 2023/24 ESR/HR Payroll [Substantial Assurance]
  - 2023/24 Key Financial Transaction Processing Controls [High (Accounts Payable, Accounts Receivable, Budgetary Control, Treasury Management)/Substantial Assurance (General Ledger)].
- Regarding the internal audit programme for 2023/24 two reports were noted as being in draft. These would be completed before the Head of Internal Audit Opinion was finalised. It was not expected that the outcome of the two reports would impact the overall opinion.
- A draft Head of Internal Audit Opinion was noted. This provided a draft substantial assurance opinion. The internal auditor stated that there was evidence that the Trust was effectively directing focus to areas of potential weakness or risk.
- The Committee noted the MIAA Internal Audit Charter. Noted that new public sector audit standards were expected in January 2025.
- The Committee noted the anti-fraud update.

Decisions Made

- The Committee approved the 2024/25 internal audit plan noting that there had been constructive input from both Executive and Non-Executive Directors.
- The Committee approved the 2024/25 Anti-Fraud work plan.
- The Committee approved the areas of judgements in the accounts and agreed that the accounts would be prepared on a 'Going Concern' basis, whilst acknowledging the significant short-term and structural challenges to the financial position.
- The Committee supported the direction of travel outlined in the updated Risk Management Strategy.
- The Committee agreed to write off £60k of debt for the 2023/24 financial year.
- The Committee reviewed the 2024/25 work plan and terms of reference, recommending them for approval to the Board.

• The Committee was assured by a report outlining the preparation being undertaken towards the 2023/24 financial statements. The report included an update on a previous report tabled in January 2024. • The Committee noted the strengthening of controls around data quality following the implementation of DigiCare.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- No issues raised.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
079	Follow up of Internal Audit and External Audit Recommendations	To receive and review an update of actions taken.	085	Data Quality Assurance	For assurance
080	MIAA Internal Audit Reports a) Internal Audit Progress Report b) Draft Head of Internal Audit Opinion 2023/24 c) Internal Audit Work Plan 2024/25 d) Internal Audit Charter e) Insight Update	To note the contents and any recommendations from the report.	086	Governance & Assurance Framework Review	For assurance
081	MIAA Anti-Fraud a) Anti-Fraud Progress Report 2023/24 b) Anti-Fraud Work Plan 2024/25	To note the contents and any recommendations from the report.	087	Risk Management Strategy	For assurance
082	External Audit Plan 2023/24	To note	088	Board Assurance Framework (BAF)	To receive assurance
083	Preparation of the 2023/24 Financial Statements	For assurance	089	Chairs reports of the Board Committees	Review of Chair's Reports for overarching assurance.
084	Draft Clinical Audit Forward Plan 2024/25	To receive	090	Anti-Fraud Policy Update	To approve

3. 2023 / 24 Attendance Matrix

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

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2024/25/015*		Date: 11/04/2024	
Report Title	Corporate Objectives 2023/24: Final Outturn Review			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	Executives			
Key Issues / Messages	***The report provides the final outturn position for the 2023/24 Corporate Objectives.***			
Action required	Approve ☐	Receive ☒	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is asked to receive the performance / progress to date against the 2023/24 Corporate Objectives.			
Supporting Executive:	Executive Team			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The Board of Directors reviewed the corporate objectives 2023/24 at its meeting on 11 May 2023 and formally approved them.

The cycle of periodic review involves the Committees and the Board reviewing progress on the Corporate Objectives on a six-monthly basis. This report provides the final outturn position.

Consideration of the corporate objectives have been given by each of the respective Board Committees, and they are now presented to the Board for noting.

There will not be explicit Corporate Objectives set for 2024/25 as this process has been superseded by the Improvement Plan. The updates against the 2023/24 objectives outlines the on-going link to the Improvement Plan where appropriate.

Recommendation

The Board of Directors is asked to receive the performance / progress to date against the 2023/24 Corporate Objectives.

MAIN REPORT

NHS
Liverpool Women's
NHS Foundation Trust

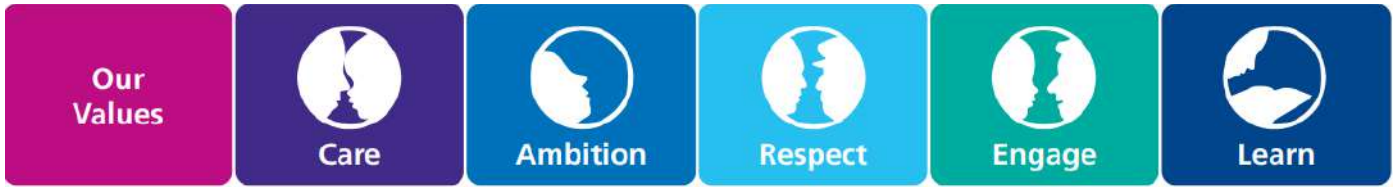
Corporate Objectives

2023 – 2024

Our Vision

To be the recognised leader in healthcare for women, babies and their families

Our shared vision at Liverpool Women's is simple and has withstood the test of time. It is underpinned by a shared set of values based around the needs of our people. We encourage these behaviours in all our staff, partners and volunteers to make sure our values are delivered in the same way, every day, to every person we care for.



We have a set of five strategic aims which are central to all of our strategies and plans, and through working with patients, staff, governors and our partners we have developed a series of ambitions to push those aims one step further, helping us create the mind-set we need to achieve our vision and be outstanding in everything we do:

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

Our partnerships with other providers and organisations across the city are central to delivering our aims; we know we need to work together to make this happen.

Liverpool Women's NHS Foundation Trust

Key	Complete	On track	Risks identified but on track	Off Track

To develop a Well Led, capable, motivated, and entrepreneurial Workforce					
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**12-month review**
Be recognised as one of the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	Moving closer to our aim of 25% of leaders (Band 7 or above) being from a racially minoritized background, by increasing to 13% in 2023/24	CPO	Putting People First Strategy	PPF	The original corporate objective has been modified to increase by 10 leadership roles each year until 25% of our leadership workforce is made up of colleagues from a racially minoritised background. At September 23 there were 27 staff from a racially minoritised background at Band 7 or above. As at March 2024 there are 36 staff at Band 7 or above, representing 9.09% of the total workforce. Actions include: - Clinical roles in Anti Racism hub ringfenced for staff from a racially minoritised background - Career conversations with Deputy Chief Nurse / Deputy Chief People Officer through Black History Month

					- Application for RCN Michelle Cox award to develop leadership programme for nurses and midwives. - Exploration with LUHT re attendance on the Elevate development programme developed by Mid Cheshire NHS Trust. - Consideration of ring-fencing leadership roles for colleagues identified through above processes. *Work will continue as part of the Anti-Racism project in the Improvement Plan.*
	Increasing the number of employees from a racially marginalised background by 5%, moving to 13% in 2023/24	CPO	Putting People First Strategy	PPF	As at September 23, 201 of our staff have declared themselves to be non-white. This represents 11% of our workforce. At March this figure has increased to 218, 11.6% of our total workforce. Again this shows incremental progress but falls short of the 13% target. Continued engagement work is taking place the patient experience / HR/ EDI teams is

					required alongside working in partnership with health, education, local authority and community partners. The aim of this engagement is to build Trust that the organisation is committed to providing quality care and employment opportunities for all. We are working closely currently with local mosque leaders and with the Primary Care Network to demonstrate that feedback is being listened to and acted upon. *Work will continue as part of the Anti-Racism project in the Improvement Plan.*
	Ensure all new leaders (B7 and above) undertake active anti-racist training within their induction programme and ensure all existing B7 and above leaders undertake that training within the next 12 months	CPO	Putting People First Strategy	PPF	Anti-racism is module at corporate induction which all staff undertake. All Band 7 and above nursing, midwifery, AHP and corporate leaders are enrolled in the LWH leadership programme which includes an anti-racism module. At 1 March 2024, 82 future/leaders have accessed the

					training across 2 programmes over the last 12 months. In addition, 12% of all staff (253) have undertaken the new face to face equality, diversity and inclusion training and this includes managers and medical staff. *Work will continue as part of the Anti-Racism project in the Improvement Plan.*
Recruit and retain key clinical staff	Demonstrate continued improvement from the 2022 NHS Staff survey in relation to staff engagement measures.	CPO	Putting People First Strategy	PPF	At 7.04 we remain below the average engagement score for specialist Trusts but above the score for acute Trusts. Our score declined very slightly from 7.07 in 2022.
	Work towards establishing 24/7 consultant obstetric workforce by March 2024 and 8pm-12pm (twilights) for anaesthetic workforce by March 2025.	MD	Medical Workforce Strategy	PPF	Progress continues to be made. Neonatal was compliant from April 2022 and maternity has provided twilight consultant cover up to midnight since this time. Consultation is commencing with the obstetrics workforce to change their working pattern and progress is underway to recruit new consultants to support the rota. In Anaesthetics, the aim is

					to achieve consultant cover onsite for four days per week until 22:00 hrs. The medium term ambition is to achieve twilight cover on the 5th day and over the week end. Specialist doctor appointments are supporting this aspiration. *Work will continue as part of the Acute workforce project in the Improvement Plan.*

To deliver Safe services					
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**12-month review**
Progress our plans to build a new hospital co-located with an adult acute site Develop our model of care to keep pace with developments and	Support and be a major contributor to the NHS Cheshire & Merseyside ICB Women's Services Committee	CFO	Future Generations Strategy	FPBD	The Trust is fully participating in the ICB Women's Services Committee and resultant Women's Services Program Board which is chaired by the Trust CEO. The Trust has attended all meetings, provided information to support report production and supported articulation of the clinical issues in the medium and long term.

respond to a changing environment	Embed and maximise the integrated digiCare EPR system and technologies ensuring systems are optimised for care delivery, secure, data accurate and that staff and patients are digitally supported to maximise digital benefits.	CIO	Digital Generations Strategy	FPBD	The new EPR was successfully implemented in July 2023, which is a key milestone. The programme is concluded it's stabilisation activities and has now moved to an optimisation phase which will centre on integration improvements, embedding use of data, training and maximising benefits, fundamentally driving adoption and good practice.
	Deliver on key national waiting time targets included within the national 2023/24 NHS planning guidance and demonstrate progress towards the three-year delivery plan for maternity and neonatal services, published by NHSE in March 2023.	COO	Our Strategy	FPBD	Urgent Care targets against trajectory are being met for Gynaecology Emergency Department and MAU triage. Elective recovery has been challenged by Industrial Action. National planning priorities for 24/25 are that 65+ week waits are eradicated by end of Q2 24/25. The Trust is aiming to achieve this by end of Q1 24/25. Routine Diagnostic Performance is overachieving against the nationally agreed trajectory. The Trust is in Tier 2 for Cancer Performance due to the failure to meet the 28 day Faster Diagnostic Standard however there have been significant improvements made during Q4.

					There is a Trust Wide Cancer Improvement Plan in Place with the aim to be out of Tier 2 in Q1 2024/25. *This work will continue under the Operational Performance Programme in the Improvement Plan*
	Benchmark Trust's carbon footprint in Q1 and use this to set carbon footprint reduction targets through the implementation of sustainable practices across all areas of our operations.	COO	Green Plan	FPBD	The Trust has refreshed our Green Plan aims and ambitions in Q2. Benchmarking of our Carbon Footprint has been completed in Q2 and will now inform future measurement.
	To lead on the development of a refreshed Quality Strategy with associated delivery plan and supported by a suite of monitoring metrics and dashboard. Including a focus on patient experience, safety, health inequalities and clinical outcomes	Chief Nurse	Clinical & Quality Strategy	QC	The Trust has worked with AQuA and stakeholders from each division to identify quality improvement priorities through 2024/25. These priorities will be incorporated into a refreshed Trust-wide Strategy with Quality and Continuous Improvement featuring as a core component within. The delivery plan to support Quality Improvement in the Trust is near completion with a suite of metrics agreed and the accompanying dashboards

					under development. This work will provide the Trust with a platform to monitor and improve performance and is expected to be complete by Q1 2024/25.

To deliver the best possible Experience for patients and staff					
Strategic Aim	**Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**12month review**
Deliver an excellent patient and family experience to all our service users	Actively seek and use the diverse views of, patients, their families, and our communities to design and deliver services that best meet their needs. To ensure that services are utilising the findings of this intelligence to identify areas for service improvement and that we can demonstrate communication of the actions we have taken because of the feedback received.	Chief Nurse	Clinical & Quality Strategy	QC	Robust Programme of community engagement events in place with a range of stakeholders across all communities. Learning is disseminated and monitored through the PEISC. The connections made have led to designing and delivering services to meet diverse needs, including: <u>Maternity Base</u> Service user feedback via avenues including MNVP, FFT, Picker Survey, and Matron ward

					round, resulted in the extension and inclusion of partners as support to women overnight. Feedback from Picker, FFT and MNVP, perceived delayed discharge was a concern due to delay in the NIPE. Changes made by introducing Twilight staff to undertake covering 24/7 with ongoing evaluation. <u>Community</u> Women informed the midwifery managers that they were unaware of the requirement to book their own 15-week GP appointment following Dating Scan. A simple intervention consisting of Midwifery staff providing a reminder to all to ensure 15-week appointment is booked has improved timely attendance. <u>Digital Update</u> Drivers for change via the MNVP and NEST feedback regarding

					inability to interact effectively with non-English speaking cohort of women. From this feedback a new patient engagement portal has been secured enabling patients to access letters and notifications. The Essential Parent App has been integrated into the LMNS for regional collaboration. The technology implemented allows Maternity to effectively converse with service users and provide patient information leaflets in 27 different languages. Following patient feedback in the Hewitt Fertility Centre about communication and getting through to phone lines from patient representatives and complaints received, the patient portal app was considered for use and tested with a group of patients. It has since been agreed, based on positive feedback from test user group

					and endorsed by Patient Support Group for full implementation. This will be live by April 2024 and will improve the patient experience in Hewitt Centre enabling patients to track important events and show medication information, drug intake, and appointment reminders. <u>Menopause</u> Communities directly requested more information and a desire for health access closer to home on Menopause. There is project work ongoing via the Liverpool Women's Health Hubs. The project spans across the hubs within the 9 Liverpool Primary Care Networks, where clinicians undergoing the British Menopause Society certificate training could run clinics on behalf of Liverpool Womens NHSFT. The model will be a world first, solidifying LWH as the leaders in Menopause care. <u>Community Work</u>

					Through attendance at the Congolese community event concerns about not having interpreters with the correct dialects and language were raised to the Trust Patient Involvement and Experience Facilitator. The changes made included enabling and encouraging the Congolese community to direct the known Congolese Interpreters to join Language Line to support there is future access available.

To be ambitious and Efficient and make best use of available resources					
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**12-month review**
Ensure our services are financially sustainable in the long term	Ensure efficient and effective use of all available resources, meeting agreed financial targets and working across the Cheshire and Mersey system for optimum outcomes for the region.	CFO	Our Strategy	FPBD	The Trust is forecasting to be off plan by £7.2m as agreed with Cheshire and Merseyside ICB. The Trust delivered the financial plan to Q1 of the financial year; however, it was apparent that there was significant risk to delivery for the following reasons:

					• Undelivered CIP. • Impact of unfunded pay award. • Inability to unwind prior year pay investments. • Investment in maternity post CQC inspection. • Excess inflation and other non-pay pressures • Operational pressures. On identification of the likelihood of these risks materialising the Trust embarked on a program of financial recovery and enhanced grip and control. This supported the delivery of CIP but also highlighted that the Trust had limited further opportunities for improvement in year. The outputs of the financial recovery and improvement plan will inform the planning assumptions for 24/25 which recognises the limited scope of the Trust to make high levels of further efficiency or support the financial position with one off benefits. The Trust remains ambitious in resolving the issues that contribute to the deficit and

					deliver value for money services in the most effective manner possible. The Trust is compliant with national and local stipulations regarding expenditure control. *This will be taken forward as part of the Financial Improvement Programme in the Improvement Plan*
	Ensure the Trust has an updated, long-term financial plan in place during 2023/24 with clear views and actions in place in relation to long-term sustainability and with alignment to the Liverpool Clinical Services Review.	CFO	Our Strategy	FPBD	Long-term financial model updated, and 3-year Recovery Plan produced in September 2023 clearly setting out the long term drivers. The long term plan is being updated using 2024/25 as the base year and reflecting the actions the Trust and local partners can take collectively to address financial stability in the longer term.
	Develop the Trust's commercial strategy during 2023/24 and pursue appropriate opportunities to maximise Trust income and expertise for the benefit of our patients	CFO	Our Strategy	FPBD	Commercial principles agreed and embedded in Finance and Procurement Strategy. Commercial workstream in place under Financial Recovery Programme. This will remain an area of focus into 2024/25.

To participate in high quality research in order to deliver the most Effective outcomes					
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**12-month review**
Progress our research strategy and foster innovation within the Trust	Increase nursing & midwifery participation in research as per the Trust's R&D Strategy	MD	Research & Innovation Strategy	QC	Since April 2023 the number of nurses, midwives and AHPs directly employed or formally contributing to research has increased from 25 to 36. This does not include those who contribute as part of their normal role. In April 2023 there were 8 development opportunities for researchers in nursing midwifery and AHPs, this has increased to 23 and include opportunities such as NIHR Associate Principle Investigator scheme., PhDs, LSTM research secondment, early career research development programme, NHIR senior research leader programme, HEE/NIHR pre-doctoral integrated clinical practitioner academic fellowship, RCM small research award, RCM priority setting committee member, sessional

					lecturer at LMJU for research teaching module. It is also of note, is the commencement of the INTRO Project, a national programme led by Di McCarter (NIHR SRL) with the objective of including a research element in all Trust induction; and the RCM Research Prioritisation Project, led by Yana Richens (NIHR SRL) aiming to identify the top 10 national research priorities for midwifery practice and maternity care
	Work towards achieving University Hospital Accreditation by March 2025	MD	Research & Innovation Strategy	QC	Good progress made. One further academic consultant employed.
Fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	The ambition is to fully implement and embed the Trust's accreditation programme by ensuring all wards and departments have, as a minimum, had a baseline assessment undertaken by September 2023	Chief Nurse	Clinical & Quality Strategy	QC	End of Q4 2023/24 reflects all wards and departments have had a baseline assessment completed as part of the Trusts BBAS accreditation programme. Ongoing work is in progress to refresh the current framework in alignment with the CQC Quality standards and ratings.
	Ensure delivery across the 4 Maternity Transformation Programme workstreams, with good communication and engagement of the LMNS and Regional team	Chief Nurse	Clinical & Quality Strategy	QC	The Maternity Transformation Programme continues to deliver across the identified objectives

					identified in the 3 year plan including the delivery of CQC / MSSP Action plan . The plan was refreshed February 2024. Maternity Transformation workstreams meet monthly and report to the FHDB board A highlight report is sent quarterly to the Quality Committee in relation to the programmes of work and outcomes
Expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	Maintain and develop key partnerships, ensuring robust governance structures are in place and effective reporting through the Trust's assurance framework.	CFO	Our Strategy	FPBD	The Trust has a number of key partnerships in place, notably with LUHFT supported by an operational Joint Partnership Board and with Alder Hey via the Liverpool Neonatal Partnership. The partnership with LUHFT has been strengthened in year by the appointment of a joint Chair and Chief Executive which will continue to strengthen joint working arrangements across the sites. The Trust will continue to build on and improve partnership arrangements through the Trust Improvement Plan in 2024/25.

	Support the ICS for C&M and work with the system to improve outcomes for Women's Health including Maternal and Neonatal care.	CFO	Our Strategy	FPBD	Trust fully engages with system work improving women's health (and wider) and actively informs and participates in initiatives to support better outcomes, for example expansion of community- based menopause services.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***24/25/016***		**Date: 11/04/2024**	
Report Title	**Board Committee Annual Reports, 2024/25 cycles of business and Terms of Reference**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***The report presents the following for review.*** • ***Committee Annual Reports for the Quality, Finance, Performance & Business Development, and Putting People First Committees*** • ***Committee Business Cycles for 2024/25 for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees*** • ***Committee Terms of Reference for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees***			
Action required	**Approve ☒**	**Receive ☐**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	The Board is asked to receive and if deemed appropriate approve the following documents: • ***Committee Annual Reports for the Quality, Finance, Performance & Business Development, and Putting People First Committees*** • ***Committee Business Cycles for 2024/25 for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees*** • ***Committee Terms of Reference for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees***			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
PPF, FPBD, Quality, Audit Committees	March 2024	Committee Chairs	Documents reviewed and recommended for approval by the Board

EXECUTIVE SUMMARY

In line with best practice in other sectors, the Board's Committees have produced an Annual Report to the Board summarising their activities for the financial year 2023/24, setting out how they met their Terms of Reference. Similarly, to the previous year, this annual effectiveness review has been aligned with the Business Cycle and Terms of Reference review to ensure that the findings translate to improvements in practice.

The exceptions to the review process are the Audit and Nomination & Remuneration Committee – effectiveness reviews for these forums form part of the Annual Report.

Due to timings, the review of the Charitable Funds Committee will follow at a future meeting.

The Board is asked to receive and if deemed appropriate approve the following documents:

- Committee Annual Reports for the Quality, Finance, Performance & Business Development, and Putting People First Committees
- Committee Business Cycles for 2024/25 for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees
- Committee Terms of Reference for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees

Liverpool Women's NHS Foundation Trust

Quality Committee

Annual Report 2022/23

Background

This report covers the period April 2023 to March 2024. There were 11 meetings held during this period.

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

Strategy and Performance

a) Oversee the development and implementation of the Quality Strategy with a clear focus on upholding the tenants of quality (Governance, safety, patient experience and clinical effectiveness).

b) Ensure that the Quality Strategy and performance are consistent with the Trust's; Vision and strategic objectives and oversee any initiatives undertaken by the Trust that relates to the development and implementation of the Quality Strategy.

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

d) To receive assurance that action plans arising from in-patient, out-patient and other care related surveys are being undertaken and make recommendations to the Board as appropriate.

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

Governance

f) Oversee the effectiveness of the clinical systems developed and implemented to ensure they maintain compliance with the Care Quality Commission's Fundamental Standards in relation to Quality, Safety, experience and effectiveness.

g) Obtain assurance of the Trust's ongoing compliance with the Care Quality Commission registration.

h) Review the controls and assurance against relevant quality risks on the Board Assurance Framework and provide assurance to the Board that risks to the strategic objectives relating to quality and safety are being managed and facilitate the completion of the Annual Governance Statement at year end.

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

j) Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices from NHSI, the Care Quality Commission, the Health and Safety Executive and other external assessors.

k) Receive the annual clinical audit programme and provide assurance to the Board that clinical audit supports the Trust to provide safe and clinically effective patient care and obtain assurance that there is delivery against agreed annual clinical audit programme.

l) Implement and monitor the process for the production of the Trust's year end Quality Report before it is presented to the Trust Audit Committee and Board for formal approval.

m) Undertake an annual review of the Quality and Risk Management Strategies to ensure that they reflect all required priorities.

n) To have oversight of the Committees performance measures to ensure they are appropriate and provide assurance of compliance and escalate exceptions to Trust Board.

o) To review the proposed internal audit plan for all functions areas within the Committees remit e.g. Clinical Audit, Safety, Experience and Effectiveness.

p) Review the Trust's Research and Development Strategy and Innovation Strategy prior to their recommendation it to the Board of Directors.

q) Approving the terms of reference and memberships of its subordinate committees.

Overall

r) To approve any matters that, due to time constraints, could not be approved by the Board within the scope of the Committees areas of responsibility.

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

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

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

v) Assurances will be provided from internal and external sources and will be included in a work plan approved by the Committee at the commencement of each financial year.

Constitution

The Quality Committee is accountable to the Board of Directors.

Membership during the year comprised:

- Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- *Medical Director
- *Chief Nurse
- *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.

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

The Committee's constitution allows for members to participate in person or virtually on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference.

The Terms of Reference requires that all members of the Committee attend a minimum of 75% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2023/24 together with the names of senior management who were invited to attend during the year. The majority of members did not attend 75% or more of the meetings. This appendix will be updated post meeting so that a full 2023/24 picture can be provided to the Board.

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in March 2023 and were approved by the Board in April 2023. The Trust's governance framework is under review to address increased demands from systemic challenges and provide improved clarity between operational and assurance roles.

The current frequency of assurance meetings is resource intensive with much of the agendas during 2023/24 focussed on immediate operational issues. 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 from 10 meetings to 4 meetings per year 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.

Draft updated Terms of Reference for the Committees can be found in Appendix 2. 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.

The Terms of Reference is included at Appendix 2.

Proposed Amendments to the Committee Business Cycle

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

The draft Business Cycle is included at Appendix 3.

Conclusion

In the final analysis, it is concluded that the Quality Committee has achieved its objectives for the Financial Year 2023/24 and the Committee is asked to support the changes to the workplan and meeting frequency.

Mark Grimshaw, Trust Secretary
Quality Committee
March 2024

Appendix 1

Quality Committee Attendance: April 2023 – March 2024

Committee Member	Job Title	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	% (75%) attendance
Sarah Walker	Non-Executive Director **Chair**	A	✓	✓	✓		✓	A	✓	✓	✓	✓	A	73
Louise Kenny	Non-Executive Director	✓ chair	✓	A	A		A	✓	A	A	A	✓	A	36
Jackie Bird	Non-Executive Director	A	✓	A	✓		A	✓	✓	✓	✓	✓	✓ Chair	73
Gloria Hyatt	Non-Executive Director	✓	✓	✓	✓		✓	A	✓	✓	✓	✓	✓	*90*
Dianne Brown	Chief Nurse	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	*100*
Nashaba Ellahi	Deputy Director of Nursing & Midwifery	A	✓	✓	✓		✓	A	✓	A	✓	✓	✓	*70*
Gary Price	Chief Operating Officer	✓	A	✓	✓		✓	A	A	✓	✓	✓	✓	*70*
Lynn Greenhalgh	Medical Director	✓	✓	✓	✓		A	✓	✓	✓	✓	A	✓	*80*
Jenny Hannon	Chief Finance Officer	✓	✓	✓	✓		✓	✓	✓	A	✓	✓	✓	*90*
Michelle Turner	Chief People Officer	✓	✓	✓	✓		A	✓	A	A	✓	✓	✓	*70*
Philip Bartley	Associate Director of Quality & Governance	A	✓	✓	✓		A	A	A	✓	✓	✓	✓	*60*
Yana Richens	Director of Midwifery	A	✓	A	✓		A	✓	✓	✓	✓	✓	✓	*70*
Heledd Jones	Head of Midwifery	✓	✓	✓	A		✓	A	✓	✓	A	A	A	*60*
Invited Attendance														
Mark Grimshaw	Trust Secretary	✓	✓	✓	✓		✓	✓		✓	✓	✓	✓	
Chris Dewhurst	Deputy Medical Director		A		A		✓	A				✓	A	
Robert Clarke	Chairman	✓	✓	A				✓	✓	✓	✓			
Kathryn Thomson	Chief Executive	✓	✓	A	✓			✓						
Matt Connor	Chief Information Officer	✓	✓	✓	✓		✓	A	✓	✓				
Joe Downie	Deputy Chief Operating Officer	✓	✓					✓	✓	✓				
Adam Beattie	NHS Graduate Trainee, Gynaecology	✓												
Sarah Orok	Ward Manager, Gynaecology Outpatients	✓												

Kathy Franey	Head of Learning & Development	✓												
Matt Butcher	Divisional Manager Gynaecology	✓			✓								✓	
Susan Roberts	Assistant Director of Nursing & Midwifery	✓						✓						
Michelle Rushby	Head of Patient Involvement & Experience		✓											
Clare Murray	Observer, Lead Governance Manager Family Health		✓											
Tim Neal	Director of Infection, Prevention & Control			✓										
Mark Campbell	Head of Continuous Improvement			✓				✓						
Allan Hawksey	Head of Risk and Safety						✓	✓	✓				✓	
Louise Hardman	Research & Development Manager			✓										
Andy Sharp	RD&I Director			✓										
Angela Winstanley	Quality & Safety Midwife				✓									
Jodie Hollywood	Children and Young People Lead			✓										
Pippa Roberts	Observer, Chief Pharmacist			✓										
Deborah Ward	Interim Associate Director of Nursing - Safeguarding			✓	A									
Alice Bird	Clinical Director Family Health			✓										
Alison Talbot	NHS England													
Louise Wan	Consultant Gynae Oncologist				✓									
Vicky Clarke	Divisional Manager, Family Health				✓				✓	✓				
Manigandan Chandrasekaran	Consultant Neonatologist							✓						
Richard Hutchinson	Consultant Neonatologist							✓						
Rachel London	Deputy Chief People Officer								✓	✓				
Diane Taylor	Head of Nursing, Gynaecology								✓				✓	
Richard Strover	Associate Director for Information & Information Services										✓	✓		
Jen Deeney	Head of Nursing, Family Health											✓		
Rebecca Kettle	Consultant Neonatologist												✓	
Rachel McFarland	Consultant Obstetrician												✓	

NHS
Liverpool Women's
NHS Foundation Trust

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)				✓ (WP)
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						✓	✓	✓	✓	✓	✓	✓

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					

Liverpool Women's NHS Foundation Trust

QUALITY COMMITTEE

TERMS OF REFERENCE

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 are being undertaken; 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

    *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 for assurance. 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 Audit 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		

Liverpool Women's
NHS Foundation Trust

Finance, Performance & Business Development Committee

Annual Report 2023/24

Background

This report covers the period April 2023 to March 2024. There were 11 meetings held during this period – one more than the 10 scheduled meetings for the year.

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

Finance and performance

a. Receive and consider the annual financial and operational plans and make recommendations as appropriate to the Board.
b. Review progress against key financial and performance targets
c. Review on behalf of the Board, financial submissions (as reported in the Financial Performance Report) or others, as agreed by the Board, to NHS England for consistency on financial data provided.
d. Review the service line reports for the Trust and advise on service improvements
e. Provide oversight of the cost improvement programme
f. Oversee external financing & distressed financing requirements
g. Oversee the development and implementation of the information management and technology strategy
h. Examine specific areas of financial and operational risk and highlight these to the Board as appropriate through the Board Assurance Framework
i. To undertake an annual review of the NHS England Enforcement Undertaking.
j. To review and receive assurance on the appropriateness of the Trust's Emergency Planning Resilience & Response processes and procedures.

Business planning and development

k. Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management
l. Advise the Board and maintain an oversight on all major investments, disposals and business developments.
m. Advise the Board on all proposals for major capital expenditure over £500,000
n. Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy

Constitution

The Finance, Performance & Business Development Committee is accountable to the Board of Directors.

Membership during the year comprised:

- Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- Chief Executive
- Chief Finance Officer
- Chief Operations Officer
- Chief Nurse
- Chief Information Officer

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

The Committee's constitution allows for members to participate in person or virtually on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference.

The Terms of Reference requires that all members of the committee attend a minimum of 75% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2023/24, together with the names of senior management who were invited to attend during the year. The majority of members attended 75% or more of the meetings. This appendix will be updated post meeting so that a full 2023/24 picture can be provided to the Board.

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in March 2023 and were approved by the Board in April 2023. The Trust's governance framework is under review to address increased demands from systemic challenges and provide improved clarity between operational and assurance roles.

The current frequency of assurance meetings is resource intensive with much of the agendas during 2023/24 focussed on immediate operational issues. 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 from 10 meetings to 7 meetings per year 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.

Draft updated Terms of Reference for the Committees can be found in Appendix 2. 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. Other housekeeping amendments had been made e.g. change to Committee membership and updating of job titles.

Proposed Amendments to the Committee Business Cycle

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

During 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
- 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 provider controls (quarterly update as of Nov 23)	to	Executive Risk & Assurance Structure
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

The draft Business Cycle is included at Appendix 3.

Conclusion

In the final analysis, it is concluded that the Finance, Performance & Business Development Committee has achieved its objectives for the Financial Year 2023/24 and the Committee is asked to support the changes to the workplan and meeting frequency.

Mark Grimshaw, Trust Secretary
Finance, Performance & Business Development Committee
March 2024

Appendix 1

Finance, Performance & Business Development Committee Attendance April 2023 – March 2024

MEMBERS	JOB TITLE	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Jan 2024	Feb 2024	Mar 2024	% (75%) attendance
Louise Martin	Non-Executive Director (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		*100*
Tracy Ellery	Non-Executive Director	✓	✓	✓	✓	A	✓	✓	✓	✓	✓		*90*
Sarah Walker	Non-Executive Director	A	✓	A	✓	A	✓	A	✓	✓	✓		*60*
Jenny Hannon	Chief Finance Officer/ Executive Director of Strategy & Partnerships	✓	✓	✓	✓	A	✓	✓	✓	✓	✓		*90*
Kathryn Thomson	Chief Executive Officer	✓	✓	A	A	✓	✓	✓	x	NM			*60*
James Sumner	Chief Executive	NM								✓	A		
Gary Price	Chief Operating Officer	✓	A	✓	✓	✓	✓	✓	✓	✓	✓		*90*
Dianne Brown	Chief Nurse	✓	✓	✓	A	✓	✓	✓	✓	✓	✓		*90*
Matt Connor	Chief Information Officer	✓	✓	✓	✓	A	✓	A	✓	✓	✓		*80*
Invited Attendance													
Robert Clarke	Chair	✓	✓	✓	✓	✓	✓		✓	✓	✓		
Linda Haigh	Interim Deputy Chief Finance Officer	✓											
Mark Grimshaw	Trust Secretary	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Jen Huyton	Associate Director of Strategy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Joe Downie	Deputy Chief Operating Officer	A	A	A	A		✓	✓	✓		✓		
Lynn Greenhalgh	Medical Director	✓		✓		A				✓			
Claire Butler	Head of Strategic Finance		✓		✓	✓		✓		✓			
Zoe Delaney	CDC Operational Manager	✓	✓										
Richard Diamond	Estates and Facilities Manager			✓									
Ellen Matthews	Divisional Manager, CSS		✓					✓	✓				
Lucy Raven	Sustainability Manager, LUFT			✓									
Nicola Daly	Sustainability Team, LUFT			✓									
Nasha Ellahi	Deputy Director of Nursing & Midwifery				✓								
Mark Friedman	Recovery Director				✓	✓	✓						
Chris Dewhurst	Deputy Medical Director					✓							

Jackie Bird	Non-Executive Director					✓							
Gloria Hyatt	Non-Executive Director					✓							
Toni Gleave	Deputy Divisional Manager, Gynaecology					✓							
Michelle Turner	Chief People Officer					✓		✓					
Rachel Gregoire	Scientific Director					✓							
Richard Strover	Head of Information							✓					
Tom White	Acting Divisional Manager CSS							✓					
Jenny White	Finance Business Partner								✓				
Douglas Lodge	Costing Accountant								✓				

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					✓		
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						✓	✓	✓	✓	✓	✓	✓

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

Liverpool Women's NHS Foundation Trust

FINANCE, PERFORMANCE & BUSINESS DEVELOPMENT COMMITTEE

TERMS OF REFERENCE

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		

Liverpool Women's NHS Foundation Trust

Putting People First Committee

Annual Report 2023/24

Background

This report covers the period April 2023 to March 2024. There were six formal meetings held during this period and three workshop sessions.

The aim of the Putting People First Committee is to develop and oversee the implementation of the Trust's People Strategy, providing assurance to the Board of Directors that this is achieving the outcomes sought and required by the organisation. The terms of reference of the Committee were reviewed in March 2023 and notes the Committee's duties as follows:

a. Developing and overseeing implementation of the Trust's People Strategy (integrated workforce, wellbeing and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process

b. Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee)

c. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce

d. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors

e. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues

f. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys

g. Reviewing and approving partnership agreements with staff side

h. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues

i. Monitor and evaluate compliance with the public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics

j. Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings

k. Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required.

l. Receiving and considering issues from other Committees when appropriate and taking any necessary action.

Constitution

The Putting People First Committee is accountable to the Board of Directors.

Membership during the year comprised of:

- Non-Executive Director (Chair)
- 2 other Non-Executive Director
- *Chief People Officer
- Chief Nurse & Midwife
- *Chief Operating Officer
- Staff Side Chair
- Medical Staff Committee representative
- Deputy Chief Finance Officer

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

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

The Committee's constitution allows for members to participate in person or virtually on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference.

The Terms of Reference requires that all members of the Committee attend a minimum of 75% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2023/24 together with the names of senior management who were invited to attend during the year. Most members attended 75% or more of the meetings. This appendix will be updated post meeting so that a full 2023/24 picture can be provided to the Board.

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in March 2023 and were approved by the Board in April 2023. The Trust's governance framework is under review to address increased demands from systemic challenges and provide improved clarity between operational and assurance roles.

The current frequency of assurance meetings is resource intensive with much of the agendas during 2023/24 focussed on immediate operational issues. 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 from 10 meetings to 4 meetings per year 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.

Draft updated Terms of Reference for the Committees can be found in Appendix 2. 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.

Proposed Amendments to the Committee Business Cycle

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

The Putting People First Committee last reviewed its annual business cycle in March 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

The draft Business Cycle is included at Appendix 3.

Conclusion

In the final analysis, it is concluded that the Putting People First Committee has achieved its objectives for the Financial Year 2023/24 and the Committee is asked to support the changes to the workplan and meeting frequency.

Mark Grimshaw, Trust Secretary
Putting People First Committee
March 2024

Appendix 1

Putting People First Committee Attendance April 2023 – March 2024

Committee Member	Job Title	April 2023 Workshop	May 2023	June 2023 Workshop	July 2023	Sept 2023	Oct 2023 Workshop	Nov 2023	Jan 2024	Feb 2024 Workshop	March 2024	% (75%) attendance (workshop not included)
Gloria Hyatt	Non-Executive director (Chair)	✓	✓		✓	✓	✓	✓	✓	NOT HELD		
Louise Martin	Non-Executive director	✓	✓		A	A	✓	✓	✓		A	
Zia Chaudhry	Non-Executive director	✓	A		✓	✓	A	A	✓			
Michelle Turner	Chief People Officer	✓	✓		✓	✓	✓	✓	✓			
Dianne Brown	Chief Nurse	✓	A		A	A	✓	A	✓			
Gary Price	Chief Operating Officer	A	✓		A	✓	✓	✓	✓			
Joe Downie*	General Manager (Representing COO)	-	A		✓	-		-	-			
Linda Haigh	Interim Deputy Director of Finance	A	A	NM								
Jen Huyton	Deputy Chief Finance Officer (as of		A		A	✓	✓	✓	✓			
Dyan Dickins	Medical Staff Committee Chair	A	A		A	A	A	✓	✓			
Liz Collins	Staff Side Chair	✓	✓		✓	✓	A	✓	✓			
Invited Attendance												
Mark Grimshaw	Trust Secretary	✓	✓		✓	✓	✓	✓	✓			
Robert Clarke	Chairman							✓				
Nashaba Ellahi	Deputy Director of Nursing & Midwifery		A	A	✓	✓	✓	✓				
Lynn Greenhalgh	Medical Director	✓	A		✓	✓		✓	✓			
Linda Watkins	Director of Medical Education	✓	✓		✓	✓		✓	✓			
Kat Pavlidi	Guardian of Safe Working Hours	✓	A			A		A	✓			
Matt Connor	Chief Information Officer											
Rachel London	Deputy Director of Workforce	✓	✓		✓	✓	✓	✓	✓			
Rachel Cowley	Head of Culture and Staff Experience		✓									
Rachel Reeves	HR Business Partner (Family Health)	A	✓	A	✓	✓		✓	A			
Angela Hughes	HR Business Partner (Gynae)		A		✓	✓		✓	A			
Sarah Thomson	HR Business Partner (CSS)		✓		✓	✓		✓	✓			

Lisa Shoko	ED&I Project Manager	✓			**A**	**A**			✓			
Yana Richens	Director of Midwifery		✓		✓	**A**		✓	✓			
Kevin Robinson	Freedom to Speak Up Guardian		✓		✓	✓		✓				
Nicola Pittaway	Freedom to Speak Up Guardian								✓			
Shri Babarao (Srinivasarao)	Freedom to Speak Up Guardian	**A**	**A**	**A**								
Andrew Duggan	Head of Communications & Marketing						✓					
Chris Dewhurst	Deputy Medical Director		✓					✓				
Kathryn Franey	Head of Learning & Development	✓	**A**		**A**				✓			
Claire Butler	Head of Management Accounts				✓							
Gina Barr	Voluntary Services Manager		✓				✓					
Matthew Butcher	Divisional Manager, Gynaecology							✓				
Alison Murray	Deputy Head of Midwifery		✓									
Vicky Clarke	Divisional Manager, Family Health							✓				
Heledd Jones	Head of Midwifery, Family Health				✓							
Deborah Ward	Head of Safeguarding		**		✓				✓			
Katherine Fisher	GP Trainee		✓									
Susan Roberts	Assistant Director of Nursing and Midwifery					✓						
Michelle Rushby	Head of Patient Involvement & Experience						✓					
Anne Bridson	Learning and Development Facilitator						✓					
Kate Davis	Head of Fundraising						✓					
Camila Benevides	Midwife							✓				
Megan Johnson	Access Centre Manager							✓				
Caroline Brannan	Pharmacy								✓			
Emma Evans	Consultant Clinical Psychologist								✓			
Helen Preston	Junior Doctor								✓			
Claire Holroyd	Imaging Manager								✓			

Liverpool Women's NHS Foundation Trust

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 Dec*	*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						✓	✓	✓	✓

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					

Liverpool Women's
NHS Foundation Trust

PUTTING PEOPLE FIRST COMMITTEE

TERMS OF REFERENCE

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 four 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		

Audit Committee	BAF Link	Report up to Board	Exec Lead	WORKPLAN 2024/25 (5 per year)											
				Quarter 1			Quarter 2			Quarter 3			Quarter 4		
				April	May	27 June 2024	18 July 2024	Aug	Sept	24 Oct 2024	29 Nov 2023	Dec	23 Jan 2025	Feb	20 Mar 2025
Minutes of Previous meeting			TS			✓	✓			✓			✓		✓
Actions/Matters Arising			TS			✓	✓			✓			✓		✓
Chairs Report - Verbal			Chair			✓	✓			✓			✓		✓
Review of Board Assurance Framework			TS				✓			✓			✓		✓
Review of risk impacts of items discussed			CFO			✓	✓			✓			✓		✓
Any other business			Chair			✓	✓			✓			✓		✓
Review of meeting			Chair			✓	✓			✓			✓		✓
MATTERS FOR DISCUSSION & COMMITTEE ACTION/DECISION															
Data Assurance Report			CDO												✓
Follow up of Internal and External Audit Recommendations			CFO				✓			✓			✓		✓
Register of waivers of standing orders			CFO				✓			✓			✓		
Areas of Judgement in the Annual Accounts			CFO										✓		✓
Losses and special payments			CFO										✓		✓
Raising staff concerns arrangements			CPO				✓								
Settlement agreements annual report			CN&M			✓									
Bribery Act compliance			TS							✓					
Review of Board, Governor and Staff register of interests			TS			✓									
Review of Board, Governor and staff register of gifts and hospitality			TS			✓									
Corporate governance manual review		✓	TS				✓								
Review of assurances processes:			TS												
• risk management			TS												✓
• External Inspections and Accreditations			TS				✓						✓		
• ~~Integrated governance~~			TS												
COUNTER FRAUD															
Counter fraud progress report			MIAA				✓			✓			✓		
Counter fraud annual report 2024/25			MIAA			✓									
Counter fraud work plan 2025/26			MIAA												✓
INTERNAL AUDIT															
Head of Internal Audit's opinion and annual report Draft/Final		✓	MIAA			✓									✓
Internal Audit Work Plan 2025/26			MIAA												✓
Internal audit progress report			MIAA				✓			✓			✓		✓
Review of Internal Audit Charter			MIAA												✓
Follow up of Internal Audit Recommendations			MIAA				✓						✓		
Annual Review of effectiveness of Internal audit			CHAIR				✓								

Audit Committee	BAF Link	Report up to Board	Exec Lead	WORKPLAN 2024/25 (5 per year)											
				Quarter 1			Quarter 2			Quarter 3			Quarter 4		
				April	May	27 June 2024	18 July 2024	Aug	Sept	24 Oct 2024	29 Nov 2023	Dec	23 Jan 2025	Feb	20 Mar 2025
EXTERNAL AUDIT															
External audit findings (ISA 260) and management letter		✓	GT			✓									
External Audit Sector Update			GT				✓			✓			✓		✓
External Audit Plan			GT										✓		✓
Review of effectiveness of external audit			CHAIR				✓								
FINANCIAL REPORTING															
Annual Governance Statement		✓	TS			✓									
Annual report, quality report and financial accounts (to include Code of Governance compliance & Salient Features)		✓	CFO/CMO/ TS			✓									
Audit Committee Annual Report		✓	TS/CFO			✓									
Code of Governance Compliance & NED independence Dec's		✓	TS			✓									
OTHER ASSURANCE FUNCTIONS															
Review of Board Committee Annual Reports			TS				✓								
~~Review of Divisional Governance Arrangements (rota)~~			TS				✓								
Review of Governance and Assurance Framework			TS							✓					
System Governance and Risk Management			TS										✓		
Review of Committee Chair Reports			TS				✓			✓			✓		✓
Clinical Audit Forward Plan			TS												✓
Clinical Audit Annual Report & Mid-Year Update										✓					
GENERAL GOVERNANCE ARRANGEMENTS															
Review of Audit Committee effectiveness		✓	TS				✓								
Review of Committee terms of reference		✓	TS												✓
Committee Business Cycle 2025/26		✓	TS												✓

KEY CODE

Deferred

Item considered as planned

Item considered following deferral

Red text: added to workplan in year

Liverpool Women's
NHS Foundation Trust

AUDIT COMMITTEE

TERMS OF REFERENCE (DRAFT)

Authority/Constitution

1. The Committee is established by the Board of Directors and will be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

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 Audit Committee serves a crucial oversight role, primarily focused on enhancing the Trust's governance, risk management, and internal control frameworks. Its core purpose includes overseeing the integrity of financial statements, ensuring the effectiveness of the internal audit function, monitoring compliance with legal and regulatory requirements, and assessing the independence and performance of external auditors. By scrutinizing financial reporting processes, internal controls, and the management of financial and operational risks, the Audit Committee helps to ensure that the Trust operates in a transparent, efficient, and accountable manner, thereby contributing to the Trust's overall integrity and public confidence in its operations.

Duties

5. The Committee is responsible for:

6. **Governance, risk management and internal control**

7. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievements of the Trust's objectives. It will provide an independent and objective view on internal control and probity. In addition, the committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance, reviewing significant financial reports and the judgements contained in them.

8. In particular, the Committee will review the adequacy of:
    - All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance to external bodies), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
    - The process of preparing the Trust's returns to NHS England (which returns are approved by the Board's Finance and Performance Committee)
    - The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
    - The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
    - The Trust's standing orders, standing financial instructions and scheme of delegation
    - The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State directions and as required by the NHS Counter Fraud Authority
    - The arrangements by which Trust staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In so doing the Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

9. In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

10. The Committee will undertake an annual training needs assessment for its own members.

11. **Internal audit**

12. The Committee will ensure that there is an effective internal audit function established by management that meets mandatory government and Public Sector Internal Auditing Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:
    - Consideration of the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal
    - Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
    - Reviewing the internal audit programme, considering the major findings of internal audit investigations (and management's response), and ensuring coordination between internal and external auditors
    - Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
    - Annual review of the effectiveness of internal audit.

13. **External audit**

14. The Committee shall review the independence, objectivity and work of the external auditor appointed by the Council of Governors and consider the implications and management's response to this work. This will be achieved by:
    - Consideration of the appointment and performance of the external auditor, including making recommendations to the Council of Governors regarding the former

- Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure coordination with internal auditors and with other external auditors
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any audit work performed outside the annual audit plan, together with the appropriateness of management's response
- Recommending to the Council of Governors the engagement of the external auditor in respect of non-audit work, taking into account relevant ethical guidance regarding the provision of such services
- Annual review of the effectiveness of external audit.

15. **Other assurance functions**

16. The Committee will review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. These will include, but will not be limited to, reviews and reports by the Department of Health, arms length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Resolution, etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc) or the Local Anti-Fraud Specialist.

17. In addition the Committee will review the work of other Committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality Committee, Finance, Performance & Business Development Committee and Putting People First Committee, and include a review of an annual report of each of the Committees against their terms of reference. In reviewing the work of the Quality Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

18. The Committee will also review all suspensions of standing orders and variation or amendment to standing orders.

19. The Audit Committee will report to the Board and to the Council of Governors any matters in respect of which it considers action or improvement is needed.

20. **Counter fraud**

21. The Audit Committee will satisfy itself that the Trust has adequate arrangements in place for countering fraud and will approve the appointment of the Local Anti-Fraud Specialist. The Committee will review the outcomes of counter fraud work.

22. **Management**

23. The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

24. The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

25. **Financial reporting**

26. The Audit Committee shall monitor the integrity of the Annual financial statements of the Trust.

27. The Audit Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

28. The Audit Committee will review the Trust's annual report and financial statements before submission to the Board, focusing particularly on:

    - The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
    - Changes in, and compliance with, accounting policies and practices
    - Unadjusted mis-statements in the financial statements
    - Major judgemental areas, and
    - Significant adjustments resulting from the audit
    - Letter of representation
    - Qualitative aspects of financial reporting.

Membership

29. The Committee membership will be appointed by the Board of Directors from amongst its Non-Executive members and will consist of not less than three members.

30. 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.

31. 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.

32. **Voting**

33. 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

34. **Members**
35. Members will be required to attend a minimum of 75% of all meetings.

36. **Officers**
37. The Chief Finance Officer, Deputy Chief Finance Officer, Financial Controller and Deputy Chief Nurse & Midwife shall normally attend meetings. At least once a year the Committee will meet privately with external and internal auditors.

38. The Chief Executive and other executive directors will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are within the responsibility of that director.

39. The Chief Executive will also be required to attend when the Audit Committee discusses the process for assurance that supports the Annual Governance Statement.

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

Equality Diversity & Inclusion

41. In conducting its business, members must demonstrably consider the equality, diversity and inclusion 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

42. 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

43. The Audit Committee will be accountable to the Board of Directors.

44. 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.

45. The Committee will report to the Board annually on its work and performance in the preceding year and, as part of this report, will provide commentary in support of the Annual Governance Statement (AGS), specifically dealing with the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts. In providing this commentary in support of the AGS the Committee will seek relevant assurance from the Chair of the Board's Quality Committee.

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

Administration of Meetings

47. Meetings shall be held at least four times per year.

48. The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

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

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

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

Review

52. The Terms of Reference of the Audit 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		

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**24/25/017**		**Date: 11/04/2024**	
Report Title	**Digital.Generations Strategy Review**			
Prepared by	***Matt Connor, Chief Digital Information Officer*** ***Richard Strover, Associate Director of Digital***			
Presented by	***Matt Connor, Chief Digital Information Officer***			
Key Issues / Messages	***The purpose of this paper is to provide an update on the implementation of the Digital.Generations Strategy. This review provides key achievements and challenges from year 3 of the 4 year strategy.***			
Action required	**Approve ☐**	**Receive ☒**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – ***If no – please outline the reasons for deviation.***			
	The Trust Board is asked to receive the report the progress of the Digital.Generations strategy implementation.			
Supporting Executive:	***Matt Connor, Chief Digital Information 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* 3.1 Failure to deliver an excellent patient and family experience to all our service users	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

This report seeks to provide Trust Board members an annual update on the progress on implementing the **Digital.Generations** Strategy and will describe the key activities completed that support the digital initiatives under each of the four strategic themes. This paper has been received with positive feedback at Finance, Performance and Business Development (FPBD) Committee during February and at Digital Hospital Sub-Committee (DHSC) during March. The digital strategy is a 4-year strategy with the final year encompassing the 24/25 financial year. This report assesses the delivery of the strategy within year 3 covering the 23/24 financial year. The report will describe progress made since the last review and any challenges faced that has impacted on progress and as well as planned activities for the forthcoming year. The report is generated on an annual basis.

The Digital Strategy launched in September 2020 has been in place for 3 years. The first year was spent balancing the underpinning strategic activities with supporting the Trust through the pandemic and subsequent recovery. However, since 2021, there has been an increasing focus on the digiCare EPR programme, delivering on the implementation activities to support the go-live of MEDITCH Expanse Electronic Patient Record, as well deliver a clinically focussed optimisation programme following go-live. The previous report highlighted good overall progress across the digital strategic themes.

Under **Digital.Identity**, this review highlights that establishing a clear brand and communications capability for the electronic patient records programme has been successful. Since EPR go-live, the department has strengthened communications to support the adoption of the EPR, with future communications to emphasis the optimisation programme, listening events and benefits. From a staffing aspect, there has been a focus on implementing a sustainable EPR support structure. The business case to achieve this was approved in Q3 of 23/24 and enables the Trust to retain talented staff who have built the system during implementation. This is key to ensure the system remains safe, and optimisations can be delivered to deliver on the benefits of the system.

Under **Digital.Fundamentals**, this review describes the many significant developments since the last report, which places a real emphasis on improving the end user experience through several initiatives. The review highlights demonstrable benefits realisation from the Fast User Logon project, completion of the Office 365 migration, and significant IT improvements to the network connectivity for Community Maternity. The IT team provided significant resources to deliver the IT readiness workstream for EPR which was an enabling factor for go live, this meant that staff have the right device in the right place to support care provision when using digiCare MEDITECH Expanse.

Under **Digital.Excellence**, this review summaries the milestone achievement of successfully implementing the Trusts digiCare MEDITECH Expanse EPR system. The activities undertaken within the last year have predominantly supported this programme which has resulted in a safe go live during July 2023 replacing the Trusts legacy MEDITECH Magic system. Following go-live, the department has focussed on stabilisation activities and has now transitioned to an optimisation phase where over 20 improvements have already been delivered. The report illustrates the journey of maturity within Digital Maternity celebrating 3 years of K2 EPR adoption. A significant area of progress since the last report is the innovation and improvements within the Trusts Business Intelligence, with a focus on bringing data to the clinical frontline through live clinical dashboards. Finally, the department celebrated winning the Health Tech News (HTN) Tech Team of the Year award for the successful first deployment of MEDITECH Expanse within the NHS.

Under **Digital.Innovation**, this review reports the ongoing progress made within Robotic Process Automation (RPA) to support mitigation of multiple systems and highlights significant amounts of external funding secured since the strategy was launched to support digital innovation and adoption. There is ongoing emphasis on improving the patient experience through digital innovation and the review describes the work underway on the Maternity 'Essential Patient' App, Hewitt Fertility Centre Patient Portal and the funding secured for a Trust Patient Engagement Portal.

The overall assessment of this review is that the implementation of the strategy continues to make good progress which is demonstrated within many of the strategic themes and underpinning initiatives. At this stage of the strategy implementation the emphasis is on embedding and optimising digiCare which will provide the Trust with the benefits of a modern Electronic Patient Record.

Recommendation

This report reflects that demonstrable progress has and continues to be made in each of the four key themes of the strategy. The Trust Board is asked to receive the report and the progress of the **Digital.Generations** strategy implementation.

MAIN REPORT

1.0 Digital.Identity

The Digital.Identity theme comprises of two main programmes of work; Digital Brand and Digital Front Door.

1.1 Digital Brand

Digital Brand is about promoting Digital Services and aligning the understanding of what we provide, so that both staff within the Digital Services department have a clear identity and likewise the consumers of digital; the Trust staff are better placed to understand how we can help them to fulfil their digital requirements regardless of whether this is a support incident, a new project or service request.

The previous strategy review described how the Digital Services Department had an EPR brand known as digiCare and implemented regular robust communications through a dedicated Digital Communications officer. This has been successful as the MEDITECH EPR is often referred to as the digiCare system with Trust staff linking the clear branding.

Within the last period, the department have focused on supporting the Trust with adoption of the new system; highlighting new features or standard operating procedures. The department have successfully implemented a digiCare Trust intranet site.

In the forthcoming year the department will deliver an optimisation focussed digiCare EPR communications campaign supported by scheduled listening events. Digital Services will also strengthen the content within the Intranet departmental and EPR microsites.

1.2 Digital Front Door

Digital Front Door is intended to build on the Digital Identity and aims to improve embedding the service across the Trust. Since the previous Digital Strategy review, there has been further activities to strengthen the clinical digital leadership. The Chief Nurse Information Officer (CNIO) role has been successfully assessed and banded within the Agenda for Change process. This can be recruited to within the 24/25 financial year. The outstanding Associate Chief Clinical Information Officer role within Family Health was also filled which strengthens the digital engagement within Family Health.

However, the most significant development since the last review is the successful approval of a Clinical Systems Staffing business case, which following assessment of EPR support requirements detailed a new structure and support capability. This ensures that the system is maintained and optimised safely, builds on developed knowledge, and reduces the risk of regretted loses within the department.

There were changes within the CIO role, which has become a joint Chief Digital Information Officer (CDIO) role across Liverpool Women's Hospital and Liverpool University Hospitals. This presents collaboration opportunities across the service which will be explored through 24/25.

In the forthcoming year the Trust will appoint a digital CNIO which will conclude the clinical digital leadership structure. The department will progress the Digital Service Desk project working in collaboration with LUHFT. The CDIO will explore collaboration opportunities across his joint portfolio to maximise service delivery, best practice and digital systems innovation.

2.0 Digital.Fundamentals

Digital Fundamentals is about getting our basics right, first time and every time. Whilst we understand and accept that errors or mistakes occur, we aim to learn and reduce these so we can offer an improving service, which is consistent and allows best use of our resources. There are four key programmes of work to support this.

2.1 Digital Compliance

Effective digital compliance reflects the activities we undertake to improve upon the standards within Digital Services. Specifically relating to **Excellent digital standards,** the departments achievement of Excellence in Informatics Level 2 accreditation underlines the departments ambition to provide high quality digital services.

Since the launch of the Digital.Generations strategy, there has been significant progress within this initiative, with the implementation of the Trust Cyber Security Strategy, service level security policies, successful compliance against the Data Security and Protection Toolkit (DSPT) submission.

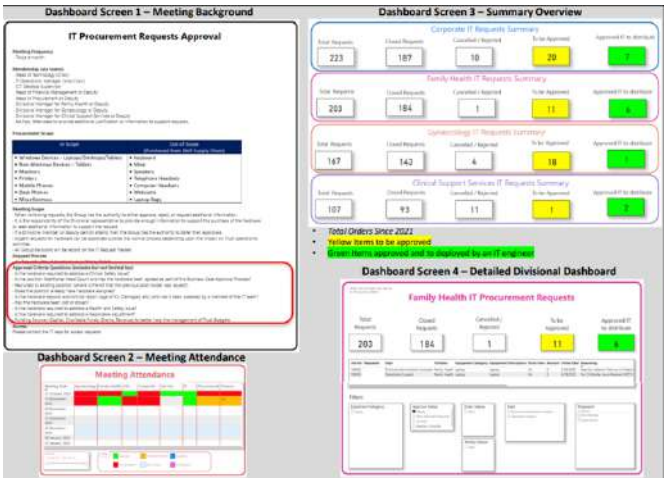
The department has successfully implemented Secure Records scanning and destruction process compliant within the BS10008 standard (of which it is assessed against). These activities have transitioned to 'business-as-usual'.

2.2 Digital Accessibility

Digital Accessibility is focused on providing our Trust staff with the best end user experience. There are three initiatives.

Right Device, Right Place is an important initiative to improve the end user experience. Since the launch of the Digital Strategy, we have completely replaced the Trusts end user devices through several capital investment phases. A necessary requirement to have modern computers in place for the EPR implementation. The EPR programme had a dedicated IT workstream which ensured that Trust requirements where fully met. This meant that not only traditional computers were updated or replaced, but that new printers including mobile label printers, mobile computers on wheels, and tablet devices where provided.

Alongside the planned end user device refresh programme, the department have also strengthened its processes for IT procurement requests. New dashboards have been created that divisional leads have access to showing data on total requests, approved/ rejected and outstanding requests. The outstanding requests can be drilled down so that divisional leads are able to approve and assess whether staff have logged their requests for new equipment in the standard way.

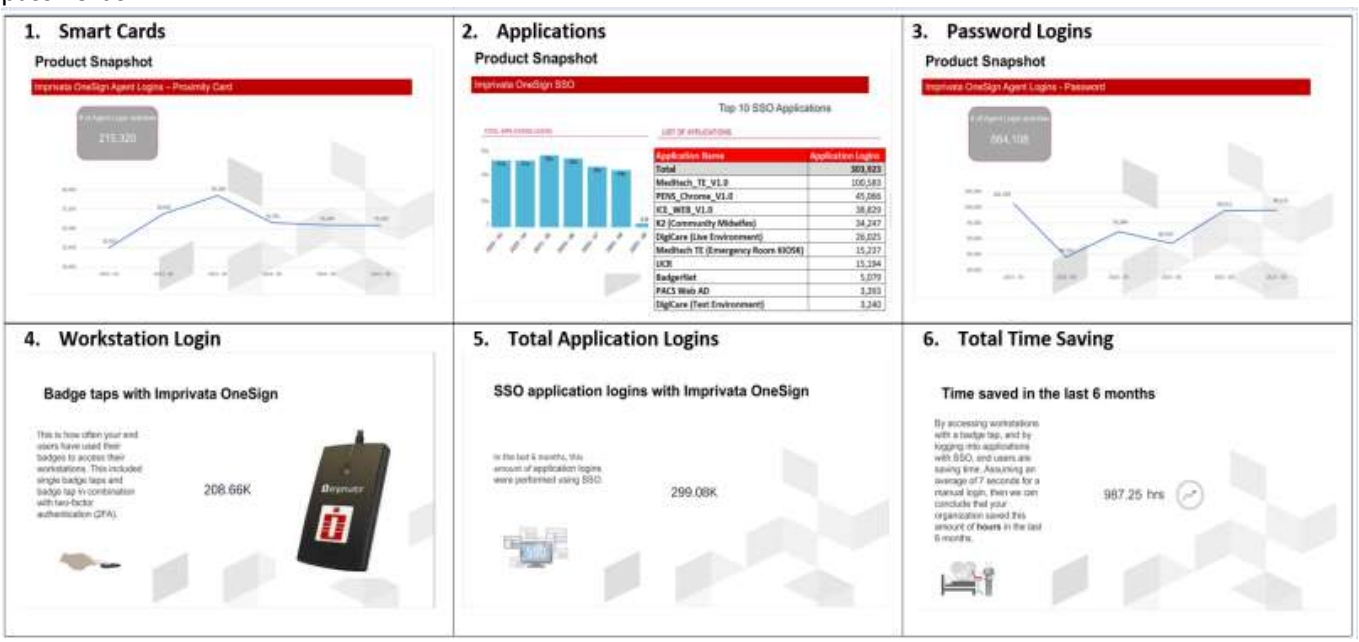


The right device is not always a physical one, and there have been significant activities undertaken resulting in the implementation of the Trusts Virtual Desktop Infrastructure (VDI) project which provides staff with a remote access solution. This is successfully used in Maternity Community teams.

Office 365 is an **End User Experience** project that has successfully concluded since the previous strategy review. This project replaced over 1800 legacy Microsoft Office 2010 applications with the modern cloud-based Microsoft Office 365.

The previous strategy review identified a successful pilot of the **Single Sign On (SSO) Fast User Access project** had been completed in Gynaecology and another 8 areas underway. Since then, the programme has fully delivered Single Sign On across 60% of the Trust with significant benefits achieved. There has been positive feedback received by staff, and since go-live (data based on 6 months) over 208,000 logins have been achieved using a tap-and-go

smart card as opposed to typing a password, and over 985 hours saved by using this technology over traditional passwords.



2.3 Digital Infrastructure

Robust infrastructure is essential to maintain a consistent and reliable digital service. When running optimally, this should be invisible to the end user, but when it fails it can be catastrophic. There are five key initiatives underpinning the Digital Infrastructure programme.

Since the launch of the strategy, a significant programme of work has been focused on replacing the Trusts legacy data network. Previous strategy review reports have established that the programme has resulted in the total replacement of the physical network switches in the data rooms, replacement and migration of the firewall and successfully replaced over 130 legacy Wi-Fi access points. The last strategy review stated that the IT team were commencing a project to strengthen the Internet connectivity resilience. Since then, the IT team have delivered on these activities successfully implementing Trust network connectivity in 10 out of the 12 community sites, and the remaining to be fully connected by the end of the 23/24 financial year.

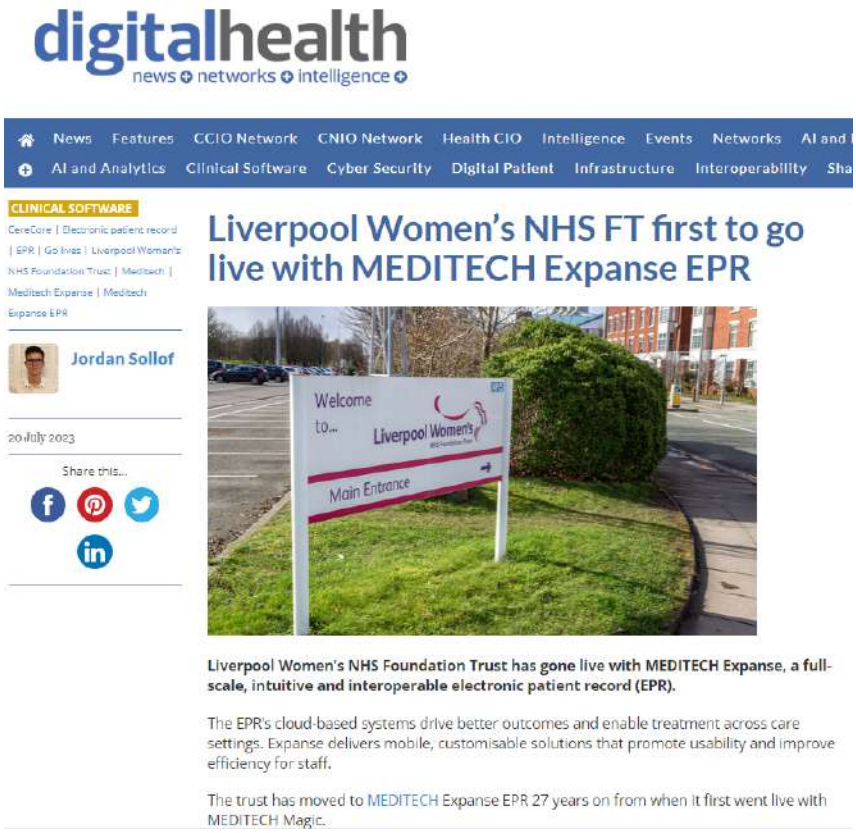
In addition to the Community network progress, the IT team have fully implemented resilient network links for internet and cloud services, this means that services such as Microsoft Teams is less prone to outages due to a local network incident.

Within the coming year, the IT team will be focussed on strengthening the Trust Wi-Fi Coverage following an optimisation audit, deploying a better public and patient Wi-Fi service, and replacing the Trusts primary data storage platform. The IT team will continue to support the EPR optimisation work through deploying more mobile computers, large digital screens, and tablets to support the Trusts Deteriorating Patient collaborative.

3.0 Digital.Excellence

Digital.Excellence represents the pinnacle of an effective digital culture within the Trust, building on the previous themes Digital Excellence offers perhaps the most benefit to our patients and staff. Focused on delivering effective integrated systems, built on rich, structured, and comprehensive datasets, this allows staff to input data once and access clinical information at the right place, right time. In synergy, digital inclusion and skills are equally important so that staff can get the most out of the systems, using them in a safe manner and understand the consequence of their use operationally. There are four programmes to underpin the ambitions of Digital.Excellence.

3.1 Digital Capabilities


digitalhealth
news networks intelligence

News Features CCIO Network CNIO Network Health CIO Intelligence Events Networks AI and
AI and Analytics Clinical Software Cyber Security Digital Patient Infrastructure Interoperability Sha

CLINICAL SOFTWARE

CereCore | Electronic patient record | EPR | Go live | Liverpool Women's NHS Foundation Trust | Meditech | Meditech Expanse | Meditech Expanse EPR

Liverpool Women's NHS FT first to go live with MEDITECH Expanse EPR

Jordan Sollof

20 July 2023

Share this...

Liverpool Women's NHS Foundation Trust has gone live with MEDITECH Expanse, a full-scale, intuitive and interoperable electronic patient record (EPR).

The EPR's cloud-based systems drive better outcomes and enable treatment across care settings. Expanse delivers mobile, customisable solutions that promote usability and improve efficiency for staff.

The trust has moved to MEDITECH Expanse EPR 27 years on from when it first went live with MEDITECH Magic.

Digital Capabilities is focused on ensuring the Trust has the most efficient and appropriate clinical system capabilities, where the perception of a single clinical record is presented through effective systems integration. A key initiative is the **Electronic Patient Record (EPR) Programme**. Since the last strategy review, this programme of work continues to consume the majority of the Digital Services resource due to its strategic importance and organisation priority. Several key milestones have been achieved: EPR go-live, post go-live stabilisation and more recently a move into optimisation activities.

During July 2023, and following a significant amount of work and careful planning, the Trust went live with MEDITECH Expanse EPR. A true digital milestone resulting in a transformational step change as our modern EPR replaced MEDITECH Magic; a system that had been in use for over a quarter of a century at the Trust. The outcome of a successful go-live was built on several key factors: effective staff engagement and organisational change, clear programme branding, talented EPR systems team, strong digital clinical and nursing leadership, responsive IT input, honest listening and acting upon external reviews and true hand in glove approach between Digital, Operations, Clinical and Nursing to achieve a safe go live. Every Trust Executive had a part to play in leading the change.

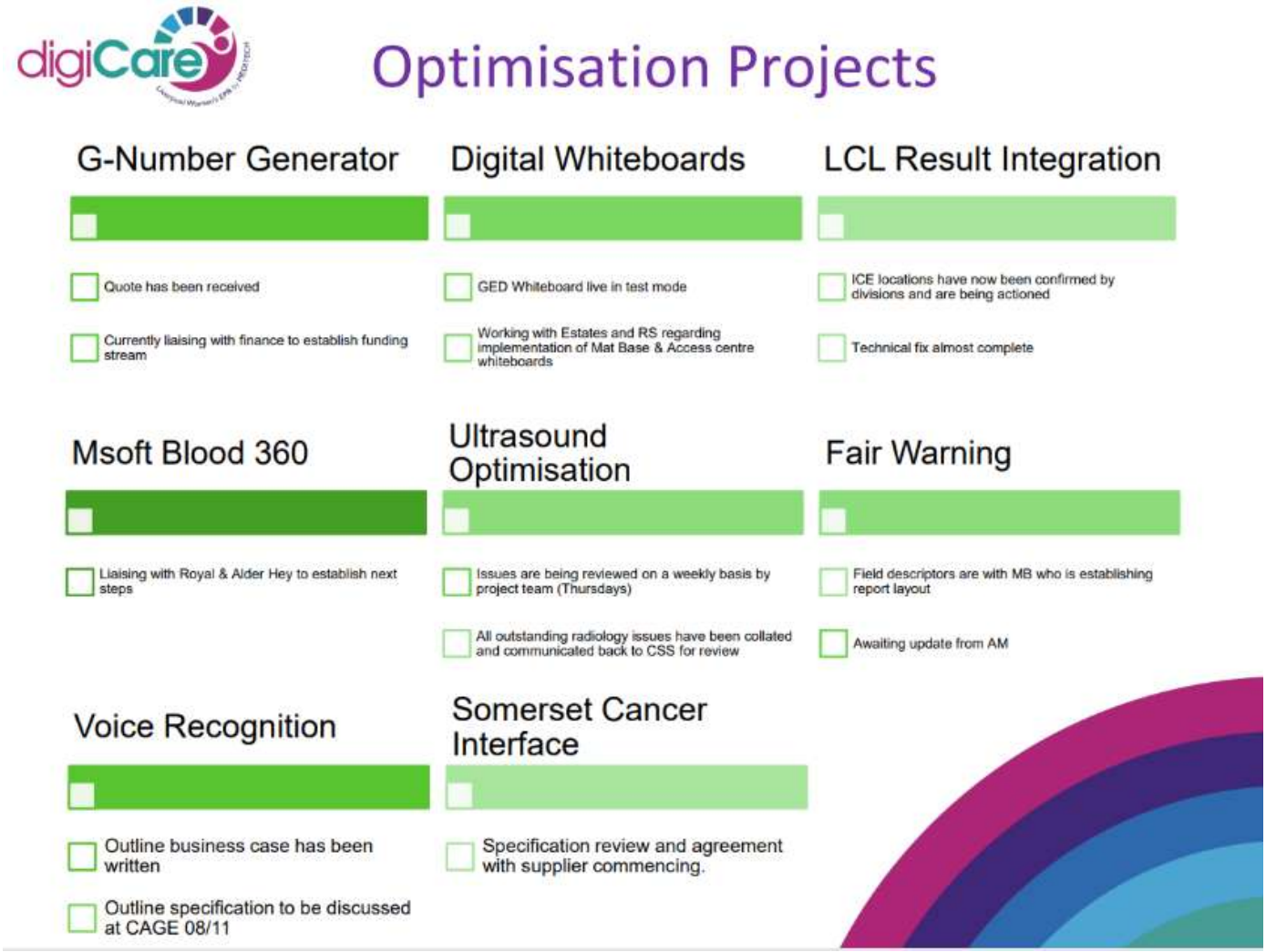
This has been a complex programme underpinned by effective robust governance and underpinning workstreams. Immediately following the go-live, the Trust enacted an intense 8-week stabilisation support phase. Operational leadership led daily silver command touchpoints ensuring clinical risks where managed and translated to bronze technical command for resolution, with some issues requiring escalation to Gold Executive Command. This proved to be very effective and navigated the Trust through a complex and unstable period for the staff.

Since October 2023 and following conclusion of the stabilisation phase, the Digital Services team have shifted to optimisation activities, with significant amount of progress already evident. The digital systems team have already implemented 24 prioritised optimisations since go-live. These relate to:

- Improvement to the Outcome process, saving staff time and improving data quality.
- Electronic GP letter correspondence, ensuring GPs have timely access to LWH transfer of care information.
- Strengthening patient safety and care quality through data collection optimisations such as mandatory VTE data collection, improving procedure name accuracy, improving front end special indicators visibility, and improved Theatre LocSSIP documentation.
- Deployment of real-time digital whiteboards in some clinical areas, built on MEDITECH Expanse and K2 record data.
- Improvements to the Pathology and Radiology order process, particularly to the sample taking process exploiting mobile phlebotomy.

- Strengthen integration: improved Centricity anaesthetic chart integration and developing PENS integration for Gynaecology.
- Additional e-Consent document developed and deployed.
- Refresher training provided to staff.
- And many more optimisations.

In the forthcoming year a number of larger optimisations are planned:



The digital systems team can implement many of the requests without relying on costly vendor developments which is a benefit of the MEDITECH Expanse system. In addition to the planned activities above the department will be planning to upgrade MEDITECH Expanse from V2.1 to V2.2 which will provide further user interface improvements. Liverpool Women's Hospital has led the way with developing and implementing MEDITECH Expanse in the NHS.

In the forthcoming year the Digital Service department will focus on delivering the planned optimisations, 2.2 system upgrade, improving systems integration to reduce the multiple systems risk, supporting the Trusts Deteriorating patient collaborative and further development of Digital Benefits Realisation dashboard and KPIs.

Outside of the main **digiCare Electronic Patient Record (EPR) Programme**, there has been progress within the wider digital programme. Digital Services have successfully implemented a significant upgrade to the Hewitt Fertility system known as **IDEAS** and has within the last year successfully developed an interface from MEDITECH Expanse improving the patient demographic data quality and removing some manual processes. The Digital

Programme team continue to work with the Trusts PACS Manager on the transition from the current version of PACS (on-premise) to the new Cloud-hosted and centrally managed C&M instance.

Outside of the digiCare EPR Programme, the Trusts **Digital.Maternity** programme has been the most complex programme delivered to date, and since the successful go-live of K2 Digital Maternity EPR system in January 2021, the Trust celebrates 3 years of K2 adoption and optimisation. Much of the success of the system can be attributed to the Trusts investment in our two talented digital midwives who in collaboration with Digital Services has driven the development and adoption of the system. There have been over 300 system optimisations delivered since go-live which reflect the evolving needs of Maternity Care in-line with CNST and wider patient safety and quality requirements.

In the forthcoming year, the Digital Services team together with our Digital Midwives will deploy a further 90 optimisations and focus on strengthening integration between K2 and MEDITECH Expanse. The optimisation work will focus on supporting the Trusts deteriorating patient collaborative. The infographic on the following 3 pages draws out the 3-year digital maturity journey undertaken thus far.

LWH Maternity DigitalJourney: 2021/22

Digital Generations

19th Jan 2021
K2 GO LIVE!
-2919 Women signed up to MPN and 712 logins by 31st Jan

March
- First post-go live scope of work submitted to enhance K2 V5
- K2 V7 demonstrated to K2 customers

Integrated Care Pathway for Emergency Obstetric procedures

May
- Theatre module and Family Origin Questionnaire scope of work started

July
6204 Women signed up to MPN
82462 logins to MPN

Sept
- Amy becomes Trusts second Digital Midwife.
- Paper notes phased out
- Two scopes of development work defined for K2 optimisations

BSOTS

November
- BSOTS launched
- Ockenden Report optimisations went live
- Digital maternity bid submitted for £1.2 million to improve maternity records, kit and interoperability at LWH

19th Jan 2022
- Visits to community hubs
- GP electronic letters pilot commenced
- Delivery plan for digital funding submitted
-9731 Women signed up to MPN
164568 logins

1 2021 2

Our Maternity EPR Implementation Journey

2022 12

February
- Floorwalking and training continued
- Hot fixes implemented for issues found since go live
- Reports set up

April
- 4123 women signed up to MPN and 41293 log in's

June
- Visits to community hubs to assess connectivity and listen to experiences and feedback from midwives.
- £52 million pledged to improved digital by NHSX

August
- Gen appointed as permanent Digital Midwife
- Integration between K2 V7 and Meditech Expanse defined for antenatal referral and pre - registration interfacing

October
- P2 and P3 Guardian portals replaced with new P4's
- Connectivity issues at Belle Vale resolved by installing data point. Plan to do the same at other community hubs

December
- SBL & CNST risk assessment optimisations went live
- Successful in obtaining significant funding in the UTF and Maternity Digital bid to improve interoperability, kit and e - consent

NHSX

Liverpool Women's NHS Foundation Trust

LWH Maternity DigitalJourney: 2022/23

January
- We celebrated 1 year of K2!
- All outstanding optimisations send to K2 for scope, quote and timeline.
- 180,250 MPN logins & 10,080 pregnancies logged

February
- K2 provided a quote & timeline for high priority optimisations
- Development work for GROW 2.0 to interface into K2 commenced
- We continued community hub visits

March
- K2 and Viewpoint, CRIS and Badger integration defined
- Project manager, Manny, employed to implement multiple interfaces & optimisations

April
- K2/GROW 2.0 interface testing commenced. CRIS is also tied to the interface for automatic estimated fetal weight plotting.

May
- GROW 2.0 training commenced
- 'My Pregnancy Notes' survey released to gain an insight into women's experiences of online records.

June
- Integrated electronic growth charts launched, the first of its kind.
- Testing for Meditech Expanse (MtE)/K2 interfaces commenced

July
- Gen & Amy accepted onto digital health leadership course at Imperial College London
- Testing of >100 high priority optimisations commenced
- 285,185 MPN logins & 13,655 pregnancies logged

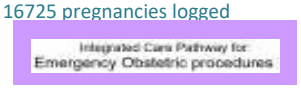
August
- Bespoke MAMA Academy passports implemented
- We shared our GROW success with Doncaster NHSFT

Sept
- 1 year anniversary of the Digital Dream Team!
- K2/GROW project poster presented at Better Births conference
- K2/MtE ADT interface signed off

October
- Amy appointed permanent post as digital midwife!
- Gen commenced digital health leadership PG Certificate
- Subject Access Request functionality released.

November
- Implementation of 150 optimisations, including preterm and honeysuckle pathways
- K2/GROW project poster presented at Maternity Conference
- New standardised WHO checklist launched in maternity theatres

December
- Electronic theatre pathways launched
- Project 'Documentation December' completed
- K2/Viewpoint/GROW 2.0 interface signed off ready for Jan 23 launch
- Testing for Imprivata badge -taps commenced
- MPN logins 388644 & 16725 pregnancies logged

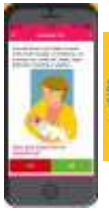


NHS
Liverpool Women's
NHS Foundation Trust

LWH Maternity DigitalJourney: 2023/24

Digital Generations

K2



the lullaby trust

2023

Our Maternity EPR Implementation Journey

2024

January
- We celebrated 2 years of K2!
- Imprivata rollout across Maternity commenced
- 443,668 MPN logins & 17,476 pregnancies logged

February
- MAU improvement work commenced following CQC inspection. New digital whiteboard, K2 training implemented
- We launched our new LWH infographic design

March
- Viewpoint > K2 interface launched sending scans directly into K2 and EFW's to the growth chart
- Digital midwives won the poster competition at the MatNeo Summit

April
- GROW training relaunched on OBS 2 study day
- Gen and Amy nominated for a Dedicated to Excellence award for GROW 2.0

May
- Risk assessment May
- Digital midwives shared our maternity digital journey at the NHS Northwest conference

June
- Funding approved for 160 K2 optimisations
- Work commenced to update the NICE 2022 CTG guidance in K2.
- Amy completed a Foundation Course in Digital Health Leadership with Imperial College London

Imperial College London

July
- DigiCare launched trust wide.
- New Pre-reg interface implemented
- New pregnancy referral interface implemented
- 586,892 MPN logins & 21,475 pregnancies logged

August
- DigiCare > K2 Pre-reg interface improved
- Testing for the first sprint of K2 high risk optimisations commenced

Sept
- Jenna joined the Digital Dream Team and Amy gave birth to our lucky mascot, Robin!
- Gen completed the Emerging Leaders course

October
- 40 high risk optimisations released into K2, including NICE 2022 CTG guidance
- Gen completed a PGCERT in Digital Health Leadership with Imperial College London

November
- Gen and Ted completed the NHS Clinical Safety Officer training in London
- Lullaby Trust Baby Check App rolled out
- Mobile phlebotomy training rolled out trust wide

December
- Sprint 2 of K2 optimisations defined and agreed with K2, along with SBL requirements
- We were shortlisted for a Health Tech Newspaper award for our MAU improvement project!
- MPN logins 731,534 & 25,047 pregnancies logged

HTN

3.2 Digital Empowerment

Providing staff with the knowledge and skills to maximise the use of our systems is essential to deliver the best patient care. Furthermore, staff need to have the skills and knowledge to understand the impact of digital use and to be able to work to good digital standards of safety and compliance ensuring risk to patient care is minimised. Digital inclusion for our patients is an important ambition of the strategy. We aim to ensure we exploit the use of digital for our patients so that can maximise their experience of Liverpool Women's Hospital. There are four initiatives which support this theme.

Tools for training is centred on implementing technologies that aid remote or e-learning and support wider diffusion of training knowledge in ways that is convenient with how staff want to learn. The focus within this initiative is the establishment of an effective digital training function to support the upskilling of Trust staff to use and exploit the benefits of digiCare MEDITECH Expanse EPR. There have been ongoing activities to initially support the go-live and then intense post-go-live floorwalking and refresher training support. This has been led by our Digital Nurses. **In the forthcoming year the programme team will continue to develop and deploy e-learning / training videos on the Trusts digiCare microsite, provide classroom and targeted refresher training for existing and new staff.**

Digital Staff will deliver a robust development programme that equips our staff with the required digital skills when using Trust systems now and in the future. In alignment we must also develop an effective digital culture, and this is covered under the **Digitally Responsible** initiative. An effective digital culture goes beyond a training programme as it identifies a need for on an openness and desire to use digital systems within our clinical, midwifery and nursing cohorts. Since the launch of the strategy, we have worked on establishing robust clinical leadership to support the digital programmes, this is ongoing and is a key activity within the digiCare Programme. **The key activity underway since the last Strategy review is the development of a digital hygiene element of the Be Brilliant Accreditation Scheme (BBAS) which transfers ownership of data and IT use onto the divisions. This will be rolled out during 24/25.**

Digital Patient will explore opportunities for patients to use digital as part of their delivery of care at Liverpool Women's Hospital. As part of the Digital Maternity (K2) implementation we successfully deployed 'my pregnancy notes' which is an electronic patient held record. Since the last review the Digital Programme team have been working with Maternity Leadership to progress the 'Essential Parent' app project. The Digital Programme team have focussed on ensuring that patient facing digital solutions are inclusive and support the diverse language needs of our patients, and this was a key factor in the Hewitt Fertility Centre Patient Portal design and pilot testing. **In the forthcoming year we will be deploying a Trust wide Patient Engagement Portal that will improve how patients receive and manage their appointments.**

3.3 The Power of Information

The benefit of investing in digital systems and people, drives enhanced digital maturity capabilities. Comprehensive and integrated digital systems based on structured dataset combined with effective end user adoption and good quality data input provides an information capability that allows the Trust to make informed decisions in near real-time.

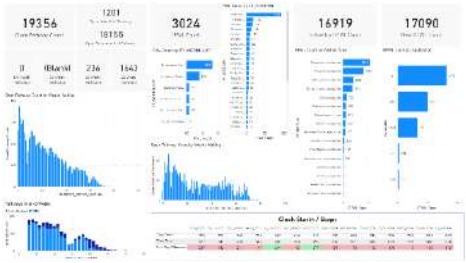
The **Digital Dashboards (Power BI**) initiative has continued to build on the progress described in the previous Digital

Rm	Bed	Unit Number	Name	Age	Type of Stay	Gravida	Parity	Single/Multip	Gestation	Safe guarding	Days Ward	Days Del	Reason for Admission / Delivery Method	MEWS	MEWS Mins	VTE Score	Theatre Visit	Baby 1 Unit Number	Int Feed	Wgt	Baby 1 Path Flag	Baby 2 Path Flag	NICU	NIPE	Heal. Screen	Target Discharge Date	TTO Status
SR	SR 1	[redacted]			PND	3	2	Singleton	37+1		4	4	Emergency CS	1	0h 34m		Y	[redacted]	BF	3040							
SR	SR 2				PNA	1	0	Singleton	40+0	!	7	8	Other	2	1h 5m	1			AF	3111							
SR	SR 3				PND	4	1	Singleton	36+3		0	1	Forceps	2	0h 48m	3			AF	2820							
SR	SR 4				PND	1	0	Singleton	41+0		2	2	Emergency CS	0	0h 14m	3	Y		BF	3680							
SR	SR 5				PND	2	0	Singleton	32+6		5	5	Emergency CS	1	7h 20m		Y		BF	1875			Y			12/02/2024	
SR	SR 6																										
SR	SR 7				PND	1	0	Singleton	39+3		1	1	Emergency CS	1	1h 4m		Y		BF	3760						18/02/2024	
SR	SR 8																										
SR	SR 9				AN	1	0	Singleton	30+0	!	3		Pain	2	7h 44m	2											
SR	SR 10																										
1	Bed 3				PND	1	0	Singleton	35+5		1	1	Ventouse	0	8h 59m	2			AF	3020							

Strategy review. The implementation of digiCare has allowed for real time dashboards to be deployed across all areas of the organisation. Real time digital status boards are now live in the Maternity Assessment Unit, Gynaecology Emergency Department, Gynaecology Ward and Maternity Base. All other clinical areas have draft dashboards scheduled to be deployed by July 2024. Having been developed in house these are bespoke for the areas, combining data from all required systems with positive feedback from clinical staff.

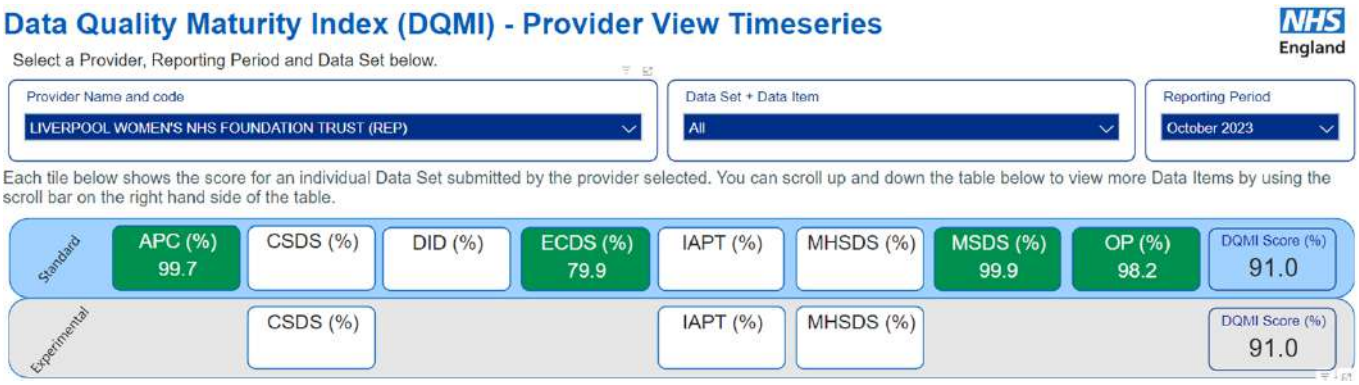
As part of the digiCare implementation, operational reports were redeveloped to move away from daily refreshes and towards real time data. This has now been achieved with all waiting lists, Cancer Waiting Times data, outpatient and theatre utilisation data and outpatient booking reports now refreshed every 30 minutes and available through Power BI. This has helped enable a safe migration to digiCare, improved efficiencies in how waiting lists are managed and better oversight of key operational metrics.

During 2023 the Trusts performance reporting platform was further developed, with both committee level and bespoke service level dashboards available and in line with the 'making data count' best practice guidelines. The department continue to work closely with divisions to ensure effective and concise performance reporting.



The department has contributed significantly to the successful implementation of the Maternal Medicine Network, providing a referral form and app to receive, process and automatically respond to referrals received from across Cheshire & Merseyside. Similar processes are planed for other regional maternity referral requirements in 2024.

The digiCare implementation represented the most significant change possible for reporting and data capture within the Trust and there has been a focus on ensuring that the implementation produced both improvements in reporting and information availability but also in the effectiveness of data capture and data quality. Since go live there has been anticipated drop in the Trusts DQMI however this is on an upward trajectory and forecast to continue improving through 2024 as the Trust becomes more familiar and confident with the new systems in place. The Trust continues to perform well compared to national averages. A revamped Data Quality Group are focussing in on those key data quality metrics and is now being chaired by the operational team.



The Information and Performance team have recently rolled out digiHub. Acting on feedback from staff to make the Trusts information reporting platform more user friendly and accessible, staff can now access all reports from a single place with an intuitive search function to find the data and information they require, further promoting the power of information across the Trust.

In the next year the focus will be on delivering Clinical investigations dashboard, improved cancer PTL and performance data, digital status boards for all clinical areas, dashboards to support the Trust improvement plan, enhanced health inequalities reporting and multilingual Friends & Family capability and continuous improvement in the Trust DQMI score.

Accreditation & Awards

Liverpool Women's Wins Health Tech Team of the Year Award for Expanse Implementation

Winning in the category of Frontline Digitisation Project of the Year, the Trust was recognised for its work as it went LIVE with the MEDITECH Expanse Electronic Patient Record (EPR) through their digiCare Programme.

February 1, 2024 | *C Level, Industry Awards, United Kingdom*

During the launch of the Strategy in September 2020 up to the last Strategy review in February 2023, the Digital Services department have celebrated 3 digital awards and achieved the Informatics Skills Development Network (ISDN) Excellence in Informatics Level 1 and subsequently Level 2 accreditation. During the last year and following the successful EPR go-live the Digital Service department won the Health Tech News Tech Team of the Year which is the most impressive award achieved to date. This reflects the amazing efforts of collaborative team approach built on the talents of digital services staff.

4.0 Digital.Innovation

Continuing the on the Robotic Process Automation (RPA) theme from the last strategy review, there has been an emphasis on using this technology to improve integration between systems and reducing manual processes. The colposcopy system referral interface has been successfully implemented which means that the manual process of entering referral information has been replaced with the automated RPA processes saving significant administration time. Within the digiCare programme RPA will be utilised to strengthen systems integration between K2 and MEDITECH Expanse.

During the last year there have been digital innovations deployed in Hewitt Fertility Centre, of note is the Fertility Patient Portal which transforms how patients are involved in their fertility care pathway. A pilot was initially undertaken with a focused patient group to test the ease of use, providing valuable information, and was the first project to take the approach of direct patient involvement in the design.

Work continues with the Maternity app known as 'Essential Parent'. The innovation has been adopted by the Cheshire & Merseyside Local Maternity and Neonatal System (LMNS) and will be deployed across other C&M Maternity Providers.

Digital Services continues to support the ground-breaking research project C-GULL. The Information team are working closely with the C-GULL team, providing access to requested datasets under approved data sharing agreements.

In the forthcoming year the department will focus on further direct patient accessible digital solutions including the deployment of a wider Trust Patient Engagement Portal (PEP) and will look to streamline patient letters through digitisation and PEP integration.

Digital Bid Success

Since the launch of the Digital Strategy in September in 2020 up to the last strategy review in February 2023, Digital Services has secured almost 5.3 million in external investment. During the 23/24 financial year, Digital Services has secured an additional 450k external funding from NHS England to support with the Patient Engagement Portal project which will improve how patients receive and confirm their appointment information.

5.0 Conclusion

This report reflects that demonstrable progress has and continues to be made in each of the four key themes of the strategy. The Board is asked to receive the report and the progress of the Digital.Generations strategy implementation.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*24/25/018*		**Date: 11/04/2024**	
Report Title	**Board Assurance Framework**			
Prepared by	*Mark Grimshaw, Trust Secretary*			
Presented by	*Mark Grimshaw, Trust Secretary*			
Key Issues / Messages	*To provide information relating to the BAF and Corporate Risk Register / 15 and above risks associated with the Committee's business and to provide assurance that these risks are being managed.*			
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 of Directors is requested to review the BAF risks and • *note their contents and actions*			
Supporting Executive:	*Mark Grimshaw, Trust Secretary*			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* All	Comment: The purpose of the report is to consider issues against both of the BAF risks aligned to the Committee
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment: Links to CRR outlined in the report.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
The BAF has been discussed at the respective Committee meetings since the previous update to the Board in February 2024.			

EXECUTIVE SUMMARY

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

The BAF updates, including the agreed Q3 risk scores, have been consolidated since they were agreed at the February 2024 Board meeting. No further significant updates have been made for this month's report. Next month's report will present the proposed Quarter 4 scores.

MAIN REPORT

Introduction

The following report outlines the aligned BAF items to the Committee.

The report is intended to allow the members of the Quality Committee to review any proposed changes or additions and agree them moving forward. The report is also an opportunity for the Quality Committee to make informed judgements as to the level of assurance that they can take, and which can then be provided to the Board in relation to each BAF area and to identify any further action required to improve the management of the identified risks.

Process for reviewing BAF areas during the meeting

As the Committee works through the agenda, members are requested to consider the BAF areas contained in Appendix 1 and the associated interdependent 15 and above risks / CRR risks. Keeping these risks in mind should support consideration of whether any assurances provided through the reports received could contribute to mitigation of the BAF risks.

At the end of the meeting under the agenda item 'Review of risk impacts of items discussed', members should consider whether any new risks have been identified that are not already recorded that should be highlighted in the Chair's report and noted for consideration into the BAF.

In addition, members should consider whether as a result of the review of assurances and/or identification of risks, whether there is a need to commission additional assurance to be reported to future Committee meetings. (Consideration should also be given as to whether it is the role of another corporate governance meeting to receive the assurance being commissioned). Any information that has been discussed in the meeting that needs to be shared with other corporate governance meetings should be included in the Chair's Log.

Updates to BAF Items

The BAF updates, including the agreed Q3 risk scores, have been consolidated since they were agreed at the February 2024 Board meeting. No further significant updates have been made for this month's report. Next month's report will present the proposed Quarter 4 scores.

New Risks or Strategic Threats

No new risk items.

Closed Risks

No closed risks to report.

Conclusions

Quality Committee members are asked to comment on the current content and where required make further recommendation for change and agree the current BAF risks.

Recommendation

The Board of Directors is requested to review the BAF risks and

- note their contents and actions

Liverpool Women's
NHS Foundation Trust

Board Assurance Framework 2023/24

Trust Board

April 2024

Board Assurance Framework Key

Risk Rating Matrix (Likelihood x Consequence)					
Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

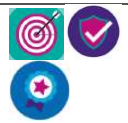
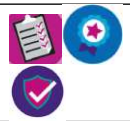
Director Lead	
CEO	Chief Executive
CPO	Chief People Officer
COO	Chief Operating Officer
CFO	Chief Finance Officer
CIO	Chief Information Officer
CN	Chief Nurse
MD	Medical Director

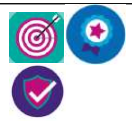
Key to lead Committee Assurance Ratings	
	Green = Positive assurance: the Committee / Board is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity - no gaps in assurance or control AND current exposure risk rating = target OR - gaps in control and assurance are being addressed
	Amber = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy
	Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each BAF Risk and also to identify any further action required to improve the management of those risks.

Board Assurance Framework: Legend	
Strategic Aim	The 2021/25 strategic aim that the BAF risk has been aligned to.
BAF Risk:	The title of the strategic risk that threatens the achievement of the aligned strategic priority
Rationale for Current Risk Score:	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk.
Controls:	The measures in place to reduce the risk likelihood or risk consequence and assist secure delivery of the strategic priority.
Assurances:	The measures in place to provide confirmation that the controls are working effectively in supporting the mitigation of the risk. Level 1 – Operational oversight Level 2 - Board / Committee oversight Level 3 – external (independent) oversight
Gaps in Controls / Assurance:	Areas that require attention to ensure that systems and processes are in place to mitigate the BAF risk Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the BAF risk.
Required Action:	Actions required to close the gap in control/ assurance
Lead:	The person responsible for completing the required action.
Implemented By:	Deadline for completing the required action.
Progress:	A RAG rated assessment of how much progress has been made on the completion of the required action.

Board Assurance Framework Dashboard 2023/2024

BAF Risk	Strategic Aim(s)	Committee	Lead	May 2023	Q2	Q3	Q4	Q2Q Movement	2023/24 Target
1 – *Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities*		PPF Committee	Chief People Officer	16 (I4 x c4)	16 (I4 x c4)	12 (I3 x c4)			12 (I3 x c4)
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.		Quality Committee	Chief Operating Officer / Medical Director	20 (I4 x c5)	20 (I4 x c5)	20 (I4 x c5)			15 (I3 x c5)
3 – *Failure to deliver an excellent patient and family experience to all our service users*		Quality Committee	Chief Nurse	12 (I3 x c4)	8 (I2 x c4)	8 (I2 x c4)			8 (I2 x c4)
4 – *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.*		FPBD Committee	Chief Information Officer	20 (I4 x c5)	16 (I4 x c4)	16 (I4 x c4)			15 (I3 x c5)
5 – *Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term*		FPBD Committee	Chief Finance Officer	16 (I4 x c4)	16 (I4 x c4)	20 (I5 x c4)			12 (I3 x c4)
6 – *The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative*		FPBD Committee	Medical Director / Chief Finance Officer	9 (I3 x c3)	6 (I2 x c3)	6 (I2 x c3)			6 (I2 x c3)

7 - Failure to meet patient waiting time targets		Quality Committee	Chief Operating Officer	16 (I4 x c4)	16 (I4 x c4)	16 (I4 x c4)			12 (I3 x c4)

BAF HEAT MAP

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic				BAF 2 BAF 5	
4 Major		BAF 3	BAF 1	BAF 4 BAF 7	
3 Moderate		BAF 6			
2 Minor					
1 Negligible					

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

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Challenges with Workforce Supply, particularly in relation to medical and other clinical staff, combined with a lack of staff engagement, may result in an inability to deliver safe, high quality care and organisational objectives.	The Trust may struggle to provide safe and effective care, achieve organisational objectives, and engage effectively with patients and staff due to the staffing challenges.	If the Trust is unable to address these staffing challenges, it may result in negative outcomes for patients and staff, including reduced trust in the quality of care provided, a negative impact on staff morale, and potential legal and regulatory consequences for failing to create a diverse workforce that is representative of the community it serves. Additionally, it may negatively impact the Trust's reputation and lead to reduced patient confidence.

	We will be an outstanding employer	✓		**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience	✓		**To be ambitious and efficient and make the best use of available resources**	
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Putting People First Committee**	**Lead Director:**	**Chief People Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**	**4**	**3**		**3**	**March 2024**	Our risk appetite for workforce **is moderate.** Liverpool Women's NHS Foundation Trust has a moderate appetite for risk to this objective. The Trust operates in a complex environment in which it faces challenging financial conditions and changing demographics alongside intense political and regulatory scrutiny. However, the continued delivery of high-quality healthcare services and service sustainability requires some moderate risk to be accepted where this is likely to result in better healthcare services for patients. Support for moderate risk in service redesign that requires innovation, creativity, and clinical research to improve patient outcomes are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.
Consequence	**4**	**4**	**4**		**4**		
Risk Level	**16**	**16**	**12**		**12**		

Rationale for risk score and quarterly update – *January 2024*

The reduction from '16' to '12' from Q2 to Q3 was justified by several positive developments. First, the 'big conversation' held in September 2023 revealed a positive sentiment among the staff, reflecting an improvement in the overall staff culture. Second, the Trust's consistent recognition among the top 50 inclusive employers for the third consecutive year signifies sustained efforts in fostering diversity and inclusivity. Additionally, the indictive data (subject to change) from the 2023 Staff Survey shows promising signs of improvement. While acknowledging that risks persist, particularly in relation to postgraduate doctors and rota gaps, the Trust has received assurance regarding robust mitigating plans, instilling confidence in effective risk management. A business case for securing the required additional roles is also in development.

These positive indicators collectively suggest a favourable trajectory for workforce engagement and satisfaction. Therefore, the proposed reduction in the risk score from '16' to '12' is supported by tangible evidence of progress. Continued vigilance and proactive measures, especially in addressing issues related to the junior medical workforce, will be crucial for sustaining and building upon these improvements throughout the year.

Key Controls and Assurance Framework

Key Controls:

- Putting People First Strategy articulates the actions the Trust will take to support the development of a skilled and motivated workforce. A new iteration of this strategy for 2024 onwards is in development.
- Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff which includes a structured career conversation enabling identification of future talent. Consultants and other
- Shared appointments with other provider across a range of clinical and corporate services
- Extension of opportunities for new ways of working including hybrid working and an increase in flexible working in clinical areas
- NHSP utilisation for bank staff has reduced agency expenditure and improved governance

	clinical staff also undertake a re-validation process. All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities. • PDR window for Band 7 and above to support the clear dissemination of shared divisional objectives • A tiered leadership programme is in place which is compulsory for new leaders at all levels of seniority and has had high levels of attendance • A long-standing set of values linked to a behavioural framework. Great Place to Work Group Launched as a cross section of staff committed to improving staff experience and a source of two-way communication • Comprehensive review of mandatory training undertaken with competencies linked to roles and detailed reporting at 3 levels, core, clinical and speciality specific. Training data validated on a quarterly basis by workforce and senior nursing / midwifery team. • Pay progression linked to mandatory training compliance • Targeted OD intervention for areas in need to support. • LWH Staff Support Service in place, a trauma informed staff wellbeing service including psychologists and health and wellbeing coaches • Workforce planning processes aligned to annual planning processes and Divisional Workforce Plans in place in place to deliver safe staffing. • Utilisation of workforce tools and methodologies to plan safe staffing including Birthrate Plus and BAPM • Medical Workforce Review Group to review development of alternative roles and undertake roster reviews to enable effective workforce planning • Two Freedom to Speak Up Guardians (including representation from a diverse and clinical background) which supports a culture of openness and transparency, supported by the Whistleblowing Policy • Annual NHS Staff Survey, supported by 3 Pulse surveys in the other quarters. • Bi-Annual Trust wide listening events - Big Conversation- led by Executive and Non-Executive Directors • Local governance structures to support compliance with HR KPIS including review of mandatory training in senior nursing/ midwifery meetings					• Award winning preceptorship programme for midwifery staff • Industrial action working group • Commitment to Anti-Racism and an ED&I annual improvement plan focused on increasing diversity at all levels, specifically leadership roles. Associated actions include a positive discrimination scheme, career conversations , reciprocal mentoring, diverse interview panels and widening participation programmes Links with community leaders established to improve under-representation and a range of pre-employment programmes and work experience opportunities • WDES and WRES action plan delivery in line with timescales presented from NHS England • Establishment of staff inclusion Networks and work in collaboration with local Trusts to promote staff networks and LGBTQ Network to be launched in 2022. • Education and celebration of the key EDI events: Black History Month, Disability History Month, LGBT+ History Month and key faith observance days/festival • Utilising widening participation programmes and alternative ways to advertise and promote our job opportunities to attract local population to work at LWH. • Management of industrial action planning via the strike planning committee • Introduction of Advanced Practitioners, Surgical Assistants and Physicians Associates • Nursing, Midwifery & AHP Review Group focused on recruitment and retention • Establishment control process underway to ensure accurate reporting of vacancy levels • Positive culture of partnership working including shared decision making with JLNC and Partnership Forum. • Systems of 2-way communication with postgraduate doctors including junior doctors forum and monitoring of junior doctors working hours and experience through the GMC Survey and Guardian of Safe Working. • Director of medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN • Local ownership of staff survey and pulse check results to enable improvements to be created and implemented at a local level	
		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**		
Key Assurances:	The ED&I sub-committee oversee progress against ED&I actions	**2**			**Gaps in Control / Assurance:**	To ensure that there are robust processes in place to target advertising, work shadowing opportunities, pre-application training and offering career advice (Action 1.1 / 1) To simplify the EIA process (Action 1.1 / 11) To further widen opportunities for the local community to join the LWH workforce (Action 1.1 / 4) To continue to develop more diverse recruitment and selection processes (Action 1.1 / 4) Enhance availability and quality of training across all protected characteristics including disability and inter-sectionality (Action 1.1 / 9) Embedding of LWH as an Anti-Racist Organisation – *actions to be defined as part of the Improvement Programme* Development of ED&I Strategy (Action 1.1 / 11) Need to ensure that career conversations are being undertaken for all staff, particularly racially minoritized staff with a focus on their development and talent management (action 1.1 / 9) Maximise the benefits of using rostering and job planning systems (Action 1.2 / 3) Requirement to respond effectively to Ockenden recommendations regarding staffing (Action 1.2 / 5) Clinical risks associated with isolated site impact upon recruitment & retention of specialist medical staff (Action 1.2 / 6) Implement establishment control and revised integrated workforce report to improve workforce planning processes (Action 1.2 / 9) Recognise that some people services are better delivered at scale and look at the potential to further collaborate or outsource(Action 1.2 / 8)
	Annual quality of appraisal audit (November 2022)	**2**				
	Annual mandatory training audit (November 2022)	**2**				
	WRES and WDES submissions	**2**				
	PPF Strategy and action plan – monitored by PPF Committee	**2**				
	Policy schedule for all HR policies	**2**				
	Policy review process reported to PPF	**2**				
	Range of internal and 2-way staff communications	**1**				
	EDI Lead and monitoring through the ED&I Action Plan networks	**1**				
	Monthly KPI's for controls.	**2**				
	Great Place to work minutes to PPF	**2**				
	Divisional Board and Divisional Performance Reviews	**2**				
	Chair's Reports to PPF Committee	**2**				
	Report form Guardian of Safe Working	**2**				
	Bi-annual Speak Up Guardian Reports.	**2**				
	Annual Report whistle blowing report to PPF and Audit Committee	**2**				
	Quarterly internal staff survey (Let's Talk)	**1**				
	KPI reports from all outsourced services, Recruitment, Payroll and Occupational Health	**2**				
	Reports and feedback from Big Conversation into the Board and Divisional Boards	**2**				
	A suite of KPIs which measure the performance of the People Services including customer feedback based on the nationally developed questions	**2**				
	Assurance that MT competencies are assigned correctly via sign off from practice educators and Heads of Nursing	**2**				
	Ownership of workforce plans at Divisional Level (reported via Divisional performance reviews).	**1**				

						Business Case for additional clinical roles to support 24/7 cover to be developed (Action 1.2 / 10)

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
1.1 / 1	Robust targeting of job adverts – engagement in health and careers fairs with local community groups for example Pakistani Centre, Al Ghazali Centre	Deputy Chief People Officer	Ongoing	Wellbeing Coach and Assistant Psychologist vacancies will be targeted via universities with specific focus on racially minoritised communities. Review piece with Patient Experience to identify and prioritise communities within which to target entry level roles. HCA and admin roles- specific careers event in Toxteth (small numbers of roles). Advertisement of key roles via Inclusive Companies jobs page in place. Supported internships for BAME individuals from the local area to commence in January 2023.	
1.1 / 4	Exploration and implementation of more diverse recruitment and selection processes including diverse interview panels and alternative recruitment methods Diverse interview panels have commenced but are yet to be consistently applied to all senior roles.	Deputy Chief People Officer	~~January 2023~~ March 2024	Process in place to ask staff with protected characteristics to join interview panels for Band 8A and above. Employees with protected characteristics have been invited to take part in national training to participate in recruitment processes in other NHS Trusts. Access to pool of interviewers via the ICB in addition to REACH network. Will audit consistency of application (new deadline suggested)	
1.1 / 9	Enhance availability and quality of training across all protected characteristics including disability and inter-sectionality	Deputy Chief People Officer	~~December 2022~~ April 2024	Enhanced training for senior leaders developed, additional baseline training in development, additional training around neurodiversity etc required. Roll out to subject to budget setting (new date suggested)	
1.1 / 11	Development of ED&I Strategy	Deputy Chief People Officer	~~January 2023~~ April 2024	This will be included as a major strand of a revised PPF Strategy – to be rolled out by April 2024	
1.2 / 3	E-rostering system for doctors - Allocate is implemented for medical staffing	Deputy Chief People Officer	~~November 2022~~ April 2024	O&G implemented, Neonates and Anaesthetics to roll out by April 2024	
1.2 / 5	Respond to Ockenden recommendations relating staffing	Deputy Chief People Officer	~~September 2022~~ April 2024	Midwifery staffing levels are compliant – no current vacancies and we are adherent to BR+ recommendations. Additional roles being funded via CNST monies to support Ockenden recommendations. 24/7 Obs cover remains in development.	
1.2 / 6	To ensure that staffing issues are included and noted as a key risk in discussions regarding the single site risk.	CPO	On-going		
1.2 / 7	To ensure that workforce data tracks the key indicators and areas of risk through development of integrated workforce report	Deputy Chief people Officer	November 2023	Report in development	
12 / 8	To work collaboratively within the C&M and NW system to implement shared services or ways or working to improve quality and / or efficiency	CPO	Ongoing	LWH actively participating in regional workstreams	
1.2 / 9	To introduce scrutiny of the performance of the people function through KPIS (in addition to the existing workforce KPIS)	Deputy Chief People Officer	November 2023	Review national KPIS when published	
1.2/10	Business Case for additional clinical roles to support 24/7 cover to be developed	CPO / MD	April 2024		

Linked Corporate and High Scoring Divisional Risks Heat Map

Ref	Description	Risk Rate Score
	Corporate Risks	
2641	Condition: There is a significant risk to the dietetic service and delivery of patient care at LWH	20
2660	In November Occupational Health alerted the Trust via Infection Prevention Committee that there were clinical staff in the organisation who were not compliant with screening / evidence of immunity/ up to date vaccination for a) EPP procedures and b) HEP B	8
2087	Condition: Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	12
2491	Noncompliance with mandated level of fit mask testers qualification, accreditation and competency.	15

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2491	2641	
4 Major		2660	2087, ~~1704~~, 2549	2760, 2732, 2578	2768, 2770, 2645
3 Moderate					
2 Minor					
1 Negligible					

Return to Dashboard

~~1704~~	~~Effective management systems are not in place or sufficient to ensure all employees complete and keep up to date with their mandatory training requirements.~~	~~12~~
2549	Condition: Staff shortages in the Ultrasound Team within the Imaging Department due to Vacancies and 5 staff members leaving in May & June 22	12
2645	NWAS INDUSTRIAL ACTION FOR 21 AND 28 DECEMBER 2022 Condition: National ambulance and NHS trade unions recently announced two days of strike action. GMB, Unite, and Unison members will take part in industrial action on the 21 December, with GMB also taking a further 24 hours of action on the 28 December. Specifically, as follows: _GMB - 21 and 28 December 00.01 to 23.59 _Unite - 21 December 00.01 to 23.59 _Unison - PES staff only 21 December 12:00 - 00.00	15
2732	Condition: Following the CQC review (January 2023) it was again identified and highlighted within the CQC initial report regarding the lack of medical cover out of hours within GED	16
2549	Condition: Staff shortages in the Ultrasound Team within the Imaging Department due to Vacancies and 5 staff members leaving in May & June 22	12
High Scoring (15+) Divisional Risks		
2768	Condition: Shortage of middle grade and Consultant level Anaesthetics medical workforce	20
2760	Condition: Lack of on-site leadership and governance structure for MRI and CT	16
2770	Condition: Risk to Anaesthetics capacity for out of hours emergency Obstetrics and Gynaecology procedures	20
2758	Condition: Lack of on-site Imaging Medical Cover, currently dependant on 3 external providers for Radiologist support	16

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.*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Inadequate comprehension of the evolving healthcare requirements of the local population, along with a failure to adequately consider the needs of marginalized groups or communities during the formulation of clinical service strategies, increases the risk of patient harm. The omission of all viable precautions to guarantee the safety of services delivered from the Crown Street site, while enhancing our facilities for the well-being of our patients and the broader system, exacerbates this risk.	Clinical service strategies that do not adequately foresee the changing healthcare needs of the local population and do not address health disparities may lead to patient harm. Moreover, the current services' location, size, layout, and accessibility may not support sustainable integrated care or the safe delivery of high-quality services. The failure to implement all feasible measures to ensure the safety of services provided from the Crown Street site, while enhancing our facilities for the benefit of patients throughout the system, amplifies the risk of patient harm.	The consequences of these issues include suboptimal patient outcomes, heightened health disparities, and the unsustainability of clinical services. This could lead to inefficient care delivery, jeopardized patient safety, and a diminished patient experience. Failing to optimize the Trust's available facilities and ensure their safety could result in adverse events, an increased threat to patient safety, and potential damage to the Trust's reputation.

	We will be an outstanding employer			**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience	✓		**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Quality Committee**	**Lead Director:**	**Chief Operating Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	4	4	4		3	**March 2024**	Our risk appetite for safety is **low.** Our fundamental strategic aim describes our commitment to patient and staff safety. When and wherever possible we will apply strict safety protocols for all clinical and non-clinical activity. We will not compromise the safety of our patients, we will report, record, and investigate our incidents and we will ensure that we continue to learn lessons to improve the safety and quality of our services.
Consequence	5	5	5		5		
Risk Level	20	20	20		15		

Rationale for risk score and quarterly update – ***September 2023***

One of the most critical risks facing the Trust stems from its location on an isolated site, detached from an acute centre, posing an immediate-term threat to patient safety. Beyond geographical remoteness, patient harm risks encompass:

- Delays in accessing specialist care: Patients needing unavailable specialised treatment may experience critical delays, especially endangering critically ill individuals.
- Reduced resource access: Isolated hospitals contend with limited resources, leading to diagnostic and treatment delays, heightening short-term patient harm risk.

Mitigation measures include significant investments in enhancing the Crown Street site's safety, with emergency department improvements and a new neonatal intensive care unit. Additionally, proactive horizon scanning, and strategic planning enhance preparedness.

Despite robust efforts, some immediate-term risk persists due to geographic isolation, as confirmed by an independent review in February 2022. The Trust faces substantial immediate-term risks to the organisation and patient safety, despite proactive measures, necessitating ongoing vigilance.

Key Controls and Assurance Framework

Key Controls:

- Programme for a partnership in relation to Neonates with AHCH has been established which supports collaboration between the LWH and AHCH sites reducing risk for transfers
- Formal partnership and board established with Liverpool Universities Hospitals to support shared recognition of risks and ways that collaboration can be utilised to help mitigate this
- Blood product provision by motorised vehicle from nearby facility, with revised protocols in place to prioritise transport of blood products.
- Investments in additional staffing inc. towards 24/7 cover - Anaesthetics joint anaesthetic appointments with LUHFT
- Investments in additional staffing inc. towards 24/7 cover – Gynaecology, including additional investment in ANP roles within GED
- Investments in additional staffing inc. towards 24/7 cover - Neonates
- Enhanced resuscitation training provision – Adult – to reduce risk of critically ill patient on site
- Crown Street Enhancements Programme Board established to oversee progress against existing improvement programmes and horizon scan for additional opportunities:
- Community Diagnostic Centre established at Crown Street, for additional diagnostic capacity, reducing transfers and speeding up access.
- Theatre slots at LUHFT with access to colorectal surgeons
- Purchase of sentinel node biopsy and 3D laparoscopic kit
- Operational 'Plans on a page' for Divisions – incorporates horizon scanning section
- Operational planning process
- Availability of data on service trends and demographics
- SOP implemented for paediatric resus provision
- Liverpool Clinical Services Review (LCSR) review outcome prioritising the sustainability of women's services as one of the top clinical risks in the system
- Use of telemedicine to facilitate consultations both at Crown Street and other sites (for Neonates)
- Use of cell salvage & ROTEM
- Innovative use of bedside clotting analysis and fibrinogen concentrates
- Early order of blood products (high wastage)
- Out of hours transfusion lab provided off-site by LCL
- Outreach midwife post
- Gynaecology Tier 2 rota providing cover for LWH and Liverpool Place
- Expanded role of anaesthetists to cover HDU patients and provide pain service
- Upskilling of HDU staff
- SLAs in place for clinical support services from LUHFT
- Ambulance transfer of patients for urgent imaging or other diagnostics not currently provided on site
- Planned pre-op diagnostics provided off-site by LUHFT
- Appointment of resus officers, upgrading of resus trolleys and provision of automated defibrillator trolleys
- Transfer of patients for critical care
- Workforce plans are informed by trends and data led intelligence
- Deep-dive reports on isolated site risks and incidents maintaining a 'live' view of the level of risk and contributing factors

		Assurance Level	Assurance Rating	Overall Assurance Rating
Key Assurances:	Divisional Board meetings with divisional risk meeting themes reporting	1		
	Operational plans and budgets	2		
	Transfers out monitored by Partnership Transfers out monitored at HDU Group Critical Care transfers subject to PSII	3		
	Serious incidents, should they occur are tracked and reported through the governance framework,	1		
	Partnership activity to report through to Board on a quarterly basis	2		
	Staff Staffing levels reports to board	2		
	Training compliance rates reported to PPF Committee	2		
	LWH working as part of NW Maternal Medicine Network	3		
	Crown Street Enhancements Programme progress	2		
	Community Diagnostic Centre Oversight Group reviews progress on a fortnightly basis. Progress also reported to and monitored by regional CDC Programme Board.	2		
	Partnership Board meetings and involvement in wider Estates Strategy	2		
	Mapping of requirements from and interdependencies with LUHFT across all Trust specialties	2		
	Single Site risk reports – provided to QC and Board since July 2022 on a regular basis	2		
	Corporate Risk Committee – wider opportunity to review significant risk	1		
	Engagement from appropriate Executives in designated working groups	2		

Gaps in Control / Assurance:

Delivery of the short-term actions identified and agreed by the Women's Services Programme Board regarding isolated site clinical risks (Action 2/10)

To ensure that Divisions are fully utilising data to understand changing service demands (Action 2.1)

Need to improve the sustainability and deliverability of the dietetic service provided at LWH (Action 2/9)

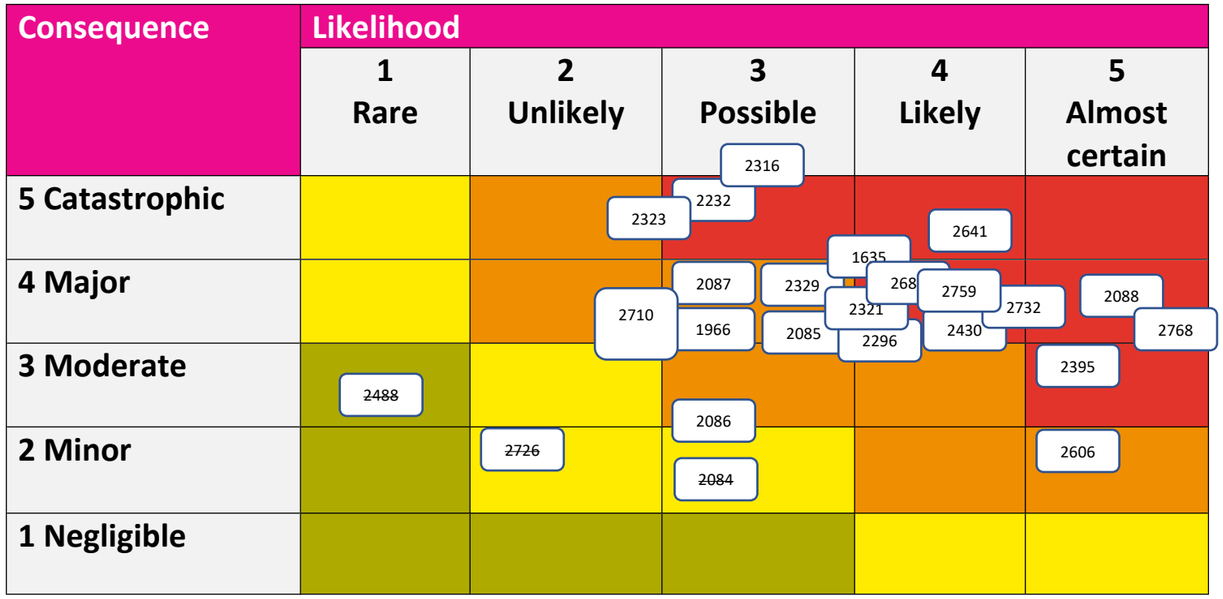
Assurance regarding process to develop and oversee the medium – long term actions regarding the isolated site clinical risks (Action 2/11)

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
2/1	To ensure that Divisions are fully utilising data to understand changing service demands	Deputy COO	April 2024	5 year transformational plans include section on horizon scanning to support future planning – further evidence required that data is being utilised as effectively as possible to support this.	

				Updated performance reports will support this. Suggest that deadline is amended to reflect the need to assess the maturity of this process.	
2/9	Improvements to the sustainability and delivery of Dietetic Service required	Chief Nurse	April 2024		
2/10	Assurance regarding delivery of short term actions identified and agreed by the Women's Services Programme Board regarding isolated site clinical risks	Medical Director	September 2024		
2/11	Assurance regarding process to develop and oversee the medium – long term actions regarding the isolated site clinical risks (Action 2/11)	Medical Director	September 2024		

Linked Corporate and High Scoring Divisional Risks Heat Map



Ref	Description	Risk Rate Score
	Corporate Risks	
2641	Condition: There is a significant risk to the dietetic service and delivery of patient care at LWH	20
2087	Condition: Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high level MAU cover.	12
2329	Condition: There is a risk to the Trust is not meeting it requirements for the safe and proper management of medicines	12
1966	Condition: Risk of safety incidents occurring when undertaking invasive procedures.	12
2085	Condition: Uncertainty around access to dedicated diagnostic capacity and physiological measurement needed to support needs of a changing patient demographics and an increase in complex multiple co-morbidities, and meeting the pre-operative assessment standards of the Association of Anaesthetists of GB & Ireland (AAGBI) and the Royal College of Anaesthetists (RCoA), to asses patients' clinical risk and plan for additional requirements for their safety and provide an optimal experience.	12
2232	Condition: There is a risk that due to a number of causes the Trust is unable to meet the safety requirements related to Blood Transfusion	15
2296	Condition: The LWH laboratory autoview analyser (the machine used to process Blood Group and Save samples on site) will no longer be supported as of 1st march 2020. This machine cannot continue to be used after this date.	12
2086	Condition: Uncertainty about provision of adequate on-site Blood bank stocking all major blood products necessary to support the needs of the Maternity service.	9
2321	Condition: Due to the Trust not being located next to or with acute services, it is unable to meet the National Recommendations for Maternal Medicine.	12
1635	Risk of delays to treatment due to significant problems with the junior doctor rotas-vacancies and maternity leave.	16
2088	Condition: Lack of on-site specialist staff and services	20
2323	Condition: The Trust is currently non-compliant with standards 2,5,6 of the seven-day service standards	15
2395	Condition: Ambulatory gynaecology demand is exceeding current capacity	15
2606	Failure to comply with national infection trajectory specifically in relation to E. coli bacteraemia	10

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2732	Following the CQC review (January 2023) it was again identified and highlighted within the CQC initial report regarding the lack of medical cover out of hours within GED.	16
High Scoring (15+) Divisional Risks		
2768	Condition: Shortage of middle grade and Consultant level Anaesthetics medical workforce	20
2759	Condition: Risk of sustainability of HSSU service	16

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

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Inadequate systems and processes in place to listen to patient voices and our local communities, including lack of patient and community engagement mechanisms. Failure to act on the feedback provided by patients, carers, and the local communities. Inadequate systems and processes for timely patient care and inability to effectively engage with patient groups with protected characteristics.	Inability to adequately listen to patient voices and our local communities, and failure to act on the feedback provided by patients, carers, and the local communities. Inability to effectively engage with our patient groups to understand further the needs of individuals with protected characteristics and respond proactively to identified needs.	Decreased patient satisfaction, lack of trust in the Trust's ability to provide effective care, and negative impact on the Trust's reputation. Failure to effectively engage with patient groups with protected characteristics may result in poor patient experience and reduced access to appropriate care, as well as potential legal or regulatory issues. Overall, the risk is the inability of the Trust to provide patient-centred care that meets the needs of the local population, including those with protected characteristics, leading to decreased patient outcomes, decreased patient satisfaction, and potential legal or regulatory issues.

	We will be an outstanding employer			**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience	✓		**To be ambitious and efficient and make the best use of available resources**	
	To participate in high quality research in order to deliver the most effective outcomes	✓			

Responsibility for Risk			
Committee:	**Quality Committee**	**Lead Director:**	**Chief Nurse**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**3**	**2**	**2**		**2**	**March 2024**	Our risk appetite for experience is **low.** Liverpool Women's NHS Foundation Trust has a low-risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality and sustainability of the Trust and its patients, may affect the experience of our patients, the reputation of the Trust or the reputation of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Senior Management Team. Despite retaining this a 'low' risk appetite the Quality Committee agreed that the Trust would need to be more ambitious in its attempts to better understand the views of patients and local communities.
Consequence	**4**	**4**	**4**		**4**		
Risk Level	**12**	**8**	**8**		**8**		

Rationale for risk score and quarterly update – January 2024

The reduction in the risk rating from 12/25 to 6/25 (Q1 to Q2) reflects significant progress in strengthening controls and assurances within the organization. Several actions addressing gaps in control and assurance have been successfully closed out, contributing to this improvement. Additionally, recent positive external assurances, such as the 2022 inpatient survey results (published in August 2023) indicating improved patient satisfaction, a decrease in complaints, and an increase in compliments, have contributed to the overall reduction in risk.

However, to further enhance risk mitigation, it remains imperative that the organisation continues to prioritize listening to patient voices and the local community while ensuring services remain responsive to diverse needs. The evidence of how effectively the organization accomplishes this must be further bolstered from its current position.

The Ockenden Final Report emphasized the critical importance of trusts effectively listening to the patient voice. Accordingly, strengthening the Trust's approach in this area will be a significant focus in 2023/24 and an updated Quality Strategy is in development.

Key Controls and Assurance Framework

Key Controls:

- Women, Babies, and their Families Strategy 2021 - 2026
- PALs and Complaints data
- Patient Stories to Board
- Friends and Family Test
- National Patient Surveys
- Healthwatch feedback
- Social media feedback
- Membership feedback
- Patient Experience Matron and Patient Involvement and Experience Facilitator in place to build relationships with local community leaders and mechanisms for hearing feedback on the Trust's services
- Bespoke Patient Surveys
- Patient experience review reports produced by the Divisions and reported to Patient Involvement and Experience Sub Committee
- BBAS – Ward Accreditation Scheme
- PLACE assessment
- MNVP
- Care Opinion
- Patient Experience Walkabouts
- Matron Walkabouts
- Non-Executive Director Quality Walkabouts
- Managing Concerns and Complaints Policy
- Annual Quality Schedule returns to the ICB (WELL-LED-01CARING-01)
- Bi-monthly update on status of patient leaflet at the Patient Involvement and Experience Sub Committee
- Women, Babies and their Families experience Strategy 2021 - 2026
- KPI for displeased Friends and Family and Bi-Monthly reports from the Divisions at the Patient Involvement and Experience Sub Committee.
- KPI for Complaint responses
- KPI for Complaint action plans
- K041 national return
- Patient information leaflets are accessible for all protected groups. Patient leaflets are on the website that can translate this information into various languages/ fonts and read aloud versions.
- Utilisation of the Health Inequalities data within power BI to lead work between the Patient Experience Team and the EDI Manager to target areas of disparity.
- Engagement with community groups led by the Patient Experience Matron and Patient Involvement and Experience Facilitator to listen to the concerns and required adjustments and improvements desired. These include the Whitechapel Homeless (Liverpool), Rotunda (deprived areas and different ethnic minorities), Irish Community and Travellers, Deaf Society, Chinese Community, North Liverpool, Storrington Avenue, Norris Green (deprived areas), Women's Health and Social Care Groups (WHISK), Women's Muslim Association, Brain charity, Chinese community and other groups that show Health Inequalities are forming part of the Trust Schedule of Involvement Events.
- An Involvement calendar produced that reflects all listening and engagement events that the Trust participates in.
- FFT Data now included EDI monitoring to allow experience reviews to be compared between groups with and without a protected characteristic.
- Enhanced communication and patient experience for people with disabilities coming for care at the Trust as part of Reasonable Adjustment activities
- Barriers removed to access/health inequalities to maternity services for all with specific focus to migrant and asylum-seeking women as part of the NEST work.
- Role created in patient experience team to improve engagement with the local community groups
- Regular Divisional reporting on protected characteristics for staff and their experience

		Assurance Level	Assurance Rating	Overall Assurance Rating		
Key Assurances:	Annual audit of patient leaflets to ensure accessibility and usability	1			**Gaps in Control / Assurance:**	Work being undertaken to review the pathway for trans patients going through fertility prior to the commencement of hormone therapy - The trans female pathway for sperm storage has been reviewed and is now a scientific led pathway, avoiding unnecessary delays due to waiting times to see a Consultant medic. The patients are often referred with NHS funding in place or funding is requested by the Hewitt funding team and are then booked into the sperm cryopreservation clinic. From referral to completion of sperm storage will take approx. 12 weeks as this includes extended screening for potential donation to ensure the patient has all reproductive choices for future relationships. Now the pathway is working well, the trans male pathway (egg storage) now needs further attention as we work with CMagic and GPs with special interest in gender identity, to ensure secondary investigations are managed appropriately. This includes further training for our nursing team to again, ensure we avoid unnecessary delays in waiting for a Consultant appointment as this can be nurse-led. We expect this piece of work to be completed by April 2024, monitoring progress through our Clinical Transformation team. The education starts on Weds 20th December with Adrian Harrop a GP-SI presenting at the Hewitt annual training day on 'Healthcare for trans patients'. All referrals for fertility preservation for gender reassignment are over the age of 18 MNVP oversight of complaints actions and themes for improvement presented at PIESC – MNVP on the distribution list for the Patient Involvement and Experience Sub Committee. Gaps in effective delivery of Access Policy including training of staff associated with RTT pathway management – Access policy currently under review for sign off in April 2024. Reviewed following implementation of digi care and revision of SOPs to reflect new system and processes. RTT validation audit took place in September 2022 by external company which demonstrated that application of
	Personalised Maternity Care Budgets/ Maternity Early Adopter and Pioneer site – LMS Cheshire and Mersey	1				
	Patients with learning difficulties, mental health or autism spectrum are allowed relatives to stay with them throughout their stay. Pro-active admissions for these groups with preadmission and discharge planning	1				
	Admission procedures and assessments e.g. MUST /VTE/ FALLS / risk assessment Maternity	1				
	Pre-operative assessments	1				
	Development of a Supporting Patients with Additional Needs Strategy Barriers identified and measures put in place to remove e.g. Presence of representatives from MRANG in the antenatal clinic to support asylum seekers	1				
	Patient Involvement & Experience Sub-Committee review the progress against the Women's, Babies and Families Experience Strategy. This is undertaken in June of each year and any concerns are escalated to the Quality Committee via the Chairs report.	2				
	Patient Involvement & Experience Sub-Committee review PALs and Complaint data quarterly via the Themes and Trend report, and any concerns raised are escalated to the Quality Committee via the Chairs report.	2				
	The Trust Board Meeting has a patient/women's story to Board most months throughout the year	2				

	Patient Involvement & Experience Sub-Committee review the Friends and Family data as part of the Themes and Trends report that is reviewed quarterly. Friends and Family themes and trends from each Division are reviewed at every Patient Involvement & Experience Sub-Committee meeting. Friends and Family also form part of the Trust Performance report that each Division must review. A KPI regarding displeased comments has also been added. This has given each area the opportunity to review displeased comments and act on them. This also enables the areas to display the 'you said we did' data out in the areas. The Patient Involvement and Experience Sub Committee has a standing agenda item for the relevant Divisions to discuss the key findings from the Friends and Family and show what improvements have been made as a result and to also discuss any Quality Improvement Projects that they are undertaking	**2**				RTT rules against patient pathways was excellent with less than 2% error rate, noted as best Gynaecology PTL management from 56 Trusts audited. This report was submitted to Executive team to demonstrate effectiveness of PTL management. Timescales for delivery of key elective recovery programme actions – Trajectories for Elective Recovery have been set and monitored weekly & monthly with regional NHSE colleagues and through Access sub-committee. These are reported monthly to Trust sub-committees through the Integrated Performance Report. Actions noted at Access sub-committee for delivery of recovery actions and progress against targets is provided by Operational teams. Work to reconfigure the MLU estate to maximise efficiencies for IOL - Work is ongoing and phase 1 of the development has been completed. Phase 2 is likely to be delivered by April 2024
	Patient Involvement & Experience Sub-Committee review the results of the National Maternity Survey, National Inpatient Survey and the National Cancer Survey Annually. All surveys are also reviewed by the Trust Quality Committee.	**2**				
	Patient Involvement & Experience Sub-Committee have both Healthwatch Sefton and Healthwatch Liverpool on the group as active participants.	**2**				
	Communications team and Patient Experience Team work together reviewing the social media comments and these form part of the quarterly themes and trends reports that are reviewed at Patient Involvement and Experience Sub Committee.	**2**				
	Patient Experience Matron reports on community engagement and relationships via the Patient Involvement and Experience Sub-Committee report and attends CoG Comms and Engagement Group to share experiences.	**2**				
	Patient Involvement & Experience Sub-Committee listen to the Patient Experience Strategy updates from each Division via the Patient Experience review paper and any patient experience intelligence that they have.	**2**				
	Safety and Effectiveness Sub Committee review the BBAS quarterly and any issues are escalated to the Quality Committee via the chairs report. Patient Experience Matron forms part of the accreditation team	**2**				
	Patient Involvement & Experience Sub-Committee review the outcomes form the PLACE assessment, this is also on the Quality Committee	**3**				
	Patient Experience Matron attends the MNVP meetings and MNVP chair is part of the circulation list for Patient Involvement and Experience Sub Committee.	**2**				
	Patient Involvement & Experience Sub-Committee review the Friends and Family themes and trends quarterly	**2**				
	Matrons' operation group reviews the feedback gained and issues escalated on the chairs report to the Nursing and Professional forum	**1**				
	Complaints annual report is approved by Quality Committee and the Quarterly themes and trends report is discussed at Patient Involvement and Experience Sub Committee. The Integrated Governance report includes Patient Experience data and is reviewed at Quality Committee.	**2**				
	The Quality schedule is reviewed by the ICB and this covers an annual submission for Well Led 01 and Caring 01. The reports are also discussed at the CQPG.	**2**				
	External reporting to NHSE digital to monitor the complaints activity	**3**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)					
Ref:	**Action required**	**Lead**	**Due Date**	**Quarterly Progress Update**	**RAG**
3/5	Divisional Boards to review Patient Experience Data prior to being reviewed by the Patient Involvement and Experience Sub Committee	Divisional Management Teams	Dec 23	Head of Patient Involvement and Experience and Patient Experience Matron are on Divisional Boards.	
3/7	QI projects need to be developed from patient voices and experience-based co-design.	Quality Manager	April 2024	Patient Experience Team have registered QI projects as part of patient voices and a Lived Experience Panel is in development.	

3/8	Improvement of compliance against Trust KPI relating to displeased comments in FFT and to ensure that Power BI is updated so the 'You said we did data' can be extracted	Divisional Management Teams	Feb 2023	All Divisions report on the Displeased Comments at the Patient Involvement and Experience Sub Committee. The compliance against this KPI has improved over time and current performance 76% (November 23)	
3/10	Continue to provide updates to the Board regarding the Elective Recovery Plan through Divisional Performance Reviews and to FPBD on a monthly basis through the Integrated Performance Report	Deputy COO	On-going	Updates on Elective Recovery are provided to the Board and FPBD through the Integrated Performance Report – a paper summary is submitted every month which highlights actions delivered and progress against trajectory. Also, a Chairs report is produced monthly from Access sub-committee which is submitted to FPBD which gives updates on positive assurances and key risks associated with elective recovery delivery.	
3/11	Work to reconfigure the MLU estate to maximise efficiencies for IOL.	FH Div Manager	April 2024	Work is ongoing and phase 1 of the development has been completed. Phase 2 is likely to be delivered by April 2024	

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2316, 2667		
4 Major			2087	2485, 2418	
3 Moderate					
2 Minor			2084		
1 Negligible					

Return to Dashboard

Ref	Description	Risk Rate Score
Corporate Risks		
2087	Condition: Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	12
2084	Condition: Uncertainty of adequacy of 24/7 access to specialist input to support changing patient profiles and needs, new guidance and the Chief Medical Officer's recommendation of the specialist multidisciplinary team approach to treatment planning and co-ordination, including pre-operative, surgical and up to level 3 post-operative care for improved patient safety and improved outcomes.	6
High Scoring (15+) Divisional Risks		
2418	Condition: Lack of support and appropriate care for patients presenting with mental health conditions	16
2485	Condition: Limited access to MRI scan (currently 5-6 weeks wait) needed for cancer patient pre-treatment (both surgical and radiotherapy treatment). MRI requested and undertaken at CCC as per pathway, as expertise in reporting is there and feeds into specialist MDT. Of note MRI added into clinical pathway as part of BGCS stratification for surgery during the first wave of COVID pandemic - this is considered best practice.	16
2316	Condition: Risk of women needing to access emergency care with pregnancy complications and not being able to be triaged in the MAU within 30 minutes of presenting at the department as per BSOTS. Impact on the safety of patients (physical and psychological);	15
2667	Risk: Delay in access to timely radiography out of hours	15

BAF Risk 4 – *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.*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Sub-optimal clinical records system, including both paper and electronic systems. Inability to embed aims and objectives in the Trust's digital strategy. Insufficient financial and staffing resources to adequately support and protect the digital service provision.	Major and sustained failure of essential IT systems due to a cyber-attack, leading to the inability to access patient records, deliver care, and support administrative functions. Sub-optimal clinical records systems, including difficulty in accessing or locating information, duplication of effort, and potential errors or omissions in patient care. Failure to embed aims and objectives in the Trust's digital strategy may lead to ineffective use of technology and missed opportunities to improve patient outcomes and experiences.	Patient safety compromised due to inability to access critical clinical information in a timely and accurate manner. Disruption to Trust operations and reduced capacity to deliver care. Reputational harm to the Trust, as well as potential regulatory or legal issues. Failure to embed aims and objectives in the Trust's digital strategy may result in missed opportunities to improve efficiency, quality, and safety of patient care. Overall, the risk is the inability of the Trust to effectively manage and utilize digital systems, including clinical records, leading to potential patient safety issues, operational disruption, and reputational harm.

	We will be an outstanding employer			**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience			**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Finance, Performance & Business Development Committee**	**Lead Director:**	**Chief Information Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**	**4**	**4**		**3**	**March 2024**	Our risk appetite for safety is **low.** Our fundamental strategic aim describes our commitment to patient and staff safety. When and wherever possible we will apply strict safety protocols for all clinical and non-clinical activity. We will not compromise the safety of our patients, we will report, record, and investigate our incidents and we will ensure that we continue to learn lessons to improve the safety and quality of our services.
Consequence	**5**	**4**	**4**		**5**		
Risk Level	**20**	**16**	**16**		**15**		

Rationale for risk score and quarterly update – January 2024

The Trust's Digital Services department places cyber security management at the core of operational activities, ensuring it maintains its Cyber Essentials standard. Various controls are implemented that are considered effective and this reduces the likelihood of a cyber-attack impact from Q1 and Q2 assessments. The assessment of consequence from a cyber threat perspective has resulted in a rating reduction from catastrophic to major based on the multi-layered technical controls which have proven effective in terms of alerting and protection resulting capability to contain the impact of a successful in some scenarios. However, if a cyber-attack was successful the impact would likely have a major negative impact on Trust services, likely rendering digital systems that clinical services are increasingly dependent on, unavailable for a period. The Digital Services department continue to strengthen controls through process refinement and the introduction of security technologies.

Contributing to the consequence reduction is the successful introduction of the MEDITECH Expanse EPR which by design has improved systems integration with other Trust systems. Whilst there is ongoing programme to further improve integration and system adoption (through the stabilisation and optimisation phases of the DigiCare programme), there is a demonstrable progress to mitigate the multiple systems elements of this risk. There remains to risk to adoption due to staff engagement, availability, and digital staffing resources, however, to control these activities are prioritised based on safety assessment.

Based on this, the impact is considered major (4). Due to recent world events, the environment risk or likelihood for a cyber-attack increased in the last quarter from possible (3) to likely (4) due to increased cyber threats from Russia. The NHS has reflected the increased threat through guidance issued to all NHS providers and arm's length bodies during March 2022. The current situation with regards to adopting of a new EPR system influences the likelihood remaining 4 for this reporting period as the Trust develops the optimisation phase of the programme.

Key Controls and Assurance Framework

Key Controls:

- Successful implementation of digiCare MEDITECH EPR
- Enhanced integration between MEDITECH EPR and other Trust systems over the legacy environment.
- Stabilisation and optimisation phases planned and underway to ensure system is 'used as intended', with oversight at digiCare EPR Programme board.
- Clinical Safety Officer processes established and operating, ensuring clinical risk through digital design and use is identified and mitigated.
- Approved EPR Staffing business case.
- Approved Digital Generations Strategy.
- Approved Meditech Expanse Business Case.
- Approved Trust Cyber Strategy.
- Fully resilient external (Internet/Clinical) network links.
- Improved Community Network connectivity.
- Incident reporting based on clinical safety focus.
- Tactical solutions including the implementation of K2 Athena system.
- Exchange/LHCRE enables for patent information sharing.
- Virtual Desktop technology to aid staff working flexibly.
- PACS upgrade removes a separate login for that system, reducing multiple systems issues.
- Task and Finish group established to improve Order and Results reporting for Pathology, Radiology.
- Appropriate task and finish groups established as required by Safety and Effectiveness sub-committee
- Digital clinical leadership business case approved.
- Optimisations to K2 system and refinements implemented
- Fast User Logon Project (Imprivata) successfully rolled out to majority (75%) of Trust, simplifying multi-application logon experiences for staff.
- Microsoft Windows security and critical patches applied to all Trust servers on all servers\laptops and desktop devices on a monthly basis.
- Network switches and firewalls have firmware updates as and when required installed. Wifi network firmware patches applied for Controllers and Access points.
- Mobile end devices patched as and when released by the vendor.
- Effective USB Port Control implemented.Externally managed network service provider to ensure network is a securely managed with underpinning contract.
- Robust CareCert process to enact advice from NHS Digital regarding imminent threats.
- Network perimeter controls (Firewall) to protect against unauthorised external intrusion.
- Robust Information Governance training on information security and cyber security good practice.
- Regular staff educational communications on types of cyber threats and advice on secure working of Trust IT systems.
- Additional cybersecurity communications in relation to Covid phishing/ scams, advising diligence.
- Enhanced VPN solution including increased capacity to secure home working connections into the Trust.
- Review and updating of information security policies and home working IG guidance to support staff who are remote working.
- Malware protection identifies and removes known cyber threats and viruses within the Trust's network and at the network boundaries.
- Cyber Security Monitoring System identifies suspicious network and potential cyber threat behaviour.
- Mobile device management – providing enhanced security for mobile devices
- Implementation of Multi-Factor Authentication (MFA) to support reduction of risk of unauthorised or privileged system access due to user account credentials being compromised.
- digiCare MEDITECH Expanse optimisations programme established.
- Ongoing review of systems and mitigations quarterly
- Robust implementation plan for Secure Boundary (Web Filtering)

		Assurance Level	Assurance Rating	Overall Assurance Rating
Key Assurances:	Quarterly risk assessments completed	1		
	FPBD Committee overview and scrutiny	2		
	Digital Hospital Committee oversight	2		
	Approved EPR Business case which define clear direction and preferred solution.	2		
	digiCare EPR programme board chaired by CIO	2		
	Clinical Safety Officer governance to mitigate clinical risk through digital use.	2		
	Independent lessons learnt Positive review	3		
	MIAA Critical Application Audit (rolling programme across trust systems)	3		
	Effective Staff communications on Digicare	1		
	Cyber Essentials Plus Standards/KPIs	3		
	IMT Risk Management Meeting	2		
	Medical Devices Committee	2		
	MIAA Cyber Controls Review	3		
	Cyber Essentials Plus Accreditation	3		
	Cyber Penetration Test	3		
	NHS Care Cert Compliance	3		

Gaps in Control / Assurance:

Multiple Clinical Systems issues remain (Action 4/5)

Variation in training experience and capability (4/6)ICS wide Shared Care Record programme not fully implemented/ active programme of work)

Lack of visibility of Internet of Things (IoT) and medical devices (Action 2.4 / 4)

Resilience / single points of failure within the IT staffing. (4/7)

Ineffective service desk provision (4/8)

Lack of effective local asset ownership (4/9)

Additional resilience improvements to back up solution required. (4/10)

Conclude implementation, adoption of Secure Boundary (4/11)

Improve network segmentation (4/12)

Improve User Account Directory Services hygiene (4/13)

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG

4/4	Improve grip, control and governance on medical devices	CIO	December 2024	Digital attendance at Medical Devices Committee. Asset inventory of medical devices under review. Funding for Digital solution to protect medical devices submitted to ICS in October. External MIAA audit concluded in Dec, with review of recommendations underway,	
4/5	Optimise digiCare MEDITECH Expanse to reduce multiple systems effect through efficient processes and integration.	Associate Dir - Information	March 2025	EPR staffing business case approved, optimisation programme underway. Task and finish groups established.	
4/6	Establish effective digital training capability and end user experience	EPR Systems Manager	March 2024	EPR staffing business case approved, training booking on processes currently being optimised.	
4/7	Review IT staffing structure and identify potential options to improve resilience and capacity	Associate Dir - Technology	March 2024	To be considered during financial planning for 24/25	
4/8	Address the Ineffective service desk provision	CIO	July 2024	Commence collaborative work with LUHFT to resolve.	
4/9	Implement an Information Asset Ownership workshop and awareness campaign	Head of Records & IG	March 2025	Cultural shift in organisational asset ownership mindset to be challenged through 24/25 as digital objective.	
4/10	Enhance backup solution resilience	Associate Dir - Technology	December 2025	Business case underway for 24/25 capital planning consideration	
4/11	Conclude implementation of Web Filtering (Secure Boundary)	Associate Dir - Technology	September 2024	Implementation is underway. Careful consideration of impact – mitigation is place in monitoring mood initially.	
4/12	Improve Network segmentation	Associate Dir - Technology	March 2025	Business case underway for 24/25 capital planning consideration	
4/13	Improve User Account Directory Services hygiene	Associate Dir - Technology	March 2025	Review of options including collaboration with LUHFT to be undertaken initially.	

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic					
4 Major				2772	
3 Moderate			~~2603~~		2531
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
High Scoring (15+) Divisional Risks		
2531	Condition - Inadequate and unsustainable IT Helpdesk Provision	15
2772	Lack of IT equipment available on Mat Base to enable staff to complete contemporaneous documentation.	16

Return to Dashboard

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

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Insufficient funding, or failure to secure funding, from external sources. Inadequate cost control and/or cost reduction measures. Inadequate financial management and controls, including lack of effective financial planning and forecasting.	Risk that the Trust will not have sufficient cash resources in the 2023/24 financial year, resulting in inability to pay suppliers, staff, or meet other financial obligations. Risk that the Trust will not deliver agreed plan in the 2023/24 financial year, including inability to meet operational targets or clinical quality standards. The Trust is not financially sustainable in the long term, potentially leading to intervention from external regulators and the Trust no longer being a going concern.	The Trust fails to meet its financial plan and is unable to secure sufficient resource to safely deliver its clinical services, resulting in negative outcomes for patients and staff, reduced trust in the quality of care provided.

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	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Finance, Performance & Business Development Committee**	**Lead Director:**	**Chief Finance Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	4	4	5		3	**March 2024**	Our risk appetite for efficient is **moderate** This is in respect to meeting our statutory financial duties of maintaining expenditure within the allocated resource limits and adherence to departmental and internal expenditure and financial controls. This includes the demonstration of value for money in our spending decisions, while ensuring quality and safety is maintained.
Consequence	4	4	4		4		
Risk Level	16	16	20		12		

Rationale for risk score and quarterly update

The Trust has a well-defined and evidence-backed case that it is not financially sustainable due to the size of the organisation and resulting lack of economies of scale, the particular mix of services including the costs of delivering maternity services as well as remaining on an isolated site. This situation is exacerbated each year due to capital investment, ongoing revenue investment in delivery of services, and other pressures including a reduction in top up income. The Trust is facing a significant financial challenge in 2023/24 and is at risk of not being able to deliver its financial plan.

The likelihood of this risk has been assessed at Quarter 3 as '5 - almost certain' rather than '4 - likely. At Month 9, the Trust is reporting an adverse variance to plan of £2.7m year to date and a full year adverse variance forecast of £8m. The Trust has applied for Cash Support from the Department of Health to ensure liabilities are met on an ongoing basis. The primary drivers leading to the adverse variance to plan include ongoing requirements in previous workforce investments, addressing CQC actions and the costs associated with Industrial Action. The Trust has produced a long-term financial recovery plan which demonstrates that recovery is not possible without implementation of strategic, system-wide solutions including additional income into the Trust to support the costs of delivering maternity care and associated CNST costs. The Trust introduced a targeted program of Financial Recovery in July 2023 to support the in-year and long-term position and continues to work with system partners to resolve the underlying deficit issues. The Trust continues to maintain strong financial grip and control processes on expenditure and identify further opportunities for increased productivity and efficiency.

Key Controls and Assurance Framework		
Key Controls:	• Financial Recovery Plan produced and shared with ICS with ongoing dialogue in relation to solutions • Consistent achievement of the safety standards associated with the CNST Maternity Incentive Scheme. • Reference costs at 103 (latest data) indicating cost efficiency in the context of an isolated site and compared to other Trusts	• Trust is part of the system-wide expenditure controls group with the ICB reviewing grip and control and expenditure on a monthly basis. • Agency and Premium Pay is well controlled as demonstrated in the low overall usage (0.7% of pay budget at M8).

	• Finance Recovery Board in place with multiple workstreams to address the identified drivers of the deficit, each supported by Executive Sponsors.
	• Rapid transformation workstreams identified.
	• Collaboration and efficiency at scale is developing across Liverpool and C&M, underpinned by findings of Liverpool Clinical Services Review.
	• Internal audit reports giving strong assurance in relation to financial controls and reporting and Cost Improvement Plans
	• Cost Improvement identification process in place, including QIA and EIA process, supported by the establishment of and internal PMO.
	• Monthly reporting and monitoring of position including taking corrective action where required.
	• Monthly review of financial position with divisional leadership and CFO ahead of financial close down
	• Sign off of budgets by budget holders and managers, and holding to account against those budgets
	• Divisional performance reviews
					• Vacancy control panel in place, meeting weekly to consider all posts, with Executive Committee review and approval.
					• Revised non-pay expenditure controls in place
					• Detailed log of investments since 2019/20 and prior has been produced with post-implementation review underway.
					• Review of services and related costs and income
					• The 'No PO No Pay' policy has been re-enforced.
					• Partnership working with other providers to enhance efficiency and minimise duplication
					• Cash management controls in place:
					  • 13-week cashflow updated weekly showing impact of cash advances received to date and any requested cash support
					  • Explanation of need for cash provided with triangulation to financial position
					  • Internal Audit plan for the year shared with ICB, showing cash/treasury management as a key area for review.
					  • Cash balances reviewed by the CFO and DCFO on a daily basis
					  • Successful application for central Cash Revenue Support

		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**		
	Long term financial recovery plan produced and submitted (Sept 23)	**2**				
	Recovery plan with agreed actions in place; monitored through Financial Recovery Board, Executive Team and Finance, Performance and Business Development Committee and reported to Board.	**2**				
	Establishment of Women's Services Committee to address medium to long term issues	**2**				
	Place based focus on resources initiated (Jan 24)	**2**				
	Active participation in C&M planning processes and ongoing regular review of financial position at system level	**2**				
	Process in place regarding CNST MIS. Prior achievement of MIS. Engagement with NHS Resolution and learning from claims and incidents.	**2**				
	Focus on benchmarking and efficiencies, including joint working where possible.	**2**				
	FPBD and Board (monthly reports)	**2**				
	FPBD Committee receives monthly reports, chair's reports from the Financial Recovery Board and specific recovery centred reports.	**2**				
	Internal Audit- high assurance for all finance related internal audit reports in 2020/21, 2021/22 and 2022/23. Substantial Assurance 2022/23 in relation to Recovery Plan	**3**				
	External Audit – no amends to accounts and largely low rated recommendations in ISA260.	**3**				
	Mitigations being worked up in case of identified risks materialising	**2**				
	Agency use monitored regularly	**2**				
	Enhanced grip and control to manage influenceable spend	**2**				
	Approval of cash support	**2**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)					
Ref:	**Action required**	**Lead**	**Due Date**	**Quarterly Progress Update**	**RAG**
5/4	Deliver outcomes from Financial Recovery Board workstreams	CFO	March 2024	Ongoing	
5/5	Identify full CIP programme	CFO/COO	April 2023	Ongoing – workshops held	
5/6	Monitoring and management of existing CIP programmes	CFO/COO	Ongoing	Ongoing – through financial recovery programme	
5/7	Delivery of activity and income targets	COO	Ongoing	Ongoing, delivery at risk due to industrial action	

5/8	Careful monitoring of cashflow forecast and close working with ICB to manage cash in year	CFO	Monthly	Ongoing, with additional discussions with system partners regarding options for cash support	
5/9	Negotiation of CDC contract for 2024/25 and beyond	COO	February 2024		
5/10	Active participation in the Women's Services ICB Sub-Committee	MD	Ongoing	Ongoing – meetings held in September 2023, workstreams established.	
5/11	Progression of estates workstream with LUHFT	CFO	December 2023	Ongoing - outputs reported to LWH/LUH Partnership board in September 2023, with further work agreed.	
5/12	Focussed review of productivity to support 24/25 planning	COO	March 2024		

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic					
4 Major				1635, 2722, 2730	
3 Moderate			2301		
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
2301	Condition: There is both an operational and a financial risk related to the position in relation to contracts and SLAs for services provided to and by the Trust.	12
1635	Risk of delays to treatment due to significant problems with the junior doctor rotas-vacancies and maternity leave. This is placing severe strain on the ability to fulfil the on-call rota as well as covering in hours duties. There is an increased reliance on locums, causing financial pressures. The risk include potential gaps in the rota which may put patients at risk, regular locum use which may result in potential compromise to the quality of the service provided and risk to the training provision of junior doctors if they are being moved around to fulfil the basic rota.	16
High Scoring (15+) Divisional Risks		
2722	Condition: There is a risk to the division being overspent against budget due to unfunded cost pressures identified as part of the annual planning process.	16
2730	Condition: Trust has insufficient internally generated capital to expand ambulatory estate	16

Return to Dashboard

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

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Conflicting priorities and objectives among clinical services providers in the Integrated Care System (ICS), including differing views on clinical strategy, resource allocation, and accountability. Ineffective governance structures or processes that do not facilitate effective decision-making or resource allocation.	The Trust may struggle to engage effectively with provider, commissioner, and other partners across the system. The Trust may also struggle to maintain those partnership relationships required to safely deliver its services from an isolated site.	If the Trust is unable to engage effectively with system partners, this could result in limitations in the Trust's ability to influence system plans and decision-making, including during contract negotiation with commissioners and agreement regarding capital funding to deliver the Future Generations Programme. Additionally, if the Trust is unable to maintain partnership relationships with providers, it may have a negative impact on the Trust's ability to deliver safe care, resulting in negative outcomes for patients and staff, reduced trust in the quality of care provided.

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	To participate in high quality research in order to deliver the most effective outcomes	✓			

Responsibility for Risk			
Committee:	**Finance, Performance & Business Development Committee**	**Lead Director(s):**	**Chief Finance Officer & Medical Director**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**3**	**2**	**2**		**2**	**March 2024**	Our risk appetite for effective is **high.** A level of service redesign to improve patient outcomes that requires innovation, creativity, and clinical research are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.
Consequence	**3**	**3**	**3**		**3**		
Risk Level	**9**	**6**	**6**		**6**		

Rationale for risk score and quarterly update

The Trust has well defined partnerships and relationships with a number of key stakeholders. These have been strengthened and added to during the Covid-19 pandemic response. The Trust has strengthened partnerships further during Q2 by securing agreement to appoint a shared Accountable office with partners Liverpool University Hospital NHS FT. A shared Chair and joint Chief Digital Officer and Chief Transformation Officer roles confirmed during Q3. ToRs have been drafted for a new Partnership Board with AHCH. In addition, the ICB's Women's Services Committee has begun making progress towards delivery.

Key Controls and Assurance Framework

Key Controls:

- Appointment of Joint Accountable Officer with Liverpool University Hospitals NHS FT
- Robust engagement with ICS discussions and developments through CEO and Chair
- Evidence of cash support for the Trust's 2023/24 position
- Chair of the Maternity Gold Command for Cheshire and Merseyside
- C&M Maternal Medicine Centre
- Liverpool Trusts Joint Committee
- Neonatal partnership in place with Alder Hey, with developing partnership board arrangements
- Partnership Board in place with LUHFT and involvement in wider Estates Plan
- Crown Street Community Diagnostic Centre Partnership
- Positive and developing relationship with Merseycare NHS FT
- Women's Services ICB Sub-Committee, chaired by ICB Chair
- Women's Services Programme Board established to oversee delivery of short-, medium- and long-term actions relating to the isolated site risks.
- Signed up to CMAST Joint Working Agreement and Committee in Common
- Participation in CMAST networks and workstreams
- Health care partnership are using existing memorandum of understanding in relation to staff movement between local hospital at time of staffing need.
- LWH have provided assistance to LUFT by taking over LWH non obstetric Ultrasound scanning activity
- LWH identified as Gynaecology Oncology Hub for Cheshire and Mersey.
- Effective relationships with Higher Education institutions for research activity and staff development

		Assurance Level	Assurance Rating	Overall Assurance Rating		
Key Assurances:	Quarterly Partnership Reporting to Board	**2**			**Gaps in Control / Assurance:**	Governance arrangements are developing (Action 6.2) Some partnership arrangements are not yet underpinned by formal governance arrangements and/or service level agreements. (Action 6.2)
	LNP Assurance meeting	**2**				
	The ICB is providing oversight on the programme of work to address the clinical sustainability challenges related to the isolated site.	**2**				
	The majority of dialogue with regulators will be led by the ICB in future. Chair and CEO will maintain ongoing dialogue with relevant key stakeholders at both national and regional level, as appropriate. Trust Communications Team has established good links with respective teams at Place and the ICB and will support any future communication and engagement activities regarding the programme.	**2**				
	Partnership with Liverpool University Hospitals in place and strengthening. Shared dashboard and risk register under development. Shared review of relevant SIs	**2**				
	Active engagement with commissioners ongoing via newly established sub-committee of ICB	**2**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
6/1	Continue to provide updates to the Board regarding the development of the ICS, highlighting when decision points are likely	CEO	On-going		
6/2	Underpin all partnership arrangements with formal governance and service level agreement where appropriate	CFO	April 2023	Limited progress made towards putting SLA documentation in place. AHCH Tors and workplan in development. Suggested to be area of work within the Trust's Improvement Programme.	

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2757		
4 Major					
3 Moderate					
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
High Scoring (15+) Divisional Risks		
2757	Condition: Trust wide Pathology services are dependent on third party providers	15

Return to Dashboard

BAF Risk 7 – *Failure to meet patient waiting time targets*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Inadequate clinical systems, processes and governance to ensure delivery of national waiting time standards. Insufficient management capacity. External factors that cannot be easily influenced.	The event occurs when the demand for services exceeds the Trust's capacity to deliver timely care, leading to increased waiting times for patients. This can manifest in various ways, such as delayed appointments, extended waiting lists, or increased waiting times for diagnostic tests or treatments.	Prolonged waiting times at Liverpool Women's NHS Foundation Trust can result in patient dissatisfaction, negative feedback, and loss of confidence in the Trust's services. Delays in accessing care can compromise patient outcomes, leading to increased pain, discomfort, and complications. Breaches of regulatory targets and standards, such as NHS maximum waiting time targets, may trigger regulatory scrutiny and financial penalties. The Trust may incur additional costs and resource utilization to address the backlog, impacting its budget and sustainability. Persistent waiting time issues can also damage the Trust's public perception and relationships with stakeholders.

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	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Quality Committee**	**Lead Director:**	**Chief Operating Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**	**4**	**4**		**3**	**March 2024**	Our risk appetite for experience is **low.** Liverpool Women's NHS Foundation Trust has a low-risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality and sustainability of the Trust and its patients, may affect the experience of our patients, the reputation of the Trust or the reputation of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Senior Management Team. Despite retaining this a 'low' risk appetite the Quality Committee agreed that the Trust would need to be more ambitious in its attempts to better understand the views of patients and local communities.
Consequence	**4**	**4**	**4**		**4**		
Risk Level	**16**	**16**	**16**		**12**		

Rationale for risk score and quarterly update – September

Following the operational pressures faced as a result of the COVID pandemic, a large number of patients had their treatment and appointments delayed as a result of changes to clinical capacity. This has led to an increasing number of patients waiting beyond 52 weeks to receive their treatment. Continued rises in referrals from Primary Care and an increasing backlog of patients to be seen has led to increased delays in care and deterioration of Trust performance in relation to national Referral to Treatment (RTT) standards.

Key Controls and Assurance Framework

Key Controls:

- Fortnightly Access Board meetings with Divisional Operational Teams and Information present monitoring key performance
- Daily monitoring of performance through Power BI dashboards – daily and weekly updates on key performance metrics
- Weekly Patient Tracking List (PTL) meetings with Divisional Operational teams and Patient Access
- Elective Recovery Programme in place with workstreams to improve performance and reduce waits
- Theatre Utilisation Group
- Sub-specialisation of Gynaecology and sub-specialty recovery plans in place to monitor actions/risks at a sub specialty level and establish performance trajectories to deliver improvements
- Controls in place to monitor length of stay for women in induction of labour
  - Daily safety huddles
  - IoL metrics included on Executive and SLT live dashboards

	• External validation programme of work reviewing all admitted and non-admitted pathways to ensure RTT guidance being applied correctly – audited by MIAA. • Review of Medical & Nursing job plans to ensure capacity in place to treat patients in a timely manner				• C&M weekly maternity escalation cell • Cancer Committee – meets bi-monthly to review Cancer performance and track actions to improve performance. Tier 2 multi partner cancer oversight meets monthly to oversee a cancer action plan. • Increased staffing capacity in MAU	
		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**		
Key Assurances:	Access Board reporting	**2**			**Gaps in Control / Assurance:**	Work underway to explore most effective Gynae ED model Work against checklists within 'Further Faster - Gynaecology Handbook'
	Escalation through to FPBD and Board	**2**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
7/1	Continue to provide updates to the Board regarding the Elective Recovery Plan through Divisional Performance Reviews and to FPBD on a monthly basis through the Integrated Performance Report	Deputy COO	On-going		
7/2	Access Policy review and delivery of SOP's via Waiting List Management audit action plan	Patient Access Lead	April 2024		
7/3	Work to reconfigure the MLU estate to maximise efficiencies for IoL.	FH Div Manager	**April 2024**		
7/4	Work against checklists within 'Further Faster - Gynaecology Handbook'	COO	July 2024		

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic					
4 Major			2087		2770
3 Moderate					
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
2087	Condition: Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	12
High Scoring (15+) Divisional Risks		
2770	Condition: Risk to Anaesthetics capacity for out of hours emergency Obstetrics and Gynaecology procedures	20

Return to Dashboard

Appendix 1 – System BAF risk mapping

	LWH BAF 1				LWH BAF 2				LWH BAF 3				LWH BAF 4				LWH BAF 5				LWH BAF 6				LWH BAF 7			
	Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities				Inability to ensure the on-going sustainability of clinical services and prevent patient harm by maintaining a high standard of care at the current Crown Street site.				Failure to deliver an excellent patient and family experience to all our service users				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.				Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term				The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative				Failure to meet patient waiting time targets			
	Target 12 (I3 x c4)				Target 15 (I3 x c5)				Target 8 (I2 x c4)				Target 15 (I3 x c5				Target 12 (I3 x c4)				Target 6 (I2 x c3				Target 12 (I3 x c4)			
	Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
LWH BAF	16	16	12		20	20	20		12	8	8		20	16	16		16	16	20		9	6	6		16	16	16	
LUHFT BAF	8 (8)				1 (9)				6 (10)				10 (10)				5 (9)				11 (9)				2 (9)			
					3 (12)				7 (10)								9 (12)											
					4 (9)				12 (7)																			
					13 (9)																							
WC BAF	5 (12)	5 (12)			2 (9)	2 (9)			1 (12)	1 (12)			11 (15)	11 (15)			3 (9)	3 (9)										
	8 (9)	8 (9)			4 (9)	4 (9)			6 (12)	6 (12			12 (12)	12 (12)			7 (9)	7 (9)										
	9 (12)	9 (12)			10 (12)	10 (12)																						
LHCH BAF	4 (12)	4 (16)			8 (9)	8 (9)			1 (6)	1 (6)			9 (12)	9 (12)			3 (12)	3 (12)			7 (4)	7 (4)			2 (12)	2 (12)		
					6 (12)	6 (12)											5 (12)	5 (12)										
AHH BAF	2.1 (15)	2.1 (20)			1.1 (9)	1.1 (9)							4.2 (16)	4.2 (16)			3.4 (16)	3.4 (16)			3.2 (12)	3.2 (12)			1.2 (15)	1.2 (20)		
	2.2 (9)	2.2 (9)			1.3 (12)	1.3 (12)															3.5 (16)	3.5 (12)						
	2.3 (15)	2.3 (15)																										
CCC BAF	10 (12)	10 (16)			1 (15)	1 (10)							13 (12)	13 (9)			3 (16)				6 (12)	6 (8)						
	11 (16)				2 (12)	2 (12)							14 (12)	14 (12)														
MC BAF	P1 (16)	P1 (16)			S3 (12)	S3 (12)			S1 (12)	S1 (12)			R2 (12)	R2 (12)			R1 (12)	R1 (12)			F2 (16)	F2 (12)			S4 (16)	S4 (16)		
									S2 (12)	S2 (12)																		
									P2 (12)	P2 (12)																		
ICB BAF	P9 (16)	P9 (12)			P1 (16)	P1 (16)			P4 (15)	P4 (10)			P2 (12)	P2 (6)			P7 (20)	P7 (16)							P3 (25)	P3 (15)		
					P8 (12)	P8 (12)			P5 (20)	P5 (20)															P6 (20)	P6 (16)		

LUHFT BAF Risks Summary	
1	If we do not enhance the systems and processes employed to deliver planned care at elective activity plans level, we will not reduce patient delays, negative impact on health outcomes, negative impact on finances, and potential increase in demand for social care
2	If we do not introduce innovative solutions to address the safety concerns within Urgent & Emergency Care, we may not see improvements in the delivery of safe care and the health and safety of staff.
3	If we do not embed the plans to achieve improvements in the fundamentals of nursing care (falls, pressure ulcers, nutrition and hydration), we may not achieve a reduction in length of patient stay and positive health outcomes for patients.
4	If corporate and quality governance arrangements do not meet the requirements of the Well-Led Framework, the Trusts assurance and escalation processes may not be fit for purpose, impacting on the provision of high quality, sustainable, harm free care.
5	If we do not support the wellbeing and resilience of our people, then our ability to recruit and to provide safe staffing levels in order to provide safe, caring and effective care may be compromised
6	If we do not address Equality Diversity & Inclusion (EDI) inequalities affecting our workforce, we may fail to improve the experience of staff from diverse background and fail to recruit, promote and retain diverse talent.
7	If we are unable to embed agreed leadership behaviours throughout the organisation, we may fail to strengthen our current leadership capability, which will have a negative impact on our ability to recruit and retain the best people.
8	If we do not deliver the agreed financial plan this may result in a detrimental impact on medium/long term sustainability and effective system collaboration.
9	If we are unable to develop cyber secure and compatible patient information systems due to resourcing and lead time limitations, this may result in detrimental impact on service continuity and consistency.
10	If we are unable to build and sustain effective partnerships with other health, care, voluntary sector and other key organisations, this may impact adversely on our ability to deliver the Trust strategy and the Liverpool Clinical Services Review
11	If we are unable to fulfil our responsibilities as an anchor organisation to the wider community, this may result in missed opportunities to support the Liverpool system and its people to improve health outcomes and address health inequalities.
12	If we do not deliver agreed milestones in line with the Research Strategy to become a clinically research active organisation, this may reduce the patient access to clinical research and reduce opportunities to improve patient care and treatment options.
13	If we do not deliver agreed milestones in line with the Research Strategy to become a clinically researchactive organisation, this may reduce the patient access to clinical research and reduce opportunities to improve patient care and treatment options

WC BAF Risks Summary	
1	Impact on patient outcomes and experience
2	Inability to develop further regional care pathways
3	Inability to deliver financial plan for year
4	Inability to deliver the operational plan
5	Inability to attract, retain and develop sufficient numbers of qualified staff
6	Inability to improve equitable access to services
7	Inability to secure capital funding to maintain the estate to support patient needs
8	Inability to develop a national training offer
9	Inability to develop and attract world class staff
10	Inability to grow an innovative culture
11	Inability to prevent Cyber Crime
12	Inability to deliver the Digital Aspirant plan and associated benefits

LHCH BAF Risks Summary	
1	Failure to maintain safety and quality and avoid harm would result in poorer patient & family experience
2	Inability to deliver annual planning activity and performance targets could result in poorer patient outcomes, inability to address the backlog of patients waiting and result in financial consequences to the Trust.
3	Inability to achieve the five year capital programme within a challenging and uncertain operating environment and deliver an Estates Strategy that supports the provision of outstanding services
4	Challenges in recruiting, developing, retaining and ensuring the wellbeing of a high quality, diverse and inclusive workforce would affect our ability to deliver world class care
5	Failure to deliver financial plans and changes in the funding regime could impact sustainability for the Trust and system partners
6	Inability to delivery the Research and Innovation agenda to exploit future opportunities
7	Failure to be recognized as an Anchor Institution, demonstrating social value, sustainable green strategy and contribution to population health may increase costs in the longer term and disappoint public, staff and regulatory expectations
8	System architecture is still maturing and may present tensions for our LHCH leadership role, alignment of priorities with the ICS and system partners, and ensuring wider view to Cheshire & Merseyside and beyond.
9	Failure to ensure strong digital transformation and IT service resilience could erode LHCH's position as a world-class provider of specialist care delivering services for patient needs

Alder Hey BAF Risks Summary	
1.1	Inability to deliver safe and high-quality services
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care

Clatterbridge Cancer Centre BAF Risks Summary	
1	Quality governance
2	Demand exceeds capacity

Merseycare BAF Risks Summary	
S1	There is a risk we will not deliver the best clinical practice to the people we serve, due to the Trust not understanding thehealth needs of it's local population, resulting in increased risk in the identification and reduction of safety and quality issues and the continuesimprovement of medical care and leadership.
S2	There is a risk that Mersey Care will not improve the quality of our health services, due to us not considering the wider issuesthat impact on health and wellbeing, resulting in the unfair and unjust differences in access and outcomes for the communities we serve.

1.3	Building and infrastructure defects that could affect quality and provision of services		3	Insufficient funding		S3	There is a risk that the care for people with complex health and social needs will be fragmented and poorly coordinated, due to a focus on treatment which misses opportunities for earlier intervention, resulting in poorer coordination and less integration of wholeperson care at all ages. Executive Lead Trish Bennett
1.4	Access to Children and Young People's Mental Health		4	Board governance		S4	There is a risk of delivering the winter/resilience plan, due to demand exceeding expected levels, reduction in workforce capacity and data inaccuracies impacting decision making, resulting in the Trust not being able to address the immediate challenges of winter and the significant changes to the acute bed base across the system.
2.1	Workforce Sustainability and Development		5	Environmental sustainability		P1	There is a risk of reduced health and wellbeing of staff, due to workforce pressures and the Trust not address sickness absence and vacancy hot spots within our services, resulting in a working environment that struggles to be restorative, safe, supportive and inclusive.
2.2	Employee Wellbeing		6	Strategic influence within ICS		P2	There is risk that the trust fails to tackle the rising demand, due to a lack of insight into the experiences of our service users and communities, resulting in great inequality in access and enabling people to have greater control of their care.
2.3	Workforce Equality, Diversity & Inclusion		7	Research portfolio		R1	There is a risk to the modernisation of our inpatient and community estates, due to changes to the financial framework withinthe NHS meaning that the Trust will have less autonomy in prioritising its investments, resulting in potentially less capital for buildings thatsupport new models of care
3.1	Failure to fully realise the Trust's Vision for the Park		8	Research resourcing		R2	There is a risk that the Trust doesn't utilise the benefits of digital technology, due to the challenges in balancing growingdemand for finite resources and moving away from a 'one size fits all', technological solutions, resulting in delays in transforming the way wedeliver clinical excellence, population health, and care coordination within our services.
3.2	Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships		9	Leadership capacity and capability		F1	There is a risk that the trust will not increase its research capacity and capability, due to us not capitalising on new interventions with, academic and industry partners in real-world settings, resulting in us not advancing research and innovation in mental health and our understanding of how mental, physical, and social conditions are interlinked.
3.4	Financial Environment		10	Skilled and diverse workforce			
3.5	System working to deliver 2030 Strategy		11	Staffing levels			
4.1	Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People		12	Staff health and wellbeing			
4.2	Digital Strategic Development & Delivery		13	Development and adoption of digitisation			
			14	Cyber security			
			15	Subsidiaries companies and Joint Venture			

C&M ICB BAF Risks Summary

P1	The ICB is unable to meet its statutory duties to address health inequalities
P2	The ICB is unable to address inadequate digital and data infrastructure and interoperability which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities
P3	P3: Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. This may result in inability to meet increased demand, increase in backlogs of care, resulting in poor access to services, increased inequity of access, and poor clinical outcomes
P4	Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience
P5	Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience
P6	Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population
P7	The Integrated Care System is unable to achieve its statutory financial duties
P8	The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services

P9	**Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives**						
P10	**ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population**						

Commentary

In development.

Appendix 2 – Corporate Risks and High Scoring Divisional Risks

Ref	Description	Severity	Likelihood	Risk Rate Score	Directorate	Review Date	Next Review Date	BAF Link(s)
Corporate Risk Register								
2732	Condition: Following the CQC review (January 2023) it was again identified and highlighted within the CQC initial report regarding the lack of medical cover out of hours within GED	4 Major	4 likely	16	Gynaecology		28/01/2024	
2641	Condition: There is a significant risk to the dietetic service and delivery of patient care at LWH	4 Moderate	5 Almost Certain	15	Clinical Support Service	19/12/2023	18/01/2024	1 & 2
2087	Condition: Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	4 Major	3 Possible	12	Maternity	07/12/2023	06/03/2024	1, 2 & 3
2301	Condition: There is both an operational and a financial risk related to the position in relation to contracts and SLAs for services provided to and by the Trust.	4 Major	3 Possible	12	Financial Services	10/01/2024	09/04/2024	5
2329	Condition: There is a risk to the Trust is not meeting it requirements for the safe and proper management of medicines	4 Major	3 Possible	12	Pharmacy	03/01/2024	02/02/2024	2
2223	Condition: LWH has been involved in a police investigation of public and media interest as a Neonatal Nurse on the Local Neonatal Unit at Chester who has alleged involvement in the murder and harm of babies.	3 Moderate	4 Likely	12	Neonatal	04/12/2023	03/03/2024	
1966	Condition: Risk of safety incidents occurring when undertaking invasive procedures.	4 Major	3 Possible	12	Governance	08/01/2024	07/02/2024	2
2085	Condition: Uncertainty around access to dedicated diagnostic capacity and physiological measurement needed to support needs of a changing patient demographics and an increase in complex multiple co-morbidities, and meeting the pre-operative assessment standards of the Association of Anaesthetists of GB & Ireland (AAGBI) and the Royal College of Anaesthetists (RCoA), to asses patients' clinical risk and plan for additional requirements for their safety and provide an optimal experience.	4 Major	3 Possible	12	Theatres & Anaesthesia	08/12/2024	01/02/2024	2
2232	Condition: There is a risk that due to a number of causes the Trust is unable to meet the safety requirements related to Blood Transfusion	5 Catastrophic	3 Possible	15	Pathology	29/12/2023	28/03/2024	2
2491	Noncompliance with mandated level of fit mask testers qualification, accreditation and competency.	5 Catastrophic	3 Possible	15	Governance	08/01/2024	08/03/2024	1
2296	Condition: The LWH laboratory autoview analyser (the machine used to process Blood Group and Save samples on site) will no longer be supported as of 1st march 2020. This machine cannot continue to be used after this date.	3 Moderate	3 Possible	12	Pathology	04/12/2023	27/06/2024	2
2549	Condition: Staff shortages in the Ultrasound Team within the Imaging Department due to Vacancies and 5 staff members leaving in May & June 22	4 Major	4 Possible	12	Clinical Support Service	28/12/2023	27/03/2024	1
2086	Condition: Uncertainty about provision of adequate on-site Blood bank stocking all major blood products necessary to support the needs of the Maternity service.	3 Moderate	3 Possible	9	Maternity	19/09/2023	19/03/2024	2
2321	Condition: Due to the Trust not being located next to or with acute services, it is unable to meet the National Recommendations for Maternal Medicine.	4 Major	3 Possible	12	Maternity	13/09/2023	19/02/2024	2
1635	Risk of delays to treatment due to significant problems with the junior doctor rotas- vacancies and maternity leave. This is placing severe strain on the ability to fulfil the on-call rota as well as covering in hours duties. There is an increased reliance on locums, causing financial pressures. The risk include potential gaps in the rota which may put patients at risk, regular locum use which may result in potential compromise to the quality of the service provided and risk to the training provision of junior doctors if they are being moved around to fulfil the basic rota.	4 Major	4 likely	16	Human Resources	03/11/2023	01/02/2024	1, 2 & 5
2088	Condition: Lack of on-site specialist staff and services	4 Catastrophic	5 Almost Certain	20	Neonatal	21/12/2023	10/07/2024	1 & 2
2323	Condition: The Trust is currently non-compliant with standards 2,5,6 of the seven-day service standards	5 Catastrophic	3 Possible	15	Governance	10/01/2024	18/10/2023	2

2606	Failure to comply with national infection trajectory specifically in relation to E. coli bacteraemia	2 Minor	5 Almost Certain	10	Governance	13/09/2023	13/09/2024	2
2607	There is a risk of disruption to services as a result of industrial action from a number of trade unions in relation to matters relating to pay and conditions of service. Exemptions and derogations are to be agreed at a local level, if these are in line with previous years, maternity and neonatal services would be exempted, some activity across gynaecology and fertility will be stood down. We are working in partnership at a system level to agree a shared approach to managing industrial action, as well as ongoing liaison with our staff side colleagues.	4 Major	3 Possible	12	Human Resources	08/01/2024	07/02/2024	1
High Scoring Divisional Risks								
2768	Condition: Shortage of middle grade and Consultant level Anaesthetics medical workforce	4 Major	5 Almost Certain	20	Clinical Support Services	NEW	NEW	
2760	Condition: Lack of on-site leadership and governance structure for MRI and CT	4 Major	4 Likely	16	Clinical Support Services	NEW	NEW	
2770	Condition: Risk to Anaesthetics capacity for out of hours emergency Obstetrics and Gynaecology procedures	4 Major	5 Almost Certain	20	Clinical Support Services	29/12/2023	28/01/2024	
2759	Condition: Risk of sustainability of HSSU service	4 Major	4 Likely	16	Clinical Support Services	NEW	NEW	
2758	Condition: Lack of on-site Imaging Medical Cover, currently dependant on 3 external providers for Radiologist support	4 Major	4 Likely	16	Clinical Support Services	NEW	NEW	
2048	Condition: Risk to patients and staff of not having availability of a chaperone when performing intimate examinations in the main department or Community sites.	3 Moderate	5 Almost Certain	15	Clinical Support Services	28/12/2023	27/03/2024	
2757	Condition: Trust wide Pathology services are dependent on third party providers	3 Moderate	5 Almost Certain	15	Clinical Support Services	NEW	NEW	
2730	Condition: Trust has insufficient internally generated capital to expand ambulatory estate	4 Major	4 Likely	16	Corporate	NEW	NEW	
2752	Condition: Staff are not trained in supporting people with a learning disability / autism in line legislative requirements. Recommended training is Oliver McGowan Mandatory Training, however other training can be delivered but must be in line with code of practice (including co delivered face to face with person with lived experience both LD and Autism)	4 Major	5 Almost Certain	20	Corporate	08/01/2024	07/02/2024	
2684	T5, T8, Compact fluorescent lamps are becoming obsolete from October 2023 to February 2024. Stocks of lamps will become depleted and then non-existent.	4 Major	4 Likely	16	Estates and Facilities	11/12/2023	10/03/2024	
2418	Condition: Lack of support and appropriate care for patients presenting with mental health conditions	4 Major	4 Likely	16	Governance	15/08/2022	13/11/2022	
2386	Condition: Data Loss Prevention	3 Moderate	5 Almost Certain	15	Information Governance	27/12/2023	26/03/2024	
2531	Condition - Inadequate and unsustainable IT Helpdesk Provision	4 Major	4 Likely	16	IT	27/12/2023	26/01/2024	
2372	Condition: Inability to safely provide a joint obstetric/endocrine/diabetes ANC across BOTH Aintree University Hospital and LWH sites for women with pre-existing and gestational diabetes	4 Major	4 Likely	16	Family Health	12/01/2024	12/03/2024	
2746	Condition: 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	4 Major	4 Likely	16	Family Health			
2772	Lack of IT equipment available on Mat Base to enable staff to complete contemporaneous documentation.	4 Major	4 Likely	16	Family Health			
2430	Condition: Network outlier for pre-term mortality - rate is higher than the national average	4 Major	4 Likely	16	Family Health	12/09/2023	12/03/2024	
2667	Delay in access to timely radiography out of hours	5 Catastrophic	3 Possible	15	Family Health	22/11/2023	20/02/2024	
2769	Risk of inability to use laboratory and procedure rooms at the Knutsford site.	5 Catastrophic	3 Possible	15	Hewitt			

Changes to Risk Summary (Quarterly)

Since the November 2023 meeting, there have been the following developments in various risks.

De-Escalated Risk:

One risk, Gynaecology Medical (Risk 2084), with an initial score of 6 and a target score of 2, has been de-escalated by the Risk Manager and Divisional Manager. The de-escalation, dated 09/01/2024, is attributed to the Divisional Governance - Oncology gaining access to theatre sessions at LUFT, with the risk now de-escalated to the Divisional Level. Although there is no change in the current risk score, further actions or a review for closure are recommended.

Closed Risks:

A Gynaecology Ambulatory risk (Risk 2395) with a score of 15 at closure has been closed on 22/11/2023, merged with another risk due to duplication. Another risk, Pathology (Risk 2488), related to the clinical demand for red blood cells, has a score of 3 and has been recommended for closure. The rationale involves the low supply of red blood cells and a review on 29/12/2023, with plans to move it from the corporate to the service risk register.

New Risks:
A new risk, Gynaecology Emergency (Risk 2732), has been added to the register with a current score of 16. This risk stems from the identified lack of medical cover after 10 p.m. within GED, impacting patient outcomes and resulting in increased incidents. The risk has been escalated with a corporate business case being developed to request additional specialty doctors.

Appendix 3 - Risk Descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long- term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on many patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day)	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days)	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff
			Low staff morale Poor staff attendance for mandatory/key training	Loss of key staff Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10– 25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met

Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?
The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Liverpool Women's
NHS Foundation Trust

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