Liverpool Women's
NHS Foundation Trust

Trust Board

12 September 2024, 09.30am
The June Henfrey Suite
Blackburne House

NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

Location	The June Henfrey Suite, Blackburne House
Date	12 September 2024
Time	9.30am

AGENDA					
Item no. 24/25/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
103	Introduction, Apologies & Declaration of Interest	Note	Verbal	Chair	09.30 (5 mins)
104	Patient Engagement and Activity	Note	Presentation	Chief Nurse	09.35 (20 mins)
105	Minutes of the previous meeting held on 11 July 2024	Approve	Written	Chair	09.55 (5 mins)
106	Action Log and any urgent matters arising	Note	Written	Chair	
PERFORMANCE					
107	Chief Executive Report • Executive Risk & Assurance Group Report • Integrated Performance Report • Women's Services Programme Board • Strategy Update	Note	Written	Chief Executive	10.00 (30 mins)
108	Finance Performance: Month 04, 2024/25	Note	Written	Chief Finance Officer	10.30 (10 mins)
109	Ambulatory Programme Capital Spend	Information	Verbal	Chief Operating Officer	10.40 (15 min)
110	LWH Improvement Plan Monthly Update	Note	Written	Chief Transformation Officer	10.55 (15 mins)
BREAK – 11.10– 11.25					
QUALITY, SAFETY & EFFECTIVENESS					
111	a) Maternity Incentive Scheme Year 6 – August 2024 Compliance Update (including Perinatal Dashboard) b) Bi-annual maternity staffing report	Assurance	Written	Chief Nurse	11.25 (10 mins)
112	Guardian of Safe Working Hours, Quarter 1 2024/25	Information	Written	Guardian of Safe Working Hours	11.35 (10 mins)
113	Learning from Deaths, Quarter 1 2024/25	Assurance	Written	Chief Medical Officer	11.45 (10 mins)
PEOPLE & CULTURE					

114	Whistleblowing Bi-Annual Report/ Freedom to Speak Up Guardian	Assurance	Written	Chief People Officer	11.55 (10 mins)
GOVERNANCE					
115	Committee Chair's Reports	Note	Written	Committee Chairs	12.05 (5 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.*					
116	Sustainability Annual Report (Green plan)	Assurance	Written	Chief Operating Officer	Consent
117	SID appointment	Note	Written	Director of Corporate Affairs	Consent
CONCLUDING BUSINESS					
118	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	12.10 (5 mins)
119	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
120	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
121	Jargon Buster	For reference	Written	Chair	
Finish Time: 12.15 Board Thank you following closure of public meeting.					

Liverpool Women's NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held in The June Henfry Suite, Blackburne House, at 9.30 am on 11 July 2024

PRESENT

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

IN ATTENDANCE

Matt Connor	Chief Digital Information Officer
Tim Gold	Chief Transformation Officer
Hollie Holding	Associate Director of Corporate Governance (minutes)
Daniel Scheffer	Director of Corporate Affairs & Company Secretary

IN ATTENDANCE TO OBSERVE:

Felicity Dowling	Member of the Public
Helen Gavin	Communications Officer
Louise Florensa	Deputy Trust Secretary
Lesley Mahmood	Member of the Public
Teresa Williamson	Member of the Public

IN ATTENDANCE TO PRESENT:

Olu Akanni	Patient Story (to present item 78)
Adam Beattie	Transformation Lead – Gynaecology (to present item 78)
Paula Briggs	Consultant (to present item 78)
Kat Pavlidi	Guardian of Safe Working Hours (to present item 85)
Deborah Ward	Head of Safeguarding (to present item 87)

APOLOGIES:

Tracy Ellery	Non-Executive Director / Vice-Chair
Gloria Hyatt MBE	Non-Executive Director
Louise Martin	Non-Executive Director
Sarah Walker	Non-Executive Director

Core members	**May**	**Jul**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
David Flory - Chair	✓	✓								
James Sumner – Chief Executive	✓	✓								

Tracy Ellery - Non-Executive Director / Vice-Chair	✓	A								
Louise Martin – Non-Executive Director	✓									
Prof Louise Kenny - Non-Executive Director	✓	✓								
Dianne Brown – Chief Nurse	A	✓								
Gary Price - Chief Operating Officer	✓	✓								
Michelle Turner - Chief People Officer	✓	✓								
Dr Lynn Greenhalgh – Chief Medical Officer	✓	✓								
Zia Chaudhry – Non-Executive Director	A	✓								
Gloria Hyatt – Non-Executive Director	✓	A								
Sarah Walker – Non-Executive Director	✓	A								
Jackie Bird – Non-Executive Director	✓	✓								
Jenny Hannon - Chief Finance Officer / Executive Director of Strategy & Partnerships	✓	✓								
Matt Connor – Chief Digital Information Officer (non-voting)	✓	✓								
Tim Gold – Chief Transformation Officer (non-voting)	✓	✓								
Daniel Scheffer Director of Corporate Affairs	-	✓								

2024/25	
077	**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. Welcome was extended to Daniel Scheffer, Director of Corporate Affairs. The Board thanked Mark Grimshaw for his contribution to the role of Company Secretary at the Trust and wished him luck in his new role.
078	**Patient Story – Menopause Journey** Dianne Brown introduced Olu Akanni, Paula Briggs and Adam Beattie to the meeting, who were in attendance to explain the benefits of the new Menopause Community Clinic Project. Olu described her experience as a patient with Sickle Cell Disease and a diagnosis of early menopause. She detailed her background and patient journey in the NHS following a move to the UK from Nigeria in 2017. The Board received a description of the comorbidities associated with Sickle Cell Disease and early menopause with Olu explaining the difficulties, symptoms and experiences she has had as a result. The Board received an overview of the Menopause Primary Care Collaboration Pilot, which detailed how care was brought closer to patients at home and a reduction in long waiting times. Patients like Olu would receive the same care in the community as in hospitals, with easier access to appointments at clinics closer to home.

	The Quality Improvement Methodology Approach was presented, which included continuous process improvement, stakeholder engagement, performance measurement and evaluation and data-driven decision-making. In response to a question, it was detailed that a variation in practice had been seen throughout the city's acute, primary care and community services. It was the aim of the pilot to align those so that a consistent service was provided to all patients. A discussion took place regarding training for GPs within Primary Care. It was confirmed that whilst at an early stage in the pilot, the impact within GP practices could be seen as there had been an increase in the awareness of menopause symptoms. Further, data was available which confirmed more complex cases of menopause were being dealt with directly within the community. Board members queried what aspects Olu felt could be handled differently, following her own experiences. Olu confirmed that she felt more could be done to raise awareness of patients with Sickle Cell Disease with the symptoms of menopause. With regard to her own experience, Olu detailed how she had felt supported throughout her journey as her doctor had listened to her and referred her directly to the Trust. The Board welcomed the update and thanked Olu for sharing her story.
079	**Minutes of the previous meeting held on 09 May 2024** The minutes of the Board of Directors meeting held on 09 May 2024 were agreed as a true and accurate record.
080	**Action Log and any urgent matters arising** Updates against the action log were noted.
081	**Chief Executive Report** James Sumner presented the Chief Executives Report. <u>The Women's Hospital Services in Liverpool (WHSIL) Programme</u> The Programme aims to develop a clinically sustainable model of care for hospital-based maternity and gynaecology services that are delivered in Liverpool. A draft Case for Change was considered by the Board in a private session in June 2024. It was reviewed by the Boards of Liverpool University Hospitals NHS Foundation Trust (LUHFT), Alder Hey Children's Hospital NHS Foundation Trust (AHFT) and Clatterbridge Cancer Centre NHS Foundation Trust (CCC), with all noting their support. This would then go to the Integrated Care Board (ICB) later in the year. Ongoing progress with the case was expected until September 2024 as additional evidence and comparative data became available. Other actions taken in the period included: • A strategic plan for communications and engagement had been developed. • The plan for recruiting lay advisers and establishing a lived experience panel was ready but recruitment was on hold until after the election. • A draft plan for pre-consultation. <u>Executive Risk and Assurance Group (ERAG) and Performance</u> The ERAG had met twice since the previous Board meeting – on 12 June 2024 and 3 July 2024. Previous feedback raised following Non-Executive Director walkarounds had highlighted challenges around the visibility of leadership, staffing and acuity in some areas. The Divisions were asked to clarify any safety risks related to staffing or estates because the two should not be conflated. This work had been undertaken, with measures related to staffing having improved and an acknowledgement that the perceived estate risk was around

	experience as opposed to safety. The visibility of leadership was noted as improving with Executive walkabouts in place and the Executive Assurance and Risk Group (ERAG) getting a good grip on risks, which were being embedded. The view regionally was that maternity performance was continuing to improve so external oversight could be stepped back, with the Trust removed from regional house monitoring for maternity services. It had been identified that there were several policies out of date, with the request issued to the relevant teams to have the number reduced from 60 to zero in four weeks. At the time of the ERAG meeting, there remained 13 policies out of date, with all being reviewed and a performance report requested to be tracked monthly. ERAG discussed Never Events, with three occurring in recent months. However, all three events were different and the learning from each had not shown any correlation, with no common theme. Performance metrics were noted as improving, with work on waiting lists resulting in the number of patients reducing, elective recovery had also seen an improvement, as had cancer recovery. A query was raised relating to the 91 patients waiting for 65 weeks and whether a robust trajectory was in place to manage those numbers. It was confirmed that the Trust was ahead of the trajectory, with 70 patients waiting at the time of the Board meeting and the improvement plan methodology had had a positive impact on the overall position. The Board raised a concern related to the third- and fourth-degree tear data within the Integrated Performance Report (IPR), with the rates significantly lower than the national average. The concern was that this could be a result of a lack of recognition and underreporting. It was noted that there was a need to understand the underlying issue and any action required to address it. The Board discussed the risk-based approach to meetings and whether the right things were being captured and discussed, with assurance sought that there was a clear pathway for risks through the organisational structure. It was believed that the supporting risk scoring matrix change would further enhance the risk-based approach and was starting to be used effectively, with attendees at meetings understanding their risks on the risk register and being prepared to discuss controls and mitigations in forums. However, it was acknowledged that there was more work to be done in departments to assist them with understanding the initial reporting of risks and how to effectively use the system. The Board noted the update.
082	**Finance Performance: Month 03, 2024/25** Jenny Hannon presented the Finance Report. The Board learned that at Month 2 the Trust reported a £5.6m deficit, which represented a breakeven-to-plan position, with the position shared with the Cheshire and Merseyside Integrated Care Board (C&M ICB). £0.4m of Cost Improvement Programme (CIP) savings had been delivered to date, resulting in a £0.1m favourable variance to the CIP target of £0.3m. The cash balance was £4.6m at the end of Month 2. The Board were reminded that an application had been submitted for an additional £23.9m with an anticipation that the outcome would be known within the week. Clarity was sought by the Board in relation to concerns about the achievement of future CIP. It was confirmed that this was related to both recurrent and non-recurrent CIP. The Board discussed the stretch target amongst the five adult acute and specialist trusts within Liverpool, with the collective challenge of £18.5m. A need to understand the burden

	of the LWH contribution to that figure was raised, with a further requirement to understand the governance of the collective target. The Board noted the update provided in the report.
083	**LWH Improvement Plan Highlight Report** Tim Gold presented the Improvement Plan Highlight Report. The Trust's Improvement Plan, designed for the next 12-18 months, aimed to address the clinical challenges and risks while embedding a culture of continuous improvement and safety. The plan, launched in May 2024, focuses on immediate priorities to pave the way for the longer-term strategy. The Board were informed that progress during the reporting period included the establishment of effective project monitoring systems and processes. The next period will emphasise quality assurance, ensuring risk calibration and actively managing project plans. It was noted that significant risks progress on project benefits had been identified and addressed, with assurance being provided that all projects were progressing well, with no significant barriers to milestones having been identified at this stage. An overview of progress against each programme within the Improvement Plan was provided, which included Well Led, Financial Sustainability, People and Culture, Operational Performance, Clinical Effectiveness and Quality and Safety. A spotlight had been placed on the Deteriorating Patient Collaborative as part of the Quality and Safety programme, which had been launched at an event held in June 2024. In response to a question, it was confirmed that a robust quality-checking process was in place to ensure that Key Performance Indicators (KPIs) and data were accurate. The process was ongoing and would be presented to the Board in future updates. Board members discussed safety culture within the Plan, noting that the status was reported as red. It was confirmed that this related to the Medicines Safety Project, and that specialist input from the Pharmacy Team had been sought to shape the plan. The Board noted the update.
084	**Maternity Incentive Scheme Year 6 – June 2024 Compliance Update** Dianne Brown presented the Maternity Incentive Scheme Year 6 – June 2024 Compliance Update, which outlined progress in relation to the defined 10 safety actions and standards of the Scheme Year 6. The Board also received an update on a position statement for all standards and clarity on Board reporting for the forthcoming year. Attention was drawn to concerns identified with the ability to meet the compliance targets within the medical workforce of attendance at PROMPT and Fetal Surveillance Study Days, due to ongoing Industrial Action. A further risk was posed regarding the availability of a Multi-Disciplinary Team within the Education Faculty and deliverance of PROMPT training days, also as a result of Industrial Action. Assurance was provided that mitigations were in place to ensure that staff who had planned to attend the cancelled session had been allocated to other PROMPT days. Escalation would be monitored via the Educational Governance Committee. In response to a question, assurance was provided that the risk would be monitored and escalated to the Executive Risk and Assurance Group if the controls in place did not mitigate the risk, therefore increasing the risk rating for review. A discussion took place regarding the overall risk rating of the defined actions, noting the broad spectrum utilised in the national process. The Board noted the update.

085	**Guardian of Safe Working Hours (Junior Doctors) Quarterly Report – Q4 2023/24** Dr Lynn Greenhalgh presented the Guardian of Safe Working report. The Board was reminded of the unrest within the doctor cohort of the Trust, recognising the industrial action that took place over the last year and that there were opportunities to improve for graduate doctors. A success was shared, with improvements in the rota gap of neonates and anaesthetic services, bringing together one rota between them. There remained gaps within the rota, with an acknowledgement that by Quarter 4 (Q4) more gaps appeared due to various reasons including training and moving to other programmes. This was not an exception and was a typical theme throughout the year. The Board was informed that communications continued to be shared highlighting to staff who the Guardian of Safe Working was and what their role was. The Board queried whether the Trust was doing everything possible to mitigate the safety issue for doctors. It was recognised that, with more complex patients and cases, there was a need for more senior support, with Obstetrics and Anaesthetics having more out-of-office support put in place. Conversations were ongoing within Gynaecology. It was also noted that, with more postgraduate doctors in post, the level of support and safety would improve as there would be more people on the rota. It was reiterated that staff were safe in terms of working hours however, the gaps on rotas required filling to release staff for training. The Board questioned whether there was more that could be done to ensure issues with safe working were raised. It was noted that this was a cultural issue, with work ongoing to address this. Learning from the National Guardians group would also be shared, as well as a poster with a QR code on how to exception report. A query relating to benchmarking against comparator organisations was raised. It was outlined to the Board that, as the unit was of a smaller size and made up of specialities, there were no comparators. From a regional and national perspective, there were Trusts with 100,000+ junior doctors in place, which addresses any issues with gaps in rotas. However, it was highlighted that data was shared quarterly with the deanery. The Board noted the update provided within the report.
086	**Mortality and Learning from Deaths Report Quarter 4, 2023/24** Dr Lynn Greenhalgh presented the Quarterly Mortality and Learning from Deaths Quarterly Report which covered the period from January to March 2024. A summary of the following deaths that occurred during the reporting period was presented, which included: • Adult Deaths 3 (all expected) • Direct Maternal Deaths 0 • Stillbirths 2 (excluding TOP, rate 1.1/1000births) • Neonatal Deaths (inborn) 3 (0.6/1000 live births) The Board noted that this is the lowest stillbirth rate per quarter in the last 5 years and the lowest neonatal mortality rate per quarter for several years. It was confirmed for the Board that the Quality Committee had received the report for review, as referenced within the Quality Committee Assurance Report. Assurance was sought that data surrounding Feta Growth Restriction had been omitted from the report due to an administrative error. It was confirmed that there had been an issue with connectivity between the electronic systems in uploading the data, in addition to ensuring that healthcare professionals in the community were up to date with the processes involved to ensure that relevant data was being input.

	The Board noted the update.
087	**Safeguarding Annual Report 2023/2024** Deborah Ward delivered a presentation on safeguarding as a service, highlighting: • Safeguarding service/breakdown of team. • Safeguarding across LWH Data. • Safeguarding across LWH – MARAC and MASH Research with the Domestic Abuse Enquiry noted as embedded in the service. • Case Story, giving examples of a complex case over the past year. Concern was shared relating to the Domestic Abuse, Stalking and Honour Based Violence (DASH) referral drop-off highlighted within the report, with it unclear where the DASH forms and communications were shared and no definitive view as to whether improvements could be seen. It was confirmed to the Board that quarterly data would be available following the meeting, with a further update against key performance indicators (KPIs) to provide assurance to the Board. The Board queried whether there was assurance that the right staff were being trained, with a concern raised by the Shadow Board whether Mersey Internal Audit Agency (MIAA) could be commissioned to look at this in more detail. Assurance was given that training data was required as part of the KPI submission to the Integrated Care Board (ICB), as well as the S11, which is a prescribed, non-negotiable review of safeguarding processes in line with statutory guidance delivered by the local authority designated nurses. It was highlighted to the Board that MIAA had also been used in the past to undertake a gap analysis against the Trust's training needs analysis. A question relating to the Safeguarding Team and how they compare to others across the NHS was raised. It was outlined that there was no benchmarking data in place as each Trust dealt with varying levels of complexity and significance of cases. The Board noted a spike in referrals in Quarter 3 (Q3) and queried whether there was a clear reason for this. It was highlighted that this was a common trajectory for Q3, however, work was underway to understand this in more detail, with consideration given to whether there was a jump in training compliance resulting in greater awareness across staff and therefore more referrals. It was noted that there may be an opportunity for more support to be given to the Safeguarding Team from the Legal Services Collaborative to free up capacity, which would be considered as part of future collaboration. The Board noted the report and thanked the Team for the progress seen within the team while keeping the Trust compliance and patients safe.
088	**WRES & WDES 2024 Report** Michelle Turner presented the Workforce Race Equality Standard (WRES), the Workforce Disability Standard (WDES) and the Medical Workforce Equality Standard (MWRES) for 2024. The update outlined the Trust's performance against the specific WRES, WDES and MWRES mandatory requirements for all NHS Trusts in England. Attention was drawn to the updates noted against each specific requirement within the report. The Board noted the update.
089	**Sexual Safety Charter** Michelle Turner presented the Sexual Safety Charter. The update detailed the actions in progress to comply with the requirements of the Charter, including training and education, policy updates, and the implementation of a clear reporting mechanism. Collaboration with

	Liverpool University Hospitals NHS Foundation Trust had been established to provide training across the two Trusts. The Board noted the importance of a session at the Trust's Senior Leadership Forum which had been key to raising awareness on issues experienced across the Trust. The discrepancy between the information provided in staff survey results against the number of incidents reported internally at the Trust was discussed. It was noted that this was a national issue across the wider NHS workforce, and why there was an enhanced focus on psychological safety in the workplace to help tackle the issues. The Board noted the update and supported the recommendations to ensure compliance with the Sexual Safety Charter.
090	**Women's Health Taskforce and Strategy Development** Dianne Brown presented the Women's Health Taskforce and Strategy Development Update. The Board were informed that the Liverpool Women's Health Strategy was a system-wide strategy, aimed to improve health outcomes for women and girls, as recommended in the 'Health 2040' report from Liverpool's Public Director of Health. It set out proposed strategic responses to the 'State of Health in the City: Liverpool 2040' report. Board members recognised the positive step in developing the strategy in collaboration across Liverpool. The benefits of ensuring input from the University of Liverpool were noted, as the lead for a significant amount of Women's Health Research in the city. The Board noted the update and confirmed support for the development of the Liverpool Women's Health Strategy, including: • Active membership of the Women's Health Taskforce. • Contribution of data, experience, expertise, ideas and relationships as appropriate to the Needs, Assessment Engagement Work and Stakeholder Workshops. • Ownership of the relevant actions as deemed appropriate once agreed upon in the Strategy and Plan.
091	**LUHFT/LWH/Alder Hey Partnership Update** James Sumner presented the LUHFT/LWH/Alder Hey Partnership Update, which noted the progress made to date and set out the direction of travel. The Board noted that it had been agreed between Chief Executive Officers and Chairs of the organisations that there was an important partnership agenda that needed to be pursued and reinvigorated. The key areas of collaboration that required focused attention were as follows: • The Liverpool Neonatal Partnership. • Women's Hospital Services in Liverpool Programme • Community Services and the Integration of the PLACE agenda (with Mersey Care NHS Foundation Trust). • Opportunities for shared Research and Innovation. The Board noted the update.
092	**Committee Chair's Reports** The Board noted the following Committee Chair's Reports: The Board noted the update to the Health and Safety Annual Report following the presentation to the Finance, Performance and Business Development Committee to include additional compliance data regarding Control of Substances Hazardous to Health (COSHH).

	The Board approved the Charitable Funds Committee Terms of Reference and Workplan.
093	**Board Assurance Framework & Risk Appetite Statement 2024/25** Daniel Scheffer presented the Board Assurance Framework (BAF) and Risk Appetite Statement 2024/25. The BAF is the monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives and to ensure it has the appropriate oversight of the Trust's risk profile and risk management arrangements. Attention was drawn to the changes made to the BAF for 2024/25, with an overview of the drivers of the end-of-year review. An overview of the changes to the Trust's risk scoring mechanism was provided, together with the reframing of several BAF risks to better align to the current strategic risk profile and key changes to the format of the BAF, In line with the Risk Management Strategy, the risk appetite statement and ratings had been aligned with the Good Governance Institute risk appetite matrix. The updated Risk Appetite Statement was presented for approval. The Board noted the BAF, and approved the following: • Approved the BAF risks, including content and actions. • Approved the suggested Q1 2024/25 score. • Approved the Risk Appetite Statement.
094 - 098	**Consent Agenda** The following items were presented with the recommendations contained in the reports adopted without debate: • Integrated Governance Report Quarter 4 2023/24 • Infection Prevention and Control Annual Report 2023/24 • Complaints Annual Report 2023/24 • Emergency Planning Resilience and Response Annual Board Report 2023/24 • Health and Safety Annual Report 2023/24
099	**Review of risk impacts of items discussed** No new risk items were identified.
100	**Chair's Log** None noted.
101	**Any other business & Review of meeting** None noted.
102	**Jargon Buster** Noted.

Date of next meeting: 12 September 2024

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
12 September 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
11 April 2024	24/25/005	Chief Executive Report	To arrange a Board training session on Making Data Count	TS	~~June 2024~~ September 2024	On track	Opportunity to hold this in September owing to the availability of the NHSE Team
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~~ September 2024	Complete	Agenda Item 24/25/112b. Six monthly midwifery staffing report scheduled for September 2024 Board.

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
None received or delegated.						

Trust Board

COVER SHEET

Meeting Date	Thursday, 12 September 2024	**Item Reference**	24/25/107
Report Title	**Chief Executive's Report**		
Author	James Sumner, Chief Executive Officer Hollie Holding, Associate Director of Corporate Governance		
Responsible Director	James Sumner, Chief Executive Officer		

Purpose of Report	To provide the Board of Directors with details of key activities and issues from the Chief Executive since the last update in July 2024.
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 since July 2024.
Key Areas of Concern	No areas of concern noted.
Trust Strategy and System Impact	The Chief Executive Report provides the Board with crucial updates and highlights the Chief Executive's activities since July 2024, aligning with the Trust's strategy and NHS Cheshire and Merseyside system priorities by addressing health and wellbeing, service quality, and resource efficiency. It ensures compliance with the 'triple aim' by considering impacts on health inequalities, service benefits, and sustainability.

Links to Board Assurance Framework		**-**
Links to Corporate Risk Register (scoring 10+)		**-**

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

Action Required by the Board	The Board of Directors is asked to: • note the content of the report • note the Integrated Performance Report • note the Executive Risk and Assurance Group Reports

REPORT DEVELOPMENT:

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

MAIN REPORT

1. Adult Acute and Specialist Services in Liverpool

The adult and specialist Trusts in Liverpool have a strong record of working together for the benefit of patients and their families across the city, and the region. We have a lot to be proud of, for example, the stroke pathway service between Liverpool University Hospitals NHS Foundation Trust and The Walton Centre NHS Foundation Trust, the cancer pathways across all Trusts, and improved diagnostics waiting times across the city.

In January 2023, a report called the Liverpool Clinical Services Review recommended we continue to build on this in several key areas to help create a healthier city. Since this report, good progress has been made towards ever further collaborative working across the system.

As the next step in this work, NHS Cheshire and Merseyside has asked the five adult acute and specialist Trusts in Liverpool to establish a Joint Committee. Its purpose is to create sustainable healthcare systems for the future with a clear focus on improving patient care and outcomes.

Staff in all Trusts work incredibly hard and care deeply about doing the right thing for patients. As we all know there are significant challenges facing the NHS – pressures every day, capacity, and funding. And this year is going to be the toughest yet.

We have been asked by NHS Cheshire and Merseyside to come up with a way to act more quickly, find solutions and have a simpler way of making decisions about things that involve us all with a clear focus on improving patient care and outcomes.

<u>Adult Acute and Specialist Hospitals Joint Committee</u>
The Chairs and Chief Executives of the five adult acute and specialist Trusts, outlined below, will sit on the Joint Committee:

- Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH)
- Liverpool University Hospitals NHS Foundation Trust (LUHFT)
- Liverpool Women's NHS Foundation Trust (LWH)
- The Clatterbridge Cancer Centre NHS Foundation Trust (CCC)
- The Walton Centre NHS Foundation Trust (TWC)

This will enable more streamlined decision-making and help to build upon existing collaboration with a specific requirement to collectively manage the financial position across the Trusts, deliver economies of scale and manage vacancy controls.

The focus of the joint committee will be to establish the new governance arrangements, meeting in shadow form (i.e. no formal authority) in September 2024 and be in place formally (i.e. with authority to make decisions) by April 2025.

<u>Shared Board of Directors for Liverpool University Hospitals NHS Foundation Trust and Liverpool Women's NHS Foundation Trust</u>

Additionally, LUHFT and LWH are building upon their existing joint board appointments and are working towards developing a shared Board of Directors. This supports Liverpool Women's Hospital's long-stated ambition to be aligned to a larger acute Trust to support the management of identified clinical risks.

Work is underway to develop detailed plans for establishing the joint board by late Autumn 2024.

An Executive Managing Director will be appointed to lead Liverpool Women's NHS Foundation Trust, who will sit as a voting member of this joint Board of Directors. This will ensure equity with other sites, retaining the Liverpool Women's Hospital identity, and voice and influence at board level.

2. Anti Racism Reporting Tool

The Trust has recently launched the Anti Racism Reporting Tool . The platform is designed to empower our staff and our community by providing a confidential and secure way to report incidents of racial discrimination and inequality. The tool is a crucial step in ensuring that every voice is heard and every concern is addressed with the seriousness and confidentiality it deserves. Both staff and patients are invited to use the tool for incidents, concerns and queries.

Key features of the reporting tool include:

- Confidential Reporting: Reports can be submitted anonymously to ensure confidentiality.
- User-Friendly Interface: The tool is designed to be easy to use, ensuring that everyone can report incidents without difficulty.
- Timely Response: Our dedicated team will review and respond to reports promptly, ensuring that appropriate actions are taken.
- Support and Resources: Access to support services and resources will be provided to those affected by racial discrimination and inequality.

The Anti Racism Reporting Tool can be found on the Trust website LWH Equality and Anti-Racism Reporting Tool (office.com) .

3. Big Conversation

The most recent Big Conversation took place in May 2024 and the top five themes were as follows:

- Staffing: Increase headcount for clinical staff and add more Ward Clerk/Administrative support across various departments.
- Processes: Address issues with interpreter services, improve email etiquette, implement green strategies, reduce recruitment delays, and standardise pay dates.
- Leadership: Increase senior leadership presence, set realistic work timelines, and clarification on future Trust strategy.
- Space: Update changing/shower facilities, improve staffrooms, and enhance patient facilities with private spaces and larger rooms.
- Estates: Improve response times, cleanliness, signage, ventilation, and car parking conditions.

A further update on progress against 'The Big 5' was circulated to staff in August 2024, with progress on key areas of feedback provided, including:

- Car parking
- Green Plan for 2024 – 2027
- Set pay dates as opposed to being paid on the penultimate day of the month
- Interpreter services

More details can be found in Appendix A.

4. Cancer Staging Data Completeness

I am pleased to confirm that Liverpool Women's reached or exceeded 80% stage completeness in the Cancer Outcomes and Services Dataset (COSD) submissions for the whole of 2023. This is a significant achievement and is directly attributable to the hard work of clinical and administrative staff in your cancer teams.

Early stage at diagnosis is one of the most important factors affecting cancer outcomes, and promoting an earlier stage at diagnosis is one of the key aims of the NHS Long-Term Plan. Measuring and monitoring national staging data is crucial to understanding variation and delivering evidence-based decisions. To support this aim, NHS England is aiming for NHS Trusts to report cancer stage for all stageable cancers at diagnosis. The staging data enables national cancer registration and the associated analyses of cancer care pathways at regional, national, and international levels. The data further supports cancer programmes for early-stage diagnosis.

5. Smoking in Pregnancy

The 2030 Smokefree ambition in Liverpool is to achieve a reduction to a 5% smoking prevalence across all populations, however, based on predictions using data up to 2021, this won't be achieved until 2039, while it is estimated that in the most deprived quintile in England, it may take four times longer to achieve 5% than in the least deprived (Matt Ashton Public Health Report). Smoking tobacco products remains a significant driver of health inequalities.

In 2022/23 the smoking prevalence amongst pregnant women reduced from 14.3% in 2016/17 to 8.8%. I am pleased to be able to report that at Liverpool Women's NHS Foundation Trust, the figure is 6%. This is a recognition of the hard work and commitment of the Smoking Cessation Team.

6. NHS England North West Regional Director

It has been announced that Louise Shepherd has been appointed as the NHS England Regional Director for the North West, and will commence in the post on 3 November 2024.

Louise has been Chief Executive of Alder Hey NHS Foundation Trust since 2008. She was responsible for leading the Trust through a major transformation to deliver Europe's first Children's Health Park. Her distinguished NHS career spans more than 30 years, including previously as CEO of Liverpool Women's Hospital. Before joining the NHS, she worked at KPMG as a financial and management consultant to the public sector. In 2017, Louise was awarded a CBE for services to healthcare in the Queen's Birthday Honours list.

In March 2023 Louise was appointed as the chair of NHS England's Children and Young People (CYP) Transformation Board, having previously been a member of this Board since April 2021 as co-chair of the National Children's Hospital Alliance.

7. Women's Hospital Services in Liverpool Programme

The Women's Hospital Services in Liverpool (WHSIL) Programme aims to develop a clinically sustainable model of care for hospital-based maternity and gynaecology services that are delivered in Liverpool. This will involve assessing the current clinical risks and issues in hospital-based maternity and gynaecology services in Liverpool and developing short, medium, and long-term solutions and proposals for mitigating, controlling, and resolving the risks and issues.

A significant amount of work has been undertaken since the previous report to the Board in July 2024. A draft Case for Change was considered by the Board in a private session in June 2024 and this has also been reviewed by the Boards of Liverpool University Hospitals NHS FT, Alder Hey Children's Hospital NHS FT and Clatterbridge Cancer Centre NHS FT, with all noting their support. Ongoing progress with the case is expected until September 2024 as additional evidence and comparative data become available.

Other actions taken in the period include:

- A strategic plan for communications and engagement has been developed.
- The plan for recruiting lay advisers and establishing a lived experience panel is ready but recruitment is on hold until after the election.

- A draft plan for pre-consultation and engagement has been reviewed and will be presented to the programme board in July 2024.

Future action will be focused on finalising the Case for Change and the continued recruitment of lay advisers and establishment of the lived experience panel.

8. National Inpatient Survey

Gynaecology have been a positive outlier for the 2nd year running for the National Inpatient Survey. There are 50 questions which make up the inpatient survey, 2 significantly improved scores, highlights 5 elements that have most improved since 2022. Gynaecology have been rated as 7/10 for overall experience with 98% of respondents reporting being treated with respect dignity, kindness, and compassion. 97% of respondents also reported that staff helped to control pain. Previous improvement work on nutrition, food choice and availability has shown to have had a beneficial impact on patients. Themes for improvement are with regards to planning of discharge.

9. Executive Risk and Assurance Group

The Executive Risk and Assurance Group (ERAG) has met twice since the previous Board meeting on 7 August and 4 September 2024. Strong engagement from attendees continues whilst the new risk-focussed approach and meeting structures are further embedded.

The ERAG meeting on 7 August 2024 explored several key issues and risks across the organisation. A need for further refinement of articulation of some of the risks within the reporting groups was noted to ensure effective outcomes from the risk-based approach adopted. Additional capital costs in relation to the expansion of the ambulatory service provision were reported however these were deemed manageable across the Trust's multi-year capital program. The response to the blood stock shortage national alert was noted.

At the meeting on 04 September 2024 emerging risks in relation to pharmacy and medicines management were noted following an initial gap analysis. A report will be prepared for the meeting in October. The plan for the procurement of the robot blood transfusion solution as part of the Trust's improvement program had met with some challenges which were noted alongside steps to manage the issues. An increased risk in relation to the availability of cash in September was highlighted and is highlighted to Board while the Trust awaits approval of the latest national cash support application.

Please see Appendix B for further detail.

10. Performance

The Executive Team with the Informatics Team have undertaken a review of Key Performance Indicators (KPI) for 2024/25. The updated Board integrated performance report includes additional metrics and makes better use of statistical process control (SPC) and benchmarking to improve the understanding and escalation of these metrics.

All Key performance metrics have been through all Trust Executive Groups for review. Below are the key metrics/areas where statistical variation has been noted and were escalated for further oversight and assurance.

Operational Performance

Overall size of the waiting list – The waiting list continues to reduce further, evidencing positive actions that have taken place in line with the Trusts Improvement Plan. It is forecasted that the Trust will meet its March 2025 target earlier than initially anticipated and therefore a revised target will be set from M7.

Elective Recovery – 65+ weeks continue to demonstrate statistical improvement with reductions ongoing and still on trajectory to be 0 by the NHSE target of September 2024. 52+ weeks continues to statistically show a sustained reduction and significantly ahead of NHSE targets.

Cancer – All metrics showed a slight deterioration in June as a result of the external decontamination supplier issues experienced in May. Recovery of patients impacted has been underway throughout June to August with additional activity taking place, with improvements in performance expected from September onwards. The Trust continues to be monitored through national Tier 1 performance oversight. A visit from the National Cancer team took place on 3rd September with positive comments noted from the National Clinical Director for Cancer, commending the work already taken place by the Trust and the Clinical team. The Cancer Improvement Plan continues to be reviewed and accelerated where possible to ensure trajectories are met.

Quality

Never Events – There are currently 4 ongoing Never Event investigations. All Never Events were 'no harm' events and a detailed paper was presented to Quality Committee. No new ones have arisen in since June 2024. All investigations are being progressed and in accordance with the Trust governance processes. The Never Events reflect special cause variation of a concerning nature and therefore is reflective of the cluster of Never Events had over a short period of time within a rolling 12-month timeframe. Nationally there is a review of the Never Event terminology.

Number of Open PSIIs – 24 open with investigations ongoing, reflecting no significant change in assurance, however high numbers of variation noted will decrease when a review of PSIRF is completed early Q3 - work is ongoing with consideration given to the NHSE PSIRF framework for Maternity. All PSII have been reported to the ICB and received an initial target date of completion.

Number of PSII (rolling) - the position reflects the cumulative number of PSIIs declared since launching PSIRF in September 2023. This number is expected to reduce and therefore be capable of remaining under threshold, with planned review of PSIRF.

FFT A&E Percentage Positive – Small improvement of FFT in A&E seen with July position at 76.83 (previously 65.91%) and continues to reflect the process is missing the target with a special cause variation of a concerning nature. The divisional senior leadership team are well sighted on themes and the GED improvement plan will draw together and continue to monitor progress to meet the target and sustain position when met.

FFT Maternity Percentage positive - Maternity have improved at 91.26% (previously 86.17%) however the improvements reflect a position of consistently failing to meet the target with no significant change to common cause variation. Maternity continues to be sighted on issues to improve.

3rd and 4th Degree Tears – Rate from instrumental births has reduced in August to 5.33% (within national parameters <7.8%) from 8.14% in July.

3rd and 4th degree tears following spontaneous vaginal birth has reduced in August to 2.09% (within national parameters 3.6%) from 2.90% in July 2024.

The reported tear rates have previously been much lower than the national average and Maternity have had a good culture for using the Obstetric and Sphincter Injury (OASI) bundle and access to Episcissors (adapted surgical scissors used for episiotomy). The division are aware of the increase in rates and have already received audit findings for the management of tears from diagnosis, presented to the clinical meeting in June 2024. All individual cases are reviewed to identify risk factors and ensure the Postnatal care is to the level expected whilst also looking at rates in cohorts of clinical staff. However, due to the increase in rates, and the limitations of learning from reviewing individual cases, a thematic analysis has been commenced undertaken by the Consultant Midwife and an Obstetric Trainee that will provide clinician level detail to support continuous understanding of the position and support any recommended improvements, including supportive training.

Workforce

Turnover – Whilst turnover (11.3%) remains well within the Trust's upper threshold (13%), the last 12 months has seen incremental increase in turnover. The People & OD Executive Group are actively monitoring the actions at divisional level to understand and address increase in turnover, where appropriate,

Clinical Mandatory Training – Following revision to the mandatory training targets for core, clinical and local mandatory training from 95% to 90% to ensure alignment with the region, Clinical Mandatory Training (generic clinical competencies required for all clinical staff) is the only mandatory training element below target at 88% (increasing from 86% last month).
Recruitment to a new role within the practice education team is expected to deliver an improvement in the planning and delivery of mandatory training and opportunities cross-division and cross-speciality maximised. PODEG recently reviewed and supported a recommendation to reduce the targets for mandatory training compliance for core, clinical and local mandatory training from 95% to 90% to ensure alignment with the region, following a benchmarking exercise with other Trusts in C&M.

Face to Face Anti Racism Training – Excellent progress has been made in delivering face to face anti racism and inclusion training to the workforce with 74% of staff having completed this to date against a target of 80% by the 31.3.25.

Sickness Absence – Sickness absence has increased for the last 2 month and stands at 5.69%, following a historic low of 4.86% in May 2024. It remains however within expected parameters when compared with Sickness in July 2024 which was 5.23%. Anxiety / stress / depression related absence continues to be at lower levels than last year, a contributing factor being the in house Staff Support Psychological Service.

PDR Rate - PDR compliance has improved from 79% last month to 84% though remains under the target of 90% and has been a deteriorating trend over the last 12 months. Engagement with staff and managers confirmed support for a group PDR model for some staff groups and bands and this is in the process of being rolled out. The new PDR Microsoft form paperwork has been simplified and this has been well received. Improved compliance with the PDR window of March and April for Band 8as and above is required to ensure consistent and targeted objective setting across the organisation.

The Integrated Performance Report is included at Appendix C.

Equality, Diversity & Inclusion Implications
Not applicable

Quality, Financial or Workforce implications
Not applicable

RECOMMENDATION

The Board of Directors is asked to:

- note the content of the report
- note the Integrated Performance Report.
- Note the Executive Risk and Assurance Group Reports

SUPPORTING DOCUMENTS

Appendix A – Big Conversation Infographic
Appendix B – Executive Risk and Assurance Group Reports
Appendix C – Integrated Performance Report

BIG CONVERSATION
YOU SAID, TOGETHER WE WILL

NHS Liverpool Women's NHS Foundation Trust

THANK YOU FOR A GREAT CONVERSATION

We know that actions speak louder than words, so here are *'The Big 5'* Trust-wide themes that we have been actioning since our Big Conversation in May..

1. **Staffing**: Managers will receive comprehensive support from HR and Finance in reviewing our workforce structure, where needed, including administrative support within clinical areas. This will help ensure that we have the right people in the right roles, benefiting both our colleagues and patient care.

2. **Processes**: Each area will have unique challenges, and your division will work on addressing these. However, we have streamlined Trust-wide processes such as:
   - ***Vacancy Control Pane***l, allowing vacancies to be reviewed by the panel and Executives on the same day. This will enable quicker responses and more efficient operations within the Trust.
   - ***PDRs***: Separate options now exist, including a Microsoft Forms PDR and Group PDRs, to make your reviews more meaningful and efficient.
   - ***Contract Change Forms***: One central form is now in place for all HR changes, making the process much more simpler and easier to complete.

3. **Leadership:** Our Executive team is committed to engaging with you directly through "Walkabout Wednesday", where they will visit clinical areas across the Trust. Additionally, James Sumner, our Chief Executive, will continue with "In the Loop," providing an open forum for you to ask questions and interact with our leadership team.

4. **Space:** Our Great Place to Work Group is actively supporting initiatives to enhance staff wellbeing, including improvements to breakrooms and rest areas. The Great Place to Work Group would welcome your suggestions for wellbeing and inclusion projects. If you have specific requests for your department's existing break or rest area, please reach out to the Estates and Facilities team. Having recently renovated staff spaces in Obs Theatres & Physio, they will be delighted to meet and discuss plans for your area.

5. **Estates:** We're excited to announce a new system to enhance and streamline the logging and tracking of estates and facilities jobs at LWH, coming soon! In the meantime, we've made some positive changes: we've added a PA to Estates and Facilities to improve reporting and feedback, and we're recruiting a Senior Estates Officer to focus on ongoing and future projects. Our team is also collaborating with LUHFT to develop new signage for LWH. For estate requests, email ESTATES.HELPDESK@lwh.nhs.uk or call 1234 with your log number. Please log OCS jobs directly with OCS.

Liverpool Women's
NHS Foundation Trust

Executive Risk & Assurance Group Assurance Report

Report to	Trust Board
Date	12 September 2024
Meeting Name	Executive Risk & Assurance Group
Date of Meeting	07 August 2024
Chair's Name & Title	Jenny Hannon, Deputy Chief Executive

Agenda Items

The following agenda items were discussed by the meeting:

1. Executive Group Reports
    a. Finance & Performance
    b. Quality, Risk & Safety
    c. People & Organisational Development
    d. Research
2. Divisional Board Reports
    a. Family Health
    b. Gynaecology
    c. Clinical Support Services
3. Reportable Issues Log

Matters for Escalation from ERAG to the Board

Calibration of risks aligned to FPEG: limited assurance was taken by FPEG in relation to the articulation of risks reported into the group. It was reported that some of the risks as currently articulated on the register did not reflect the most significant risks being managed by the group. A calibration exercise would be undertaken and the addition of required risks by members ahead of the next meeting.

Ambulatory Capital Project: additional cost pressure on the ambulatory programme had been identified. Based on the causes and requirements the Group supported the continuation of the Ambulatory capital program noting risks to the capital envelope and required approvals within SFIs.

Pathology risk: reinstated due to a national alert of blood stock shortage. Ongoing weekly huddles and oversight of stock levels in place and consideration towards the introduction of blood collection clinics on site.

Other issues

The following issues were noted during the meeting:

- The introduction of a CIP Portfolio Improvement Board supported by the Trust TDU as part of the wider Improvement Program.
- The significant volume of reports submitted through to the Quality, Risk and Safety Executive Group was noted and a request to focus on ensuring appropriate prioritisation of reporting into this group as it becomes established.
- Lack of consistency in risk articulation and scoring across divisions, emphasising the need for a more standardised approach to ensure accurate risk management and adequate controls.
- Risk added pertaining to Fresenius pumps inconsistently miscalculating occasional infusions on the volumetric pumps. Controls had been put in place to manage the risk including daily audit and monitoring. The Group raised concern about the sustainability of the control in place and advised the SLT to escalate any support requirements to the Digital Team for a long-term solution to support a long-term resolution.
- Risk to Anaesthetics capacity out of hours escalated by both the Clinical Support Service and Family Health Division. Task and Finish groups in place to review Gynaecology and Obstetric capacity and clinical patient pathways, a Business Case was in production and ongoing recruitment plans in Anaesthetics to increase middle grade presence and additional controls to manage those risks identified.
- Emerging risk in relation to Liverpool Clinical Laboratories and turnaround time of Histology tests that could impact cancer performance targets.
- Family Health reported Continuity of Carer hybrid model 12-month service evaluation paper and approved recommendations to continue with the hybrid model for a further 12 months.
- Family Health Divisional Board had approved the CNST MIS Year 6 Maternity Staffing report to be submitted to the Quality Committee in August 2024 and onward to Trust Board in September 2024, in line with national reporting requirements for CNST.
- The addition of a number of Pharmacy risks linked to the Pharmacy Review currently underway by the Chief Pharmacist was noted.
- The Trust was engaged in a national discussion regarding the definition of never events, considering the implications of events that result in no patient harm.

Decisions Made

To seek Board approval for additional expenditure to continue the Ambulatory Capital Program.

Recommendations

The Board of Directors is asked:

- to note the content of the report;
- approve the request for additional expenditure to continue the Ambulatory Capital Program (under separate agenda item).

Liverpool Women's NHS Foundation Trust

Appendix 1: Attendance Matrix

Core members	May 24	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar 25
Chief Executive	A	✓	✓	A							
Chief Finance Officer / Deputy Chief Executive	✓	✓	A	✓							
Chief Medical Officer	✓	✓	✓	A							
Chief Nurse	✓	✓	✓	✓							
Chief Operating Officer	✓	✓	✓	✓							
Chief People Officer	✓	✓	✓	✓							
Chief Transformation Officer	✓	✓	✓	✓							
Chief Digital Information Officer	A (R)	✓	✓	✓							
Deputy Chief Operating Officer	✓	✓	✓	A							
Deputy Director of Nursing	✓	✓	✓	✓							
Deputy Medical Director	A	A	✓	✓							
Deputy Chief Finance Officer	✓	✓	✓	✓							
Deputy Director of Workforce	✓	✓	✓	✓							
Head of Communications	✓	✓	✓	✓							
Associate Director of Quality & Governance	A	✓	✓	✓							
Head of Risk & Patient Safety	✓	✓	✓	A							
Divisional Manager, Gynaecology	✓	✓	✓	✓							
Divisional Manager, CSS	A	✓									
Divisional Manager, Family Health	✓	✓	✓	✓							
Head of Nursing, Gynaecology	✓	✓	✓	✓							

Head of Midwifery	✓	✓	✓	✓							
Head of Nursing, Neonates	**A**	✓	✓								
Head of AHPs – Clinical Support Services	✓	✓	✓	✓							
Clinical Director, Family Health	✓	✓	**A**	**A**							
Clinical Director, CSS	✓	✓	**A**	**A**							
Clinical Director, Gynaecology	✓	✓	**A**	**A**							
Director of Midwifery			✓	✓							
Trust Secretary	✓	✓	✓	**A**							
Other Attendees											
Head of Information	✓	✓	✓								

Liverpool Women's
NHS Foundation Trust

Executive Risk & Assurance Group Assurance Report

Report to	Trust Board
Date	12 September 2024
Meeting Name	Executive Risk & Assurance Group
Date of Meeting	04 September 2024
Chair's Name & Title	Jenny Hannon, Deputy Chief Executive

Agenda Items

The following agenda items were discussed by the meeting:

1. Divisional Board Reports
    a. Family Health
    b. Gynaecology
    c. Clinical Support Services
2. Executive Group Reports
    a. Finance & Performance
    b. People & Organisational Development
3. Reportable Issues Log

Matters for Escalation from ERAG to the Board

Cash balances: emerging concern in relation to the cash position for September 2024. Whilst the Trust has applied for in-month cash support, confirmation had not yet been received posing a risk to cashflow and ability to meet obligations.

Other issues

The following issues were noted during the meeting:

- Request for approval of additional expenditure for the ambulatory project would be taken to the Trust Board in September 2024. Enabling works had commenced in August 2024.
- A positive site visit from the National Clinical Director to review cancer services at the Trust had taken place.
- Potential areas of risk in relation to Medical Devices and a requirement for a consistent approach to be undertaken across the Trust. Executive Team to review.
- Initial gap analysis in relation to pharmacy and medicines management had been undertaken which identified a number of risks. A full report would be produced for the next meeting.
- Hindrance to obtaining a robotic solution for blood transfusion was noted with work underway to resolve the issues.

- The volume of risks in Family Health relating to capacity including elective caesarean sections and induction of labour. This was to be reviewed by the division and noted for inclusion within upcoming Capacity and Demand plans.
- Family Health Division had received an RCM award nomination in relation to the sustained service improvements within Maternity Assessment Unit Triage.
- Calibration of the risks reporting into FPEG had taken place with increased assurance received.
- Risks to the 28-day faster diagnosis standard compliance, which was below 50% due to scope decontamination issues. Improvement was expected from September 2024.
- Risks to Cost Improvement Programme (CIP) as a significant element of the total remained non-recurrent. CIP Portfolio Board meeting fortnightly to support resolution.
- Issue in relation to fertility premises rental agreement expiry and potential renewal costs and timeframes, currently being managed by the division.
- The Group supported the request to undertake a piece of work on the organisation's approach to maternity leave cover.
- It was suggested that Risk 2768 and Risk 1344 in relation to the Anaesthetic workforce be merged and aligned as a single risk due to duplication. The Chief Medical Officer and the CSS Divisional Manager agreed to consider.
- Dr Penny Dash review into the operational effectiveness of the Care Quality Commission (CQC) noted. The interim report, which will be followed by a final report in autumn, provided a summary of the emerging findings and outlined a series of recommendations.
- The meeting noted the number of risks aligned to more than one executive group/division and the need to verify lead ownership and oversight to prevent potential failures.

Decisions Made

The Group agreed to the request to undertake a piece of work on the organisation's approach to maternity leave cover.

Recommendations

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

Appendix 1: Attendance Matrix

Core members	May 24	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar 25
Chief Executive	A	✓	✓	A	A						
Chief Finance Officer / Deputy Chief Executive	✓	✓	A	✓	✓						
Chief Medical Officer	✓	✓	✓	A	✓						
Chief Nurse	✓	✓	✓	✓	✓						
Chief Operating Officer	✓	✓	✓	✓	A						
Chief People Officer	✓	✓	✓	✓	✓						
Chief Transformation Officer	✓	✓	✓	✓	✓						
Chief Digital Information Officer	A (R)	✓	✓	✓	✓						
Deputy Chief Operating Officer	✓	✓	✓	A	A						
Deputy Director of Nursing	✓	✓	✓	✓	✓						
Deputy Medical Director	A	A	✓	✓	✓						
Deputy Chief Finance Officer	✓	✓	✓	✓	✓						
Deputy Director of Workforce	✓	✓	✓	✓	✓						
Head of Communications	✓	✓	✓	✓	✓						
Associate Director of Quality & Governance	A	✓	✓	✓	A						
Head of Risk & Patient Safety	✓	✓	✓	A	A						
Divisional Manager, Gynaecology	✓	✓	✓	✓	✓						
Divisional Manager, CSS	A	✓			A						
Divisional Manager, Family Health	✓	✓	✓	✓	✓						
Head of Nursing, Gynaecology	✓	✓	✓	✓	A						
Head of Midwifery	✓	✓	✓	✓	A						

Head of Nursing, Neonates	**A**	✓	✓								
Head of AHPs – Clinical Support Services	✓	✓	✓	✓	✓						
Clinical Director, Family Health	✓	✓	**A**	**A**	**A**						
Clinical Director, CSS	✓	✓	**A**	**A**	**A**						
Clinical Director, Gynaecology	✓	✓	**A**	**A**	**A**						
Director of Midwifery			✓	✓	✓						
Trust Secretary	✓	✓	✓	✓	**A**						
Other Attendees											
Head of Information	✓	✓	✓								

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report

September 2024

Section 1: Statistical Variation Summary

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'.

Positive Higher or Lower Variation

KPI	P	A	V
18 Week RTT: Incomplete Pathway > 52 Weeks	806	?	L
18 Week RTT: Incomplete Pathway > 65 Weeks	68	?	L
18 Week RTT: Incomplete Pathway > 78 Weeks	0	?	L
GM staff in leadership roles (B7 or above)	9.32%		H
Overall size of active patient waiting list	16675	?	L
Overall Staff Vacancies WTE	31.88		L
Sickness Absence Rate	5.69%	F	L

Common Cause Previously Concerning

KPI	Target	P	A	V
Face to Face Inclusion & Anti Racism training completed by staff	>= 80%	73.78%	?	

Concerning Higher or Lower Variation

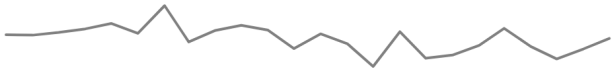
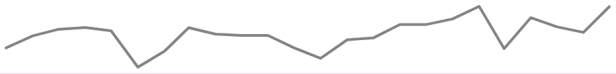
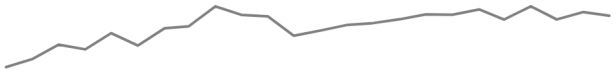
KPI	P	A	V
Never Events (Rolling 12 Months)	4	F	H
Number of Open Patient Safety Incident Investigations	24		H
Total Number of Patient Safety Incident Investigations (Rolling)	24	P	H
Turnover Rate	11.30%	P	H

Liverpool Women's NHS Foundation Trust

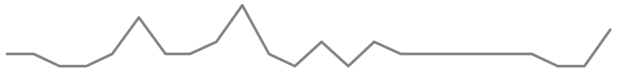
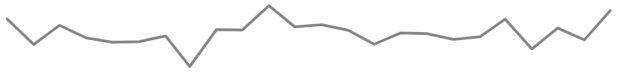
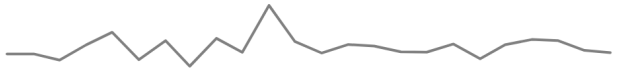
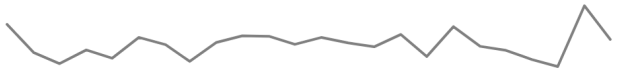
Quality & Safety Indicators

Executive Leads:
Dianne Brown, Chief Nurse
Lynn Greenhalgh, Chief Medical Officer

LWH Quality & Safety Indicators Summary

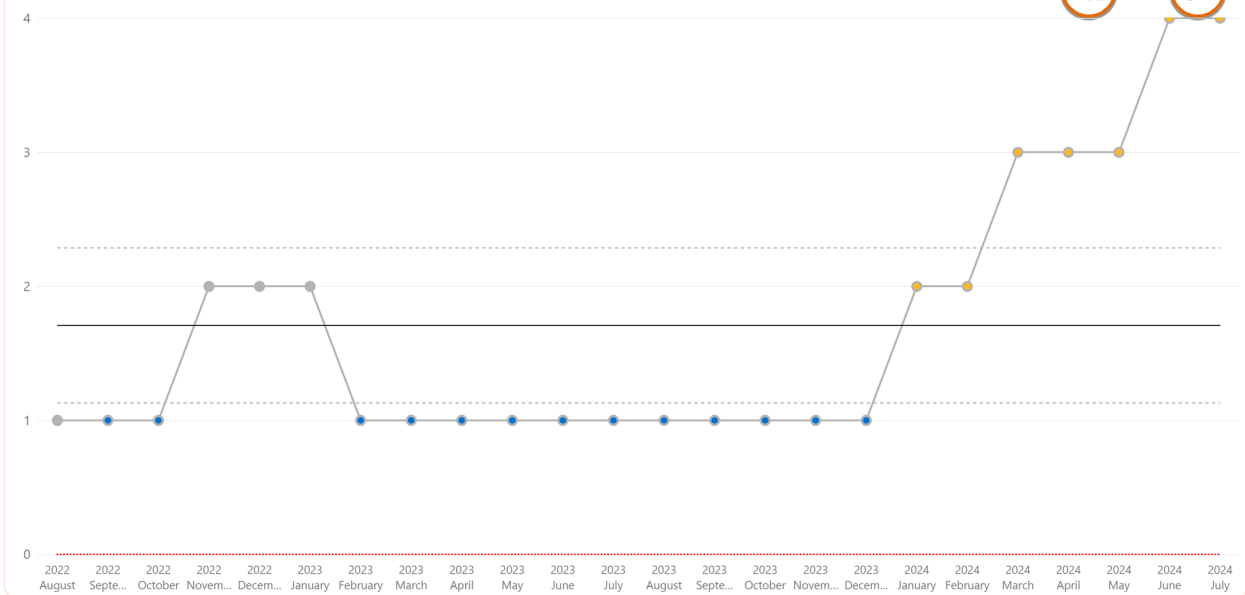
Domain	Date	Target < or >	Performance	Assurance	Variation	Assurance Category	Trend
Governance							
Never Events (Rolling 12 Months)	July 2024	<=	4	F	H	Take Action	
NHSE / NHSI Safety Alerts Outstanding	May 2024	<=	0	P		Celebrate	
Number of Open Patient Safety Incident Investigations	July 2024	<=	24		H	Take Action	
Total Number of Patient Safety Incident Investigations (Rolling)	July 2024	<=	24	P	H	Take Action	
Infection Control							
Infection Control: Clostridium Difficile	July 2024	<=	0	P		Celebrate	
Infection Control: MRSA	July 2024	<=	0	P		Celebrate	
Patient Experience							
Complaints: Number Received	July 2024	<=	2	P		Celebrate	
Friends & Family Test: A&E % positive	July 2024	>=	83.33%	F		Take Action	
Friends & Family Test: In-patient/Daycase % positive	July 2024	>=	93.37%	?		Watch	
Friends & Family Test: Maternity % positive	July 2024	>=	91.06%	F	H	Take Action	
Patient Safety							
Venous Thromboembolism (VTE)	July 2024	>=	94.60%	?		Watch	

LWH Quality & Safety Indicators Summary

Domain	Date	Target < or >	Performance	Assurance	Variation	Assurance Category	Trend
Maternity Signals Chart							
3rd and 4th Degree Tears	July 2024	<=	4.93%			Take Action	
Hypoxic Encephalopathy (Grade 2,3)	July 2024	<=	3			Watch	
Inborn term babies admitted to NICU	July 2024	<=	6.93%			Watch	
Number of births	July 2024	N/A	618			Watch	
Number of stillbirths per 1,000 total births	July 2024	<=	4.85			Watch	
PPH > 1500 (per 1000)	July 2024	<=	38.02			Watch	

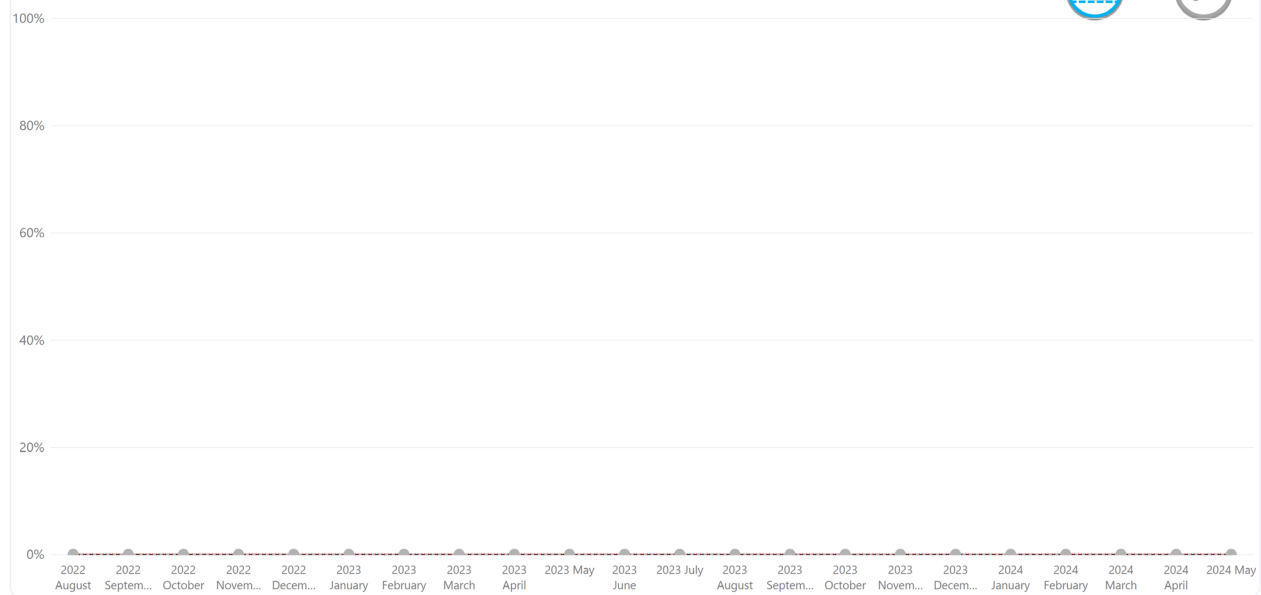
Never Events (Rolling 12 Months) - Medical Director

Target	Target < or >	Performance	Assurance	Variation
0	<=	4	F	H



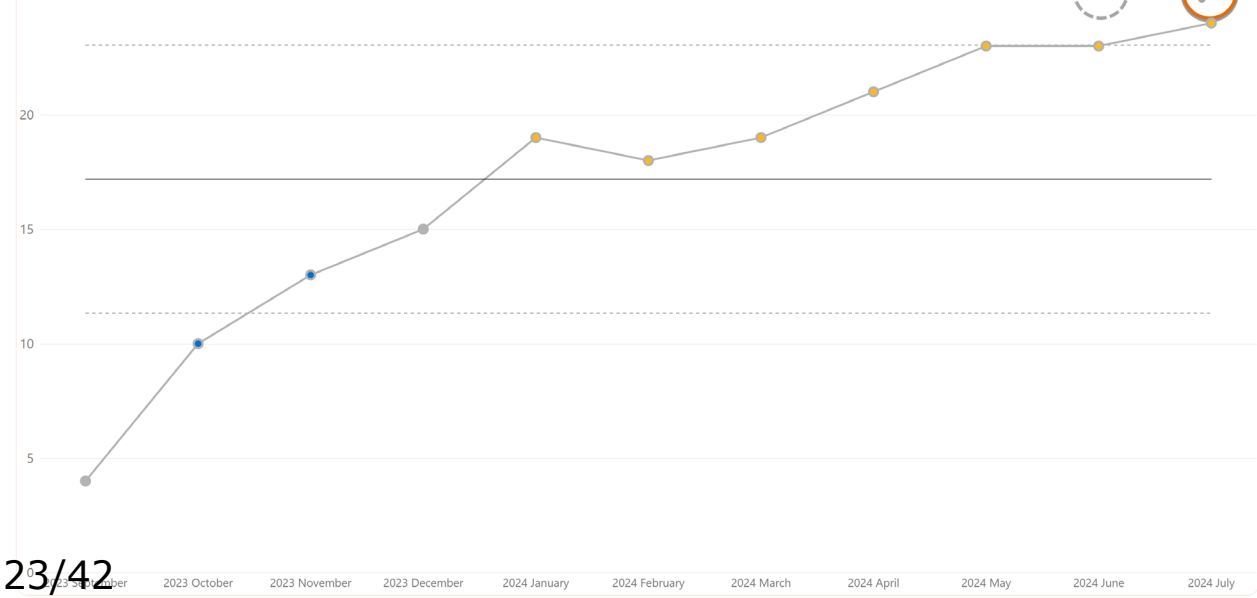
NHSE / NHSI Safety Alerts Outstanding - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
0	<=	0	P	



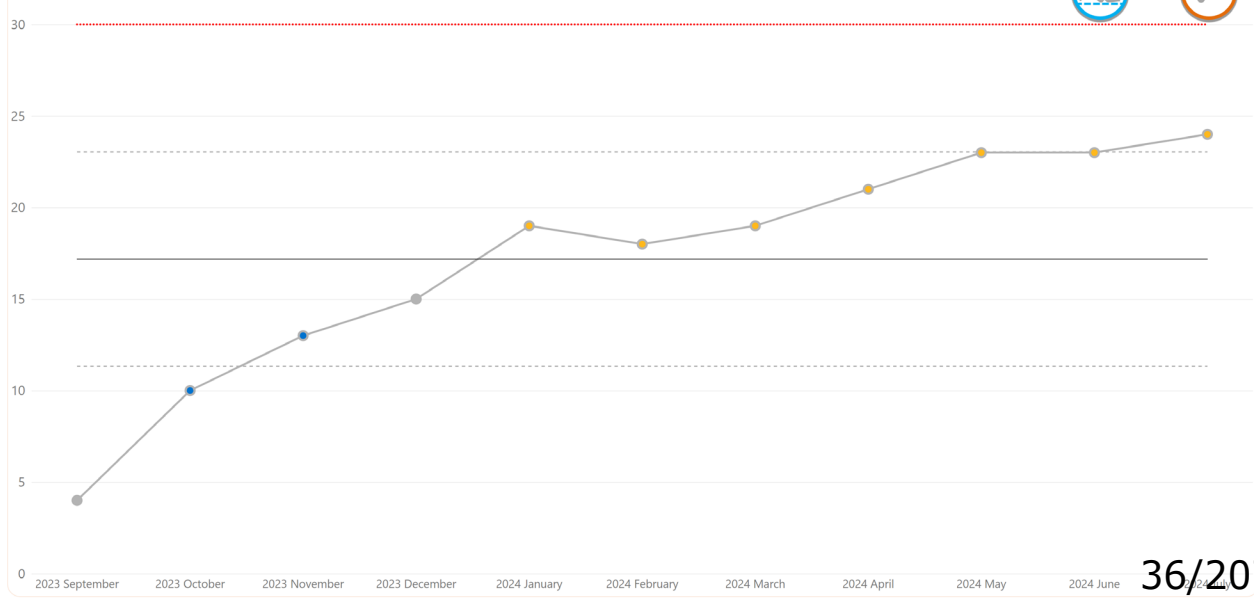
Number of Open Patient Safety Incident Investigations - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
8	<=	24		H



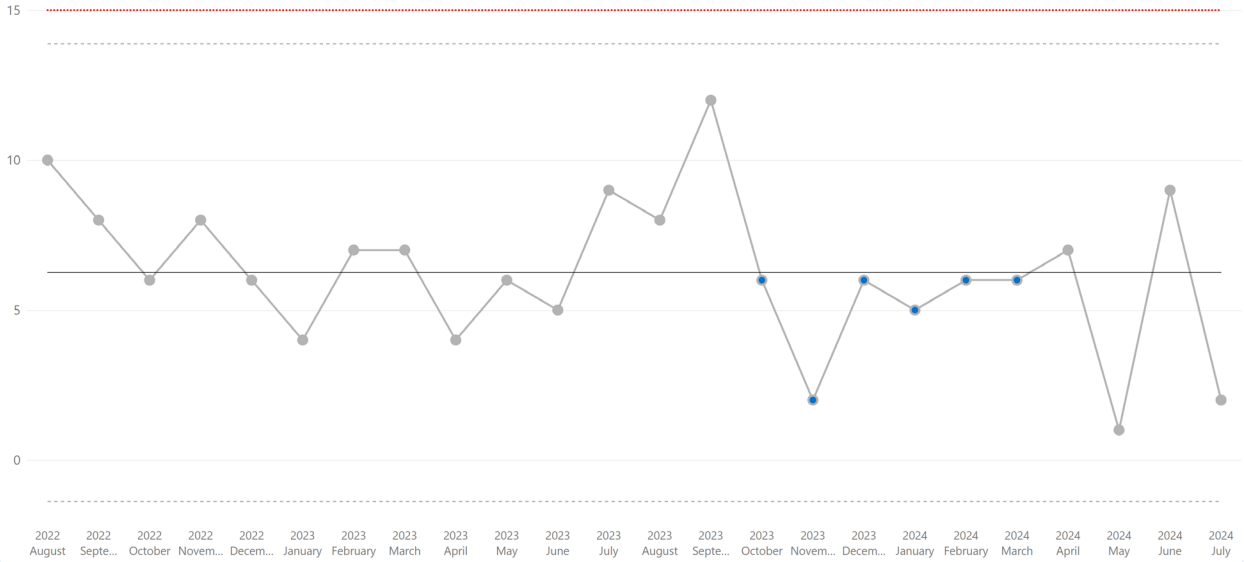
Total Number of Patient Safety Incident Investigations (Rolling) - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
30	<=	24	P	H



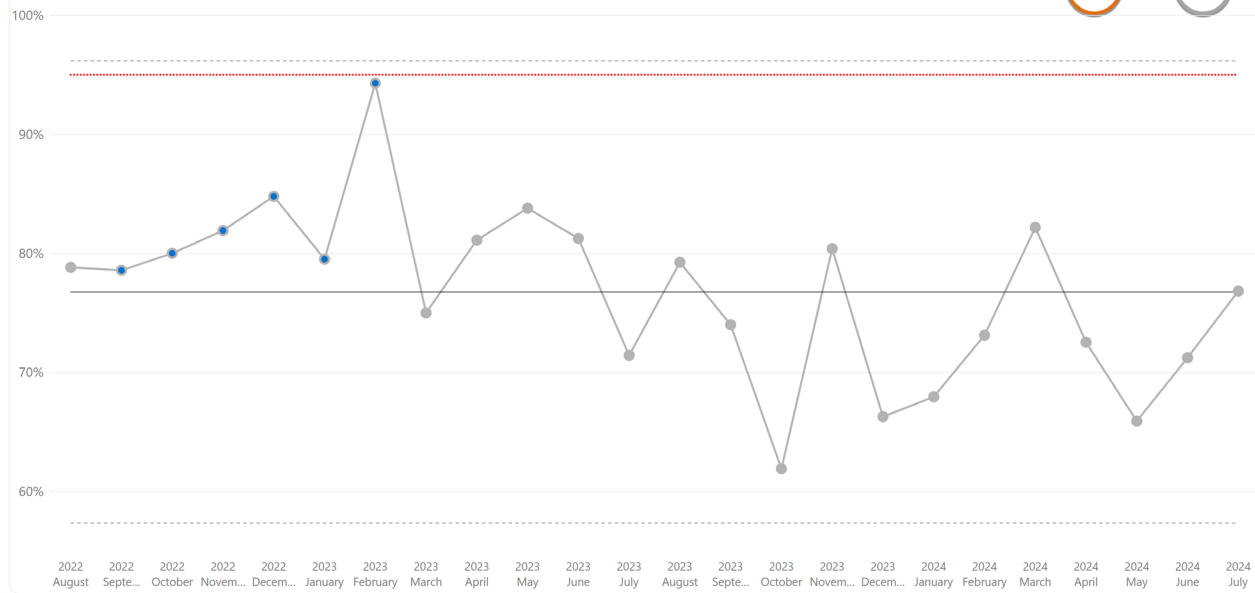
Complaints: Number Received - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
<= 15	<=	2	P	



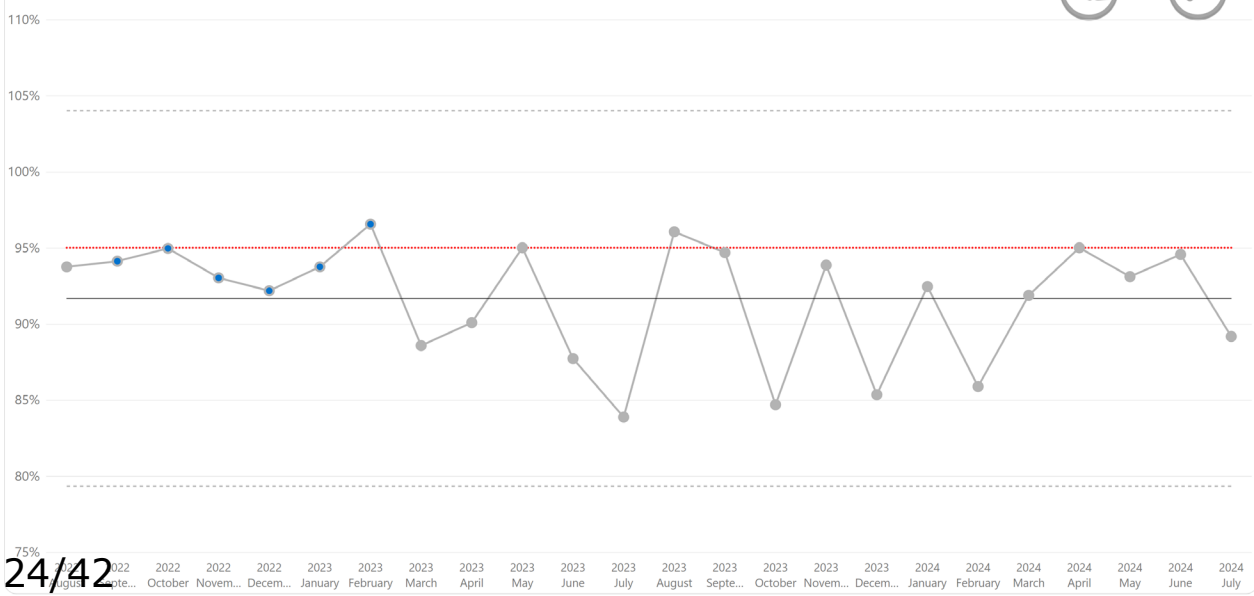
Friends & Family Test: A&E % positive - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
95%	>=	76.83%	F	



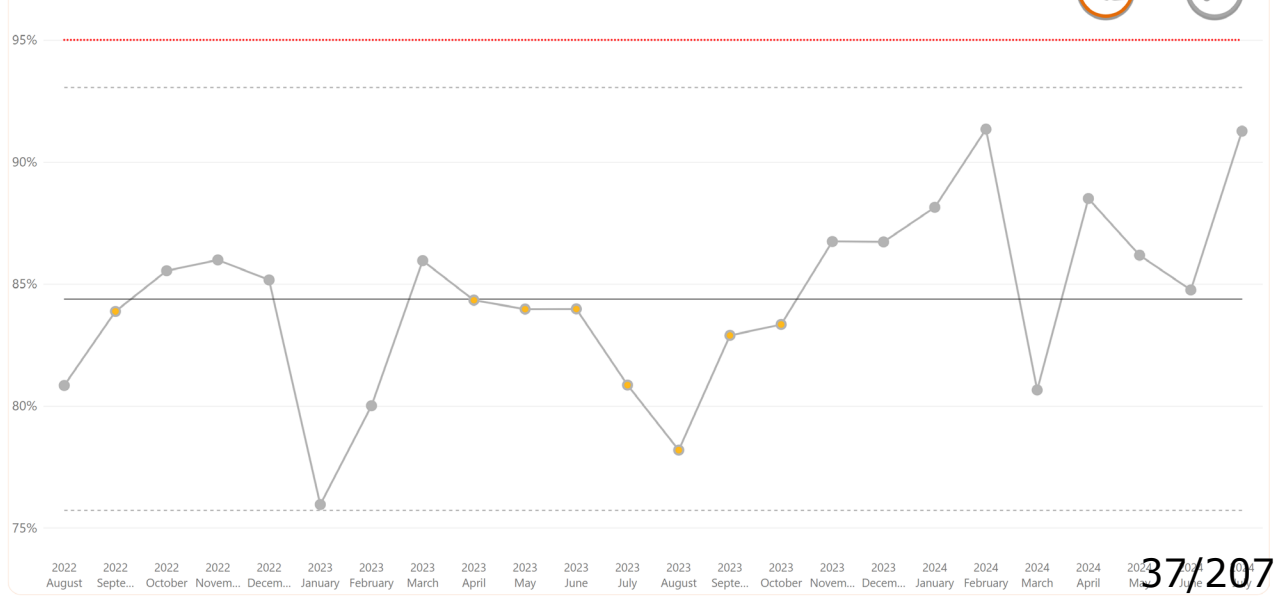
Friends & Family Test: In-patient/Daycase % positive - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
95%	>=	89.17%	?	



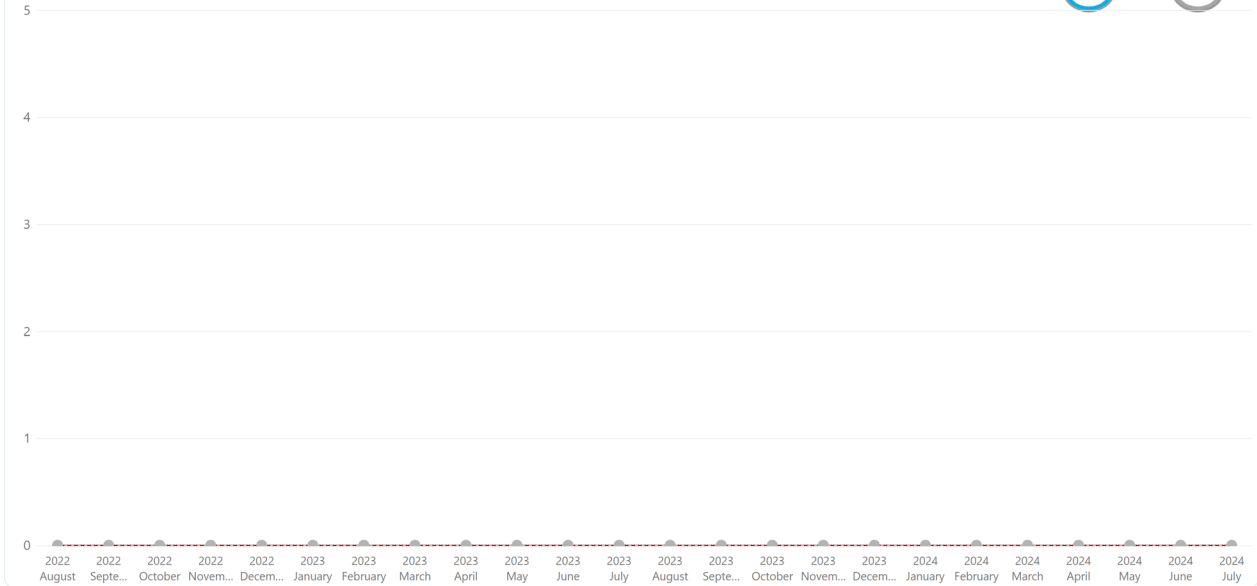
Friends & Family Test: Maternity % positive - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
95%	>=	91.26%	F	



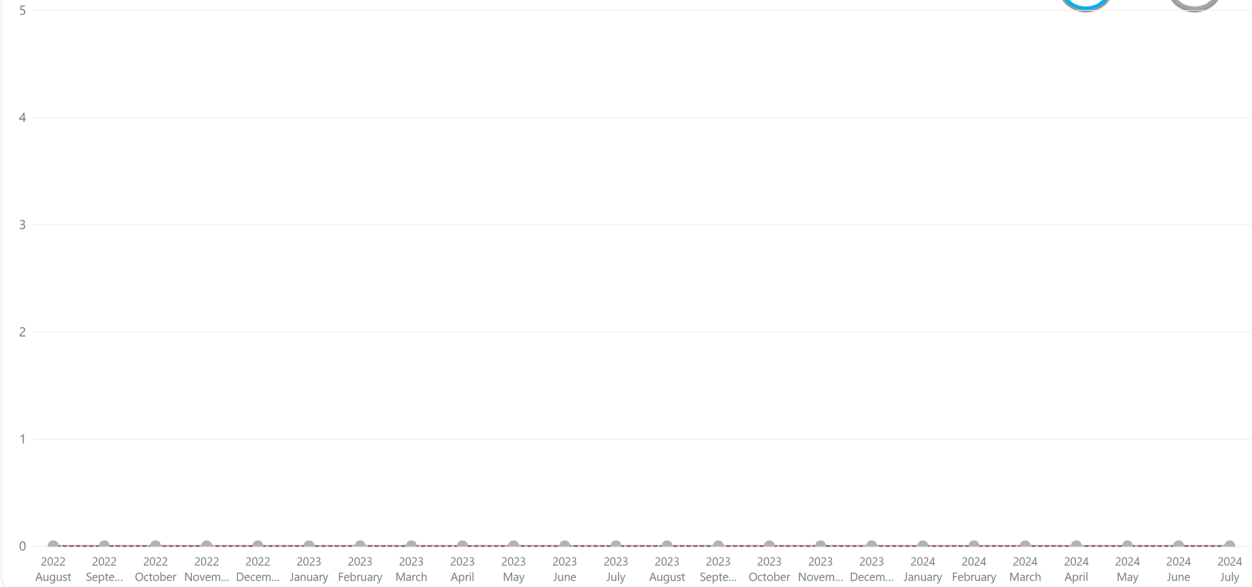
Infection Control: Clostridium Difficile - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
0	<=	0	P	



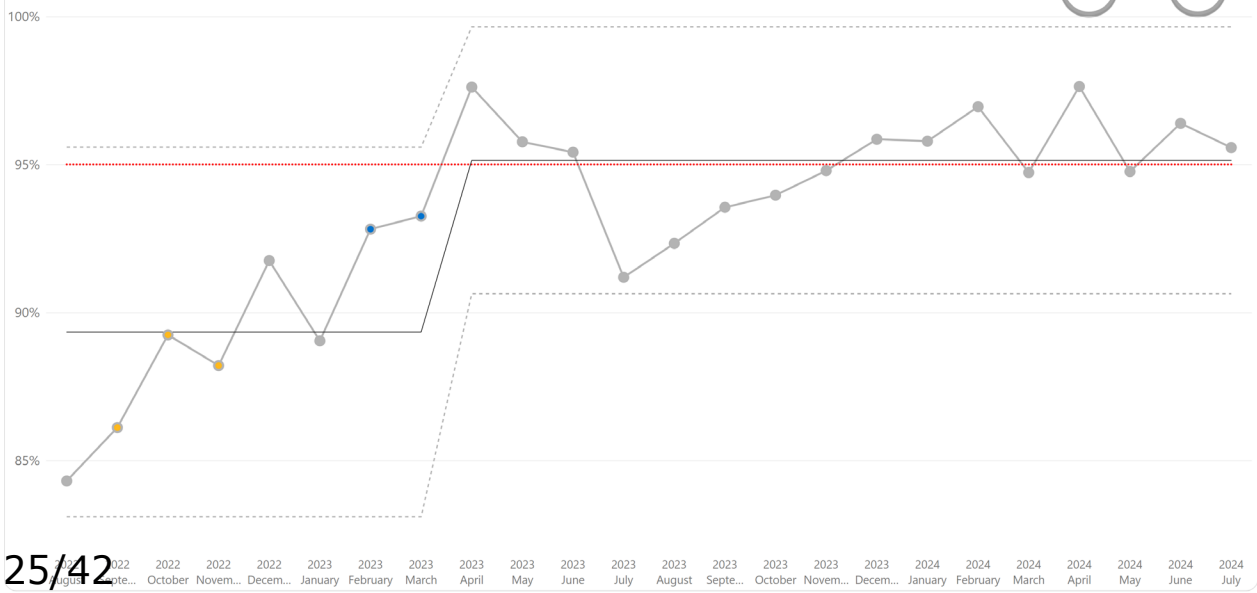
Infection Control: MRSA - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
0	<=	0	P	



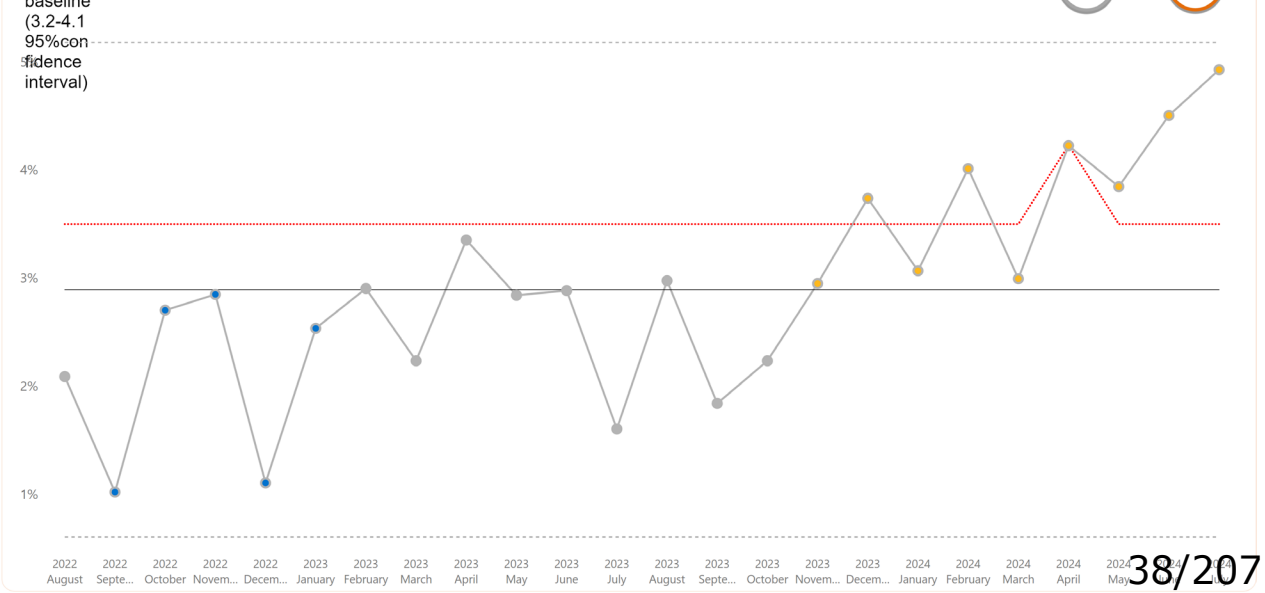
Venous Thromboembolism (VTE) - Medical Director

Target	Target < or >	Performance	Assurance	Variation
>= 95%	>=	95.57%	?	



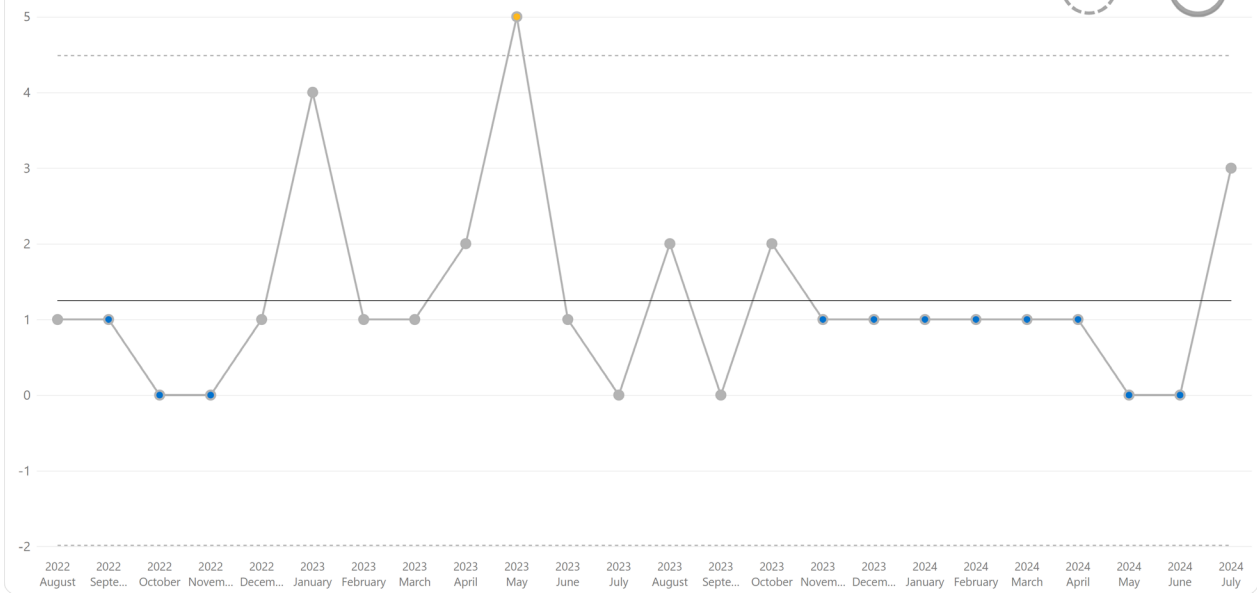
3rd and 4th Degree Tears - Medical Director

Target	Target < or >	Performance	Assurance	Variation
3.5% NMPA baseline (3.2-4.1 95%confidence interval)	<=	4.93%	?	H



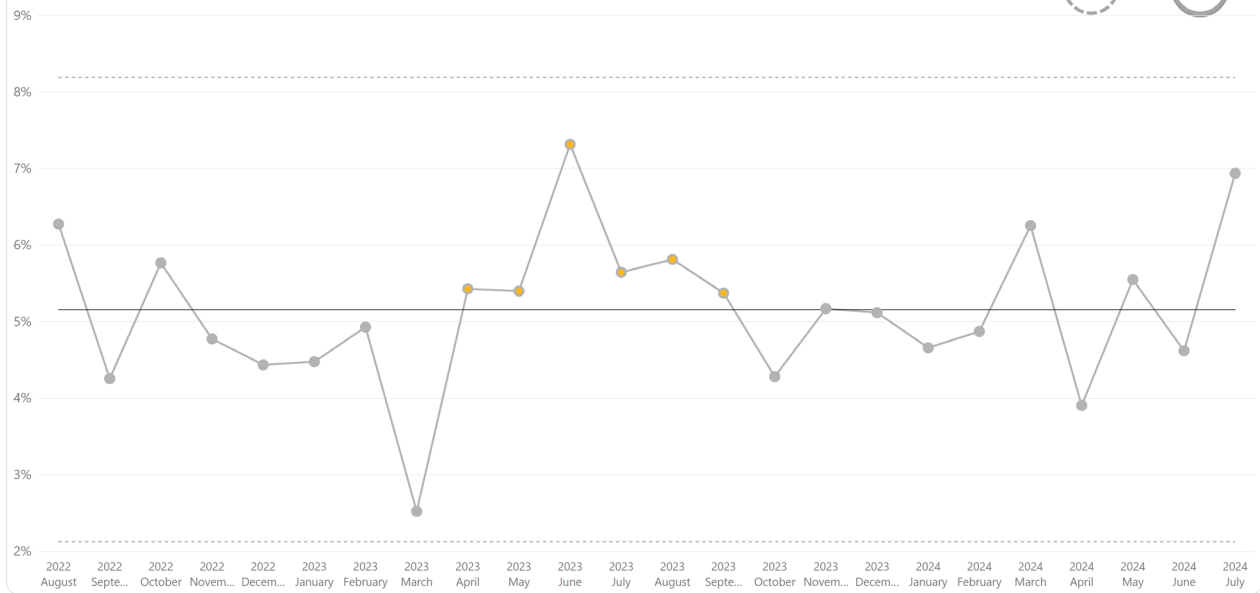
Hypoxic Encephalopathy (Grade 2,3) - Medical Director

Target	Target < or >	Performance	Assurance	Variation
TBA	<=	3		



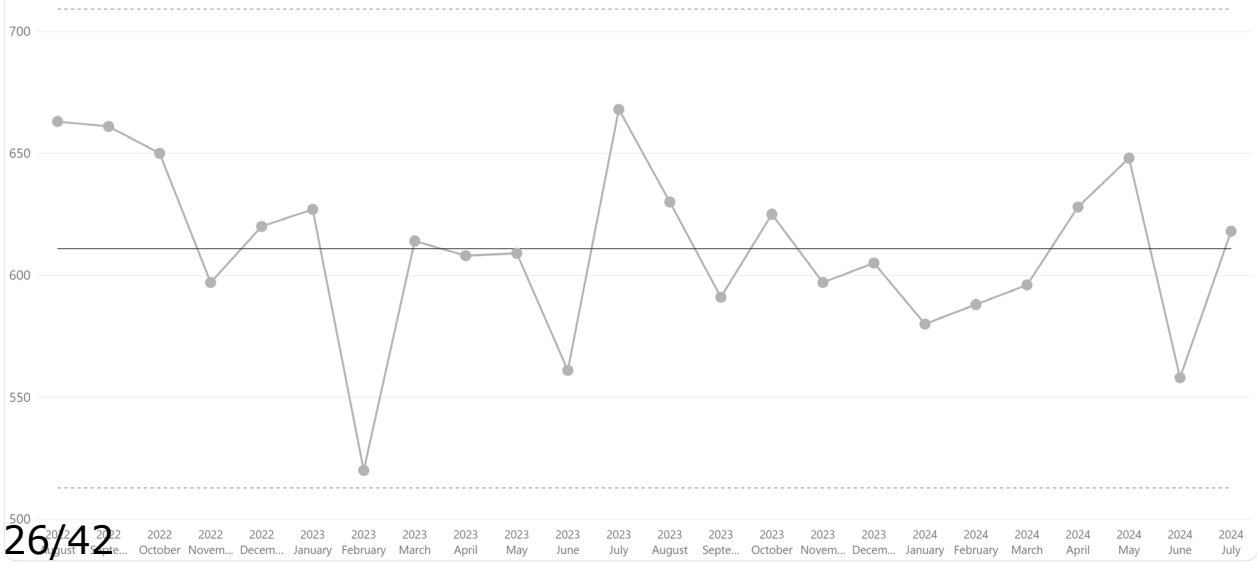
Inborn term babies admitted to NICU - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
<= 5%	<=	6.93%		



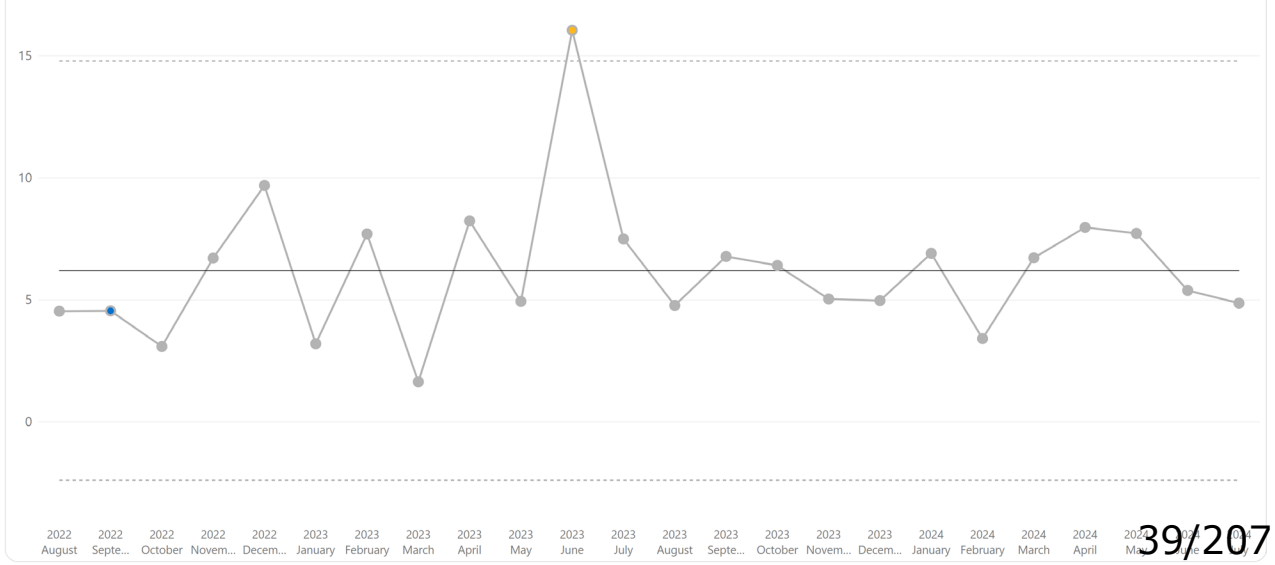
Number of births - Medical Director

Target	Target < or >	Performance	Assurance	Variation
	N/A	618		



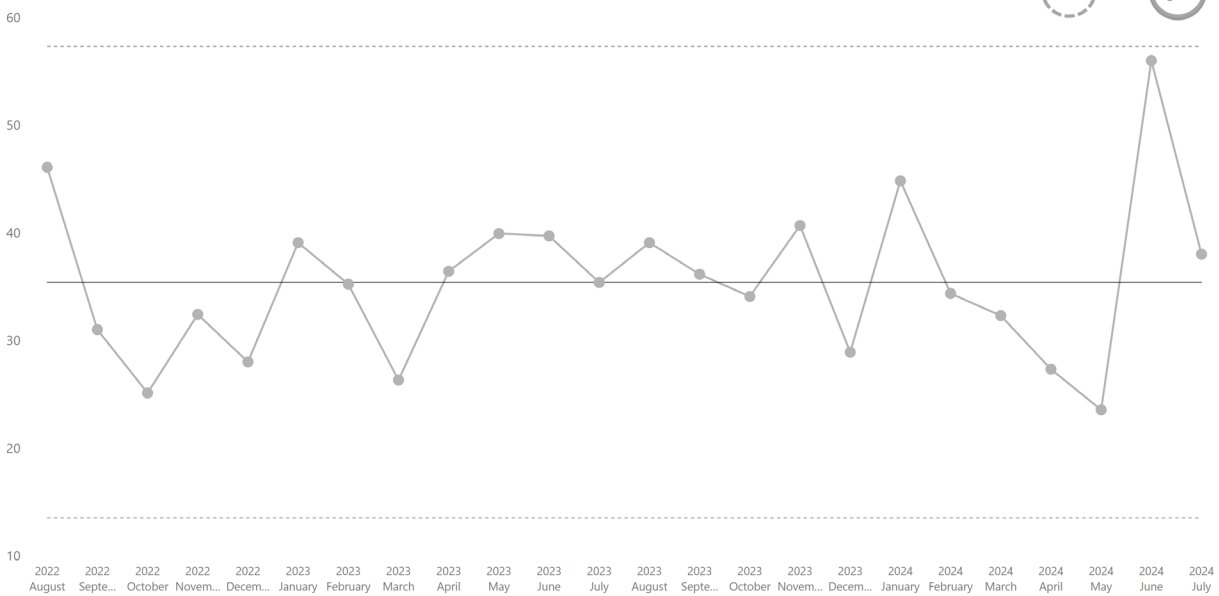
Number of stillbirths per 1,000 total births - Medical Director

Target	Target < or >	Performance	Assurance	Variation
	<=	4.85		



PPH > 1500 (per 1000) - Medical Director

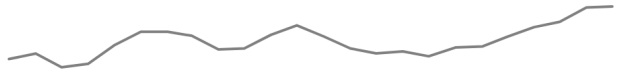
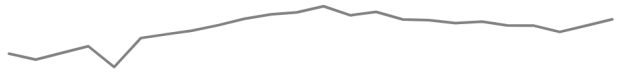
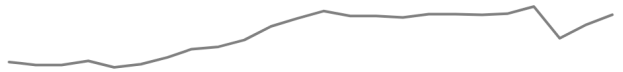
Target	Target < or >	Performance	Assurance	Variation
	<=	38.02		



People Indicators

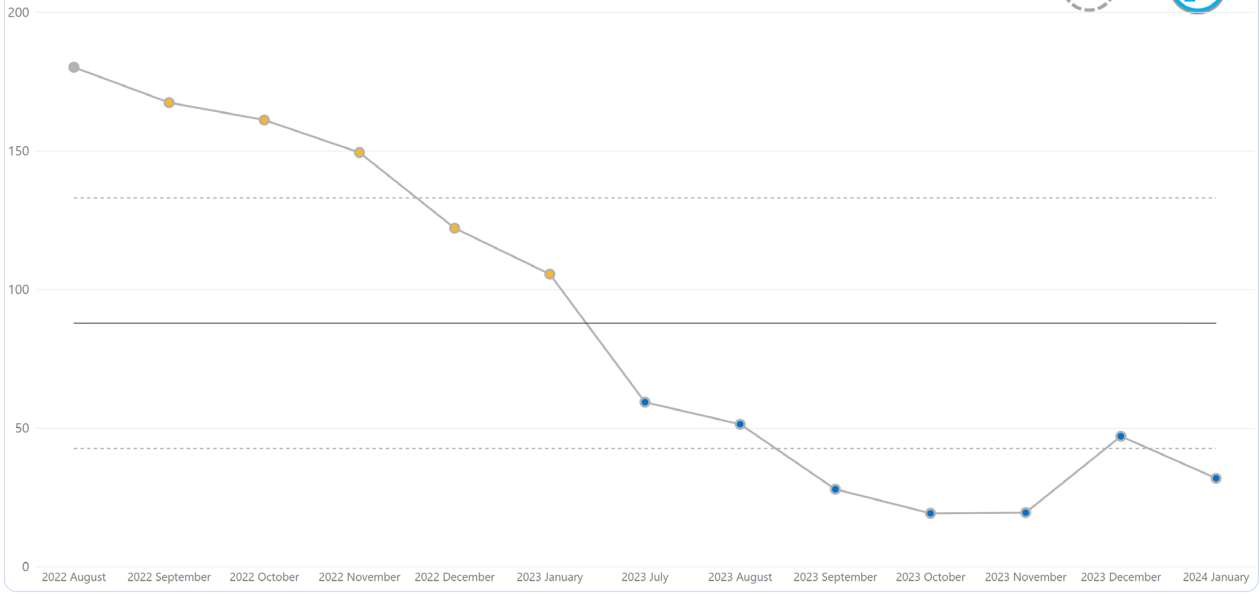
Executive Lead:
Michelle Turner, Chief People Officer

LWH Integrated Performance Report - People Indicators Summary

Domain	Date	Target < or >	Performance	Assurance	Variation	Assurance Category	Trend
Workforce Development							
PDR Rate	July 2024	>=	84.00%	F		Take Action	
Workforce Planning							
Overall Staff Vacancies WTE	January 2024	<=	31.88		L	Celebrate	
Workforce Retention							
Engagement Pulse survey response rate	July 2024	N/A	229	?		Unsure	
GM staff in leadership roles (B7 or above)	July 2024	>=	9.32%		H	Celebrate	
Number of staff leaving within 12 months	July 2024	N/A	12	?		Watch	
Turnover	July 2024	<=	11.30%	P	H	Take Action	
Workforce Training							
Face to Face Inclusion & Anti Racism training completed by staff	July 2024	>=	73.78%	?		Watch	
Mandatory Training	July 2024	>=	93.20%	P		Celebrate	
Mandatory Training (Clinical)	July 2024	>=	88.10%	F		Take Action	
Workforce Wellbeing							
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	February 2024	>=	40.88%	F		Take Action	
Sickness	July 2024	<=	5.69%	F	L	Take Action	

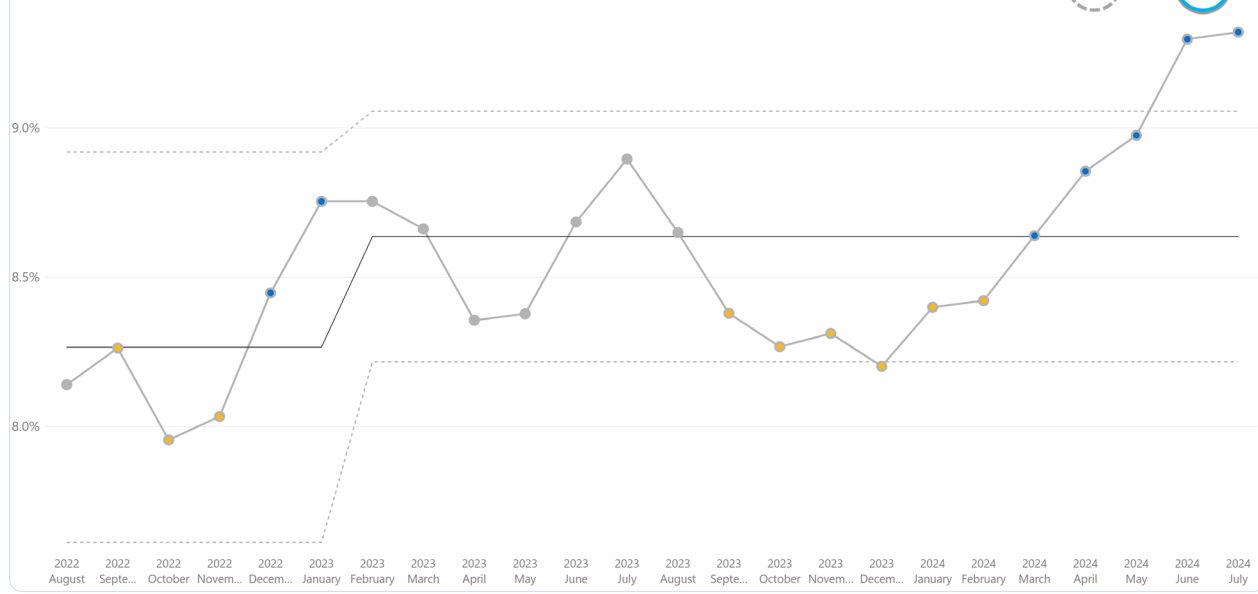
Overall Staff Vacancies WTE - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
	<=	31.88		L



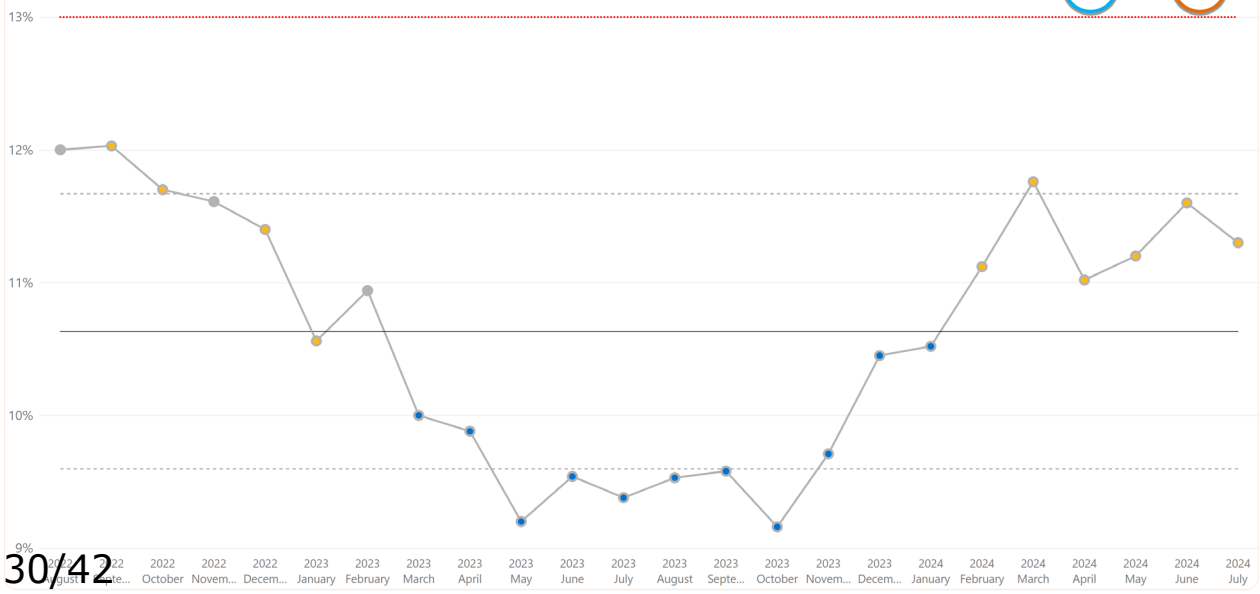
GM staff in leadership roles (B7 or above) - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
	>=	9.32%		H



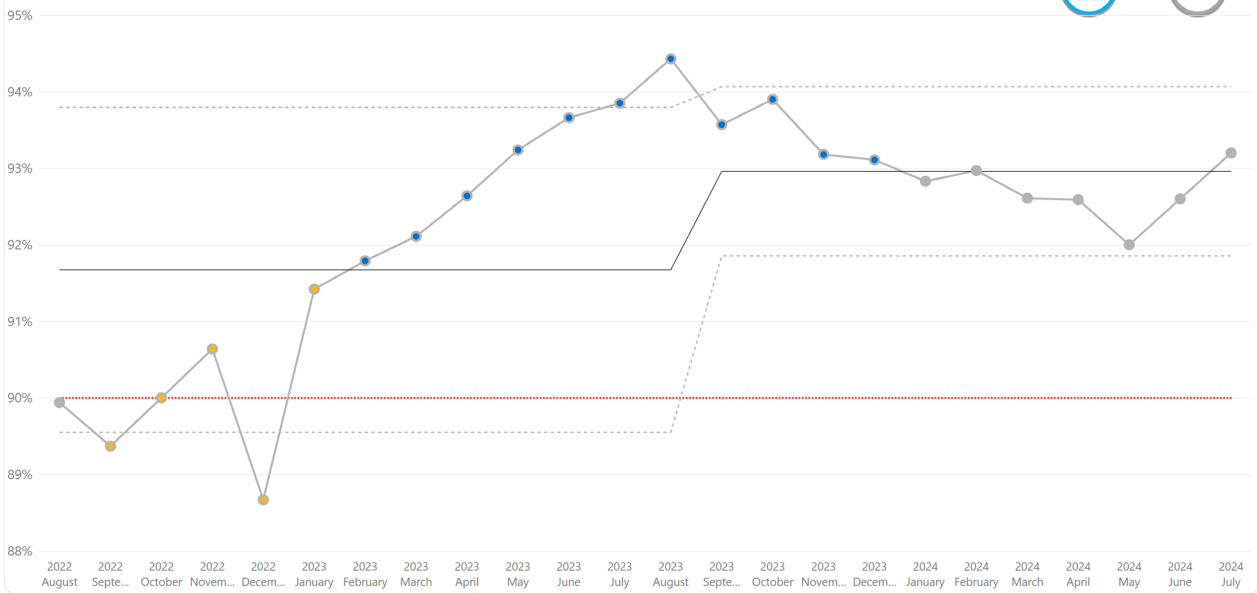
Turnover - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
<= 13%	<=	11.30%	P	H



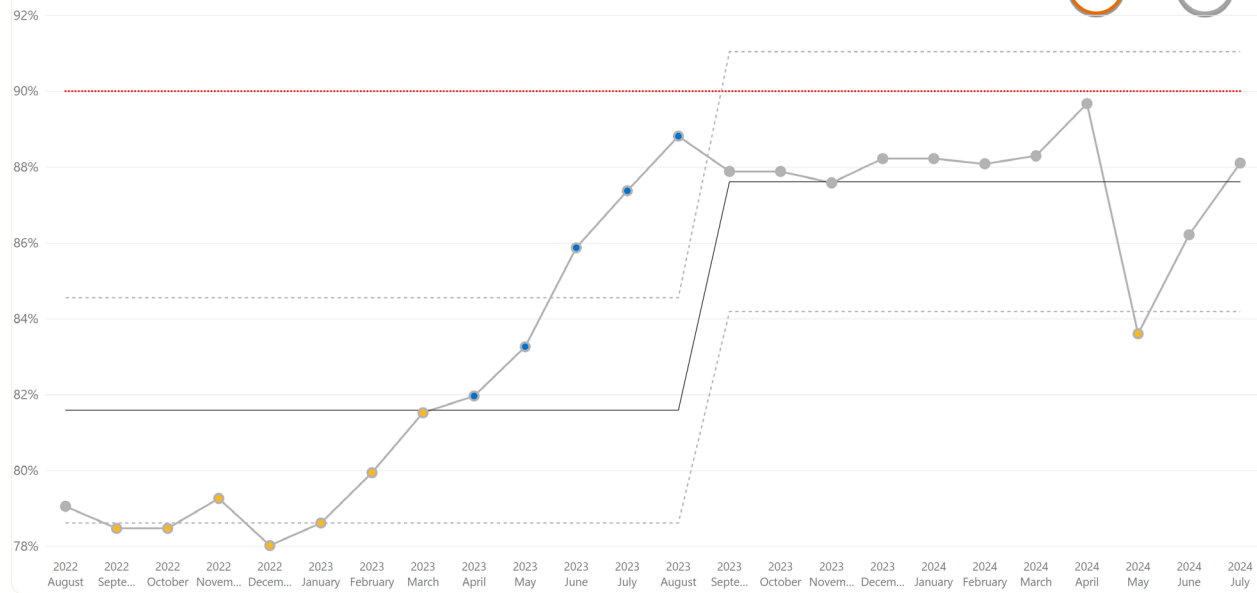
Mandatory Training - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
>= 95%	>=	93.20%	P	



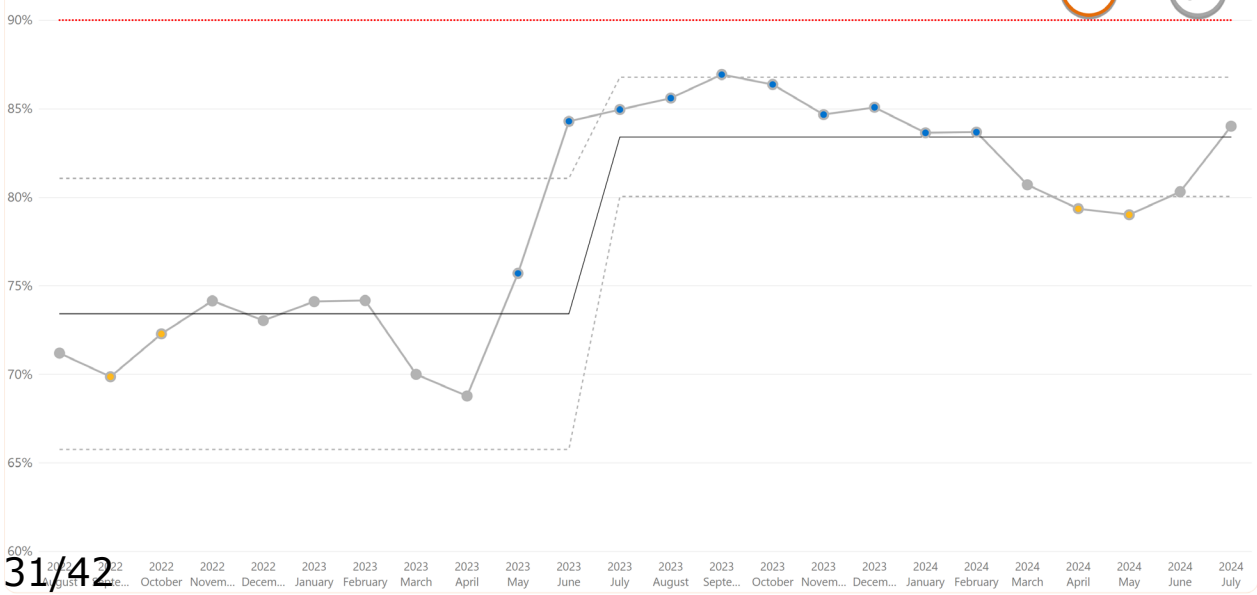
Mandatory Training (Clinical) - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
>= 95%	>=	88.10%	F	



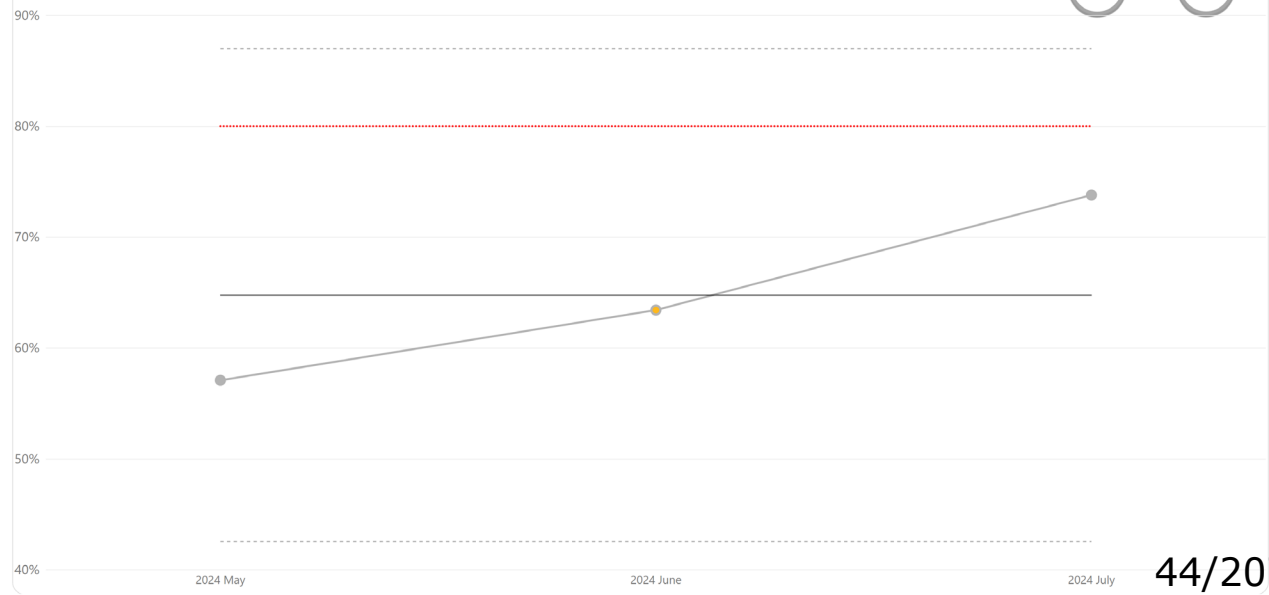
PDR Rate - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
>= 90%	>=	84.00%	F	



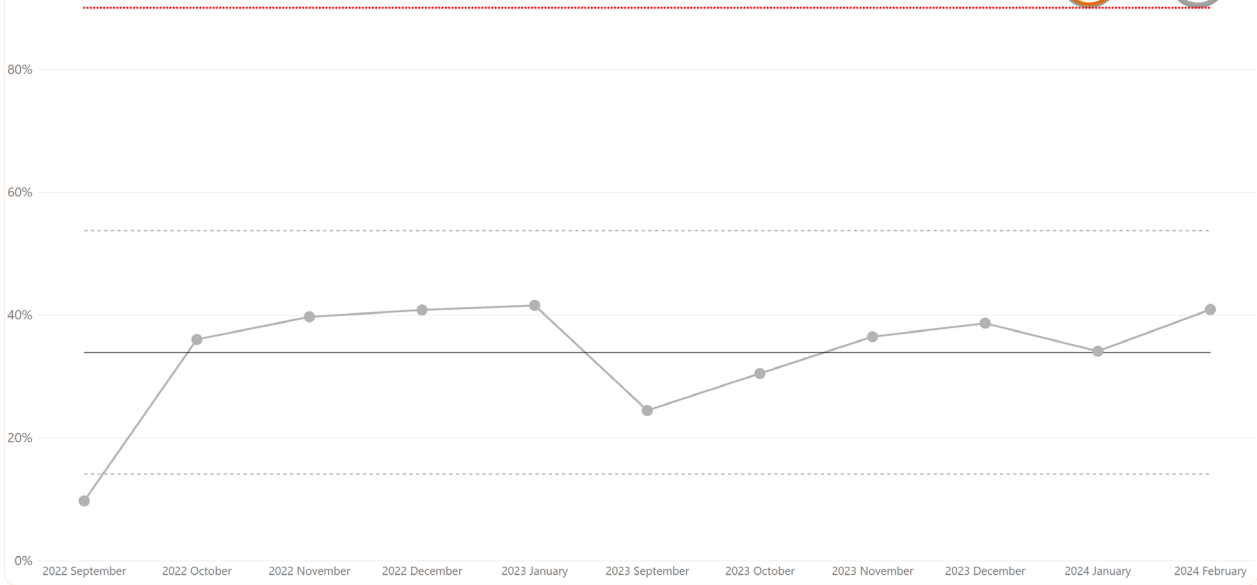
Face to Face Inclusion & Anti Racism training completed by staff - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
>= 80%	>=	73.78%	?	



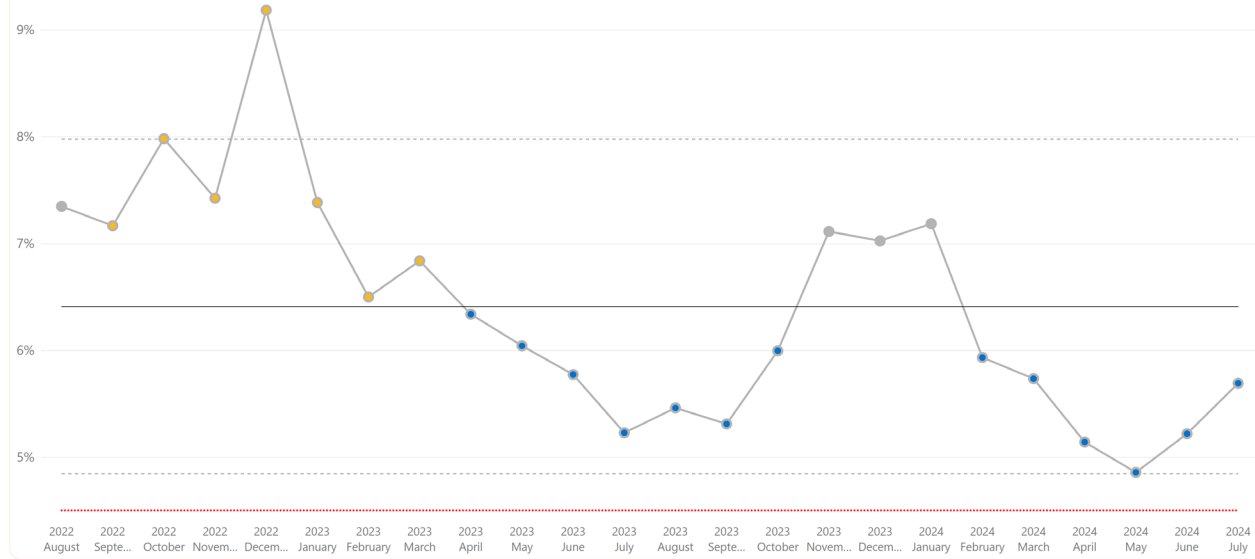
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
>= 80%	>=	40.88%	F	



Sickness - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
<= 4.5%	<=	5.69%	F	L



Liverpool Women's NHS Foundation Trust

Operational Performance Indicators

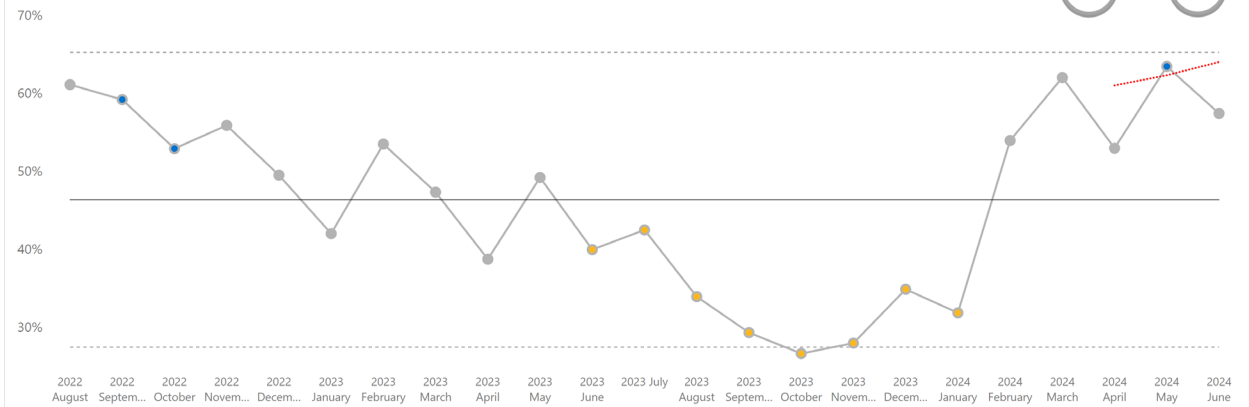
Executive Lead:
Gary Price, Chief Operating Officer

LWH Integrated Performance Report - Operational Indicators Summary

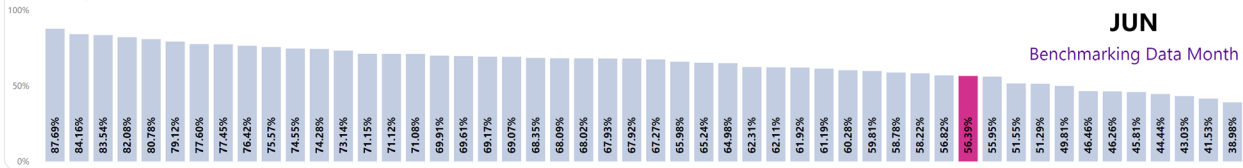
Domain	Date	Target < or >	Performance	Assurance	Variation	Assurance Category	Trend
Cancer							
Cancer: 28 Day Faster Diagnosis	June 2024	>=	57.41%	?		Watch	
Cancer: 31 Day decision to treat to treatment	June 2024	>=	68.18%	F		Take Action	
Cancer: 62 Day referral to Treatment	June 2024	>=	28.57%	?		Watch	
Planned Care							
18 Week RTT: Incomplete Pathway > 52 Weeks	July 2024	<=	806	?	L	Celebrate	
18 Week RTT: Incomplete Pathway > 65 Weeks	July 2024	<=	68	?	L	Celebrate	
18 Week RTT: Incomplete Pathway > 78 Weeks	July 2024	<=	0	?	L	Celebrate	
Diagnostic Tests: 6 Week Wait	July 2024	>=	95.80%	?		Watch	
Overall size of active patient waiting list	July 2024	<=	16675	?	L	Celebrate	
Urgent Care							
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	July 2024	>=	90.74%	?		Watch	
MAU - Arrival to Triage within 15 Mins	July 2024	>=	90.77%	?		Watch	
MAU - Arrival to Triage within 30 Mins	July 2024	>=	98.65%	P		Celebrate	

Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 75%	>=	57.41%		



CWT % Compliant by ORG CODE

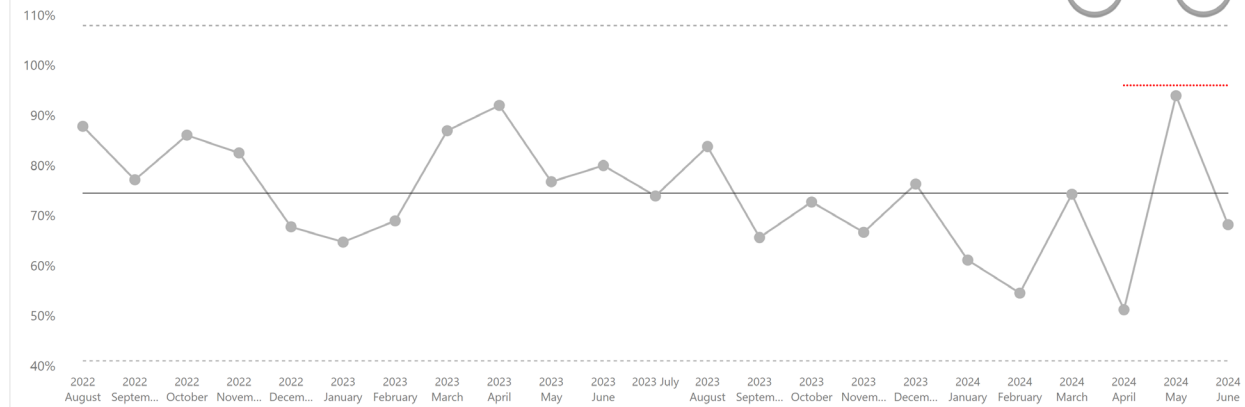


JUN

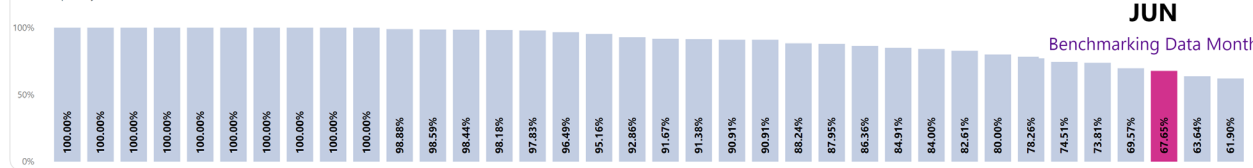
Benchmarking Data Month

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

Target	Target < or >	Performance	Assurance	Variation
>=96%	>=	68.18%		



CWT % Compliant by ORG CODE

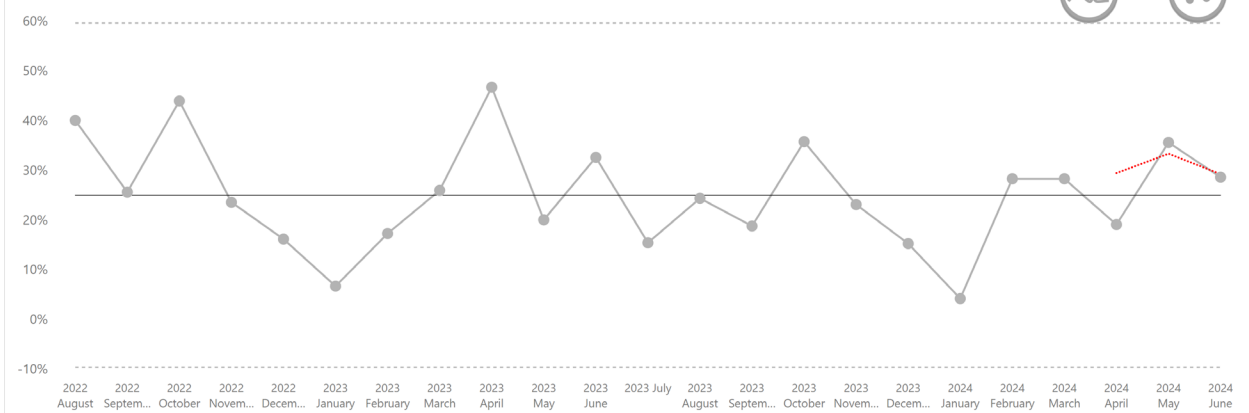


JUN

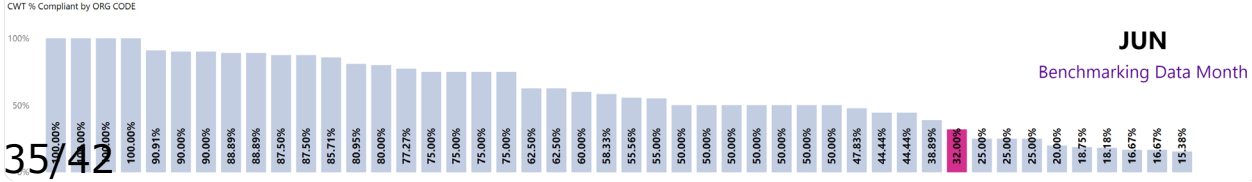
Benchmarking Data Month

Cancer: 62 Day referral to Treatment - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>=85%	>=	28.57%		



CWT % Compliant by ORG CODE

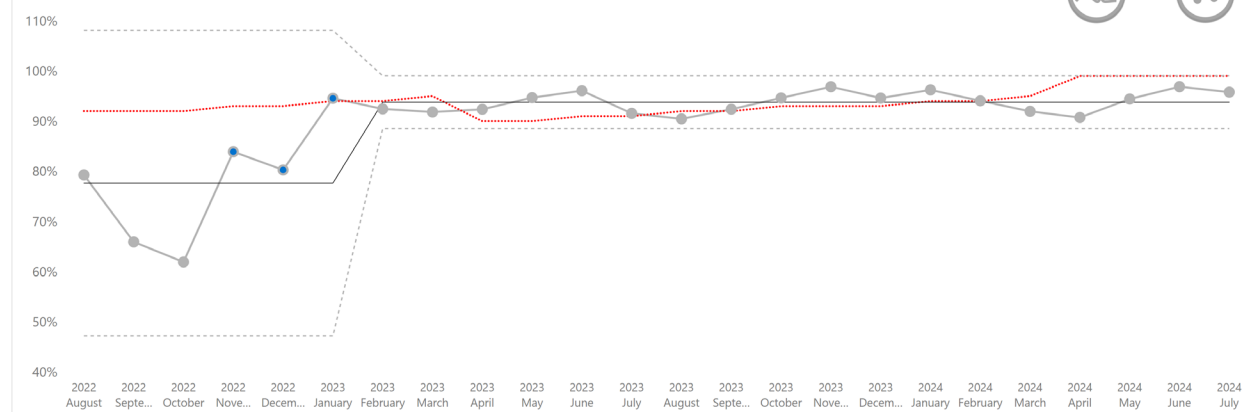


JUN

Benchmarking Data Month

Diagnostic Tests: 6 Week Wait - Chief Operating Officer

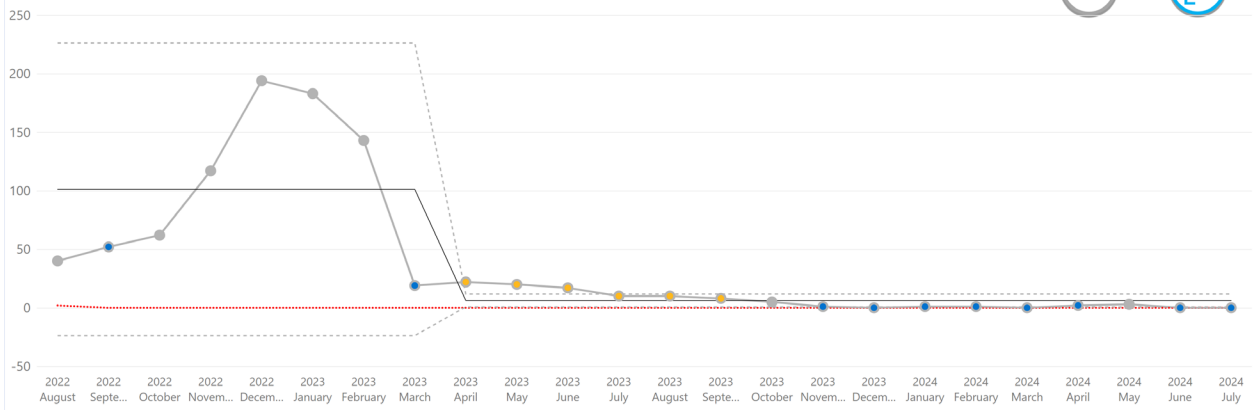
Target	Target < or >	Performance	Assurance	Variation
>= 99%	>=	95.80%		

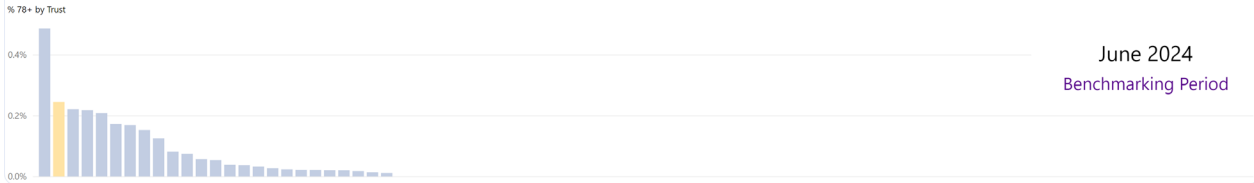


Percentage waiting 6+ weeks by Provider Name

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

Target	Target < or >	Performance	Assurance	Variation
0	<=	0	?	L

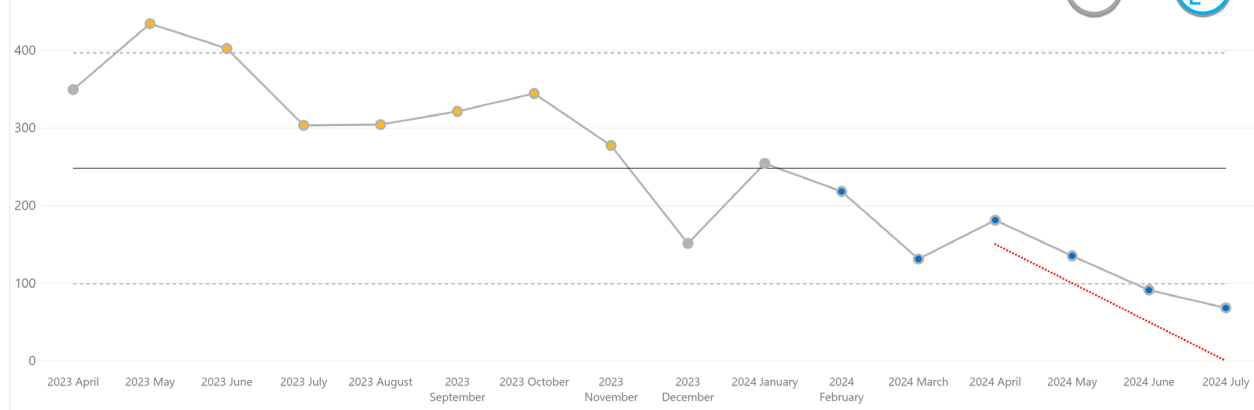


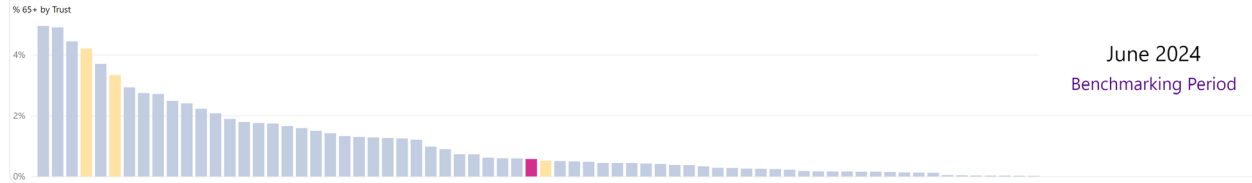


June 2024
Benchmarking Period

18 Week RTT: Incomplete Pathway > 65 Weeks - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
0	<=	68	?	L

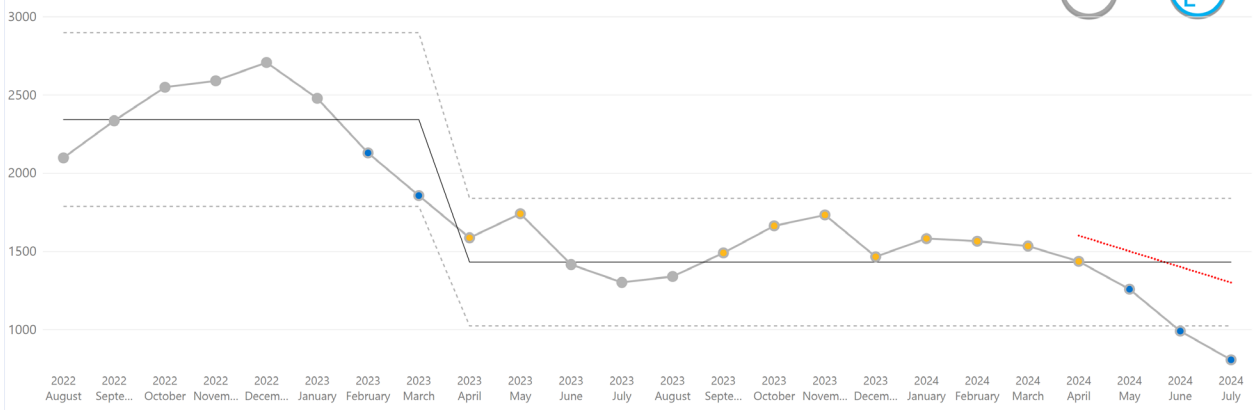


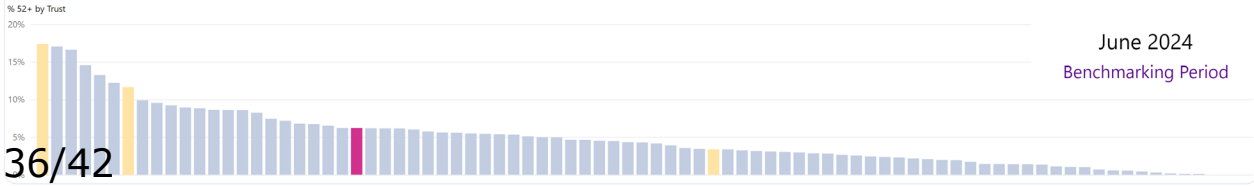


June 2024
Benchmarking Period

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

Target	Target < or >	Performance	Assurance	Variation
0	<=	806	?	L

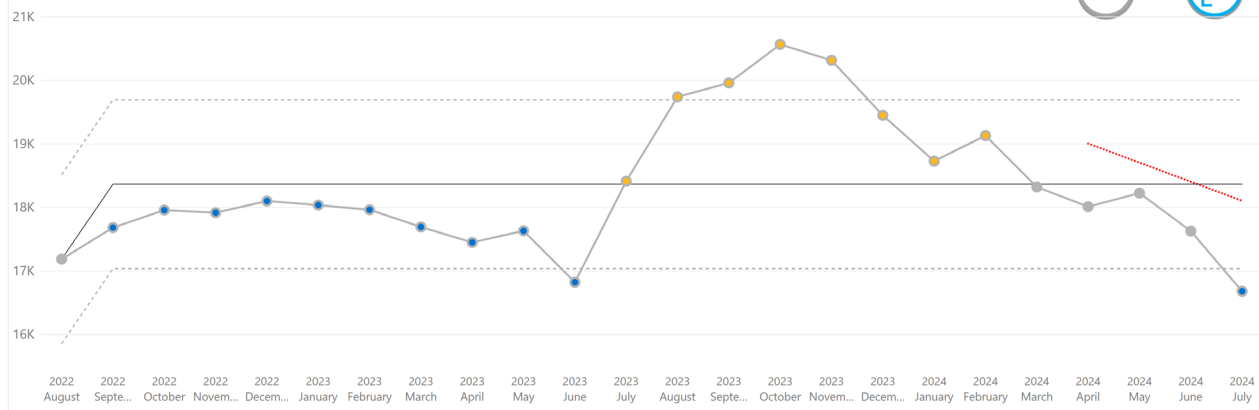


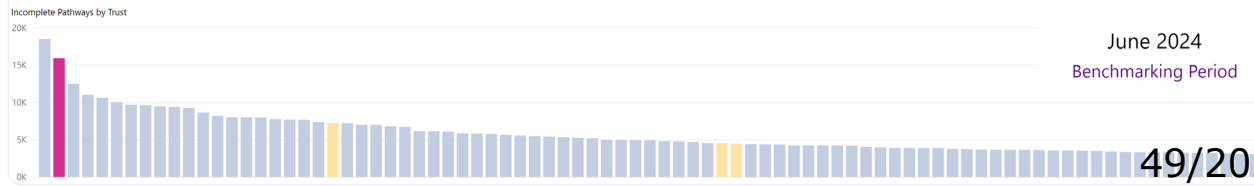


June 2024
Benchmarking Period

Overall size of active patient waiting list - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
<= 16500	<=	16675	?	L

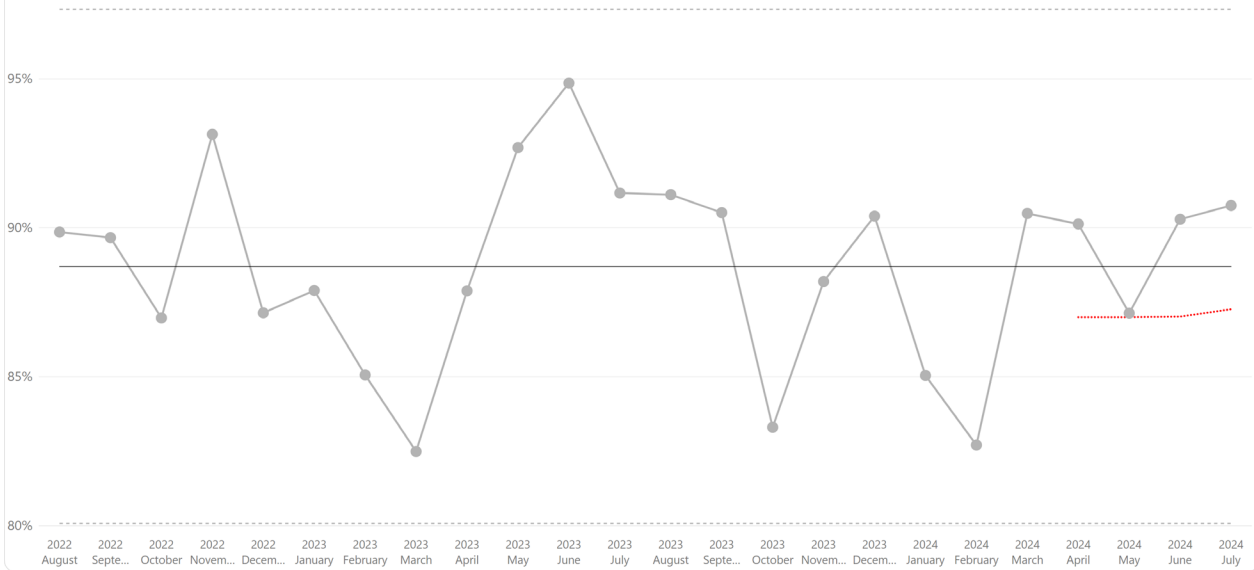




June 2024
Benchmarking Period

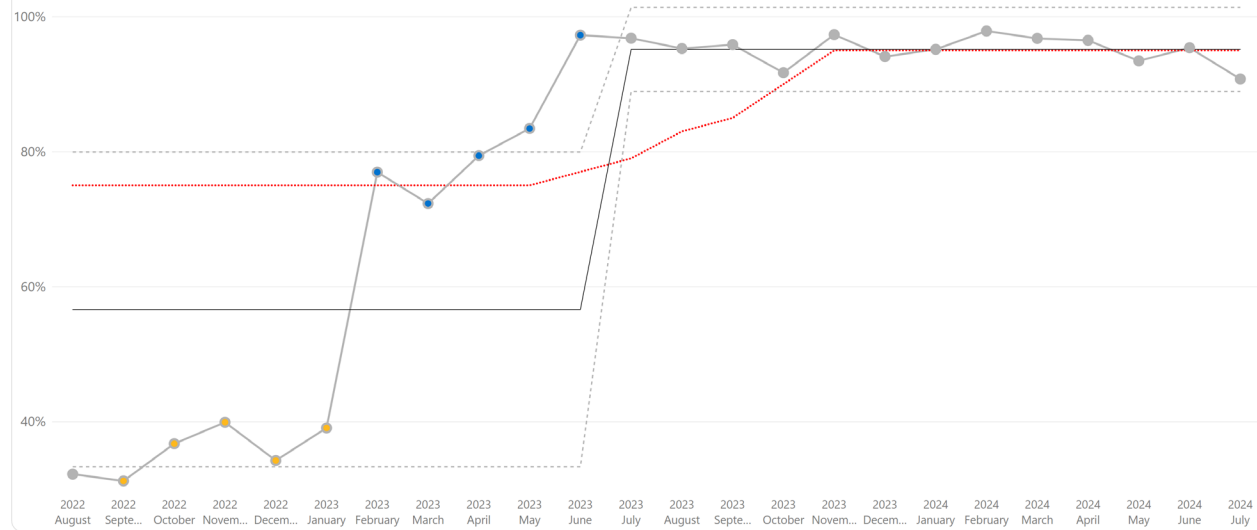
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 90%	>=	90.74%		



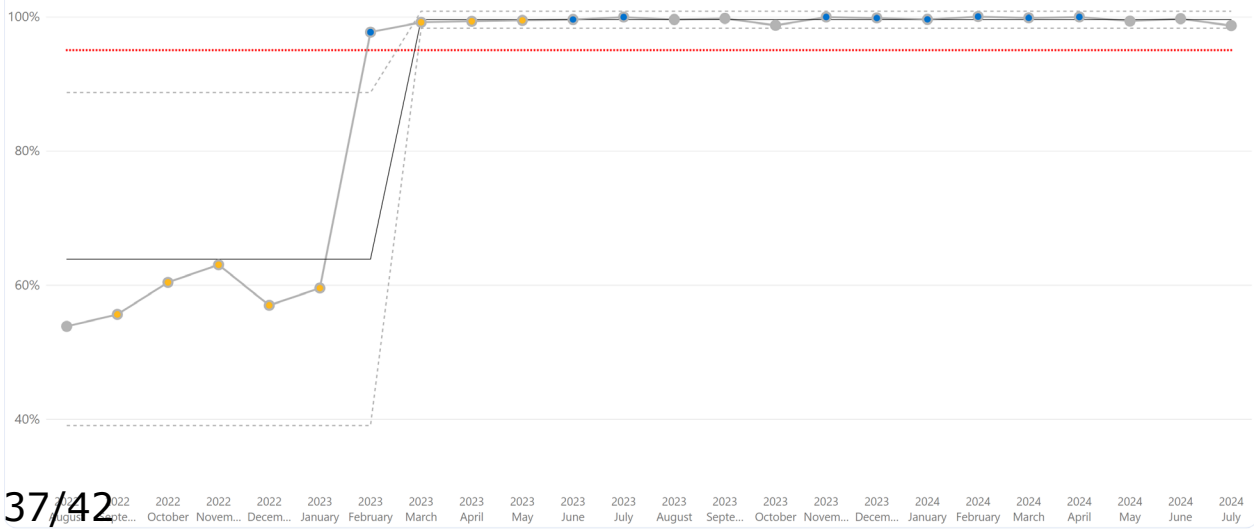
MAU - Arrival to Triage within 15 Mins - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 95%	>=	90.77%		



MAU - Arrival to Triage within 30 Mins - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 95%	>=	98.65%		

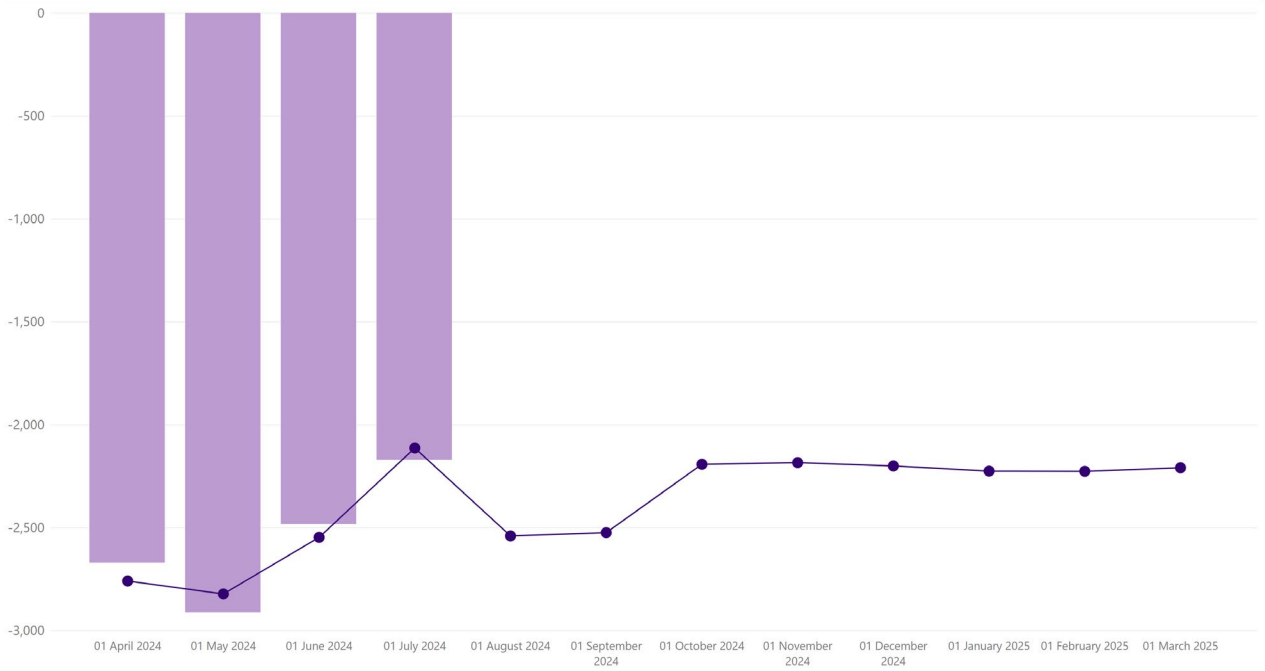


Target	Target < or >	Performance	Assurance	Variation

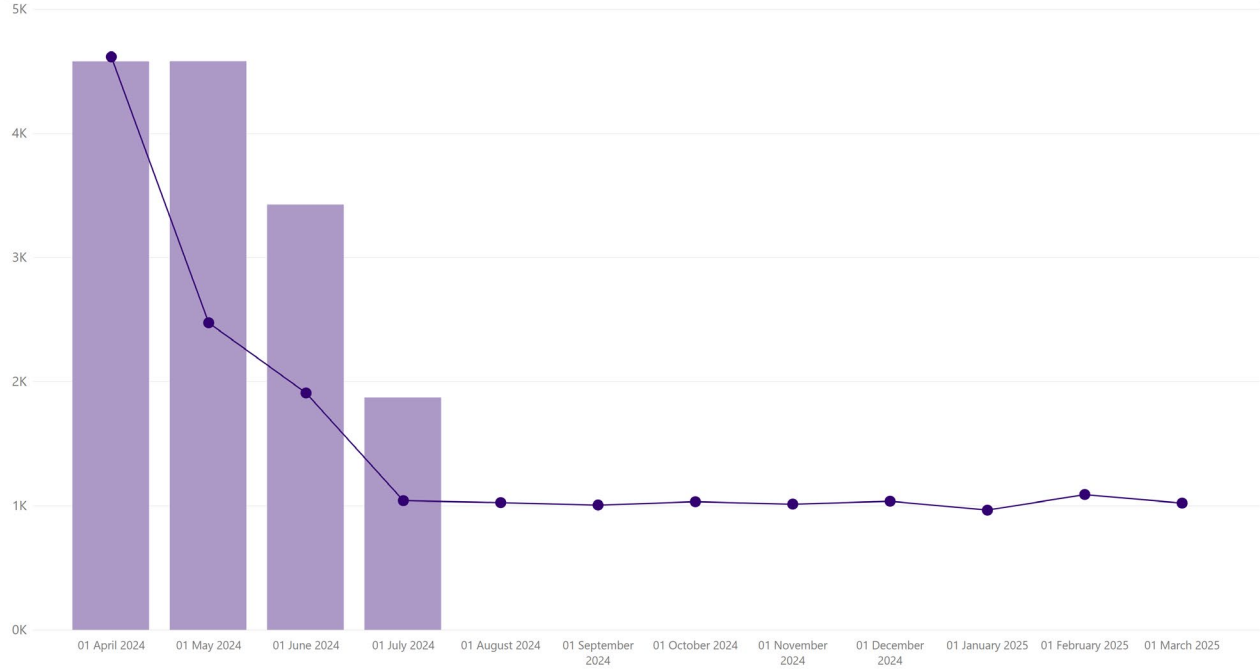
Financial Duty Indicators

Executive Lead:
Jenny Hannon, Chief Finance Officer

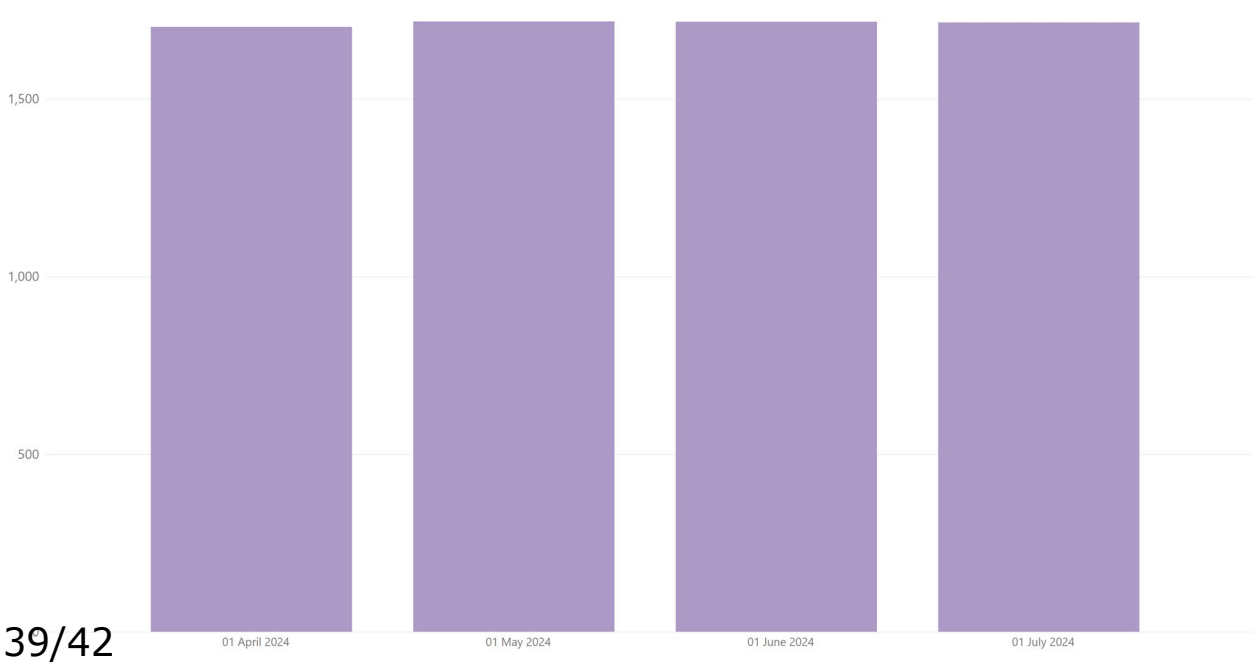
I&E Actual vs Plan



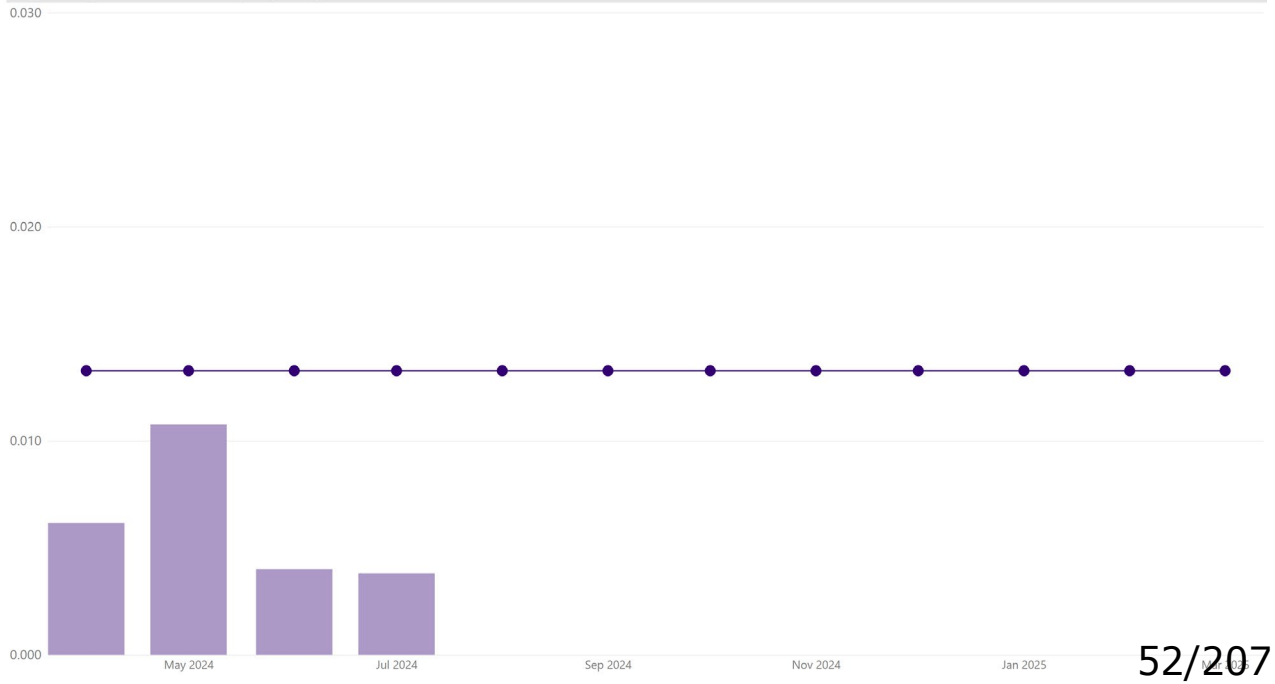
Cash Actual vs Plan



WTEs actual vs plan



Agency % of total pay, by month



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: Pass	Assurance: Uncertain	Assurance: Fail	Assurance: None
Higher is better	**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.
Lower is better	**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.
Common cause	**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.
Higher is better	**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.
Lower is better	**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.
Special cause improvement				**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.
Special cause concern				**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.
No judgement				**Unknown** — Watch and Learn • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

Appendix 3: Benchmarking Guidance

Overview

Benchmarking data is incorporated within the report for specific KPIs. This will increase to all KPIs where national data is available. The benchmarking data is visualised as a bar chart and can be seen underneath the charts for these specific KPIs. Each of the bars represents an organisation with Liverpool Women's highlighted in pink, Cheshire & Merseyside organisations in yellow, and all other Trusts in blue.

Rules are applied to each KPI to identify relevant organisations and activity to benchmark against LWH. The following rules have been applied within this report:

Cancer

28 Day Faster Diagnosis: Speciality is Gynaecology and organisations have 200 or more reported within the most recent months data.
31 day decision to treat to treatment: Speciality is Gynaecology and organisations have 20 or more treatments within the most recent months data.
62 day referral to treatment: Speciality is Gynaecology and organisations have 7 or more treatments within the most recent months data.

Referral to Treatment KPIs

For all metrics related to RTT standards only Gynaecology is included and organisations with 3000 or more incomplete pathways within the most recent months data.

6 Week Diagnostics

Only organisations in the North West are included.

Maternity Signals

The data is sourced from NHS Maternity Statistic Publication. Data is usually 2-3 months behind. Trusts with 500 or more births within the reporting month are included.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 12 September 2024	**Item Reference**	24/25/108
Report Title	**Finance Performance - Month 4**		
Author	***Jen Huyton, Deputy Chief Finance Officer / Deputy Director of Strategy***		
Responsible Director	***Jenny Hannon, Chief Finance Officer / Deputy Chief Executive Officer***		

Purpose of Report	The report presents the financial position at Month 4.
Executive Summary	The Trust has an approved plan for 2024/25 of £28.5m deficit. At Month 4 the Trust reported a £10.2m deficit, which is in line with plan. The Trust is forecasting to deliver its plan of £28.5m deficit. This position has been reported to the Cheshire and Merseyside Integrated Care Board (C&M ICB). £1.5m of Cost Improvement Programme (CIP) savings have been delivered to date, resulting in a £0.2m favourable variance to the CIP target of £1.3m. The cash balance was £1.9m at the end of Month 4.
Key Areas of Concern	Risk to cash flow management driven by delayed approval of distressed finance application.
Trust Strategy and System Impact	This links to the sustainable and efficient use of resources by both the Trust and other relevant bodies.

Links to Board Assurance Framework	*BAF Risk 4 – Financial Sustainability*	***10***
Links to Corporate Risk Register (scoring 10+)		

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

Action Required by the Committee	The Trust has delivered against plan at Month 4, as well as delivering its CIP target. The Board is asked to: • Note the Month 4 position. • Note increasing risk to effective cash flow management. • Approve virements made in the period.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
FPEG	20/08/24	CFO	The Group noted the position.

MAIN REPORT

1. Summary Financial Position

	Plan	Actual	Variance	RAG	R	A	G
Surplus/(Deficit) YTD	-£10.2m	-£10.2m	£0.0m	1	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast M4	-£28.5m	-£28.5m	£0.0m	1	*>10% off plan*	*Plan*	*Plan or better*
Cash	£7.0m	£1.9m	-£5.1m	6	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£1.3m	£1.5m	£0.2m	5	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£1.1m	£0.6m	-£0.5m	6	*>10% off plan*	*Plan*	*Plan or better*
Aligned Payment Incentive	108%	109%	2%	1	*>10% off plan*	*<10% off plan - plan*	*Plan or better*
Capital Spend YTD	£2.1m	£1.0m	-£1.1m	6	*>10% off plan*	*Plan*	*Plan or better*

At Month 4 the Trust reported a £10.2m deficit, which represents a breakeven position against plan. The Trust is forecasting to deliver its revised plan of £28.5m deficit. The Cost Improvement Programme (CIP)has delivered £1.5m of savings year to date (YTD), however only £0.6m of this is recurrent. Capital spend is significantly behind plan YTD. This position has been reported to the Cheshire and Merseyside Integrated Care Board (C&M ICB).

2. Drivers of the Position

Key Drivers

Within the position two key areas treated as 'pass through', where income is matched to expenditure (Liverpool Neonatal Partnership and Research budgets) which are underspent in terms of expenditure. This results in a favourable variance against pay costs and equivalent adverse variance in income, with a nil net impact.

The key drivers of the adjusted position are as follows:

- Recruitment behind plan within the Liverpool Neonatal Partnership resulting in a favourable pay variance, offset by an equivalent reduction in income.
- Higher than planned out of area activity and associated income, and over delivery of Aligned Payment and Incentive (API) income.
- Increased bank usage across Maternity and Theatres, offset by vacancies in Neonatal nursing.
- Slippage against immediate quality and safety investment, offset by underperformance against the pay CIP target.
- Increased drug and clinical supplies costs (noting increased activity above).

Industrial action took place across Month 3 and Month 4, however impact was minimal. The total net cost of industrial action, including pay cost impact, is estimated to be £0.3m.

Workforce

Whole Time Equivalents (WTEs) are shown in Appendix 1.

At Month 4 WTEs totalled 1,715, compared to 1,703 at Month 1, and 1,687 at M12 2023/24. This increase is driven by ongoing maternity and theatres bank usage, and agency medical staff covering gaps in rotas. There is a favourable variance of 58WTEs compared to plan at Month 4; this is driven by Liverpool Neonatal Partnership recruitment behind plan, and therefore has a nil financial impact.

Enhanced controls remain in place regarding agency spend including Divisional oversight and enhanced senior approvals required, and there is a favourable variance against the Trust plan (£0.1m YTD) and against the national

cap of 3.2% of total pay bill (£0.4m). However, year to date, agency costs remain higher than the 2023/24 run rate, due to the requirement to cover junior doctor rota gaps.

3. Cost Improvement Programme (CIP)

CIP performance is shown in Appendix 1. The Trust has a cost improvement programme target of £5.9m (3.2% of expenditure), phased towards the end of the year. At Month 4 the Trust has delivered £1.5m of CIP (of which £0.6m is non-recurrent), leading to a favourable a variance against plan of £0.2m.

The Trust has fully identified it's £5.9m target for 2024/25, however the majority is non-recurrent. The Trust has further strengthened focus on recurrent CIP identification and delivery this period through establishing a CIP Portfolio Board, meeting fortnightly.

4. Cash and Borrowings

Cash at the end of Month 4 was £1.9m. The Trust's cashflow forecast indicated that cash support was required from August 2024 onwards reflecting the Trust's deficit financial position. The Trust submitted a distressed finance application on 19 July for £1.4m in August and £5.2m in September, however the August application was declined, due to a reversion to monthly (from quarterly) submissions, and because the Trust's cash balance did not drop below the de minimis £1.0m until after the monthly cutoff date of 17 August (despite cash being required in August to meet payroll obligations). The Trust managed cash during August through careful review of payment runs, and mutual agreement with system partners regarding timing of invoice payment. A revised application was submitted on 14 August 2024, requesting £7.0m of cash support in September. The outcome of this application is due to be communicated on 13 September 2024. Without this support, cash will fall to £0.2m on 22 September, and the Trust will need to identify alternate mitigation in order to meet its obligations for the remainder of September. The wait for the response to distressed finance applications has increased risk to the organisation's ability to successfully manage cash flow.

Applications for distressed finance will be monthly for the foreseeable future, and the Trust will continue to maintain stringent cash management processes and controls, including production of rolling 13-week cashflow forecasts, senior review and approval of payment runs, and daily monitoring of cash levels.

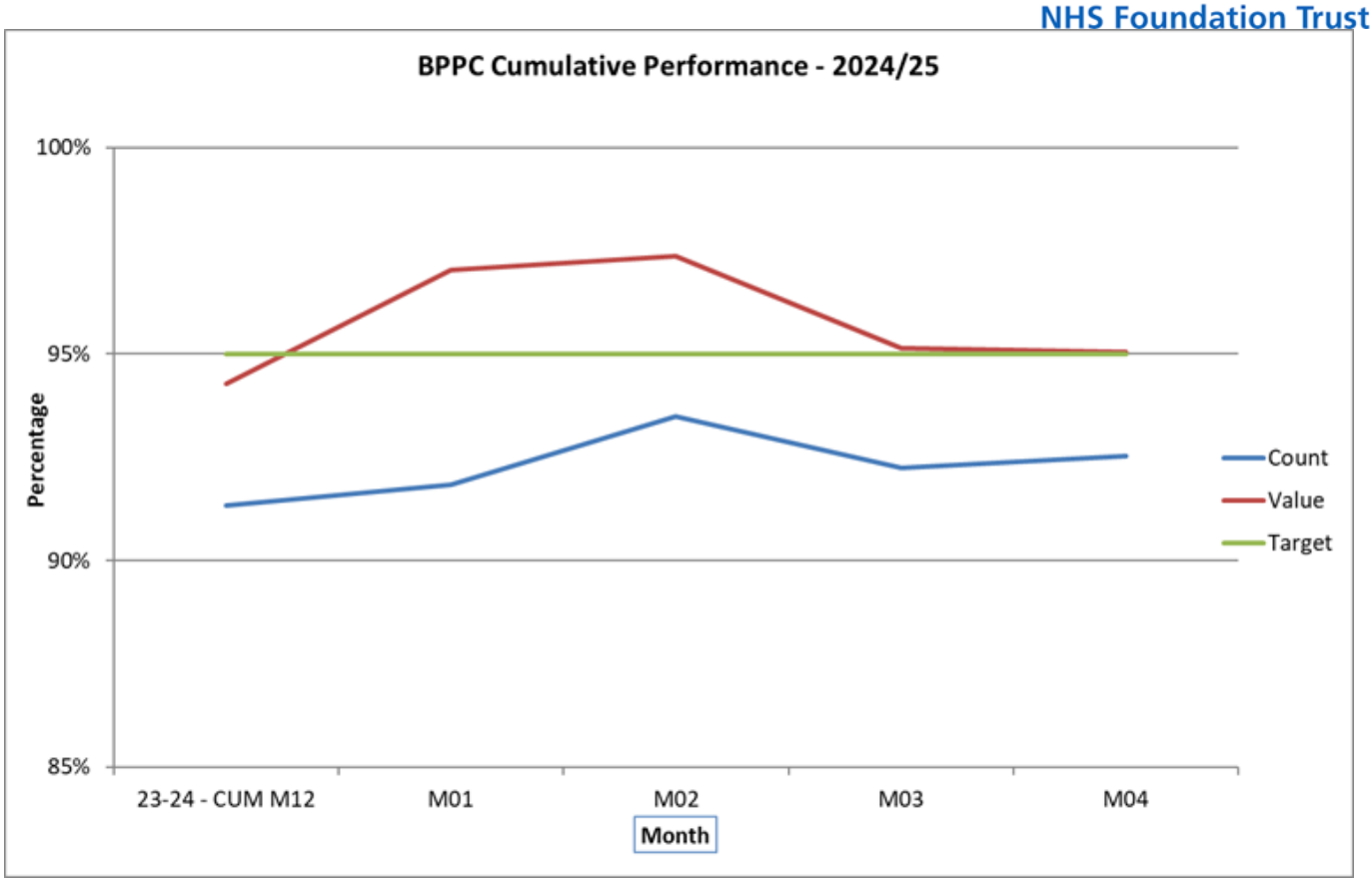
Cash at the end of Month 5 (August) was £0.8m (against a plan of £0.6m).

The total forecast cash requirement for 2024/25 remains at £23.9m.

5. Better Payment Practice Code

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

The Trust continues to demonstrate an improved performance above the 95% target on value but is still slightly under the performance target by invoice count. It should be noted that performance may be impacted by any further delays to cash support.



6. Capital Expenditure

The Trust is currently on track to spend the capital allocation for 2024/25. Year to date spend is £1.1m behind plan, predominantly due to phasing of the capital plan in Month 4, in relation to a particular piece of equipment.

7. Virements

Two virements were transacted in Month 4:

- Family Health identification of CIP against Divisional Target net £0.8m.
- Gynaecology transfer of expenditure budget in relation to insourced activity from central income into Gynaecology net £1.1m.

In line with Trust SFIs, budget virements require Trust Board approval. These virements are accompanied by opposite central adjustments, to ensure that there is no change to the overall plan. Both virements were completed appropriately and now require Board approval.

8. Board Assurance Framework (BAF) Risk

There are no proposed changes to the BAF score this period, which remains at 10 (Likelihood 3, Impact 4, Control 3). This will remain under close review as the efficiency programme further develops.

9. Conclusion & Recommendation

The Trust has delivered against plan at Month 4. The Board is asked to:

- Note the Month 4 position.

- Note increasing risk to effective cash flow management.
- Approve virements made in the period.

Appendices

Appendix 1 – Board Finance Pack, Month 4

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M4

YEAR ENDING 31 MARCH 2025

Liverpool Women's
NHS Foundation Trust

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
INCOME & EXPENDITURE: M4
YEAR ENDING 31 MARCH 2025

INCOME & EXPENDITURE £'000	MONTH 4 Budget	 Actual	 Variance	YTD Budget	 Actual	 Variance	FULL YEAR Budget	 Actual	 Variance
Income									
Clinical Income	(11,783)	(11,936)	152	(47,006)	(46,894)	(112)	(141,491)	(142,219)	728
Non-Clinical Income	(614)	(532)	(82)	(2,452)	(2,357)	(96)	(7,365)	(7,107)	(258)
Total Income	**(12,398)**	**(12,468)**	**70**	**(49,458)**	**(49,251)**	**(208)**	**(148,856)**	**(149,326)**	**470**
Expenditure									
Pay Costs	8,926	8,670	256	35,746	35,071	675	106,647	106,236	412
Non-Pay Costs	2,929	3,433	(504)	13,335	13,951	(616)	38,898	39,827	(928)
CNST	1,897	1,853	43	7,587	7,439	148	22,760	22,335	426
Total Expenditure	**13,752**	**13,957**	**(205)**	**56,668**	**56,461**	**207**	**168,306**	**168,397**	**(91)**
EBITDA	**1,354**	**1,489**	**(134)**	**7,210**	**7,211**	**(1)**	**19,450**	**19,071**	**379**
Technical Items									
Depreciation	564	585	(21)	2,256	2,335	(79)	6,768	6,796	(27)
Interest Payable	2	1	1	7	2	5	21	19	2
Interest Receivable	(17)	(38)	21	(68)	(167)	99	(203)	(233)	30
PDC Dividend	210	135	75	839	856	(17)	2,516	2,900	(384)
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	0	0	0	0	0
Total Technical Items	**759**	**682**	**76**	**3,034**	**3,026**	**8**	**9,102**	**9,481**	**(379)**
(Surplus) / Deficit	**2,113**	**2,171**	**(58)**	**10,244**	**10,236**	**8**	**28,552**	**28,552**	**0**
Remove capital donations/grants/peppercorn lease I&E impact	(2)	(2)	0	(8)	(9)	1	(23)	(24)	0
Adjusted financial performance (Surplus) / Deficit	**2,111**	**2,169**	**(57)**	**10,236**	**10,228**	**9**	**28,529**	**28,529**	**0**

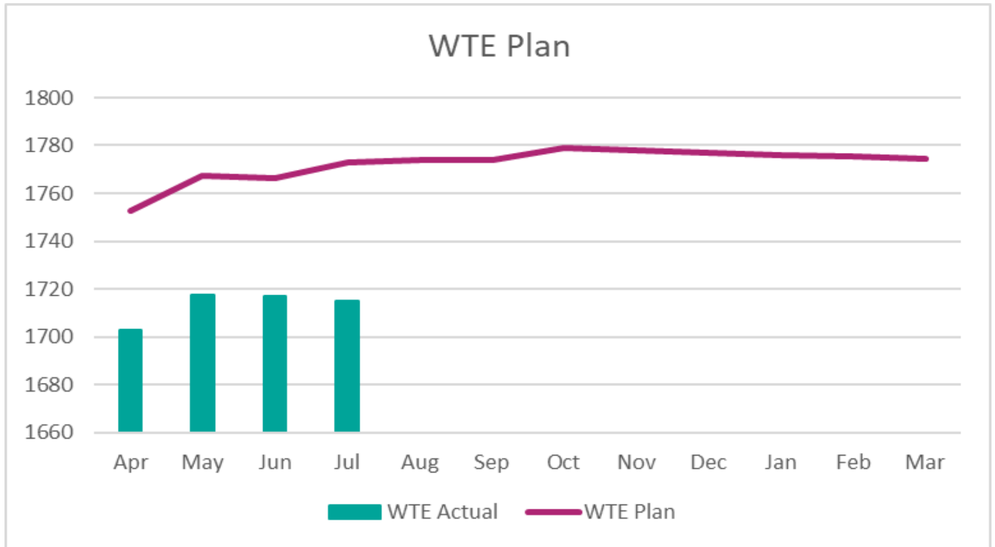
Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2a
WTE: M4
YEAR ENDING 31 MARCH 2025

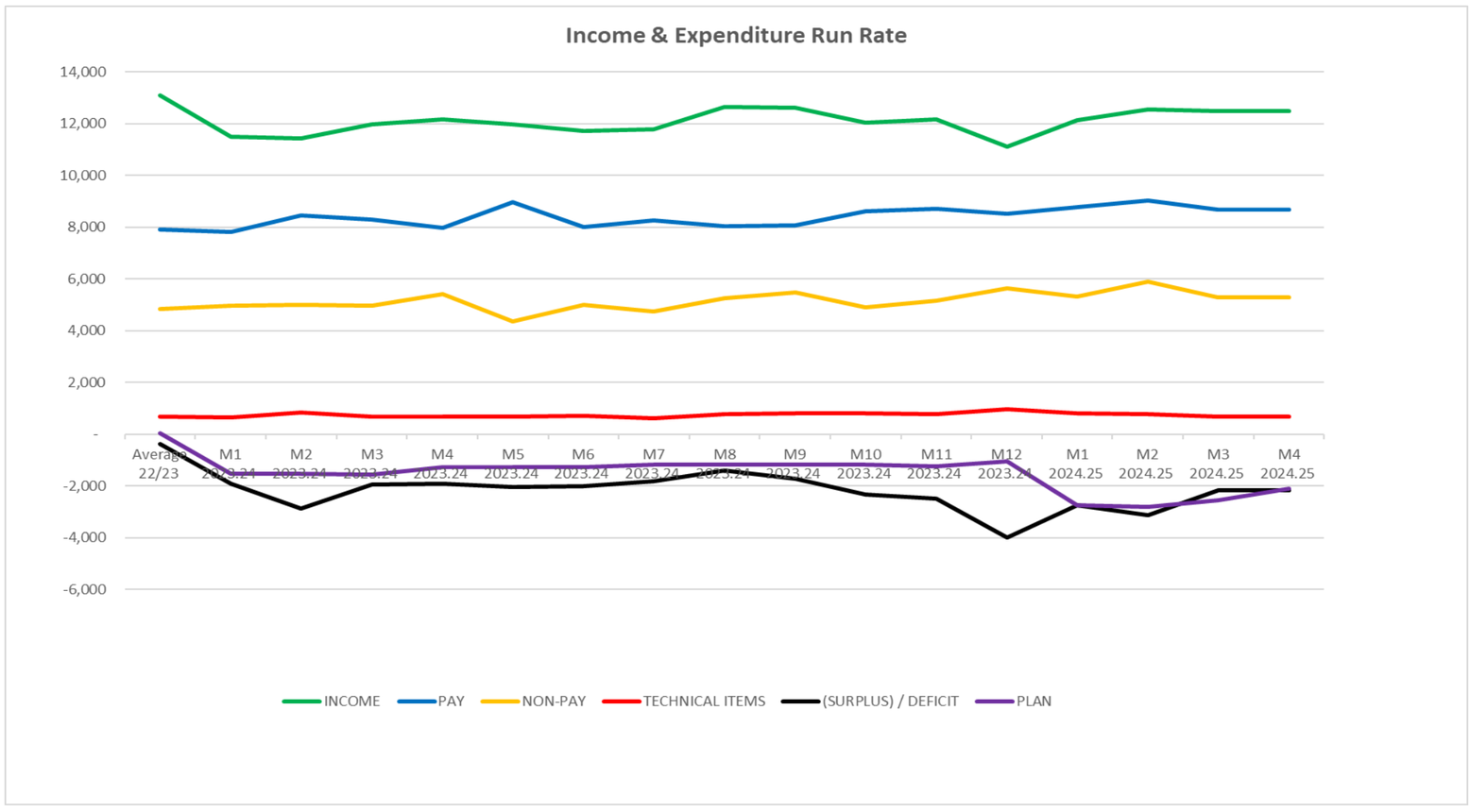
TYPE	DESCRIPTION	M12	M1	M2	M3	M4	Movement M3 - M4	Movement M12 - M4
SUBSTANTIVE	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	664.88	665.08	657.66	650.24	654.19	3.95	(10.69)
	ALLIED HEALTH PROFESSIONALS	83.29	84.23	84.95	87.65	90.10	2.45	6.81
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	11.31	12.31	15.31	16.22	16.22	0.00	4.91
	REGISTERED HEALTH CARE SCIENTISTS	61.48	59.39	58.39	57.99	59.19	1.20	(2.29)
	HCA & SUPPORT TO CLINICAL STAFF	229.76	233.51	233.87	233.59	226.11	(7.48)	(3.65)
	MANAGERS & SENIOR MANAGERS	61.19	65.53	70.13	70.83	74.63	3.80	13.44
	ADMIN AND ESTATES STAFF	13.00	13.00	13.00	14.00	14.00	0.00	1.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	285.33	280.55	284.68	286.83	286.70	(0.13)	1.37
	MEDICAL AND DENTAL	195.69	189.96	186.91	196.11	198.08	1.97	2.39
	ANY OTHER STAFF	13.50	13.50	13.00	13.00	12.00	(1.00)	(1.50)
SUBSTANTIVE TOTAL		**1,619.43**	**1,617.06**	**1,617.90**	**1,626.46**	**1,631.22**	**4.76**	**11.79**
BANK	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	28.56	37.21	39.69	38.66	31.76	(6.90)	3.20
	ALLIED HEALTH PROFESSIONALS	10.18	11.79	13.57	13.38	9.24	(4.14)	(0.94)
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	-	-	-	-	-	0.00	0.00
	REGISTERED HEALTH CARE SCIENTISTS	0.15	-	0.01	0.11	0.85	0.74	0.70
	HCA & SUPPORT TO CLINICAL STAFF	14.05	23.32	25.03	26.35	21.20	(5.15)	7.15
	MANAGERS & SENIOR MANAGERS	-	-	-	-	-	0.00	0.00
	ADMIN AND ESTATES STAFF	0.23	-	0.10	0.80	1.32	0.52	1.09
	OTHER INFRASTRUCTURE & SUPPORT STAFF	8.84	6.97	10.75	1.46	5.87	4.41	(2.97)
	MEDICAL AND DENTAL	1.44	1.41	1.80	1.80	1.69	(0.11)	0.25
	ANY OTHER STAFF	-	-	-	-	-	0.00	0.00
BANK TOTAL		**63.45**	**80.70**	**90.95**	**82.56**	**71.93**	**(10.63)**	**8.48**
AGENCY	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	-	-	-	0.38	-	(0.38)	0.00
	ALLIED HEALTH PROFESSIONALS	3.87	3.93	4.50	4.50	8.71	4.21	4.84
	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	-	-	-	-	-	0.00	0.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	-	-	-	-	0.14	0.14	0.14
	MEDICAL AND DENTAL	-	1.00	4.40	2.90	2.90	0.00	2.90
	ANY OTHER STAFF	-	-	-	-	-	0.00	0.00
AGENCY TOTAL		**3.87**	**4.93**	**8.90**	**7.78**	**11.75**	**3.97**	**7.88**
TRUST TOTAL		**1,686.75**	**1,702.69**	**1,717.75**	**1,716.80**	**1,714.90**	**(1.90)**	**28.15**
LNP	SUBSTANTIVE	40.18	38.99	42.18	41.62	41.62	0.00	1.44
	BANK	-	0	0	0	0	0.00	0.00
	AGENCY	-	0	0	0	0	0.00	0.00
TRUST TOTAL exc LNP		**1,646.57**	**1,663.70**	**1,675.57**	**1,675.18**	**1,673.28**	**(1.90)**	**26.71**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2b
WTE PLAN: M4
YEAR ENDING 31 MARCH 2025



Note:WTE figures include bank and agency



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: M4
YEAR ENDING 31 MARCH 2025

1. Total Efficiencies

GBP	Month 4			YTD			Forecast			Full Year Effect		
Status	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Pay	85	7	(77)	276	28	(248)	2,103	369	(1,734)	2,718	722	1,995
Non-Pay	563	346	(217)	745	387	(358)	1,799	650	(1,149)	2,524	532	1,992
Income	49	174	125	64	217	153	655	623	(33)	661	569	93
Total Recurrent Schemes	**697**	**527**	**(170)**	**1,085**	**632**	**(453)**	**4,558**	**1,642**	**(2,916)**	**5,904**	**1,823**	**4,080**
Pay	51	66	14	205	286	80	617	1,104	487	-	-	-
Non-Pay	48	70	22	57	182	125	723	1,694	971	-	-	-
Income	1	151	150	2	434	432	6	1,463	1,457	-	-	-
Total Non-Recurrent Schemes	**99**	**286**	**187**	**264**	**901**	**637**	**1,346**	**4,262**	**2,916**	**-**	**-**	**-**
Total CIP	**796**	**813**	**17**	**1,349**	**1,533**	**184**	**5,904**	**5,904**	**0**	**5,904**	**1,823**	**4,080**

2. Total Efficiencies by scheme

GBP	Month 4			YTD			Forecast		
Status by scheme	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Pay - Service re-design	67	46	(21)	205	229	24	1,391	538	(852)
Pay - Corporate services transformation	52	5	(48)	210	20	(190)	929	702	(227)
Pay - Bank - increase bank supply	0	0	0	0	0	0	200	0	(200)
Pay - Establishment Reviews	0	6	6	0	6	6	0	54	54
Pay - Agency - reduce the reliance on agency	2	0	(2)	7	0	(7)	20	0	(20)
Pay - Pay - Other	15	16	1	60	58	(2)	180	178	(2)
Total Pay Schemes	**136**	**73**	**(63)**	**481**	**313**	**(168)**	**2,720**	**1,473**	**(1,247)**
Non-Pay - Medicines efficiencies	2	1	(1)	8	4	(4)	26	21	(5)
Non-Pay - Procurement (excl drugs) - non-clinical directly achieved	205	8	(197)	380	41	(339)	1,319	474	(845)
Non-Pay - Procurement (excl drugs) - non-clinical through NHS Supply Chain	0	1	1	0	5	5	0	15	15
Non-Pay - Estates and Premises transformation	0	335	335	0	335	335	0	557	557
Non-Pay - Service re-design	403	70	(333)	414	183	(230)	1,177	1,277	100
Total Non-Pay Schemes	**611**	**416**	**(195)**	**802**	**569**	**(233)**	**2,522**	**2,345**	**(178)**
Income - Non-Patient Care	44	9	(35)	47	9	(38)	396	375	(21)
Income - Overseas Visitors	1	5	4	5	7	2	15	19	4
Income - Private Patient	5	3	(2)	14	7	(7)	250	17	(233)
Income - Income - Other	0	308	308	0	627	627	0	1,674	1,674
Total Income Schemes	**49**	**325**	**275**	**66**	**651**	**585**	**661**	**2,086**	**1,425**
Total CIP	**796**	**813**	**17**	**1,349**	**1,533**	**184**	**5,904**	**5,904**	**0**

3. Efficiency Plan Risk

GBP	Forecast		
Risk	Plan	Actual	Variance
High	2,090	0	(2,090)
Medium	3,433	3,735	302
Low	381	2,169	1,788
Total CIP	**5,904**	**5,904**	**0**

4. Efficiency Plan Status

GBP	Forecast		
Risk	Plan	Actual	Variance
Fully Developed - In Delivery	1,611	3,641	2,029
Plans in progress	696	2,263	1,567
Opportunity	3,597	0	(3,597)
Unidentified	0	0	0
Total CIP	**5,904**	**5,904**	**0**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5a
CASHFLOW STATEMENT: M4
YEAR ENDING 31 MARCH 2025

CASHFLOW STATEMENT	
£'000	Actual
Cash flows from operating activities	(9,545)
Depreciation and amortisation	2,335
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	9,382
Net cash generated from / (used in) operations	**2,172**
Interest received	161
Purchase of property, plant and equipment, ROU and intangible assets	(2,519)
Proceeds from sales of property, plant and equipment and intangible assets	8
Net cash generated from/(used in) investing activities	**(2,350)**
PDC distressed funding received	0
PDC Capital Programme Funding - received	0
Loans from Department of Health - repaid	0
Interest paid	0
PDC dividend (paid)/refunded	0
Net cash generated from/(used in) financing activities	**0**
Increase/(decrease) in cash and cash equivalents	**(178)**
Cash and cash equivalents at start of period	2,049
Cash and cash equivalents at end of period	**1,871**

Finance Support	2023/24 Year £000	2024/25 Qu1 ACTUAL £000	2024/25 Qu2 PLAN £000	2024/25 Qu3 PLAN £000	2024/25 Qu4 PLAN £000	2024/25 Total £000
ICB cash support	21,400	0	0	0	0	0
ICB cash repayment (LMS)	(21,400)	0	(900)	0	0	(900)
Alder Hey cash support	0	4,623	0	0	0	4,623
Alder Hey deferred income movement	0	(1,156)	(1,156)	(1,156)	(1,156)	(4,623)
National cash support	20,100	0	7,000	9,500	7,400	23,900
Total support required						**23,000**
DH Loan repayment	612	0	306	0	-	306
DH Loan outstanding at year end	301					0

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5b
CASHFLOW ROLLING FORECAST: M4
YEAR ENDING 31 MARCH 2025

	Actual Apr-24	Actual May-24	Actual Jun-24	Actual Jul-24	Plan Aug-24	Plan Sep-24	Plan Oct-24
	£000	£000	£000	£000	£000	£000	£000
Opening cash	**1,948**	**4,776**	**6,984**	**3,424**	**1,647**	**605**	**868**
Income flows							
NHS England*	1,669	438	430	2,071	430	486	2,000
ICB income	10,153	10,123	10,058	10,099	10,134	10,299	10,749
NHS Trust/FT**	611	1,765	283	554	1,176	809	693
Private patients	313	443	428	356	405	265	310
Overseas	4	10	4	10	10	10	10
ICR/RTA scheme	1	4	4	4	4	4	1
Non-NHS (Wales/Man)	104	195	204	118	109	234	258
R&D	35	104	84	42	133	33	28
Other	126	245	23	34	80	11	54
Bank interest	33	36	49	44	36	21	20
Total operating inflows	**13,049**	**13,363**	**11,567**	**13,332**	**12,517**	**12,172**	**14,123**
Expenditure flows							
Wages and salaries	(4,308)	(4,358)	(4,346)	(4,384)	(4,513)	(4,412)	(6,233)
HMRC	(2,081)	(1,944)	(1,958)	(1,978)	(1,972)	(1,950)	(2,050)
Pensions	(1,241)	(1,250)	(1,270)	(1,271)	(1,256)	(1,330)	(1,350)
CNST - cash movement	(2,476)	(2,476)	(2,476)	(2,476)	(2,476)	(2,476)	(2,476)
Other expenditure (ex depn)***	(4,543)	(2,743)	(4,978)	(5,074)	(4,394)	(6,035)	(3,999)
VAT recovery	465	0	202	176	1,054	109	84
PDC/Loan (inc Ambulatory PDC)	0	0	0	0	0	(1,713)	500
Interest payable	0	(1)	(1)	(2)	(2)	(2)	(1)
Capital plan (inc movement on creditors)	(660)	(803)	(300)	(100)	0	(1,100)	(1,006)
Total operating outflows	**(14,844)**	**(13,575)**	**(15,127)**	**(15,109)**	**(13,559)**	**(18,909)**	**(16,531)**
Other cash in/outflows							
National/local distressed finance support	0	0	0	0	0	7,000	2,500
National payroll	0	0	0	0	0	0	0
Accrued/Deferred income *(forecast only)* **	4,623	0	0		0	0	0
NHS Resolution MIS****	0	2,420	0	0	0	0	0
TOTAL CASH IN GBS ACCOUNT	**4,776**	**6,984**	**3,424**	**1,647**	**605**	**868**	**960**
Barclays, bank rec and cash in hand	36	50	50	224	20	20	20
TOTAL CASH HOLDING	**4,812**	**7,034**	**3,474**	**1,871**	**625**	**888**	**980**

**the split of income direct from NHS England and paid via the ICB has changed since prior year*
***in April the Trust received an advance payment from Alder Hey for the 2024/25 contract and in May they paid the residual 2023/24 contract payment*
****other expenditure payments include LUHFT payments in M1, and delays in MWL NHS FT junior doctor payments in M2 which were settled in M3*
*****NHS Resolution repaid Maternity Incentive Scheme payments in May, earlier in the year than initially anticipated*

Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
CAPITAL EXPENDITURE: M4
YEAR ENDING 31 MARCH 2025

			Year To Date			Full Year		
Funding Source	NHSE Ref	Capital Scheme	Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000
CDEL	Estates backlog	NHSE Scheme 4	0	20	20	751	751	0
CDEL	Medical equip - ultrasound	NHSE Scheme 7	535	535	0	535	535	0
CDEL	Medical equipment - general	NHSE Scheme 6	364	82	(282)	651	651	0
CDEL	Medical equip - transfusion on site	NHSE Scheme 8	0	0	0	300	300	0
CDEL	Medical equip - fluoroscopy	NHSE Scheme 9	400	0	(400)	400	400	0
CDEL	Other building	NHSE Scheme 10	205	20	(185)	205	205	0
CDEL	Digital tangible	NHSE Scheme 2	45	33	(12)	245	245	0
CDEL	Digital intangible	NHSE Scheme 3	492	268	(224)	1,948	1,948	0
CDEL Total			**2,041**	**958**	**(1,083)**	**5,035**	**5,035**	**0**
NON CDEL FUNDED PROJECTS	Ambulatory	NHSE Scheme 1	100	0	(100)	4,751	4,751	0
NON CDEL FUNDED PROJECTS	CAMRIN	NHSE Scheme 5	0	0	0	56	56	0
NON CDEL FUNDED PROJECTS	Charitable funded	NHSE Scheme 11	0	37	37	0	235	235
NON CDEL FUNDED PROJECTS Total			**100**	**37**	**(63)**	**4,807**	**5,042**	**235**
Grand Total			**2,141**	**995**	**(1,146)**	**9,842**	**10,077**	**235**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
AGENCY USAGE: M4
YEAR ENDING 31 MARCH 2025

		MONTH 4			YTD			FULL YEAR		
Division	Directorate	Budget	Actual	Variance	Budget	Actual	Variance	Budget	FOT	Variance
Family Health	Maternity	0	8	(8)	-	39	(39)	-	68	(68)
Gynaecology	Gynaecology	0	13	(13)	-	35	(35)	-	98	(98)
Gynaecology	HFC	0	0	0	-	2	(2)	-	7	(7)
CSS	Theatres	0	9	(9)	-	53	(53)	-	171	(171)
CSS	Imaging	0	28	(28)	-	61	(61)	-	148	(148)
Corporate	All Corporate Directorates	115	(24)	139	338	24	314	1,354	24	1,330
Total Agency		**115**	**34**	**81**	**338**	**214**	**124**	**1,354**	**516**	**838**
Performance against cap		**286**	**34**	**252**	**572**	**214**	**358**	**3,427**	**516**	**2,911**

Note that the agency premium budget is held centrally.
The Trust is reporting performance against the NHSE cap of 3.2% of total pay bill.

Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
VIREMENTS: M4
YEAR ENDING 31 MARCH 2024

Directorate	Account Code/Type	GBP Total	WTE Total	Description
Maternity	Non-Pay	(2,000)	0.00	Virement of CIP scheme back into Divisional target as not approved at QIA committee
Maternity	Non-Pay	2,000	0.00	Virement of CIP scheme back into Divisional target as not approved at QIA committee
Maternity	Non-Pay	(420,000)	0.00	Virement to move new CIP scheme out of Divisional target onto subjective code associated with scheme
Maternity	Non-Pay	420,000	0.00	Virement to move new CIP scheme out of Divisional target onto subjective code associated with scheme
Maternity	Income	(223,846)	0.00	Virement to move new CIP scheme out of Divisional target onto subjective code associated with scheme
Maternity	Non-Pay	223,846	0.00	Virement to move new CIP scheme out of Divisional target onto subjective code associated with scheme
Maternity	Income	(200,000)	0.00	Virement to move new CIP scheme out of Divisional target onto subjective code associated with scheme
Maternity	Non-Pay	200,000	0.00	Virement to move new CIP scheme out of Divisional target onto subjective code associated with scheme
Gynaecology	Non-Pay	1,053,000	0.00	Virement to move outsourced expenditure budget into Division along with income and costs.
Central Income	Non-Pay	(1,053,000)	0.00	Virement to move outsourced expenditure budget into Division along with income and costs.
Total		**-**	**0.00**	

Note: Where CIP virements take place, the opposite entry is transacted centrally to keep the overall Trust budget in line with the submitted plan.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 12 September 2024	**Item Reference**	24/25/110
Report Title	Improvement Plan Highlight Report 3		
Author	Tim Gold, Chief Transformation Officer		
Responsible Director	Tim Gold, Chief Transformation Officer		

Purpose of Report	To provide a delivery progress update on the Trust's Improvement Plan.
Executive Summary	The Trust's Improvement Plan, designed for the next 12-18 months, focuses on addressing clinical challenges and risks while embedding a culture of continuous improvement and safety. Significant progress has been made in key areas, including the refinement of risk management practices, the establishment of streamlined governance structures, and enhanced partnership governance. The Transformation Delivery Unit has concentrated on verifying milestone achievements and ensuring their sustainability. With a focus on quality assurance, huddle meetings have improved governance, and the development of an evidence repository is underway. The plan remains on track, with ongoing efforts to enhance operational effectiveness and sustain progress. The report also provides a subjective assessment of progress against the National Oversight Framework Segment 3 Exit Criteria – a key objective for Phase 1 of the LWH Improvement Plan.
Key Areas of Concern	Overall, the plan is progressing well and is scored as 'yellow' on the RAYG rating system. There is currently one 'high' (12+) risk identified and one 'red rated issue. The first is a long-standing issue relating to the Trust being challenged to recruit consultant anaesthetists to create 24/7 cover. The second, is a new emerging issue relating to the supplier of the Blood Transfusion Robot. Further detail is provided in the main body of the report.
Trust Strategy and System Impact	The Improvement Plan aligns with the Trust Strategy and the triple aim by focusing on enhancing health and wellbeing, improving service quality, and promoting sustainable, efficient resource use. This alignment ensures that the Improvement Plan not only supports the Trust's strategic goals but also contributes to the broader objectives of the NHS. By prioritising these areas, the Trust can foster equity, better health outcomes, and operational efficiency, which are essential for meeting the needs of the community it serves.

Links to Board Assurance Framework		**-**
Links to Corporate Risk Register (scoring 10+)	*N/A*	**-**

Assurance Level	1. MODERATE - Adequate system of internal control applied to meet existing objectives

Action Required by the Group	The Board of Directors is asked to • note the Improvement Plan Highlight Report. • note the closure of the Well-Led Programme

	• note the current self-assessment against the NOF Segment 3 Exit Criteria.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Improvement Plan Portfolio Board	**28.08.24**	**CTO**	**Outlined in main body of the report.**

MAIN REPORT

INTRODUCTION

The Trust has developed its Improvement Plan to provide a clear direction of travel for the next 12-18 months, with a focus on making improvements in some key priority areas, particularly where we have clinical challenges and risks. The vision for Our Improvement Plan is to:

Embed a culture of continuous improvement and safety for all, minimising risks and ensuring high-quality, sustainable services through collaboration, challenge, and openness.

Our Improvement Plan is not a long-term strategy for the Trust but a roadmap for the short-medium term. Focussing on the immediate priorities for the Trust will allow us to then look at a longer-term strategy for the next 3-5 years. This report provides an overview of the progress made since the previous update (July 2024) and outlines the key areas of focus for the next period.

The Improvement Plan Highlight Report provides supplementary detail and relevant key performance indicators for the Improvement Plan and can be found in Appendix A.

PROGRESS TO DATE

Overall, the plan is progressing well and is scored as ‘yellow’ on the RAYG rating system.

The past period has seen a significant shift towards quality assurance across all projects. This included extensive sessions with project leads focusing on refining risk articulation and score reviews, which has led to the scrutiny and subsequent de-escalation of several significant project risks. The development of an evidence repository for completed milestones has commenced, aiming to ensure good governance and readiness for any potential audits. Governance of programme huddles has also seen marked improvements, with consistent use of set agendas, action tracking, and enhanced check-and-challenge processes now in place. The PowerBI report has been instrumental in identifying late and overdue milestones, facilitating timely interventions.

As systems and processes continue to mature, the Transformation Delivery Unit has concentrated on verifying that milestones are not only achieved but are also integrated and sustainable within the organisation's ongoing service delivery. Attendance at huddle meetings has improved, and the resilience of membership has strengthened, contributing to more effective governance.

Key points to note from the respective programmes:

KEY FOCUS LAST PERIOD	KEY FOCUS THIS PERIOD
Quality and Safety	
Conducted process mapping sessions to improve the escalation process for deteriorating patients, with actions fed into the Medical Emergency team (MET) Task and Finish group for monitoring. Supported CQC/MSSP Action Plans with ongoing review and submission of evidence, ensuring compliance and readiness across divisions.	Develop options appraisal for the MET and HDU service model and establish governance for the digital platform work. Finalising the review of evidence for CQC/MSSP Action Plans and ensuring continuous compliance and readiness across divisions.
Clinical Effectiveness	
Focused on overcoming recruitment challenges for key clinical roles, particularly in Advanced Clinical Practitioners (ACPs), postgraduate doctors, and consultants. Developed an Acute Emergency Dept (ED) Dashboard to provide detailed performance and clinical triage data, aiding decision-making in Acute Gynae Services. Continued to identify gaps in pharmacy services and added relevant risks to the register, supporting overall medication safety.	Draft a comprehensive paper on service delivery gaps in pharmacy services, with ongoing monitoring and management of identified risks. Clarify the emerging issue in relation to the Transfusion Robot and to identify impact on the project milestones / timeline and available mitigations. Continue to progress with recruitment processes for essential clinical roles.
Operational Performance	
Cleared the backlog of long-waiting cancer patients, improving overall performance while temporarily impacting the Faster Diagnosis metric. Resolved operational pressures on hysteroscopy and improved staffing in Cancer Clinics, leading to reduced wait times. Monitored and improved the MRI/CT pathway, collaborating with CDC/LUHFT and CCC to streamline processes and reduce waiting times.	Continue optimising MRI/CT pathways in collaboration with CDC/LUHFT and CCC, with a focus on reducing waiting times and improving overall efficiency. Stabilise and reduce hysteroscopy waiting times through additional sessions and capacity planning.
People and Culture	
Completed a literature review and preliminary analysis as part of the Safety Culture initiative, advancing understanding and planning for the next steps. Launched initiatives to support becoming an Actively Anti-Racist Organisation, including staff listening events, training, and the development of educational materials. Secured Executive sponsors for Staff Networks and established connections between Freedom to Speak Up Guardians (F2SUGs) and the Anti-Racism Hub.	Recruit to the Elevate programme and further develop cultural adjustment initiatives in clinical practice, particularly in women's health. Roll out the Anti-Racism Reporting Tool for patients, families, and visitors, enhancing access and engagement across the organisation.
Financial Sustainability	
Established and reported on the Liverpool Acute & Specialist Trusts Finance Group (LAASFG) financial recovery workstreams, with bi-weekly updates provided to Chief Finance Officers (CFOs). Developed long lists for the five workstreams in the Three-year financial plan, with prioritisation underway. Held a CIP Portfolio Board meeting to approve workplans and identified the need to transition from non-recurrent to recurrent savings.	Drive progress through newly formed CIP Portfolio Board and identify schemes to close the gap. Agree on workstream priorities and identify the value for each within the three-year financial plan.
Well-Led	
See section below	

Well-Led Programme Closure

The Trust has recognised that significant operational and financial challenges has necessitated Improvement Plan projects focused on streamlined governance, improved risk management, and enhanced partnership governance. To address these issues, the Well Led Programme aimed to strengthen risk escalation processes from ward to Boardroom, streamlined governance and further develop partnership arrangements.

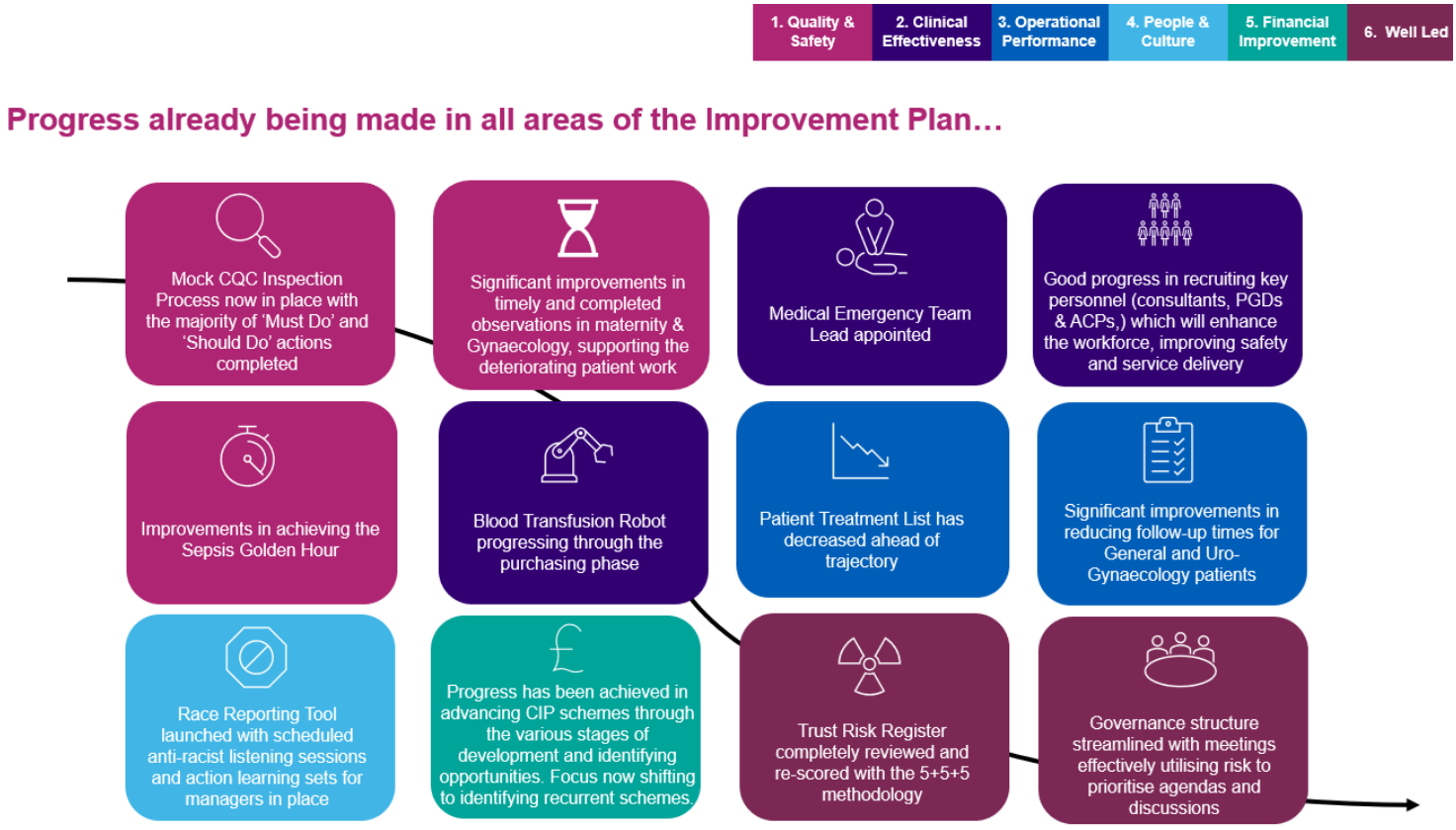
Key outcomes to date have included the implementation of a revised governance structure in April 2024, which reduced the frequency of Board and Committee meetings and focused on strategic issues, supported by comprehensive staff engagement. Additionally, the Trust updated its Risk Management Strategy, introducing a 5+5+5 risk scoring system and providing senior management with comprehensive training. The Ulysses system was integrated with the new methodology, and risks were re-scored by May 2024.

The risk management and streamlined governance projects, as originally initiated, have reached completion. The Improvement Plan Portfolio Board (IPPB) deliberated moving both projects into a 'phase 2' with new milestones but it became clear that the future direction would overlap with existing pieces of collaboration work with Trust partners. This was also the case for the partnership governance project.

A closure report was considered by the IPPB on 28 August 2024, and it was agreed that the Programme be closed. The closure report provided assurance that on-going issues would be included within other programmes of work or business as usual activity.

Benefits to date

It is also important to continue to communicate the progress that the Improvement Plan is making to the wider organisation. The graphic below was shared during the August 2024 'In the Loop' staff briefing:



RISK & ISSUE PROFILE

There remains one 12+ risk which relates to the ability of the Trust to recruit consultant anaesthetists. To address the long-standing risk of recruiting consultant anaesthetists, several initiatives are underway. The team is collaborating closely with the anaesthetic department to define their needs and develop a strategic recruitment plan. They are addressing concerns about workload overlaps with other trusts and exploring broader collaboration to share resources, particularly in obstetric anaesthesia. Additionally, efforts are focused on identifying and supporting fragile services within the anaesthetic specialty to maintain adequate staffing levels. Continuous monitoring and adjustment of recruitment strategies are being implemented to ensure the sustainability and effectiveness of anaesthetic services.

Risks for the Deteriorating Patient Collaborative have been reviewed and two risks have been re-scored (Risk 2847 – Reduced from 10 to 9, Risk 2852 – Reduced from 9 to 8). Two risks remain scored at '11' – further assurance is required to reduce the staff engagement risk as there continues to be challenges in securing attendance at test of change meetings.

The issue rating for the LWH Transfusion Lab has been marked as 'red,' primarily due to a new issue that emerged in the week commencing 26 August 2024. The company the Trust had been in discussions with can no longer fulfil the quoted agreement. While there is still an opportunity to pursue the identified solution, uncertainty now surrounds the procurement process and potential ongoing maintenance arrangements. The Trust is actively working to clarify the situation and assess the level of assurance currently available. If an alternative procurement process or solution is required, due diligence and a comprehensive risk assessment will be undertaken by procurement and operational teams. Although the full impact on the project plan is not yet known, delays are likely.

BENEFITS PROFILE

Progress has been made with both the identification of KPIs and the inclusion of data since the previous report. A key focus for this period will be on ensuring the quality of data for the deteriorating patient project is at an adequate level to accurately demonstrate improvement (or otherwise) following the actions being put into place.

The SPC charts have been moved to a separate appendix to aid the clarity of reporting.

A key area of focus for future programme huddles will be to assess if the improvement work being undertaken is driving the desired outputs. The following are identifiable benefits to date:

- Enhanced Workforce for Acute Workload: Good progress in recruiting and appointing key personnel, such as individual consultants, ACPs, and anaesthetic doctors, which will enhance the workforce and improve service delivery.
    - Recruitment to date:
        - 10 WTE funded Post Graduate Doctors
            - One role to be advertised – awaiting clarification on most effective placement
            - Seven recruited, two awaiting start date.
        - Advanced Care Practitioners (Four gynaecology and six maternity) have begun training.
    - Sufficient obstetric consultants now in place to staff rota 24/7 – this will commence in October 2024.

- Cancer Improvement: Positive impacts from the new endometrial pathway, with significant reductions in hysteroscopy wait times, demonstrating effective recovery efforts. Audit results of the

new pathway showed 31% of patients being discharged following triage, 13% not examined by a GP prior to RAC referral and 1% identified as high risk, aligning with current diagnosis rates. The impact on overall cancer performance has yet to be statistically significant but the Gynaecology division will continue to audit the pathway and expect to see a positive impact on the benefit profile.

- Reduced Waiting List: Significant improvements in reducing the follow-up times for General and Uro Gynaecology patients. The percentage of overdue General Gynaecology patients reduced from 0.66% to 0.04%, and Uro Gynaecology patients from 0.51% to 0.18% of the overall waiting list. The Gynaecology Division is working towards a zero position for patients waiting over 65 weeks with the current number 41. A zero position is expected to be achieved by October 2024 and the Trust is continuing to accept patients as part of mutual aid.
- The overall Patient Treatment List (PTL) has continued to decrease with the current number at 16,500 (end of August 2024) – ahead of the expected trajectory (16,500 by end of March 2025). The Trust is looking to re-profile the trajectory to achieve a stretch target of 15,000 by the end of March 2025.

PROGRESS AGAINST THE NATIONAL OVERSIGHT FRAMEWORK SEGMENT 3 CRITERIA

Although the design and contents of the Improvement Plan are not solely driven by the exit criteria of the National Oversight Framework segmentation (from 3 to 2), the Plan serves as a crucial mechanism for demonstrating progress. In August 2024, the Executive Team conducted a self-assessment to evaluate the status against the established exit criteria, as detailed below. The RAG rating is intended to assess likelihood of achieving Exit Criteria by Target Exit Date. Whilst a Target Exit Date has not formally been agreed with the Cheshire & Merseyside Integrated Care Board (ICB), it has been assumed as April 2025 for the purposes of the assessment. This is consistent with the ICB requesting a full review of Exit Criteria progress in their November 2024 System Oversight Group.

As can be seen, good progress is being made against the 11 Exit Criteria overall with 8 rated green, 2 rated amber and one red. The key areas of delivery risk are the amber financial recovery Exit Criteria and the red Exit Criteria relating to NHSE's Cancer Tier 2.

With regards to the former, this is currently being strongly influenced by the system collaboration work and whilst progress has been made, there remains several areas that have yet to reach a conclusion or produce tangible outputs – hence the rating as 'amber'.

For the latter, the Board will be aware that the Trust was placed in Cancer Tier 1 (deterioration from Tier 2) and therefore this has been rated as 'red' as is it assumed that there will need to be a sequential exit from NHSE's cancer tiers which will take longer than the remainder of 2024/25. As demonstrated by the update on the Improvement Plan, the Trust continues to make improvements to its cancer performance and is currently on track with the tier 1 recovery trajectory. It is now imperative to continue to provide assurance to NHSE and the ICB that our improvements are sustainable to move out of the tiering process.

The Trust is continuing to work with the Integrated Care Board, Cancer Alliance and NHS England to provide assurance on the actions being taken to drive improvements. To support this, the National Clinical Director for Cancer at NHS England, Professor Peter Johnson, visited the Trust on 3 September 2024. Professor Johnson stated that the Trust had an excellent clinical service with dedicated staff and that the visit had highlighted some of the key challenges. The next meeting to review the Trust's cancer tier position is scheduled for October 2024 and the next System Oversight meeting with the ICB is scheduled for November 2024.

NHS
Liverpool Women's
NHS Foundation Trust

LWH Improvement Plan

Exit Criteria

LWH Self-Assessment as @ August 2024

1 Financial Improvement	2 Operational Performance	3 Quality	4 Workforce
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).	Exit NHSE's Cancer Tier 2.	Close out of CQC / MSSP Actions – Trust Board and SOG sign off of completed action plan.	Agency spend - no more than 3.2 % of total pay for 3 quarters in succession.
Delivery of at least 2 quarters of the recovery plan to demonstrate sustainable improvement.	Delivery of at least 2 quarters of locally agreed planning requirements 2024/25.		Turnover - under Trust ceiling (13%) for 3 quarters in succession.
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).			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.
Compliance with national, regional and system expenditure control regimes.			
Production of rolling 13 week cashflow underpinning ongoing cash requirement (for scrutiny) and internal audit review of cashflow management processes.			

SAFETY | QUALITY | SUSTAINABILITY

4

RAG Definition

High levels of confidence that Trust can provide Exit Criteria Evidence by Target Exit Date.

Medium levels of confidence that Trust can provide Exit Criteria Evidence by Target Exit Date

Low levels of confidence that Trust can provide Exit Criteria Evidence by Target Exit Date.

Equality, Diversity & Inclusion Implications

N/A

Quality, Financial or Workforce implications

N/A

RECOMMENDATION

The Board of Directors is asked to:

- note the Improvement Plan Highlight Report;
- note the closure of the Well-Led Programme; and
- note the current self-assessment against the NOF Segment 3 Exit Criteria.

SUPPORTING DOCUMENTS

Appendix A - LWH Improvement Plan Highlight Report

OUR IMPROVEMENT PLAN

SAFETY | QUALITY | SUSTAINABILITY

NHS
Liverpool Women's
NHS Foundation Trust

Liverpool Women's NHS FT

Improvement Plan Highlight Report

HEATMAP

Organisation	Overall	Overall DoT	Plan	Plan DoT	Benefits	Benefits DoT	Issues	Issues DoT	Risk	Risk DoT	Resource	Resource DoT	Stake holders	Stake holders DoT
LWH	Y	→	Y	→	A	↓	G	→	A	↓	G	→	G	→
1. Quality and Safety	G	→	G	→	G	→	G	→	A	↓	G	→	G	→
1.1 Deteriorating Patient Collaborative	Y	→	G	↗	G	→	G	→	R	↘	G	→	G	→
1.2 CQC and MSSP Actions	G	→	G	→	G	→	G	→	G	→	G	→	G	→
2. Clinical Effectiveness	Y	→	A	→	Y	↓	Y	↓	A	→	Y	→	G	→
2.1 Enhanced Workforce for Acute Workload	Y	→	Y	↓	A	→	G	→	A	↗	A	→	G	→
2.2 Acute Gynae Services	Y	→	Y	→	G	→	G	→	R	→	G	→	G	→
2.3 LWH Transfusion Lab	A	↘	A	→		↓	R	↓	R	→	G	→	G	→
2.4 Medicines Safety	G	→	G	↗		↓	G	→	G	→	G	→	G	→
3. Operational Performance	Y	→	Y	→	Y	↓	G	→	A	↓	G	→	G	→
3.1 Cancer Improvement	Y	→	G	→	A	→	G	→	R	→	G	→	G	→
3.2 Reduced Waiting List	G	↗	Y	↗	G	→	G	→	G	→	G	→	G	→
4. People and Culture	Y	→	Y	↓	A	→	G	→	A	→	G	→	Y	→
4.1 Safety Culture	Y	→	R	→	A	→	G	→	Y	↗	G	→	G	→
4.2 Actively Anti-Racist Organisation	Y	→	G	↑	A	→	G	→	A	→	G	→	A	→
5. Financial Sustainability	Y	→	Y	↗	Y	↘	G	→	A	↓	G	→	G	→
5.1 Delivering the Three Year Financial Plan	G	→	Y	→	G	→	G	→	G	→	G	→	G	→
5.2 2024/25 CIP Delivery	Y	→	A	↗	A	↓	G	→	R	↘	G	→	G	→

MILESTONES

LWH Improvement Portfolio

(Blank)	Complete	Future	Late	On Track	Overdue

Project	Milestones Count	Overdue Milestones	Late Milestones	On Track Milestones	Future Milestones	Completed Milestones	Start	Finish	Link	Progress	Project SRO
1.1 Deteriorating Patient Collaborative	11			1	6	4	08/05/2024	07/05/2025		35%	Dianne Brown
1.2 CQC and MSSP Actions	29			2		27	15/04/2024	31/03/2025		91%	Dianne Brown
2.1 Enhanced Workforce for Acute Workload	4			4			15/04/2024	31/03/2026		43%	Lynn Greenhalgh
2.2 Acute Gynae Services	11		1	3	3	4	15/04/2024	14/04/2025		31%	Lynn Greenhalgh
2.3 LWH Transfusion Lab	13	1	1	3	7	1	15/04/2024	28/03/2025		37%	Lynn Greenhalgh
2.4 Medicines Safety	10			1	5	4	15/04/2024	28/02/2025		32%	Lynn Greenhalgh
3.1 Cancer Improvement	34		1	16	3	14	15/04/2024	27/03/2026		72%	Gary Price
3.2 Reduced Waiting List	29		1	9	5	14	15/04/2024	31/07/2025		43%	Gary Price
4.1 Safety Culture	9		2	4		3	15/04/2024	31/03/2025		34%	Michelle Turner
4.2 Actively Anti-Racist Organisation	19			7	3	9	15/04/2024	31/03/2026		32%	Michelle Turner
5.1 Delivering the Three Year Financial Plan	8					8	15/04/2024	30/04/2025		46%	Jenny Hannon
5.2 2024/25 CIP Delivery	11	2			1	8	15/04/2024	19/11/2024		82%	Jenny Hannon

TRUST IMPROVEMENT PLAN SUMMARY UPDATE

Embed a culture of continuous improvement and safety for all, minimising risks and ensuring high-quality, sustainable services through collaboration, challenge, and openness

Key Focus Last Period

The past period has seen a significant shift towards quality assurance across all projects. This included extensive sessions with project leads focusing on refining risk articulation and score reviews, which has led to the scrutiny and subsequent de-escalation of several significant project risks. The development of an evidence repository for completed milestones has commenced, aiming to ensure good governance and readiness for any potential audits. Governance of programme huddles has also seen marked improvements, with consistent use of set agendas, action tracking, and enhanced check-and-challenge processes now in place.

The PowerBI report has been instrumental in identifying late and overdue milestones, facilitating timely interventions. As systems and processes continue to mature, the Transformation Delivery Unit has concentrated on verifying that milestones are not only achieved but are also integrated and sustainable within the organization's broader framework. Attendance at huddle meetings has improved, and the resilience of membership has strengthened, contributing to more effective governance. Overall, the projects are progressing well, and efforts are ongoing to maintain and enhance the quality and sustainability of the work being done.

Key points to note from the respective programmes:

Quality and Safety - Risks for the Deteriorating Patient Collaborative were updated, with process improvements underway and ongoing CQC/MSSP compliance efforts.

Clinical Effectiveness - Recruitment challenges for key clinical roles are being addressed, while new dashboards and risk management processes support performance and medication safety.

Operational Performance - Long-wait cancer patients have been cleared, hysteroscopy wait times reduced, and MRI/CT pathways streamlined.

People and Culture - Progress continues on the Safety Culture initiative and anti-racism efforts, with staff engagement and leadership support in place.

Financial Sustainability - Financial recovery workstreams and the three-year financial plan are progressing, with a focus on transitioning to recurrent savings in the CIP programme.

The IPPB approved the closure of the Well Led Programme owing to the progress made to date and considering that work would potentially be duplicated with other existing workstreams. This is detailed in the report cover sheet.

Key Focus Next Period

Quality and Safety - Planning for the September 27th Learning Session is underway, joint appraisals for MET and HDU are being developed, and CQC/MSSP compliance is being finalised.

Clinical Effectiveness - Recruitment for key clinical roles is being finalised, service delivery gaps in pharmacy are being addressed, and emerging risks in the Transfusion Robot project are being assessed.

Operational Performance - Daily PTL meetings are reducing cancer wait times, MRI/CT pathways are being optimized, and hysteroscopy wait times are being stabilised through additional sessions.

People and Culture - The Controlled Drugs project is progressing, recruitment for the Elevate program is underway, and the Anti-Racism Reporting Tool is being rolled out.

Financial Sustainability - Priorities for the Three-year financial plan are being set, PIDs are being completed, and CIP schemes are being implemented to ensure recurrent savings.

In the next period, there will be a focus on benefits and Programmes/Projects will be asked to reflect if the progress being made against the identified benefits in the respective PIDs/Project Charters is on track.

TRUST IMPROVEMENT PLAN SUMMARY UPDATE

Embed a culture of continuous improvement and safety for all, minimising risks and ensuring high-quality, sustainable services through collaboration, challenge, and openness

IP Risk & Issue Profile

There remains one 12+ risk which relates to the ability of the Trust to recruit consultant anaesthetists. To address the long-standing risk of recruiting consultant anaesthetists, several initiatives are underway. The team is collaborating closely with the anaesthetic department to define their needs and develop a strategic recruitment plan. They are addressing concerns about workload overlaps with other trusts and exploring broader collaboration to share resources, particularly in obstetric anaesthesia. Additionally, efforts are focused on identifying and supporting fragile services within the anaesthetic specialty to maintain adequate staffing levels. Continuous monitoring and adjustment of recruitment strategies are being implemented to ensure the sustainability and effectiveness of anaesthetic services.

Risks for the Deteriorating Patient Collaborative have been reviewed and two risks have been re-scored (Risk 2847 – Reduced from 10 to 9, Risk 2852 – Reduced from 9 to 8). Two risks remain scored at '11' – further assurance is required to reduce the staff engagement risk as there continues to be challenges in securing attendance at test of change meetings.

The issue rating for the LWH Transfusion Lab has been marked as 'red,' primarily due to a new issue that emerged in the week commencing 26 August 2024. The company the Trust had been in discussions with can no longer fulfil the quoted agreement. While there is still an opportunity to pursue the identified solution, uncertainty now surrounds the procurement process and potential ongoing maintenance arrangements. The Trust is actively working to clarify the situation and assess the level of assurance currently available. If an alternative procurement process or solution is required, due diligence and a comprehensive risk assessment will be undertaken by procurement and operational teams. Although the full impact on the project plan is not yet known, delays are likely.

IP Benefits Profile

Progress has been made with both the identification of KPIs and the inclusion of data since the previous report. A key focus for this period will be on ensuring the quality of data for the deteriorating patient project is at an adequate level to accurately demonstrate improvement (or otherwise) following the actions being put into place.

The SPC charts have been moved to a separate appendix to aid the clarity of reporting.

A key area of focus for future programme huddles will be to assess if the improvement work being undertaken is driving the desired outputs. The following are identifiable benefits to date:

- Enhanced Workforce for Acute Workload: Good progress in recruiting and appointing key personnel, such as individual consultants, ACPs, and anaesthetic doctors, which will enhance the workforce and improve service delivery.
o Recruitment to date:
 10 WTE funded Post Graduate Doctors
• One role to be advertised – awaiting clarification on most effective placement
• Seven recruited, two awaiting start date.
 Advanced Care Practitioners (Four gynaecology and six maternity) have begun training.
o Sufficient obstetric consultants now in place to staff rota 24/7 – this will commence in October 2024.

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TRUST IMPROVEMENT PLAN SUMMARY UPDATE SIGNIFICANT RISKS & ISSUES (>= 12/15)

ID	Project Name	Description	Score	Controls in Place	Manager
2842	2.1 Enhanced Workforce for Acute Workload	Insufficient available consultant anaesthetists to recruit to cover for delivery suite and unable to agree hours of work.	12	Initiatives are underway to address the long-standing issue of recruiting consultant anaesthetists. • Collaboration with the anaesthetic department to define needs and develop a strategic recruitment plan. • Addressing concerns about workload overlaps with other trusts. • Exploring broader collaboration to share resources, particularly in obstetric anaesthesia. • Focus on identifying and supporting fragile services within the anaesthetic specialty to maintain staffing levels. • Continuous monitoring and adjustment of recruitment strategies to ensure sustainability and effectiveness of anaesthetic services.	Christopher Dewhurst

Quality & Safety Programme Update

To minimise risks, optimise on site safety and deliver high quality care.

Organisation	Overall	Overall DoT	Plan	Plan DoT	Benefits	Benefits DoT	Issues	Issues DoT	Risk	Risk DoT	Resource	Resource DoT	Stake holders	Stake holders DoT
LWH	Y	→	Y	→	A	↓	G	→	A	↓	G	→	G	→
1. Quality and Safety	G	→	G	→	G	→	G	→	A	→	G	→	G	→
1.1 Deteriorating Patient Collaborative	Y	→	G	↗	G	→	G	→	R	↘	G	→	G	→
1.2 CQC and MSSP Actions	G	→	G	→	G	→	G	→	G	→	G	→	G	→

Key Focus Last Period

Deteriorating Patient Collaborative
Since its launch on 18 June 2024, the Deteriorating Patient Collaborative has made solid progress, initiating five tests of change supported by fortnightly Quality Improvement walk rounds. Key appointments, including a Medical Emergency Team Lead and Clinical Transformation Lead, are in place, and Project Initiation Documents for these supporting sub-projects are being developed. Work is also underway on digital observation recording. Despite some engagement challenges due to annual leave, the team is focused on improving clinical documentation accuracy and addressing staff educational needs.

CQC/MSSP Action Plans
The CQC Action Plan is now complete, with all 'must do' and 'should do' actions finished on time. A recent mock inspection provided positive feedback, highlighting trust-wide issues like equipment and competency, which are being addressed. A CQC review meeting on 13 August, led by the Chief Nurse and senior leadership, assessed progress on key actions across Gynaecology and Maternity, with mitigations and evidence reviewed to demonstrate completion.

Key Focus Next Period

Deteriorating Patient Collaborative
Recent efforts in the Deteriorating Patient Collaborative have focused on reviewing and updating risks, with appropriate rescores and narrative corrections completed. Mitigations are being sought for emerging risks around clinical digital systems and data inconsistencies. Two process mapping sessions were conducted to improve escalation processes for deteriorating patients, with key actions incorporated into ongoing work by the Medical Emergency Team (MET) group. Collaboration with Business Intelligence is ensuring data quality for monitoring benefits. Planning is underway for the 27 September learning session, which will include updates and engagement strategies for the next phase of action. Regular walk rounds continue, supporting teams with tests of change. Collaboration between the MET and HDU groups is progressing, with a joint options appraisal in development, particularly for the digital platform work.

CQC/MSSP Action Plans
Following the recent CQC check and challenge meeting, divisions are reviewing evidence and compliance in preparation for a follow-up session. The Associate Director of Governance and Quality is assisting divisions with self-assessments, evidence submission, and ongoing reviews to ensure continued readiness for CQC standards.

Key Points to Note

Deteriorating Patient Collaborative:
Key developments include ongoing clinician engagement with the new digital system and improvements in sepsis data collection. Significant progress has been made in patient observation reliability, though documentation on managing deteriorating patients remains an area for improvement. Educational needs for midwives and nurses are being streamlined for greater effectiveness. A proposed digital group will involve key stakeholders to improve data management.

Several incidental findings have been identified through the work completed to date, including issues relating to the digital capture and recording of information, the process of response to emergency calls within the Trust and education and training of Registered Midwives. These issues are being assessed; work to address these may be included in the project plan.

CQC/MSSP Actions
Regarding the CQC/MSSP work, risks have been identified in medicines management, specifically in policy compliance, audit, and oxygen therapy management. These risks are managed via the Pharmacy division and not the Improvement Plan, as they do not represent risks to project delivery at this time, however there is a potential risk to closing the specific CQC action without expedited progress through the Improvement Plan.

Quality & Safety Benefits Update

To minimise risks, optimise on site safety and deliver high quality care.

Project Name	Date	Target < or >	Performance	Assurance	Variation
1.1 Deteriorating Patient Collaborative					
% of MEWS Scores within time	August 2024	>=	71.68%		
% of NEWS Scores within time	August 2024	>=	87.03%		
% of patient with a MOEWS of more than 7 to be reviewed by the medical team caring for the patient as per policy	August 2024	>=	3.85%		
% of patient with a NEWS of more than 7 to be reviewed by the medical team caring for the patient as per policy	August 2024	>=			
% of patients with MOEWS of 3 in one single parameter/5 overall viewed by a medic team caring for that patient as per policy	August 2024	>=	25.34%		
% of patients with NEWS of 3 in one single parameter/5 overall to be reviewed by a medic team caring for the patient as per policy	August 2024	>=	15.56%		
Sepsis Golden hour – % patients identified as requiring antibiotics and antibiotics delivered within one hour	August 2024	>=	62.50%		
Sepsis Golden hour – % patients identified as requiring Sepsis bundle have bundle delivered within one hour	August 2024	>=	31.25%		
1.2 CQC and MSSP Actions					
BBAS - % of areas rated as Good or Outstanding	August 2024	>=	50.00%		
BBAS - Number of areas which have had an accreditation (rolling number each month)	August 2024	>=	11		

Clinical Effectiveness Programme Update

To strengthen healthcare delivery through an enhanced workforce for acute services, with a strong focus on Medicine Safety, and establishing a Blood Transfusion Laboratory on site.

Organisation	Overall	Overall DoT	Plan	Plan DoT	Benefits	Benefits DoT	Issues	Issues DoT	Risk	Risk DoT	Resource	Resource DoT	Stake holders	Stake holders DoT
LWH	Y	→	Y	→	A	→	G	→	A	→	G	→	G	→
2. Clinical Effectiveness	Y	→	A	→	Y	↓	Y	↓	A	→	Y	→	G	→
2.1 Enhanced Workforce for Acute Workload	Y	→	Y	↓	A	→	G	→	A	↗	A	→	G	→
2.2 Acute Gynae Services	Y	→	Y	→	G	→	G	→	R	→	G	→	G	→
2.3 LWH Transfusion Lab	A	↘	A	→		↓	R	↓	R	→	G	→	G	→
2.4 Medicines Safety	G	→	G	↗		↓	G	→	G	→	G	→	G	→

Key Focus Last Period

Enhanced Workforce for Acute Workload
All Advanced Clinical Practitioners (ACPs) have been appointed, with training starting in September 2024. Consultants have agreed to provide 24/7 obstetrics coverage starting in September, with some consultants beginning in January 2025. Improvements to the consultant on-call room are expected by 1 September. Recruitment for consultant anaesthetists remains challenging, but efforts to address these issues are ongoing.

Acute Gynaecology Services
A review of patient pathways into the acute gynaecology service identified three main streams: emergency walk-ins, early pregnancy assessment patients, and ward referrals. A process mapping exercise has highlighted areas for improvement. Stakeholders have decided to focus on internal improvements first, and an Acute ED Dashboard has been developed to track performance and triage data.

LWH Transfusion Lab
A meeting on 17 July addressed MHRA requirements, and mitigation plans are in place. The Tender Waiver has been completed, though an additional £50k cost for IT integration is under review. The project plan and training timelines are being assessed to ensure alignment with the overall schedule.

Medicine Safety
The project has identified risks within pharmacy services and medication provision, with interviews nearly complete. Risks have been entered into the Ulysses risk register to guide future planning. Scoping continues across wards and clinics, focusing on high-risk areas and Service Level Agreements (SLAs) in procurement, clinical governance, and fertility services.

Key Focus Next Period

Enhanced Workforce for Acute Workload
Efforts are underway to ensure the Obstetrics on-call room meets the requirements of consultant obstetricians, with necessary updates and air conditioning installation in progress. Ongoing discussions with anaesthetic leads are focused on future workforce models. The team is also reviewing candidates from the gynaecology oncology recruitment round to identify potential for other roles.

Acute Gynaecology Services
A meeting with the Chief Medical Officer on 27 August 2024 outlined the next steps for the project plan. A site visit to Birmingham Women's Hospital took place on 3 September 2024, which identified a number of processes that could support improvements if implemented locally.

LWH Transfusion Lab
In the coming month, clinical teams will identify staff for training on the new system, ensuring that governance and competency requirements are clear. A significant issue was identified in the week of 26 August 2024, and efforts are focused on assessing available mitigations (see key points to note).

Medicine Safety
A comprehensive paper is being drafted to document service delivery gaps and risks, with these risks continuously added to the risk register for monitoring.

Key Points to Note

LWH Transfusion Lab
The Trust was informed of an emerging issue relating to the supplier of the transfusion robot the w/c 26 August 2024. The technology remains viable, but assurances are now required in relation to the available procurement route and on-going maintenance arrangements. Until adequate assurances can be provided, the procurement of the robot will not be able to progress, and this will result in a delay to the project – the length of which cannot yet be determined. Officers from the Trust and LCL visited the new supplier w/c 2 September 2024 and have reported back to the Executive Team. The Procurement Team is now progressing with the relevant due diligence work.

Medicine Safety
Overall risk of capacity in pharmacy services to deliver on the medicines agenda discussed is to be escalated to the Executive Risk and Assurance Group for review. This is then likely to be added to the risk register – actions to include diagnostic and population of gap analysis report.

Clinical Effectiveness Benefits

To strengthen healthcare delivery through an enhanced workforce for acute services, with a strong focus on Medicine Safety, and establishing a Blood Transfusion Laboratory on site.

Project Name	Date	Target < or >	Performance	Assurance	Variation
2.1 Enhanced Workforce for Acute Workload					
Hypoxic Encephalopathy (Grade 2,3)	July 2024	<=	3		
Number of emergency admissions from Matbase to NICU	July 2024	>=	19		
Reduction in Obestetric Adverse Events on Delivery Suite	August 2024	<=	0		
2.2 Acute Gynae Services					
EPAU patients seen within 24 hours of referral	August 2024	>=	19.82%		
GED 15 Minutes to Triage	August 2024	>=	35.70%		
GED 4 hours from arrival to admission, transfer or discharge	August 2024	>=	88.28%		
GED Decrease in Time Taken to Treat	August 2024	<=	126		
GED Increased patient satisfaction (Friends & Family Scores)	August 2024	>=	83.33%		

Operational Performance Programme Update

Improve the Trust's Elective & Cancer Performance to reduce the amount of time patients are waiting for diagnosis and treatment

Organisation	Overall	Overall DoT	Plan	Plan DoT	Benefits	Benefits DoT	Issues	Issues DoT	Risk	Risk DoT	Resource	Resource DoT	Stake holders	Stake holders DoT
LWH	Y	→	Y	→	A	→	G	→	A	→	G	→	G	→
3. Operational Performance	Y	→	Y	→	Y	↓	G	→	A	↓	G	→	G	→
3.1 Cancer Improvement	Y	→	G	→	A	→	G	→	R	→	G	→	G	→
3.2 Reduced Waiting List	G	↗	Y	↗	G	→	G	→	G	→	G	→	G	→

Key Focus Last Period

Cancer Improvement
Since July 2024, the service has focused on clearing the long-wait patient backlog, which may temporarily affect Faster Diagnosis performance in August and September but is expected to return to target by October. NHSE was informed of this during the Tier 1 meeting on 15 August. Over the past six months, there has been significant improvement in the median time from referral to diagnosis, with a 52% reduction in the 70th percentile wait time, dropping from 85 days in October 2023 to 41 days in August 2024 (see Appendix 2 for graphs).

The hysteroscopy sterilisation issue has been resolved, and the backlog cleared with a current two-week wait time. Additional funding from NHSE has been secured to further support recovery efforts. A solution is being explored for delays in histopathology results.
A capacity and demand review of cancer clinics is underway to ensure stability in job planning. Pre-op and hysteroscopy session scheduling has improved, with reserved slots based on demand. The Endometrial Cancer Pathway and F2F RAC clinic capacity are well-positioned for September.

Work has been initiated with the CDC/LUHFT and CCC to streamline the CT/MRI process and reduce waits.

Reduced Waiting List
The initiative to reduce waiting lists continues to show positive results, with a significant reduction in patients waiting over 65 weeks. The overall Patient Treatment List (PTL) has decreased to approximately 16,500 as of the end of August 2024. Milestones for clinic template reviews in Gynaecology and CSS have been set, with a structured approach to ensure ongoing progress. Weekly monitoring and improved scheduling are crucial in maintaining this momentum and further reducing waiting times.

Key Focus Next Period

Cancer Improvement
In the coming month, daily PTL meetings will continue to focus on reducing long-wait patients, particularly those over 104 and 62 days, while maintaining Faster Diagnosis patients under 28 days. Efforts will also focus on reducing hysteroscopy wait times and optimizing the MRI and CT pathways. The NHSE Elective Care Intensive Support Team will review PTL tracking and progression to MDT to support further improvements.

Reduced Waiting List
Next steps include intensifying efforts to reduce long-wait patients through continuous monitoring and targeted interventions. Managing increased referrals will require capacity planning and improved triage systems. Optimising scheduling practices and introducing flexible options are also key priorities.

Key Points to Note

None to note.

Operational Performance Benefits Summary - Cancer Improvement

Improve the Trust's Elective & Cancer Performance to reduce the amount of time patients are waiting for diagnosis and treatment

Project Name	Date	Target < or >	Performance	Assurance	Variation
3.1 Cancer Improvement					
Cancer: 28 Day Faster Diagnosis	July 2024	>=	46.11%		
Cancer: 28 Day Faster Diagnosis Benchmarked Percentile	June 2024	>=	23.64%		
Cancer: 31 Day decision to treat to treatment	July 2024	>=	79.49%		
Cancer: 31 Day decision to treat to treatment Benchmarked Percentile	June 2024	>=	8.33%		
Cancer: 62 Day referral to Treatment	July 2024	>=	18.60%		
Cancer: 62 Day referral to Treatment Benchmarked Percentile	June 2024	>=	13.92%		

Operational Performance Benefits Summary - Reduced Waiting List

Improve the Trust's Elective & Cancer Performance to reduce the amount of time patients are waiting for diagnosis and treatment

Project Name	Date	Target < or >	Performance	Assurance	Variation
3.2 Reduced Waiting List					
1st Appointment Waiting Times	August 2024	<=	131		H
Capped Theatre Utilisation rate	August 2024	>=	67.27%	F	H
Moved or discharged outpatient attendances to PIFU pathways	July 2024	>=	2.55%	P	H
Number overdue follow up appointments	August 2024	<=	9443		
Overall size of active patient waiting list	July 2024	<=	16675	?	L
Overall size of the Inpatient Waiting List	August 2024	<=	3403		H
Uncapped Theatre Utilisation rate	August 2024	>=	70.38%	F	

People & Culture Programme Update

To drive a truly inclusive culture, underpinned by shared values and respect for diversity, with strong leadership and teamwork, and an openness to learning in a psychologically safe setting.

Organisation	Overall	Overall DoT	Plan	Plan DoT	Benefits	Benefits DoT	Issues	Issues DoT	Risk	Risk DoT	Resource	Resource DoT	Stake holders	Stake holders DoT
LWH	Y	→	Y	→	A	→	G	→	A	→	G	→	G	→
4. People and Culture	Y	→	Y	↓	A	→	G	→	A	→	G	→	Y	→
4.1 Safety Culture	Y	→	R	→	A	→	G	→	Y	↗	G	→	G	→
4.2 Actively Anti-Racist Organisation	Y	→	G	↑	A	→	G	→	A	→	G	→	A	→

Key Focus Last Period

Safety Culture
The literature review has been completed, and a preliminary review of the findings is underway. Focus groups with staff on Matbase have been conducted to discuss culture and safety issues. An engagement event with medical staff took place on 26 July 2024, resulting in the appointment of a medical lead. Additionally, a Controlled Drugs improvement plan is in progress, aligning with the overall efforts to enhance safety culture within the organisation. These activities are key to defining and implementing effective improvement measures.

Actively Anti-racist organisation
A race reporting tool has been launched on the website, with QR codes available for staff, patients, and visitors. The Anthony Walker Foundation is engaged to conduct staff listening events, with dates and content confirmed. The Anti-Racist Hub (ARH) has been promoted through leaflets, posters, and branding. Additionally, 76% of staff have completed face-to-face training, of a target of 80%by March 2025. Efforts continue to integrate anti-racism into clinical education and organisational policies, with ongoing development of support resources and reporting mechanisms.

Key Focus Next Period

Safety Culture
- Progress Controlled Drugs project against agreed milestones
- Secure additional resource/support to the overarching programme in the absence of the programme lead
- Reschedule the Leading for Safety Masterclass

Actively Anti-racist organisation
- Recruit to Elevate programme
- Further development and roll out of cultural adjustment in clinical practice in women's health

Key Points to Note

Safety Culture
Ongoing absence of project lead, mitigating strategies are in place.

Actively Anti-racist organisation
No key points noted.

People & Culture Programme Update

To drive a truly inclusive culture, underpinned by shared values and respect for diversity, with strong leadership and teamwork, and an openness to learning in a psychologically safe setting.

Project Name	Date	Target < or >	Performance	Assurance	Variation
4.1 Safety Culture					
% of safety huddles taking place	KPI in development – to be available in future reports				
% of staff completing human factors training	August 2024	>=	86.69%		
% of staff completing safety culture leadership training	KPI in development – to be available in future reports				
BBAS score for questions indicating a positive safety culture	KPI in development – to be available in future reports				
4.2 Actively Anti-Racist Organisation					
Anti Racism Action Learning Set completed by Leaders	KPI in development – to be available in future reports				
Face to Face Inclusion & Anti Racism training completed by staff	July 2024	>=	73.78%		
GM staff in leadership roles (B7 or above)	July 2024	>=	9.32%		
No of GM staff enrolled on/completed formal leadership in last 12 months	KPI in development – to be available in future reports				
No of patient contacts with Anti Racism Hub	KPI in development – to be available in future reports				
No of staff contacts with Anti Racism Hub	KPI in development – to be available in future reports				
Overall GM staff in workforce	July 2024	N/A	12.53%		

Financial Sustainability Programme Update

Development and delivery of a Three-Year Plan to improve and sustain the financial position of the Trust.

Organisation	Overall	Overall DoT	Plan	Plan DoT	Benefits	Benefits DoT	Issues	Issues DoT	Risk	Risk DoT	Resource	Resource DoT	Stake holders	Stake holders DoT
LWH	Y	→	Y	→	A	→	G	→	A	→	G	→	G	→
5. Financial Sustainability	Y	→	Y	↗	Y	↘	G	→	A	↓	G	→	G	→
5.1 Delivering the Three Year Financial Plan	G	→	Y	→	G	→	G	→	G	→	G	→	G	→
5.2 2024/25 CIP Delivery	Y	→	A	↗	A	↓	G	→	R	↘	G	→	G	→

Key Focus Last Period

Delivering the Three-year financial plan
- LAASFG financial recovery delivery workstreams all fully established with bi-weekly reporting/updates to CFOs in place.
- Long lists developed for all 5 workstreams, prioritisation underway.
- LWH leading on shared services workstream – progression towards procurement, overseas visitors, and legal shared services, with plans considered for digital in-year.
- Mechanism for transacting £18.5m target proposed and under consideration.
- Engagement with PWC re external support process.
- Trust rated Amber by NHSE Nominated Lead and has re-submitted risk-adjusted forecast for 2024/25 and revised WTE forecast, indicating delivery of £28.5m deficit plan.

24/25 CIP Delivery
- CIP Portfolio Board held 14/08/24, workplan and ToR agreed.
- QIAC held 20/08/24, 4 PIDs presented, 3 of 4 approved.
- As per last period – CIP fully identified but requires move from non-recurrent to recurrent.

Key Focus Next Period

Delivering the Three-year financial plan
- Agree workstream priorities.
- Identify value against each workstream.

24/25 CIP Delivery
- Completion of PIDS - 7 outstanding for completion.
- QIAC approval of schemes – 9 (including 7 above).
- Identification of recurrent schemes for delivery.

Key Points to Note

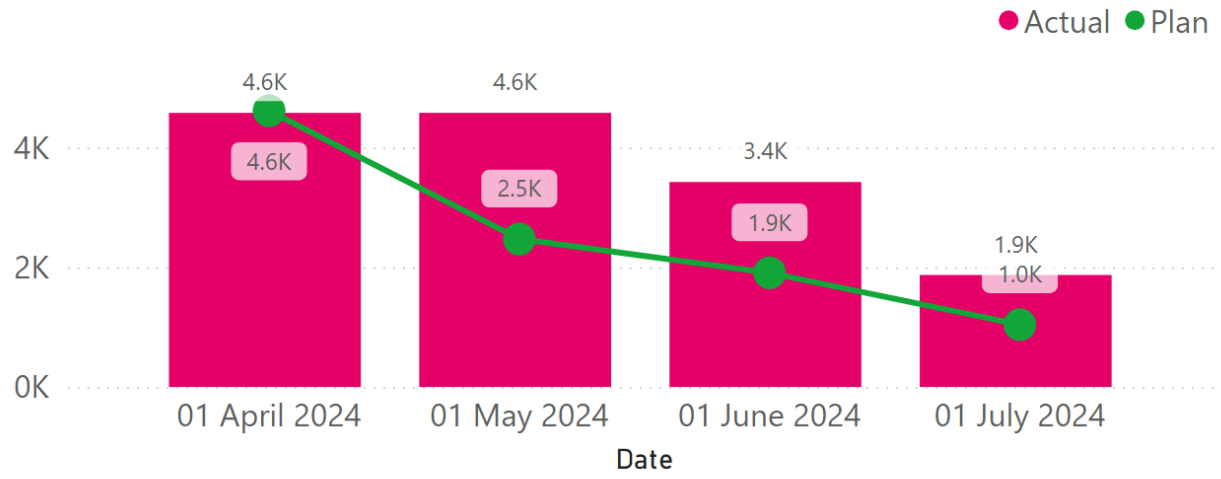
Delivering the Three-year financial plan
- Long list developed for LAASP FG workstreams.
- Trust rated Amber by NHSE Nominated Lead.
- PWC draft recommendations received.

24/25 CIP Delivery
- Risk of non-recurrent delivery.
- £0.4m scheme held at QIAC.

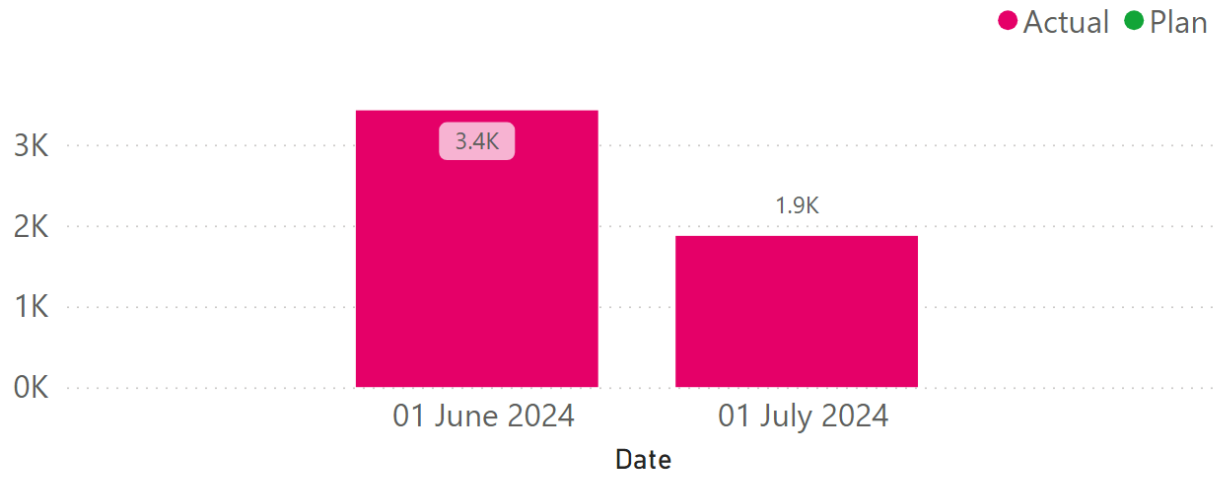
Financial Sustainability Benefits

Development and delivery of a Three-Year Plan to improve and sustain the financial position of the Trust.

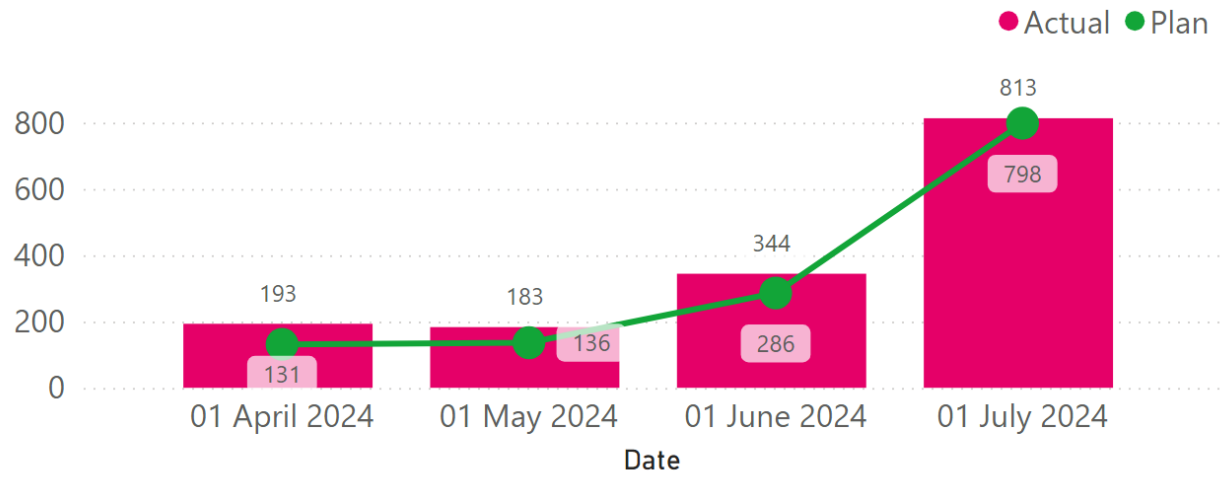
Cash Actual vs Plan



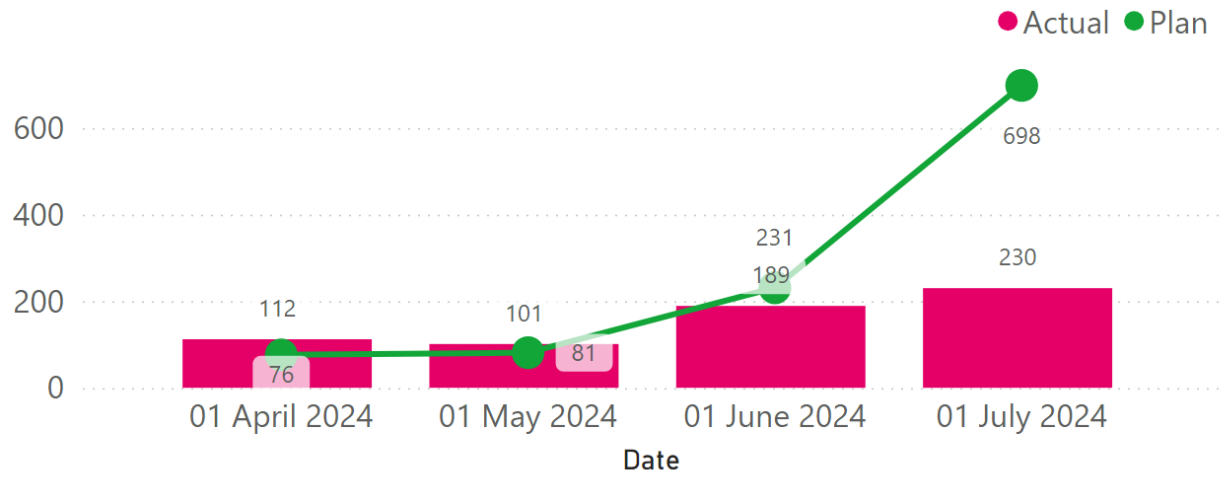
Cash actual vs Distressed finance Forecast



CIP Actual vs Plan



CIP actual recurrent vs planned recurrent



OUR IMPROVEMENT PLAN

SAFETY | QUALITY | SUSTAINABILITY

NHS
Liverpool Women's
NHS Foundation Trust

Appendix 1

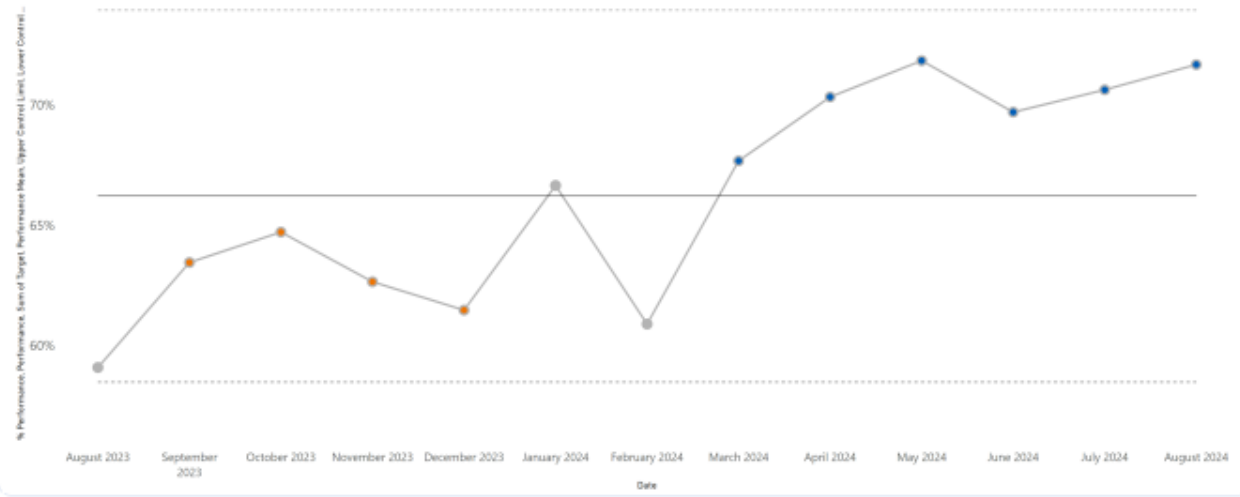
Statistical Process Control Charts for Benefits

Quality & Safety Benefits

To minimise risks, optimise on site safety and deliver high quality care.

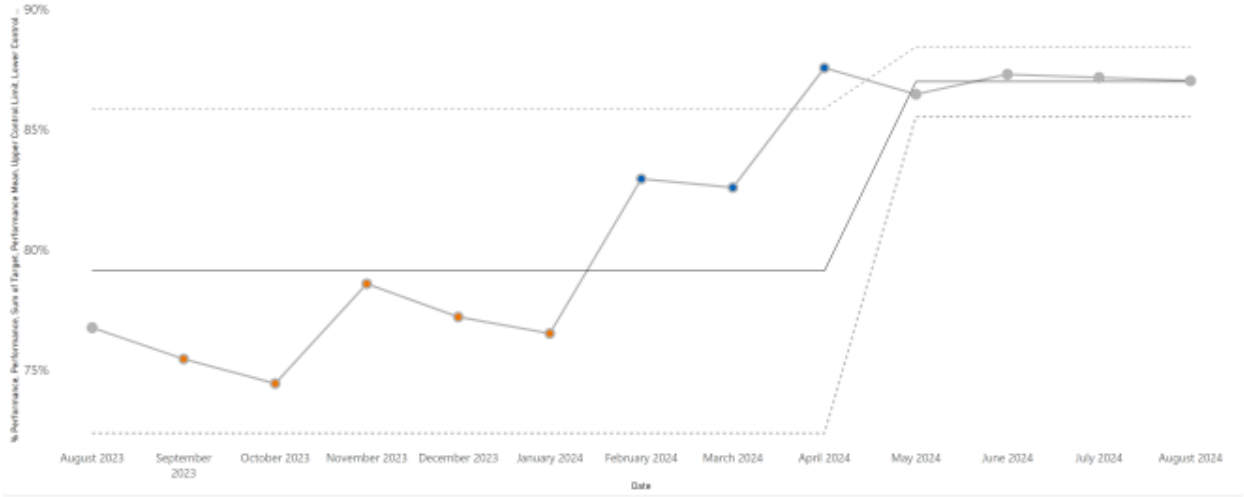
% of MEWS Scores within time -

Target	Target < or >	Performance	Assurance	Variation
	>=	71.68%		



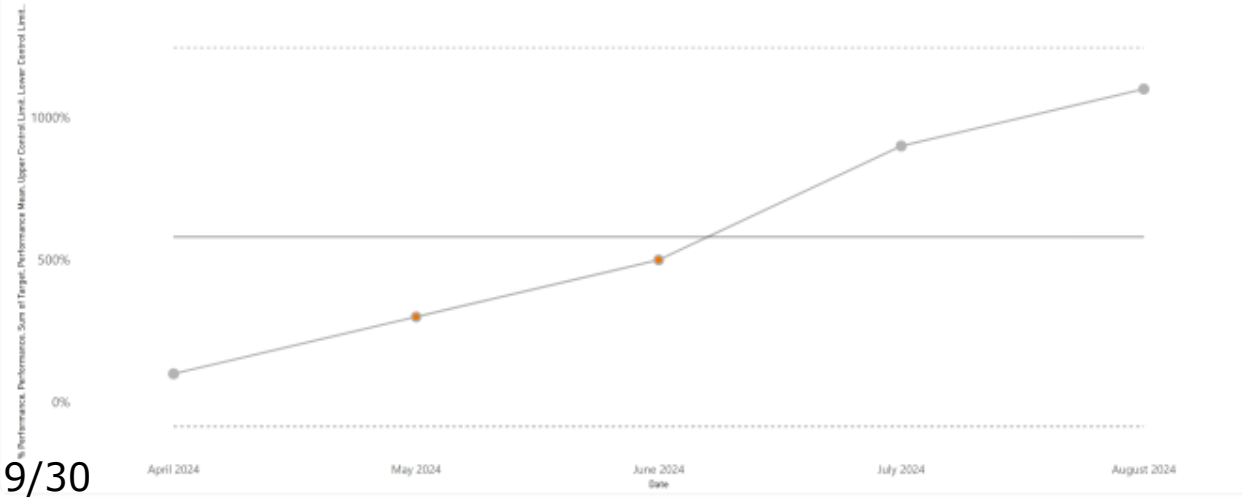
% of NEWS Scores within time -

Target	Target < or >	Performance	Assurance	Variation
	>=	87.03%		



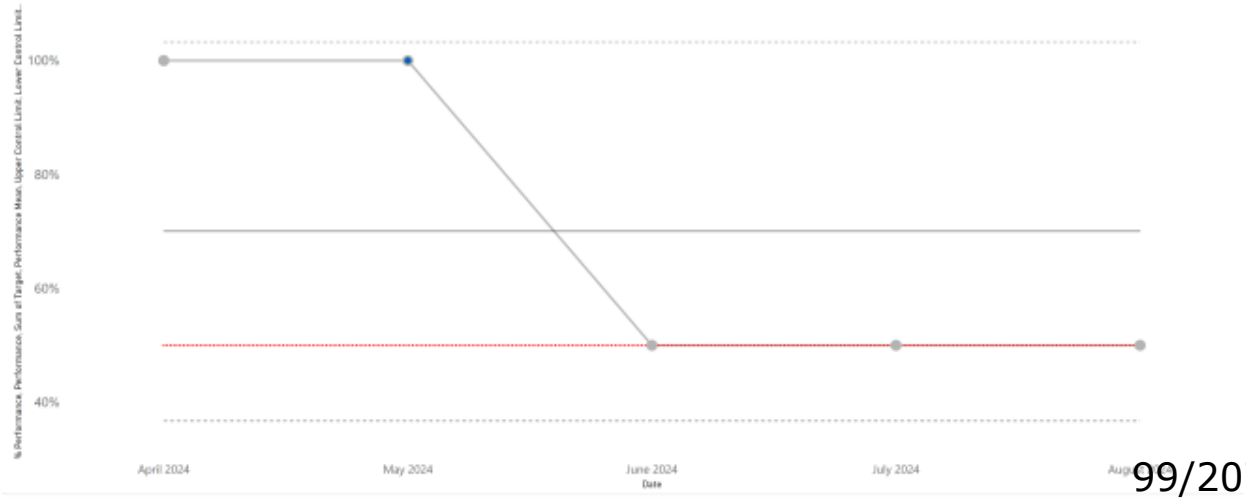
BBAS - Number of areas which have had an accreditation (rolling number each month) - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
	>=	11		



BBAS - % of areas rated as Good or Outstanding - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
>= 50%	>=	50.00%		

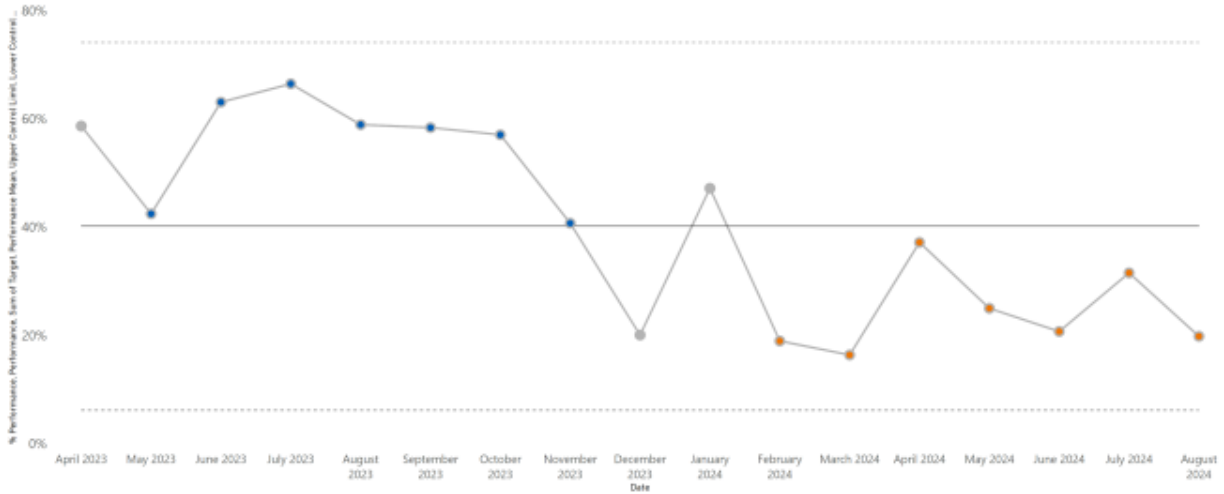


Clinical Effectiveness Benefits

To strengthen healthcare delivery through an enhanced workforce for acute services, with a strong focus on Medicine Safety, and establishing a Blood Transfusion Laboratory on site.

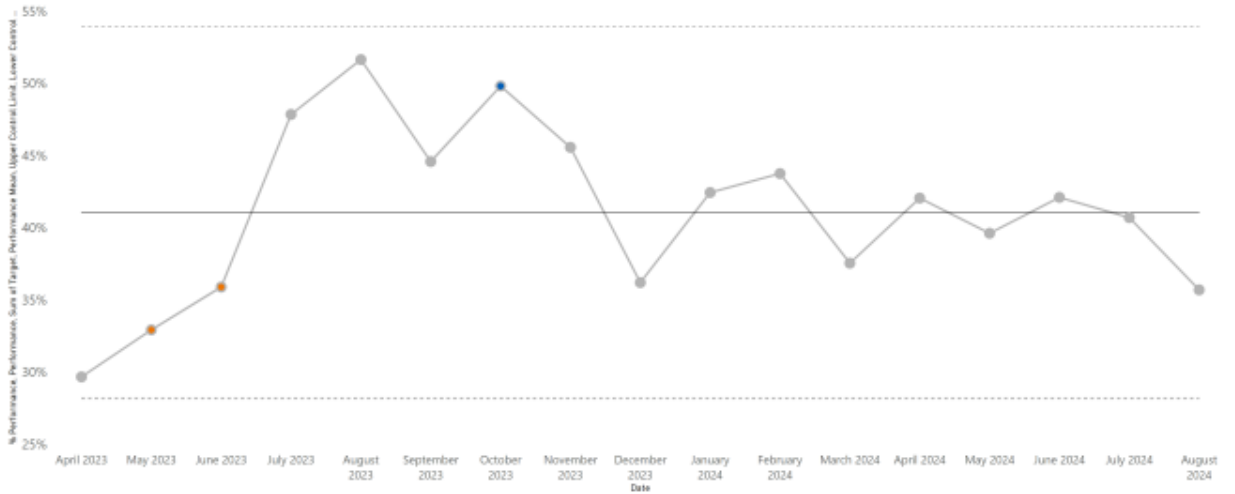
EPAU patients seen within 24 hours of referral -

Target	Target < or >	Performance	Assurance	Variation
	>=	19.82%		



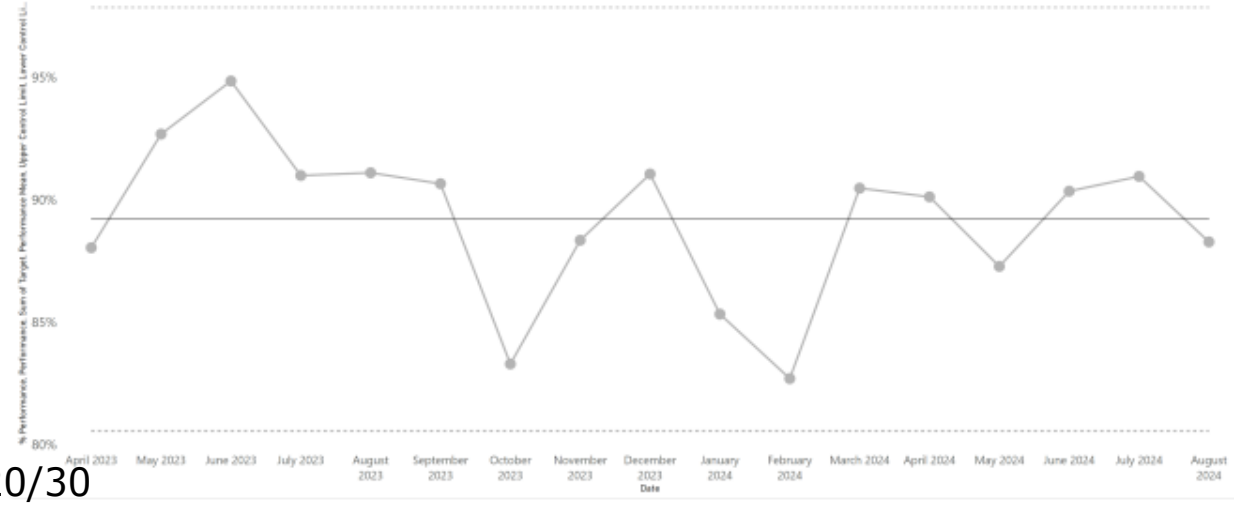
GED 15 Minutes to Triage -

Target	Target < or >	Performance	Assurance	Variation
	>=	35.70%		



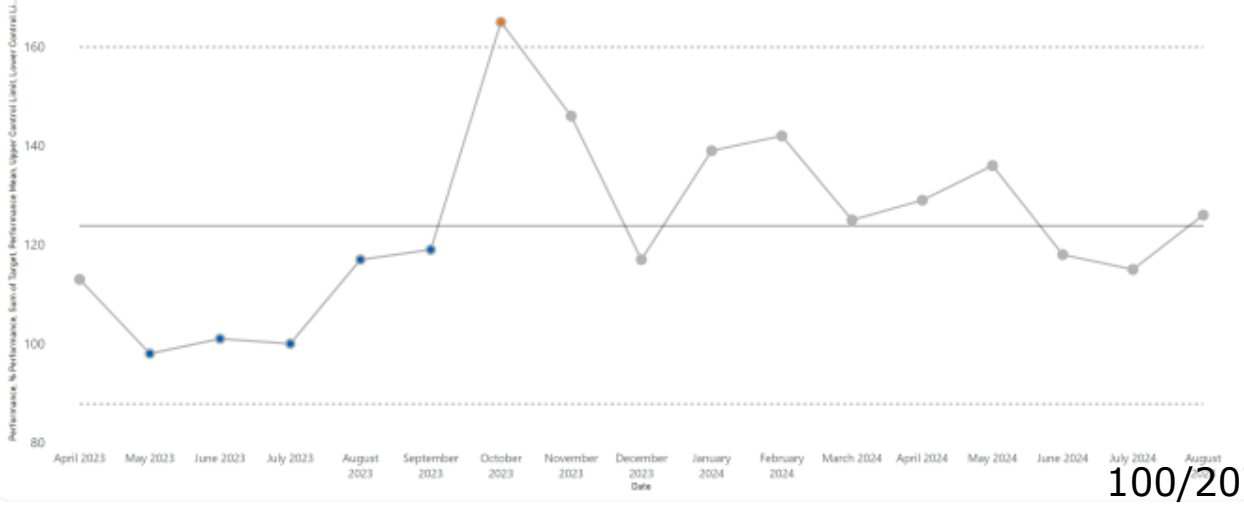
GED 4 hours from arrival to admission, transfer or discharge -

Target	Target < or >	Performance	Assurance	Variation
	>=	88.28%		



GED Decrease in Time Taken to Treat -

Target	Target < or >	Performance	Assurance	Variation
	<=	126		

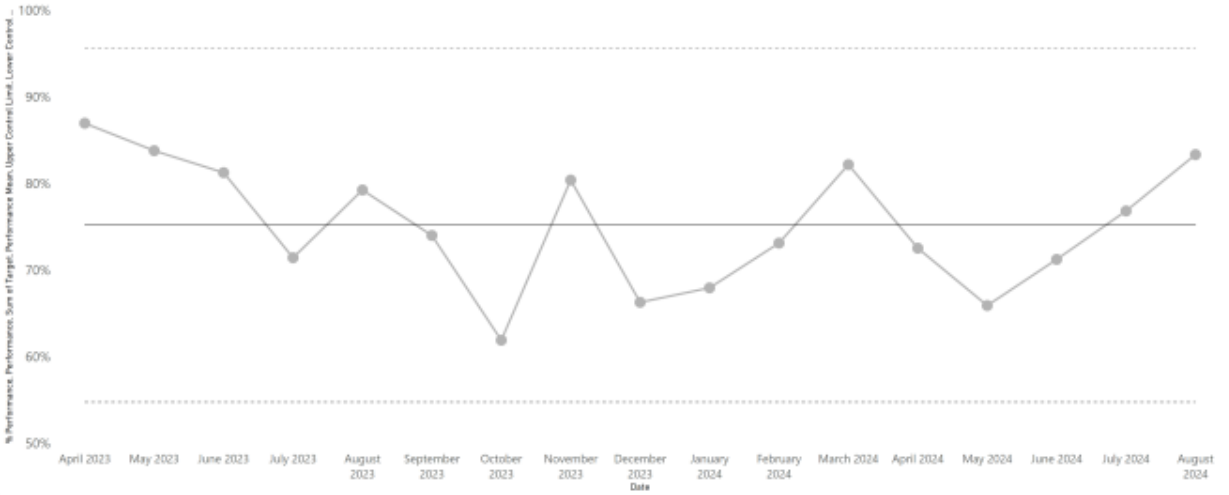


Clinical Effectiveness Benefits

To strengthen healthcare delivery through an enhanced workforce for acute services, with a strong focus on Medicine Safety, and establishing a Blood Transfusion Laboratory on site.

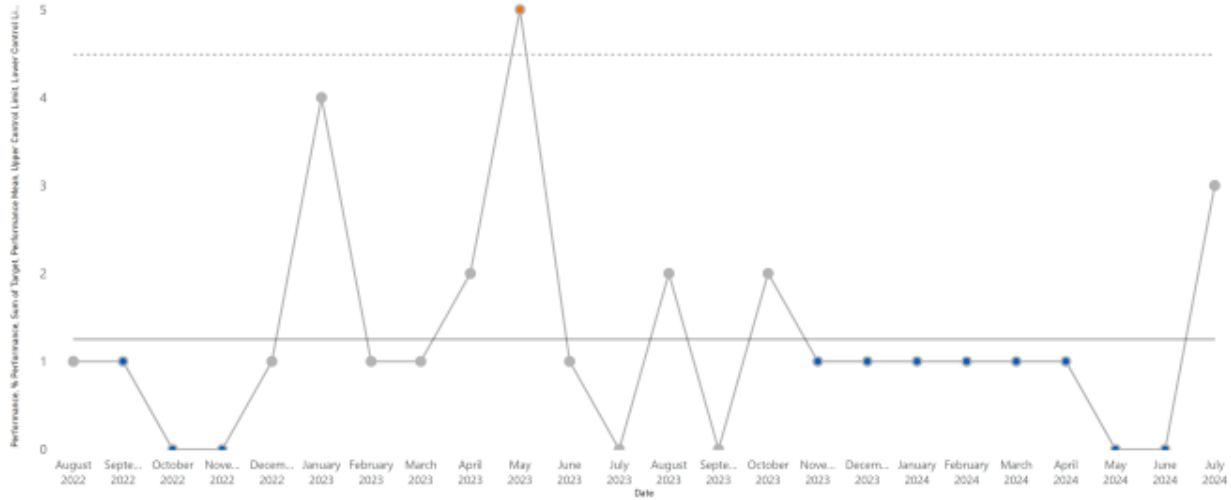
GED Increased patient satisfaction (Friends & Family Scores) -

Target	Target < or >	Performance	Assurance	Variation
	>=	83.33%		



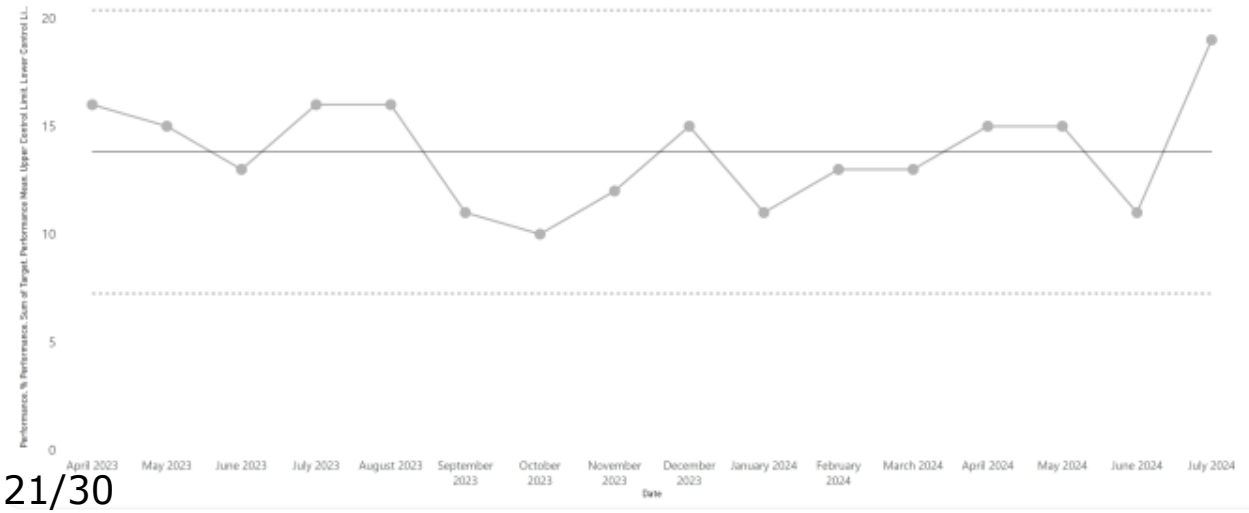
Hypoxic Encephalopathy (Grade 2,3) - Medical Director

Target	Target < or >	Performance	Assurance	Variation
TBA	<=	3		



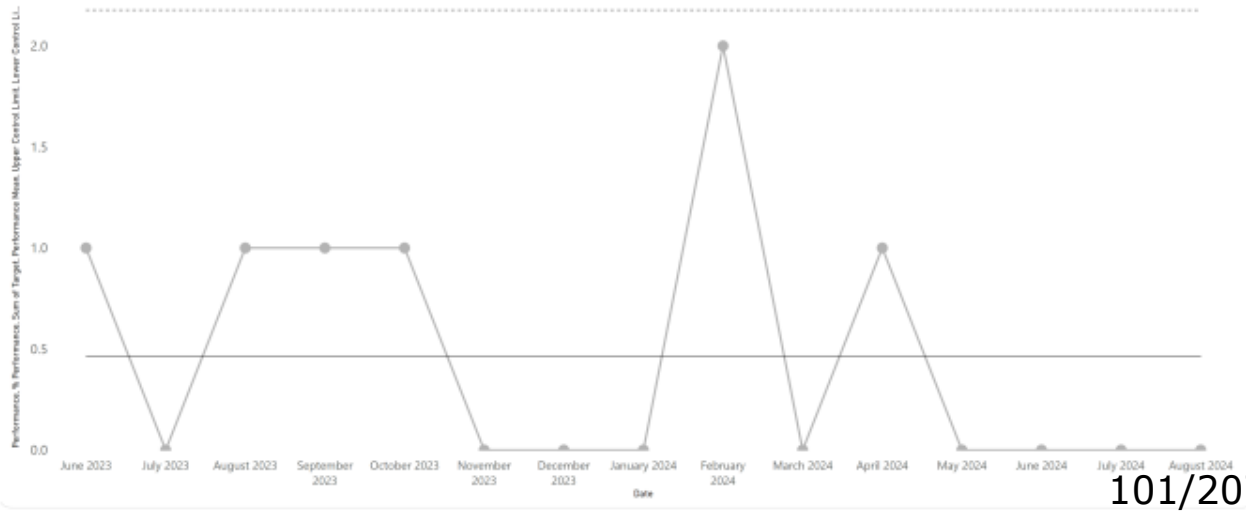
Number of emergency admissions from Matbase to NICU -

Target	Target < or >	Performance	Assurance	Variation
	>=	19		



Reduction in Obestetric Adverse Events on Delivery Suite -

Target	Target < or >	Performance	Assurance	Variation
	<=	0		

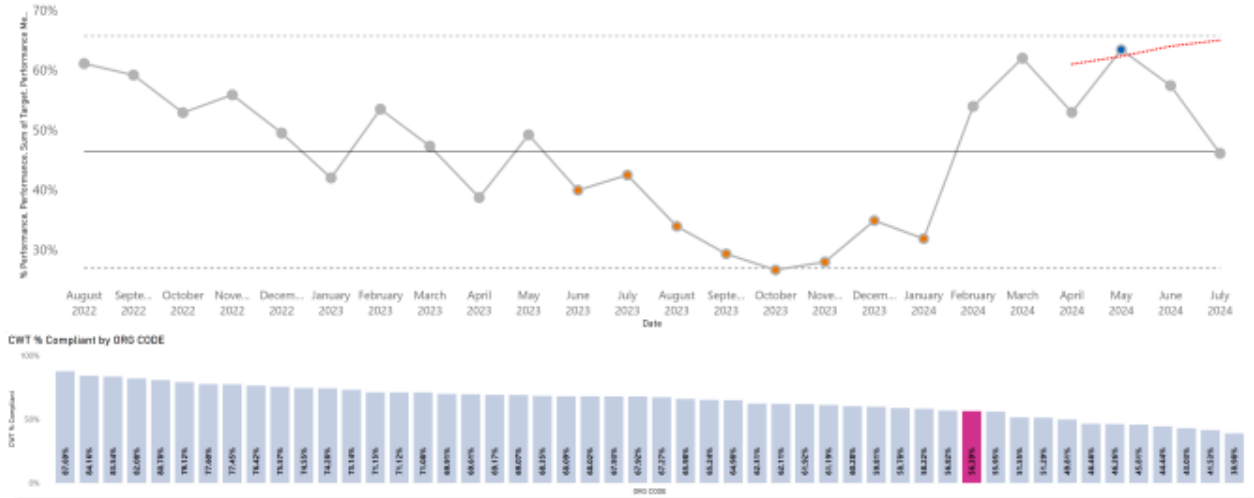


Operational Performance Benefits - Cancer

Improve the Trust's Elective & Cancer Performance to reduce the amount of time patients are waiting for diagnosis and treatment

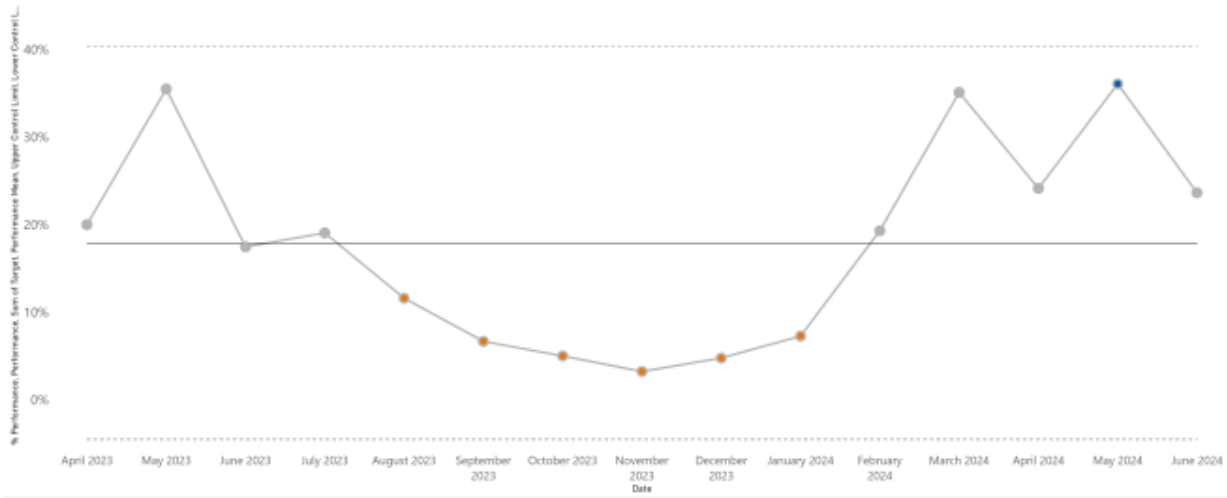
Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 75%	>=	46.11%		



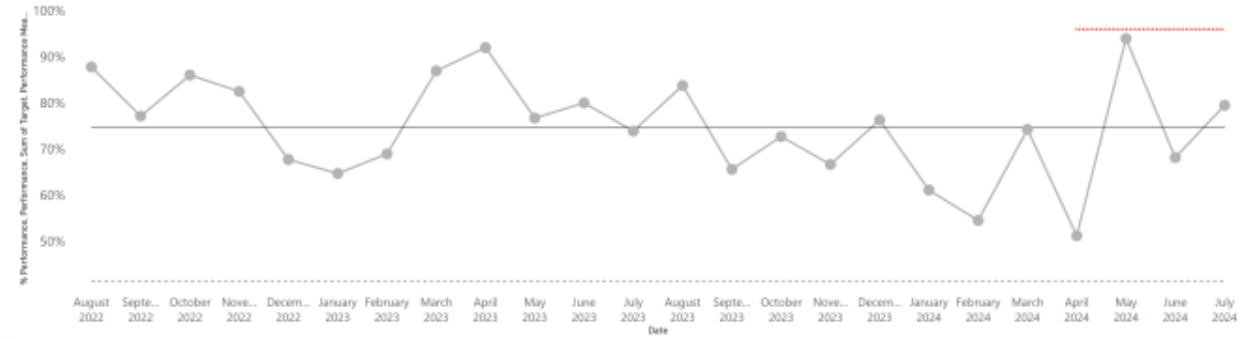
Cancer: 28 Day Faster Diagnosis Benchmarked Percentile -

Target	Target < or >	Performance	Assurance	Variation
	>=	23.64%		



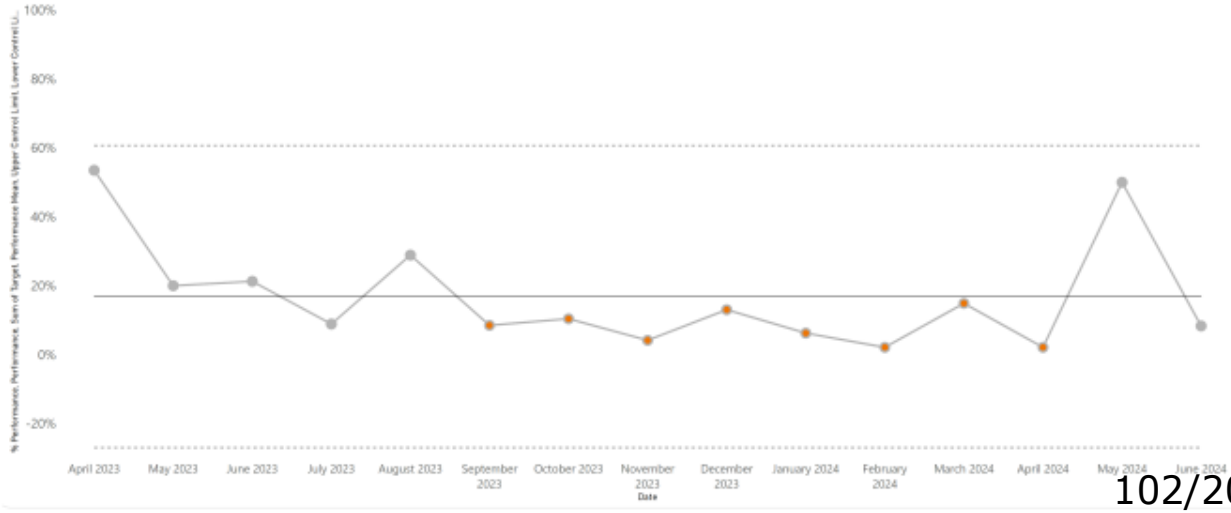
Cancer: 31 Day decision to treat to treatment - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>=96%	>=	79.49%		



Cancer: 31 Day decision to treat to treatment Benchmarked Percentile -

Target	Target < or >	Performance	Assurance	Variation
	>=	8.33%		

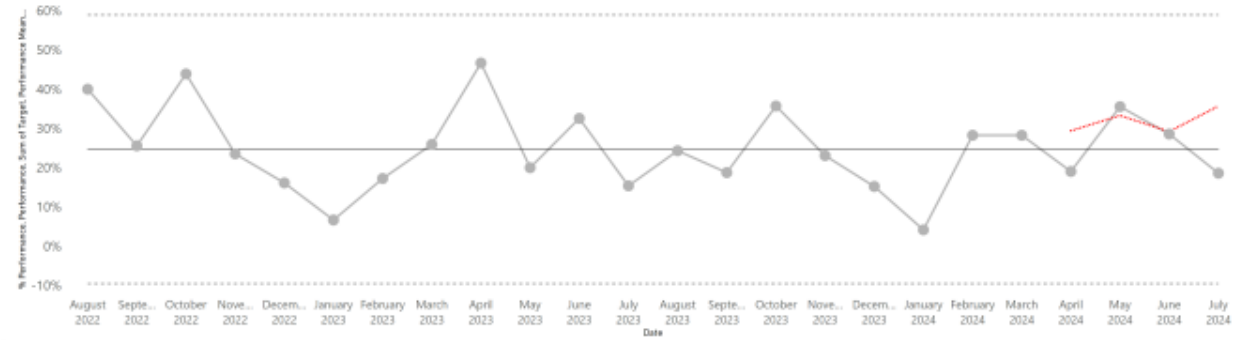


Operational Performance Benefits - Cancer

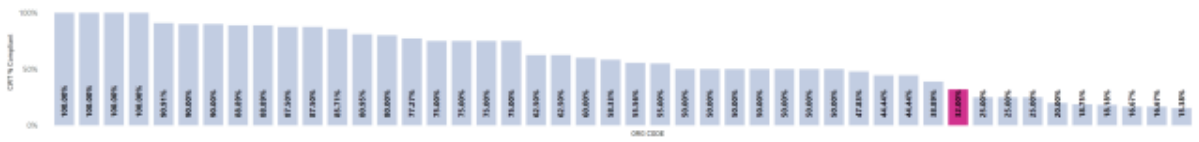
Improve the Trust's Elective & Cancer Performance to reduce the amount of time patients are waiting for diagnosis and treatment

Cancer: 62 Day referral to Treatment - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>=85%	>=	18.60%		

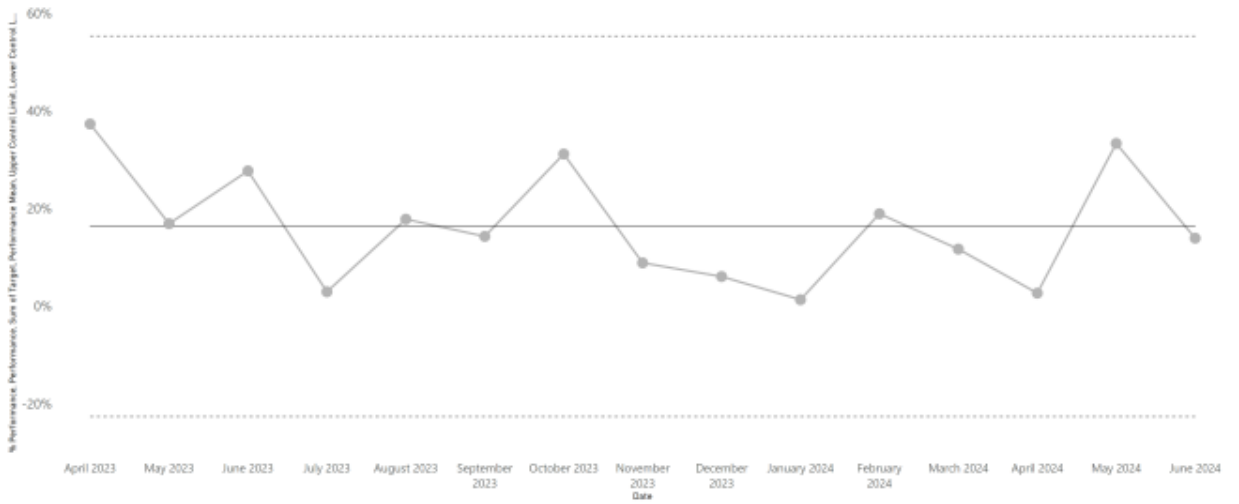


CWT % Compliant by ORG CODE



Cancer: 62 Day referral to Treatment Benchmarked Percentile -

Target	Target < or >	Performance	Assurance	Variation
	>=	13.92%		

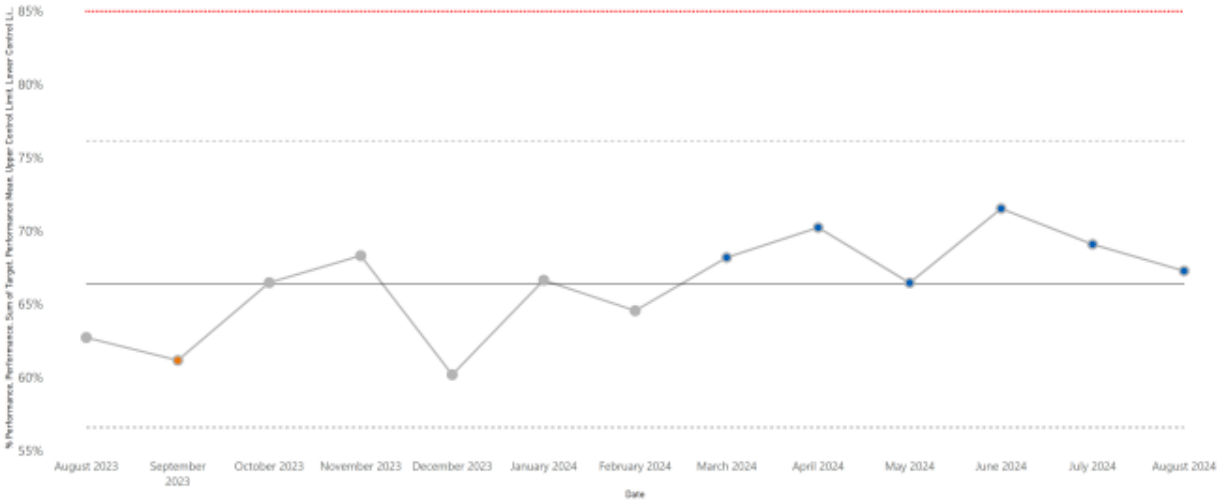


Operational Performance Benefits

Improve the Trust's Elective & Cancer Performance to reduce the amount of time patients are waiting for diagnosis and treatment

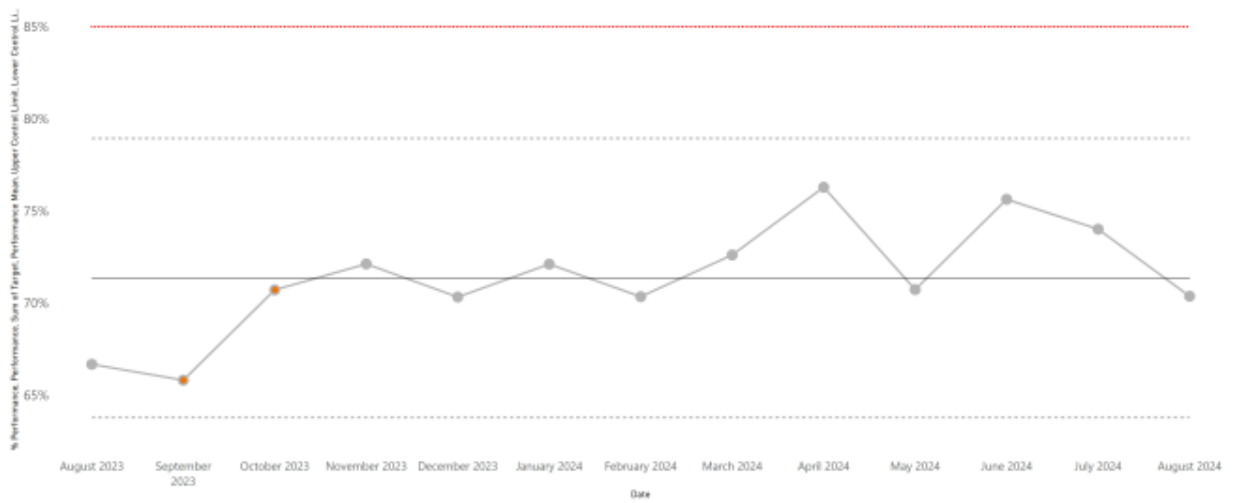
Capped Theatre Utilisation rate - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 85%	>=	67.27%	F	H



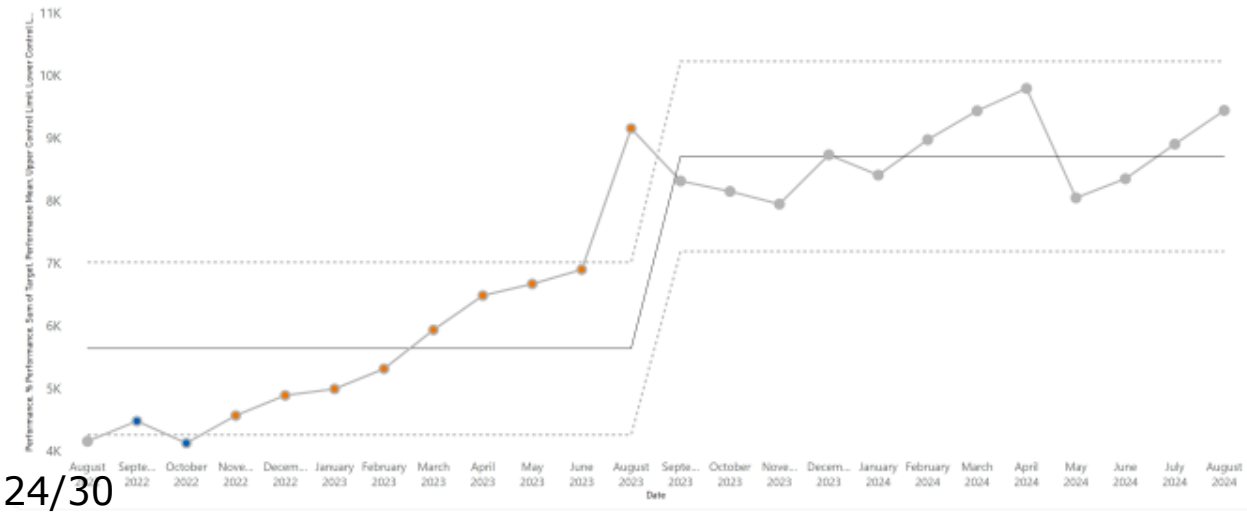
Uncapped Theatre Utilisation rate - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 85%	>=	70.38%	F	



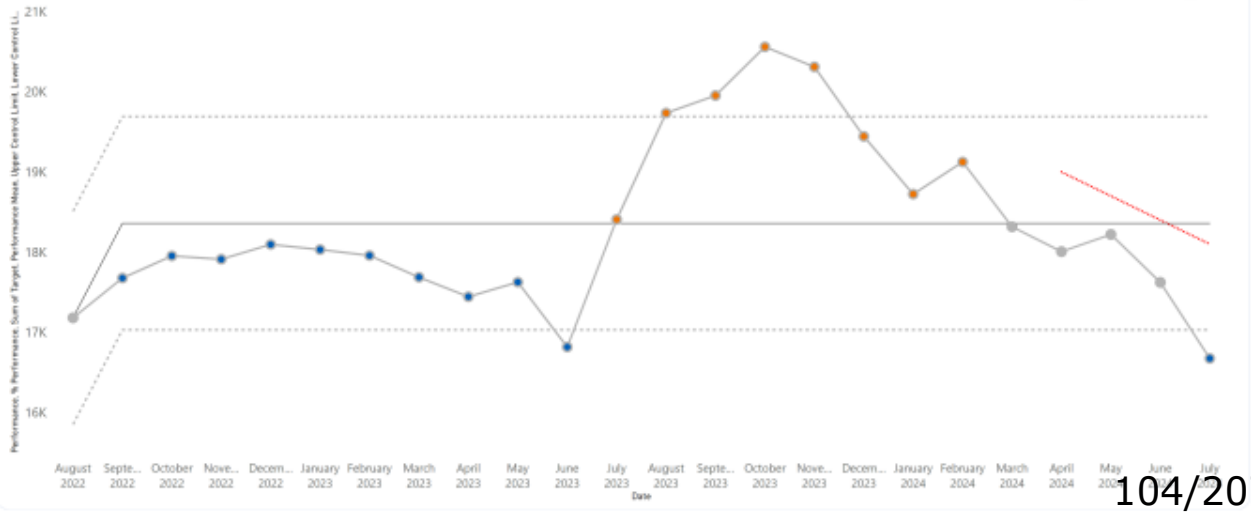
Number overdue follow up appointments - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
	<=	9443		



Overall size of active patient waiting list - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
<= 16500	<=	16675	?	L

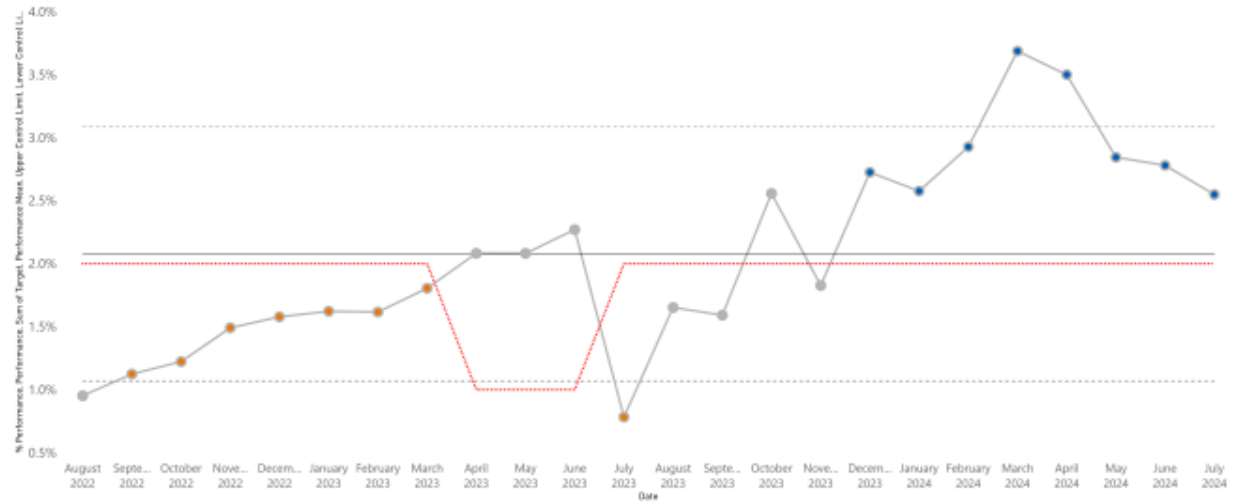


Operational Performance Benefits

Improve the Trust's Elective & Cancer Performance to reduce the amount of time patients are waiting for diagnosis and treatment

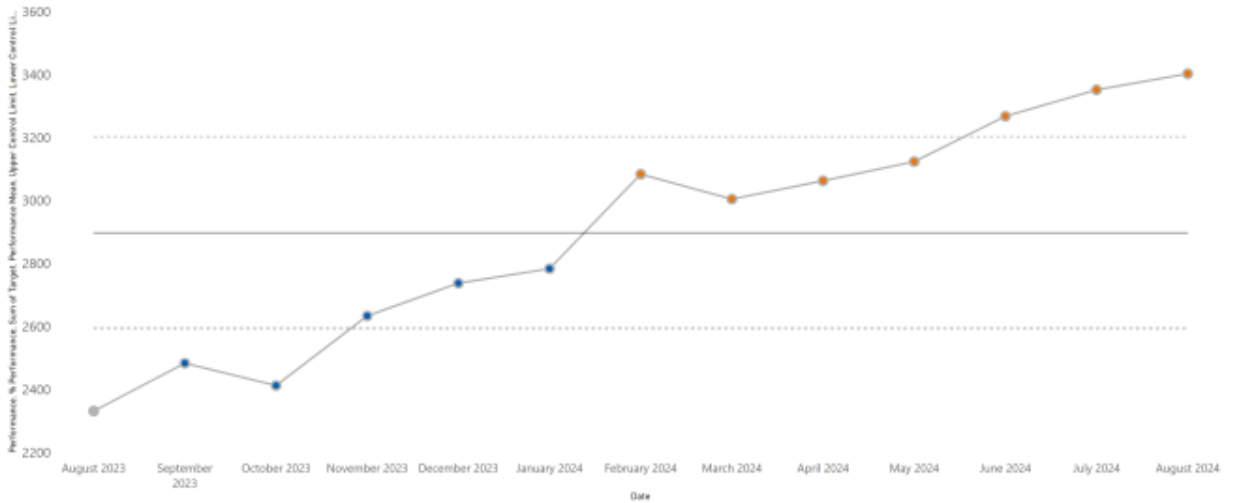
Moved or discharged outpatient attendances to PIFU pathways - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>=2%	>=	2.55%	P	H



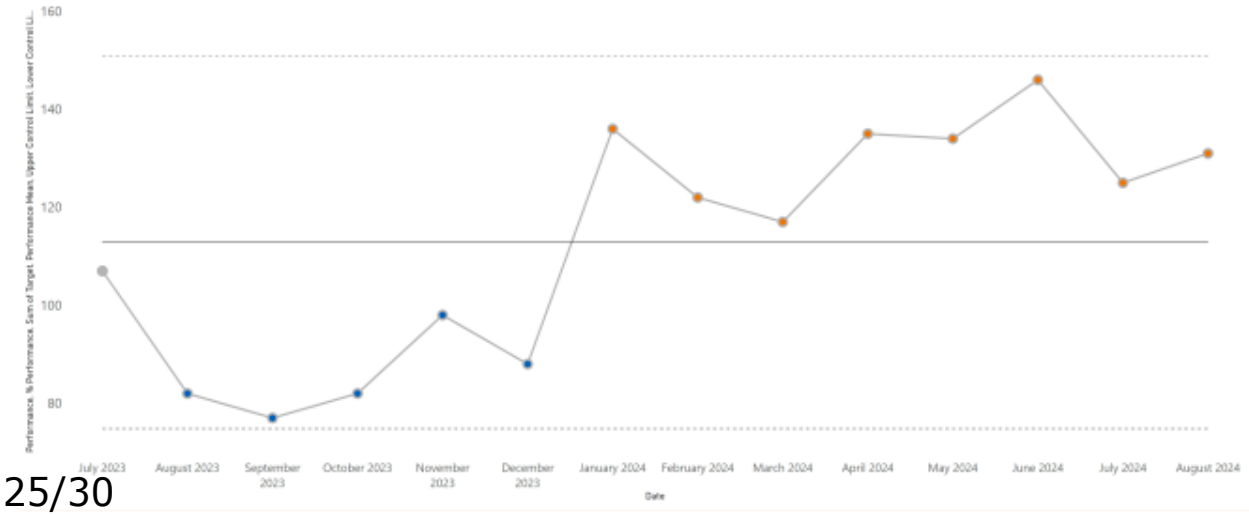
Overall size of the Inpatient Waiting List -

Target	Target < or >	Performance	Assurance	Variation
	<=	3403		H



1st Appointment Waiting Times -

Target	Target < or >	Performance	Assurance	Variation
	<=	131		H

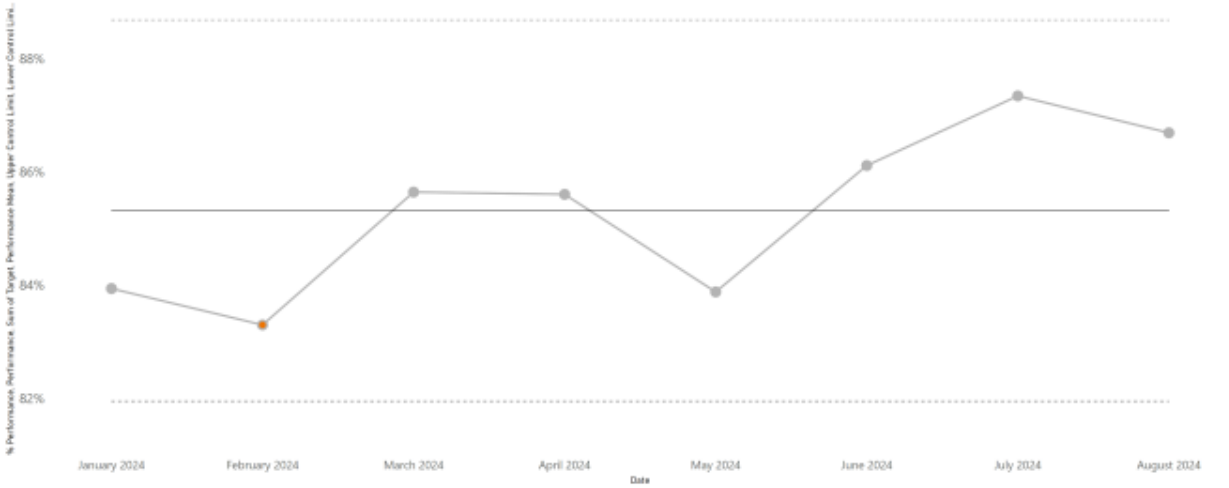


People & Culture Benefits

To drive a truly inclusive culture, underpinned by shared values and respect for diversity, with strong leadership and teamwork, and an openness to learning in a psychologically safe setting.

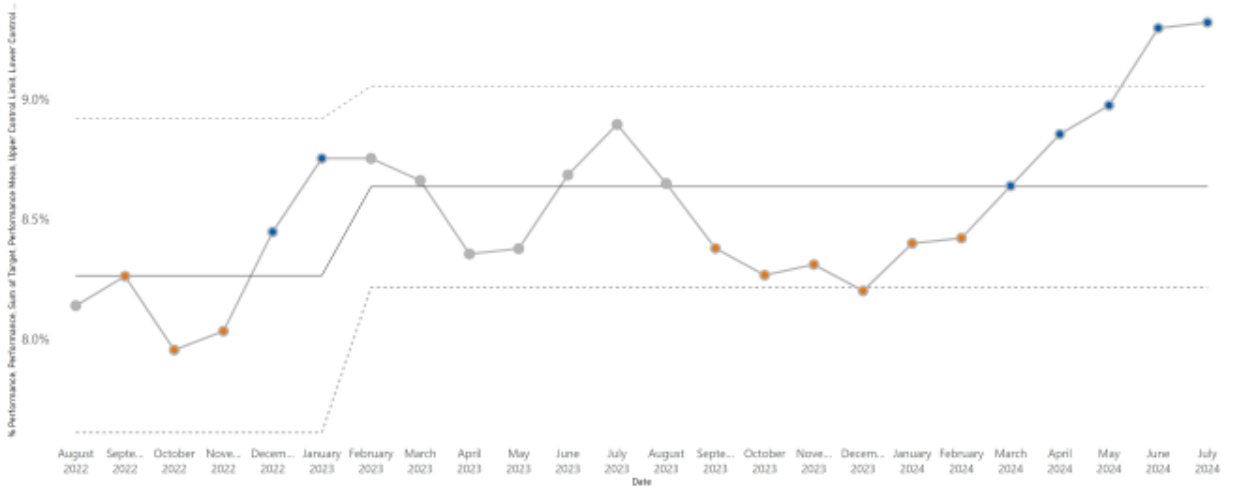
% of staff completing human factors training -

Target	Target < or >	Performance	Assurance	Variation
> = 90%	>=	86.69%		



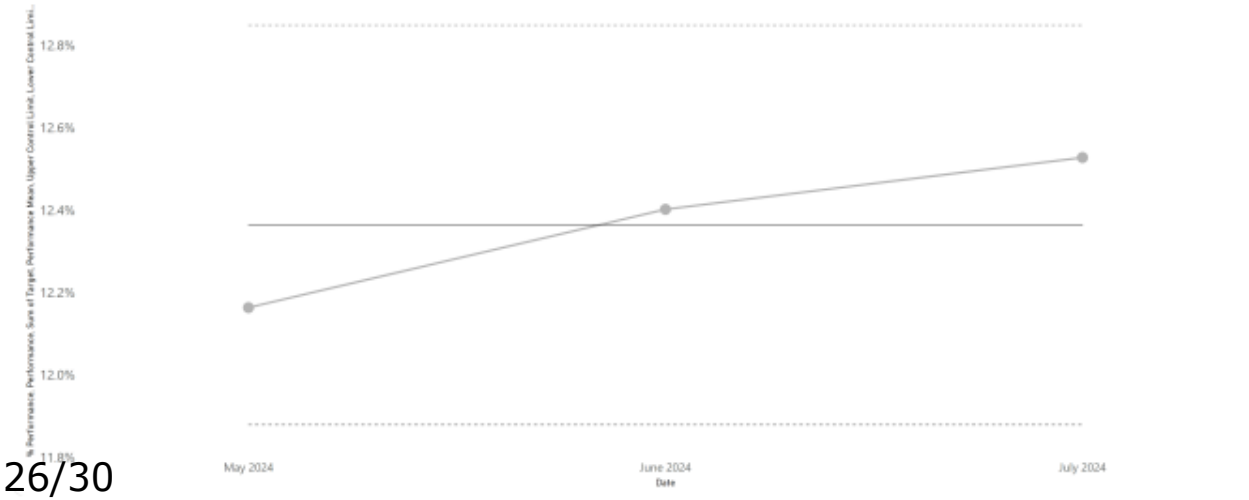
GM staff in leadership roles (B7 or above) - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
	>=	9.32%		



Overall GM staff in workforce - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
	N/A	12.53%		



OUR IMPROVEMENT PLAN

SAFETY | QUALITY | SUSTAINABILITY

NHS
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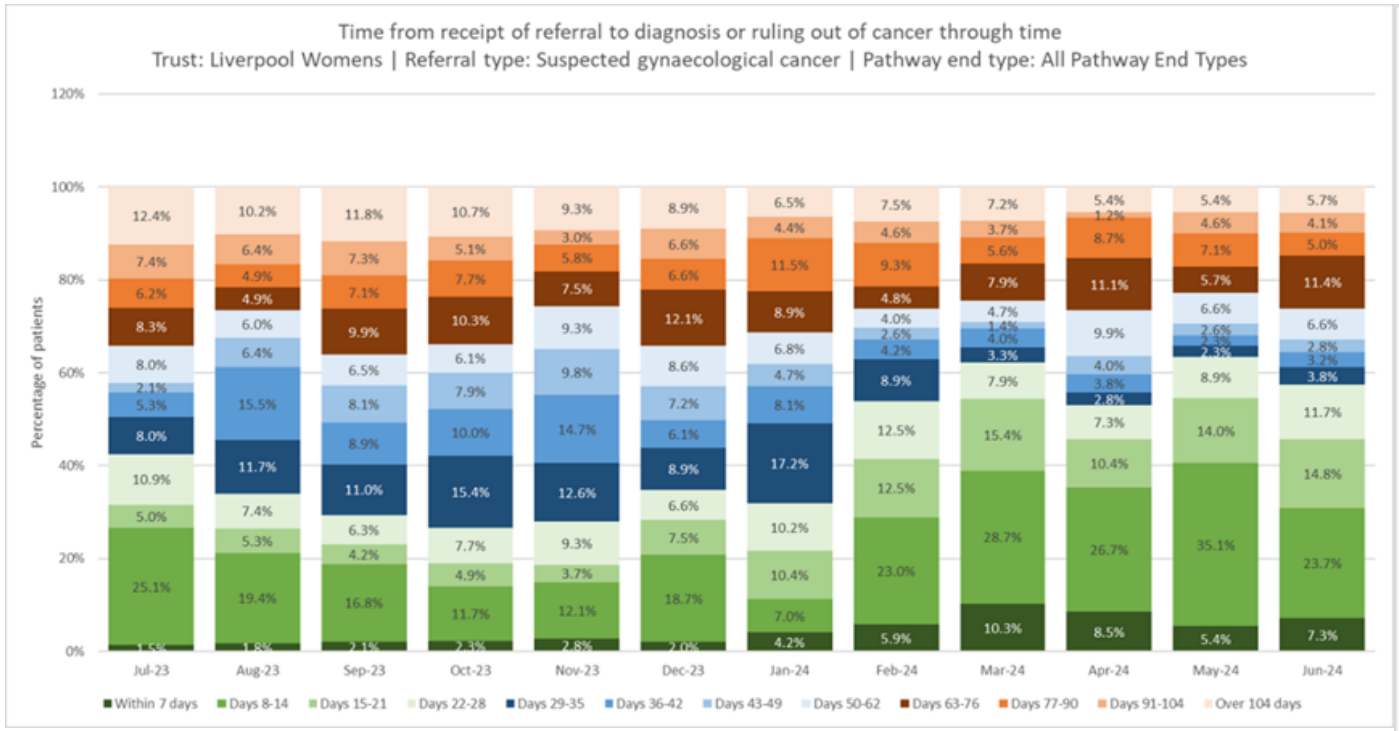
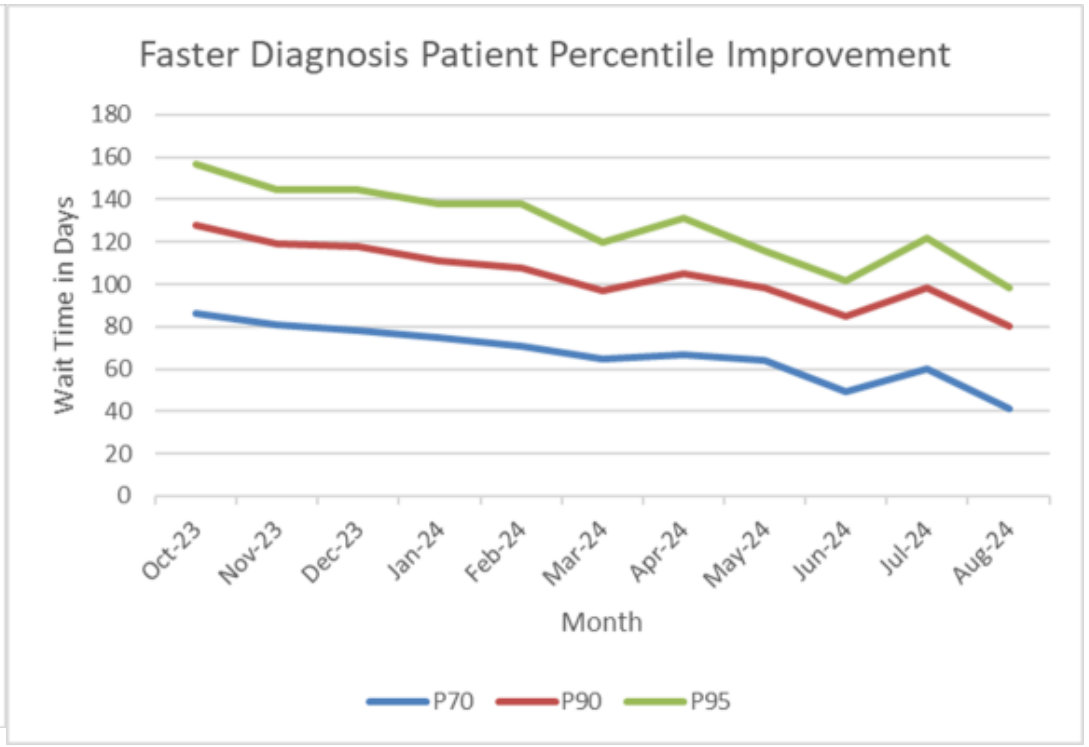
NHS Foundation Trust

Appendix 2 - Improvement Plan RAYG Definitions

Appendix 2 – Additional Cancer Metrics





OUR IMPROVEMENT PLAN

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Liverpool Women's
NHS Foundation Trust

Appendix 3 - Improvement Plan RAYG Definitions

Appendix 3 - Improvement Plan RAYG Definitions

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 12 September 2024	**Item Reference**	24/25/111a
Report Title	Maternity Incentive Scheme Year 6 – August 2024 Compliance Update		
Author	Angela Winstanley – Quality & Safety Matron Maternity Yana Richens – Director of Midwifery		
Responsible Director	Dianne Brown – Executive Chief Nurse		

Purpose of Report	This paper outlines the progress updates in relation to the defined 10 safety actions and standards of the Maternity Incentive Scheme Year 6. The paper provides a position statement for all 10 standards and clarity on Board reporting for the forthcoming year.
Executive Summary	This paper presents the requirements and progress required to achieve compliance with the ten safety actions and their associated standards for the Maternity Incentive Scheme Year 6. It is a requirement of the scheme that the Quality Committee and Trust Board receive regular reports highlighting progress against the 10 Safety Standards and that they ensure appropriate oversight, scrutiny, and support to ensure full compliance by the scheme **sign off on 03.03.2025.**
Key Areas of Concern	Identified Risk: There are concerns identified with the ability to meet the compliance targets within the medical workforce (Obstetric and Anaesthetic) of attendance at PROMPT and Fetal Surveillance Study Days due to ongoing industrial action (IA). A risk further posed is that of the availability of an MDT within the education faculty and the deliverance of PROMPT training days due to ongoing Industrial action. To mitigate this, staff who had planned to attend the cancelled session have been re-allocated to other PROMPT days, which in the short term is manageable. However, further cancellations and the potential requirement to deliver 'extra' sessions, in response to further IA, will mean taking the faculty away from clinical rota hours. With the uncertainty of future IA, and ability to deliver sessions to an MDT group, with an appropriate MDT faculty, this poses a risk to Year 6 Scheme compliance. This has been escalated to the Educational Governance Committee".
Trust Strategy and System Impact	The report aligns with the Trust's strategy by promoting quality improvement, patient safety, and workforce development. It supports the triple aim by enhancing patient outcomes, improving population health, and ensuring cost-effective, high-quality maternity care, ultimately contributing to overall healthcare excellence.

Links to Board Assurance Framework	*None*	***n/a***
Links to Corporate Risk Register (scoring 10+)	*NA*	***n/a***

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

Action Required by the Committee	The Board is asked to • Note the current position in relation to the recently published Maternity Incentive Scheme Year 6. • Note the identified risk to SA8 in relation to IA and delivery and compliance with PROMPT Training • Take assurance that the Family Health Division has clear oversight and management of the scheme requirements. • August 2024 NHS Resolution provided updates SA6, SA7 and SA8 no action required

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Divisional MIS Oversight Committee	Twice Monthly	Director of Midwifery	Weekly progress updates from scheme safety action leads.
Family Health Divisional Board	August 2024	Clinical Director for Family Health	Accepted and approved for submission to August 2024 Quality Committee.
Quality Committee	August 2024	Chief Nurse	Accepted and approved for submission to Trust Board.
LMNS Oversight	Quarterly	Head of Midwifery Quality & Safety Matron	Quarterly Oversight and Improvement Meeting in relation to Safety Action 6.

MAIN REPORT

INTRODUCTION

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

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

Trusts that can demonstrate they have achieved all ten safety actions and will recover the element of their contribution relating to the CNST maternity incentive fund and will receive a share of any unallocated funds. Since 2021, successful compliance of Maternity Incentive Schemes, NHSr has returned monies of over £5.5million to Liverpool Women's NHS Foundation Trust.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the maternity incentive (CNST) fund but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved.

The Trust Board must also be aware of the conditions of the scheme and are detailed in the April 2024 release. These are as follows:

- Trusts must achieve all ten maternity safety actions.
- The declaration form must be submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Head of Midwifery, Director of Midwifery and Clinical Director for Maternity Services
- The **Board Declaration Form** must be sent to NHS Resolution via email between **17th February 2025 and 3rd March 2025 at 12 Noon.**
- The Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO).

Family Health Division Scheme Management and Leadership

On 02.04.2024, NHSr published scheme guidance relating to Year 6 of the Maternity Incentive Scheme. The guidance contains the same ten safety actions, with reduction of some evidential requirements in comparison to year 5.

Each of the 10 safety actions has been allocated a senior lead who is responsible for ensuring their progress and delivery. Any risks to delivery are presented and overseen by the FHD MIS Progress and Escalation Group. This bimonthly meeting is chaired by the Director of Midwifery and the Quality & Safety Matron who will provide updates and assurance to the FHD Board, with regular reporting to Quality Committee and Trust Board as per schedule.

Regular meetings are held between the Trust leadership teams and the Local Maternity Neonatal System (LMNS) who act as oversight and scrutiny on behalf of the ICB. The meetings provide scrutiny and challenge, and as required eventual sign off, including evidence and data review.

ANALYSIS

10 Safety Actions – Current Position in relation to MIS Year 6 guidance

An updated table of MIS year 6 scheme progress can be found below: please note, boxes remain amber until such time the scheme period ends, and all evidence collated and validated.

- **Table 1 Current Position MIS for Year 6 – August 2024.**

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

Safety Action Point & Description	Required Standard	Status and Actions Required.
SA.1 Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	All eligible births and deaths (born and died at LWH), must meet the following conditions: A. All deaths have been reported to MBRRACE within the seven working day timeframe with **100%** of deaths having surveillance completed within one month to date from 08.12.2024 until 30.11.2024.	**August 2024 - This standard is on target to be achieved.** **100%** Compliance – 29 Deaths eligible for notification, at this time, all reported within the time frame required.
	B. **95%** of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 08.12.2023 onwards. - Parental perspectives of care and questions have continued to be collated by the Honeysuckle Team and incorporated into the PMRT reports – **97%**	**August 2024 - This standard is on target to be achieved.** **100%** Compliance – Of 29 cases reported, that are eligible for full PMRT review, all 28 families have been informed and perspectives of care sought.
	C. For deaths of babies who were **born and died** in your Trust multi-disciplinary reviews using the PMRT should be carried out from 08.12.2023. a) **95%** of reviews should be started within two months of the death. - **100%** Cases started within two months – 29 Cases all have had PMRT Reviews commenced. **b)** **60%** of multi-disciplinary reviews should be completed and published within six months. 16 Cases - Fully published within six months – NA at present. No issues identified. **100%** Compliance with this standard at this time.	**August 2024 - The FH Division needs to undertake additional actions to achieve this standard.** - 2 cases assigned to external Trusts, therefore unable to commence review at this time. No issues identified with timescales and team working in collaboration with external trusts. -Deaths reported in scheme period to be progressed to completed and published. The PMRT Team have weekly oversight to ensure that all reports are started within 2 months of the death and reports published within 6 months.

<table>
<tr>
<td></td>
<td>D) Quarterly reports submitted to Trust Executive Board from 08.12.2023.
<table>
<tr><th colspan="3">Learning from Perinatal Deaths Reports</th></tr>
<tr><th>Quarter</th><th>Received by Quality Committee</th><th>Received by Trust Board</th></tr>
<tr><td>Q2 2023 - 2024</td><td>January 2024</td><td>February 2024</td></tr>
<tr><td>Q3 2023 - 2024</td><td>April 2024</td><td>April 2024</td></tr>
<tr><td>Q4 2023 - 2024</td><td>June 2024</td><td>July 2024</td></tr>
<tr><td>Q1 2024 - 2025</td><td>July 2024</td><td>Sept 2024</td></tr>
</table>
</td>
<td>August 2024 - This standard is on target to be achieved.
Learning from Deaths Reports are scheduled for Quality Committee throughout the forthcoming scheme period.</td>
</tr>
<tr>
<td>SA.2 Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?</td>
<td>1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024. Final data for July 2024 will be published during October 2024

2. July 2024 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)</td>
<td>August 2024 - This standard is on target to be achieved.
NHS Digital issue a monthly scorecard to Trusts which is used by NHS Digital to assess whether each MSDS data quality criteria has been met.

Data has been submitted to the MSDS for July 2024, outcome awaited, anticipated in October 2024. No issues identified at this time.</td>
</tr>
<tr>
<td rowspan="2">SA.3 Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?</td>
<td>1 Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.</td>
<td>August 2024 - This standard is on target to be achieved.
Transitional Care pathways are embedded at LWH. A designated, five bed ward, located within the Maternity Base provides Transitional Care. A supporting Transitional Care on the Postnatal Ward SOP with admission criteria can be found on the Trust Intranet.</td>
</tr>
<tr>
<td>2 Drawing on the insights from the themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and the LMNS

Evidence Required:
- By 6 months into MIS Year 6, register the QI project with local Trust quality/service improvement team.
- By end of the reporting period, present an update to the LMNS and Safety Champions regarding development and any progress.</td>
<td>August 2024 - This standard is on target to be achieved.
The Family Health Division have a very well embedded ATAIN (Avoiding Term Admission into Neonatal Unit) and TC (Transitional Care) audit programmes. An identified theme from this audit noted an increase in babies at >37 weeks admitted to NICU with a degree of hypothermia. A QI Project has been registered and is progressing well within the Division – QI Proj / 0107.</td>
</tr>
</table>

SA.4 Can demonstrate an effective system of clinical workforce planning to the required standard?	**Obstetric Medical Workforce** 1. NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: - A) currently work in their unit on the tier 2 or 3 rota or - B) have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or - C) hold an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums **Evidence Required:** Trusts/organisations should audit their compliance via Medical Human Resources.	**August 2024 - The FH Division needs to undertake additional actions to achieve this standard.** 1. The Temporary Staffing Policy addresses the requirements of this safety action. Audit to be completed after 6 months of activity in November 2024.
	2. Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings. **Evidence Required:** Trusts should use the monitoring/effectiveness tool contained within the RCOG guidance to audit their compliance, using 6 months of activity from 02.04.2024 to 30.11.2024	**August 2024 - The FH Division needs to undertake additional actions to achieve this standard.** Audit to be completed, using the monitoring and effectiveness tool, after 6 months of activity. Audit findings to FFP if required, QC and Trust Board in November 2024. This action will remain amber until such time the scheme period ends and all evidence collated and validated.
	3. Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. **While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.** **Evidence Required:** Trusts/organisations should be working towards developing standard operating procedures, to assure Boards that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and senior SAS doctors about their ability to take appropriate compensatory rest in such situations	**August 2024 - This standard is on target to be achieved.** At this time, Currently, the Division of Family Health, do not employ specialty or specialist doctors and it is not anticipated in the next 12 months that any will be employed. The maternity consultants are job planned to work twilight shifts. This pattern of work factors in a minimum of 11 hours rest between shifts as evidenced in job plans. Emergency Cover Arrangements for Senior Medical Staff Covering Post
	4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations 27 listed in the RCOG workforce document: *'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'* into their service when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed	**August 2024 - This standard is on target to be achieved.**

	at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. **Evidence Required**: Trust positions with the requirements should be shared with the Trust Board, the Board-level safety champions as well as the LMNS.	Audits of compliance of consultant attendance continue within the Division. Consultant attendance at the situations listed in the RCOG guidance is directly monitored through Power BI with 6 monthly updates an action plan developed and sighted at FHDB, MRC and Trust Board in line with MIS Scheme requirements. The CD for FH has completed an audit of compliance with consultant attendance in the period July to Dec 2023, this data has been shared within the Division. An action plan has been developed and compliance continues to be monitored within the FHDB. See Appendix for full audit report. Previous Compliance: Jan to June 2022 – 81% Compliance July to Dec 2022 – 87% Compliance January 23 to June 23 – 93% Compliance. July to Dec 2023 – 82% Compliance.
	Anaesthetic Medical Workforce 1. A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) **Evidence Required:** The rota should be used to evidence compliance with ACSA standard 1.7.2.1, Trusts to evidence position by 30th November 2024.	**August 2024 - The CSS Division needs to undertake additional actions to achieve this standard.** A six-month period of anaesthetic rotas will be reviewed to assure there are no gaps in service provision. It is not anticipated there will be any gaps as the obstetric unit currently has 24/7 unit obstetric anaesthetic cover. This will be completed in October 2024. This action will remain amber until such time the scheme period ends and all evidence collated and validated.

	Neonatal Medical Workforce **1.** The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing or if the standards are not met, there is an action plan with progress against any previously developed action plans. **Evidence Required:** Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN). A review should be undertaken of any 6-month period between 02.04.2024 and 30.11.2024, in a time frame 6 months post April.	**August 2024 - The FH Division needs to undertake additional actions to achieve this standard.** The Neonatal Unit at LWH complied with the requirements of BAPM and was evidenced in scheme year 5 with a medical workforce review. An updated position and report will be provided to Trust Board in November 2024 and detailed minutes should be made available. This action will remain amber until such time the scheme period ends and all evidence collated and validated.
	Neonatal Nursing Workforce 1. The neonatal unit meets the BAPM neonatal nursing standards or if the standards are not met, there's an action plan with progress against any previously developed action plan. **Evidence Required:** The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).	**August 2024 - The FH Division needs to undertake additional actions to achieve this standard.** In January 2024, the Trust Board received a biannual staffing paper which contained the Neonatal nursing review using the CRG Workforce Calculator and action plan as per the Year 5 scheme. An update paper and action plan will be prepared and will be progressed through Family Health Division Board in September and to Trust Board in October 2024. This action will remain amber until such time the scheme period ends and all evidence collated and validated.
SA.5 Can demonstrate an effective system of midwifery workforce planning to the required standard?	A. A systematic, evidence-based process to calculate midwifery staffing establishment is completed. B. Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. C. The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having rostered, planned supernumerary co-ordinator and an actual supernumerary coordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	**August 2024 – This standard is on target to be achieved.** A refreshed Birth-rate Plus midwifery staffing report was received by Quality Committee and Trust Board in February 2024, covering the period July to December 2023, with all safety

	D. All women in active labour receive one-to-one midwifery care. E. Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.	action standards addressed and sign off full compliance completed. An updated paper, consisting of January to June 2024 data period, has been completed and has progressed through the FHDB. This paper has been tabled to be presented in July 2024 QC Agenda and Trust Board in September 2024.
SA.6 Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version 2?	1. Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLCV3 through quarterly quality improvement discussions with the ICB. **Evidence Required:** Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate. The Three-Year Delivery Plan for Maternity and Neonatal Services set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory. Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.	**August 2024 – This standard is on target to be achieved.** The Division have worked closely with the LMNS and have, to date, held **five** quality improvement discussions with scrutiny of progress monitored using the national SBLCBV3 Implementation Tool through the NHS Future Portal. In August 2024, the FHD reviewed their Q1 position in relation to SBLCBV3 and have uploaded all evidence and audits to support a continued strong position of compliance. The next LMNS SBL Oversight meeting is planned for 2nd September, where progress and quality improvements will be discussed. An updated position will be feedback to the Trust in mid-September 2024, which will reported to Trust Board in the October MIS Scheme Update.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	90%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Partially implemented	95%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	60%	CNST Met
Element 5	Preterm birth	Partially implemented	96%	Fully implemented	100%	CNST Met
Element 6	Diabetes	Partially implemented	83%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	94%	Partially implemented	94%	CNST Met

August 2024: Compliance with SBLCBV3 position as per LMNS validation. Next compliance position will be available in September 2024 update.

August 2024 Update from NHS Resolution:

"Regarding the requirement for a signed declaration from the Trust Executive Medical Officer in support of the Trust SBL compliance as agreed with the LMNS. If your Trust have continued to use the Implementation tool to support LMNS oversight, this separate SBL declaration will not be required. This step was introduced ensure that Trusts/LMNSs not using the implementation tool have robust assurances in place. We would expect to see oversight of the Trust SBL progress as agreed with the LMNS in your routine Trust Board maternity reporting."

Safety Action Lead Response: The FHD and SBLCBV3 Lead continued to meet on a quarterly basis with the LMNS in relation to the implementation of SBLCBV3. The LMNS Team and have a validated compliance position every quarter. These compliance positions have been and will continue to be reported in the MIS Scheme update and within the Perinatal Dashboard Paper. There will be no requirement for the MD to sign a declaration following updates from NHSR received August 27th 2024

SA.7 Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MNVP) to coproduce local maternity services?	1. Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting: a. Engagement and listening to families. b. Strategic influence and decision-making. c. Infrastructure. 2. Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board. **August 2024 - Update from NHS Resolution** "*We understand that in some circumstances the full CQC survey free text comments are not all available to Trusts. We understand from NHS England that this may be to ensure that the confidentiality of the survey respondent is protected. For this reason, we are changing the wording of this requirement slightly to accommodate this: Evidence of review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and, if available, free text analysis, such as an action plan.*" **Safety Action Lead Response**: Analysis of the free text available within the annual CQC report was reviewed by the Senior Leadership Team in collaboration with the MNVP and is reflected co-developed action plan. The main theme identified from this analysis was concerns raised in relation to midwifery staffing. Oversight of this action plan is completed in the Maternity Transformation Plan Workstream 1.	**August 2024 – This standard is on target to be achieved.** The CQC maternity Survey data (2024) has been shared with the MNVP and a fully co-produced action plan developed. Oversight of this action plan will be completed in the Maternity Transformation Programme Workstream 1, where MNVP are members. An annual workplan has been co-produced by the MNVP with the DoM and HoM. This has been shared with the LMNS through the Future NHS LMNS MIS oversite meetings This standard is now on target to be achieved. A review of all MNVP evidence in line with the Divisional CQC Action Plan Check & Challenge Meeting has provided assurance of safety action achievement.

SA.8 Can you evidence that at least 90% of each maternity unit staff group attendance an 'in-house' multi-professional maternity emergencies training session within the last year.

Requirements that 90% of attendance in each relevant staff group at:

1. Fetal monitoring training
2. multi-professional maternity emergencies training
3. Neonatal Life Support Training See technical guidance for full details of relevant staff groups.

ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for MIS. It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.

Evidence Required:

- Monitoring of attendance at each of the three training days using local held records or ESR
- Time period 01.12.2023 to 30.11.2024

CNST SA8	Staff Group	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Notes
SA 8b. MPMET	Midwives	96%	93%	94%	90%	89%	87%				All remaining midwives booked over 7 remaining sessions of 2024, before end of November.
	Maternity HCA	82%	80%	92%	88%	89%	84%				All HCAs booked over 7 remaining sessions of 2024, before end of November.
	Cons Obstetrician	87%	74%	50%	64%	59%	45%				2 Consultant Obstetricians yet to book before end of November. Have been contacted by Education Lead.
	Trainee Obstetrician	87%	91%	93%	90%	84%	39%				New rotation 7th August 2024. All obstetric trainees have been rostered to 7 remaining dates. No further planned rotations.
	Cons Anaesthetist	100%	82%	82%	82%	76%	76%				Static % noted – Two Consultant Anaesthetists attended in last 2 months that had not yet expired. All Consultants have booked onto remaining dates.
	Trainee Anaesthetist	47%	53%	28%	24%	35%	25%				New rotation every 3 months. Of the 4 remaining all have attended this year. The new starters commenced after 1st August. All new trainees booked over Sept and Oct by Linda Dowling. New rotation 1st November – Linda aware all will need to attend either of the 2 dates in Nov.
SA 8c. Fetal Surveillance	Midwives	91%	92%	93%	92%	94%	94%				All midwives booked over 6 remaining sessions of 2024, before end of Nov 2024
	Cons Obstetrician	81%	68%	50%	72%	72%	77%				All Consultant Obstetricians booked to attend training dates.
	Trainee Obstetrician	94%	93%	93%	90%	91%	33%				New rotation 7th August 2024. All obstetric trainees have been rostered to 6 remaining dates. No further planned Obstetric trainee rotations.
SA 8d. NLS	Midwives	96%	93%	94%	90%	89%	87%				Delivered on PROMPT - All midwives booked over 6 remaining sessions of 2024, before end of Nov 2024
	Cons Neonatologist	100%	90%	100%	100%	100%	100%				
	Trainee Neonatologist	100%	100%	100%	100%	100%	100%				
	ANNPs	93%	97%	97%	100%	100%	100%				
	Neonatal Nurses	93%	93%	100%	97%	96%	98%				Remaining 3 staff booked for training sessions planned before end of scheme period.

Table 2 (Above) – August 2024 Updated MPMET/PROMPT and associated training attendance.

August 2024 - The FH Division and CSS Division need to undertake additional actions to achieve this standard.

The Trust have invested in the PROMPT model of MDT training within Family Health. PROMPT provides training for maternity units, helping midwives, maternity support workers, obstetricians, anaesthetists and other members of the maternity team to provide safe and effective obstetric care to women and babies. Table 2, outlines the current training compliance, up to 31st August with MPMET, Fetal Surveillance Day and New-born Life support.

Identified Risk: There are concerns identified with the ability to meet the compliance targets within the medical workforce (Obstetric and Anaesthetic) attendance at PROMPT and Fetal Surveillance Study Days due to ongoing industrial action (IA). A risk further posed is that of the availability of an MDT within the education faculty and the delivery of PROMPT training days because of ongoing IA. To mitigate this, staff who had planned to attend the cancelled session have been allocated to other PROMPT days, which in the short term is manageable.

However, further cancellations and the potential requirement to deliver 'extra' sessions, in response to further IA, will mean taking the faculty away from clinical rota hours. With the uncertainty of future IA and ability to deliver sessions to an MDT group, with an appropriate MDT faculty, this poses a risk to Year 6 Scheme compliance. This has been escalated to the Educational Governance Committee to the People and Organisational

	Monitoring of attendance at each of the three training days using local held records or ESR **August 2024 – NHS Resolution Update**. *"In response to feedback from Trusts expecting a large proportion of their rotational trainees to commence with them in October this year, and to support Trusts to forward plan their training and ensure they are able to provide multi-disciplinary team training throughout the whole year, we have provided the following update to the training compliance for rotational medical staff:* *90% compliance is required for all rotational medical staff that commenced work with the Trust prior to 1 July 2024 by the end of the 12-month MIS reporting period (1 December 2023 to 30 November 2023). For rotational medical staff that commenced work on or after 1 July 2024 a lower compliance will be accepted, provided there is a commitment and action plan approved by Trust Boards and recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust. Evidence from rotating trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12-month period) will be accepted in line with the attached flow chart and the MIS year six technical guidance".* **Safety Action Lead Response:** The Safety Action Leads and Education Team have anticipated a drop in compliance due to the rotation of both obstetrician and anaesthetists in training. There are now no further obstetric trainees, expected to be rotated into the unit, with all remaining outstanding trainees booked onto planned sessions. The next rotation of anaesthetic trainees, anticipated in November will be booked on the two remaining dates in November, with the anaesthetic rota co-ordinator and safety action leads in close communication. If required, an action plan can be developed, and Trust Board sign off in the November 2024 update paper, as outlined in the NHSR Update received in August 2024	Development Executive Group and is an identified risk of the risk register". This action will remain amber until such time the scheme period ends and all evidence collated and validated.
SA.9 Can you demonstrate that there are robust processes in place to provide assurance to the Board on Maternity and neonatal safety and quality issues?	A) All Trust requirements of the Perinatal Quality Surveillance Model must be fully embedded. B) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings. **Evidence Required for Point A and B** ▪ Evidence that a non-executive director (NED) has been appointed and is working with the Board Safety Champions to develop trusting relationships between staff, the frontline maternity, neonatal and obstetric safety champions, the	**August 2024 - The FH Division needs to undertake additional actions to achieve this standard.** The Quality Committee and Trust Board receive the Perinatal Quality Surveillance Dashboard, and Integrated Governance paper detailing, themes and trends in relation to PSII, Ulysses Incidents, Complaints and legal updates. This must continue in order to provide assurance of oversight of Maternity Services at divisional and Trust Board level.

	perinatal leadership team 'Quad', and the Trust Board to understand, communicate and champion learning, challenges, and best practice. ▪ Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (**or an appropriate Trust committee with delegated responsibility**) using a minimum data set at every meeting. This should be presented by a member of the **perinatal leadership team** to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback. ▪ Evidence of collaboration with the LMNS/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM. ▪ Evidence of ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than July 2024. ▪ Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.	The Family Health Division, with the LMNS Team, attend shared meetings where trust and system level intelligence are shared. The newly introduced Maternity Safety Oversight Group, Saving Babies Lives Oversight Meeting, Quality Safety Surveillance Group and LMNS Touch Point Meetings are examples of meetings that members of the FHD attend. The Trust meets regularly with our partners in the LMNS and NHSE at a monthly oversight meeting. The Safety Champions and MNVP undertake monthly walkarounds and engage with staff. Details of safety escalations discussed and logged at the Safety Champions Meeting and feedback to staff is completed through a wide variety of comms channels. The Annual Legal Claims Scorecard is regularly reviewed, and all closed, ongoing and settled legal claims are regular reviewed at both the Maternity Risk & Governance meeting in addition to the Family Health Divisional Board. Details of learning from Legal Claims are regularly communicated to staff via a number of routes and local MPMET/PROMPT training is based on locally identified cases.
	C) All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures. **Evidence Required**: Evidence that the Maternity and Neonatal Board Level Safety Champions (BLSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering relevant support where required.	**August 2024** - The HoM and DoM, both integral part of the perinatal quadrumvirate team, attend the monthly Safety Champions Meeting, where the BLSC is in attendance. This action will remain amber until such time the scheme period ends and all evidence collated and validated.

SA.10 Have you reported 100% of qualifying cases to MNSI and NHS Resolution's Early Notification (EN) scheme?	A) Reporting of all qualifying cases to MNSI from 08.12.2023 to 30.11.2024 B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 08.12.2023 to 30.11.2024 C) For all qualifying cases which have occurred during the period 08.12.2023 to 30.11.2024, the Trust Board are assured that: i. the family have received information on the role of MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	**August 2024 - The FH Division needs to undertake additional actions to achieve this standard.** There have four cases reported MNSI at the time of this report, all of whom have been informed of NHSr and EN scheme requirements in the duty of candour process. An update of compliance will be maintained through the scheme year within this update report and full breakdown of MNSI, NHSr and Duty of Candour information will be provided in December 2024. The Division must continue to report all cases that meet the criteria for MNSI and EN and continue to work closely with out legal colleagues to ensure that all updates are reported to the CR Wizard. This action will remain amber until such time the scheme period ends and all evidence collated and validated.

Equality, Diversity & Inclusion Implications

The Maternity Incentive Scheme and its ten safety actions, aim to reduce variation in the provision of care in NHS Maternity Care. The safety actions are designed to enable Trusts to develop robust assurance processes in relation to clinical care and its delivery. It is designed to have a positive impact on pregnant women and their families. Upon review of the whole Maternity Incentive Scheme, it's clear that the safety actions are designed to be inclusive, span across a wide range of disciplines, staff and service users groups. It mandates Trusts to ensure that there are clear strides being taken to reduce inequalities and therefore improve access to and provision of maternity care.

There do not appear to be any negative impacts on the protected characteristics.

Quality, Financial or Workforce implications

Failure to comply with all 10 safety standards within the scheme, can pose a risk to the deliverance of safe and effective maternity & neonatal care and as such invite increased oversight from external regulators and stakeholders. As outlined in the introduction, failure to comply with all 10 safety actions will lead to a non-re-imbursement of 10% of the Trusts annual contribution to the CNST premium.

RECOMMENDATION

The Board is asked to:

- Note the current position in relation to the recently published Maternity Incentive Scheme Year 6.
- Note the identified risk to SA8 in relation to Industrial Action and delivery and compliance with PROMPT Training
- Take assurance that the Family Health Division has clear oversight and management of the scheme requirements.
- Note the updates to SA6, SA7 and SA8 in relation to the August 2024 NHS Resolution Update to the scheme.

SUPPORTING DOCUMENTS

Trust Board

COVER SHEET

Meeting Date	Thursday, 22 August 2024	**Item Reference**	24/25/111a
Report Title	**Perinatal Quality Surveillance & Safety dashboard**		
Author	Clare Murray Governance Lead Manager Family Health Division Angela Winstanley – Quality & Safety Matron Heledd Jones, Head of Midwifery		
Responsible Director	Dianne Brown, Chief Nurse		

Purpose of Report	This report will: Inform the Quality Committee of key quality & safety KPIS as outlined in the NHS England Perinatal Quality Surveillance Framework. Provide evidence of compliance with interventions as detailed within MIS Year 6, Safety Action 9, where evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set at every meeting.
Executive Summary	The dashboard includes the minimum dataset as described within the NHS England framework and as mandated by the Maternity Incentive Scheme (MIS), in addition to local insights, operational activity, and workforce.
Key Areas of Concern	Induction of Labour KPIs and Red Flags remain under scrutiny within the Division, with data showing some minimal improvements.
Trust Strategy and System Impact	To deliver safe services To be ambitious and efficient and make the best use of available resource.

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 Family Health Division requests that the Board receive this paper and seek assurance that perinatal quality surveillance and safety is a key Divisional priority, and evidence of ongoing progress and compliance with the implementation of a Perinatal Quality Dashboard and Framework.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

MAIN REPORT

INTRODUCTION

In December 2020, following the publication of the Ockenden Report, Trusts were mandated to plan and implement a new quality surveillance model.

implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk)

This model proactively seeks to identify trusts that require support before serious issues arise. Implementation of a new quality surveillance model seeks to provide for consistent and methodical oversight of all services, specifically including maternity services. The model has also been developed to gather ongoing learning and insight, to inform improvements in the delivery of perinatal services. Provider Trusts and their Boards, supported by the senior maternity and neonatal triumvirate and the board-level perinatal safety champion at its centre, ultimately remain responsible for the quality of the services provided and for ongoing improvement to these. As part of the guidance, the development of a locally agreed dashboard was mandated to include, as a minimum, the measures set out within the screenshot below. This enables the drawing out of locally collected intelligence to monitor maternity and neonatal safety at board meetings. This dashboard should form part of the discussion held at Board Level with respect to maternity and neonatal safety issues, as set out within the national guidance.

The Year 4, Maternity Incentive Scheme (MIS) introduced the perinatal surveillance dashboard reporting to Trust Board as a mandatory element of the scheme.

The MIS Year 6 Scheme details the Trust Board and Maternity & Neonatal Service requirements within safety Action 9.

“Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set at every meeting. This should be presented by a member of the perinatal leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback”.

In all NHS Trusts who provide Maternity & Neonatal Care, in order to comply with MIS Year 6 Scheme are mandated for this to continue, therefore this report is produced in line with the Perinatal Quality Surveillance Model designed by NHS England to support sharing safety intelligence Board to Frontline / Frontline to Board. The dashboard includes the minimum dataset as described within Maternity Incentive Scheme (MIS) and the NHSE perinatal quality surveillance model, in addition to local insights, operational activity, and workforce.

Perinatal Safety Surveillance Dashboard - Data to July 2024.

The table below, demonstrates key safety KPIs (key performance indicators), as recommended by NHS England in the perinatal quality surveillance model (see link document on page 3) to be reported to Trust Board. In order to achieve standardisation of reporting across the LMNS, the Division have requested further information from our collaborative partners at the LMNS (Local Maternity and Neonatal System) and WHaM (Women's Health and Maternity) to consider co production of a standard set of quality and safety KPIs for the Cheshire and Mersey system to ensure uniformity across all providers.

In Q4 23/24 the stillbirth rate was 1.1% per 1,000, demonstrates a downward trend in our SB rate, with rates now lower than we saw in pre-covid years for two consecutive months.

A QI project has been launched as part of saving babies lives care bundle to reduce term admissions to NNU.

	Metric	Standard/ National Standard	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Perinatal	1:1 Care in Labour	100% CNST	100.00%	100.00%	100.00%	100.00%	99.70%	99.57%	100.00%	100.00%
	Stillbirth Number >24 weeks (Adjusted)	Actual Number	2	1	1	0	2	3	2	2
	Stillbirth Adjusted % per 1,000 Birth		5.10%	5.20%	1.72%	3.40%	3.40%	0.00%	4.63%	3.24%
	Apgar <7 @ 5 Minutes (>37wks)	<1.6%	1.30%	1.53%	1.48%	1.32%	1.06%	1.21%	1.54%	2.01%
	Term Admission to NICU	<6%	5.11%	4.66%	4.87%	6.25%	3.90%	5.55%	4.62%	6.93%
	Women in receipt of COC	No standard	18.80%	16.96%	20.92%	19.52%	19.57%	17.06%	22.87%	17.45%
	BAME in receipt of COC	No standard	39.60%	32.22%	43.68%	37.00%	33.70%	37.62%	42.57%	27.50%
	Social Depravation of CoC	No standard	20.62%	18.69%	20.92%	22.06%	24.32%	17.36%	22.87%	20.12%
	Total number of women attended by anaesthetist after request for an epidural within 60 minutes	>=90%			91.20%	91.20%	91.20%	91.89%	89.32%	89.26%
	Coroner Reg 28 Made to Trust	Actual Number	0	0	0	0	0	0	0	0
	MNSI Referals Accepted	Actual Number	1	0	0	1	0	0	0	2
Workforce	MNSI Completed Reports Returned	Actual Number	0	2	1	0	1	0	0	2
	Supernumary Shift Leader	100% CNST	100%	100%	100%	100%	100%	100%	100%	100%
	Midwifery Sickness	% of Workforce <=5%	8.61%	7.91%	7.09%	5.95%	5.42%	5.20%	6.40%	7.10%
	Midwifery Vacancy	% of Workforce	2.20%	0.00%	0%	0%	0%	0%	0%	0%
Feedback	Rostered Cons Hrs on DS	>60	106.5	106.5	106.5	106.5	106.5	106.5	106.5	106.5
	Number of Formal Complaints	Actual Number	1	1	1	1	3	1	4	2
	Number of Maternity Incidents over 30 days	Actual Number	26	26	45	28	43	43	43	43
	Number of PALS/PALS +	Actual Number	43	43	36	29	0	36	36	38

Perinatal Quality Surveillance & Safety Narrative – July 2024.

Midwifery Red Flags:

94 red flags were reported during July 2024, a further increase from the 67 reported in June 2024. The delays pertain to three specific categories:

Reason	Number
IOL>12 hours	70
30-minute triage	16
IOL >2 hours of arrival	8

The Midwifery red flags reported in July were the highest numbers seen this year and is reflective of the unit acuity and occupancy position. The number of Induction of labours performed during July 24 was 230 compared to 178 in June 24. In addition, throughout July the Division reported its highest sickness rates at 7.1 % for maternity (6.9% overall) and c – section delivery rates had increased in month due to additional WLI session performed every weekend throughout July. The delays to triage occurred over two separate shifts which seen an increase in footfall through the department unexpectedly. A full root cause analysis has been undertaken. No harm was reported for each of the delays.

March	April	May	June	July
Total IOLs = 190 (46 delays of >12 hrs) = Approximately 24%	Total IOLs = 190 (46 delays of >12 hrs) = Approximately 24%	Total IOL= 178 (58 delays >12 delays Approximately 33%	Total IOL = 178 (20 delay > 12 hours) Approximately 11 %	Total IOL = 235 (70> 12 hours Approximately 29.78%

There are several QI projects ongoing within Maternity services to address IOL delays. A dedicated midwifery improvement lead has been appointed into post and a multidisciplinary task and finish group improvement approach has been adopted. A number of key interventions have been introduced: including but not limited to, updated IOL Guidance co-produced with the MNVP, estates reconfiguration in relation to IOL Suite to improve environment and enhance patient experience when delays occur, which in turn has created an additional bay within Intrapartum Area. Additionally we have introduced alternative methods of IOL for non-hormonal induction, pre-labour aromatherapy and acupressure clinics. A real time Induction of labour interactive whiteboard is currently 'under development' which will allow Family Health Division to respond to delays in induction of labour prospectively and this will also be discussed on twice daily staffing huddles.

Midwifery red flags are reported on the Trust Board Bi-Annual Staffing Reports, of which the Trust Board and Quality Committee are expected to receive later in the year.

MNSI Referral Details:	Two cases required external reporting to MNSI throughout July 2024. Five cases are currently under investigation by MNSI. All cases are on track and progressing within the allotted timeframes set out by MNSI. In this reporting period the Trust received one draft report for Family Health and factual accuracy process has commenced.
Maternity Serious Safety Incidents	There were no PSII declared in July 2024 for the Maternity Division. There are 57 incidents that remain open 30 days after they were reported onto the system, all incidents are in the process of being reviewed, triaged and investigated further where required. The Division continues to support managerial and lead clinician and staff to ensure timely review and closure of clinical incidents. All incidents are reviewed daily (Monday to Friday) at the Trust daily huddle where any issues for escalation are highlighted. There are currently 2 staff members currently providing focused support for reviewing and investigating the incidents in the web holding file. The Divisional Governance Team provide support and guidance for any member of staff that needs assistance in updating or closing incidents. A breakdown of the Web Holding File is presented to the Family Health Divisional Board for oversight and assurance.
Perinatal Mortality.	Number of Stillbirth Perinatal Deaths in June and July 2024: 2 Number of Neonatal Perinatal Deaths in June and July 2024: 0 All cases have been reported to MBRRACE and parental support continues to be provided by the Honeysuckle Team. The process for reporting PMRT cases has been reviewed and strengthened, particularly in Neonatal, to ensure all timeframes are met and reviews are held in a timely manner. The annual stillbirth rate for 2023/2024 has demonstrated a decrease in the stillbirth rate, now at 1.1%. In comparison with pre-covid rates, of the 2019/2020 of 1.7%. This is a significant improvement and is the lowest stillbirth rate LWH have reported for 6 years. The Neonatal teams are reporting all deaths within the unit on the Ulysses system for oversight and understanding of the numbers.
FHD Risk Register.	All maternity risks are monitored at the Family Health Divisional Board and at the Liverpool Neonatal Partnership) LNP Operational Programme Board, to demonstrate mitigation and provide assurance that risks remain on track. Family Health Division have a total of 44 open risks on the Risk Register, with Maternity services holding 36 of the risks and Neonatal holding. 8. All Risk Status have been reviewed and are in date, with risk owners using protected time with the Governance managers to monitor and updates risks, actions and controls where necessary.

	A new Risk Management process was implemented in the Trust on 1 May 2024 and as a result, all risks have been reviewed, their scores. refreshed in line with the new 5+5+5 matrix and aligned to the current risks sat within the Division.
Family Health Safety Champions.	A Safety Champions walkaround took place on 14 August 2024 with the Quality and Safety Matron and Board Level NED Safety Champion. Meetings have been booked until April 2025 and have included an out of hours walkabout to engage as many staff as possible. The Divisional Manager and Head of Midwifery attend the monthly safety champions meeting, where updates on the perinatal quadrumvirate programme are provided.
MNVP Feedback.	Meetings are held on a fortnightly basis. A 15 steps review was undertaken in Delivery suite with positive feedback and some actions. highlighted, and an action plan formulated by Midwifery Manager and Matron. Key messages have been fed back to FHDB and Staff Quarter 2 meeting has been arranged for 9 September. The MNVP have met with the HoM and DoM to discuss the annual co-production workplan and the CQC Patient Survey SMART Action Plan, a key element of Safety Action 7 in the MIS Year 6 scheme.
Midwifery Sickness	Sickness across the division remained largely static at 6.9%. There was a slight increase in Maternity from 6.4% to 7.1%. The weighting of short term and long term in Maternity is similar to May and June with a slight shift towards increased long term absence at 59.4% (3% increase) 40.5% short term. For Neonates absence remained static at 6.5% which is weighted towards long term absence 63% to 36% short term. Reasons for absence remained the same with an increase in absences due to Covid-19 (9) Return to work compliance in Maternity reduced to 46%. This requires immediate attention a list of those not completed will be circulated. Compliance for Neonates remained static at 78%. Sickness in the Obstetric Medical Teams decreased to 2.7% HR support is in place for long term absence. There was no absence in the neonatal medical workforce.
Saving Babies Lives	On 03.06.2024, the FHD met with the LMNS and received positive feedback in regard to continued progress of implementation of SBLCV3 and received assurance from the LMNS. A full compliance table will be provided for the Trust Board and Quality Committee within the MIS Year updated paper.

RECOMMENDATION

The Family Health Division requests that the Board receive this paper and seek assurance of ongoing compliance and progress with the implementation of a perinatal quality dashboard and framework.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 12 September 2024	**Item Reference**	24/25/111b
Report Title	Midwifery Staffing report 1st January- 30th June 2024		
Author	Heledd Jones, Head of Midwifery		
Responsible Director	Dianne Brown, Chief Nurse		

Purpose of Report	CNST MIS Year 6, Safety Action 5 requires submission to Trust Board on a 6 monthly basis of a midwifery staffing oversight report that covers staffing/safety issues (in line with NICE midwifery staffing guidance). Included in the report is a breakdown of Birth Rate+ (workforce planning tool for midwifery) and funded establishment for financial year 24/25, demonstrating compliance with outcomes of Birth Rate+ audit 2023. For reporting period January-June 2024 included in the report is the midwife to birth ratio, evidence from the maternity clinical dashboard demonstrating compliance with supernumerary labour ward co-ordinator on duty at the start of every shift and the provision of one-to-one midwifery care in active labour.
Executive Summary	The report highlights the following areas for discussion and noting (January-June 2024): • LWH midwifery and MSW budgeted posts for financial year 2024/25 equates to 353.53wte, demonstrating compliance with outcomes of Birth Rate+ audit 2023. • Budgeted posts are inclusive of 23% headroom for midwives and 21.4% uplift for MSW. • Nil vacancy rate for midwives in month 3 (FY24/25). • Sickness absence rate in June 2024 is 6.43% which is above the Trust target rate of 4.50%. • Midwife: Birth ratio in June 2024 is 1:23 against a BR+ audit recommendation of 1:23. • There were 268 midwifery red flags reported between January-June 2024 which is an increase of 56 from the previous reporting period (July-December 2023) where 212 red flags were reported. Majority of the red flags relate to delays in ongoing Induction of Labour, owing to capacity and demand. An induction of labour Quality Improvement project is ongoing with estates work scheduled to be completed in July to create a separate IOL area consisting of 5 rooms. This will help to improve patient flow on Delivery Suite to be able to expedite IOL patients to continue the process whilst also improving the patient experience. • Supernumerary shift co-ordinator on Delivery Suite is maintained at 100% for the past six months. • 1:1 care in labour achieved a compliance rate of 99.56% - 100% in the reporting period, against a standard of 100% (total of 3 women did not receive 1:1 midwifery care in established labour).
Key Areas of Concern	No areas of concern to highlight.

Trust Strategy and System Impact	• *The health and wellbeing of the people of England (including inequalities in that health and wellbeing)* • *To deliver the best possible experience for patients and staff* • *To deliver safe services*

Links to Board Assurance Framework		
Links to Corporate Risk Register (scoring 10+)		

Assurance Level	1. HIGH - Strong system of internal control applied to meet existing objectives

Action Required by the Committee	The Trust Quality Committee is asked to receive and note the information provided in this paper and take assurance for how safe staffing is managed, recruited, and retained to keep women and babies safe within Maternity services.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

MAIN REPORT

INTRODUCTION

To provide the Trust Board with a six-monthly update of the 2024/2025 staffing establishment reviews in relation to midwifery workforce requirements. To report against the workforce requirements identified in 2024/2025 to achieve safe staffing across Maternity Services in the Trust.

ANALYSIS

1.0 Workforce planning- Birth Rate Plus

The Maternity Incentive Scheme (MIS) Year 6 Safety Action 5 requires that Trusts demonstrate an effective system of midwifery workforce planning. Birth Rate Plus (BR+) is a recognised tool for workforce planning and strategic decision-making. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour.

A Birth Rate plus refresh audit was completed in April 2023 and the report received in May 2023. Included in the assessment is the staffing required for antenatal, intrapartum, and postnatal inpatient and outpatient services, including community births. Birth Rate+ calculates the clinical establishment based on agreed standards of care and includes the midwifery management and specialist roles required to

manage maternity services. A skill mix of 90/10 is applied to clinical staffing between midwives and maternity support workers (Band 3). The recommendation is to provide total care to women and their babies over 24 hours, 7 days a week basis, inclusive of the local percentage for annual, sick & study leave allowance and for travel in community. 23% uplift for midwives and 21.4% uplift for MSW's has been calculated to enable this.

2.0 Maternity Staffing Establishments

Birth Rate Plus refresh audit was completed in maternity at LWH in April 2023 based on FY22/23 annual activity and total births of 7386 (1st April 2022-31st March 2023). The report published in May 2023 recommended a workforce establishment of 353.53wte inclusive of 90:10 skill mix (90% midwives and 10% maternity support worker).

LWH midwifery and MSW budgeted posts for financial year 2024/25 equates to 353.53wte, demonstrating compliance with outcomes of Birth Rate+ audit 2023.

CNST Maternity Incentive Scheme Year 6, Safety Action 5 requires a clear breakdown of Birth Rate+ or equivalent calculations to demonstrate how the required establishment has been calculated. In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of Birth Rate+ or equivalent calculations. Where Trusts are not compliant with a funded establishment based on Birth Rate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. The plan to address the findings from the full audit or tabletop exercise of Birth Rate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

Midwifery and MSW funded establishment 2024/25 compared to the Birth Rate Plus audit requirements (May 2023) illustrated below in Table 1:

Table 1- Funded establishment 2023/24

Maternity Tables - 2024/25

Table 1 - Funded Establishment	2024/25 BRP Reccomendation Wte	2024/25 LWH Funded Establishment wte	2024/25 LWH Funded M3 Establishment Wte	2024/25 M3 Variance Budget to BRP Wte
Clinical	292.61	292.61	298.00	- 5.39
Clinical - Support Staff	32.08	32.08	28.51	3.57
Total Direct Care Giving Midwives	324.69	324.69	326.51	- 1.82
Non-Direct Care	28.84	28.84	28.84	-
Total Budget to BRP Model	353.53	353.53	355.35	- 1.82
Clinical		9.37	5.52	3.85
Clinical - Support Staff		52.96	43.47	9.49
A&C		31.90	34.38	- 2.48
Total Funded Roles outside of the BRP Model	-	94.23	83.37	10.86
Total Establishment	353.53	447.76	438.72	9.04

2.1 Care Hours Per Patient Per Day (CHPPD)

Table 2: Safe Staffing, Rota Fill Rates January-June 24 (average %)

	DAY	DAY	NIGHT	NIGHT
	Average fill rate Midwives (%)	Average fill rate Support staff (%)	Average fill rate Midwives (%)	Average fill rate Support staff (%)
Induction of Labour and Delivery Suite	86.4%	84%	81%	81.2%
Maternity Base and Jeffcoate	83%	106%	85%	96.6%
Midwifery Led Unit (MLU)	81.2%	83.8%	75.2%	82%

Data in Table 2 is the average rota fill rates January-June 2024. 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 midwives and maternity support workers 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.

CHPPD data is rarely referenced in Maternity Services, and not included in national reports. However, maternity services do review CHPPD and comment on this in the monthly fill rates report submitted within the integrated board report that is reported to Trust Quality Committee.

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 in 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.

2.2 Maternity Staffing (Planned versus Actual)

Maternity has a process for daily review of planned versus actual staffing, this information is fed into the Trust bed meetings that occur three times per day. In addition, staffing is reported Trust wide in the daily virtual huddle (Bronze command) which consists of senior managers and the manager on call. LWH procure the services of NHS Professionals to fill bank shifts to support temporary staffing shortfalls. Twice weekly meetings are held to monitor staffing fill rates and to allocate bank shifts to ensure consistent and safe staffing levels. Bank shifts have consistently been allocated to provide safe midwifery staffing cover owing to maternity leave and sickness.

One of the main service priorities is to maintain safe midwifery staffing levels. Maternity staffing and acuity are assessed on a 4hrly basis by the Maternity Bleep Holder and should staffing fall by the numbers of midwives to provide safe care, the Maternity Escalation Guideline (V3.3) is followed which includes the redeployment of staff. Midwives and MSW undertake a rotational training programme, allowing midwives to rotate between all clinical areas, ensuring a workforce that are skilled to work across all clinical areas of the maternity service. The Maternity Bleep holder consistently reviews staffing with the aim of redeploying non- direct care givers to address periods of high acuity in clinical activity to maintain a safe clinical staffing ratio.

3.0 Maternity Workforce Measures

3.1 Recruitment

There are zero midwifery vacancies in month 3 (June 2024) at LWH. Staffing establishment includes 1.82wte in addition to the BR+ requirement, which consists of 2 additional fixed term Preceptorship lead midwife posts, providing clinical support to newly qualified midwives and international recruited midwives.

Maternity has 14.71% (17 heads) ongoing maternity leave, with projected 13wte rolling rate. The workforce profile is reviewed monthly by the senior midwifery team with support from the HR Business Partner. Effective from April 2024, maternity leave temporary backfill is requested via the vacancy control process, to apply improvement in cost efficiency than utilisation of costly NHSP (bank) shifts.

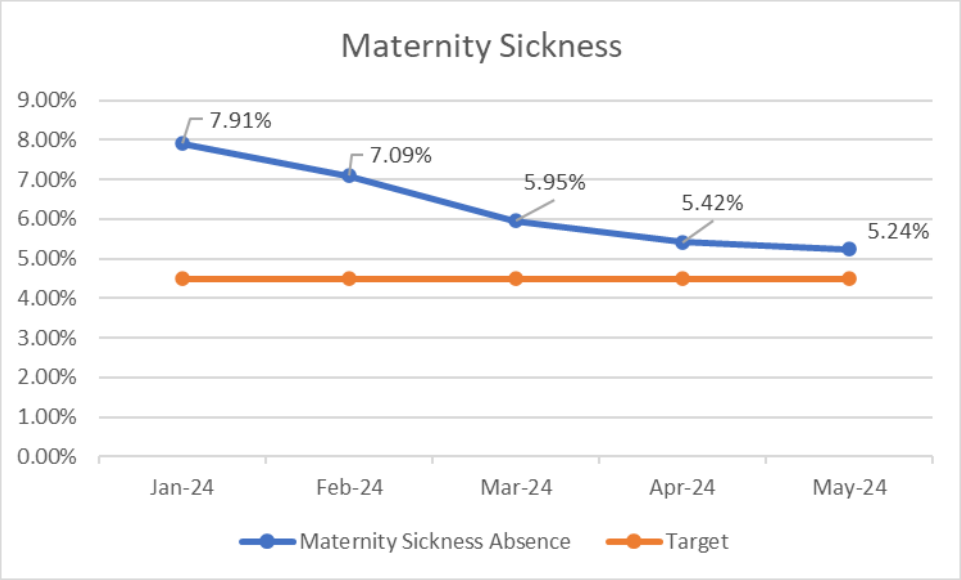
3.2: Midwives and MSW's who leave the Trust

Rolling number of staff who have left the Trust during January-June 2024 is 8% which is 5% below the Trust threshold of 13%. Overall, there are no concerns to raise with respect to staff leaving maternity services at the Trust. The service continues to receive retirement and return requests, along with general flexible working requests, these are considered on a weekly basis by the senior midwifery leadership team to ensure consistency and fairness in decision making.

3.3: Sickness absence

Whilst sickness absence is a continuing challenge in the service, there are improvements being seen in the overall sickness rate which stood at 6.43% in June 2024, which is comparable to the same period in 2023. Sickness across Maternity was at 5.74% in May 2024, which is the lowest rate seen since pre-covid. Weighting in Maternity is towards LTS cases at 56.48%. Divisional sickness reviews continue as does the emphasis on completing return to work interviews. 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 in the 0–3-month timescale.

Table 3: Sickness absence



4.0 Quality of Care measurements:

4.1 Midwife to Birth Ratio

Birth Rate plus audit requirement (May 2023) overall ratio for all births at LWH is 23.2 births to 1.0wte midwife. The midwife to birth ratio calculation has recently been reviewed by Family Health Finance Business Partner and Senior Midwifery Leadership team in accordance with the BR+ monthly midwife birth ratio formula, with June reporting 1:23.

Midwife to Birth					
January 24	February 24	March 24	April 24	May 24	June 24
1:19	1:20	1:19	1:19	1:19	1: 23

Table 4: Midwife to birth ratio

4.2 Supernumerary Shift Coordinator on Delivery Suite

Within LWH Delivery Suite, supernumerary shift leader compliance is consistently maintained at 100% as listed (Table 5). This role is pivotal in providing oversight into all birth activity on the Delivery Suite. A supernumerary maternity bleep holder is rostered to provide operational leadership of the maternity unit over a 24hr period, 7 days per week. The Labour Ward shift co-ordinator is rostered independently from the core midwifery staffing, and this is evidenced in e-roster with a distinct marker against the shift coordinator indicating supernumerary status.

Supernumerary Shift Coordinator					
January 24	February 24	March 24	April 24	May 24	June 24
100%	100%	100%	100%	100%	100%

Table 5: Supernumerary shift co-ordinator status

4.3: 1:1 Care in Labour

NICE (2021) guidance supports one to one care in established labour, as one of the indicators of effective midwifery workforce planning. LWH has consistently across intrapartum areas of Midwifery Led Unit (MLU) and Labour Ward (Consultant high risk care), achieved a compliance rate between 99.56% and 100% in this reporting period. Total of 3 women did not receive 1:1 midwifery care in labour during this reporting period, with no harm caused to the mothers or newborn babies.

1:1 Care in Established Labour					
January 24	February 24	March 24	April 24	May 24	June 24
100%	100%	100%	99.70%	99.56%	100%

Table 6: 1:1 midwifery care in labour

MIS (Year 6), Safety Action 5 requires organisations to produce an action plan when compliance is less than 100%. As part of the review of the non-compliance to this required standard, each case where 1:1 care is not achieved has been reviewed to ensure no adverse clinical outcomes have occurred. The common themes identified for non-compliance include midwifery sickness and an increase in service acuity, which is reflective of the nature of maternity services including precipitate labour or presentation of a woman about to birth imminently.

This action plan held within maternity services is monitored at Maternity Risk and Clinical Meetings and reviewed as part of the assurance process to Family Health Divisional Board upwardly reporting to safety and effectiveness committee, as well as external reporting to the LMS.

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 (V9.2). 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 all women who are scheduled to come in the following day for induction of labour, to identify and pre-empt any areas of challenge. All midwifery red flags are reviewed monthly at the Maternity Clinical Risk meeting.

5.0: Midwifery Red Flags

There were 268 midwifery red flags reported between January-June 2024 which is an increase of 56 from the previous reporting period (July-December 2023) where 212 red flags were reported. Majority of the red flags relate to delays in ongoing Induction of Labour, owing to capacity and demand. An induction of labour Quality Improvement project is ongoing with estates work scheduled to be completed in July to

create a separate IOL area consisting of 5 rooms. This will help to improve patient flow on Delivery Suite to be able to expedite IOL patients to continue the process whilst also improving the patient experience.

Midwifery Red Flag Event - Validated	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
1:1: Care in Labour Not Supported	0	0	0	1	2	0
>30 min Delay in Presentation to Triage	5	0	1	0	1	0
>2 hour delay in admission to IOL	0	9	11	11	5	0
12> hour delay in ongoing IOL	4	48	54	47	34	32
Delay in time critical activity	0	0	0	0	0	0
Delay in pain relief >30 mins	0	0	0	0	0	0
Missed medication during hospital admission	0	0	0	0	0	0
Delayed recognition of and action on abnormal vital sign	0	0	0	0	0	0
Full clinical examination - presenting in labour	0	0	0	0	0	0
Missed or Delay Care (Suturing)	0	1	1	0	1	0
Total	9	58	67	59	43	32

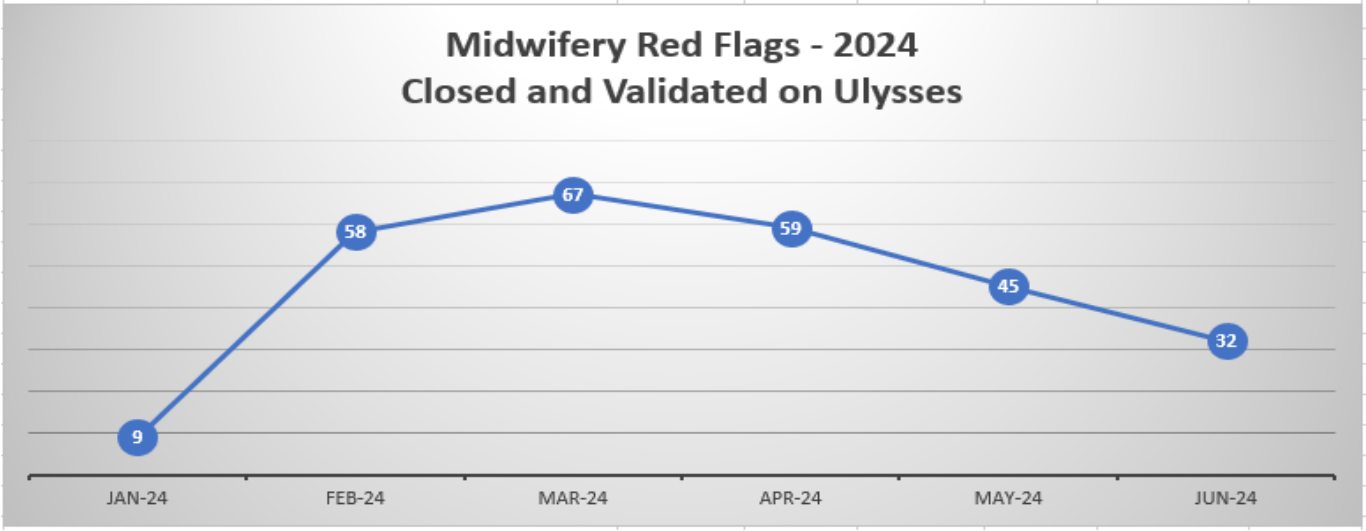


Table 7: Red flag themes

RECOMMENDATION

It is recommended that the Trust Quality Committee receive and note the information provided in this paper and take assurance for how safe staffing is managed, recruited, and retained to keep women and babies safe within Maternity services.

Equality, Diversity & Inclusion Implications – DO NOT DELETE [state N/A if necessary)

N/A

Quality, Financial or Workforce implications - DO NOT DELETE [state N/A if necessary)

N/A

SUPPORTING DOCUMENTS

- Birth Rate Plus audit report May 2023
- Maternity Escalation guideline (V3.3)
- Induction of Labour guidelines (V10)
- 1:1 midwifery care in labour audit report and action plan

Liverpool Women's NHS Foundation Trust

Trust Board Meeting

Cover Sheet

Meeting Date	Thursday, 12 September 2024	**Item Reference**	24/25/112
Report Title	Guardian of Safe Working Hours Quarterly Report – Q1 24/25		
Author	Kat Pavlidi, Guardian of Safe Working Hours		
Responsible Director	Lynn Greenhalgh, Medical Director		

Purpose of Report	The 2016 contract requires the Guardian of Safe Working Hours (GoSWH) to report to the Trust Board and Sub Board Committee on a quarterly basis, with the following information; • Aggregated exception reports including outcomes • Details of fines levied • Data on rota gaps • Data on locum usage • Other relevant data • Qualitative narrative highlighting areas of good practice or persistent concern
Executive Summary	This report covers the period 1st April – 30th April 2024 and relates to the first quarter of the year. • Rota establishment continues to fluctuate throughout the year with processes in place to mitigate the use of high-cost agency locums wherever possible by using internal bank, doctors in training and ANNPs, with 289 shifts being put out for cover in all three specialities out of hours. • Nine exception reports were submitted relating to difference in hours of work and patterns of work. Two educational exception reports were submitted and one relating to service support available to doctors. This is an decrease compared to Q4 of 2023-2024. • This report does not include data on gaps caused by the ongoing Industrial Action by the Junior Doctor cohorts, as with previous reports since IA started taking place. • Although the hours and templates of rotas are safe and compliant in each service and in line with the Junior Doctor contract, there are still concerns intensified by the continued rota gaps which need covering to ensure patient care is provided, mostly within the O&G service.
Key Areas of Concern	Continued short- and long-term gaps in all services, particularly within anaesthetics and neonates.
Trust Strategy and System Impact	This report supports the Trust's strategy on having a safe and effective workforce leading to positive effects on the health and wellbeing of the population.

Links to Board Assurance Framework	BAF 1 - Workforce	***10***

Links to Corporate Risk Register (scoring 10+)		

Assurance Level	1. MODERATE - Adequate system of internal control applied to meet existing objectives

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

MAIN REPORT

INTRODUCTION

The 2016 contract requires the Guardian of Safe Working Hours (GoSWH) to report to the Trust Board and Sub Board Committee on a quarterly basis, with the following information;

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

This report covers all of the above for the reporting period 1st April – 30th June 2024, and relates to the first quarter of the year.

ANALYSIS

Guardian Report

a) Aggregated exception reports including outcomes

During this quarter, 12 exception reports were made, all from O&G doctors.

Period	Specialty	Grade	Reason	#exceptions	No: hours	Outcome
Q1	O&G	Tier 1	Hours	6	6.5	TOIL Payment
Q1	O&G	Tier 1	Service support	1	-	TOIL
Q1	O&G	Tier 1	Pattern	1	-	Payment
Q1	O&G	Tier 3	Hours	2	4.5	Work schedule review Payment
Q1	O&G	Tier 3	Education	2	-	Work schedule review No further action

Of note, these 12 exception reports were completed by 5 different PG doctors, and the majority (10) by 3 doctors. This does not suggest that there are only some doctors who struggle with frequently working over their hours or missing natural breaks, but does suggest that only a small percentage of doctors feel empowered to submit exception reports.

The GoSWH does encourage the doctors to submit ERs frequently, and ensures that she meets each cohort of new PG doctors at their induction to introduce herself and the exception reporting system alongside the doctors' responsibilities with their contract. As discussed in previous reports, submission

of ERs is significantly underutilised for various reasons. This is in contrast with other Trusts where they have a much higher number of Foundation year trainees who are much more likely to submit ERs compared to Specialty trainees which make up the majority of LWH doctors.

b) Details of fines levied

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

c) Data on rota gaps

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

Each specialty continues to be supported by fixed term clinical fellows, clinical research doctors and other locally employed doctors who are either out of programme or in between training. There continues to be other PGDs commencing their posts throughout the quarter to help fill expected long term gaps and reduce the need for external locum cover.

The below tables give context to the number of unsocial shifts requiring a doctor or ANNP to work, the number of gaps in each month and who covered the shift. As in previous reports, this data excludes shifts worked for gaps due to Industrial Action (Junior Doctors).

Anaesthetics

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training/bank/ trust Dr cover	Consultant cover	Unfilled
April 24	150	32	32	0	0
May 24	150	11	11	0	0
June 24	150	27	27	0	0

Of the 70 locum shifts in Q1, all shifts were covered by the current PGD cohort undertaking additional shifts, bank doctors, and Trust doctors. During this reporting period, no shifts remained uncovered due to short term sickness. The number of gaps in this reporting period has significantly compared to the previous quarter (23). This is mainly due to the requirement of shifts requiring a 3rd anaesthetist to cover for ongoing support. This is likely to continue owing to increasing numbers of more junior members of the PGD cohort on placement at LWH and the need for further senior support with increasing clinical complexity.

Neonates

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training Dr's/ANNPs cover	Consultant cover	Unfilled
April 24	240	4	4	0	0
May 24	240	14	14	0	0
June 24	240	16	16	0	0

Of the 34 locum shifts in Q1, all shifts were covered by the current PGD cohort undertaking additional shifts, ANNPs, bank doctors, and Trust doctors. During this reporting period, no shifts remained uncovered due to short term sickness. The number of gaps in this reporting period has significantly increased due to increased sickness and maternity leave in this quarter compared to Q4 (2), but is similar in numbers to Q2 and approximately half of Q1's numbers of 2023-2024.

Genetics

As previously mentioned in reports, there is no requirement for locum cover as genetic doctors do not work unsocial hours.

Obstetrics and Gynaecology

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training/bank/trust Dr cover	Consultant cover	Unfilled
April 24	496	62	26	0	10
May 24	496	72	46	0	9
June 24	496	51	38	0	4

Of the 185 locum shifts in Q1, shifts were covered by the current PGD cohort undertaking additional shifts, bank doctors, and Trust doctors. This reporting period, 23 shifts remained uncovered; this was due to short term sickness as with previous quarters. The number of gaps in this reporting period has remained stable compared to the previous quarter (191).

d) Other relevant data

This quarter has seen a significant increase in the need for anaesthetic and neonatal cover for rota gaps, which is something that has been interestingly noted from previous years. This is in comparison to O&G whose worst quarters tend to be Q3 or Q4 most years. This data may help to plan the workforce better throughout the course of the year.

The GoSWH has noted during the writing of this report that the number of unsociable hours documented within the data tables was based on older rotas where less doctors were required to be on shift. Owing to the nature of increasing workload and the need to increase the number of doctors requiring to cover unsociable shifts, this has been updated for this quarter and will be updated for Q2 again. Despite this, the number of gaps in total is still an ongoing issue, although in the majority of specialities will show an overall percentage reduction of number of gaps compared to number of unsociable shifts, due to the latter being increased on the data tables.

e) Qualitative narrative highlighting areas of good practice or persistent concern

All services continue to cover locum shifts within the PGD and ANNP workforce via the Bank system to reduce the need for agency staff. This has been successful in this quarter as with previous months and continues to ensure financial savings for the Trust.

As with previous quarters, there will always be a need to cover gaps on a short term basis owing to sickness and unprecedented vacancies. The Trust has made a lot of progress with workforce planning and has been able to appoint several new clinical and research fellows to be able to support the rotas, both during daytime and unsociable hours. This should have a positive effect on the doctors morale as well as giving 'breathing space' to rotas and hopefully reducing the gaps needing to be covered over the next quarters.

CONCLUSION

The Committee are advised:

- the number of gaps in this quarter has increased within the Neonatal and Anaesthetic services, due to short term sickness and the need for a 3rd doctor for clinical support cover.
- The Trust continues to appoint locally employed doctors to help reduce the long-term gaps and aid service provision, with a significant number of doctors due to commence their posts in Q2.
- There are positive changes due to occur within PGD rotas in the next quarter, particularly within O&G and specifically the gynaecology rotas, which looks to ensure better senior doctor cover, thus improving patient safety and allowing for reduced workload amongst all staff and better access to training.

This report advises the Board that doctors in training are safely rostered at the start of their placement at LWH and enabled to work hours that are safe and in compliance with their contract.

Finally, the GoSWH notes, as in previous reports, that although rotas are created to be safe, the number of gaps and shifts needing to be covered at short notice continues to be an ongoing issue. There is hope that with an overall increase in the number of PGDs within the services and better workforce planning, that this issue will soon resolve.

Equality, Diversity & Inclusion Implications

N/A

Quality, Financial or Workforce implications

As per the content in the report, the number of gaps and shifts needing to be covered at short notice continues to present an ongoing concern and continues to create workforce difficulties for PG doctors, with the potential to impact on quality of care and workforce culture.

RECOMMENDATION

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 12 September 2024	**Item Reference**	24/25/113
Report Title	Mortality and Learning from Deaths Report Quarter 1, 2024/25		
Author	Chris Dewhurst, Deputy Chief Medical Officer Lidia Kwasnicka, Gynaecologist; Ai-Wei Tang, Consultant Obstetrician; Rebecca Kettle, Consultant Neonatologist		
Responsible Director	Lynn Greenhalgh, Chief Medical Officer		

Purpose of Report	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 PSIRF • 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.
Executive Summary	In Quarter 4 there were the following deaths: Adult Deaths 0 Direct Maternal Deaths 0 Stillbirths 7 (3.8/1000 births) Neonatal Deaths (inborn) 8 (4.4/1000 live births)
Key Areas of Concern	No areas of concern to note.
Trust Strategy and System Impact	

Links to Board Assurance Framework		
Links to Corporate Risk Register (scoring 10+)		

Assurance Level	1. HIGH - Strong system of internal control applied to meet existing objectives

Action Required by the Committee	The Board is 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**.**

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	**22.08.24**	**CMO**	**Assured**

MAIN REPORT

This 'Mortality and Learning from Deaths' paper presents the mortality data for Q1 2024/25. The learning from review of deaths will be from deaths that occurred in Q4 2024/25 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 PSIRF
- 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 4 there were the following deaths:

Adult Deaths	**0**
Direct Maternal Deaths	**0**
Stillbirths	**7 (3.8/1000 births)**
Neonatal Deaths (inborn)	**8 (4.4/1000 live births)**

The PMRT review of stillbirths in Q4 reported one case where care issues were identified that were likely to have made a difference to the outcome. This case proceeded to a PSII with a summary of the learning and actions taken included in this report.

The PMRT review of neonatal deaths identified learning but there were no LWH neonatal care issues identified that were likely to have made a difference to the outcome. One case (graded C – care issues that may have impacted on the outcome) proceeded to a PSII with the learning/actions included in this report.

The annual reports for stillbirth and neonatal mortality for 23/24 are included in the report.

- The stillbirth rate of 2.2/1000 births is lower than the UK target to half stillbirths by 2025 (target 2.6/1000 births).
- There was no overrepresentation from the Global majority nor the most deprived deciles in either stillbirths or neonatal deaths.
- The neonatal mortality rate for booked and in-born babies at LWH is the same as for the rest of the UK. The latest MBRRACE data (2022) shows that LWH mortality is significantly lower (>5% lower) than comparator trusts.
- The preterm mortality (24-27 weeks) is static, and remains higher than the other surgical centre in the North West. Possible reasons for this are discussed in the paper with ongoing work to understand this explained.

Recommendation: The trust board are requested to accept the recommendation of the Quality committee of 22nd August 2024 that assurance was provided regarding adequate governance processes in place when learning from deaths. The committee were also assured regarding

1. the annual stillbirth and neonatal mortality for 23/24

2. the ethnicity data for both neonatal deaths and stillbirths does not show an over representation significant difference between white and non-white populations.
3. the preterm mortality remains higher than the other level 3 surgical centre in the north-west and work with the maternity and neonatal networks is ongoing to understand reasons. In discussion the complexity and multifactorial nature of preterm mortality was highlighted.

This is the Quarter 1 2024/25 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 Q1 2024/25. The learning relates to deaths in Q4 2023/24 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 Q1 2024/25

There were **0 maternal deaths in Q1 2024/25**

1.3 Gynaecology Mortality data Q1 2024/25

There was 0 unexpected death within Gynaecology services in Q1 2024/25.

1.4 Learning from Gynaecology Deaths

There were 3 deaths in Q4 2023/23 all of which were expected deaths. These deaths were the first to use the process of referral to the medical examiner with 2/3 of the deaths being agreed by the ME and 1/3 having the wording amended on the MCCD. There was also learning around the new ME referral process with action already taken.

2. Stillbirths

2.1 Stillbirth data

There were 7 stillbirths, excluding terminations of pregnancy (TOP) in Q1 2024/25. This has resulted in an adjusted stillbirth rate of 3.8/1000 births for Q1 2024/25. There were nolate fetal losses at 22 – 23+6 weeks gestational age.

Quarter	Rate 2020/21	Rate 2021/22	Rate 2022/23	Rate 2023/24	Rate 2024/25
Q1	5.5	4.0	3.7	1.7	**3.8**
Q2	2.5	5.3	3.6	2.2	
Q3	2.7	5.1	4.3	3.3	
Q4	3.2	5.0	2.3	1.1	
ANNUAL	3.4	4.9	3.5	2.2	

Table 2: Quarter and Annual Stillbirth rate/1000 births since 2019/20 (excluding terminations).

Demographic information for the 4 stillbirths and late fetal losses:

- 1/7 cases was an unbooked pregnancy
- 2/7 women were non-white British and did not speak English as their first language. Translation services were used appropriately.

2.1 Learning from Stillbirths

All eligible cases from Q4 23/24 (Stillbirths > 22 weeks but excluding terminations, n=4) underwent a full multi-disciplinary team PMRT review with external clinician presence. Care from across the antenatal and intrapartum period was subject to clinical and managerial scrutiny. All bereaved parents were invited to be involved in the review process by submitting comments and questions via the Honeysuckle Team for discussion at the MDT Review.

The 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.

The MDT reviews of 2 Stillbirths and 2 late fetal losses (22-24 weeks gestation) found no antenatal care issues identified (Grade A) in 1 case, and 1 case where the care was graded D. The D graded case was due to a missed opportunity for earlier delivery due to ruptured membranes and breech delivery. This case proceeded to a PSII with the following learning/recommendations (PSII 109548).

1. Review of the MAU estate with the aim of improving clinical oversight of women receiving ongoing care.
2. Patient story to feature within the Martha's Rule improvement project.
3. Medical cover for Maternity Assessment Unit to be extended to 23.00 hours.
4. Maternity Bleep Holder Standard Operating Procedure to be reviewed and to include direct escalation for women in suspected labour or with increasing analgesia requirements on MAU.
5. Review all guidelines relating to administration of analgesia in pregnancy to ensure that this is not restricted by location.
6. Digital report to be developed to identify women who have delivered and have appointments scheduled to improve process for cancellation.

There was D graded bereavement care in one case related to the woman being contacted regarding antenatal appointments after the stillbirth. Ongoing actions are work is included in the appendix report.

2.2 Annual Stillbirth report 23-24

The annual stillbirth report for 23-24 is attached as an appendix. The following points are highlighted:

- The annual mortality rate of 2.2/1000 births is the lowest recorded rate. This is lower than the UK governments ambition for 2025 to halve stillbirths.
- There is no over-representation in stillbirths from the Global Majority nor most deprived populations.
- There was 1/25 cases where care issues were reported that were likely to have made a difference to the outcome.

3. Neonatal Mortality

3.1 Neonatal mortality Data Q1 2022/23

Neonatal deaths can be reported in several ways. The population can include in-born babies only (includes in-utero transfers) LWH booked pregnancies or all babies cared for in LWH (including babies transferred to LWH from other care providers). Deaths may be those within 28 days (reported in MBRRACE) those occurring prior to discharge from the NICU and those who die following transfer to another hospital. The population can be further refined by weight and/or gestational age. The data may include or exclude babies with congenital anomalies (MBRRACE).

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. This last group is reported nationally by the National Neonatal Audit Project and monitored locally by the ODN. The benchmark of 6.3% is locally derived by the ODN. The threshold was the overall mortality in the UK in 2020 for the population of 24 – 31+6 week babies. As LWH receives IUTs of (higher risk) preterm mortality it is unlikely that our mortality would be below the average for the whole population. In addition, as this is an absolute measure, it would be expected that 50% of neonatal units would be above this figure. Discussion with the ODN has resulted in an acceptance that LWH mortality is not excessive. As can be seen in the chart, preterm mortality is below 6.3%.

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	March-24	*Apr-24*	*May-24*	*Jun-24*	*24_25 Total*
Births	629	612	587	619	594	591	573	583	586	628	645	563	**1836**
Total mortality on NICU	3	4	1	6	5	2	1	1	2	2	1	3	**6**
INBORN Neonatal Mortality (all live births)	3*	4	1	6*	6*	3	0	1	2*	4*	1	3	**8**
IUT Mortality	0	4	0	2	3	1	0	1	0	0	0	1	**1**
PNT Mortality	1	0	0	2	1	1	2	0	3	0	1	1	**2**
INBORN Neonatal Mortality Rate/1000LB	4.8	6.5	1.7	6.5	6.7	1.7	0	1.7	0	6.4	1.5	5.3	**4.4**
MBRRACE eligible deaths *Excl. congenital anomaly*	*1* *0*	*4* *2*	*1* *1*	*6* *4*	*3* *2*	*1* *0*	*0* *0*	*1* *1*	*1* *0*	*4* *2*	*1* *1*	*3* *1*	***8*** ***4***
Benchmark: MBRRACE LWH data 2022 ***3.15/1000LBs***	*1.6* *0*	*6.5* *3.3*	*1.7* *1.7*	*9.7* *6.5*	*5.1* *3.4*	*1.7* *0*	*0* *0*	*1.7* *1.7*	*1.7* *0*	*6.4* *3.2*	*1.5* *1.5*	*5.3* *1.8*	***4.4*** ***2.2***

(excl. congenital anomaly) 1.38/1000LBs													
NWNODN benchmark INBORN 24-31 w	*0*	*3*	*1*	*3*	*3*	*1*	*0*	*1*	*0*	***0***	***0***	***3***	***3***
Benchmark (NNAP >6.3% of admissions)	*0*	*25*	*10*	*37.5*	*23*	*10*	*0*	*14*	*0*	***0***	***0***	*15.8*	***5.5***
NWNODN benchmark INBORN 24-27 w	*0*	*1*	*1*	*3*	*2*	*1*	*0*	*1*	*0*	***0***	***0***	***1***	***1***
Benchmark (NNAP >15% of admissions)	*0*	*25*	*25*	*60*	*50*	*33.3*	*0*	*33.3*	*0*	***0***	***0***	*20*	***3.8***

*****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.

NMR *in born*	*23_24*	*24_25*
Q1	5.1	**4.4**
Q2	3.8	
Q3	5.0	
Q4	0.6	

Table 5: Neonatal Mortality Rate/1000 live births per quarter (inborn LWH)

There were 8 babies who were born at LWH who died in this quarter. This results in a mortality rate of 4.4/1000 live births. One of these deaths was following an in-utero transfer (IUT). A further 2 babies were transferred to LWH and died either at LWH or elsewhere following transfer.

There were 3 babies who died after being born at 24 – 31+6 weeks gestational age.

Demographic data (n = 10 babies cared for at LWH)

- 4/10 (40%) babies were born to mothers from the Global Majority. This is higher than the booking population but numbers are too small to make meaningful conclusion. Recent annualised review of data showed there was not a statistically significant difference in neonatal mortality between white and non-white babies.

3.2 Learning from neonatal mortality reviews for neonatal deaths from Q1 23/24

There were 8 deaths in Q4 23/24 subject to a PMRT review. There were no cases in which neonatal care issues at LWH identified were graded D. There were 2 cases where Grade C care issues were identified. One related to non co-location with Paediatric surgical services and another to an error with a potassium infusion. A PSII was initiated for the drug/infusion case (PSII). Learning and actions form this case included improving the prescribing of potassium, reviewing blood samples, communication of blood results and ongoing QI project into reducing blood sampling errors.

There were 5 cases of neonatal care issues identified that didn't affect the outcome care graded B including non co-location, thermal control and accidental extubation. These are issues previously identified with work ongoing to resolve/ continue QI projects.

There are examples of parental feedback received about the high quality of care they received with details below. Additional examples are included in the attached appendix.

The NICU team were amazing with [redacted] and with us, they explained everything they did and why they were doing it, encouraged our involvement with handling [redacted] (cares, positive touch), included us in some decision making around [redacted] care.

3.3 Annual Neonatal Mortality Report 23/24

The annual neonatal mortality report is attached as an appendix. This report includes the following:

- The mortality for babies whose mothers booked their pregnancy at LWH and whose babies were born at LWH was 2.8/1000 live births, in keeping with the latest UK figure of 2.9/1000 live births.
- The number of babies being cared for at 22 weeks gestation shows a dramatic increase in the past 2 years (12 since 22/23 cf. 4 in the previous 3 years). There was 1 survivor at this gestation in 22/23 ((n=8)
- There is no over-representation in mortality from the global majority nor most deprived population.
- The most recent published MBRRACE data (2022) shows that 60% of neonatal deaths at LWH were due to congenital anomalies. Once these are removed LWH mortality is >5% lower than comparator trusts.
- Preterm mortality (24 – 27 weeks) is similar for 23/24 as 22/23, 23.5% vs 25.5%. Preterm mortality for LWH remains higher than the other level 3 surgical centre in the NWODN, 23.5% v 7.2%.
- The current rate of preterm mortality at LWH has been seen for several years. There have been two reviews of our service since 2020 that did not identify a clear causative factor but made recommendations that resulted in action plan that is included the annual report.
- There are differences in the patient population and referral pathways. For example, LWH have 3.5 times as many in-utero transfers (2019-21). We are working with the Maternity and Neonatal networks to further investigate these differences to determine the impact on neonatal mortality.

4. Medical Examiner

A new statutory medical examiner system is being rolled out across England and Wales to provide independent scrutiny of deaths, and to give bereaved people a voice. From 9 September 2024 all deaths in any health setting that are not investigated by a coroner will be reviewed by NHS medical examiners. This process has been in place for adult deaths since Q1 23/24, utilising the ME at LUFHT. For neonatal/infant deaths a new process will initiate at on 9th September 2024. There has been an SOP developed which has been assessed with a test case. A SLA has been finalised and agreed.

Recommendations

The trust board are requested to accept the recommendation of the Quality committee of 22nd August 2024 that assurance was provided regarding adequate governance processes in place when learning from deaths. The committee were also assured regarding

1. the annual stillbirth and neonatal mortality for 23/24
2. the ethnicity data for both neonatal deaths and stillbirths does not show an over representation significant difference between white and non-white populations.
3. the preterm mortality remains higher than the other level 3 surgical centre in the north-west and work with the maternity and neonatal networks is ongoing to understand reasons. In discussion the complexity and multifactorial nature of preterm mortality was highlighted.

6. Appendices


Annual neonatal mortality report 23_2


Q1 neonatal 24_25.docx


Annual Stillbirth Report 2023-24 (1).d


Q1 SB report 2024-25.docx

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 12 September 2024	**Item Reference**	24/25/114
Report Title	Freedom to Speak Up Guardian Bi-annual Report		
Author	Nicola Pittaway, Freedom to Speak Up Guardian		
Responsible Director	Michelle Turner, Chief People Officer		

Purpose of Report	This report is produced to give the Board assurance that the policy is in place, and that it is both appropriate and regularly updated. It also provides a summary of whistleblowing cases over the previous financial year to further provide assurance that the policy is being appropriately implemented.
Executive Summary	This report is to update the Board on any developments over the last 6 months, and also covers the number of concerns raised to the Freedom to Speak Up and highlights any themes or trends that have been identified including any associated actions received. Also included is an update on compliance with the essential training modules linked to freedom to speak up and details of the biannual temperature check survey scores relating to speaking up.
Key Areas of Concern	
Trust Strategy and System Impact	

Links to Board Assurance Framework		
Links to Corporate Risk Register (scoring 10+)		

Assurance Level	1. HIGH - Strong system of internal control applied to meet existing objectives

Action Required by the Committee	The Committee is asked to note the contents of this report and the ongoing approach to promoting Freedom to Speak at Liverpool Women's Hospital and take assurance from • the Guardians' assessment of the Trust's compliance with NHSE's expectations of Trusts with respect to Freedom to Speak Up

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
PPF Committee	**08.07.24**		
Audit Committee	**18.07.24**		

MAIN REPORT

INTRODUCTION

This report is to update the Committee on any developments over the last 6 months, and also covers the number of concerns raised to the Freedom to Speak Up and highlights any themes or trends that have been identified including any associated actions received.

Also included is an update on compliance with the essential training modules linked to freedom to speak up and details of the biannual temperature check survey scores relating to speaking up.

ANALYSIS

Latest data submitted to the NGO show that during the last half of the year, the Guardian service received a total of 42 concerns, which is an increase of 19 from the equivalent periods in 2022/23 when 23 concerns were received.

Concerns throughout the first half of the year were raised from a wide variety of staff, with concerns raised by staff of all grades and from all services. The trend data would seem to indicate that staff continue feel confident to raise concerns by identifying themselves to the Guardian, although there is still some element of apprehension to share their identity any further, with a number wishing to keep their details confidential at all stages.

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

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

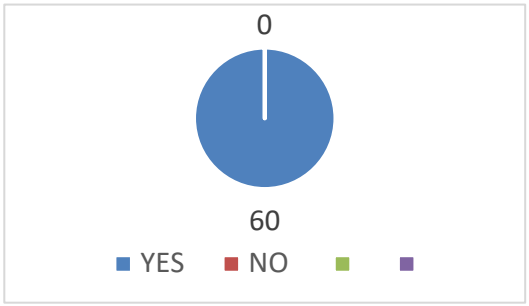
A number of interactions with the Guardians are related to Grievance or Interpersonal issues within teams where no formal action is required by the Guardian. They are recorded and monitored with the individual if required to ensure appropriate avenues can be accessed by the staff member.

Concerns continue to be raised where staff members advise they have raised issues with their line managers etc. and they either do not seem to have acted or taken action which is felt to be inconsistent and unfair. It is hoped that the follow up module training will have a positive effect on reducing the occurrences of these concerns.

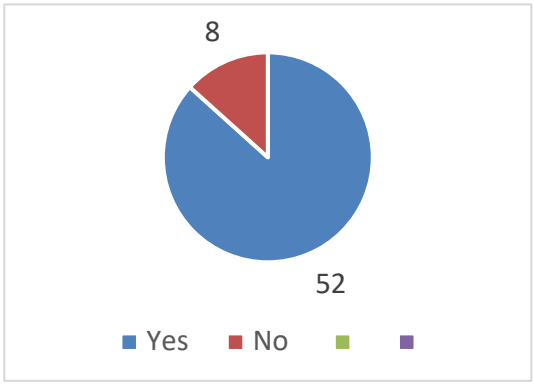
Freedom to Speak Up Temperature Check surveys

As committed to in the Freedom to Speak up strategy, we undertake temperature check surveys to understand how the role of Guardian is resonating the workforce and what we need to focus on. The six-month frequency run in October and April each year. The most recent survey was open throughout April / May 2024 and received 60 responses.

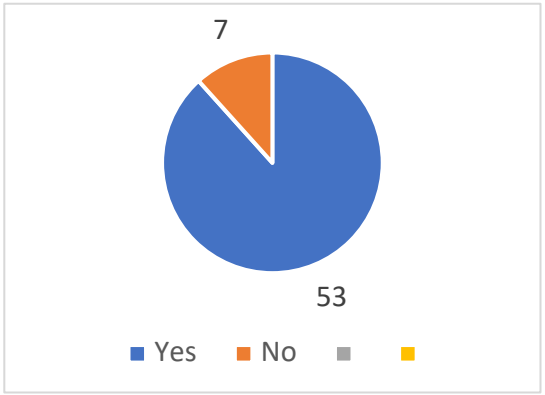
Are you aware we have the Freedom to Speak Up Guardians in the Trust?



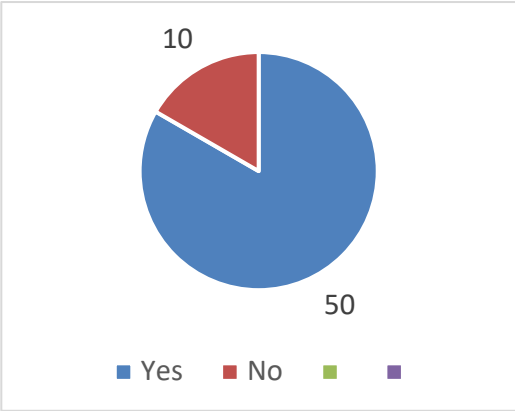
Do you know the role of the Freedom to Speak Up Guardians and why they are there for you?



Do you know how to contact the Freedom to Speak Up Guardians?



Do you feel comfortable contacting them if you have a concern?



As part of the survey, respondents are asked to provide additional comments or thoughts on the freedom to speak up at Liverpool Women's. some positive examples are:

- very approachable Staff
- I think it's a good idea that we have these guardians in place when needed.
- I have been to see the Freedom to Speak Up Guardian and they were very supportive and helpful.
- i feel that though its very important to have Freedom to speak up Guardians some staff would not feel comfortable reporting issues they have in fear of being ostracised or losing their job.
- Freedom to Speak up is a great service and I would feel comfortable contacting our officers if needed
- aware of the Freedom to Speak Up team, feel it is communicated well.

Some feedback that can be put into action by the Guardians immediately was feedback in the survey regarding increased visibility and accessibility:

- Maybe the guardians should do regular walk arounds departments to see if anyone needs to speak regarding concerns
- They need to be more visible and come and meet staff

Over the last 6 months, the Guardians have attended Trust network meetings and will continue to build on relationships and regular walkarounds to departments will be introduced and communication regarding the new Guardian office and drop in sessions made available in all staff areas. Drop in sessions will also be arranged with staff at Hewitt Knutsford and Aintree.

What is evident from the comments in this recent survey is there continues to be a suspicion and a lack of trust that needs to be focussed on and work will continue by the Guardians to build "trust across the Trust":

- There is lots of information everywhere which is good. So contacting them is not a problem. I might be uncomfortable contacting them on certain issues because we are a small hospital so I don't know how true anonymity can be achieved here but I suppose that is not something that can be easily fixed but given our relationship with the Royal could we work with them and share freedom to speak up resources more for better confidentiality when raising issues? This would help the Royal as well as us.

- i feel that though its very important to have Freedom to speak up Guardians some staff would not feel comfortable reporting issues they have in fear of being ostracised or losing their job.

These comments will be used to influence communication key messages moving forward. We will continue to promote the service and benefits of the guardian service and continue to make ourselves available to attend team and divisional meetings to reiterate the benefits of the Guardian service.

FTSU Training compliance

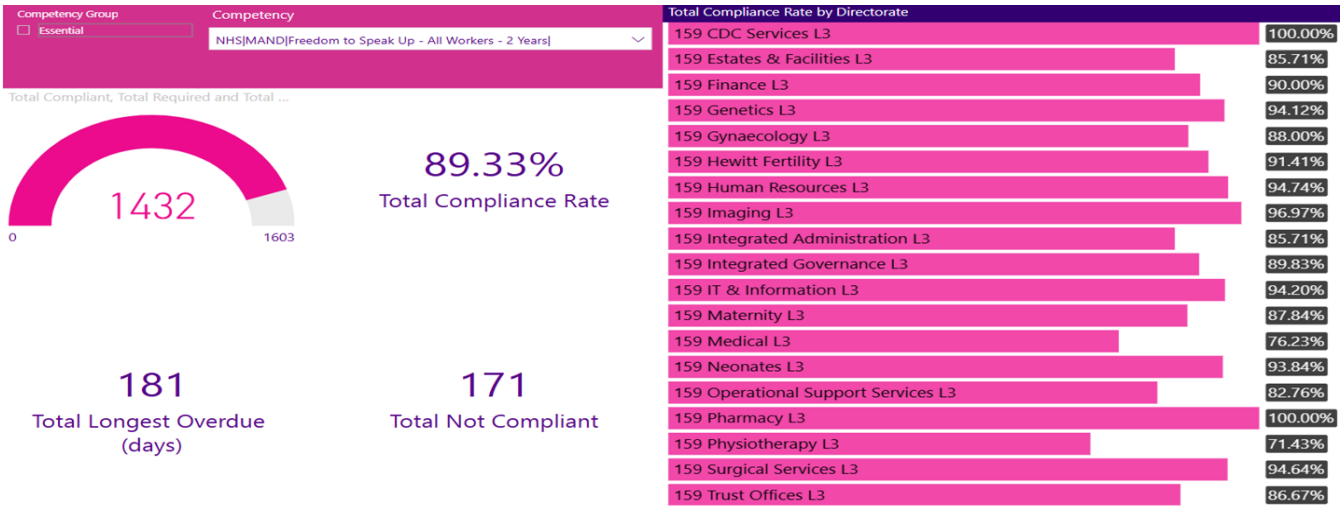
During 2022/23, 3 Freedom to Speak up modules, created by the National Guardian office, were launched. LWH has adopted all three modules and are categorised as “essential” training.

The “Speak Up” module is for all workers and as you can see from the information below has 89.44% compliance rate, with 1423 staff completing the module. The “Listen up” training is key to help managers and leaders to consistently display the behaviours that encourage and support speaking up. The “listen up” training is designed to help managers and leaders be aware of how their behaviour influences the confidence of people to speak up and what to do when concerns are raised to them.

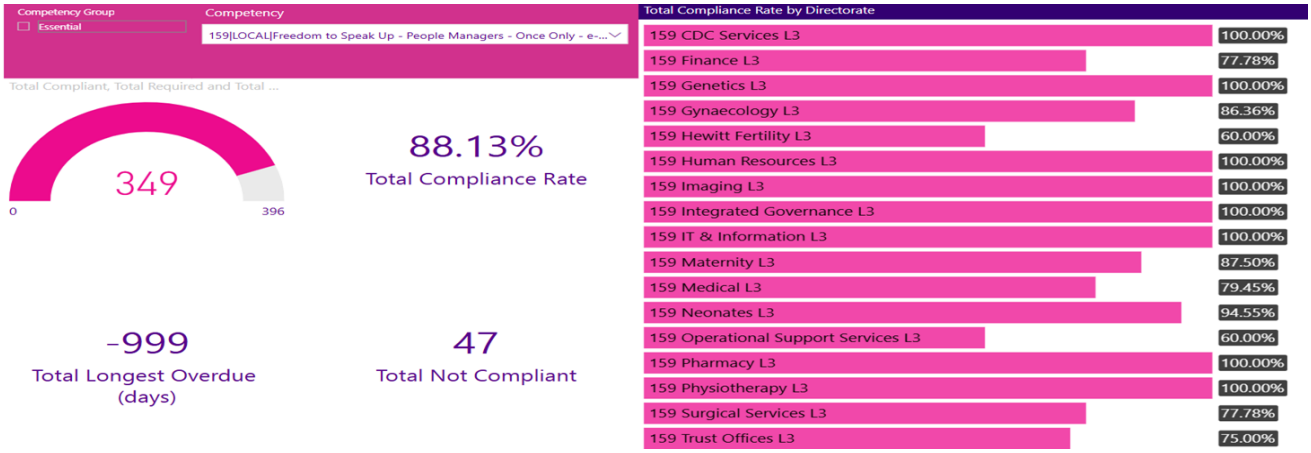
In September 2023/34 the final module for LWH was launched. “Follow up” completes the package. Developed for senior leaders – including executive and non-executive directors, lay members and governors – and aims to promote a consistent and effective Freedom to Speak Up culture across the system which enables workers to speak up and be confident they will be listened to, and action taken.

Current compliance with each module is shown below:

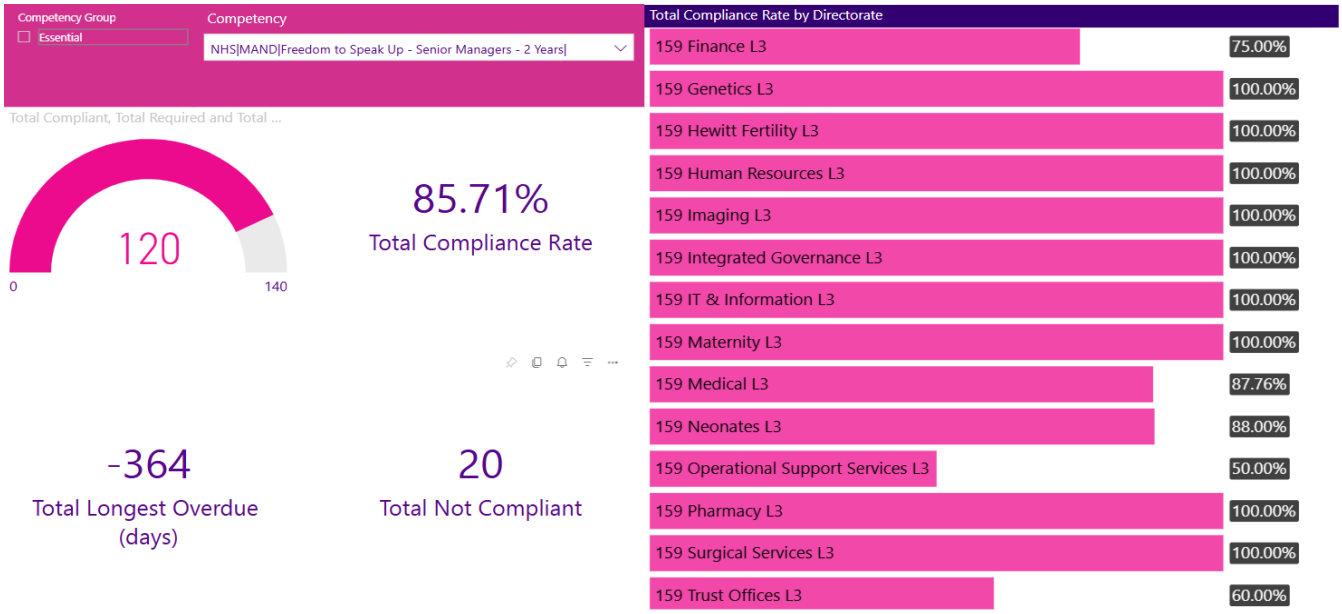
Speak Up Module – All workers



Listen Up Module – People Managers



Follow Up Module – Senior Leaders – including executive and non-executive directors



NB. Days overdue - *The total longest overdue days is relating to the arbitrary date put in when the training was created centrally by the National Guardian Office, not uploaded or when the provision was introduced at LWH. This metric it does not give a true picture on the overdue time frames currently.*

It can be seen in PowerBI reporting details available who the individuals are who are not compliant with these areas of training and the Guardians will be contacting the relevant service heads with these over the coming months with the hopes of increasing the compliance in these important areas. Senior leaders in these areas will also be asked to support this effort.

Freedom to Speak up Guardian resource and continuing work

The Trust has 2 Guardians in place, Nicola Pittaway, Patient Experience Officer and Dr Shri Babarao, Consultant Neonatologist

A dedicated safe and confidential space for the Guardians has now been identified and will be up and running over the coming weeks once furniture is in situ. This will enable the Guardians to offer weekly

drop-in sessions in a safe and confidential space and sessions will also be offered on a weekend and evenings to ensure all staff have the opportunity to meet with a Guardian.

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

Feedback from the inductions has been overwhelmingly positive, with comments such as
Informative and excellent to know the staff in this Trust
Able to now identify the freedom to speak up guardians. Reassuring that someone is available to speak up to
Very encouraging and reassuring about being able to speak up if wanting to and know where to go /what to do/how to

Focussed work with Junior Doctors continues **–** FTSU Guardians attend all their inductions and also collate feedback from them after they have left from the FTSU perspective and liaise with the medical education team to improve future experience for trainees in various specialities.

Over the last 6 months, the Guardians have attended Trust network meetings and will continue to build on relationships, regular walkarounds to departments and communication regarding the new Guardian office and drop-in sessions made available in all staff areas. Drop-in sessions will also be arranged with staff at Hewitt Knutsford and Aintree. Feedback to the Guardians is also requested at the end of a case of raising concerns with staff feedback being generally positive.
The F2SUG's are active members of the Northwest Regional F2SU Guardians network. This work helps to standardise Guardians works across a wider footprint and to create a support structure for Guardians to enable training, learning, and debriefing after difficult cases.

Actions for the Coming Year Ahead

The following actions are the priorities for the year ahead:

- Specific work within Divisions with Leaders and Staff to promote the Speak Up messages and ensure the staff are empowered to raise any concerns with their Leaders or the Guardians.
- Create specific communication and development material to address the concerns within the workforce regarding the confidentiality of speaking up.
- Continue to develop ways to celebrate speaking up across the Trust
- Continue to support the Fair and Just Culture work program within the Trust and embed its principles into all aspects of Trust business.
- Continue to work with Regional and National Guardians to improve communication and standards of working and reporting of Concerns Raised.

- Specific work to promote FTSU and ED&I, specifically in relation to the Trust's Anti - Racism work
- Specific work to promote FTSU and the implementation of the Sexual violence and domestic abuse charter
- Continue to Work with the Divisional Leads to identify any trends and themes in concerns raised.

Equality, Diversity & Inclusion Implications – DO NOT DELETE [state N/A if necessary)

Quality, Financial or Workforce implications - DO NOT DELETE [state N/A if necessary)

RECOMMENDATION

The Board of Directors is asked to note the contents of this report and the ongoing approach to promoting Freedom to Speak at Liverpool Women's Hospital and take assurance from the Guardians' assessment of the Trust's compliance with NHSE's expectations of Trusts with respect to Freedom to

SUPPORTING DOCUMENTS

None

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 12 September 2024	**Item Reference**	24/25/115
Report Title	Committee Chair's Reports		
Author	Louise Hope, Deputy Trust Secretary		
Responsible Director	Daniel Scheffer, Director of Corporate Affairs		

Purpose of Report	This report highlights key matters, issues, and risks discussed at Committees since the last report in July 2024
Executive Summary	The Chair reports for the following Board committees are included in this report and attached at Appendix 1. Audit Committee • 18 July 2024 – Chaired by Tracy Elery Quality Committee • 22 August 2024 – Chaired by Sarah Walker
Key Areas of Concern	N/A
Trust Strategy and System Impact	*N/A*

Links to Board Assurance Framework	None	**n/a**
Links to Corporate Risk Register (scoring 10+)	None	**n/a**

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

Action Required by the Board	The Board of Directors is asked to - • note the Committee Chair's Reports.

REPORT DEVELOPMENT:

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

MAIN REPORT

Audit Committee Assurance Report

Report to	Trust Board
Date	12 September 2024
Meeting Name	Audit Committee
Date of Meeting	18 July 2024
Chair's Name & Title	Tracy Ellery, Non-Executive Director

Agenda Items

The following agenda items were discussed by the meeting:

1. Follow up of Internal Audit and External Audit Recommendations
2. MIAA Internal Audit Reports (Internal Audit Progress Report; Follow Up of Audit Recommendations Report; Anti-Fraud Progress Report 2024/25; Insight Update)
3. External Audit Sector Update
4. Waiver Report – Q4 Financial Year 2023/24; Q1 Financial Year 2024/25 and summary 2023/24
5. Whistleblowing/Freedom to Speak up Annual Report 2023/24 **(Substantial Assurance)**
6. External Visits, Inspections & Accreditations Register Update
7. Chairs reports of the Board Committees **(Substantial Assurance)**
8. Board Assurance Framework (BAF) **(Substantial Assurance)**

Matters for Escalation

No matters highlighted for escalation.

Key Issues

Follow up of Internal Audit and External Audit Recommendations
Received an update on the implementation of the outstanding internal and external audit and Local Counter Fraud Service (LCFS) recommendations. All outstanding recommendations had been either implemented, partially implemented or not yet due for implementation. The Committee discussed the frequent request to extend target dates which could demonstrate a weakness within the process and advised that extensions should be agreed by exception. It was noted that the Executive Team had provided additional review and challenge of all future proposed target completion dates to ensure that they are deliverable within current capacity, and had added additional rigour by adding the open audit recommendations onto the Executive Risk and Assurance Sub-Group agendas for monthly review.

MIAA Internal Audit Progress Report
Six internal audit reports had been finalised since the last meeting, four of which had resulted in moderate and limited assurance outcomes and two received substantial assurance.

- QIP – Operation in Practice (substantial assurance)
- Data Security and Protection Toolkit (Veracity of Self-Assessment) (substantial assurance)
- Cost Improvement Programmes (moderate assurance)
- Data Security and Protection Toolkit (National Data Guardian Standards) (moderate assurance)
- Quality Spot Checks (limited assurance)
- Critical Applications: NEP Cloud – Oracle EPR (limited assurance)

Follow Up of Audit Recommendations Report
The Committee noted 23 recommendations to be followed up, 11 of which an update or evidence was awaited. It was noted that a reconciliation exercise against the Trust follow up report of internal audit recommendations would be beneficial to ensure consistent data presented.

Anti-Fraud Progress Report 2024/25
Counter fraud *understand* and *prevent* activities continued to be implemented. The Counter Fraud Functional Standard Return (CFFSR) had been submitted against the Government Functional Standard 013 for Counter Fraud and the Trust had received a Green rating overall and across all 12 component which comprise the CFFSR.

External Audit Sector Update
A verbal update provided confirmation that the audited annual report and accounts together with the unqualified audit opinion had been submitted within timescales.

Waiver Report – Q4 Financial Year 2023/24 and Quarter 1 Financial Year 2024/25 and summary 2023/24
A summary of waivers submitted for approval during 2023/24 and quarter 1 2024/25 were reviewed by the Committee. Continued focus on reducing the volume of waivers was noted and it was agreed to keep the waiver threshold at £5k to maintain grip and control.

Whistleblowing/Freedom to Speak up Annual Report 2023/24
Positive assurance taken from the Freedom to Speak Up Annual Report noting continued commitment to support staff to utilise the freedom to speak up service and that those concerns raised had been dealt with appropriately. Trend data demonstrated that staff felt confident to raise concerns although apprehension remained to share their identify further than the Guardian. The Committee noted that the majority of concerns raised related to HR issues and recommended increased signposting for staff directly to HR for queries.

External Visits, Inspections & Accreditations Register Update
This report was commissioned to provide an update of all external visits, inspections and accreditations taking place across the Trust. The register provided better oversight and the governance team continued to work with divisions to ensure that it was regularly updated. The Committee acknowledged the implementation of the register and requested continued oversight at the Quality Executive Group going forward.

The following reports were considered, no issues raised.

- Chair reports of Board Committees
- Board Assurance Framework

Decisions Made

- Requested alignment of reports to the new governance framework and executive led groups.

Recommendations

The Board is asked to note the contents of this report and the decisions taken by the Audit Committee

Appendix 1: Attendance Matrix

Core members	June	July	Oct	March
Tracy Ellery, Non-Executive Director CHAIR	✓	✓		
Jackie Bird, Non-Executive Director	✓	✓		
Zia Chaudhry, Non-Executive Director	✓	**A**		

Quality Committee Assurance Report

Report to	Trust Board
Date	12 September 2024
Meeting Name	Quality Committee
Date of Meeting	22 August 2024
Chair's Name & Title	Sarah Walker, Non-Executive Director

Agenda Items

The following agenda items were discussed by the meeting:

1. Quality and Regulatory Update
2. Maternity Incentive Scheme Update, Perinatal Quality Surveillance Dashboard & Safety and Maternity Staffing report Jan-June 2024 **(Substantial Assurance)**
3. Learning from Deaths Report Quarter 1 **(Substantial Assurance)**
4. The NHS Prevention Pledge Update
5. Integrated Performance Report

Matters for Escalation

No matters highlighted for escalation.

Key Issues

Quality and Regulatory Update
The report provided an overview of key issues of note. No matters to escalate identified.

Maternity Incentive Scheme Update
Received a progress update in relation to the defined 10 safety actions and standards of the Maternity Incentive Scheme Year 6. Noted the identified risk to Safety Action 8 in relation to delivery and compliance with PROMPT Training due to periods of industrial action. This had been escalated to the Educational Governance Committee to monitor. The Committee took assurance by the scrutiny and oversight in place across the ten safety actions.

Perinatal Quality Surveillance & Safety Dashboard
The Committee noted the key quality & safety KPIS as outlined in the NHS England Perinatal Quality Surveillance Framework. A significant number of Quality Improvement projects noted.

Maternity Staffing report Jan-June 2024
The Committee received the bi-annual Maternity Staffing Report for the period January to June 2024 (as per requirement of CNST MIS Year 6, safety action 5). Midwifery budgeted posts for 2024/25 demonstrated compliance with outcomes of Birth Rate+ audit 2023. The Committee raised concern in relation to the volume of red flags raised due to delays in Induction of Labour. Ongoing work led by the induction of labour Quality Improvement project was ongoing which would support improvement to patient flow on Delivery Suite and expedite IOL. The Committee

was also assured about the process of review by exception the delays in care and impact on patient experience and safety for each delay

Learning from Deaths Report Quarter 1, 2024/25
Received the Learning from Deaths report for Quarter 1. The Committee noted that the ethnicity data for both neonatal deaths and stillbirths did not show an over representation significant difference between white and non-white populations. The Committee was assured by the annual stillbirth and neonatal mortality rates during 2023/24. The preterm mortality rate remained higher than other level 3 surgical centres in the north-west and work with the maternity and neonatal networks was ongoing to understand reasons. In discussion the complexity and multifactorial nature of preterm mortality was highlighted.

The NHS Prevention Pledge Update
Received a progress update against the NHS Prevention Pledge. Additional work with the community had been initiated including engaging with the Liverpool Tobacco Control Consultation and Introduction of Faith Walks covering local places of worship. The Trust remained committed to being an Anchor institution within the region.

The following reports were considered on a consent agenda, no issues raised.

- Integrated Performance Report

Decisions Made

- Noted this would be the last Quality Committee meeting and requested Executive Team oversight of allocation of reports to the new governance framework to ensure continued oversight at an appropriate level

Recommendations

The Board is asked to:

- note the contents of this report and the decisions taken by the Quality Committee.
- note the current position in relation to the recently published Maternity Incentive Scheme Year 6.

Appendix 1: Attendance Matrix

Core members	Apr	June	August	Oct	Nov	Jan	March
Sarah Walker, Non-Executive Director CHAIR	✓	A	✓				
Jackie Bird, Non-Executive Director	✓	✓	✓				
Louise Kenny, Non-Executive Director	A	A	✓				
Gloria Hyatt, Non-Executive Director	✓	A	A				
Dianne Brown, Chief Nurse	✓	✓	✓				
Nashaba Ellahi, Deputy Chief Nurse	✓	✓	A				
Gary Price, Chief Operating Officer	✓	✓	✓				
Lynn Greenhalgh, Chief Medical Officer	✓	✓	✓				
Jenny Hannon, Chief Finance Officer	✓	✓	✓				
Michelle Turner, Chief People Officer	A	✓	✓				
Philip Bartley, Associate Director of Quality and Governance	A	✓	A				
Yana Richens, Director of Midwifery	✓	✓	✓				
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) *Non-quorate meetings highlighted in greyscale*							

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 12 September 2024	**Item Reference**	24/25/116
Report Title	Green Plan 2024-2027		
Author	Nicola Daley and Lucy Raven: LWH Sustainability Leads		
Responsible Director	Gary Price, Chief Operating Officer		

Purpose of Report	The purpose of this report is for the Trust Board to receive the 2024-2026 Green Plan objectives. The plan supports the Trust and wider NHS ambitions to reduce our Carbon footprint and supports the national NHS Green Plan.
Executive Summary	Climate change is one of the most serious threats to the continued health and wellbeing of millions of people worldwide. The worst aspects of climate change will inevitably impact greatest on those within society who are most vulnerable and least able to cope. It is therefore vital that action is taken at all levels to implement effective strategies not only to reduce carbon emissions, but also apply the broader principles of sustainable development and healthcare. The NHS has set a target to reduce carbon emissions. This plan responds to these targets and other requirements placed on the Trust to manage and reduce our environmental impact.
Trust Strategy and System Impact	Caring for our patients in a sustainable manner and being aware of the social impacts of our actions will help achieve the goals of caring for the environment, reducing long term expenditure, and building a supportive base in the society in which we operate. The Trust's first Green Plan was published in May 2022. The plan set out its objectives across 11 themes. Since then, significant progress has been made across all areas. This updated plan reflects revised objectives, with greater ambition and a much broader scope of activity across all themes and this reflects increased engagement from staff. The detail in this plan will not be exhaustive and time has been allocated in the governance of the programme detailed moving forwards to continue to develop our approach and response to the green agenda. This Green Plan outlines projects and activities which will evidence continual improvement in sustainability performance throughout the Trust, covering areas such as staff awareness and engagement, through to projects aimed specifically at reducing the carbon emissions associated with our service delivery and operating our estate

Action Required by the Committee	The Board is asked to note the plan. Updates on progress will come to Finance Performance and Executive Group twice yearly

MAIN REPORT

In October 2020, the NHS became the world's first health service to commit to reaching carbon net zero, with the release of the Delivering a Net Zero NHS report.

This plan sets two key targets: firstly, for emissions directly under our control, we aim to achieve net zero by 2040, with an ambitious interim target of an 80% reduction from 2028 to 2032. Secondly, for emissions we can influence, we are committed to reaching net zero by 2045, with an aspiration of achieving an 80% reduction between 2036 and 2039. In July 2022, the NHS became the first health system to embed net zero into legislation, through the Health and Care Act 2022

As an organisation, we are committed to working individually as well as at Place and System level. Since the adoption of the first iteration of our Green Plan we have actively engaged with partner organisations to establish system priorities and have been working towards delivering them. This exemplifies the collaborative efforts of Cheshire and Merseyside ICS in mitigating our carbon footprint, reducing health inequalities, and enhancing social value.

This is coordinated across a series of regional subgroups which report up to the Cheshire and Merseyside Sustainability Board, covering Air Quality, Biodiversity & Nature Recovery, Energy, Travel & Transport, Waste, Social Value and Anchors.

The following areas of focus will form the basis of our Green Plan.

1. Workforce and System Leadership
2. Sustainable Models of care
3. Digital Transformation
4. Travel and Transport
5. Estates and Facilities
6. Medicines
7. Supply Chain and Procurement
8. Food and Nutrition
9. Our People our Culture

The number of actions have grown from the last plan, recognising the growing sustainability agenda The structure of this Green Plan has been aligned to that of the Greener NHS Green Plan Guidance. Progress is reported quarterly via the Greener NHS Return and annually to the Greener Fleet Data Return.

Progress against the objectives detailed in the Action Plan is to be reported to the Trust on an annual basis. Objectives will be reviewed and updated annually. This approach will ensure that continual improvement is made in our environment and sustainability performance, which is reflective of the evolving nature of our service provision.

The Trusts Annual Report is to include a section on sustainability that provides an overview of activities undertaken during the previous financial year. This will include an update on the Trust's annual carbon emissions.

A Green Plan Steering Group co-ordinates the implementation of the Green Plan. The steering group meets quarterly and provide updates to the Trusts Finance Performance Executive Group through the production of a chairs report and annually to Trust Board. The steering group will annually review and update the objectives based on progress and identification of new initiatives and feedback received.

RECOMMENDATION

The Trust Board is asked to note this Plan and the intent to continue to reduce our Carbon producing activities in support of the wider NHS Green Plan.

SUPPORTING DOCUMENTS

Our Green Plan 2024/26

Liverpool Women's
NHS Foundation Trust

Our Green Plan
2024-26

Creating a greener Liverpool Women's

Our Green Plan 2024-26

Liverpool Women's NHS Foundation Trust has made significant progress since the publication of the first Green Plan in 2022. The Trust has shown leadership in several areas of sustainability, gaining regional and national recognition.

The Trust continues to strive to improve the performance in reducing our environmental impact. The Trust recognises the intrinsic link between the environment and health. We take our responsibility seriously to ensure the health and wellbeing of future generations.

This green plan details the contribution can make towards to that ambition.

1. Introduction

1.1 Each year Liverpool Women's Hospital comprising of a team of approximately 1,600 people, takes care of more than 50,000 patients from Liverpool, the surrounding areas and across the UK. As well as delivering care within the hospital we work in the heart of the community, providing care for patients at various clinics across the city.

1.2 Climate change is one of the most serious threats to the continued health and wellbeing of millions of people worldwide. The worst aspects of climate change will inevitably impact greatest on those within society who are most vulnerable and least able to cope. It is therefore vital that action is taken at all levels to implement effective strategies not only to reduce carbon emissions, but also apply the broader principles of sustainable development and healthcare.

The NHS has set a target to reduce carbon emissions. This plan responds to these targets and other requirements placed on the Trust to manage and reduce our environmental impact.

1.3 Caring for our patients in a sustainable manner and being aware of the social impacts of our actions will help achieve the goals of caring for the environment, reducing long term expenditure, and building a supportive base in the society in which we operate.

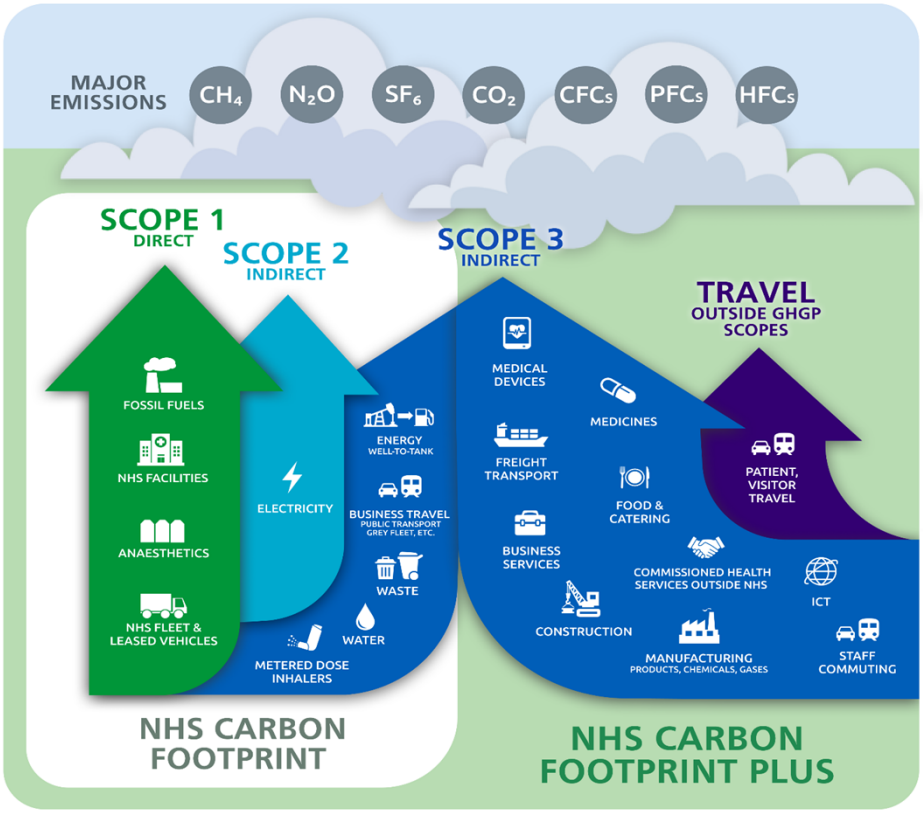
1.4 The Trust's first Green Plan was published in May 2022. The plan set out its objectives across 11 themes. Since then, significant progress has been made across all areas. This updated plan reflects revised objectives, with greater ambition and a much broader scope of activity across all themes and this reflects increased engagement from staff. The detail in this plan will not be exhaustive and time has been allocated in the governance of the programme detailed moving forwards to continue to develop our approach and response to the green agenda.

1.5 This Green Plan outlines projects and activities which will evidence continual improvement in sustainability performance throughout the Trust, covering areas such as staff awareness and engagement, through to projects aimed specifically at reducing the carbon emissions associated with our service delivery and operating our estate.

2. Drivers for Change

2.1 In October 2020, the NHS became the world's first health service to commit to reaching carbon net zero, with the release of the Delivering a Net Zero NHS report.

This plan sets two key targets: firstly, for emissions directly under our control, we aim to achieve net zero by 2040, with an ambitious interim target of an 80% reduction from 2028 to 2032. Secondly, for emissions we can influence, we are committed to reaching net zero by 2045, with an aspiration of achieving an 80% reduction between 2036 and 2039. In July 2022, the NHS became the first health system to embed net zero into legislation, through the Health and Care Act 2022.



2.2 The NHS Cheshire and Merseyside ICS launched their Green Plan in 2022, in order to align sustainable healthcare practices across the region.

As an organisation, we are committed to working individually as well as at Place and System level. Since the adoption of the first iteration of our Green Plan we have actively engaged with partner organisations to establish system priorities and have been working towards delivering them. This exemplifies the collaborative efforts of Cheshire and Merseyside ICS in mitigating our carbon footprint, reducing health inequalities, and enhancing social value.

This is coordinated across a series of regional subgroups which report up to the Cheshire and Merseyside Sustainability Board, covering Air Quality, Biodiversity & Nature Recovery, Energy, Travel & Transport, Waste, Social Value and Anchors.

3 . Progress to date

3.1 Since the publication of the first version of our Green Plan, significant progress has been across all themes.

A selection of some of the work undertaken in the last two years is highlighted below.

- ✓ Additional resource, with the intrduction of a Sustainability Team to support the ongoing progress of the Green Plan.
- ✓ A full site lighting survey has been complete with LED lighting schemes rolled out where necesary. In addition, the Trust commited to purchasing 100% renewable electricity.
- ✓ Completed a travel survey, delivered regular cycling engagement actvities, including Dr bikes, and engaged staff and local community in local active travel consultations and workshops to respond to Liverpool City Council infrastructure proposals.
- ✓ The reintroduction of a trust shuttle bus has resulted in a 50% reduction in taxi use.
- ✓ Worked with suppliers and NHS Supply Chain to consolidate medicines delivery schedules to reduce air quality impacts
- ✓ Removed the use of Desflurane, a highly carbon intensive aneasthetic gas. This completed ahead of the national mandate to cease using the gas in 2024.
- ✓ A full review of general and clinical waste streams has been complete resulting in a range of improvements being implemented, including installation of a general waste compactor on site and use of larger skips for additional on site storage resulting in fewer waste collections and reduced miles travelled by waste vehicles.
- ✓ Coffee grinds have been removed from waste streams and are used for reuse as compost saving up to two tonnes waste per year.
- ✓ Introduction of the Social Value Portal, which will be used to measure the wider social, economic and environmental impacts of supplier contracts.
- ✓ Divesting Trust charitable funds from companies who invest in fossil fuels.

In 2023, a detailed exercies was undertaken to accurately calcultate the Trust Carbon Footprint, inline with the Greenhouse Gas Protocol.

	Categories		tCO2e						Baseline to present change
			2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	
NHS Carbon Footprint	Scope 1	Fossil Fuels	989.12	913.22	1,220.04	2,126.70	2,165.20	2,181.92	120.59%
		NHS Facilities	172.48	172.48	182.91	182.91	135.30	230.52	33.65%
		Anaesthetics	1,816.80	1,736.82	1,757.53	1,543.96	1,625.15	1,474.88	-18.82%
		Fleet	33.95	34.05	33.09	32.45	32.46	32.00	-5.74%
	Scope 2	Electricity	2,042.80	1,636.58	1,343.23	812.00	712.99	657.60	-67.81%
	Scope 3	Energy WTT	696.72	529.85	475.98	468.07	635.78	603.56	-13.37%
		Business Travel	72.13	57.91	57.65	32.21	36.23	53.97	-25.18%
		Waste	18.82	17.13	18.63	47.14	69.10	21.59	14.72%
		Water	34.25	35.41	39.48	40.98	14.07	11.25	-67.15%
		Inhalers	2.40	2.68	1.77	2.25	0.86	2.45	2.25%

Total	**5,879.47**	**5,136.13**	**5,130.31**	**5,288.67**	**5,427.14**	**5,269.73**	**-10.37%**

4 . Areas of Focus

4.1 The following areas of focus will form the basis of our Green Plan.

1. Workforce and System Leadership
2. Sustainable Models of care
3. Digital Transformation
4. Travel and Transport
5. Estates and Facilities
6. Medicines
7. Supply Chain and Procurement
8. Food and Nutrition
9. Our People our Culture

4.2 The number of actions have grown from 31 to 51, recognising the growing sustainability agenda

5. Reporting

5.1 The structure of this Green Plan has been aligned to that of the Greener NHS Green Plan Guidance. Progress is reported quarterly via the Greener NHS Return and annually to the Greener Fleet Data Return.

5.2 Progress against the objectives detailed in the Action Plan is to be reported to the Trust on an annual basis. Objectives will be reviewed and updated annually. This approach will ensure that continual improvement is made in our environment and sustainability performance, which is reflective of the evolving nature of our service provision.

5.3 The Trusts Annual Report is to include a section on sustainability that provides an overview of activities undertaken during the previous financial year. This will include an update on the Trust's annual carbon emissions.

6. Governance

6.1 A Green Plan Steering Group co-ordinates the implementation of the Green Plan.

6.2 The steering group is comprised of the following members:

- Chief Operating Officer (Chair)
- Head of Sustainability
- Sustainability Team
- Estates Manager
- Health and Safety
- Procurement and Finance
- HR
- Pharmacy
- Clinical representation
- Patient Experience
- Communications

- Health Informatics

6.3 The steering group meets quarterly and provide updates to the Trusts FPBD through the production of a chairs report and annually to Trust Board. The steering group will annually review and update the objectives based on progress and identification of new initiatives and feedback received.

Green Plan Objectives: 2024-2026

Category	Objective	Lead	Timescale
Communications and System Leadership	Develop a Communications Plan specifically for the promotion of the Green Plan sustainable developments to staff, patients, and service users.	Communications	Q2 2024/25
	Complete new Green Plan Tool assessment tool once published	Sustainability Team	Within 3 months of publication
	Ongoing commitment to divest charitable funds from fossil fuels	Deputy Director of Finance	Ongoing
	Explore options for ethical banking	Deputy Director of finance	Q4 2024/25
Category	**Objective**	**Lead**	**Timescale**
Sustainable Models of Care	Develop a framework to ensure that existing and new models of care consider their environmental impact and be assessed against it	Chief Operating Officer	Ongoing
	Embed sustainability with Trust audit and quality improvement processes	Deputy Chief Nurse	1 sustainability audit per annum
	Explore opportunities to embed prevention in the patient lifecycle	Deputy Chief Nurse	March 2025
Category	**Objective**	**Lead**	**Timescale**
Informatics	To reflect the Green Plan ambition in the End User Devices Strategy including • Single device Policy • Staff Profile: Right device for right role • Shift to mobile working low power devices • Power management policy: Investment in technology to reduce digital power usage according to usage profiles • Virtual desktop Infrastructure: enable better home working, reduce the need for traditional computers	Chief Informatics Officer	Through lifecycle of Digital Strategy
	Where outpatient attendances are clinically necessary, at least 25% of outpatient activity should be delivered remotely, resulting in direct and tangible carbon reductions.	Chief Operating Officer	Ongoing
Category	**Objective**	**Lead**	**Timescale**
Travel and Transport	Develop a Trust approved Travel Plan	Sustainability Team	Q2 2024/25
	Complete staff, patient and visitor travel survey Q1 25/26	Sustainability Team	Q1 2025/26

	Review electrical capacity and opportunities for increase provision of Electric Vehicle charging points across the Trust	Estates	Q4 2024/25
	Explore opportunities to support community vehicle charging within the Trust Estates	Estates	Q4 2025/26
	Organisation's salary sacrifice scheme for vehicles must allow for the purchase of only ultra-low (ULEV) or zero emission vehicles (ZEV)	Procurement	Q2 2024/25
	Organisation's salary sacrifice scheme for vehicles must allow for the purchase of only ZEVs	Procurement	Q1 2025/26
	Introduce cycle to work scheme for staff	Sustainability Team	Q3 2024/25
	Launch a car sharing scheme for staff	Sustainability Team	Q2 2024/25
	Organisation to purchase or lease solely fleet vehicles that are ULEV or ZEV	Estates	Q4 2024/25
	Increase cycle storage facilities for staff	Sustainability Team	Q4 2024/25
Category	**Objective**	**Lead**	**Timescale**
Estates and Facilities	Embedding green plan objectives in estates strategy	Estates	Q2 2024/25
	Develop a Heat Decarbonisation Plan	Sustainability Team	Q3 2024/25
	Review and optimisation of the CHP and boiler house run regime	Estates	Q4 2024/25
	Surveying and optimising energy intensive equipment, such as electrical motors	Estates	
	Develop a Trust-wide strategy to improve water management and reduce consumption, including metering, leak detection and operational procedures	Estates	Q1 2025/26
	Deliver an annual energy awareness campaign	Sustainability Team	Ongoing
	To continue to purchase renewable sourced electricity only	Sustainability Team	Ongoing
	Explore opportunities for onsite renewable electricity	Sustainability Team	Ongoing
	Write a Climate Change Adaption Plan	Sustainability Team	Q1 2025/26
	Explore opportunities for plastics removal	Estates	Ongoing
	Explore opportunities to reuse of cardboard rather than recycling.	Estates	Q3 2024/25
	Commit to zero waste to landfill	Estates	March 2025
	Reinvest 25% of waste cost savings to new waste streams/initiatives	Estates	March 25
	Meet targets within the national NHS clinical waste strategy	Estates	March 25
	Review opportunities to improve biodiversity onsite	Sustainability Team	December 24
Category	**Objective**	**Lead**	**Timescale**
Medicines	Investigate more environmentally friendly medicine delivery, through utilisations of local pharmacies and zero emission transportation	Deputy Chief Pharmacist	Q3 2024/25 % of suppliers that utilise zero

			emission transportation
	Exploring joint procurement to streamline delivery schedules	Deputy Chief Pharmacist	Q4 2025/26
	Continuing education of patients around the impact of medicines and which may be brought into hospital from home before dispensing new medication.	Deputy Chief Pharmacist	Q4 2024/25 Education event for patients & staff regarding medication supplies
	Review opportunities for step down from IV to oral medication	Deputy Chief Pharmacist	Q3 2024/25
	Establish one-stop dispensing to reduce wastage from repeat dispensing	Deputy Chief Pharmacist	Q2 2025/26 One-stop dispensing processes established across hospital for medication
	Education for staff, making them aware of impact of certain medicine usage in the environment	Deputy Chief Pharmacist	Q4 2024/25 Education event for patients & staff regarding medication supplies
	Complete full audit of manifolds and review opportunities to isolate under utilised branches of the supply where appropriate	Deputy Chief Pharmacist	Q2 2025/26
	Complete a review to identify opportunities to reduce use of Entonox, including reducing flow rates, pressure and use of alternative for certain procedures	Deputy Chief Pharmacist	Q4 2025/26
Category	**Objective**	**Lead**	**Timescale**
Supply Chain and	Review opportunities for waste avoidance, both in terms of packaging and use of consumable products within the Trust	Procurement	Q2 2025/26

Procurement	Reduce use of single use plastic items, including PPE	Procurement	Q4 2024/25
	Create a LWH Sustainable Procurement Policy	Procurement	Q4 2024/25
	Formalise internal reuse system within the Trust with environmental reporting	Procurement	Q1 2025/26
	Use Social Value Portal to measure social value impact of suppliers and for corporate social value measurement	Procurement	Q2 2024/25
Category	**Objective**	**Lead**	**Timescale**
Food and Nutrition	Review and improve catering provision onsite to promote healthier and lower carbon menus, including seasonal and plant-based food	Facilities Manager	December 24
	Baseline food waste volumes and distribution, and develop plan to reduce	Facilities Manager	December 24
	Review opportunities for on the day electronic meal ordering	Facilities Manager	December 24
Category	**Objective**	**Lead**	**Timescale**
Our People and Culture	Complete a scoping exercise and develop a framework to support staff to undertake volunteering and other activities as part of the Trusts commitment to CSR (Corporate Social Responsibility)	HR	March 25
	Develop staff communications to improve understanding of the Trusts sustainability agenda through recruitment, selection, induction and appraisal	HR	March 25

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 12 September 2024	**Item Reference**	24/25/117
Report Title	Senior Independent Officer Update		
Author	Hollie Holding, Associate Director of Corporate Governance		
Responsible Director	Daniel Scheffer, Director of Corporate Affairs/Company Secretary		

Purpose of Report	The purpose of this report is to provide an update and to ratify the appointment to the role of the Senior Independent Director to the Board of Directors.
Executive Summary	The term of office for the Trust's current Senior Independent Director (SID) is due to end on 31 August 2024. In line with the requirements set out in the NHS Code of Governance, the Trust Chair is recommending Geoffrey Appleton be appointed to the role of SID from 1 September 2024. The position of SID will cover Liverpool University Hospitals NHS Foundation Trust and Trust and Liverpool Women's NHS Foundation Trust. The requirements within the NHS Code of Governance state: *"In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director".*
Key Areas of Concern	There are no areas of concern.

Links to Board Assurance Framework	*Risk 9 – Well led*	***9***
Links to Corporate Risk Register (scoring 10+)	*n/a*	

Assurance Level	1. HIGH - Strong system of internal control applied to meet existing objectives

Action Required by the Committee	The Board of Directors is asked to ratify the Council of Governors recommendation for Geoffrey Appleton to commence in the role of Senior Independent Director from 01/09/2024.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
LWH Council of Governors	30 July 2024	Chair / Director of Corporate Affairs	The Council of Governors approved the recommendation that Geoffrey Appleton be

		& Company Secretary	appointed to the role of Senior Independent Director.
LUHFT Council of Governors	30 July 2024	Chair / Director of Corporate Affairs & Company Secretary	The Council of Governors approved the recommendation that Geoffrey Appleton be appointed to the role of Senior Independent Director.

MAIN REPORT

1. Introduction

The Senior Independent Director is a Non-Executive Director appointed by the Board of Directors in consultation with the Council of Governors to undertake the role as described in Appendix 1: Senior Independent Role Description.

The Trust Constitution details the requirements for the appointment of the Senior Independent Director as detailed below. The requirements contained in the Trust's Constitution are in line with the requirements set out in the Provisions of the NHS Code of Governance for NHS Provider Trusts (the Code) below:

> ***2. Provisions***
>
> ***2.5*** *The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice-chair or senior independent director.*
>
> ***2.11*** *In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trusts non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the Chair appraisal framework.*

The Senior Independent Director has a key role in supporting the Chair in leading the Board of Directors and acting as a sounding board and source of advice for the Chair. The Senior Independent Director also has a role in supporting the Chair as Chair of the Council of Governors.

2. Appointment Process

In consultation with the Council of Governors, the Board of Directors should appoint one of the independent Non-Executive Directors to be the Senior Independent Director to provide a sounding board for the Chair and to serve as an intermediary for the other directors when necessary.

As part of the criteria for eligibility for the role of Senior Independent Director, candidates must be a Non-Executive Director of the Board of Directors who is considered to fulfil the criteria of 'independent' as set out in the Code. Candidates will be required to demonstrate their independence, and that they have sufficient time to meet the additional responsibilities of the role.

The Chair of the Trust is not eligible to be the Senior Independent Director. Whilst the Deputy Chair is eligible to be the Senior Independent Director, they cannot carry out this role when acting as the Chair of the Trust, due to the need to be independent of the Chair. Further, guidance outlines that this role should not be undertaken by the Chair of the Audit Committee.

The Liverpool University Hospitals NHS Foundation Trust (LUHFT) Council of Governors and Liverpool Women's NHS Foundation Trust (LWH) Council of Governors approved the recommendation to appoint Geoffrey Appleton to the role of Senior Independent Director at individual meetings held on 30 July 2024. The role will be held jointly on the Board of Directors for each Trust.

RECOMMENDATION

The Board of Directors is asked to ratify the Council of Governors decision for Geoffrey Appleton to commence in the role of Senior Independent Director from 1 September 2024.

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