Board of Directors Public 10 October 2024

Thu 10 October 2024, 09:00 - 11:00

The June Henfrey Suite, Blackburne House

Agenda

09:00 - 09:01
1 min

1. Introduction, Apologies & Declaration of Interest

Note *David Flory*

- 01. Front Sheet 10 October 2024.pdf (1 pages)
- TB24.25_130 Board of Directors Agenda 10 October 2024.pdf (2 pages)

09:01 - 09:02
1 min

2. Minutes of the Board of Directors held on 12 September 2024

Decision *David Flory*

- TB24.25_131 Draft Board of Directors Public Minutes (12 September 2024).pdf (9 pages)

09:02 - 09:04
2 min

3. Action Log

Note *David Flory*

- TB24.25_132 Action Log.pdf (2 pages)

09:04 - 09:05
1 min

4. Any Urgent Matters Arising

Note *David Flory*

09:05 - 09:20
15 min

5. Chief Executive Officer’s Report

Assurance *James Sumner*

- TB24.25_134 (i) Chief Executive Officer's Report.pdf (6 pages)
- TB24.25_134 (ii) Appendix A People Pulse Results.pdf (2 pages)
- TB24.25_134 (iii) Appendix B Integrated Performance Report.pdf (26 pages)

09:20 - 09:30
10 min

6. Finance Performance: Month 5 2024/25

Note *Jenny Hannon*

- TB24.25_135 (i) Finance Performance Month 5.pdf (4 pages)
- TB24.25_135 (ii) Finance Performance Month 5.pdf (12 pages)

09:30 - 09:40
10 min

7. Improvement Plan Monthly Update

Note *Tim Gold*

- TB24.25_136 (i) Improvement Plan Monthly Update.pdf (5 pages)
- TB24.25_136 (ii) Improvement Plan Monthly Update.pdf (31 pages)

09:40 - 09:50
10 min

8. Ambulatory Expansion Project

Decision *Gary Price*

TB24.25_137 Ambulatory Expansion Project.pdf (4 pages)

09:50 - 10:00
10 min

9. Annual Appraisal and Revalidation Report

Decision *Lynn Greenhalgh*

TB24.25_138 (i) Medical Appraisal and Revalidation Annual Report 2023-24.pdf (7 pages)
TB24.25_138 (ii) Medical Appraisal and Revalidation Annual Report 2023-24.pdf (27 pages)

10:00 - 10:10
10 min

10. Self-Assessment Review Document Approval for Submission to NHS England

Decision *Lynn Greenhalgh*

TB24.25_139 (i) Self-Assessment Review Document Approval for Submission to NHS England.pdf (4 pages)
TB24.25_139 (ii) Self-Assessment Review Document Approval for Submission to NHS England.pdf (62 pages)

10:10 - 10:20
10 min

11. Bi-Annual Safe Staffing

Assurance *Dianne Brown*

TB24.25_140 Bi-Annual Staffing (January - June 2024).pdf (23 pages)

10:20 - 10:30
10 min

12. Maternity Incentive Scheme Year 6

Assurance *Dianne Brown*

TB24.25_141 (i) Maternity Incentive Scheme Year 6.pdf (17 pages)
TB24.25_141 (ii) Perinatal Quality Surveillance Safety Dashboard.pdf (8 pages)
TB24.25_141 (iii) Neonatal Safe Staffing.pdf (18 pages)

10:30 - 10:40
10 min

13. NHS University Hospitals Liverpool Group Governance

Decision *Hollie Holding*

TB24.25_142 (i) University Hospitals of Liverpool Group Mobilisation.pdf (14 pages)
TB24.25_142 (ii) Appendix A - PCA and TOR University Hospitals of Liverpool.pdf (66 pages)
TB24.25_142 (iii) Appendix B Summary of Changes to LWH Constitution.pdf (1 pages)
TB24.25_142 (iv) Appendix C - DRAFT UHL Group Joint Committee Trust Board Cycle of Business 2024-2025.pdf (5 pages)
TB24.25_142 (v) Appendix D - Statutory Roles within an NHS FT.pdf (4 pages)

10:40 - 10:50
10 min

14. Liverpool Adult Acute and Specialist Services Programme Working Collaboration Agreement

Decision *Hollie Holding*

TB24.25_143 (i) Liverpool Acute and Specialist Providers Joint Committee.pdf (2 pages)
TB24.25_143 (ii) Joint Working Agreement and Terms of Reference.pdf (26 pages)

10:50 - 10:55

15. Nomination and Remuneration Committee Terms of Reference

5 min

Decision *Hollie Holding*

- TB24.25_144 (i) Nominations and Remuneration Committee Terms of Reference.pdf (2 pages)
- TB24.25_144 (ii) DRAFT LWH Nominations & Remuneration Committee Terms of Reference September 2024.pdf (7 pages)

10:55 - 10:55
0 min

16. Committee Chair’s Reports

Note *Committee Chair's*

- TB24.25_145 (i) Committee Chair's Cover Sheet.pdf (1 pages)
- TB24.25_145 (ii) Appendix 1 Finance, Performance and Business Development Committee Assurance Report.pdf (2 pages)

10:55 - 10:55
0 min

17. Emergency Preparedness, Resilience and Response Core Standards Annual Submission

Note *Gary Price*

- TB24.25_146 (i) Emergency Preparedness, Resilience and Response Core Standards Annual Submission.pdf (2 pages)
- TB24.25_146 (ii) Core Standards Appendix 1pdf.pdf (13 pages)
- TB24.25_146 (iii) Action Plan Appendix 2.pdf (2 pages)

10:55 - 10:57
2 min

18. Review of risk impacts of items discussed

Note *David Flory*

10:57 - 10:59
2 min

19. Any other business & Review of meeting

Note *David Flory*

10:59 - 11:00
1 min

20. Jargon Buster

Note *David Flory*

- TB24.25_149 Jargon Buster.pdf (13 pages)

Liverpool Women's
NHS Foundation Trust

Trust Board

10 October 2024, 09.00am
The June Henfrey Suite
Blackburne House

Board of Directors

Location	**The June Henfrey Suite, Blackburne House**
Date	**10 October 2024**
Time	**09.00 – 11.00**

AGENDA					
Item no. 24/25	**Title of item**	**Objectives/ desired outcome**	**Process**	**Item presenter**	**Time**
PRELIMINARY BUSINESS					
130	**Introduction, Apologies & Declaration of Interest**	Note	Verbal	Chair	**09:00**
131	**Minutes of the Board of Directors held on 12 September 2024**	Approve	Written		
132	**Action Log**	Note	Written		
133	**Any Urgent Matters Arising**	Note	Written		
PERFORMANCE					
134	**Chief Executive Officer's Report** • People Pulse Survey Results • Integrated Performance Report • Executive Risk and Assurance Group (verbal)	Assurance	Written	Chief Executive Officer	**09:05**
135	**Finance Performance: Month 5 2024/25**	Note	Written	Chief Finance Officer	**09:20**
136	**Improvement Plan Monthly Update**	Note	Written	Chief Transformation Officer	**09:30**
FINANCE					
137	**Ambulatory Expansion Project**	Approval	Written	Chief Operating Officer	**09:40**
QUALITY, SAFETY & EFFECTIVENESS					
138	**Annual Appraisal and Revalidation Report**	Approval	Written	Medical Director	**09:50**
139	**Self-Assessment Review Document Approval for Submission to NHS England**	Approval	Written		**10:00**
140	**Bi-Annual Safe Staffing**	Assurance	Written	Chief Nurse	**10:10**
141	**Maternity Incentive Scheme Year 6** • September 2024 Compliance Update (including Perinatal Dashboard) • Bi-annual neonatal staffing report	Assurance	Written		**10:20**
GOVERNANCE					
142	**NHS University Hospitals Liverpool Group Governance**	Approval	Written	Associate Director of	**10:30**

143	**Liverpool Adult Acute and Specialist Services Programme Working Collaboration Agreement**	Approval	Written	Corporate Governance	**10:40**
144	**Nomination and Remuneration Committee Terms of Reference**	Approval	Written		**10:50**
CONSENT AGENDA 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.					
145	**Committee Chair's Reports**	Note	Written	Committee Chairs	
146	**Emergency Preparedness, Resilience and Response Core Standards Annual Submission**	Note	Written	Chief Operating Officer	
CONCLUDING BUSINESS					
147	**Review of risk impacts of items discussed**	Identify any new risk impacts	Verbal	Chair	**10.55**
148	**Any other business & Review of meeting**	Consider any urgent items of other business	Verbal		
149	**Jargon Buster**	For reference	Written		
Finish Time: 11.00					

NHS
Liverpool Women's
NHS Foundation Trust

UNCONFIRMED

Meeting of the Board of Directors in Public
Thursday 12 September 2024
June Henfrey Suite at Blackburne House

Non-Executive Directors present:	**Executive Directors present:**
David Flory	James Sumner, Chief Executive Officer
Zia Chaudhry	Dianne Brown, Chief Nurse
Jackie Bird	Matt Connor, Chief Digital and Information Officer
Mike Eastwood	Tim Gold, Chief Transformation Officer
Tracy Ellery	Lynn Greenhalgh, Chief Medical Officer
Louise Kenny	Jenny Hannon, Chief Finance Officer and Deputy CEO
Sarah Walker	Gary Price, Chief Operating Officer
Thomas Walley	Daniel Scheffer, Director of Corporate Affairs/Company Secretary
	Michelle Turner, Chief People Officer
Apologies for absence:	Geoffrey Appleton (Non-Executive Director) David Gilburt (Non-Executive Director) Gloria Hyatt (Non-Executive Director)
In attendance: Louise Florensa, Deputy Trust Secretary Hollie Holding, Associate Director of Corporate Governance Michelle Rushby, Head of Patient Involvement and Experience Nicola Pittaway, Freedom to Speak Up Guardian (to present agenda item 114)	
In attendance to observe: Lesley Mahmood, Public Felicity Dowling, Public Teresa Williamson, Public (virtual) Gordon Lorimer, Regional Director, Altera Digital Health (virtual)	

Attendance 2024/25 Directors	May	Jul	Sept	Oct	Nov	Dec	Jan	Feb	Mar
David Flory	⚐	⚐	⚐						
James Sumner	⚐	⚐	⚐						
Geoffrey Appleton			A						
Jackie Bird	⚐	⚐	⚐						
Dianne Brown	A	⚐	⚐						
Zia Chaudhry	A	⚐	⚐						
Matt Connor	⚐	⚐	⚐						
Mike Eastwood			⚐						
Tracy Ellery	⚐	A	⚐						
David Gilburt			A						
Lynn Greenhalgh	⚐	⚐	⚐						
Tim Gold	⚐	⚐	⚐						
Jenny Hannon	⚐	⚐	⚐						
Gloria Hyatt	⚐	A	A						
Louise Kenny	⚐	⚐	⚐						
Gary Price	⚐	⚐	⚐						
Daniel Scheffer		⚐	⚐						
Michelle Turner	⚐	⚐	⚐						
Sarah Walker	⚐	A	⚐						
Tom Walley			⚐						

R – Representative / A – Apologies

103 **Introduction, Apologies & Declaration of Interest**

David Flory welcomed everyone to the meeting, noting this was the first meeting of the Board with the two new Non-Executive Directors in attendance. Apologies were received from Geoffrey Appleton (Non-Executive Director), David Gilburt (Non-Executive Director) and Gloria Hyatt (Non-Executive Director)

The Board passed its thanks to Louise Kenny (Non-Executive Director) for her invaluable leadership at the Board as part of her long history serving Liverpool as a city.

One declaration of interest was brought to the attention of the Board by the Chief Operating Officer (COO), who is also the COO at The Walton Centre NHS Foundation Trust. It was confirmed that any interests would be dealt with as they arose.

104 **Patient Engagement and Activity**

Dianne Brown presented the Patient Engagement and Activity Update. The update provided an overview of the work undertaken across all aspects of patient engagement and activity over the previous 12 to 18 months. The Head of Patient Involvement and Experience outlined the key areas within the update for the attention of the Board, highlighting that the aim was to build trust and form relationships with communities.

Sarah Walker joined the meeting.

The Board heard that a stakeholder map had been developed; a significant number of engagement opportunities led by the patient experience team had taken place. Details of community listening events that the Trust had been involved in with patients and families were shared with the Board noting that there was a wide range of activities the Trust was involved in. Events highlighted included:

- Severa and Kumba Imani coffee mornings
- Bereaved fathers, Honeysuckle FC / LFC Foundation
- Asylum Link and Refugee Health events
- Baby Well refugee group
- Severa International women’s event
- Severa men’s event – honour based crime and health
- Antenatal birth clinics
- Numerous listening events across baby groups and children’s centres
- 15 Steps events at the Fetal Medicine Unit and Delivery Suite.

The Board was also informed of action that had been taken to address feedback that had been received through various channels. Areas included:

Maternity base
- overnight visiting for partners and accompanying bed cards, contracts and bedside posters
- screens to neonatal resus bays
- provision of fresh fruit and juice
- bay curtain posters
- improved signage
- improved staffing information
- improved postnatal information on the website.

Maternity Assessment Unit (MAU)
- Birmingham Symptom Specific Obstetric Triage System (BSOTS) implementation including ‘Welcome to MAU’ posters
- increased selection in the waiting room vending machine

- Maternity Quick Reference guide
- Additional high-backed chairs in the waiting room
- reception desk made wheelchair accessible
- boxes to store urine samples in MAU
- staff room door closed during handovers
- monthly infection control audits
- waiting room reassurance when alarms sound.

Neonatal Unit
- provision of meals for parents
- improved signage for the feeding room.

Induction of Labour
- leaflets in appropriate language
- videos for information
- development of an App.

Communities
- invested in Interpreter on Wheels with specific targeted recruitment for language line led by patient experience
- arranged for direct access to women within Asylum system and education on sexual health
- focused and targeted recruitment of volunteers from local community
- introduction of bi-lingual volunteers, roll out to staff, bi- lingual volunteers qualifications
- introduced Faith Walks for Staff led by local Faith Leader
- qualifications for both volunteer and staff to be offered working with Blackburn House.

The Board also learned that a multi-faith booklet had been introduced to help staff to care for people of all faiths, including those with no faith. Additionally, the Trust had engaged with the Chief Operating Officer from the local Mosque to ensure the faith rooms met the needs of the local community accessing it to pray.

The Trust continued to work to improve digital support for patients and their families, including enhancing accessibility to services, streamlining processes and providing personalised care.

The Board heard about Citizens Advice on Prescription (CAoP) which was a city-wide welfare (anti-poverty) service for front-line health in primary and secondary care. It targeted referrals from front-line health staff working with patients who have poor health and disadvantage, with the service expanded to include a children and families programme with a focus on the perinatal pathway, which was a service for pregnant woman or families with a child under 1 year. Several referrals had already been made, with the Trust continuing to work with system partners across the city.

Details about the refurbished and redesigned Patient Advice and Liaison Service (PALS) were shared with the Board, highlighting that a Help Hub had been introduced in January 2024, as well as a Happy to Help poster in 24 languages and an Interpreter on Wheels procured for the Hub. A Mersey Internal Audit Agency (MIAA) audit reported substantial assurance in September 2024 concerning the complaints process.

The Board noted that the improvements seen were encouraging and acknowledged the work with system partners to continue to improve the patient journey and experience.

	A query was raised relating to access to women in the asylum community to build trust and how the Trust approached that. It was confirmed that there were existing relationships in place, although it was recognised that the level of that relationship differed for every woman. Barriers remained in some areas such as unmet need, reluctance to access health services, reluctance to share details given the perceived linked to the Home Office. A commitment had been made by the Trust and local MPs to see if there was anything further that could be done to support the provision of care for patients in an asylum position. The Board raised a question concerning the work on the App and whether it was the intention to give access through the App to maternity health records. It was confirmed that this was the case. The Board passed their thanks onto all involved. *Michelle Rushby left the meeting.*
105	**Minutes of the Board of Directors held on12 July 2024** The Board noted one amendment to be made about the Guardian of Safe Working report but, subject to that change, approved the minutes of the meeting held on 12 July 2024 as a true and accurate record. The Board noted that an update given at the last meeting highlighted the number of out-of-date policies within the Trust, with a reduction from 60 to 13. A query on whether that work had been completed was raised. It was confirmed that the reduction in out-of-date policies continued on the same trajectory but the number left outstanding could not be confirmed. **ACTION: Confirm the number of out-of-date policies that remained following the targeted work to reduce them (James Sumner).**
106	**Action Log and Any Urgent Matters Arising.** The Board received the Action Log and noted the associated updates. There were no urgent matters arising. The Board noted that a Chair's Log had previously been introduced as a way of escalating a log of issues from each Committee, with consideration to be given to how issues that link with more than one area or Committee would be monitored once the Chair's Log was no longer used. It was agreed that this would be explored outside of the meeting. **ACTION: Explore a suitable mechanism for monitoring issues that would previously have been included in the Chair's Log (Hollie Holding).**
107	**Chief Executive Officer Report** James Sumner presented the Chief Executive Officer Update which set out details of key issues and activities since the last update in July 2024. The Board was informed that the most recent Executive Risk and Assurance Group had highlighted the need to ensure that the risk methodology was being consistently applied. However, it was noted that there was good traction from the Divisions using their risk registers. Mersey Internal Audit Agency (MIAA) would be undertaking an audit to give assurance. The Board discussed Never Events, noting the consistent links between the three previously discussed and the actions and learning being taken from each. Detail of a further Never Event was shared from the neonatal unit, with the team reviewing policies and procedures for learning. It was acknowledged that Never Events were

	not a definitive measure of the safety culture in the Trust, however, there was a requirement to understand what had happened, in order to avoid them happening again. A summary of the Integrated Performance Report (IPR) was shared, highlighting that the waiting list continued to reduce further, evidencing positive actions taken in line with the Improvement Plan. Cancer remained a challenge nationally with the Trust continuing to be monitored through national Tier 1 performance oversight. However, the Board noted that the Trust was moving up the table against national comparators. A visit was undertaken by the National Cancer Team in early September, with the National Clinical Director for Cancer commending the work already progressed. The Board noted a reference to new ways of managing clinical challenges and risks, particularly relating to the procurement of a robot blood transfusion solution as part of the Trust's improvement programme and the challenges that had faced due to issues with the company and its manufacturing arm. It was reiterated that the solution remained viable with due diligence underway following a visit to the company. It was hoped that the order would be placed in September for delivery in October. The Board was informed that the first meeting of the Liverpool Adult Acute and Specialist Providers (LAASP) Joint Committee would take place on 19 September. The Integrated Care Board (ICB) would also meet in September. The Board passed its thanks to Louise Shepherd as she moved to a regional role. The Board noted the update.
108	**Finance and Performance (Month 4)** Jenny Hanlon presented the Finance and Performance update, which detailed the Month 4 position. The Board heard that, at Month 4, the Trust reported a £10.2m deficit, which was in line with plan. The Trust continued to forecast delivery of its plan of £28.5m deficit by year-end. The Board was reminded of the Cost Improvement Programme (CIP) target of £5.9m (3.2% of expenditure), phased towards the end of the year. At Month 4 the Trust had delivered £1.5m of CIP (of which £0.6m was non-recurrent), leading to a favourable variance against plan of £0.2m. The Trust had fully identified it's £5.9m target for 2024/25, however, it was noted that the majority was non-recurrent. The Trust had further strengthened focus on recurrent CIP identification and delivery during this period by establishing a CIP Portfolio Board, meeting fortnightly. The Trust was on track to spend the capital allocation for 2024/25 with the year-to-date spend £1.1m behind plan, predominantly due to phasing of the capital plan in Month 4, in relation to a particular piece of equipment. A query relating to the cash flow position was raised, with concern that there was no system or mechanism in place across the System to address the ongoing challenges. It was highlighted to the Board that the LAASP presented an opportunity for the five Adult Acute and Specialist Providers on the Joint Committee to explore this in detail, but difficulties remained in determining the most appropriate way forward across the city. The Board noted the update.

109 **Ambulatory Programme Capital Spend**
Gary Price presented the Ambulatory Programme Capital Spend.

The Board heard that additional capital costs in relation to the expansion of the ambulatory service provision were reported to the Executive Risk and Assurance Group (ERAG) 7 August 2024, however these were deemed manageable across the Trust's multi-year capital program. It was proposed that a paper be circulated to the Board outside of the meeting to highlight how any pressure may be mitigated.

The Board noted the update.

ACTION: a paper to be circulated to the Board outside of the meeting (Gary Price)

110 **Improvement Plan Monthly Update**
Tim Gold presented the Improvement Plan Monthly Update.

The Board learned that examples of improvement were being seen across several areas including NEWS scores, overall size of the waiting list and cancer. There was a drop on the faster diagnosis standards against the stretch target but this did remain on the trajectory of 70%.

An update was provided about the self-assessment the Trust had undertaken against the National Oversight Framework, with progress made against the 11 exit criteria, with eight overall rated green, two rated amber and one red, which was Cancer. It was outlined that this was largely due to the nuances of the tier system as opposed to the Trust being off track with the trajectory. A formal exit date had not yet been agreed with the ICB but the Trust continued to work towards the end of the financial year.

The Board questioned whether the areas of work that had been closed down had been shared with the ICB. It was outlined that there would be a review of the exit criteria in November, whether those programmes highlighted as green would be proposed for closure, seeking agreement from the ICB.

A query related to the use of RAG ratings was highlighted, with the example of the financial projects that were showing as green but relied heavily on the delivery of CIP given. A similar query was raised in relation to Pharmacy and Medicines Management where the Improvement Plan update was green but the detail shared elsewhere gave a different picture. Assurance was given that, although a specific project or risk may show as red or amber, the impact on the overall programme was not significant enough to alter the overall RAG rating.

The Board sought assurance that Anaesthetics was being worked through given the unique nature of the specialty at the Trust. A previous piece of work in collaboration with the Royal Liverpool Hospital was highlighted, where the intention was to explore a hosted service, allowing ringfencing of Obstetric Anaesthetics. This had stalled due to concerns related to staff who were not familiar with the site and service being used to deliver a service there. It was acknowledged that this work needed to be stepped up again to address the issues. In addition, training of Obstetric Anaesthetists was an ongoing challenge given that trainees were in situ for three months before moving onto their next placement. It was suggested that there would be more opportunity to explore this in detail within the Group model being progressed.

Thomas Walley left the meeting.

The Board noted the update.

112

Maternity Incentive Scheme Year 6 – August 2024 Compliance Update
Dianne Brown presented the Maternity Incentive Scheme Year 6 – August 2024 Compliance Update.

The Board learned that NHS Resolution (NHSr) operates 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). Detail on the year 6 scheme progress was shared, with confirmation that those areas highlighted as amber would remain as such until the scheme period ended and all evidence could be collated and validated.

It was highlighted to the Board that the Company Secretary would be meeting with NHS Resolution (NHSR) in the coming weeks to bring them up-to-date with the ongoing work in the city related to the Group model.

A question was put forward in relation to the Quality Committee and how, once that meeting was closed down, assurance would be provided against the areas to be evidenced for the MIS. It was outlined that the work of the Non-Executive Director Maternity Safety Champion would be key, as well as ensuring that maternity remains a focus within the governance and assurance framework.

The Board noted the update.

Bi-Annual Maternity Staffing Report
Dianne Brown presented the Bi-Annual Maternity Staffing Report, highlighting the following areas (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 were 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 was 6.43% which was above the Trust target rate of 4.50%
- Midwife: Birth ratio in June 2024 was 1:23 against a BR+ audit recommendation of 1:23
- there were 268 midwifery red flags reported between January-June 2024 which was an increase of 56 from the previous reporting period (July-December 2023) where 212 red flags were reported
- the majority of the red flags related to delays in ongoing induction of labour, owing to capacity and demand. An induction of labour Quality Improvement project was ongoing with estates work scheduled to be completed in July to create a separate area consisting of five rooms. This would help to improve patient flow on Delivery Suite to be able to expedite patients to continue the process whilst also improving the patient experience
- supernumerary shift co-ordinator on Delivery Suite was 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%.

The Board queried the meaning of headroom within budgeted posts within the report. It was confirmed that, as the workforce was very clinical, it was part of national and best practice to have enough staff to allow for training, with a discretionary amount of days between 21-25%. It was also noted that there would be an increase in training requirements for midwifery staff as part of the outcomes from the Ockenden review, so the requirement for headroom was justified.

	The Board noted the update.
113	**Guardian of Safe Working Hours, Quarter 1 2024/25** Lynn Greenhalgh presented the Guardian of Safe Working Hours, Quarter 1 2024/25, highlighting the following • rota establishment continued 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 was a decrease compared to Q4 of 2023-2024 • although the hours and templates of rotas were safe and compliant in each service and in line with the Junior Doctor contract, there remined work to fo ensure rota gaps were covered. The Board noted the update.
114	**Learning From Deaths Quarterly Report** Lynn Greenhalgh presented the Learning from Deaths Quarterly Update which provided an overview of the Trust's mortality data including crude mortality, Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) throughout the reporting period. The Board was informed that a Perinatal Mortality Review Tool (PMRT) review of stillbirths in Q4 reported one case where care issues were identified that could have made a difference to the outcome. This case proceeded to a Patient Safety Incident Investigation (PSII) with learning and actions taken. The PMRT review of neonatal deaths identified learning but there were no neonatal care issues identified for the Trust that were likely to have made a difference to the outcome. The Board of Directors noted the update. *Nicola Pittaway joined the meeting.*
115	**Whistleblowing Bi-Annual Report/ Freedom to Speak Up Guardian** Nicola Pittaway presented the Whistleblowing Bi-Annual Report/ Freedom to Speak Up Guardian. The Board's attention was drawn to the detail within the report outlining that the Guardian service received a total of 42 concerns during the reporting period, which was an increase of 25 from the equivalent period in 2022/23. Concerns throughout the first half of the year were raised by a wide variety of staff of all grades and from all services. The trend data indicated that staff continued to feel confident to raise concerns by identifying themselves to the Guardian but were reluctant for their details to be shared further. Work was ongoing to highlight to all those who came forward that confidentiality would be maintained. The increase in concerns raised was noted by the Board, recognising that this could be seen as a positive if correlating with the Care Quality Commission (CQC) whistleblowing process. It was noted that several of the concerns raised were HR related and having the Guardian involved in the process had given confidence to those raising issues. The Board requested that future reports include thematic data on what was being raised by staff, to aid in understanding whether the increase in reports was an indicator of a positive culture or not.

	ACTION: Include thematic data on areas being reported to the Guardian Service in future reports to provide assurance that any increase was due to a positive culture shift as opposed to a negative culture (Nicola Pittaway). The Board was informed that a safe space had been developed to provide a space for people to feel psychologically safe, with the space nearing completion. The Board noted the update.
116	**Committee Chair's Reports** <u>Audit Committee</u> Tracy Ellery gave an overview of the Audit Committee, highlighting that a Mersey Internal Audit Agency (MIAA) audit had returned limited assurance on quality spot checks, which was referred to the Quality Committee. It was also highlighted that there was no central record of external inspections and visits, which was requested by the Committee. It was proposed that this move to the Executive Directors for monitoring. <u>Quality Committee</u> Sarah Walker gave an overview from the Committee, outlining that much of the agenda that was discussed at the meeting had been discussed elsewhere within the Board agenda. The Board noted the updates received.
117/118	**Consent Agenda** The following items were presented with the recommendations contained in the reports adopted without debate: • Sustainability Annual Report Green Plan • Senior Independent Director Appointment
119	**Review of risk impacts of items discussed** No new risk items were identified.
120	**Chair's Log** There was nothing to note under the Chair's Log.
121	**Any other business & Review of meeting** There was no other business to note.
122	**Jargon Buster** The Jargon Buster was noted.

NHS
Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
10 October 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
12 September 2024	24/25/105	Minutes of the Previous Meeting	Confirm the number of out-of-date policies that remained following the targeted work to reduce them.	James Sumner	October 2024	**Complete**	At the 3rd October 2024 25 policies were out of date, reduced by 19 since 12 September 2024. Work was ongoing to reduce further.
12 September 2024	24/25/106	Action Log	Explore a suitable mechanism for monitoring issues that would previously have been included in the Chair's Log.	Hollie Holding	November 2024	**On track**	The item is on track for completion for November 2024.
12 September	24/25/109	Ambulatory Programme Capital Spend	Report to be circulated to the Board outside of the meeting	Gary Price	October 2024	**Complete**	The item is on the agenda for decision at TB24/25_136.
12 September 2024	24/25/115	Whistleblowing Bi-Annual Report/Freedom to Speak Up Guardian	Include thematic data on areas being reported to the Guardian Service in future reports to provide assurance that any increase was due to a positive culture shift as opposed to a negative culture.	Nicola Pittaway	March 2025	**On track**	The item is on track for completion for March 2024.
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.						

Liverpool Women's
NHS Foundation Trust

Board of Directors

COVER SHEET

Meeting Date	Thursday, 10 October 2024	**Item Reference**	TB24/25_134
Report Title	Chief Executive's Report		
Author	James Sumner, Chief Executive Officer Louise Hope, Assistant Trust Secretary		
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 September 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 September 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 September 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

REPORT DEVELOPMENT:

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

MAIN REPORT

1. NHS England Enforcement Undertakings

The Trust submitted evidence to NHS England (NHSE) highlighting the improvements delivered across a range of areas. The improvements were reviewed by NHSE Quality and Maternity Leads who have supported proposal not to progress enforcement undertakings.

NHSE commended the Trust on the work undertaken during 2024 to rectify the requirements set out by the Care Quality Committee (CQC) highlighting the clear focus given to sustainability and reliability of ongoing actions. At the same time, the CQC Warning Notice has also been lifted and enhanced oversight and monitoring from the Regional Maternity Team have been stood down.

The focused work undertaken by staff within the Trust through the Improvement Programme have delivered benefits to our patients which we will continue to monitor at the Board of Directors.

2. Adult Acute and Specialist Services in Liverpool

On 29th July 2024 it was announced that the five adult acute and specialist hospital trusts in Liverpool had agreed to form a joint committee that would allow us to work more closely together to continue to deliver previously agreed recommendations from the Liverpool Clinical Services Review. This focused on improving the health of our population through collaborative working and reducing fragmentation of clinical services.

The shadow joint committee – which includes the chairs and chief executives of the five trusts – met for the first time on 19th September 2024. We discussed the scope of the joint committee's work and the wider Liverpool Adult Acute and Specialist Providers (LAASP) programme. This included the joint working agreement and the committee's terms of reference outlining how the trusts will deliver this programme.

Since then, the proposals have been going to all our individual trust boards for review and subsequent approved by Liverpool Heart and Chest, The Clatterbridge Cancer Centre, and Liverpool University Hospitals board meetings at the end of September. The Walton Centre board received the documents in early October.

The joint working agreement and terms of reference cover how we will seek to:

- Design, develop and implement decision-making arrangements to act as one on decisions that affect us all.
- Develop a case for change to support the development of a five-year plan to deliver the opportunities identified in the Liverpool Clinical Services Review for how we can deliver the best for our patients. It will include clinical services, research and innovation, workforce, digital and how we can get the best from estates, infrastructure, and corporate services.
- Manage financial planning, resources and risk as one, including a shared financial plan for 2025/26.
- Deliver efficient and effective corporate and support services, with transformation plans to achieve an average cost across different trusts.

The plans will also take into account the fact that all five trusts provide specialist services for a much wider geographical area than Liverpool and, in many cases, wider than Cheshire and Merseyside.

The joint committee is chaired by David Flory CBE, the Chair of Liverpool University Hospitals (LUHFT) and Liverpool Women's (LWH). It will meet at least monthly and will be accountable to each trust board, with minutes going to trust boards.

The next step is for the joint committee to begin to develop plans setting out how we aim to deliver this programme working with patients, colleagues, and partners in the coming months. A verbal update will be provided from the most recent meeting which took place on 7 October.

3. Women's Hospital Services in Liverpool Programme: Improving hospital gynaecology and maternity services in Liverpool

On Wednesday 9 October 2024, NHS Cheshire and Merseyside Integrated Care Board (ICB) were presented with a case for change document describing the risks facing hospital-based gynaecology and maternity services in Liverpool.

Subject to the board's approval of the document, a six-week period of public engagement will begin on 15 October 2024, giving people an opportunity to share their views about the issues it sets out.

Although some of the challenges outlined in the case for change have been discussed in the past (some of you will have previously known this as Future Generations), this is a new process which will focus on the situation as it stands today. The case for change doesn't set out proposals or potential solutions – these will be explored with partners, stakeholders, patients, and the public later in the programme of work – and no decisions have yet been made.

The case for change was published with the NHS Cheshire and Merseyside board papers on 1 October 2024, which are available here:: https://www.cheshireandmerseyside.nhs.uk/get-involved/upcoming-meetings-and-events/extraordinary-board-meeting-women-s-hospital-services-in-liverpool/

Subject to NHS Cheshire and Merseyside's board approving the case for change, a period of public engagement will take place from 15 October to 26 November 2024. Further details about this and how patients, staff, and the public can get involved, will be shared after 9 October.

4. Refugee Women Connect

During last month's Board of Directors, I referenced a recent meeting with Refuge Women Connect services. It was extremely difficult to hear the experiences of women within the asylum system and their experience of care here at the Trust. Following the meeting, we have agreed to the

- Development of an onsite garden of reflection.
- Review of information provided to women who access care as part of the asylum system.
- Consideration how we support women financially to attend appointments, working with system partners to understand our role in the accessing of benefits and support.
- Review of our translation services.
- Consideration of the approach to routine enquiry from a domestic abuse perspective.

The issues were discussed recently with local members of Parliament especially those of relocating women within the asylum system and a further meeting has been arranged in November.

5. Flu and Covid Vaccination Plan 2024/25

Provider Trusts are required to have a vaccination offer for the health and social care workforce. Based on the evidence that flu vaccine's effectiveness can wane over time in adults JCVI have advised moving the start of the programme for most adults to the beginning of October. This is on the understanding that the majority of the vaccinations will be completed by the end of November, closer to the time that the flu season commonly starts. It is preferable to vaccinate individuals closer to the time when the flu virus is likely to circulate (which typically peaks in December or January), as this will provide optimal protection during the highest risk period.

Key considerations and actions for the LWH Campaign are as follows:

- Weekly meetings established commencing 26th September to mobilise campaign attending by Heads of Nursing and Midwifery.
- All frontline health care workers, including both clinical and non-clinical staff who have contact with patients, should be offered flu vaccine from October.

- The trust has received additional funding to fully resource staff vaccinators and staff trained to provide vaccinations will do so via walkarounds across the clinical areas.
- Regular Covid and Flu drop-in clinics will be arranged at LWH.
- A wide range of communications will be issued, with positive messages about the importance of vaccination led by the Chief Nurse and Medical Director.
- Reporting on vaccine take up will be done via power BI and a report will be issued every Monday comparing performance by division and department.

6. Our People Pulse Results and the NHS Staff Survey

The Trust received an excellent response to the recent People Pulse Survey that ran for the month of July 2024. A positive 80% increase in responses compared to the People Pulse Survey in July 2023. The People Pulse Survey helps the Trust to check in with our colleagues and look at how we are feeling in that moment. We are extremely pleased to see that there has been a positive response to each of the 3-core metrics. It's great to know what is going well, how we can sustain that and understand what we need to do to make LWH an even better place to work.

The National NHS Staff Survey was launched on Friday 4th October 2024. The NHS Staff Survey is run independently (LWH's provider is IQVIA) and gives staff the opportunity to share - anonymously and in confidence - what it is like for them working in the NHS. The national survey is incredibly important as it informs the Trust of staff experiences and views as colleagues at a local level, enables us to benchmark our results against other Trusts to see how we compare within our region and at a national level it informs key priorities and actions for the NHS People Promise, providing an accurate picture of what it's like now and where more change is needed.

Last year the Trust received a response rate of 50.9%, and this year we will be aiming for at least 65-70%. All people managers have been asked to support staff to allocate time when safe and reasonable to complete their survey.

The Pulse Survey Results is included at Appendix A.

7. Listening Sessions for Staff with the Anthony Walker Foundation

At Liverpool Women's we are on a journey to become an actively anti-racist organisation. We know racism exists in society and in organisations. We need to call it out to eliminate it. Zero Tolerance for us at Liverpool Women's means that if we hear about racism in the organisation, we will do something about it.

The NHS national Staff Survey told us that 24% of global majority staff who responded had experienced racism from staff and 11% from patients. We are committed to changing these experiences and we are therefore working with an independent partner the Anthony Walker Foundation. The Anthony Walker Foundation has a track record of delivering successful projects which promote anti-racism, provide education support victims of racism and hate crime.

Colleagues from the Anthony Walker Foundation will be holding Listening Sessions which are confidential, open to all staff regardless of location, and will provide a safe space to talk about their experiences working at Liverpool Women's (positive or negative) in relation to race and racism. Anthony Walker Foundation will use the information to make recommendations on how we can do better at eliminating discrimination and promoting equality at LWH.

8. 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 achieve against target and shows a statistical improving trend, reducing month on month. The Trust continues to utilise additional capacity from the Independent Sector to reduce waiting times and reduce the number of patients on the waiting list.

Elective Recovery – 65+ weeks continue to demonstrate statistical improvement with reductions ongoing and one of the lowest figures in Cheshire & Merseyside. There will be circa 10 patients above 65+ weeks by the end of M6 as a result of patient choice and clinical complexity. The Trust has made significant reductions in the number of patients waiting >52 weeks, with statistical reduction month on month since March 2024 demonstrating a >50% reduction overall. Actions will continue through the Trusts Improvement Plan to reduce even further.

Cancer – All metrics showed deterioration in July, as expected, due to continued recovery actions being taken as a result of the external decontamination supplier issues experienced in May. Significant volumes of additional activity have taken place through Months 4-6 to support this recovery. Deteriorating Histology Turnaround Times (TATs) have impacted delivery of the 28 Day Faster Diagnosis Standard over the summer period, but the Trust is seeing significant improvements of these in M6 which should improve the position from M7 onwards. 28 Day FDS is showing an improvement in M6 following recovery actions taken. The Trust continues to be monitored through national Tier 1 performance oversight. The Trust is working with the Elective Care Intensive Support Team who visited the Trust on 11th September to observe the Trust MDT and performance meetings. Whilst final report is due early October, initial feedback was overwhelmingly positive. The Cancer Improvement Plan continues to be monitored and actions delivered to make continued improvements to patient pathways and access.

Quality

Never Events – There are currently 4 ongoing Never Event investigations. 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. Progression of actions from the Never Events is monitored via the Regulatory compliance working group.

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. The number of incidents declared as PSIIs has reduced since March with ongoing PSIRF tools being used for incident management such as After Action Reviews, swarm huddles and trends analysis.

FFT A&E Percentage Positive – September FFT position for A&E of 70.89% and continues to be under target with a special cause variation of a concerning nature. The divisional senior leadership team are well sighted on themes which include waiting times and satisfaction with care; the GED improvement plan will draw together and continue to monitor progress to meet the target and sustain position when met. The Medinet contract has been extended until year end to support medical resource and increased capacity to address waiting times concerns.

FFT Maternity Percentage positive - Maternity has continued to improve, with current satisfaction at 91.26% (previously 86.17%); however with ongoing efforts to improve the response to displeased comments, currently at 25% with a target of 50%. A key theme of consistency of community midwifery service provision was noted; and for postnatal ward pain relief delays.

3rd and 4th Degree Tears - 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). Due to the increase in rates, and the limitations of learning from reviewing individual cases, a thematic analysis has been commissioned to be 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 – this report is expected to be presented to division in October. Overall, the Trust's performance remains below the 7.8% target, with August rate at 5.33%.

Workforce

Clinical Mandatory Training – This figure has remained relatively static over the preceding 12 months and stands at 88.7%. A new senior clinical role is now in place in the practice education team which is expected to deliver an improvement in the planning and delivery of mandatory training and opportunities cross-division and cross-speciality maximised.

Sickness Absence –Sickness remained static in month at 5.8%, which is comparable to last year's rates. Return to work conversations are a matter for concern at 58% and additional measures have been implemented by the roster team to aid recording. Wellbeing Conversations had seen a positive increase of 5% to 75% following a number of 'train the trainer' sessions for N&M leadership.

PDR Rate - PDR compliance remained a concern with an overall Trust performance of 86.2% against target of 90%. Introduction of group PDRs and a revised PDR form have both received positive feedback but require further promotion to increase uptake.

The Integrated Performance Report is included at Appendix B.

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.

SUPPORTING DOCUMENTS

Appendix A – Pulse Survey Results
Appendix B – Integrated Performance Report

NHS
Liverpool Women's
NHS Foundation Trust

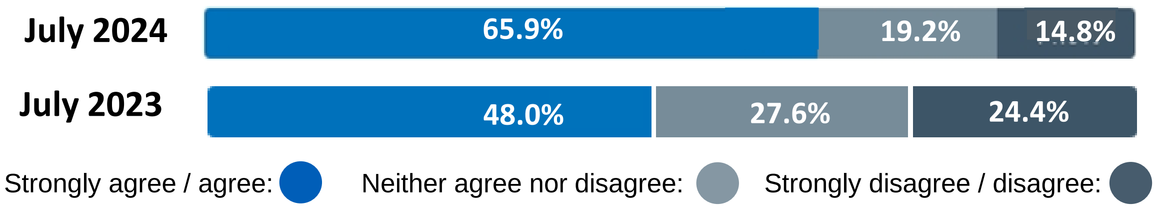
People PULSE results

Listening to you in July 2024: 229 Responses

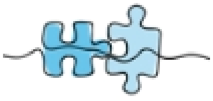
80% RESPONSE INCREASE SINCE JULY 2023

We are safe and healthy

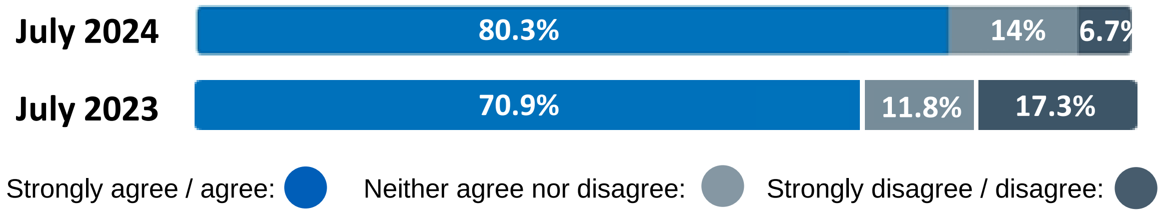
My organisation is proactively supporting my health and wellbeing:



We are a team

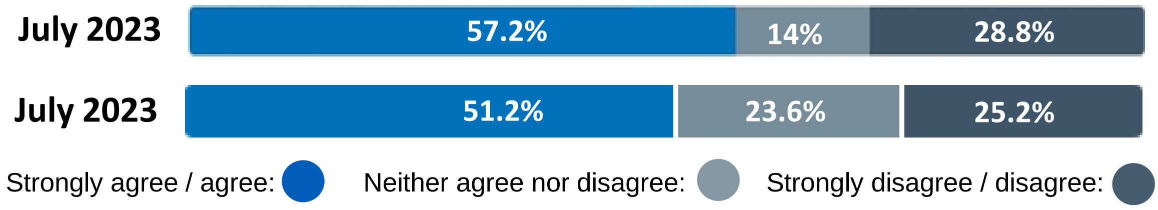


In my team we support each other



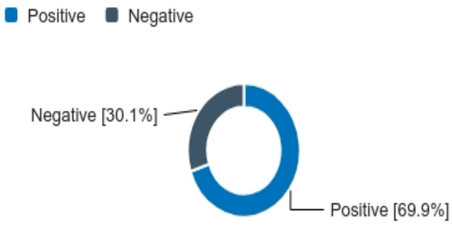
We are compassionate and inclusive

I feel well informed about important changes taking place in my organisation



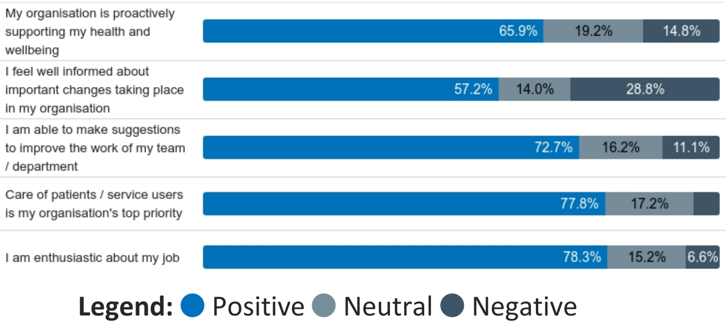
Colleague Mood

When asked how they were feeling today, just over **69.9% of colleagues reported a positive emotion** (i.e. calm, coping, happy). With 30.1% feeling negatively (i.e. stressed, demotivated).



Drivers of Positive Mood

The below areas indicate ***why*** our colleagues are feeling positive about LWH, and results show marked improvement in each of the five areas since July 2023.



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

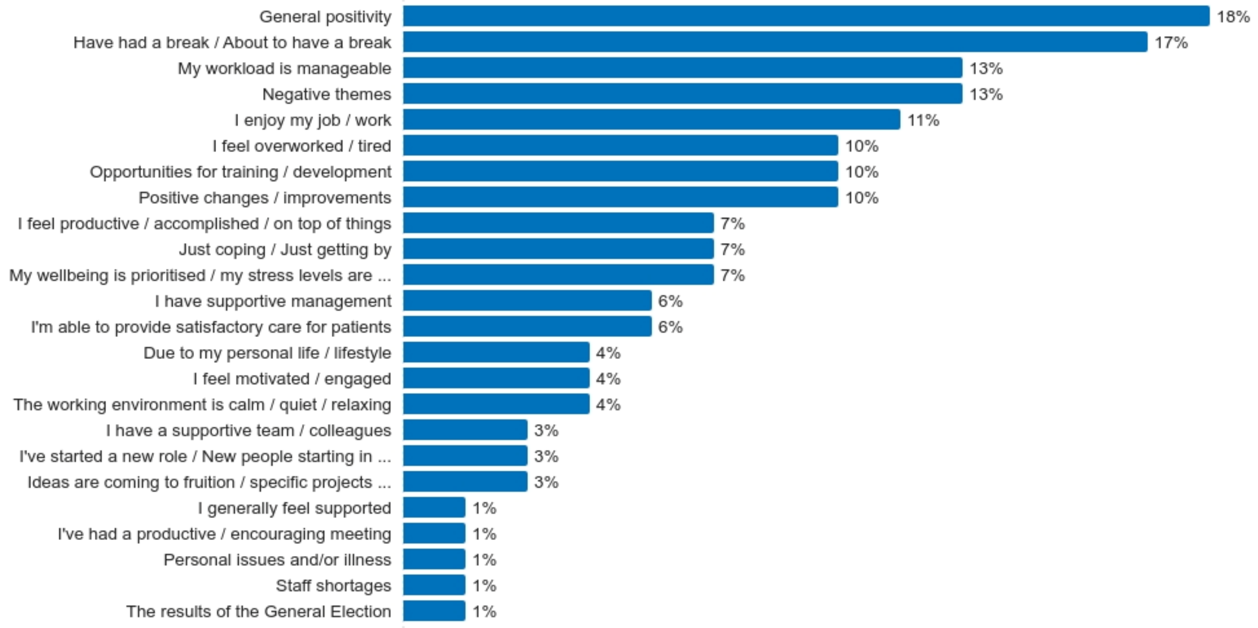
NHS
Liverpool Women's
NHS Foundation Trust

People PULSE results

Listening to you in July 2024

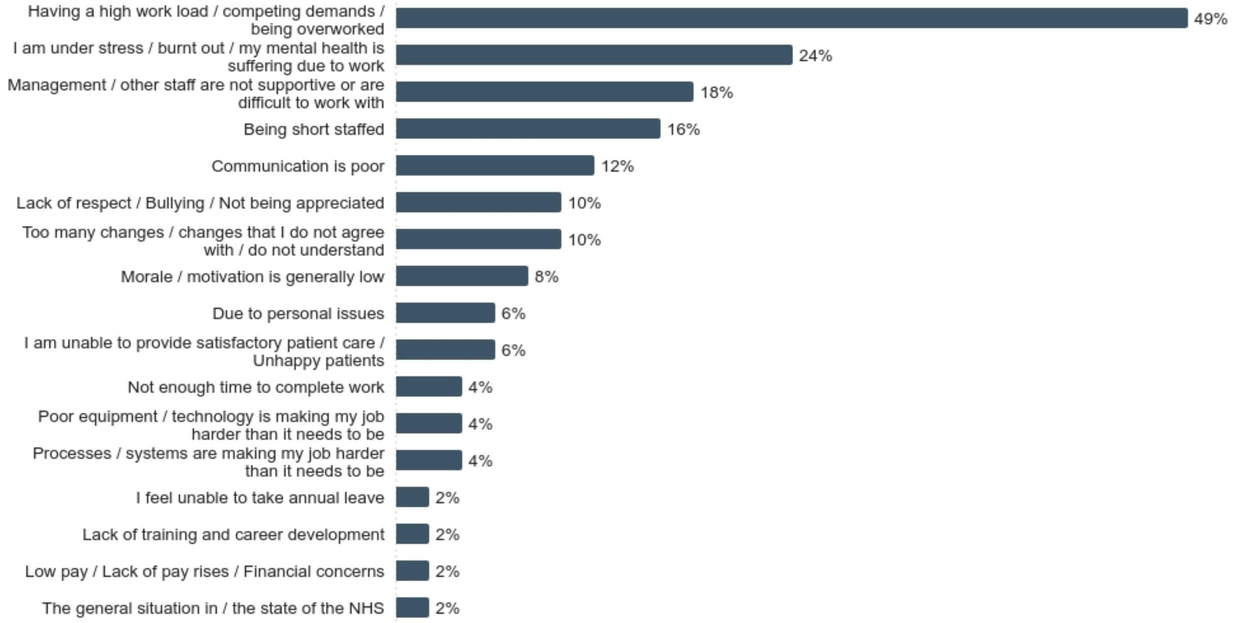
Why do you feel this way? - Positive mood

Respondents were asked to explain why they feel the way they do, in their own words.



Why do you feel this way? - Negative mood

Respondents were asked to explain why they feel the way they do, in their own words.



Listening to you

We are committed to ensuring that every colleague has a voice that counts. It is important that we continue to make improvements as an employer and as a service, so that our colleagues and patients have a fantastic experience. Here are a few of the things we have put in place to work towards being a **Great Place to Work**:

- Staff Support Service
- Amended PDRs, tailored to you
- Walk About Wednesday (Exec visits to clinical areas)
- Interview skills Sessions
- People Promise Support – Career Progression
- Set staff pay dates
- Wagestream – Flexible Loans
- Listening sessions (Anthony Walker Foundation)
- Endometrioses Support & Menopause Café
- Staff Pantry

NHS

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report

September 2024

Integrated Performance Report

Contents

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	762	?	L
18 Week RTT: Incomplete Pathway > 65 Weeks	24	?	L
18 Week RTT: Incomplete Pathway > 78 Weeks	0	?	L
Cancer: 28 Day Faster Diagnosis	46.11%	?	H
Friends & Family Test: Maternity % positive	91.06%	F	H
GM staff in leadership roles (B7 or above)	9.44%	◌	H
Mandatory Training (Clinical)	93.22%	?	H
Overall size of active patient waiting list	16466	?	L
Overall Staff Vacancies WTE	31.88	◌	L
Sickness Absence Rate	5.81%	F	L

Common Cause Previously Concerning

KPI	Target	P	A	V

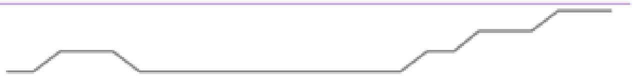
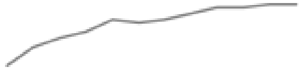
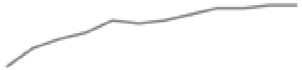
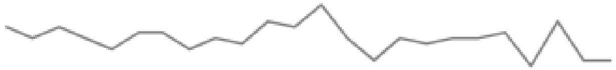
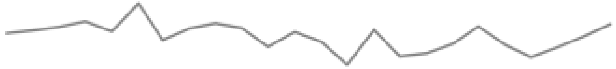
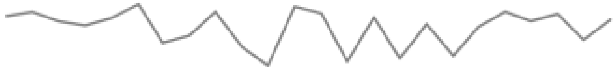
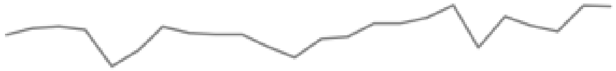
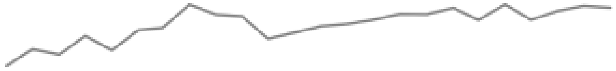
Concerning Higher or Lower Variation

KPI	P	A	V
3rd and 4th Degree Tears	3.28%	?	H
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	11.42%	P	H

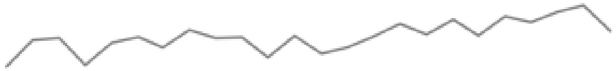
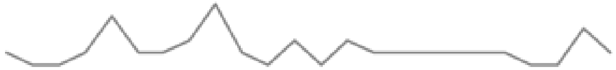
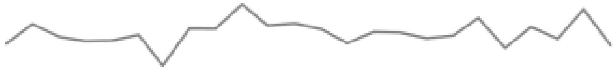
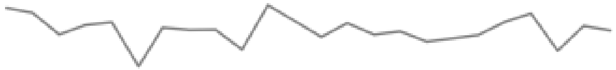
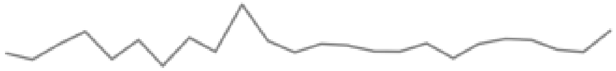
Quality & Safety Indicators

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

LWH Quality & Safety Indicators Summary

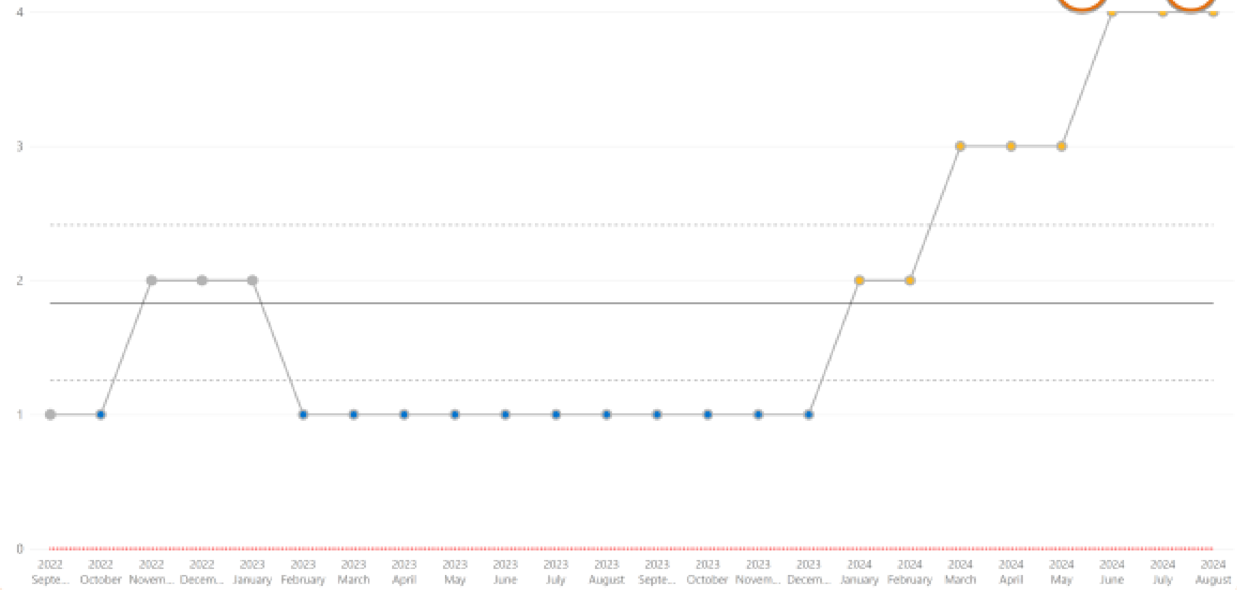
Domain	Date	Target < or >	Performance	Assurance	Variation	Assurance Category	Trend
Governance							
Never Events (Rolling 12 Months)	August 2024	<=	4	F	H	Take Action	
NHSE / NHSI Safety Alerts Outstanding	May 2024	<=	0	P		Celebrate	
Number of Open Patient Safety Incident Investigations	August 2024	<=	24		H	Take Action	
Total Number of Patient Safety Incident Investigations (Rolling)	August 2024	<=	24	P	H	Take Action	
Infection Control							
Infection Control: Clostridium Difficile	August 2024	<=	0	P		Celebrate	
Infection Control: MRSA	August 2024	<=	0	P		Celebrate	
Patient Experience							
Complaints: Number Received	August 2024	<=	2	P		Celebrate	
Friends & Family Test: A&E % positive	August 2024	>=	83.33%	F		Take Action	
Friends & Family Test: In-patient/Daycase % positive	August 2024	>=	93.37%	?		Watch	
Friends & Family Test: Maternity % positive	August 2024	>=	91.06%	F	H	Take Action	
Patient Safety							
Venous Thromboembolism (VTE)	August 2024	>=	96.69%	?		Watch	

LWH Quality & Safety Indicators Summary

Domain	Date	Target < or >	Performance	Assurance	Variation	Assurance Category	Trend
Maternity Signals Chart							
3rd and 4th Degree Tears	August 2024	<=	3.28%	?	H	Take Action	
Hypoxic Encephalopathy (Grade 2,3)	August 2024	<=	1	○	○	Watch	
Inborn term babies admitted to NICU	August 2024	<=	4.14%	○	○	Watch	
Number of births	August 2024	N/A	607	○	○	Watch	
Number of stillbirths per 1,000 total births	August 2024	<=	9.88	○	○	Watch	
PPH > 1500 (per 1000)	August 2024	<=	39.6	○	○	Watch	

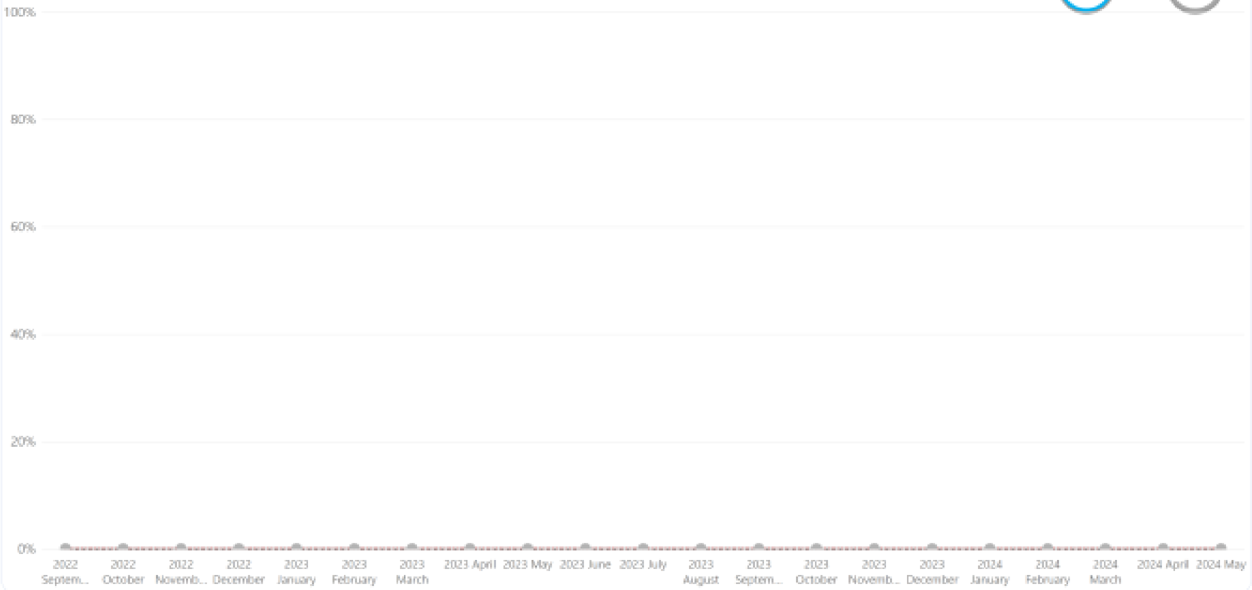
Never Events (Rolling 12 Months) - Medical Director

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



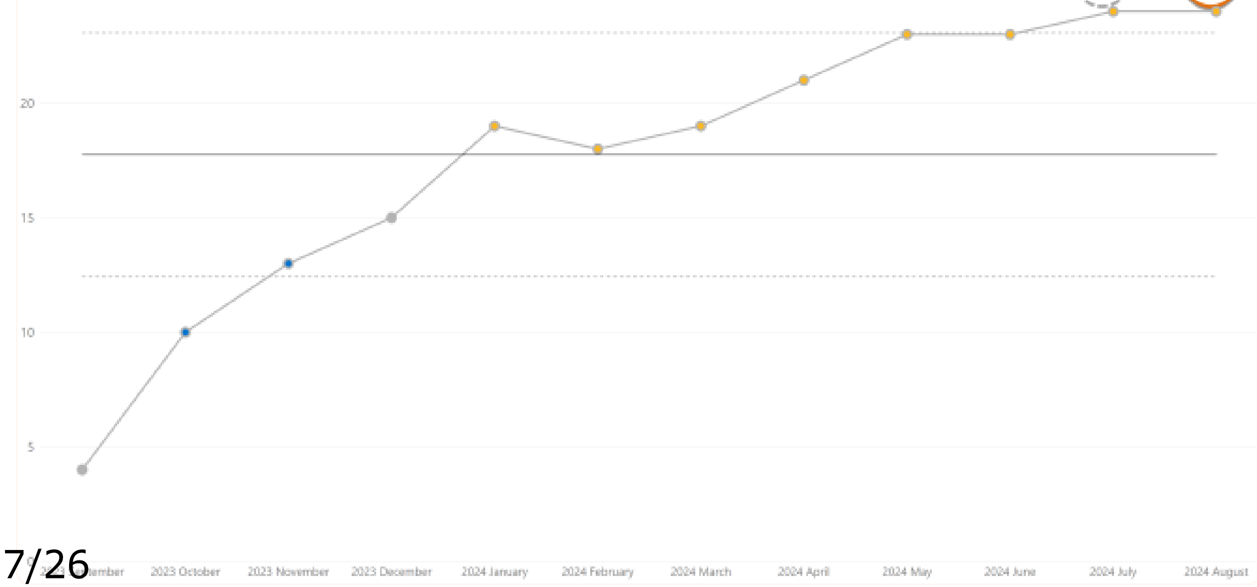
NHSE / NHSI Safety Alerts Outstanding - Chief Nurse

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



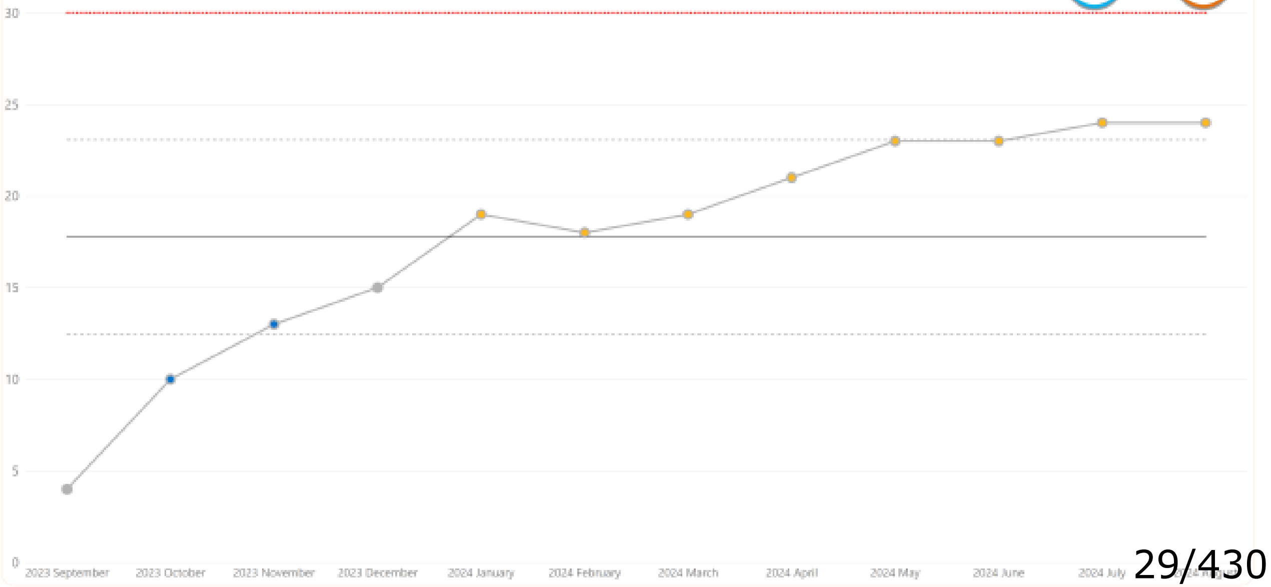
Number of Open Patient Safety Incident Investigations - Chief Nurse

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



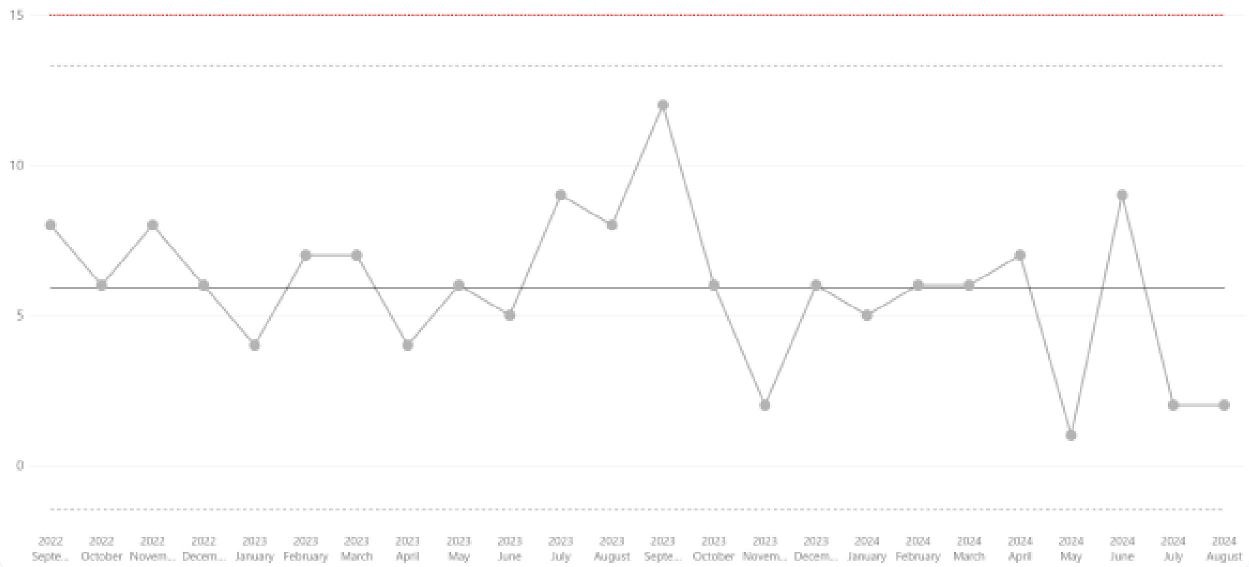
Total Number of Patient Safety Incident Investigations (Rolling) - Chief Nurse

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



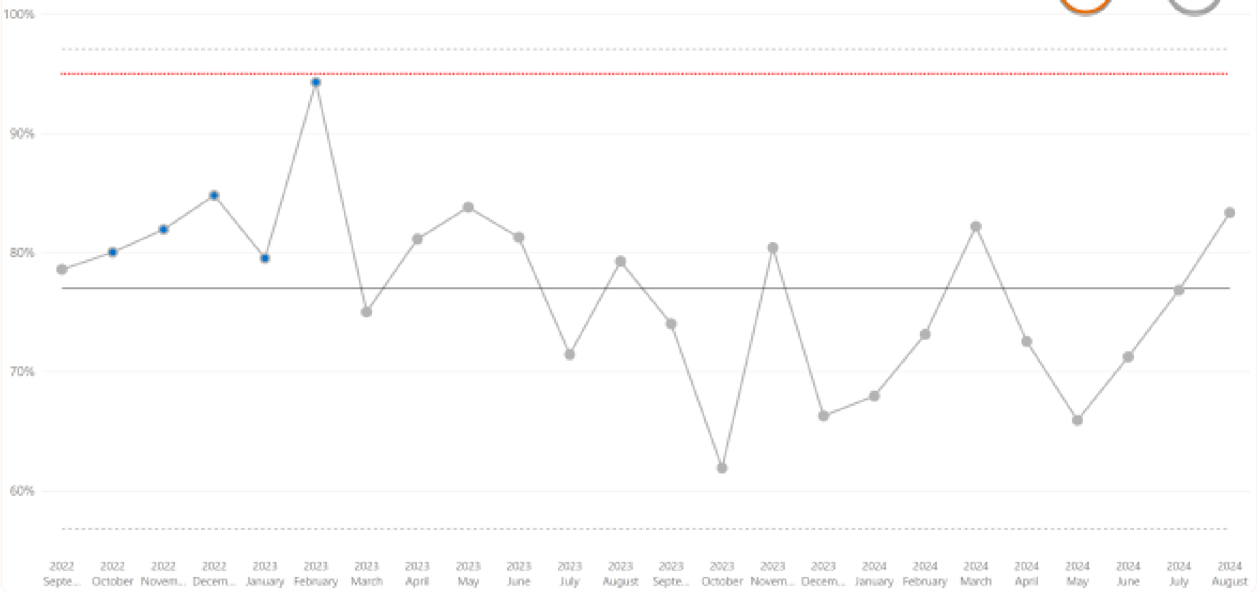
Complaints: Number Received - Chief Nurse

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



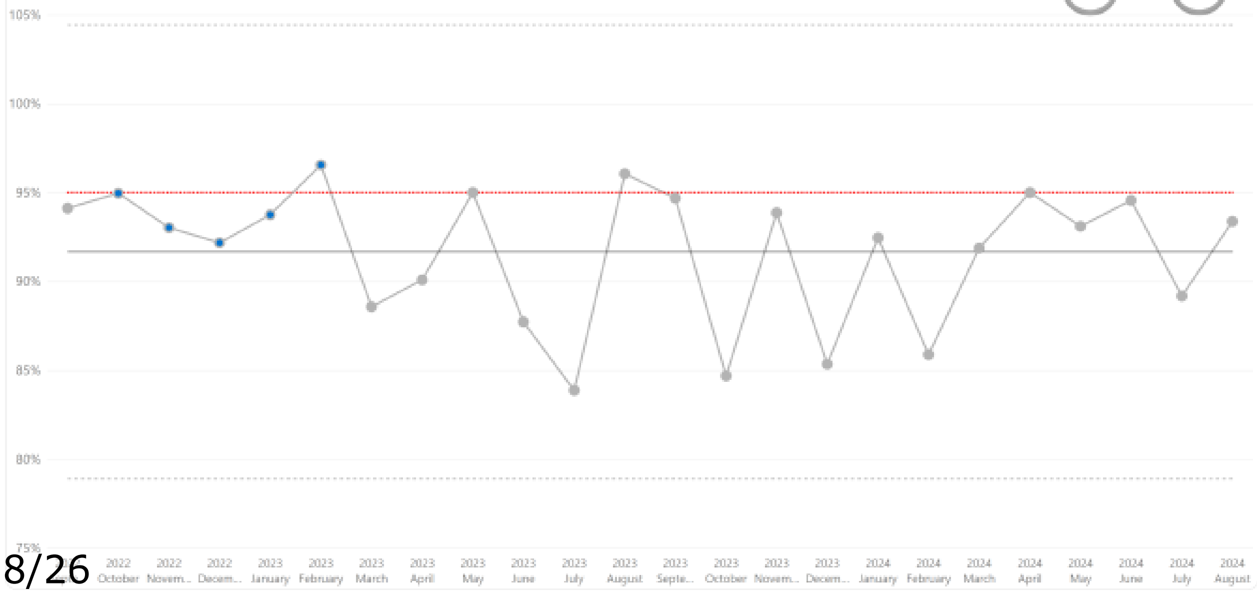
Friends & Family Test: A&E % positive - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
95%	>=	83.33%	F	



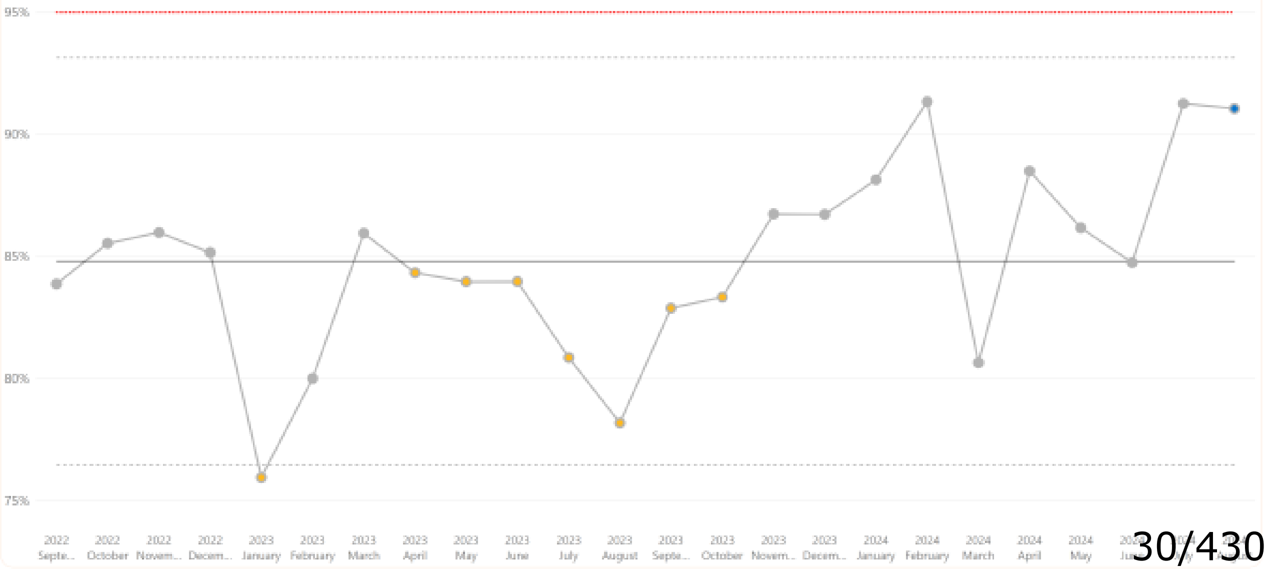
Friends & Family Test: In-patient/Daycase % positive - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
95%	>=	93.37%	?	



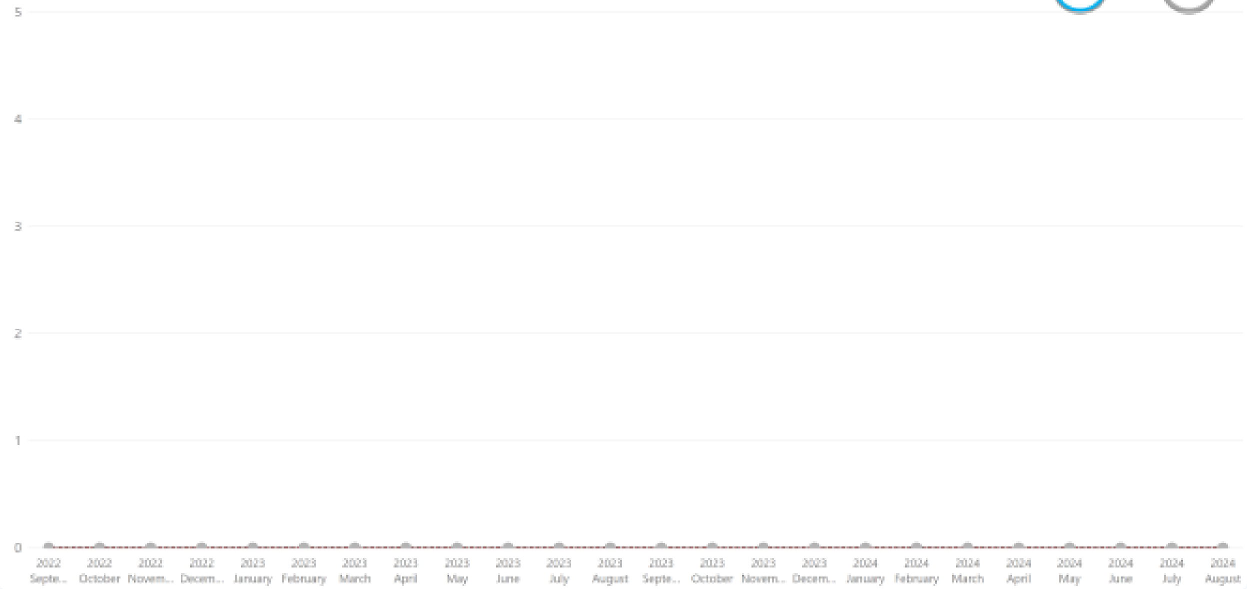
Friends & Family Test: Maternity % positive - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
95%	>=	91.06%	F	H



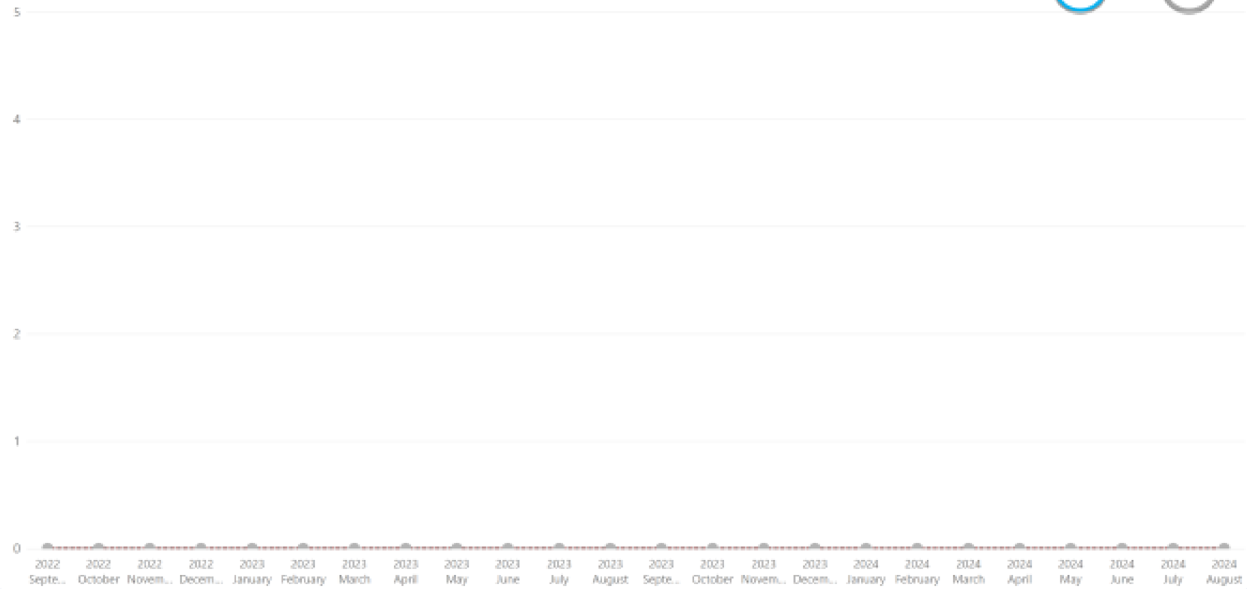
Infection Control: Clostridium Difficile - Chief Nurse

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



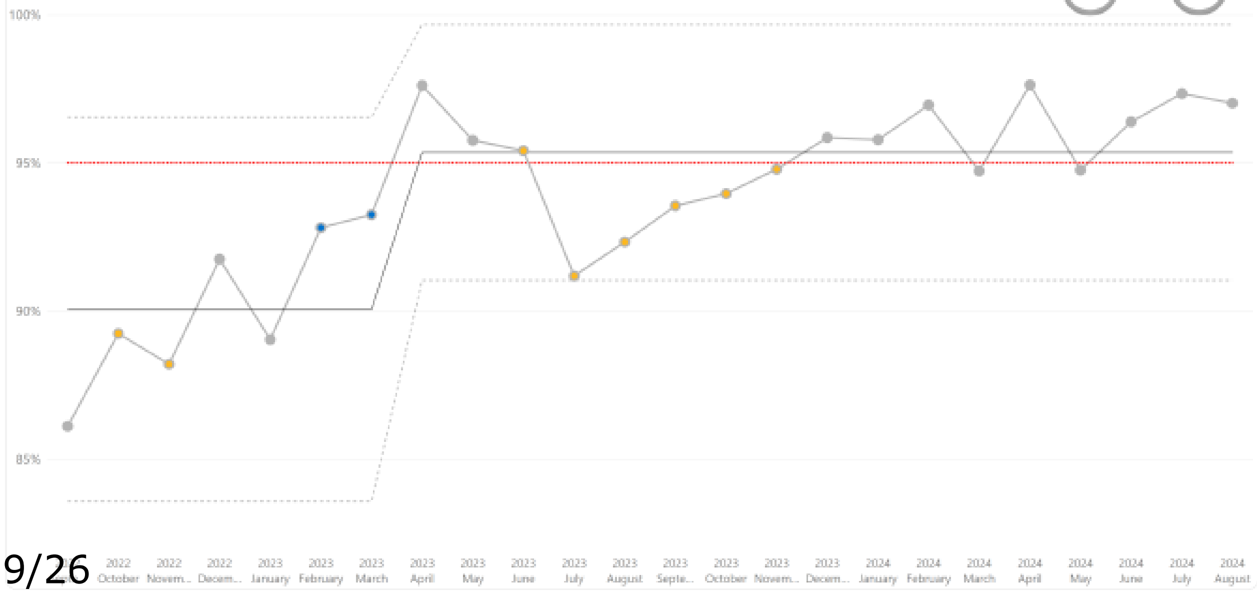
Infection Control: MRSA - Chief Nurse

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



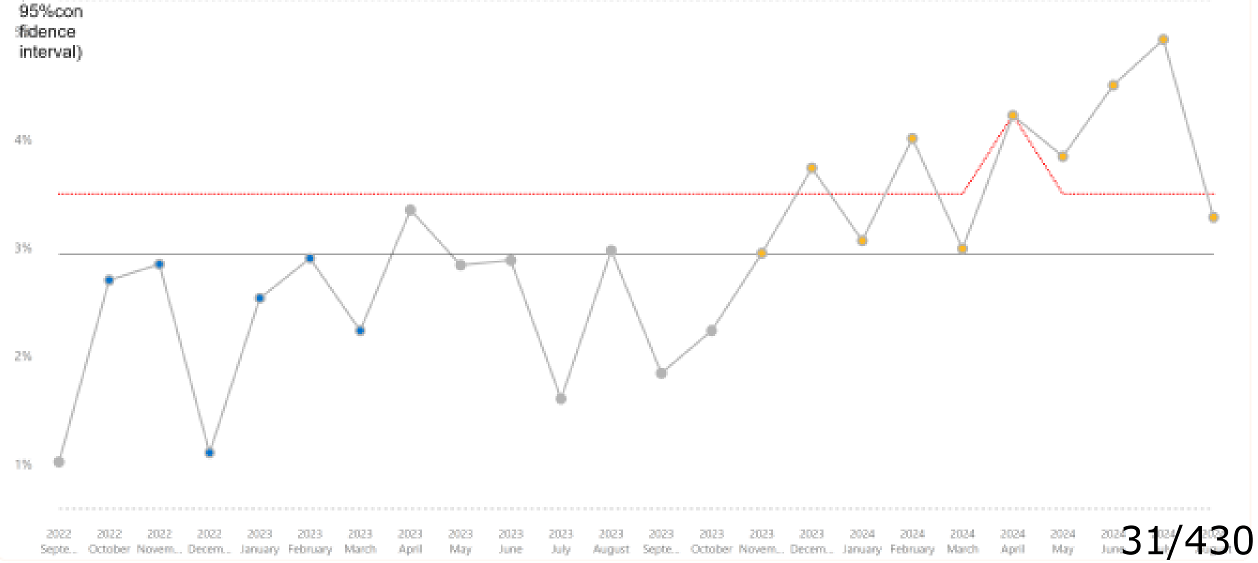
Venous Thromboembolism (VTE) - Medical Director

Target	Target < or >	Performance	Assurance	Variation
>= 95%	>=	97.01%	?	



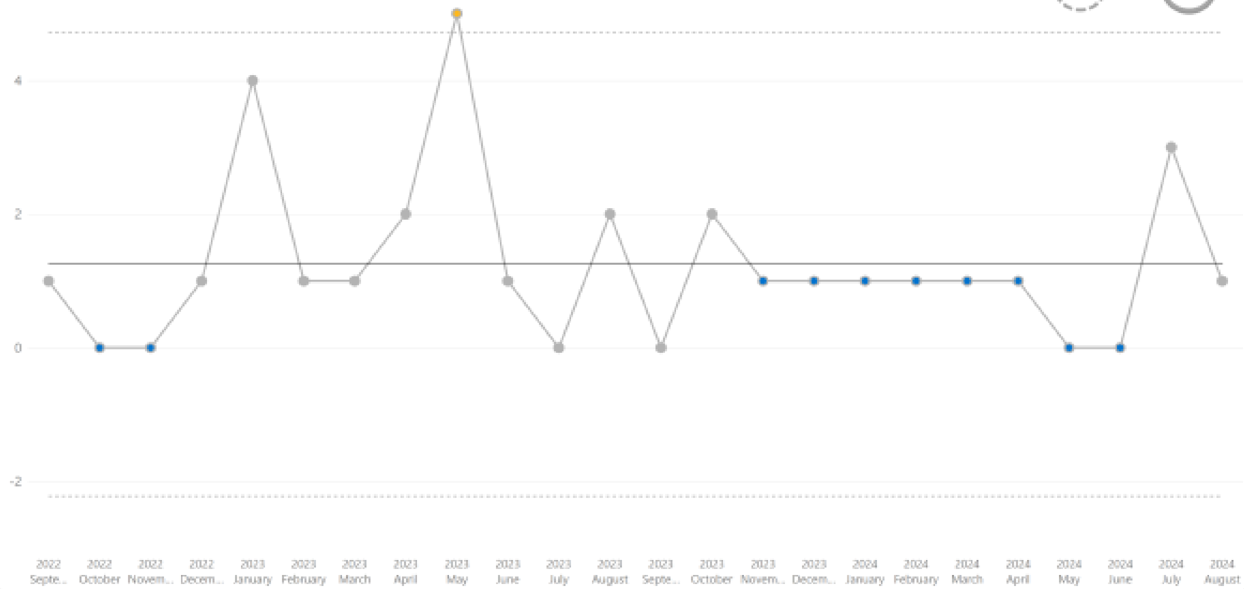
3rd and 4th Degree Tears - Medical Director

Target	Target < or >	Performance	Assurance	Variation
3.5% NMPA baseline (3.2-4.1 95%confidence interval)	<=	3.28%	?	H



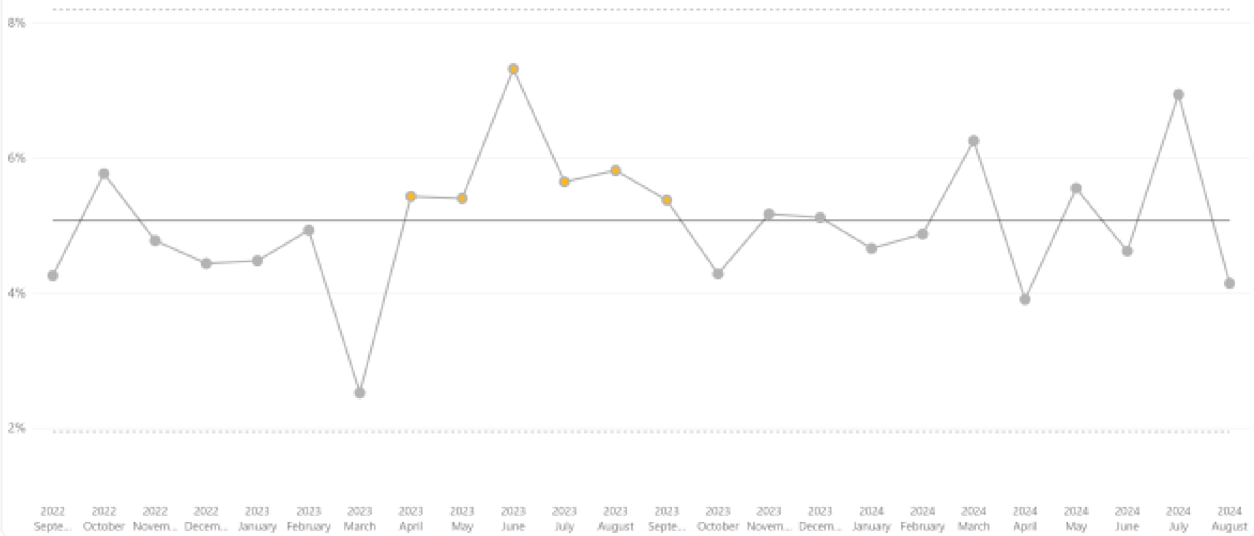
Hypoxic Encephalopathy (Grade 2,3) - Medical Director

Target	Target < or >	Performance	Assurance	Variation
TBA	<=	1		



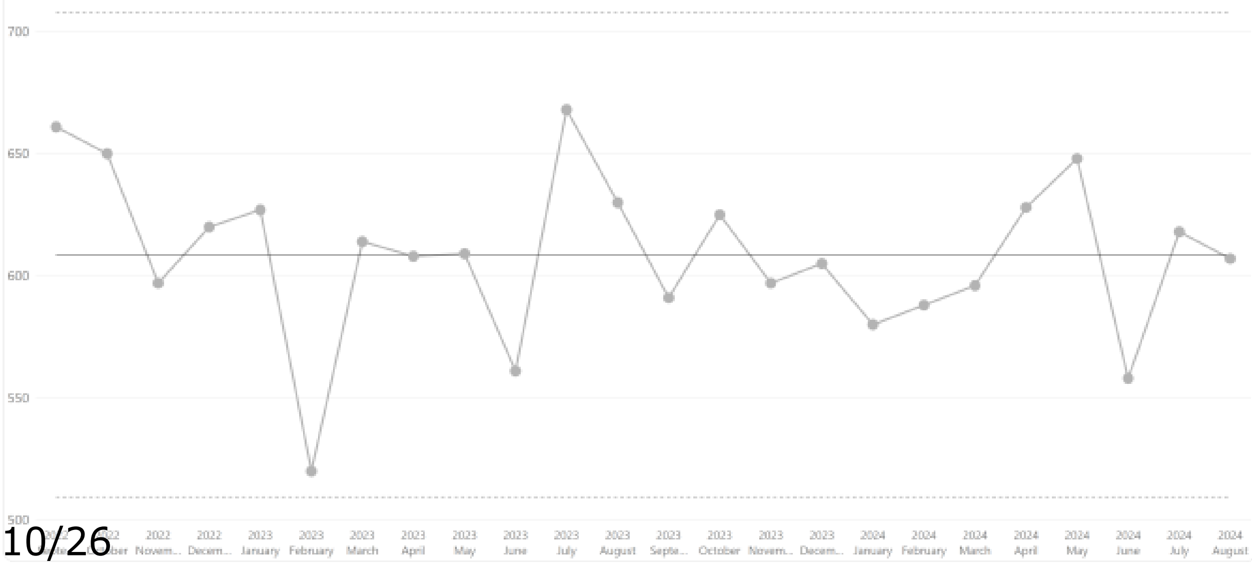
Inborn term babies admitted to NICU - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
<= 5%	<=	4.14%		



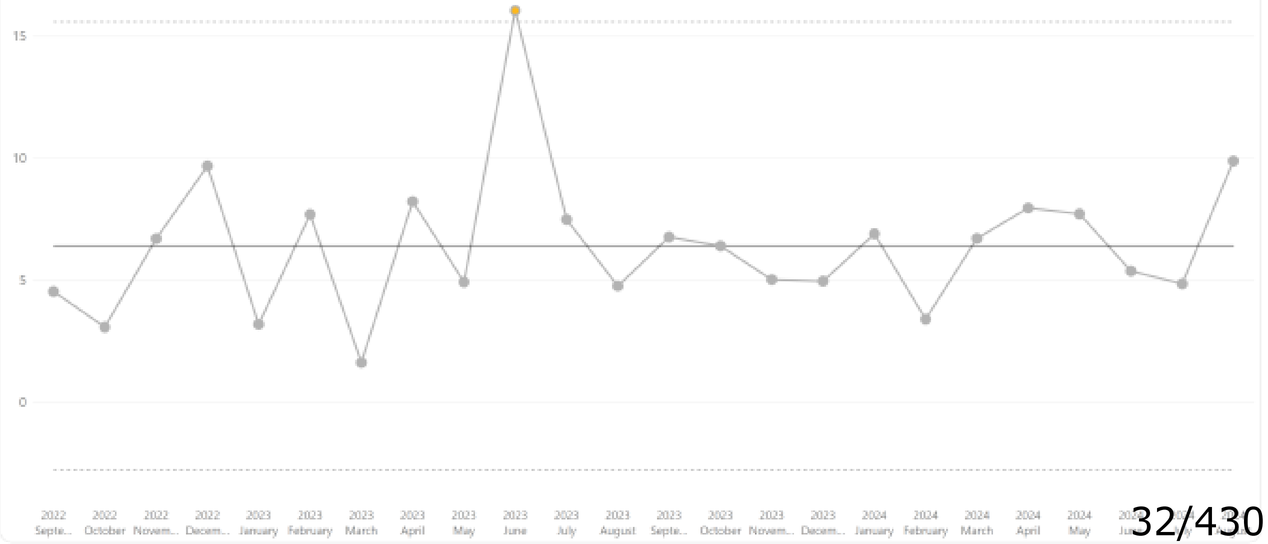
Number of births - Medical Director

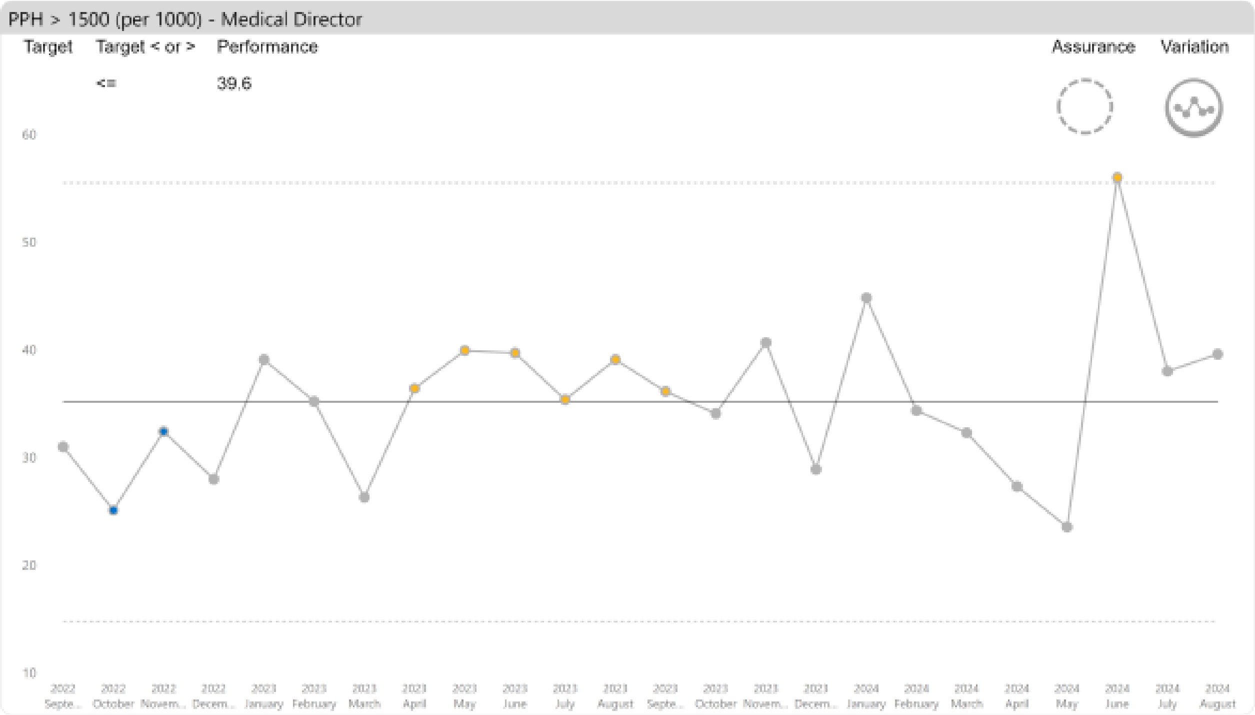
Target	Target < or >	Performance	Assurance	Variation
	N/A	607		



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

Target	Target < or >	Performance	Assurance	Variation
	<=	9.88		





PPH > 1500 (per 1000) - Medical Director

Target	Target < or >	Performance
	<=	39.6

Assurance

Variation

People Indicators

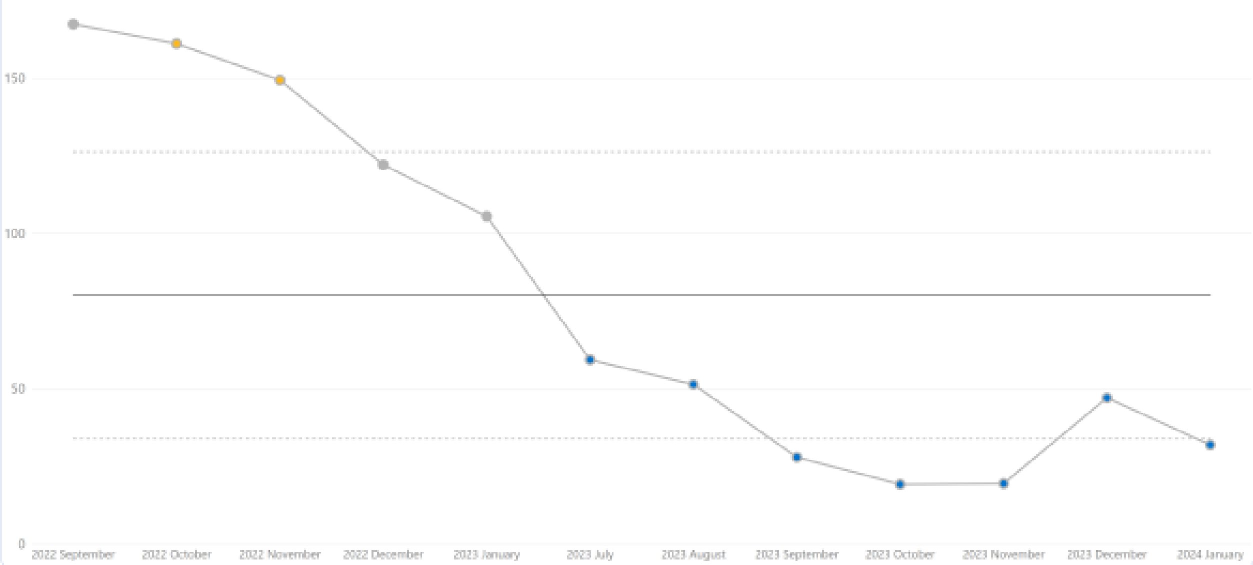
Executive Lead:
Michelle Turner, Chief People Officer

LWH Integrated Performance Report - People Indicators Summary

Domain	Date	Target < or >	Performance	Assurance	Variation	Assurance Category	Trend
Workforce Development							
PDR Rate	August 2024	>=	86.20%	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)	August 2024	>=	9.44%		H	Celebrate	
Number of staff leaving within 12 months	August 2024	N/A	19	?		Watch	
Turnover	August 2024	<=	11.42%	P	H	Take Action	
Workforce Training							
Face to Face Inclusion & Anti Racism training completed by staff	August 2024	>=	77.95%	?		Watch	
Mandatory Training	August 2024	>=	93.20%	P		Celebrate	
Mandatory Training (Clinical)	August 2024	>=	93.22%	?	H	Celebrate	
Workforce Wellbeing							
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	February 2024	>=	40.88%	F		Take Action	
Sickness	August 2024	<=	5.81%	F	L	Take Action	

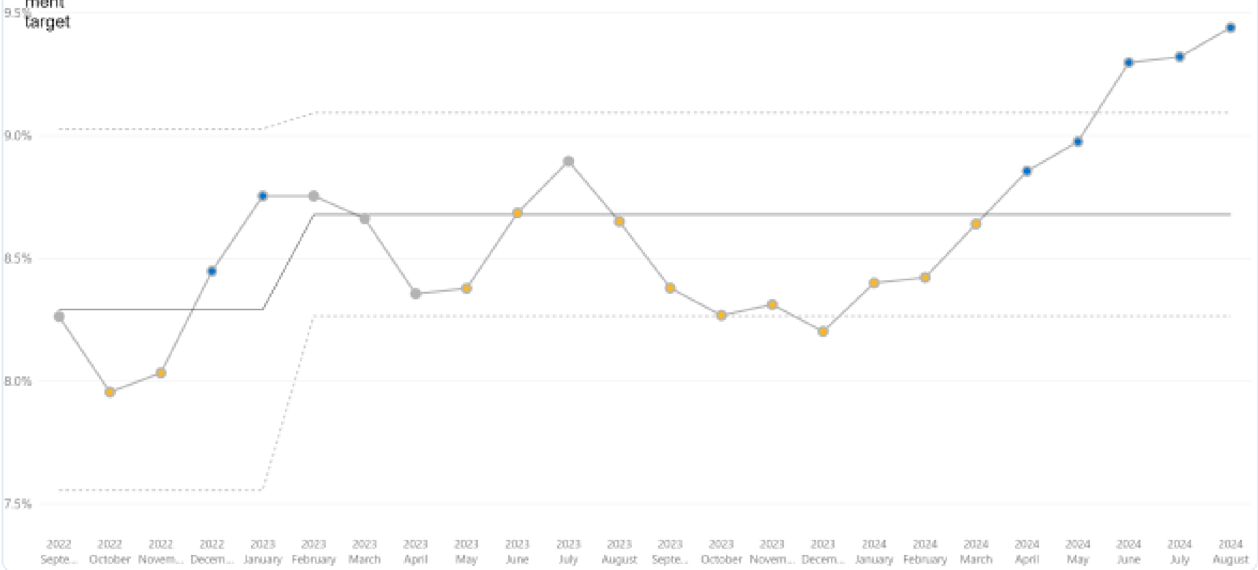
Overall Staff Vacancies WTE - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
	<=	31.88		



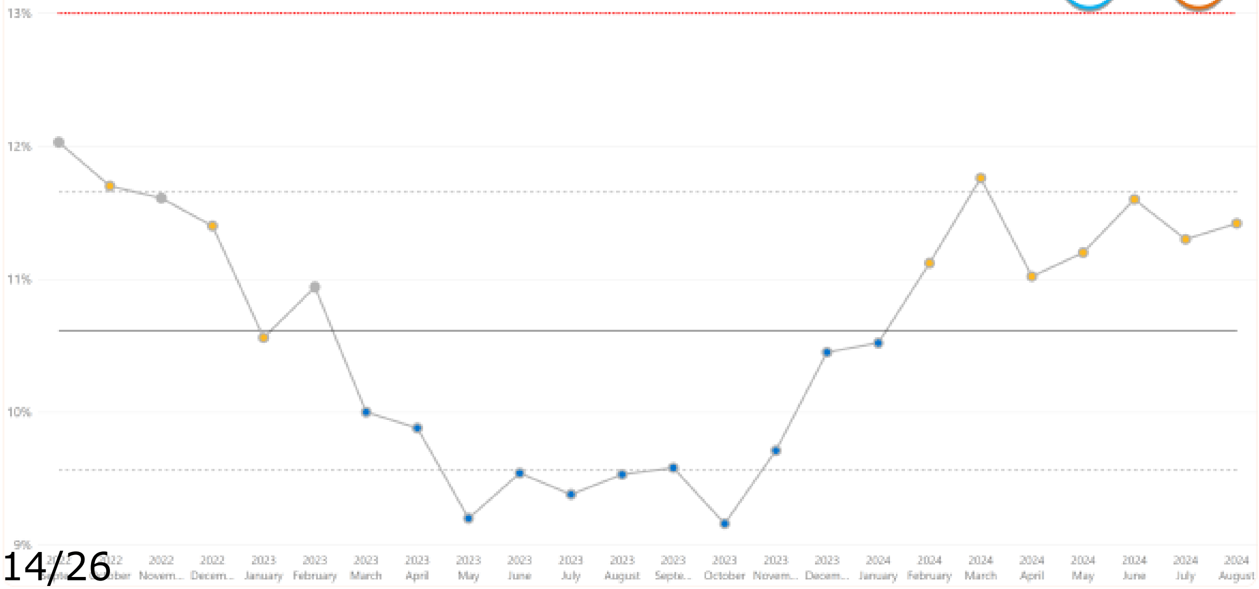
GM staff in leadership roles (B7 or above) - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
2% annual improvement target	>=	9.44%		



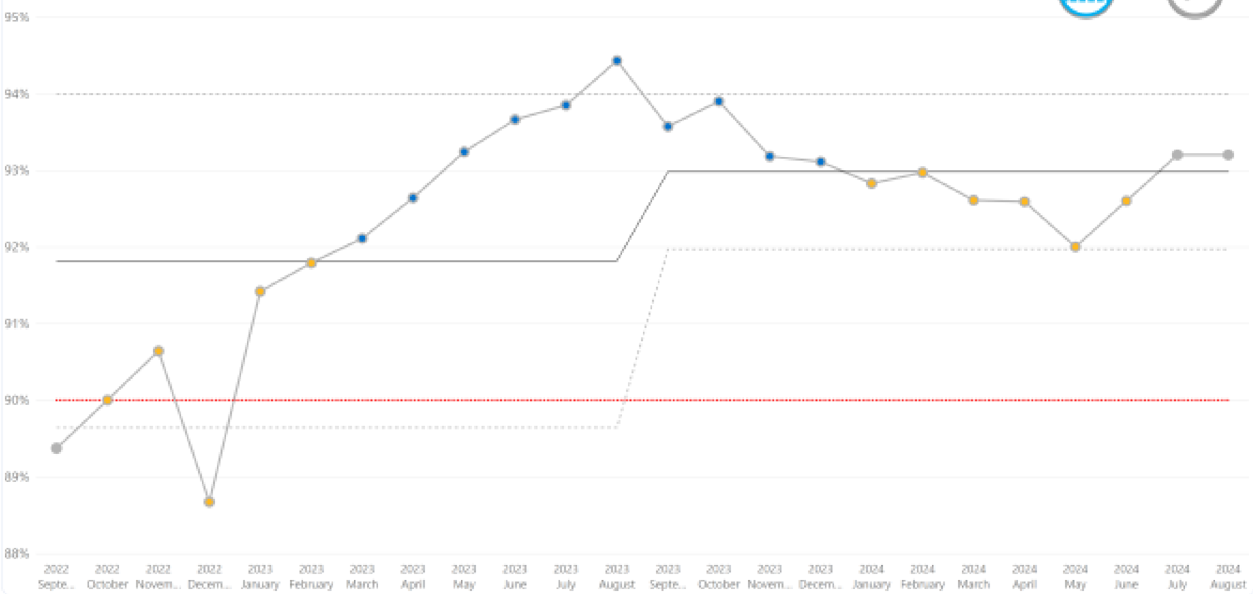
Turnover - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
<= 13%	<=	11.42%		



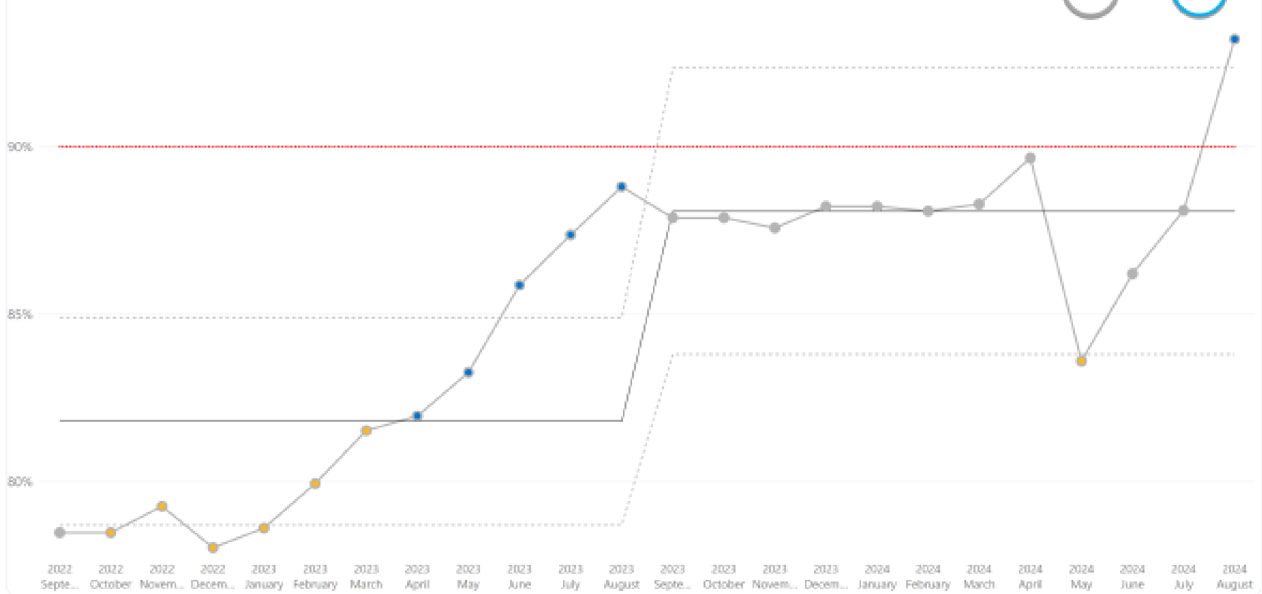
Mandatory Training - Chief People Officer

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



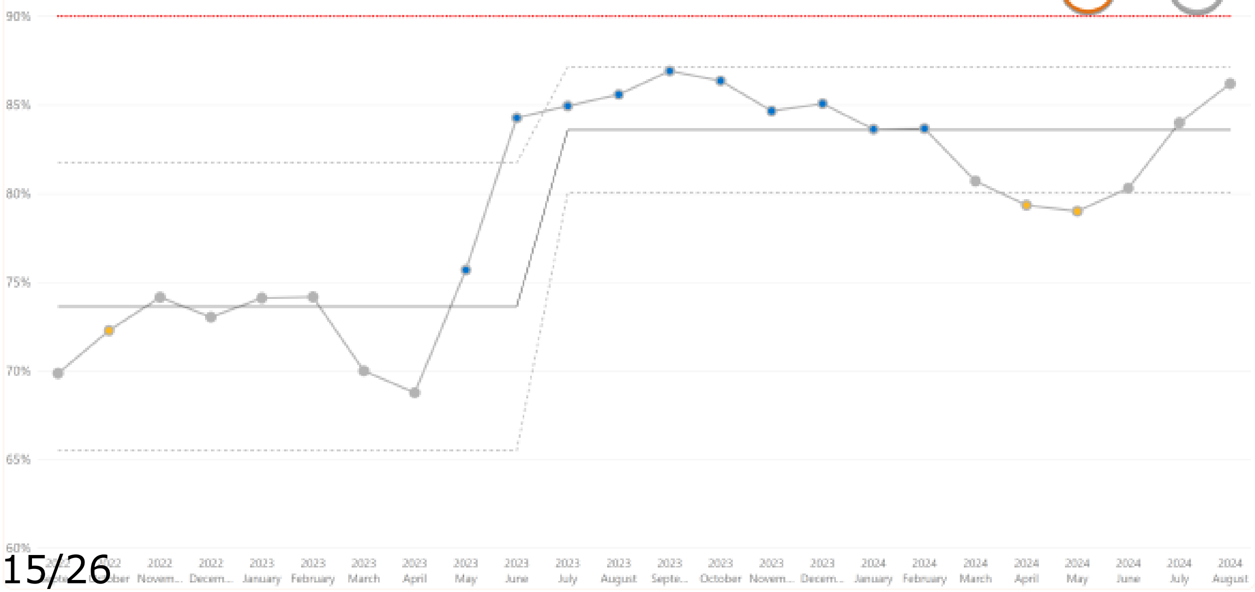
Mandatory Training (Clinical) - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
>= 95%	>=	93.22%	?	H



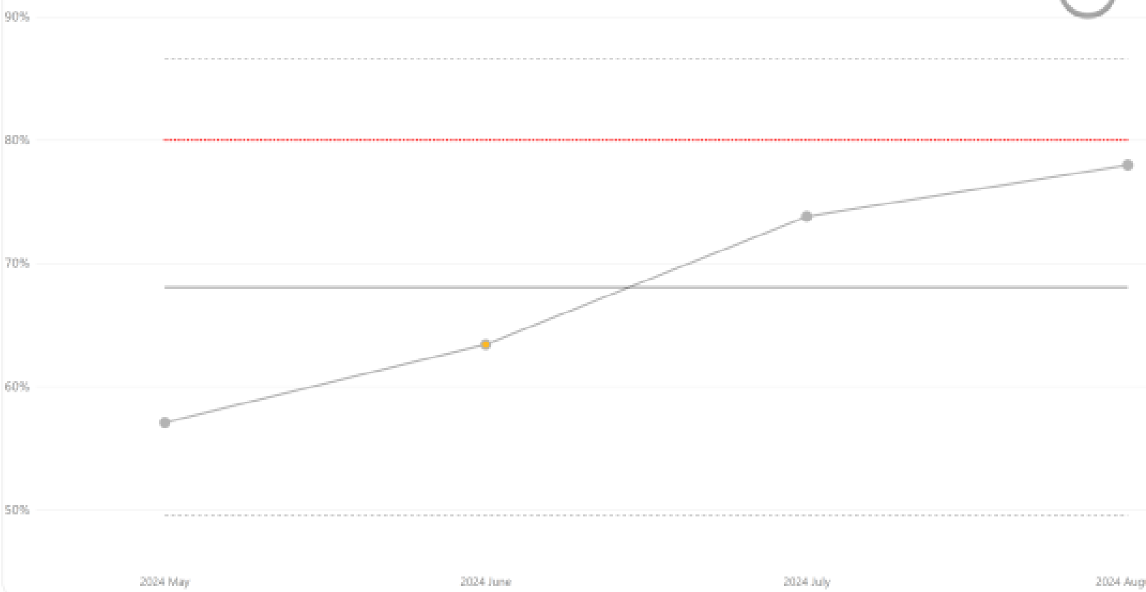
PDR Rate - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
>= 90%	>=	86.20%	F	



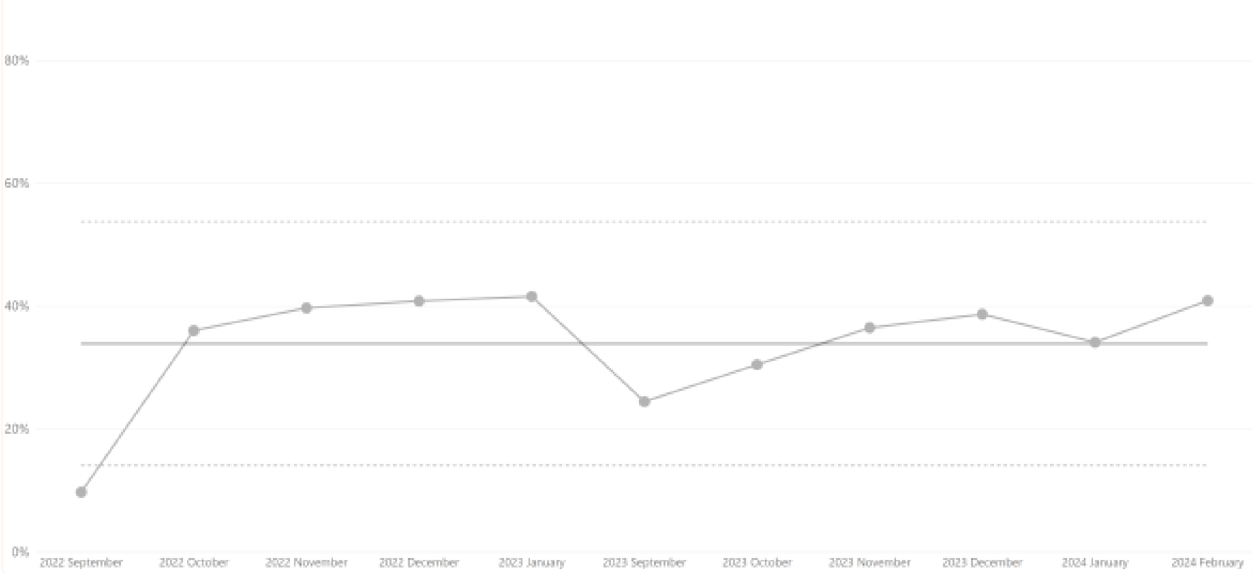
Face to Face Inclusion & Anti Racism training completed by staff - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
>= 80%	>=	77.95%	?	



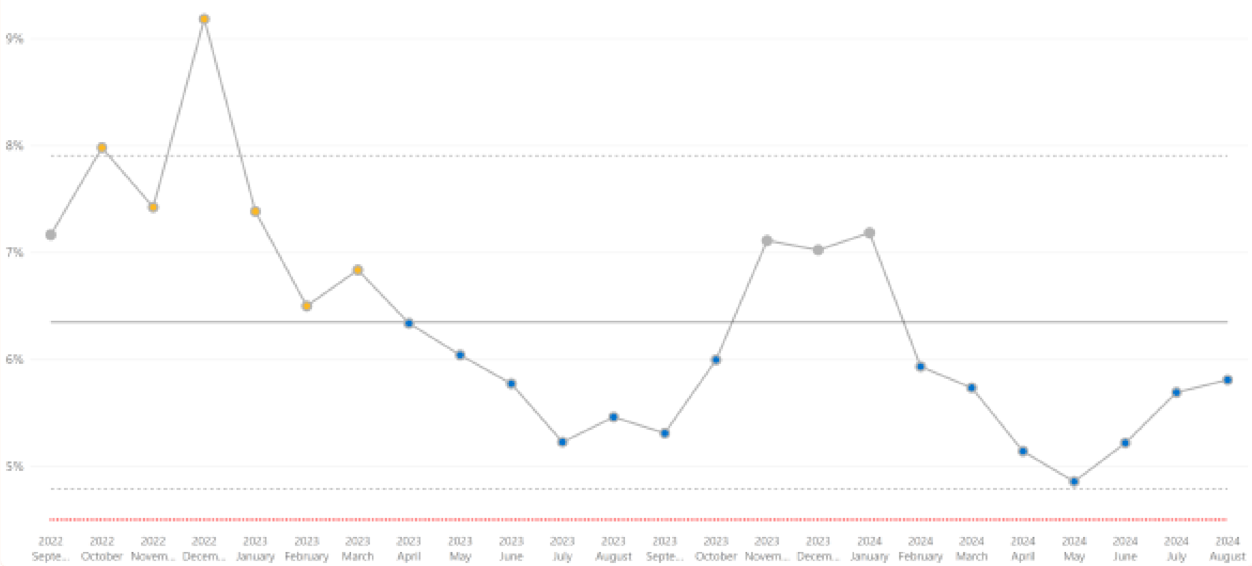
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff - Chief People Officer

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



Sickness - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
<= 4.5%	<=	5.81%	F	L



Operational Performance Indicators

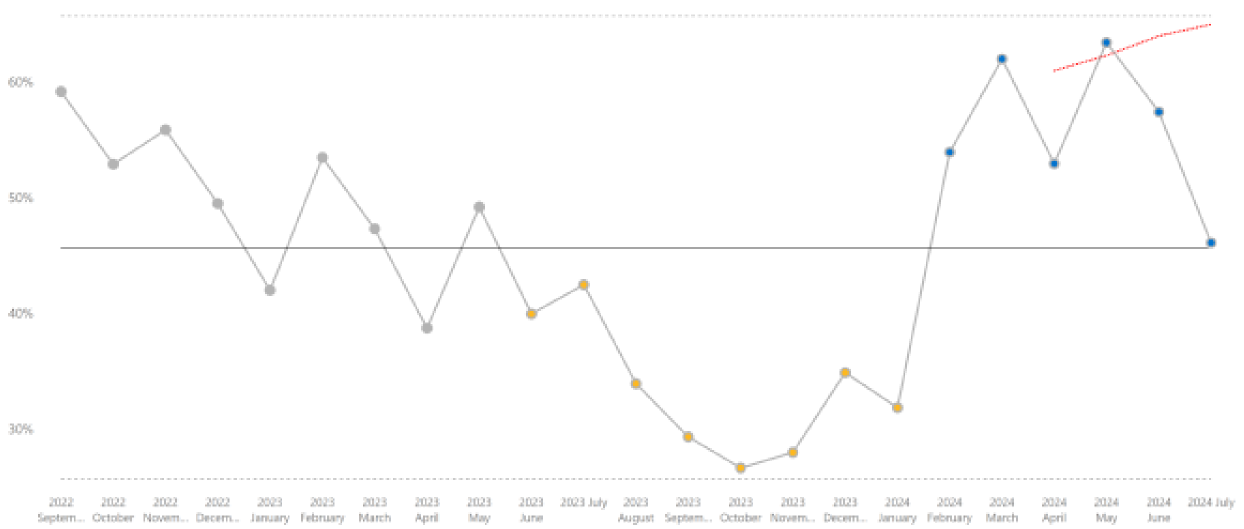
Executive Lead:
Gary Price, Chief Operating Officer

LWH Integrated Performance Report - Operational Indicators Summary

Domain	Date	Target < or >	Performance	Assurance	Variation	Assurance Category	Trend
Cancer							
Cancer: 28 Day Faster Diagnosis	July 2024	>=	46.11%	?	H	Celebrate	
Cancer: 31 Day decision to treat to treatment	July 2024	>=	79.49%	?	∿	Watch	
Cancer: 62 Day referral to Treatment	July 2024	>=	18.60%	?	∿	Watch	
Planned Care							
18 Week RTT: Incomplete Pathway > 52 Weeks	August 2024	<=	762	?	L	Celebrate	
18 Week RTT: Incomplete Pathway > 65 Weeks	August 2024	<=	24	?	L	Celebrate	
18 Week RTT: Incomplete Pathway > 78 Weeks	August 2024	<=	0	?	L	Celebrate	
Diagnostic Tests: 6 Week Wait	August 2024	>=	90.82%	F	∿	Take Action	
Overall size of active patient waiting list	August 2024	<=	16466	?	L	Celebrate	
Urgent Care							
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	August 2024	>=	88.28%	?	∿	Watch	
MAU - Arrival to Triage within 15 Mins	August 2024	>=	96.75%	?	∿	Watch	
MAU - Arrival to Triage within 30 Mins	August 2024	>=	99.94%	P	∿	Celebrate	

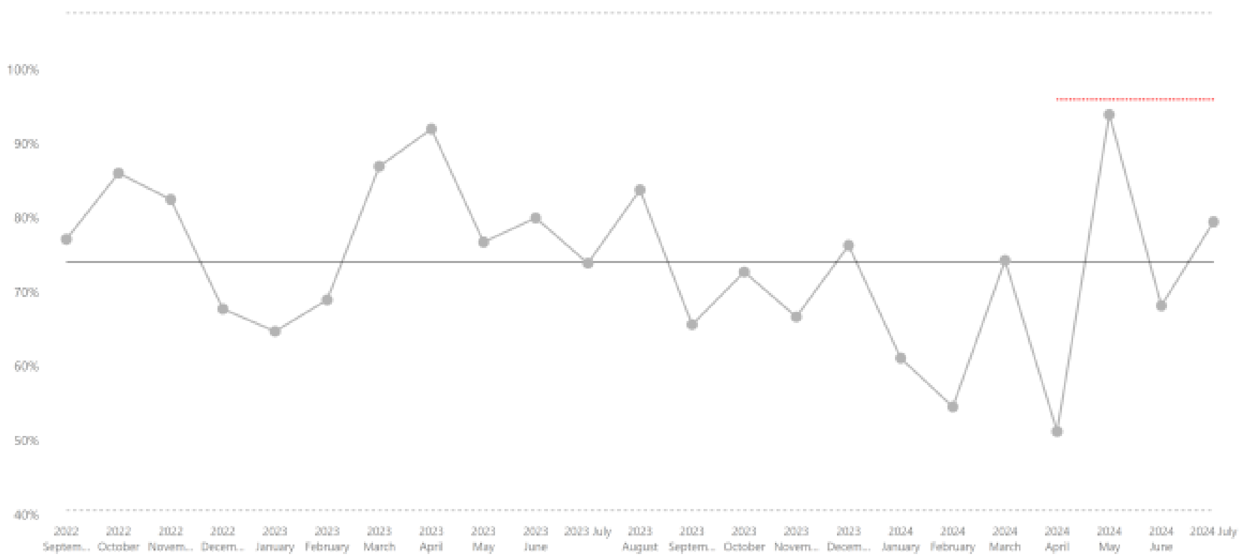
Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

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



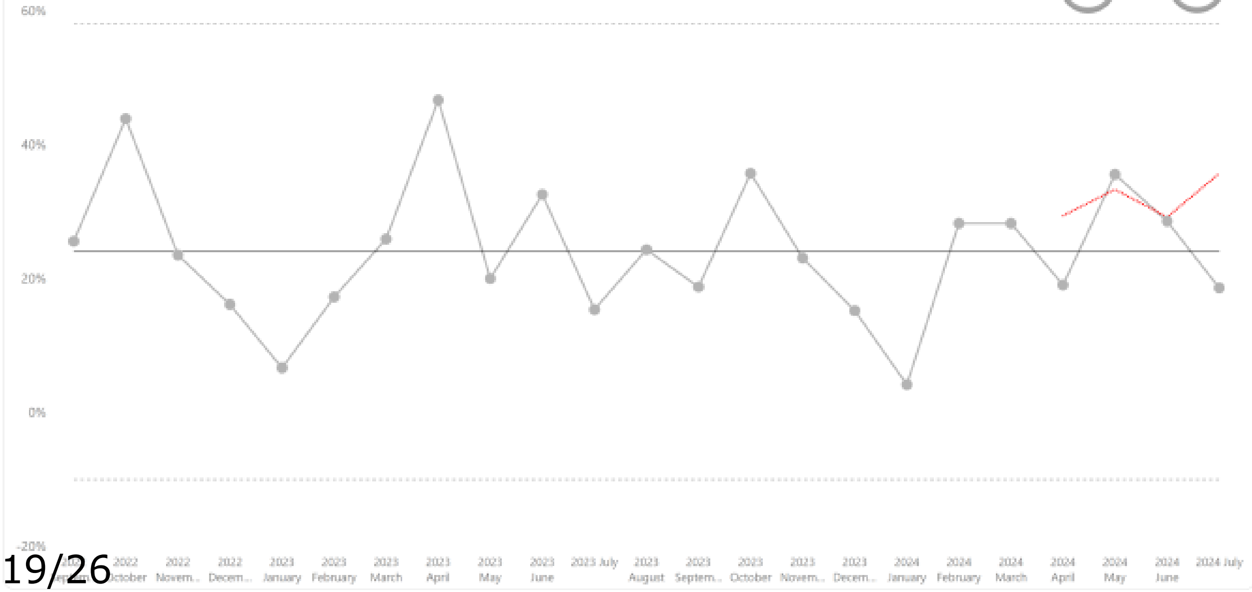
Cancer: 31 Day decision to treat to treatment - Chief Operating Officer

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



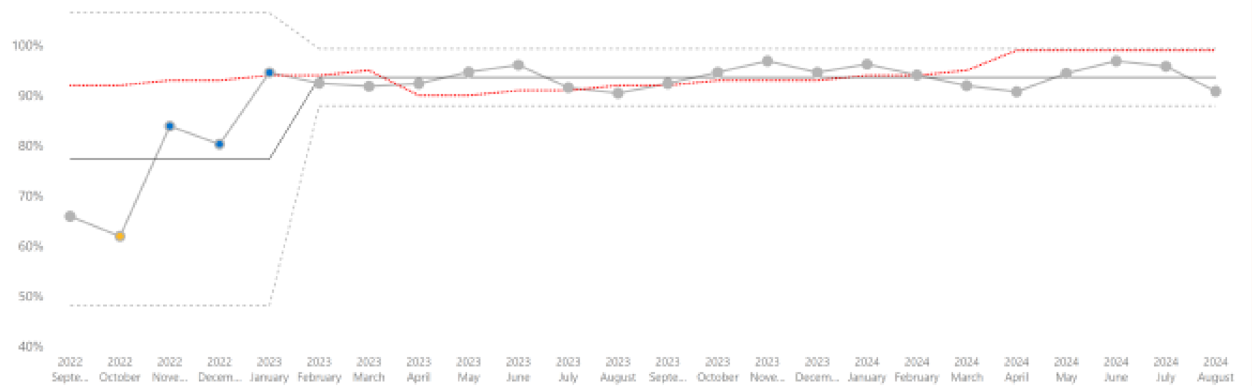
Cancer: 62 Day referral to Treatment - Chief Operating Officer

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

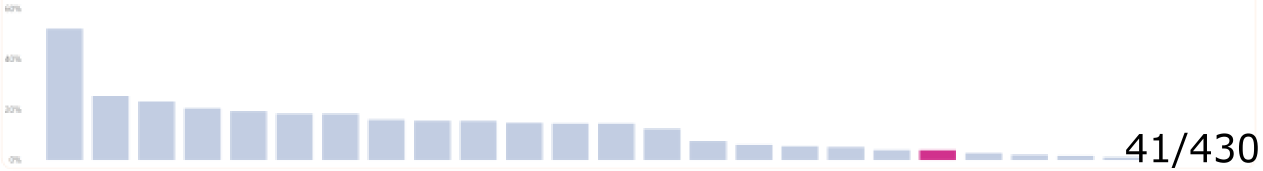


Diagnostic Tests: 6 Week Wait - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 99%	>=	90.82%	F	

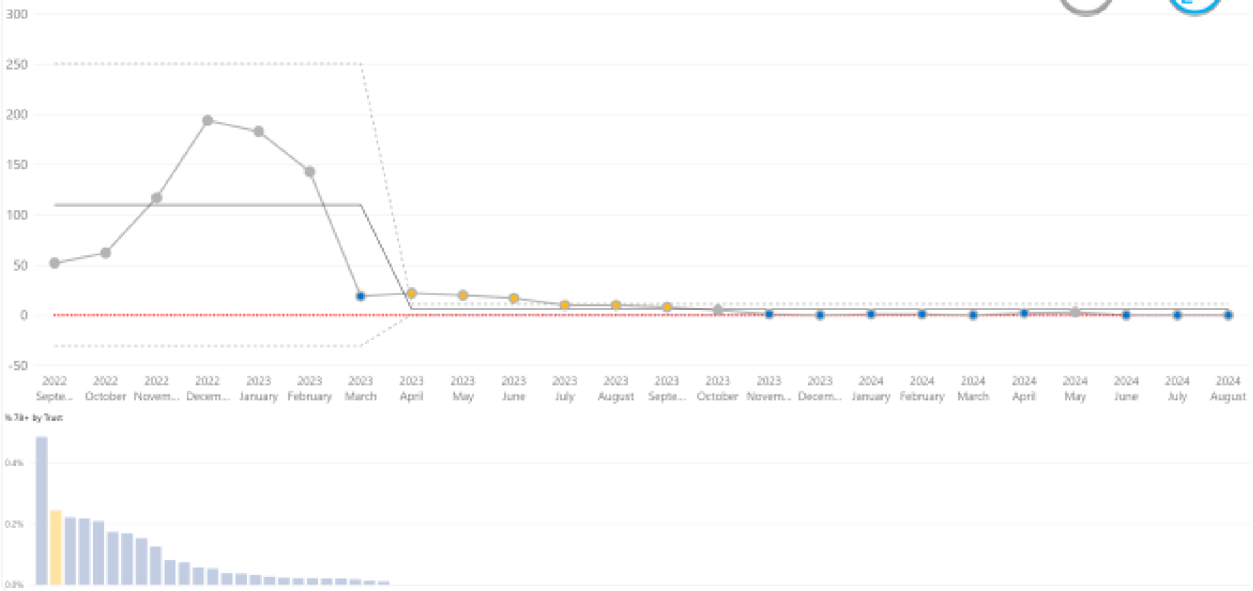


Percentage waiting 6+ weeks by Provider Name



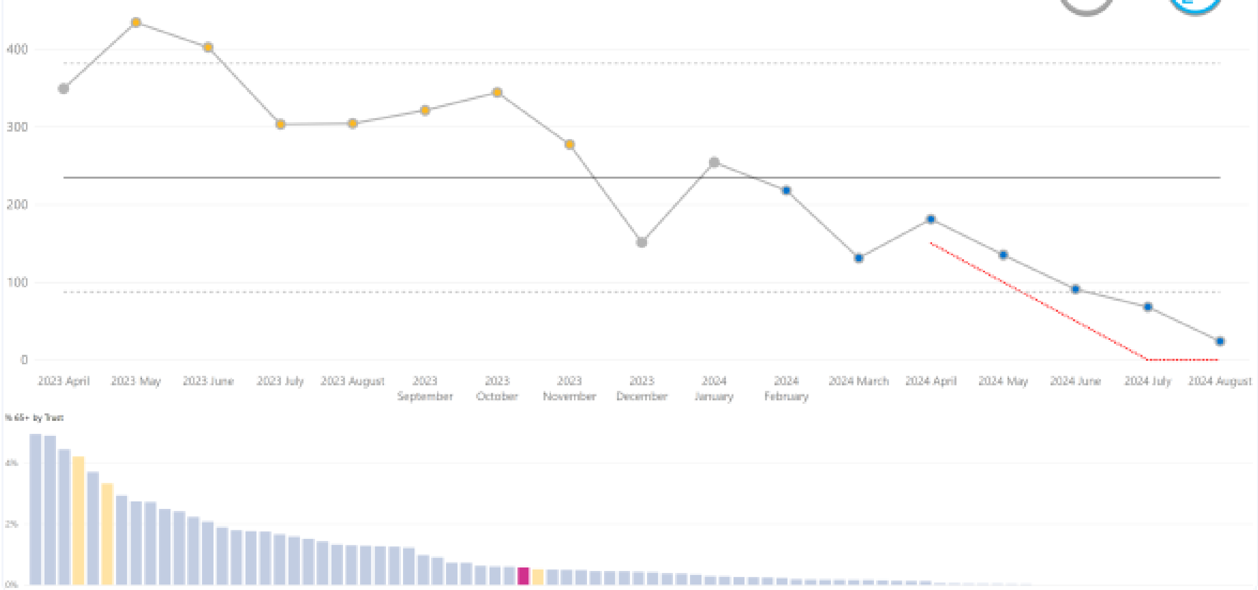
18 Week RTT: Incomplete Pathway > 78 Weeks - Chief Operating Officer

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



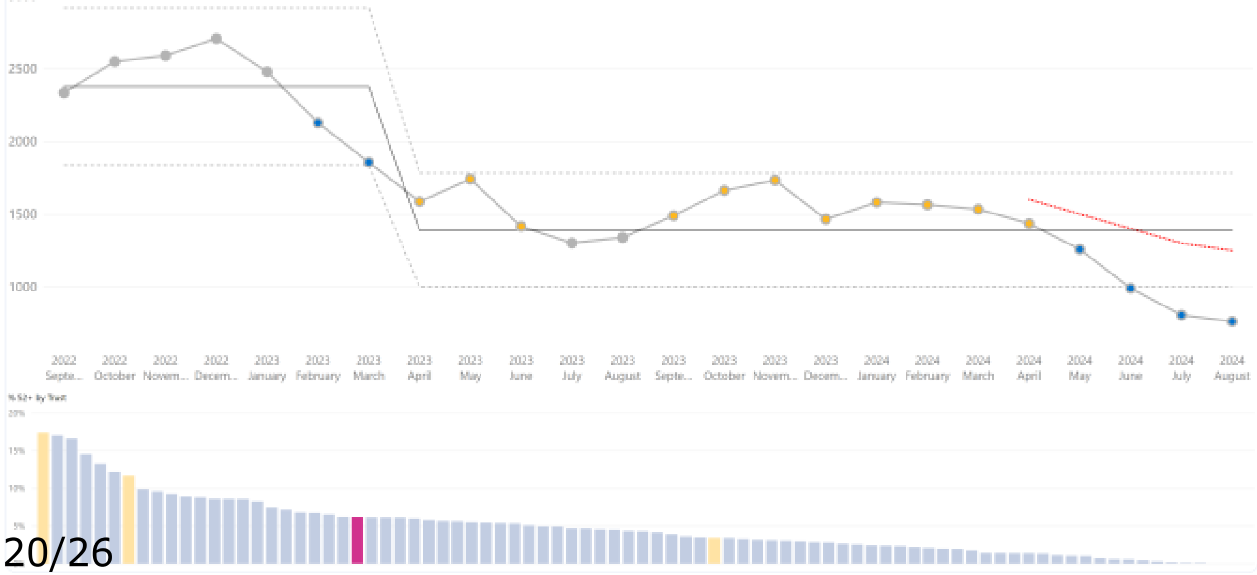
18 Week RTT: Incomplete Pathway > 65 Weeks - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
0	<=	24		



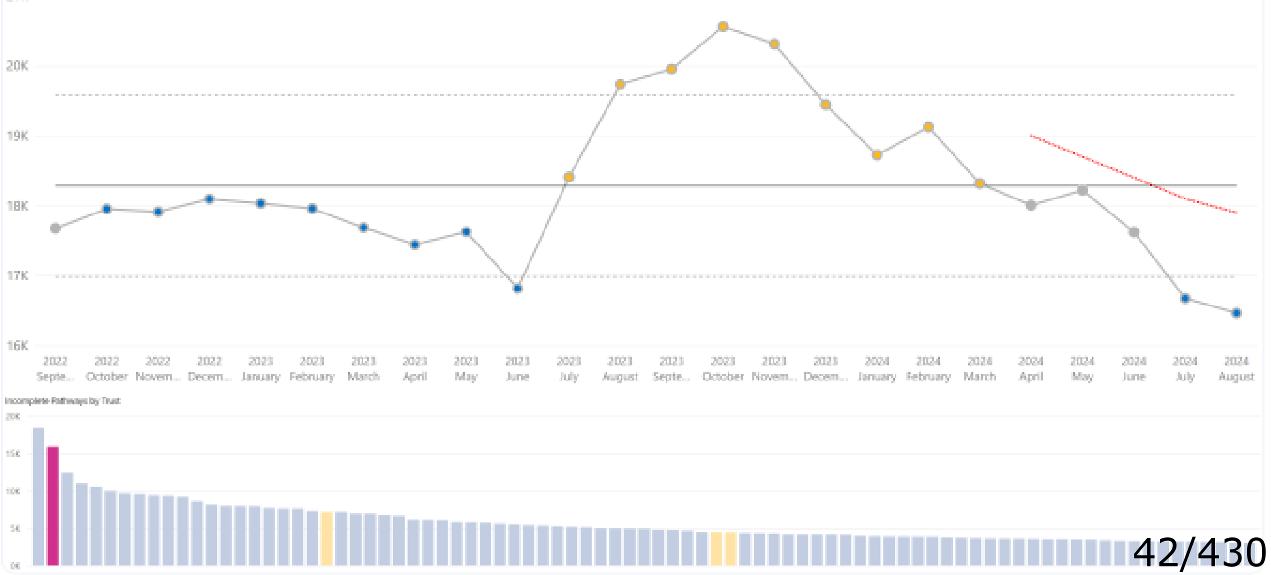
18 Week RTT: Incomplete Pathway > 52 Weeks - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
0	<=	762		



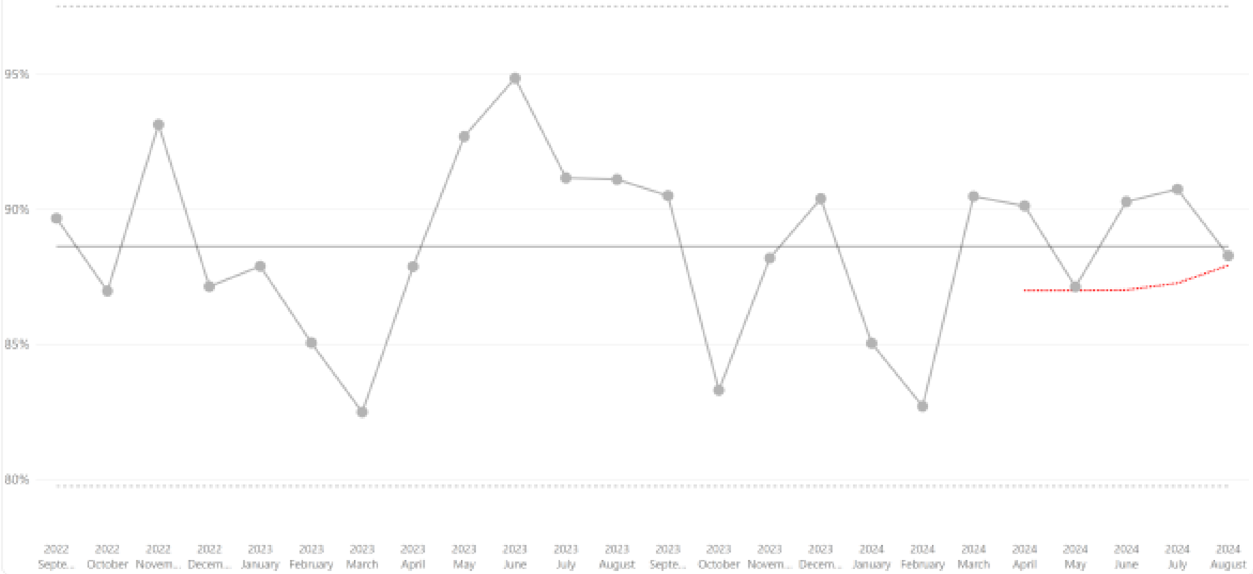
Overall size of active patient waiting list - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
<= 16500	<=	16466		



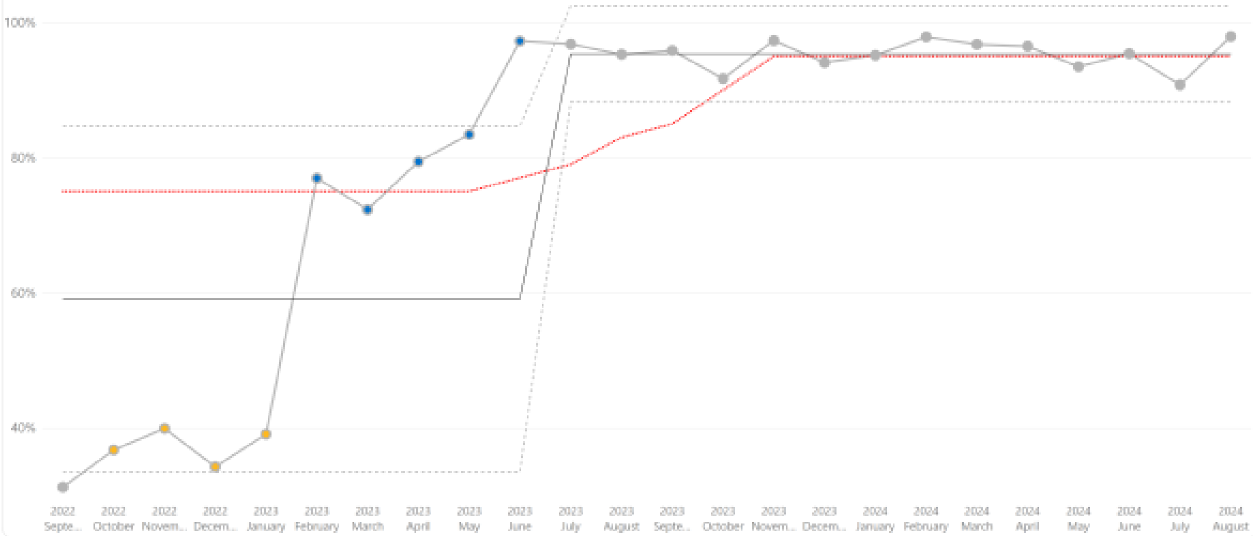
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 90%	>=	88.28%	?	



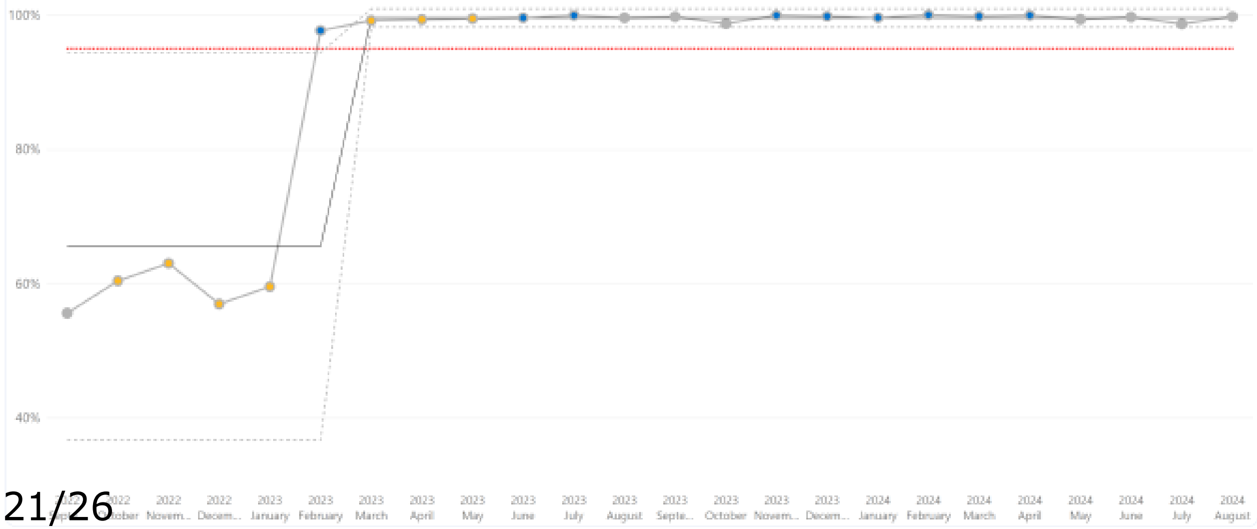
MAU - Arrival to Triage within 15 Mins - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 95%	>=	97.93%	?	



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

Target	Target < or >	Performance	Assurance	Variation
>= 95%	>=	99.74%	P	

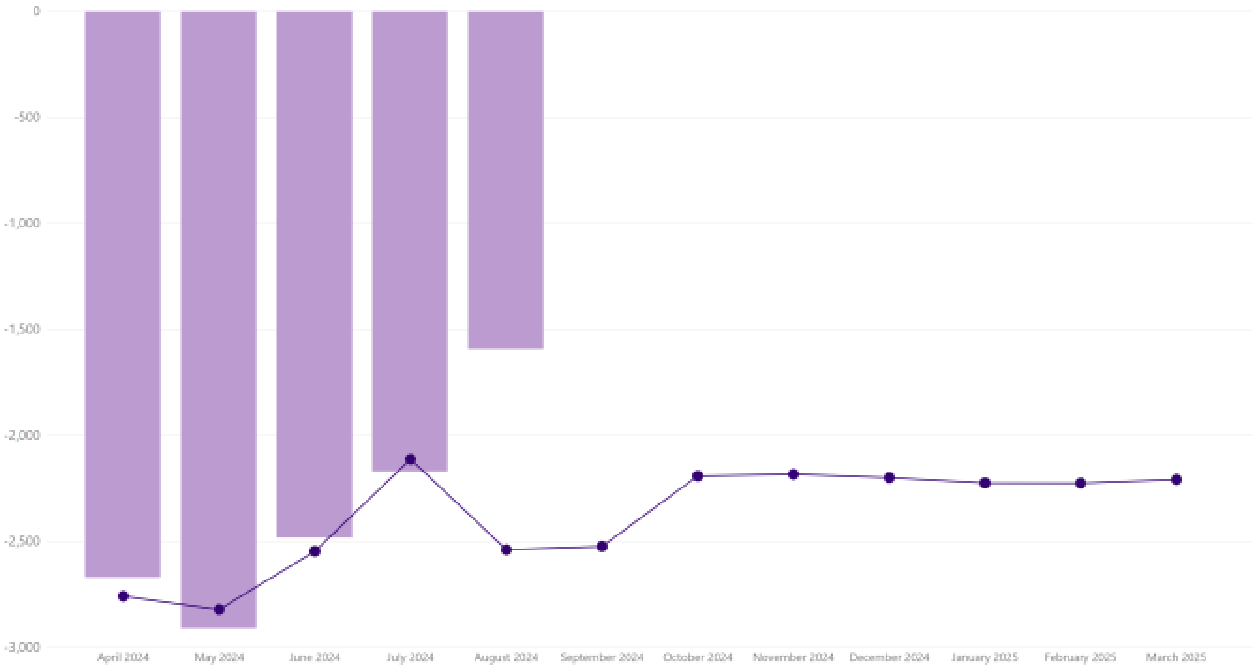


Target	Target < or >	Performance	Assurance	Variation

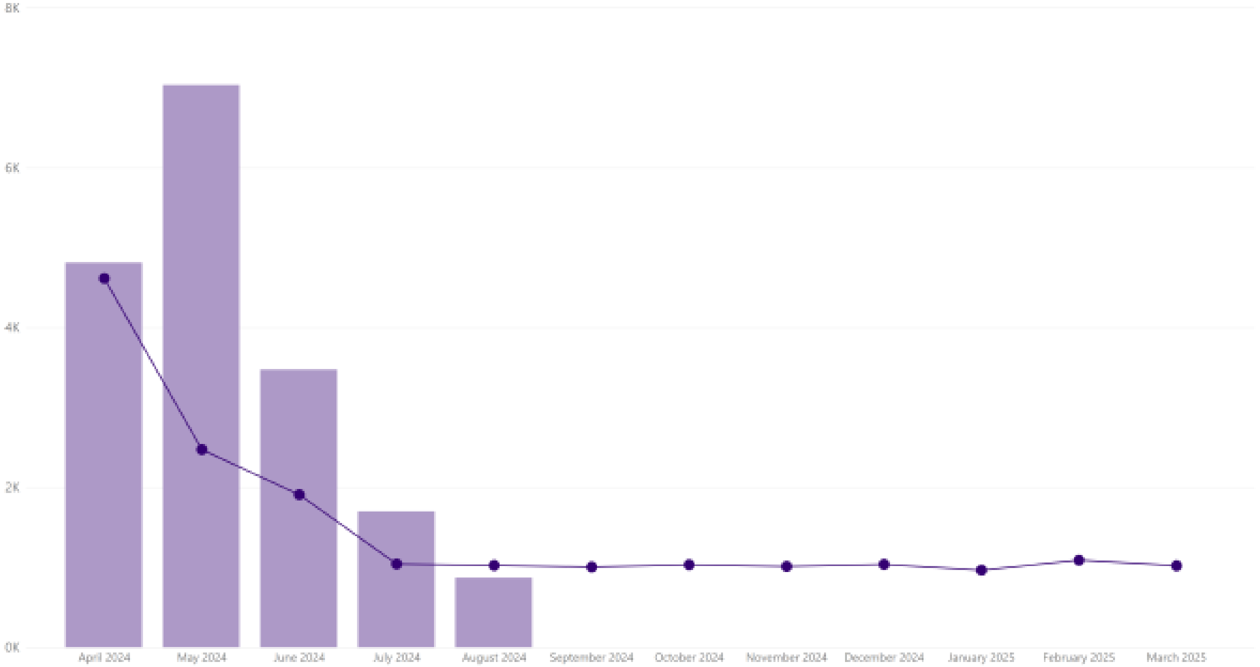
Financial Duty Indicators

Executive Lead:
Jenny Hannon, Chief Finance Officer

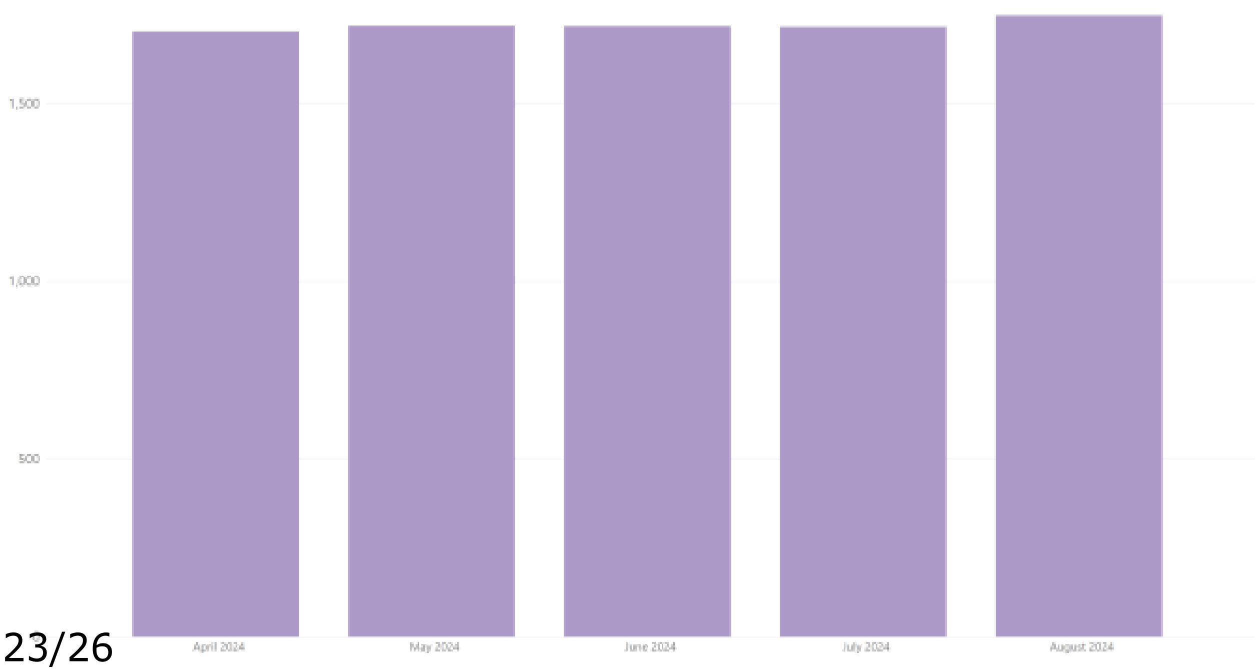
I&E Actual vs Plan



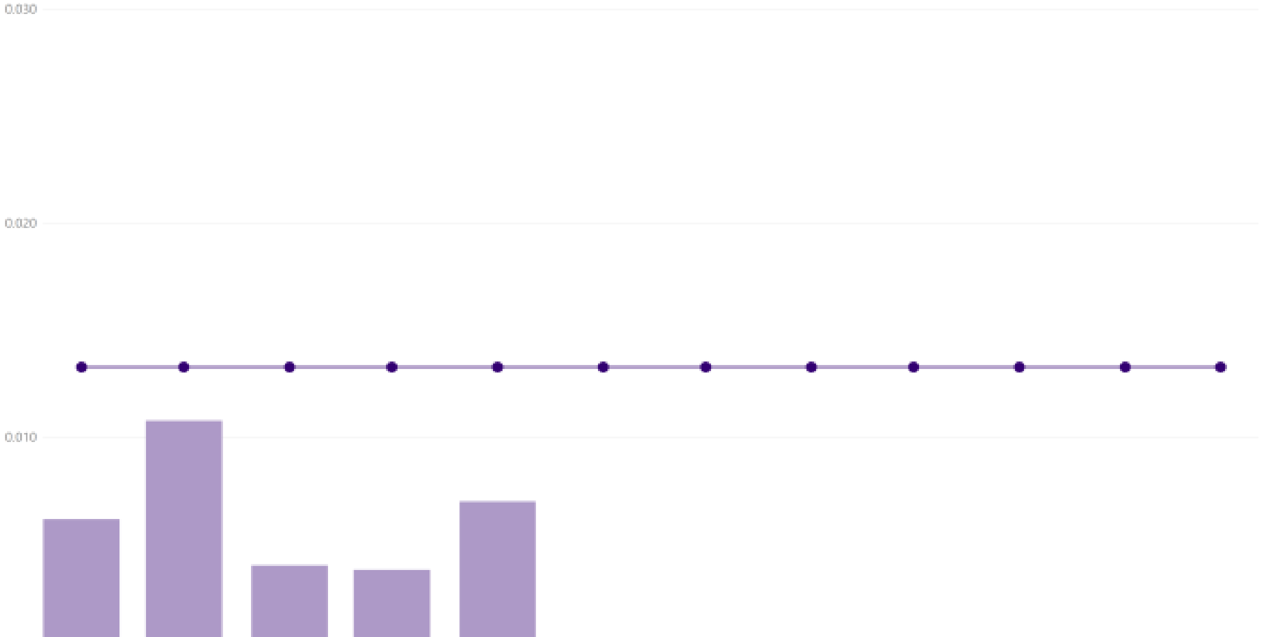
Cash Actual vs Plan



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.
H	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?
L	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.	
H	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?
L	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.
F	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.
P	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement.** Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix 2: Assurance Category Descriptions

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

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.

Board of Directors

COVER SHEET

Meeting Date	Thursday, 10 October 2024	**Item Reference**	TB24/25_135
Report Title	Finance Performance Report - Month 5		
Author	Claire Butler, Head of Strategic Finance 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 5.
Executive Summary	The Trust has an approved plan for 2024/25 of £28.5m deficit. At Month 5 the Trust reported an £11.8m deficit, which represents a £1.0m favourable variance against plan. The Trust is forecasting to deliver its plan of £28.5m deficit by year end. This position has been reported to the Cheshire and Merseyside Integrated Care Board (C&M ICB). £2.9m of Cost Improvement Programme (CIP) savings have been delivered to date, resulting in a £1.2m favourable variance to the CIP target of £1.7m. The cash balance was £0.9m at the end of Month 5.
Key Areas of Concern	None
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+)	N/A	-

Assurance Level	SUBSTANTIAL - Good system of internal control applied to meet existing objectives
Action Required by the Board of Directors	The Board is asked to note the Month 5 position

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Finance and Performance Executive Group	24/09/24	Deputy Chief Finance Officer	The financial position was received and noted.
Finance, Performance, and Business Development Committee	02/10/24	Chief Finance Officer	The financial position was noted.

MAIN REPORT

1. Summary Financial Position

	Plan	Actual	Variance	RAG	*R*	*A*	*G*
Surplus/(Deficit) YTD	-£12.8m	-£11.8m	£1.0m	5	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast M5	-£28.5m	-£28.5m	£0.0m	1	*>10% off plan*	*Plan*	*Plan or better*
Cash	£7.0m	£0.9m	-£6.1m	6	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£1.7m	£2.9m	£1.2m	5	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£1.4m	£0.9m	-£0.4m	6	*>10% off plan*	*Plan*	*Plan or better*
Aligned Payment Incentive	108%	114%	6%	5	*>10% off plan*	*<10% off plan - plan*	*Plan or better*
Capital Spend YTD	£2.4m	£1.3m	-£1.0m	6	*>10% off plan*	*Plan*	*Plan or better*

At Month 5 the Trust reported an £11.8m deficit, which represents a £1.0m favourable variance against the year to date (YTD) plan. This is due to early delivery of non-recurrent CIP (Cost Improvement Programme) against the phased plan. At Month 5 the Trust is forecasting delivery of its £28.5m deficit plan.

The Cost Improvement Programme has delivered £2.9m of savings YTD (of which £0.9m is recurrent), which represents a £1.2m favourable variance against plan.

This position has been reported to the Cheshire and Merseyside Integrated Care Board (C&M ICB).

2. Drivers of the Position

After exclusion of services treated as 'pass through' (where income matches expenditure), the key drivers of the underlying year to date position are:

- Income £1.5m favourable variance to plan, driven by early achievement of CIP (out of area income), and over delivery of Aligned Payment and Incentive (API) income.
- Pay £0.2m favourable variance to plan, driven by vacancies in the Neonatal unit and slippage against investment to address immediate quality and safety issues, offset against increased bank usage across Maternity and Theatres.
- Non-pay £0.7m adverse variance to plan, driven primarily by increased drug and clinical supplies costs.

Industrial action took place across Month 3 and Month 4 with an income loss of approximately £0.1m, however despite this the Trust remains on target for API overall. The total net cost of industrial action, including pay cost impact, is estimated to be £0.3m. The Trust will receive £0.1m of additional income in respect of industrial action, which is expected to be received in Month 6.

3. Workforce

Whole Time Equivalents (WTEs) are shown in Appendix 1 and are an area of regional and national focus for 2024/25. There is an expectation that Trusts will work to actively reduce non-clinical and non-patient facing WTEs.

At Month 5 WTEs totalled 1,748, compared to 1,703 at Month 1, and 1,687 at M12 2023/24. These increases are in line with plan and are driven by resident doctor recruitment, the August post-graduate doctor rotation, and recruitment of other clinical posts in line with budget.

The favourable variance of 26 WTEs compared to plan is driven by the Liverpool Neonatal Partnership and therefore has a nil financial impact (as income is received to match expenditure in this service).

Enhanced controls remain in place regarding agency spend and there is a favourable variance against the Trust plan (£0.3m YTD) and against the national cap of 3.2% of total pay bill (£1.2m).

4. Cost Improvement Programme (CIP)

The Trust has a cost improvement programme target of £5.9m, phased towards the end of the year. At Month 5 the Trust has delivered £2.9m of CIP (of which £0.9m is recurrent), leading to a favourable a variance against plan of £1.2m. This is driven by earlier than anticipated achievement of income schemes and identification of non-recurrent pay underspends across corporate teams. Full delivery of the CIP target is forecast. The Trust is placing significant focus on conversion of non-recurrent to recurrent delivery.

5. Cash and Borrowings

The Trust's cash and bank balance at the end of Month 5 was £0.9m. The total forecast cash requirement for 2024/25 is £23.9m.

The Trust applied for £7.0m cash support in September, which was approved and received. It was subsequently confirmed that the Trust will receive £16.9m of additional non-recurrent, cash-backed deficit support. The Trust will receive £9.9m in October and £1.4m each month thereafter until March 2025. Together with the £7.0m received in September, this totals £23.9m (equivalent to the total forecast cash requirement for 2024/25).

Trust income and expenditure plans for 2024/25 will be amended from Month 6 to reflect the additional income, resulting in a revised deficit plan of £11.6m for Liverpool Women's, and a breakeven plan for the C&M ICS.

The Trust will continue to monitor cash carefully throughout the remainder of the financial year, maintaining all stringent cash control measures implemented to date.

6. Capital Expenditure

Capital expenditure is £1.0m behind plan at Month 5, due to delays in a small number of high value schemes. The Trust expects to fully expend the capital plan of £9.8m by 31 March 2025.

7. Virements

Nine virements were transacted in Month 5, five of which are over £0.1m and require reporting to the Board in line with SFIs. Details can be seen in Appendix 1.

8. Board Assurance Framework (BAF) Risk

There are no proposed changes to the BAF score this period, which remains at 11 (Likelihood 4, Impact 4, Control 3). This will remain under close review as the efficiency programme further develops.

9. Conclusion & Recommendation

The Trust has delivered a deficit of £11.8m at Month 5, which represents a £1.0m favourable variance against plan. There is a favourable variance of £1.2m against the Trust's CIP target. The Trust is forecasting delivery of its £28.5m deficit plan.

The cash position has improved following receipt of £7.0m of national cash support in September, and agreement of an additional £16.9m of deficit support during the remainder of the year.

The Board is asked to note this position.

Appendices

Appendix 1 – Board Finance Pack, Month 5

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M5

YEAR ENDING 31 MARCH 2025

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

INCOME & EXPENDITURE: M5

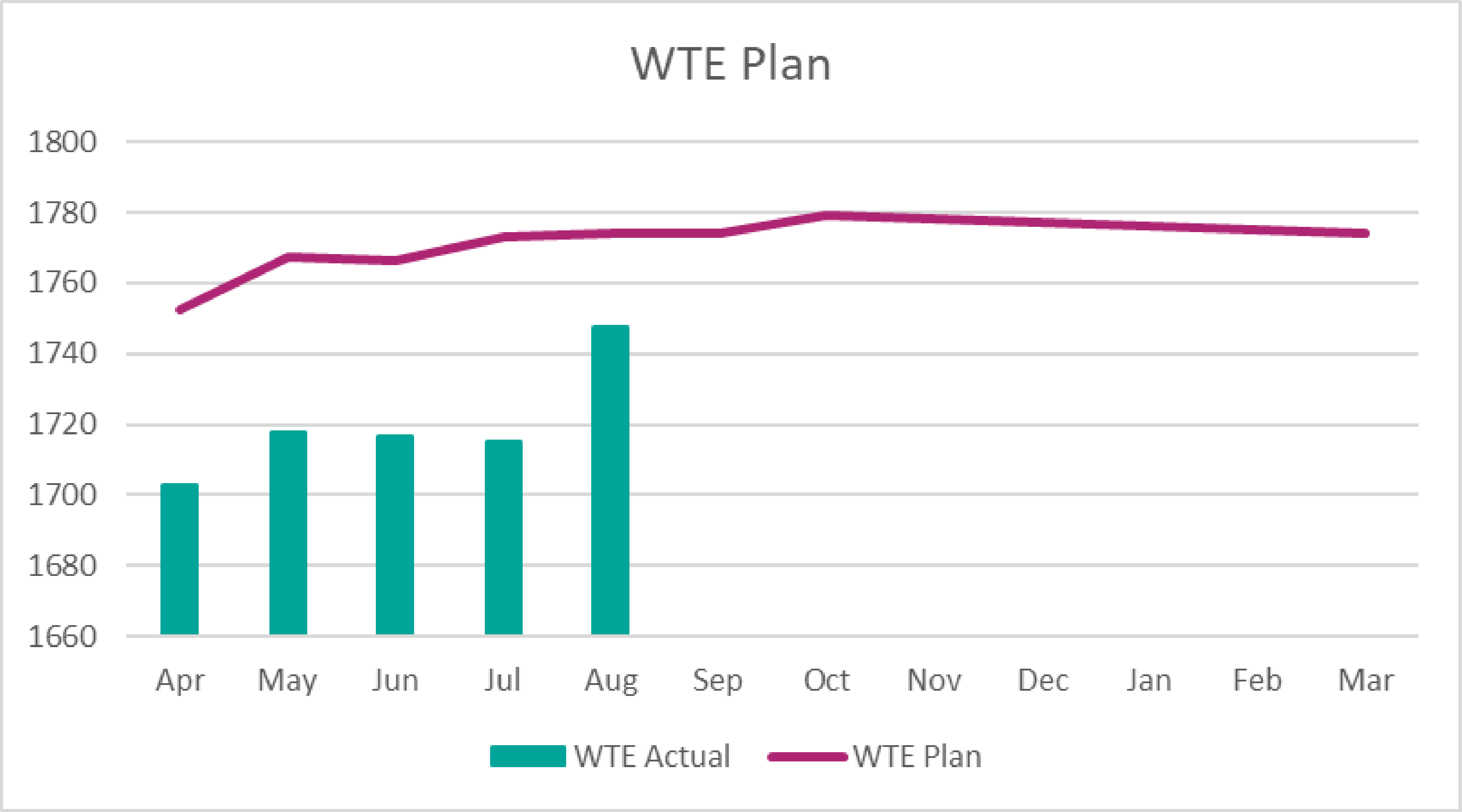
YEAR ENDING 31 MARCH 2025

INCOME & EXPENDITURE	MONTH 5			YTD			FULL YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Income									
Clinical Income	(11,783)	(12,710)	927	(58,789)	(59,605)	815	(141,491)	(144,287)	2,797
Non-Clinical Income	(614)	(598)	(16)	(3,066)	(2,954)	(112)	(7,365)	(7,143)	(222)
Total Income	**(12,398)**	**(13,308)**	**911**	**(61,856)**	**(62,559)**	**703**	**(148,856)**	**(151,431)**	**2,575**
Expenditure									
Pay Costs	8,956	8,745	211	44,702	43,815	886	106,647	108,268	(1,621)
Non-Pay Costs	3,328	3,449	(121)	16,663	17,401	(738)	38,898	39,973	(1,075)
CNST	1,897	1,844	52	9,483	9,284	200	22,760	22,283	477
Total Expenditure	**14,180**	**14,038**	**142**	**70,848**	**70,500**	**349**	**168,306**	**170,525**	**(2,219)**
EBITDA	**1,782**	**730**	**1,053**	**8,992**	**7,941**	**1,052**	**19,450**	**19,094**	**356**
Technical Items									
Depreciation	564	557	7	2,820	2,892	(72)	6,768	6,795	(27)
Interest Payable	2	1	1	9	3	6	21	18	3
Interest Receivable	(17)	(30)	13	(85)	(197)	112	(203)	(255)	52
PDC Dividend	210	335	(125)	1,048	1,190	(142)	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**	**863**	**(104)**	**3,793**	**3,888**	**(96)**	**9,102**	**9,458**	**(356)**
(Surplus) / Deficit	**2,541**	**1,592**	**949**	**12,785**	**11,829**	**956**	**28,552**	**28,552**	**(0)**
Remove capital donations/grants/peppercorn lease I&E impact	(2)	(2)	0	(10)	(11)	1	(23)	(24)	1
Adjusted financial performance (Surplus) / Deficit	**2,539**	**1,590**	**949**	**12,775**	**11,818**	**957**	**28,529**	**28,529**	**0**

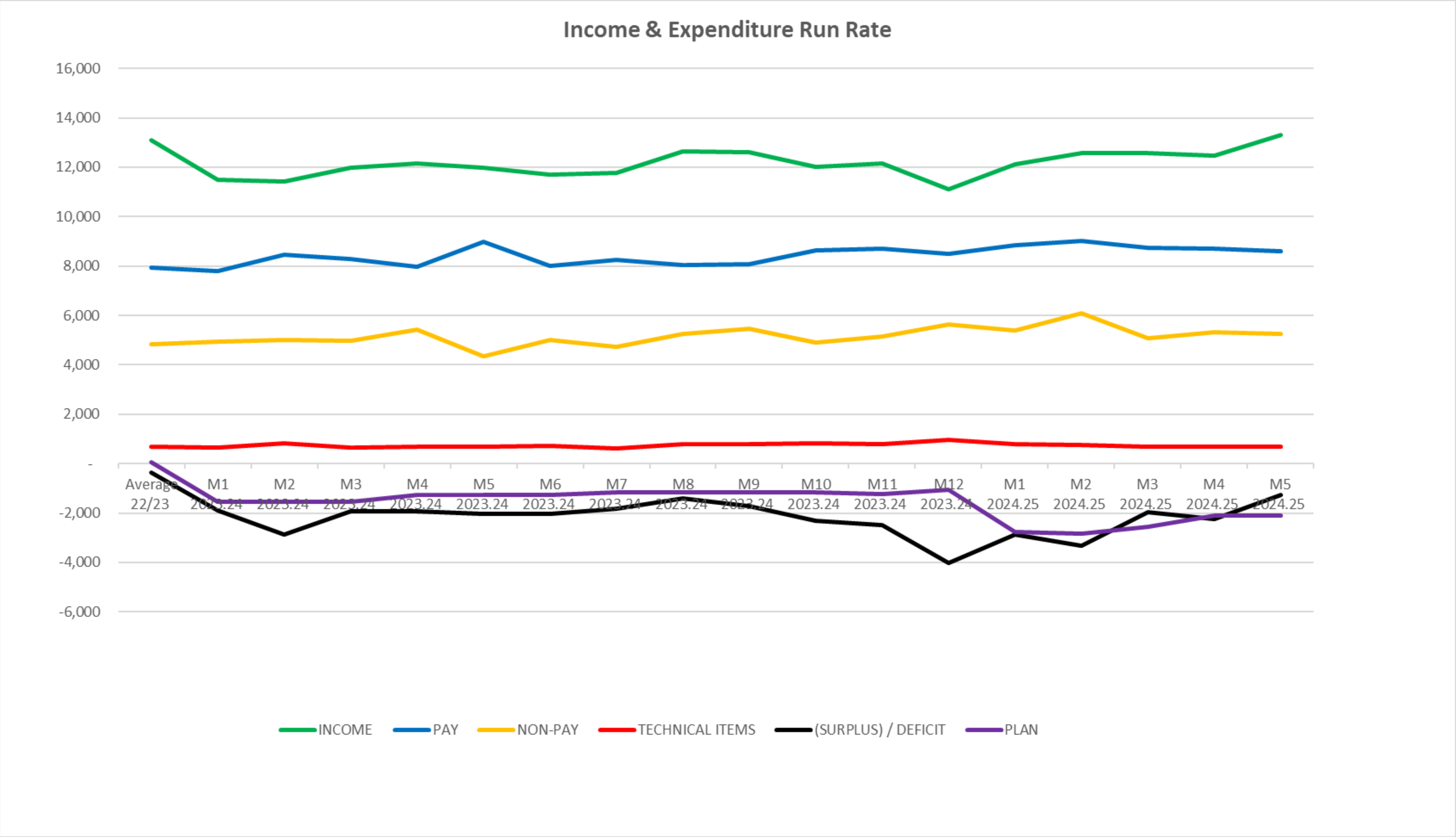
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2a
WTE: M5
YEAR ENDING 31 MARCH 2025

TYPE	DESCRIPTION	M12	M1	M2	M3	M4	M5	Movement M4 - M5	Movement M12 - M5
SUBSTANTIVE	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	664.88	665.08	657.66	650.24	654.19	656.22	2.03	(8.66)
	ALLIED HEALTH PROFESSIONALS	83.29	84.23	84.95	87.65	90.10	85.34	(4.76)	2.05
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	11.31	12.31	15.31	16.22	16.22	16.22	0.00	4.91
	REGISTERED HEALTH CARE SCIENTISTS	61.48	59.39	58.39	57.99	59.19	61.39	2.20	(0.09)
	HCA & SUPPORT TO CLINICAL STAFF	229.76	233.51	233.87	233.59	226.11	233.49	7.38	3.73
	MANAGERS & SENIOR MANAGERS	61.19	65.53	70.13	70.83	74.63	71.91	(2.72)	10.72
	ADMIN AND ESTATES STAFF	13.00	13.00	13.00	14.00	14.00	14.00	0.00	1.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	285.33	280.55	284.68	286.83	286.70	287.57	0.87	2.24
	MEDICAL AND DENTAL	195.69	189.96	186.91	196.11	198.08	217.63	19.55	21.94
	ANY OTHER STAFF	13.50	13.50	13.00	13.00	12.00	11.50	(0.50)	(2.00)
SUBSTANTIVE TOTAL		**1,619.43**	**1,617.06**	**1,617.90**	**1,626.46**	**1,631.22**	**1,655.27**	**24.05**	**35.84**
BANK	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	28.56	37.21	39.69	38.66	31.76	35.08	3.32	6.52
	ALLIED HEALTH PROFESSIONALS	10.18	11.79	13.57	13.38	9.24	6.83	(2.41)	(3.35)
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	-	-	-	-	-	-	0.00	0.00
	REGISTERED HEALTH CARE SCIENTISTS	0.15	-	0.01	0.11	0.85	0.84	(0.01)	0.69
	HCA & SUPPORT TO CLINICAL STAFF	14.05	23.32	25.03	26.35	21.20	25.64	4.44	11.59
	MANAGERS & SENIOR MANAGERS	-	-	-	-	-	-	0.00	0.00
	ADMIN AND ESTATES STAFF	0.23	-	0.10	0.80	1.32	1.48	0.16	1.25
	OTHER INFRASTRUCTURE & SUPPORT STAFF	8.84	6.97	10.75	1.46	5.87	6.44	0.57	(2.40)
	MEDICAL AND DENTAL	1.44	1.41	1.80	1.80	1.69	0.61	(1.08)	(0.83)
	ANY OTHER STAFF	-	-	-	-	-	-	0.00	0.00
BANK TOTAL		**63.45**	**80.70**	**90.95**	**82.56**	**71.93**	**76.92**	**4.99**	**13.47**
AGENCY	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	-	-	-	0.38	-	1.35	1.35	1.35
	ALLIED HEALTH PROFESSIONALS	3.87	3.93	4.50	4.50	8.71	10.16	1.45	6.29
	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	0.77	0.63	0.77
	MEDICAL AND DENTAL	-	1.00	4.40	2.90	2.90	3.21	0.31	3.21
	ANY OTHER STAFF	-	-	-	-	-	-	0.00	0.00
AGENCY TOTAL		**3.87**	**4.93**	**8.90**	**7.78**	**11.75**	**15.49**	**3.74**	**11.62**
TRUST TOTAL		**1,686.75**	**1,702.69**	**1,717.75**	**1,716.80**	**1,714.90**	**1,747.68**	**32.78**	**60.93**
LNP	SUBSTANTIVE	40.18	38.99	42.18	41.62	41.62	42.15	0.53	1.97
	BANK	-	0	0	0	0	0	0.00	0.00
	AGENCY	-	0	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**	**1,705.53**	**32.25**	**58.96**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2b
WTE PLAN: M5
YEAR ENDING 31 MARCH 2025



Note:WTE figures include bank and agency



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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

CIP: M5

YEAR ENDING 31 MARCH 2025

1. Total Efficiencies

GBP	Month 5			YTD			Forecast		
Status	**Target**	**Actual**	**Variance**	**Target**	**Actual**	**Variance**	**Target**	**Actual**	**Variance**
Pay	85	27	(58)	360	55	(306)	2,213	206	(2,007)
Non-Pay	163	28	(135)	908	415	(494)	1,690	647	(1,043)
Income	49	257	208	113	474	361	655	1,116	460
Total Recurrent Schemes	**297**	**312**	**15**	**1,382**	**943**	**(438)**	**4,558**	**1,969**	**(2,589)**
Pay	51	150	99	257	430	173	617	1,005	389
Non-Pay	48	70	22	104	252	148	723	963	240
Income	1	837	837	3	1,271	1,268	6	1,967	1,961
Total Non-Recurrent Schemes	**99**	**1,058**	**958**	**364**	**1,953**	**1,589**	**1,346**	**3,935**	**2,589**
Total CIP	**396**	**1,369**	**973**	**1,745**	**2,896**	**1,151**	**5,904**	**5,904**	**0**

2. Total Efficiencies by scheme

GBP	Month 5			YTD			Forecast		
Status by scheme	**Target**	**Actual**	**Variance**	**Target**	**Actual**	**Variance**	**Target**	**Actual**	**Variance**
Pay - Service re-design	67	57	(10)	272	286	14	1,391	487	(904)
Pay - Corporate services transformation	52	65	13	262	85	(177)	929	376	(554)
Pay - Bank - increase bank supply	0	0	0	0	0	0	200	0	(200)
Pay - Establishment Reviews	0	40	40	0	40	40	109	170	61
Pay - Agency - reduce the reliance on agency	2	0	(2)	8	0	(8)	20	0	(20)
Pay - Pay - Other	15	15	0	75	73	(2)	180	178	(2)
Total Pay Schemes	**136**	**177**	**41**	**617**	**485**	**(133)**	**2,830**	**1,211**	**(1,618)**
Non-Pay - Medicines efficiencies	2	1	(1)	11	5	(5)	26	13	(13)
Non-Pay - Procurement (excl drugs) - non-clinical direc	205	59	(146)	585	245	(340)	1,210	974	(236)
Non-Pay - Procurement (excl drugs) - non-clinical throu	0	0	0	0	0	0	0	0	0
Non-Pay - Estates and Premises transformation	0	27	27	0	362	362	0	556	556
Non-Pay - Service re-design	3	11	7	417	54	(363)	1,177	67	(1,110)
Total Non-Pay Schemes	**211**	**98**	**(113)**	**1,013**	**667**	**(346)**	**2,413**	**1,610**	**(803)**
Income - Non-Patient Care	44	1	(43)	91	10	(81)	396	332	(64)
Income - Overseas Visitors	1	4	3	6	11	5	15	22	7
Income - Private Patient	5	1	(3)	18	8	(10)	247	17	(230)
Income - Income - Other	0	1,088	1,088	0	1,715	1,715	3	2,712	2,709
Total Income Schemes	**49**	**1,094**	**1,045**	**115**	**1,745**	**1,630**	**661**	**3,083**	**2,421**
Total CIP	**396**	**1,369**	**973**	**1,745**	**2,896**	**1,151**	**5,904**	**5,904**	**0**

3. Efficiency Plan Risk

GBP	Forecast		
Risk	**Plan**	**Actual**	**Variance**
High	2,089	0	(2,089)
Medium	3,434	3,084	(350)
Low	381	2,820	2,439
Total CIP	**5,904**	**5,904**	**(0)**

4. Efficiency Plan Status

GBP	Forecast		
Risk	**Plan**	**Actual**	**Variance**
Fully Developed - In Delivery	381	4,939	4,558
Plans in progress	3,434	965	(2,469)
Opportunity	2,089	-	(2,089)
Unidentified	-	-	0
Total CIP	**5,904**	**5,904**	**0**

Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M5
YEAR ENDING 31 MARCH 2025

CASHFLOW STATEMENT

£'000	Actual
Cash flows from operating activities	(10,833)
Depreciation and amortisation	2,892
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	9,397
Net cash generated from / (used in) operations	**1,456**
Interest received	200
Purchase of property, plant and equipment, ROU and intangible assets	(2,842)
Proceeds from sales of property, plant and equipment and intangible assets	8
Net cash generated from/(used in) investing activities	**(2,634)**
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	**(1,178)**
Cash and cash equivalents at start of period	2,049
Cash and cash equivalents at end of period	**871**

Finance Support	2023/24 Year £000	2024/25 Q1 ACTUAL £000	2024/25 Q2 PLAN £000	2024/25 Q3 PLAN £000	2024/25 Q4 PLAN £000	2024/25 Total £000
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	0	0	7,000
Non-recurrent revenue support	0	0	0	12,671	4,224	16,895
Total support required						**23,895**
DH Loan repayment	612	0	306	0	-	306
DH Loan outstanding at year end	301					0

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5b
CASHFLOW ROLLING FORECAST: M5
YEAR ENDING 31 MARCH 2025

	Actual	Actual	Actual	Actual	Actual	Plan	Plan	Plan
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
	£000	£000	£000	£000	£000	£000	£000	£000
Opening cash	**1,948**	**4,776**	**6,984**	**3,424**	**1,647**	**729**	**712**	**604**
Income flows								
NHS England*	1,669	438	430	2,071	337	337	2,000	337
ICB income	10,153	10,123	10,058	10,098	10,197	10,144	10,749	10,239
NHS Trust/FT**	611	1,765	283	554	1,424	714	693	603
Private patients	313	443	428	356	341	440	310	391
Overseas	4	10	4	10	6	10	10	10
ICR/RTA scheme	1	4	4	4	4	4	1	4
Non-NHS (Wales/Man)	104	195	204	118	102	234	258	258
R&D	35	104	84	42	82	33	28	133
Other	126	245	23	35	91	11	54	28
Bank interest	33	36	49	44	38	21	20	20
Total operating inflows	**13,049**	**13,363**	**11,567**	**13,332**	**12,622**	**11,948**	**14,123**	**12,023**
Expenditure flows								
Wages and salaries	(4,308)	(4,358)	(4,346)	(4,384)	(4,390)	(4,564)	(6,245)	(4,587)
HMRC	(2,081)	(1,944)	(1,958)	(1,978)	(1,972)	(1,946)	(2,050)	(2,845)
Pensions	(1,241)	(1,250)	(1,270)	(1,271)	(1,260)	(1,271)	(1,350)	(1,849)
CNST - cash movement	(2,476)	(2,476)	(2,476)	(2,476)	(2,477)	(2,477)	(2,476)	(2,477)
Other expenditure (ex depn)***	(4,543)	(2,743)	(4,978)	(5,074)	(4,393)	(6,599)	(4,187)	(4,104)
VAT recovery	465	0	202	176	1,054	707	84	81
PDC/Loan (inc Ambulatory PDC)	0	0	0	0	0	(1,713)	500	500
Interest payable	0	(1)	(1)	(2)	(2)	(2)	(1)	(1)
Capital plan (inc movement on creditors)	(660)	(803)	(300)	(100)	(100)	(1,100)	(1,006)	(1,295)
Total operating outflows	**(14,844)**	**(13,575)**	**(15,127)**	**(15,109)**	**(13,540)**	**(18,965)**	**(16,731)**	**(16,577)**
Other cash in/outflows								
National/local distressed finance support	0	0	0	0	0	7,000	2,500	4,500
National payroll	0	0	0	0	0	0	0	0
Accrued/Deferred income *(forecast only)* **	4,623	0	0		0	0	0	0
NHS Resolution MIS****	0	2,420	0	0	0	0	0	0
TOTAL CASH IN GBS ACCOUNT	**4,776**	**6,984**	**3,424**	**1,647**	**729**	**712**	**604**	**550**
Barclays, bank rec and cash in hand	36	50	50	50	142	20	20	20
TOTAL CASH HOLDING	**4,812**	**7,034**	**3,474**	**1,697**	**871**	**732**	**624**	**570**

**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

CAPITAL EXPENDITURE: M5

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	0	0	751	751	0
CDEL	Medical equip - ultrasound	NHSE Scheme 7	535	535	0	535	535	0
CDEL	Medical equipment - general	NHSE Scheme 6	424	82	(342)	651	651	0
CDEL	Medical equip - transfusion on site	NHSE Scheme 8	0	9	9	300	300	0
CDEL	Medical equip - fluoroscopy	NHSE Scheme 9	400	0	(400)	400	400	0
CDEL	Other building	NHSE Scheme 10	205	50	(155)	205	205	0
CDEL	Digital tangible	NHSE Scheme 2	67	187	120	245	245	0
CDEL	Digital intangible	NHSE Scheme 3	651	406	(245)	1,948	1,948	0
CDEL Total			**2,282**	**1,269**	**(1,013)**	**5,035**	**5,035**	**0**
NON CDEL FUNDED PROJECTS	Ambulatory	NHSE Scheme 1	100	34	(66)	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 schemes	New capital schemes	0	37	37	0	188	188
NON CDEL FUNDED PROJECTS Total			**100**	**71**	**(29)**	**4,807**	**4,995**	**188**
Grand Total			**2,382**	**1,340**	**(1,042)**	**9,842**	**10,030**	**188**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

7

AGENCY USAGE: M5

YEAR ENDING 31 MARCH 2025

		MONTH 5			YTD			FULL YEAR		
Division	**Directorate**	**Budget**	**Actual**	**Variance**	**Budget**	**Actual**	**Variance**	**Budget**	**FOT**	**Variance**
Family Health	Maternity	0	15	(15)	-	54	(54)	-	68	(68)
Gynaecology	Gynaecology	0	21	(21)	-	56	(56)	-	100	(100)
Gynaecology	HFC	0	0	0	-	2	(2)	-	7	(7)
CSS	Theatres	0	11	(11)	-	64	(64)	-	167	(167)
CSS	Imaging	0	16	(16)	-	77	(77)	-	154	(154)
Corporate	All Corporate Directorates	115	(2)	117	573	22	551	1,374	22	1,352
Total Agency		**115**	**61**	**54**	**573**	**275**	**298**	**1,374**	**518**	**856**
Performance against cap		**286**	**61**	**225**	**1,428**	**275**	**1,153**	**3,427**	**518**	**2,909**

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

VIREMENTS: M5

YEAR ENDING 31 MARCH 2024

Directorate	Account Code/Type	GBP Total	WTE Total	Description
Genetics	Pay	(109,424)	0.00	Identification of non-recurrent CIP scheme approved at QIA Committee
CSS CIP	Non-Pay	109,424	0.00	Identification of non-recurrent CIP scheme approved at QIA Committee
Theatres	Pay	163,491	2.64	Movement of surgical first assistants from Gynaecology into Theatres
Gynaecology	Pay	(163,491)	-2.64	Movement of surgical first assistants from Gynaecology into Theatres
Maternity	Pay	579,927	10.91	Realignment of pay budgets in line with Brith Rate Plus recommendations
Maternity	Pay	(579,927)	-10.91	Realignment of pay budgets in line with Brith Rate Plus recommendations
Maternity	Non-Pay	14,583	0.00	Identification of CIP scheme approved at QIA Committee
Maternity	Non-Pay	(14,583)	0.00	Identification of CIP scheme approved at QIA Committee
Maternity	Non-Pay	279,560	0.00	Realignment of drugs budgets between services within Maternity
Maternity	Non-Pay	(279,560)	0.00	Realignment of drugs budgets between services within Maternity
Maternity	Non-Pay	200,806	0.00	Realignment of non-pay budgets
Maternity	Non-Pay	(200,806)	0.00	Realignment of non-pay budgets
Medical Director	Pay	75,000	0.50	Removal of non-clinical research allocation from service to medical director budget
Neonates	Pay	(75,000)	-0.50	Removal of non-clinical research allocation from service to medical director budget
Covid	Non-Pay	(8,408)	0.00	Realignment of fit mask testing budget from covid into Maternity and CSS
Maternity	Non-Pay	4,204	0.00	Realignment of fit mask testing budget from covid into Maternity and CSS
CSS	Non-Pay	4,204	0.00	Realignment of fit mask testing budget from covid into Maternity and CSS
Gynaecology	Income	(15,500)	0.00	Identification of CIP scheme approved at QIA Committee
Gynaecology	Pay	(50,000)	0.00	Identification of CIP scheme approved at QIA Committee
Gynaecology	Non-Pay	(33,250)	0.00	Identification of CIP scheme approved at QIA Committee
Gynaecology	Non-Pay	98,750	0.00	Identification of CIP scheme approved at QIA Committee
Total		**-**	**0.00**	

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

Board of Directors

COVER SHEET

Meeting Date	Thursday, 10 October 2024	**Item Reference**	TB24/25_136
Report Title	Improvement Plan Highlight Report 4		
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 focuses on addressing clinical challenges and risks while embedding a culture of continuous improvement and safety.
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, relates to the issues first reported to the Board in September 2024 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	All	-
Links to Corporate Risk Register (scoring 10+)	N/A	-

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

Action Required by the Board of Directors	The Board of Directors is asked to note the Improvement Plan Highlight Report.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Improvement Plan Portfolio Board	09.10.2024	CTO	Any emerging issues to be highlighted verbally at the meeting.

MAIN REPORT

INTRODUCTION

The Trust has developed its Improvement Plan to provide a clear direction of travel for 2024/25, 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 (September 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 continues to progress and is scored as ‘yellow’ on the RAYG rating system.

Since the last update in September 2024, the Transformation Delivery Unit (TDU) has maintained its focus on ensuring robust quality assurance across all projects. As the projects have been operational since June 2024, the TDU will now prioritise assessing whether early indicators suggest that the projects are making progress towards the identified key performance indicators (KPIs) and delivering the expected benefits. Should these early assessments reveal that the intended impact is not being achieved, the TDU will collaborate with Senior Responsible Owners to evaluate whether project plans need to be adjusted.

Key points to note from the respective programmes and projects:

KEY FOCUS LAST PERIOD	KEY FOCUS THIS PERIOD
Quality and Safety	
Deteriorating Patient Collaborative Progress was made towards developing the Medical Emergency Team (MET) and High Dependency Unit (HDU) model of delivery. A Task & Finish (T&F) group has been actively working on collaborative options, with a workshop planned to assess risks associated with various models.	Develop options appraisal for the MET and HDU service model and establish governance for the digital platform work.
CQC/MSSP Action Plan Weekly task and finish group established in mid-September 2024 to undertake deep dives on issues that emerged from the CQC action plan check and challenge sessions.	The focus for this period is on managing actions identified during the previous deep dives and check and challenge sessions, particularly regarding medicines management, pharmacy, and medical devices.
Clinical Effectiveness	
Enhanced Workforce for Acute Workload Work progressed to ensure that the Obstetrics on-call room met the necessary requirements for consultant obstetricians, including updates and the installation of air conditioning.	Due to pending contract changes and necessary job plan approvals for 22 consultants, the commencement of 24/7 obstetric cover is now projected for 1 November 2024, contingent on the completion of necessary updates to the on-call room. Finalising job plans and the on-call room remain key priorities.

	The ACP appointments have changed from six in maternity and four in gynaecology to seven in maternity and one in gynaecology, with two more expected in Spring 2025. This necessitates enhanced leadership and oversight and has prompted the need for a leadership review.
Acute Gynaecology Services The focus was on finalising the business case for the 7-day Early Pregnancy Assessment Unit (EPAU), which passed divisional review. Findings from a visit to Birmingham Women's Hospital were also reviewed to identify and implement best practices.	This period will focus on finalising the EPAU business case and submitting it through the appropriate governance processes for approval.
LWH Transfusion Lab The focus in the last period has been to actively work to clarify the situation with the procurement of the robot and assess the level of assurance currently available.	Liverpool Clinical Laboratories is taking legal advice regarding next steps and the TDU will work with the Project Lead to determine the impact on the project plan as likely outcomes and timeframes emerge.
Medicine Safety A comprehensive paper documenting service delivery gaps and risks, along with a resourcing ask, was submitted for review to the Executive Directors Group for consideration.	The development of supporting PIDs for proposed projects under the medicine safety improvement plan is underway.
Operational Performance	
Cancer Improvement Reducing the number of patients >62 days on the PTL has been a key focus in the last period and this has resulted in a significant reduction, from 133 to 88 in 4 weeks, a reduction of 34%. The overall PTL size has also reduced by 26% in the same time period.	Additional capacity for Hysteroscopy, funded by Tier 1 monies, will be progressed with the independent sector to reduce waiting times further and reduce burden on Trust workforce for delivery. Objective for lists to be mobilised by end of October.
Reduced Waiting List In September, patients waiting over 65 weeks decreased from 38 to 15, and those waiting over 52 weeks fell from 712 to 536, showing progress. However, the overall waiting list has stagnated and fluctuated, likely due to increased post-August referrals.	Project groups are identifying further improvements, with the booking and scheduling group reviewing processes and clinics to maximise utilisation. Clinic template reviews are progressing quickly, supported by CSS and Gynaecology. Discussions on expanding the CLPN menopause pilot to Sefton will begin soon, with a workshop scheduled for 28th October 2024.
People and Culture	
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.	This period will focus on further analysing the top five clinical incidents to better understand causation and develop improvement measures. A communications plan will be created to share updates and engage hospital staff
Actively Anti-Racist Organisation Efforts continue to integrate anti-racism into clinical education and organisational policies, with ongoing development of support resources and reporting mechanisms.	An audit of inclusive recruitment practices will be conducted, and the competencies for the Anti-Racism Action Learning Set have been agreed
Financial Sustainability	
Delivering the Three-year financial plan A mechanism for achieving the £18.5 million target has been proposed and is under review, with finalisation expected imminently. A meeting between the LAASPFG CFOs and Chief People Officers (CPOs) took place to explore where the workstreams could align with existing HR initiatives.	Developing an action plan to respond to the PwC recommendations (ICB commissioned report).

24/25 CIP Delivery During the last reporting period, the team concentrated on the review and approval of Quality Impact Assessments (QIA) milestones. A significant emphasis was placed on ensuring that all outstanding items were processed in preparation for the upcoming QIA committee meeting scheduled for the 15 October 2024.	Preparations for the mid-year review are underway, with plans to enhance communication and streamline the collection of necessary information from scheme leads
Well-Led	
Programme now closed.	

RISK & ISSUE PROFILE

It is worth noting that the risk scores in the heatmap relate to risks to project delivery only and therefore may not reflect the overall risk profile for the Trust on that issue or theme.

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 (noted in September 2024 update). Efforts are now underway to understand the timescales and the actions required to move forward with these mitigations.

A new risk (scored as 10/15) has been added to the CQC/MSSP Action Plan project relating to resource challenges in the central governance team owing to key vacancies. These vacancies have been appointed to and it is expected that this risk score will reduce and/or close over the next two months.

The issue rating for the LWH Transfusion Lab remains marked as ‘red,’ because of the procurement challenges that emerged from the end of August 2024 (reported to the Board in September 2024) i.e. the Trust is not currently in a position to progress procurement with the original identified supplier. The challenges specifically relate to the patent status for the functioning of the robotic arm and the viability of an identified alternative supplier. The Trust and its partner, Liverpool Clinical Laboratories, are currently seeking legal advice and the impact on project delivery remains currently indeterminate. A task has been undertaken by the TDU to review project milestones to assess what milestones may need to be re-profiled.

Whilst not identified as a risk or issue at this point, there has been a significant change to the appointments of Advanced Clinical Practitioners (ACPs) – part of the Enhanced Workforce for Acute Workload project. While the original plan was for six appointments in maternity and four in gynaecology, this has been revised. Now, seven ACPs have been appointed for maternity, one for gynaecology, with two further appointments for gynaecology expected in Spring 2025. This shift underscores the need for enhanced leadership and oversight of the ACP workforce at the Trust to ensure appropriate support and management going forward. A review of ACP leadership will now take place to inform next steps.

There has been a long-standing risk to the safety culture risk relating to resources. Additional resource has been secured in the reporting period and therefore it is likely that this will be reduced following review.

BENEFITS PROFILE

Key points to note in this period:

- Deteriorating Patient Collaborative - A target of 90% for benefits data (observation metrics) has been agreed, and work is underway to add Key Performance Indicators (KPIs) related to ‘2222’ calls and baby transfers from Maternity to NICU onto Power BI.

- Acute Gynae Services - A key focus for the upcoming period will be to assess when improvements to the attendant metrics will be seen (they are currently showing either stagnation or slight deterioration).
- Cancer Improvement - Recovery of the Hysteroscopy position has shown significant improvement in dating of patients with >50% now being dated within 2 weeks of being waitlisted and <5 patients undated as at end of September.
- Cancer Improvement - Reducing the number of patients >62 days on the PTL has been a key focus in the last period and this has resulted in a significant reduction, from 133 to 88 in 4 weeks, a reduction of 34%. The overall PTL size has also reduced by 26% in the same time period.
- Reduced Waiting List - Throughout September, the number of patients waiting over 65 weeks for treatment has significantly decreased, dropping from 38 to 15. Additionally, the number of patients waiting over 52 weeks has reduced from 712 to 536, showing significant progress. However, this month, the overall reduction in the size of the waiting list has stagnated and fluctuated, possibly due to an increase in referrals post-August.
- Actively Anti-Racist Organisation - 80% of staff have completed face-to-face training, (80% target by March 2025).
- Additional data for the Actively Anti-Racist Organisation will be available for the next report as this started to be collected from September 2024.
- Outstanding metrics aligned to the People and Culture Programme will be available in the next iteration of the report. The data started to be collected for the month of September 2024.

SYSTEM OVERSIGHT GROUP MEETING – NOVEMBER 2024

Preparations are underway for the full review of the Trust’s progress against the National Oversight Framework Segment 3 Exit Criteria, which is scheduled for November 2024 through a System Oversight Group meeting. The key areas of delivery risk relate to financial recovery and exiting NHSE’s Cancer Tier 2 process. The Improvement Plan Portfolio Board (IPPB) will work to assess the Trust’s progress and determine if the respective project plans require adjustment or refocus to support delivery. The check and challenge sessions into the Trust’s CQC action plan compliance has also highlighted areas that require further assurance, and this will be factored into the deliberations of the IPPB.

The outputs from the System Oversight Group meeting in November 2024 will report to the next available Board meeting.

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.

SUPPORTING DOCUMENTS

Appendix A - LWH Improvement Plan Highlight Report

OUR IMPROVEMENT PLAN
SAFETY | QUALITY | SUSTAINABILITY

NHS
Liverpool Women's
NHS Foundation Trust

Well Led
Quality & Safety
Clinical Effectiveness
Operational Performance
People & Culture
Financial Improvement

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	→	A	→	A	→	G	→	A	→	Y	↓	G	→
1. Quality and Safety	Y	→	A	↓	G	→	G	→	R	→	A	↓	G	→
1.1 Deteriorating Patient Collaborative	Y	→	A	↓	G	→	G	→	R	→	G	→	G	→
1.2 CQC and MSSP Actions	A	↘	R	↓	G	→	G	→	R	↓	R	↓	G	→
2. Clinical Effectiveness	Y	→	R	→	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	R	→	R	→		→	R	→	R	→	G	→	G	→
2.4 Medicines Safety	G	→	Y	→		→	G	→	G	→	G	→	G	→
3. Operational Performance	G	→	G	→	Y	→	G	→	Y	→	G	→	G	→
3.1 Cancer Improvement	Y	→	G	→	A	→	G	→	A	↗	G	→	G	→
3.2 Reduced Waiting List	G	→	G	↗	G	→	G	→	G	→	G	→	G	→
4. People and Culture	Y	→	A	→	A	→	G	→	A	→	G	→	Y	→
4.1 Safety Culture	A	↘	R	→	A	→	G	→	A	↘	G	→	G	→
4.2 Actively Anti-Racist Organisation	Y	→	Y	↘	A	→	G	→	A	→	G	→	A	→
5. Financial Sustainability	Y	→	A	→	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	A	↘	R	↘	A	→	G	→	R	→	G	→	G	→

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

Since the last update in September 2024, the Transformation Delivery Unit (TDU) has maintained its focus on ensuring robust quality assurance across all projects. As the projects have been operational since June 2024, the TDU will now prioritise assessing whether early indicators suggest that the projects are making progress towards the identified key performance indicators (KPIs) and delivering the expected benefits. Should these early assessments reveal that the intended impact is not being achieved, the TDU will collaborate with Senior Responsible Owners to evaluate whether project plans need to be adjusted.

Key points to note from the respective programmes:
Quality and Safety
Deteriorating Patient Collaborative: Progressed MET/HDU model, collaborative options in development.

CQC/MSSP Action Plan: Established task and finish groups to address medicines, pharmacy, and devices issues.

Clinical Effectiveness
Enhanced Workforce: On-call room continues to be progressed, and ACP appointments reviewed.

Acute Gynaecology: Finalised EPAU business case and reviewed best practices.

LWH Transfusion Lab: Procurement issues for the robot continued to be assessed

Medicine Safety: Submitted gap analysis and resourcing requests.

Operational Performance
Reducing the number of patients >62 days on the PTL has been a key focus in the last period

People and Culture
Safety Culture: Completed literature review and focus groups on safety issues.

Anti-Racist Organisation: Progressed integration into clinical education and policies.

Financial Sustainability
Three-year Plan: Mechanism for £18.5 million target proposed, workstreams aligned with HR initiatives.

24/25 CIP Delivery: Reviewed and approved QIA milestones for the upcoming committee.

Key Focus Next Period

Quality and Safety - The focus is on developing the options appraisal for the MET/HDU service model, establishing digital governance, and managing actions from the CQC action plan deep dives into medicines, pharmacy, and medical devices.

Clinical Effectiveness - This period will prioritise finalising job plans and on-call room updates for obstetrics, submitting the EPAU business case, continuing legal discussions for the Transfusion Lab, and developing medicine safety PIDs.

Operational Performance - Efforts will concentrate on maximising clinic utilisation, expanding the CLPN menopause pilot, and mobilising additional Hysteroscopy capacity to reduce waiting times by the end of October.

People and Culture - The key focus is further analysing clinical incidents for safety improvements and conducting an inclusive recruitment audit, while finalising anti-racism competencies.

Financial Sustainability - This period will involve developing an action plan based on PwC recommendations and preparing for the mid-year CIP review with improved communication from scheme leads.

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.

SAFETY | QUALITY | SUSTAINABILITY

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 (noted in September 2024 update). Efforts are now underway to understand the timescales and the actions required to move forward with these mitigations.

A new risk (scored as 10/15) has been added to the CQC/MSSP Action Plan project relating to resource challenges in the central governance team owing to key vacancies. These vacancies have been appointed to and it is expected that this risk score will reduce and/or close over the next two months.

The issue rating for the LWH Transfusion Lab remains marked as 'red,' because of the procurement challenges that emerged from the end of August 2024 (reported to the Board in September 2024) i.e. the Trust is not currently in a position to progress procurement with the original identified supplier. The challenges specifically relate to the patent status for the functioning of the robotic arm and the viability of an identified alternative supplier. The Trust and its partner, Liverpool Clinical Laboratories, are currently seeking legal advice and the impact on project delivery remains currently indeterminate. A task has been undertaken by the TDU to review project milestones to assess what milestones may need to be re-profiled.

Whilst not identified as a risk or issue at this point, there has been a significant change to the appointments of Advanced Clinical Practitioners (ACPs) – part of the Enhanced Workforce for Acute Workload project. While the original plan was for six appointments in maternity and four in gynaecology, this has been revised. Now, seven ACPs have been appointed for maternity, one for gynaecology, with two further appointments for gynaecology expected in Spring 2025. This shift underscores the need for enhanced leadership and oversight of the ACP workforce at the Trust to ensure appropriate support and management going forward. A review of ACP leadership will now take place to inform next steps.

There has been a long-standing risk to the safety culture risk relating to resources. Additional resource has been secured in the reporting period and therefore it is likely that this will be reduced following review.

IP Benefits Profile

Key points to note this period:

Deteriorating Patient Collaborative - A target of 90% for benefits data (observation metrics) has been agreed, and work is underway to add Key Performance Indicators (KPIs) related to '2222' calls and baby transfers from Maternity to NICU onto Power BI.

Acute Gynae Services - A key focus for the upcoming period will be to assess when improvements to the attendant metrics will be seen (they are currently showing either stagnation or slight deterioration).

Cancer Improvement - Recovery of the Hysteroscopy position has shown significant improvement in dating of patients with >50% now being dated within 2 weeks of being waitlisted and <5 patients undated as at end of September.

Cancer Improvement - Reducing the number of patients >62 days on the PTL has been a key focus in the last period and this has resulted in a significant reduction, from 133 to 88 in 4 weeks, a reduction of 34%. The overall PTL size has also reduced by 26% in the same time period.

Reduced Waiting List - Throughout September, the number of patients waiting over 65 weeks for treatment has significantly decreased, dropping from 38 to 15. Additionally, the number of patients waiting over 52 weeks has reduced from 712 to 536, showing significant progress. However, this month, the overall reduction in the size of the waiting list has stagnated and fluctuated, possibly due to an increase in referrals post-August.

Actively Anti-Racist Organisation - 80% of staff have completed face-to-face training, (80% target by March 2025). Outstanding metrics aligned to the People and Culture Programme will be available in the next iteration of the report. The data started to be collected for the month of September 2024.

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

All

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	→	A	→	A	→	G	→	R	→	Y	→	G	→
1. Quality and Safety	Y	→	A	↓	G	→	G	→	R	→	A	→	G	→
1.1 Deteriorating Patient Collaborative	Y	→	A	↓	G	→	G	→	R	→	G	→	G	→
1.2 CQC and MSSP Actions	Y	↘	R	↓	G	→	G	→	R	→	R	→	G	→

Key Focus Last Period

Deteriorating Patient Collaborative
During the previous period, progress was made towards developing the Medical Emergency Team (MET) and High Dependency Unit (HDU) model of delivery. A Task & Finish (T&F) group has been actively working on collaborative options, with a workshop planned to assess risks associated with various models. The final decision on the preferred option is anticipated following the session scheduled for 8 October 2024. The escalation process mapping has been completed and shared with the MET T&F group. Meanwhile, the Digital T&F group has started drafting 'mini–Project Initiation Documents' (PIDs) to drive progress, and planning for a learning session event is underway with attendees being gathered. Clinical areas have been supported by the Quality Improvement (QI) team and through walk rounds as each area continues testing change ideas using PDSA cycles.

Additionally, a target of 90% for benefits data has been agreed, and work is underway to add Key Performance Indicators (KPIs) related to 2222 calls and baby transfers from Maternity to NICU onto Power BI.

CQC/MSSP Action Plans
In the previous period, the focus was on maintaining readiness for CQC standards following the recent CQC check and challenge meeting. Divisions reviewed evidence and compliance in preparation for follow-up sessions as part of the CQC's oversight during September. The Associate Director of Governance and Quality coordinated this, with senior governance colleagues overseeing divisional efforts. Support was provided for self-assessments, evidence submissions, and continuous review processes. Deep dives and check and challenge sessions focused particularly on medicines management, pharmacy, and medical devices, with necessary escalations made to the Executive team. A weekly task and finish group was formed, meeting first on 17 September to address ongoing actions.

Key Focus Next Period

Deteriorating Patient Collaborative
The MET/HDU Task & Finish group continues to work on finalising collaborative options, with the decision to be made after the workshop on 8 October. Learning Session 2, held on 27 September, saw each collaborative area present their feedback on tests of change, followed by the development of plans for Action Period 2. Walk round activities will continue to support these efforts and to further develop tests of change within collaborative areas.

The MET/HDU and Digital T&F groups are progressing, with mini PIDs expected to be signed off by the end of October. Data from 2222 calls is now available via Power BI, but several other data milestones are overdue. The BI team and digital nurses/midwives are working closely with clinical teams to address this and ensure milestones are met.

Planning has also begun for the HCA away day, scheduled for 27 November 2024.

CQC/MSSP Action Plans
The focus for this period is on managing actions identified during the previous deep dives and check and challenge sessions, particularly regarding medicines management, pharmacy, and medical devices. These actions will continue to be monitored by the weekly task and finish group. Residual risks will be reviewed and escalated as necessary through the relevant committees and the Executive Risk Assurance Group (ERAG). Collaboration with LMNS continues to arrange a peer review of evidence for the closure of CQC actions, ensuring full compliance and verification.

Key Points to Note

Deteriorating Patient Collaborative
Some data milestones are overdue; work is in progress by the BI team and digital nurses/midwives to address this.

There are two risks scoring 11 that relate to staff engagement and data availability/quality respectively.

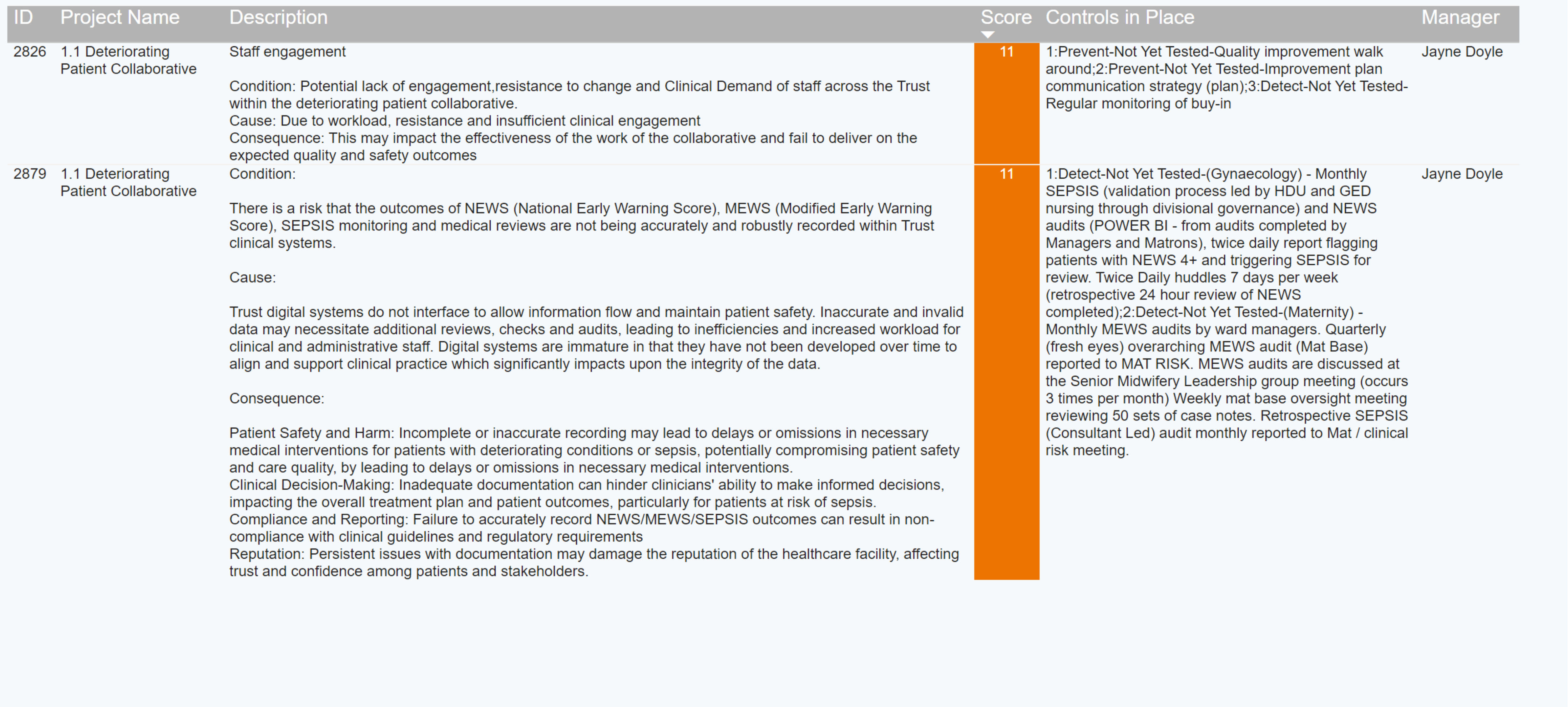
CQC/MSSP Action Plans
New risk added relating to resourcing in the corporate governance team. New staff due to start over the next couple of months which will reduce this risk.

Progress is expected following the formal regulatory compliance meeting on 9 October 2024.

SAFETY | QUALITY | SUSTAINABILITY

Quality & Safety Significant Risks & Issues

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



ID	Project Name	Description	Score	Controls in Place	Manager
2826	1.1 Deteriorating Patient Collaborative	Staff engagement Condition: Potential lack of engagement,resistance to change and Clinical Demand of staff across the Trust within the deteriorating patient collaborative. Cause: Due to workload, resistance and insufficient clinical engagement Consequence: This may impact the effectiveness of the work of the collaborative and fail to deliver on the expected quality and safety outcomes	11	1:Prevent-Not Yet Tested-Quality improvement walk around;2:Prevent-Not Yet Tested-Improvement plan communication strategy (plan);3:Detect-Not Yet Tested-Regular monitoring of buy-in	Jayne Doyle
2879	1.1 Deteriorating Patient Collaborative	Condition: There is a risk that the outcomes of NEWS (National Early Warning Score), MEWS (Modified Early Warning Score), SEPSIS monitoring and medical reviews are not being accurately and robustly recorded within Trust clinical systems. Cause: Trust digital systems do not interface to allow information flow and maintain patient safety. Inaccurate and invalid data may necessitate additional reviews, checks and audits, leading to inefficiencies and increased workload for clinical and administrative staff. Digital systems are immature in that they have not been developed over time to align and support clinical practice which significantly impacts upon the integrity of the data. Consequence: Patient Safety and Harm: Incomplete or inaccurate recording may lead to delays or omissions in necessary medical interventions for patients with deteriorating conditions or sepsis, potentially compromising patient safety and care quality, by leading to delays or omissions in necessary medical interventions. Clinical Decision-Making: Inadequate documentation can hinder clinicians' ability to make informed decisions, impacting the overall treatment plan and patient outcomes, particularly for patients at risk of sepsis. Compliance and Reporting: Failure to accurately record NEWS/MEWS/SEPSIS outcomes can result in non-compliance with clinical guidelines and regulatory requirements Reputation: Persistent issues with documentation may damage the reputation of the healthcare facility, affecting trust and confidence among patients and stakeholders.	11	1:Detect-Not Yet Tested-(Gynaecology) - Monthly SEPSIS (validation process led by HDU and GED nursing through divisional governance) and NEWS audits (POWER BI - from audits completed by Managers and Matrons), twice daily report flagging patients with NEWS 4+ and triggering SEPSIS for review. Twice Daily huddles 7 days per week (retrospective 24 hour review of NEWS completed);2:Detect-Not Yet Tested-(Maternity) - Monthly MEWS audits by ward managers. Quarterly (fresh eyes) overarching MEWS audit (Mat Base) reported to MAT RISK. MEWS audits are discussed at the Senior Midwifery Leadership group meeting (occurs 3 times per month) Weekly mat base oversight meeting reviewing 50 sets of case notes. Retrospective SEPSIS (Consultant Led) audit monthly reported to Mat / clinical risk meeting.	Jayne Doyle

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	September 2024	>=	57.68%	◌	∿
% of NEWS Scores within time	September 2024	>=	90.04%	◌	∿
⊟ **1.2 CQC and MSSP Actions**					
BBAS - % of areas rated as Good or Outstanding	August 2024	>=	100.00%	?	∿
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	→	A	→	A	→	G	→	A	→	Y	→	G	→
2. Clinical Effectiveness	Y	→	R	→	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	→	R	→		→	R	→	R	→	G	→	G	→
2.4 Medicines Safety	G	→	Y	→		→	G	→	G	→	G	→	G	→

Key Focus Last Period

Enhanced Workforce for Acute Workload
During the last period, efforts were concentrated on ensuring that the Obstetrics on-call room met the necessary requirements for consultant obstetricians, including updates and the installation of air conditioning. Discussions with anaesthetic leads continued, focusing on future workforce models. The team also reviewed candidates from the gynaecology oncology recruitment round to assess potential for other roles. Recruitment efforts led to the appointment of nine candidates for anaesthetic PGD positions, with six already in post, two expected in September, and one anticipated in January 2025.

Acute Gynaecology Services
During the last period, work continued on the five key work streams, with no significant risks identified. The focus was on finalising the business case for the 7-day Early Pregnancy Assessment Unit (EPAU), which progressed through divisional review. Additionally, findings from the recent visit to Birmingham Women's Hospital were reviewed, with the intention of identifying and implementing areas of best practice within the division.

LWH Transfusion Lab
The focus in the last period has been to actively work to clarify the situation with the procurement of the robot and assess the level of assurance currently available. Officers from the Trust and LCL visited the new supplier w/c 2 September 2024 and reported back to the Executive Team. Legal advice has been sought and a letter issued to the prospective supplier requesting assurance that procurement can proceed.

Medicine Safety
The project identified risks within pharmacy services and medication provision, with interviews with relevant staff now complete. Risks continue to be entered into the Ulysses risk register to guide future planning. Scoping continued 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
The focus this period will be on progressing the necessary updates to the Obstetrics on-call room to ensure it is ready for use by consultant obstetricians, with the aim of supporting the planned shift to 24/7 obstetrics. Ongoing discussions with anaesthetic leads regarding workforce models will continue, along with the review of additional candidates from the gynaecology oncology recruitment round. Further, attention will be given to the onboarding process for the newly appointed anaesthetic PGD candidates, ensuring a smooth transition for those expected to arrive in the coming months.

Acute Gynaecology Services
This period will focus on finalising the EPAU business case and submitting it through the appropriate governance processes for approval. Efforts will continue to integrate best practices identified during the Birmingham Women's Hospital visit into ongoing work streams, ensuring that improvements align with divisional goals and objectives.

LWH Transfusion Lab
Since engaging with the engineering firm, the previous supplier has sent a letter to LCL, stating that they will take legal action if procurement continues. LCL is taking legal advice regarding next steps and the TDU will work with the Project Lead to determine the impact on the project plan as likely outcomes and timeframes emerge.

Medicine Safety
A comprehensive paper documenting service delivery gaps and risks, along with a resourcing ask, was submitted for review to the Executive Directors Group for consideration. The development of supporting PIDs for proposed projects under the medicine safety improvement plan is underway.

Key Points to Note

Enhanced Workforce for Acute Workload
Due to pending contract changes and necessary job plan approvals for 22 consultants, the commencement of 24/7 obstetric cover is now projected for 1 November, contingent on the completion of necessary updates to the on-call room.

Additionally, a significant change has occurred in the appointments of Advanced Clinical Practitioners (ACPs). While the original plan was for six appointments in maternity and four in gynaecology, this has been revised. Now, seven ACPs have been appointed for maternity, one for gynaecology, with two further appointments for gynaecology expected in Spring 2025. This shift underscores the need for enhanced leadership and oversight of the ACP workforce at LWH to ensure appropriate support and management going forward. A review of ACP leadership at LUHFT will now take place to inform next steps.

Acute Gynae Services
A key focus for the upcoming period will be to assess when improvements to the attendant metrics will be seen.

LWH Transfusion Lab
Work is ongoing between Project Lead/Project Management Support with key stakeholders to map out updated timescales for project milestones to ensure these are in place if legal issues - as stated above - are rectified. Fortnightly Task & Finish Group meetings remain ongoing.

Medicine Safety
The overall risk of capacity in pharmacy services to deliver on the medicines agenda is to be escalated to the Executive Risk and Assurance Group for review. This risk is likely to be added to the risk register, with actions including the diagnostic and population of a gap analysis report. There is an urgent need to finalise the scoping of the medicine safety improvement plan to ensure compliance and address any highlighted issues.

All

Clinical Effectiveness Programme Significant Risks & Issues

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.

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	1:Prevent-Not Yet Tested-Resource;2:Contingency-Not Yet Tested-Adapting rotas Utilising specialist doctors rather than consultants	Christopher Dewhurst
2844	2.2 Acute Gynae Services	There is a risk the proposed changes to job planned hours will not be agreed by consultant gynaecologists leading to project failure.	11		Matthew Butcher
2839	2.1 Enhanced Workforce for Acute Workload	Risk that consultants from other areas i.e. not obstetricians, request the same or similar terms and conditions for those working on a 24/7 consultant present rota.	10		Christopher Dewhurst
2845	2.3 LWH Transfusion Lab	There is a risk that the MHRA approval required for the Blood Transfusion robot will not be achieved in a timely manner leading to project delays and a delay in project benefits	10	1:Detect-Not Yet Tested-Stakeholder;2:Prevent-Not Yet Tested-Designated SME of member of staff from LCL in ongoing contact with MHRA consultant for guidance.	Gary Price
2878	2.1 Enhanced Workforce for Acute Workload	Risk that suitable room for obstetric consultant will not be prepared by mid August 2024, resulting in delays to the commencement of 24/7 obstetric cover on 02/09/24.	10	1:Prevent-Not Effective-Suitable room identified but requires preparation before ready for use.;2:Prevent--Issues with room temperature control - this is a red line for agreement. Mitigations in place - but unlikely to sufficiently control temperature.	Richard Diamond
2885	2.3 LWH Transfusion Lab	Failure to deliver laboratory services and associated costs savings and improved patient safety via Diabots solution, due to delays to progress of project and installation date.	10	1:Prevent-Effective-Robust project management and project governance in place, including detailed project plan. Oversight by relevant forums and divisional managers and executive team. Preliminary feasibility activity in place - digital interoperability and suitable estates agreed. Provisional timeline and delivery date confirmed with supplier.	Richard Crespin

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)	August 2024	<=	1	◌	○
Number of emergency admissions from Matbase to NICU	August 2024	>=	13	◌	○
Reduction in Obestetric Adverse Events on Delivery Suite	September 2024	<=	0	◌	○
⊟ **2.2 Acute Gynae Services**					
EPAU patients seen within 24 hours of referral	September 2024	>=	11.46%	◌	L
GED 15 Minutes to Triage	September 2024	>=	49.96%	◌	○
GED 4 hours from arrival to admission, transfer or discharge	September 2024	>=	81.26%	◌	○
GED Decrease in Time Taken to Treat	September 2024	<=	158	◌	○
GED Increased patient satisfaction (Friends & Family Scores)	September 2024	>=	68.75%	◌	○

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	→	A	→	A	→	G	→	A	→	Y	→	G	→
3. Operational Performance	G	→	G	→	Y	→	G	→	Y	→	G	→	G	→
3.2 Reduced Waiting List	G	→	G	↗	G	→	G	→	G	→	G	→	G	→
3.1 Cancer Improvement	Y	→	G	→	A	→	G	→	A	↗	G	→	G	→

Key Focus Last Period

Cancer Improvement
Two visits from NHS England National Cancer Team and Elective Care IST took place in September with feedback from both overwhelmingly positive on the work being carried out on the Cancer Improvement Plan with particular focus on function of the MDT and PTL meetings. Feedback given on both visits was the recognition that there are system wide challenges impacting LWH performance and this requires system support to make further improvements.

Recovery of the Hysteroscopy position has shown significant improvement in dating of patients with >50% now being dated within 2 weeks of being waitlisted and <5 patients undated as at end of September. Work is continuing to increase numbers dated within 2 weeks which will help to sustain delivery of the 28 Day FDS standard.

Reducing the number of patients >62 days on the PTL has been a key focus in the last period and this has resulted in a significant reduction, from 133 to 88 in 4 weeks, a reduction of 34%. The overall PTL size has also reduced by 26% in the same time period.

Reduced Waiting List
Throughout September, the number of patients waiting over 65 weeks for treatment has significantly decreased, dropping from 38 to 15. Additionally, the number of patients waiting over 52 weeks has reduced from 712 to 536, showing significant progress.

However, this month, the overall reduction in the size of the waiting list has stagnated and fluctuated, possibly due to an increase in referrals post-August.

As a result, project groups have been tasked with identifying further areas for improvement. The booking and scheduling group is reviewing their booking processes and identifying additional clinics to maximize utilisation. Clinic template reviews are progressing rapidly, with collaboration between CSS and Gynaecology to implement planned activities in this workstream. Discussions are set to begin on expanding the successful CLPN menopause pilot to Sefton, with ongoing efforts to understand its further impact on reducing the waiting list. A workshop is scheduled for 28th October 2024.

Key Focus Next Period

Cancer Improvement
CT/MR Pathway T&F group is now established, and key actions are being delivered to improve time taken for scan request to delivery. Focus through this period will be to bring turnaround times down for Vetting to Reporting, so that wait times are reduced from >21 days to <10 days.

Additional capacity for Hysteroscopy, funded by Tier 1 monies, will be progressed with the independent sector to reduce waiting times further and reduce burden on Trust workforce for delivery. Objective for lists to be mobilised by end of October.

Reduced Waiting List
Further reduction in overdue follow-ups

Menopause clinic template review
Pre-op clinic template review
Physio clinic template review
Genetics clinic template review
Booking and scheduling, booking out process review
Detailed review of clinic utilisation, introduction of whiteboard monitoring to maximise clinics.

Key Points to Note

Cancer Improvement
Histology TATs with LCL have impacted performance of 28 Day FDS from July – September. Over the last period the Trust has seen improvements being made however performance will still be lower than target. Increase in Hysteroscopy activity through recovery actions is impacting this though and this should be noted.

Through Tier 1 meetings, challenges re: Warrington referrals have been raised on numerous occasions. Warrington have now appointed a lead Cancer Gynaecologist who commenced in the summer period and the SMDT is already starting to feel the benefit of this appointment. The Trust will be working with this individual to provide training and mentorship to enable Warrington to become a local Cancer Unit which will help LWH in management of these patients, reducing pressures on our own service. This process will likely take up to 12 months but is a positive step forward.

Reduced Waiting List
The ongoing pre-assessment work remains unchanged, but productivity will be re-evaluated. The workstream will continue to follow the actions outlined in the further faster guidelines incorporated into the project plan.

New milestones will be added to the project plan to identify actions aimed at further reducing the overall waiting list. This is especially due to the efforts of the booking and scheduling project group as mentioned earlier.

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%	?	H
Cancer: 28 Day Faster Diagnosis Benchmarked Percentile	July 2024	>=	8.57%	○	○
Cancer: 31 Day decision to treat to treatment	July 2024	>=	79.49%	?	○
Cancer: 31 Day decision to treat to treatment Benchmarked Percentile	July 2024	>=	13.73%	○	○
Cancer: 62 Day referral to Treatment	July 2024	>=	18.60%	?	○
Cancer: 62 Day referral to Treatment Benchmarked Percentile	July 2024	>=	5.81%	○	○

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	September 2024	<=	146	○	H
Capped Theatre Utilisation rate	September 2024	>=	70.30%	F	○
Moved or discharged outpatient attendances to PIFU pathways	August 2024	>=	2.34%	P	H
Number overdue follow up appointments	September 2024	<=	9631	○	○
Overall size of active patient waiting list	August 2024	<=	16466	?	L
Overall size of the Inpatient Waiting List	September 2024	<=	3167	○	H
Uncapped Theatre Utilisation rate	September 2024	>=	77.04%	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	→	A	→	A	→	G	→	A	→	Y	→	G	→
4. People and Culture	Y	→	A	→	A	→	G	→	A	→	G	→	Y	→
4.1 Safety Culture	A	↘	R	→	A	→	G	→	A	↘	G	→	G	→
4.2 Actively Anti-Racist Organisation	Y	→	Y	↘	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 organization. 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, 80% of staff have completed face-to-face training, (80% target 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
This period will focus on further analysing the top five clinical incidents to better understand causation and develop improvement measures. A communications plan will be created to share updates and engage hospital staff. Continued engagement with the project team stakeholders is planned to update actions and perform further data analysis, aiming to establish a broader baseline for safety culture across the hospital.

Actively Anti-Racist Organisation
During this period, evidence packs and reference documentation for the Anti-Racism Framework will be compiled. An audit of inclusive recruitment practices will be conducted, and the competencies for the Anti-Racism Action Learning Set have been agreed. Band 8A and Equality, Diversity, and Inclusion (EDI) objectives have been embedded into the Personal Development Reviews (PDRs). Work towards achieving the Gold standard has also commenced.

Key Points to Note

Safety Culture
The plan remains overdue primarily because of milestones relating to controlled drugs element being overdue. Resources for this are being reviewed to support timely delivery.

Actively Anti-Racist Organisation
Currently, 80% of staff have completed the mandatory EDI training. The Anti-Racism Hub continues its activities, and four Anthony Walker Foundation Listening Sessions have been held.

People & Culture Programme Significant Risks & Issues

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.

ID	Project Name	Description	Score	Controls in Place	Manager
2855	4.2 Actively Anti-Racist Organisation	Failure to secure resources for continuation of programme	11	1:Prevent-Not Yet Tested-Demonstrate success, outcomes and sustainability of programme within reasonable cost envelope Resource control	Lisa Shoko
2833	4.1 Safety Culture	Leader engagement - there is a risk that due to other operational and strategic pressures, senior leaders and clinical leaders at LWH will not have the capacity or motivation to engage in the project. There is also a communications challenge to convey the key aim of the project which is to understand how cultural and climate factors (such as leadership or role clarity) impact on patient safety outcomes.	10	1:Prevent-Effective-Senior leaders across departments identified and confirmed.	Diane Martin

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	August 2024	>=	77.95%	?	○
GM staff in leadership roles (B7 or above)	August 2024	>=	9.44%	◌	H
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	August 2024	N/A	12.74%	?	○

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	→	A	→	A	→	G	→	A	→	Y	→	G	→
5. Financial Sustainability	Y	→	A	→	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	A	↘	R	↘	A	→	G	→	R	→	G	→	G	→

Key Focus Last Period

Delivering the Three-year financial plan
The LAASPFG financial recovery delivery workstreams are now fully established, with bi-weekly reporting and updates provided to Chief Financial Officers (CFOs). Long lists have been developed for all five workstreams, which have been prioritised, and the associated values are currently being calculated. Liverpool Women's Hospital (LWH) is leading the shared services workstream, progressing towards initiatives related to procurement, overseas visitors, and legal shared services, with plans for digital services to be considered within the current financial year. A mechanism for achieving the £18.5 million target has been proposed and is under review, with finalisation expected imminently. A meeting between the LAASPFG CFOs and Chief People Officers (CPOs) took place to explore where the workstreams could align with existing HR initiatives.

24/25 CIP Delivery
During the last reporting period, the team concentrated on the review and approval of Quality Impact Assessments (QIA) milestones. A significant emphasis was placed on ensuring that all outstanding items were processed in preparation for the upcoming QIA committee meeting scheduled for the 15 October 2024. Specific attention was given to addressing hurdles related to pharmacy and governance non-recurrent spends, with team members actively working to resolve these issues and advance the necessary documentation (PID). Additionally, the review of disseminated opportunities progressed from 50% to 75%, reflecting positive movement in this area.

Key Focus Next Period

Delivering the Three-year financial plan
Efforts are ongoing to identify value against each priority within the workstreams. Principles for collective reporting between LAASPFG are being finalised. A further review of the risk-adjusted forecast and potential stretch targets for the Integrated Care Board (ICB) is expected by the end of September. Additionally, project milestones are being reviewed in light of the LAASPFG work.

24/25 CIP Delivery
In the current reporting period, the primary focus remains on finalising all outstanding QIA items to ensure readiness for the upcoming committee meeting. The team is also prioritising follow-ups on critical projects, including the Clinical Negligence Scheme for Trusts (CNST) and the Rapid Access Clinic (RAC) initiative, to facilitate timely progress and address any emerging issues. Furthermore, preparations for the mid-year review are underway, with plans to enhance communication and streamline the collection of necessary information from scheme leads.

Key Points to Note

Delivering the Three-year financial plan
Financial values are being developed for the prioritised schemes within each LAASPFG workstream. The full PwC report will be shared with Chief Executive Officers (CEOs) and Chief Financial Officers (CFOs) and was presented to the Integrated Care Board (ICB) meeting in September. Each organisation is tasked with developing an action plan to address the PwC recommendations, which will require Board approval and will be incorporated into a system-wide recovery plan.

24/25 CIP Delivery
Delays in the delivery of certain projects, some of which have been pending since before April 2024, are becoming increasingly urgent.

Financial Sustainability Programme Significant Risks & Issues

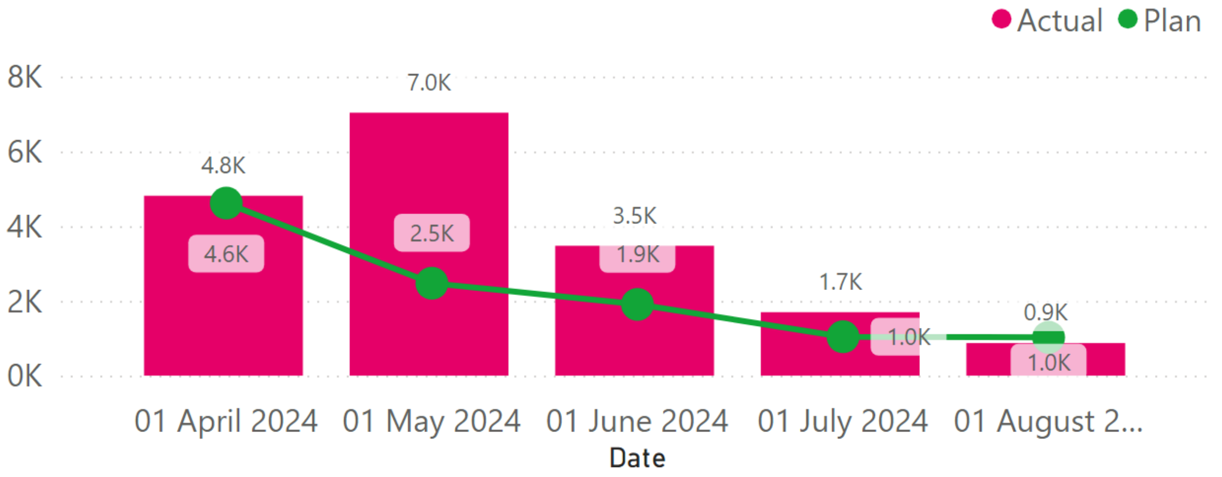
Development and delivery of a Three-Year Plan to improve and sustain the financial position of the Trust.

ID	Project Name	Description	Score	Controls in Place	Manager
2849	5.2 2024/25 CIP Delivery	Traditional CIP opportunities exhausted, leading to inability to identify sufficient level of schemes and non-delivery of CIP and financial plan.	11	1:Contingency--Ensure review and compliance with grip & control checklists and CIP idea logs from relevant external parties such as NHSE, HFMA etc;2:Prevent--Internal and external audit reviews and recommendations in place with appropriate actions completed;3:Detect--Regular review of CIP opportunities through use of Model Hospital, reference costs etc.;4:Contingency--Regular review of risks and opportunities/balance sheet items that can be released to support the position non-recurrently	Helen Chainey
2848	5.2 2024/25 CIP Delivery	Capacity constraints due to increasing asks on small teams from system in terms of reporting and administrative requirements.	10	1:Prevent-Effective-Stakeholder control Resource control Wider accountability for completion of CIP documentation and delivery throughout the Trust - Divisional and department leaders to be held accountable for delivery by Executive Team through regular review and reporting/monitoring supported by TDU. ;2:Prevent-Not Yet Tested-Establish CIP Portfolio Board to provide opportunity for review, scrutiny and challenge. First meeting took place 14/08/24.	Helen Chainey
2850	5.2 2024/25 CIP Delivery	Requirement for operational capacity to focus on productivity improvement	10	1:Prevent--The Trust has an agreed Improvement Plan detailing aligned organisational priorities for the next 12 months. This plan focuses capacity on productivity gains.;2:Detect--Regular review of productivity at the Finance and Performance Executive Group	Helen Chainey

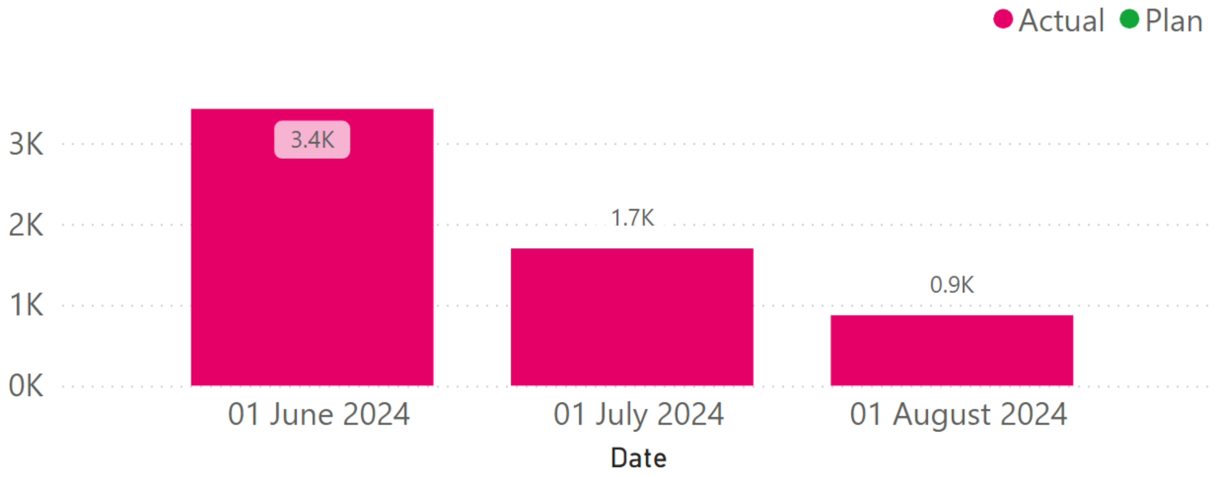
Financial Sustainability Benefits

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

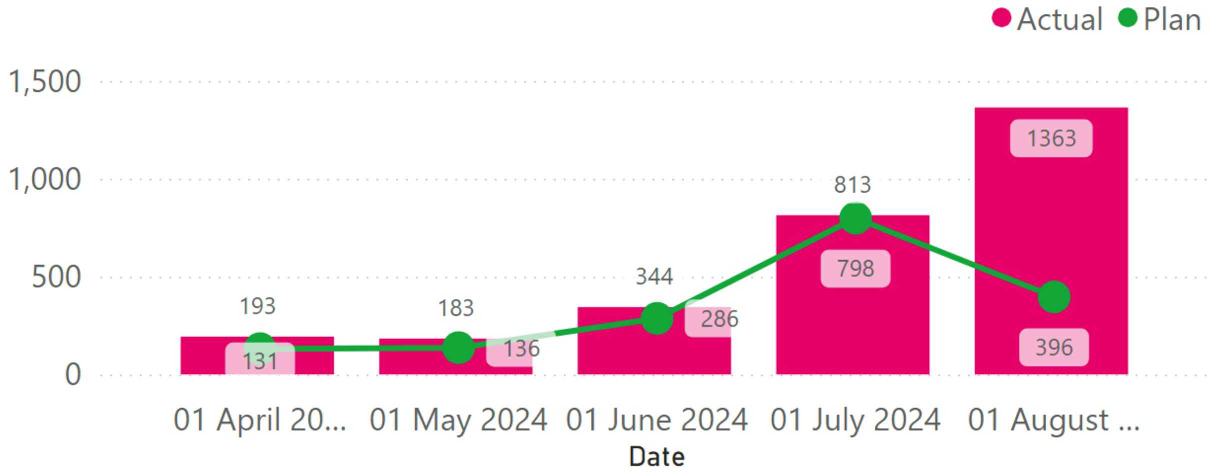
Cash Actual vs Plan



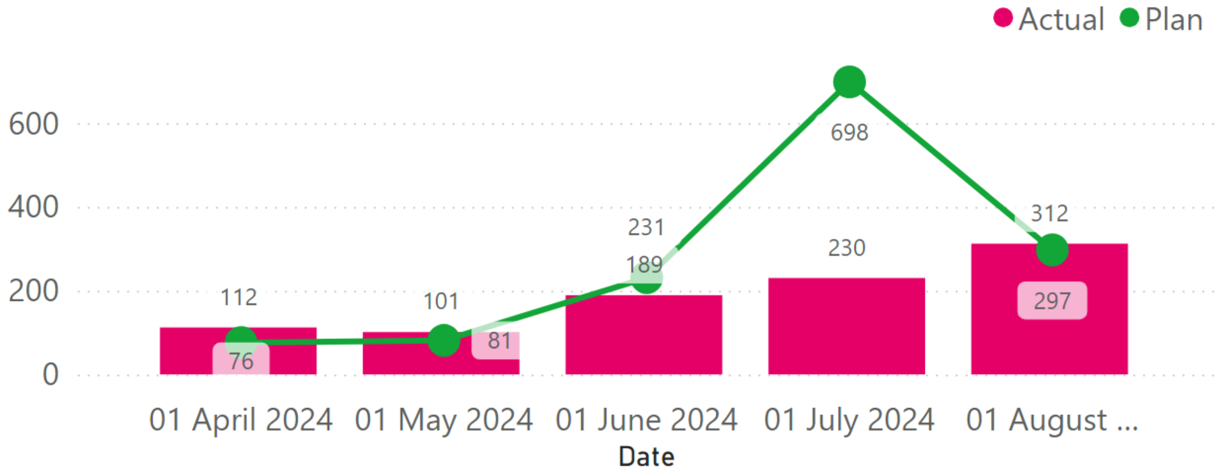
Cash actual vs Distressed finance Forecast



CIP Actual vs Plan



CIP actual recurrent vs planned recurrent



Appendix 1

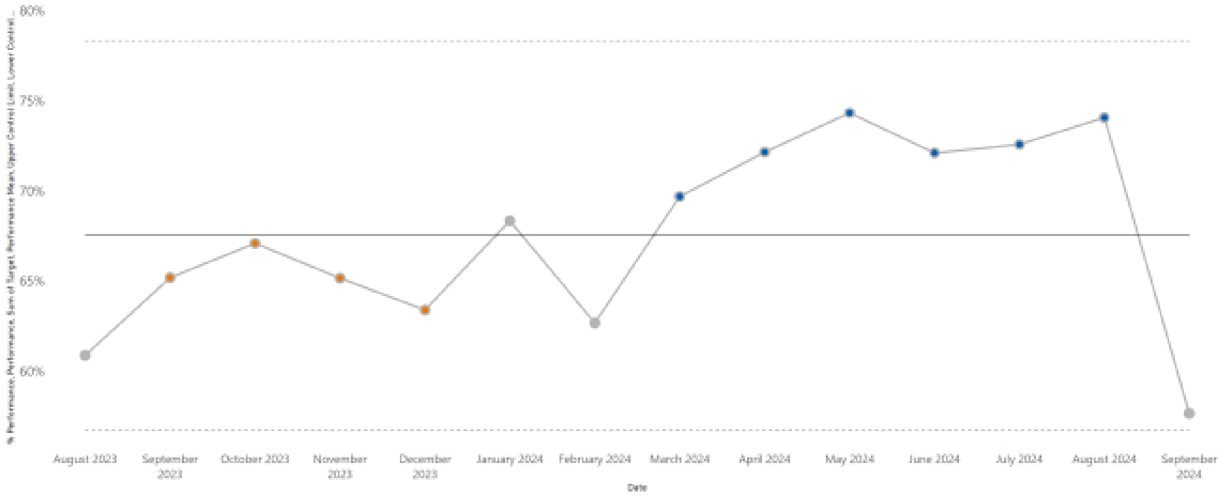
Statistical Process Control Charts for Benefits

Quality & Safety Benefits

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

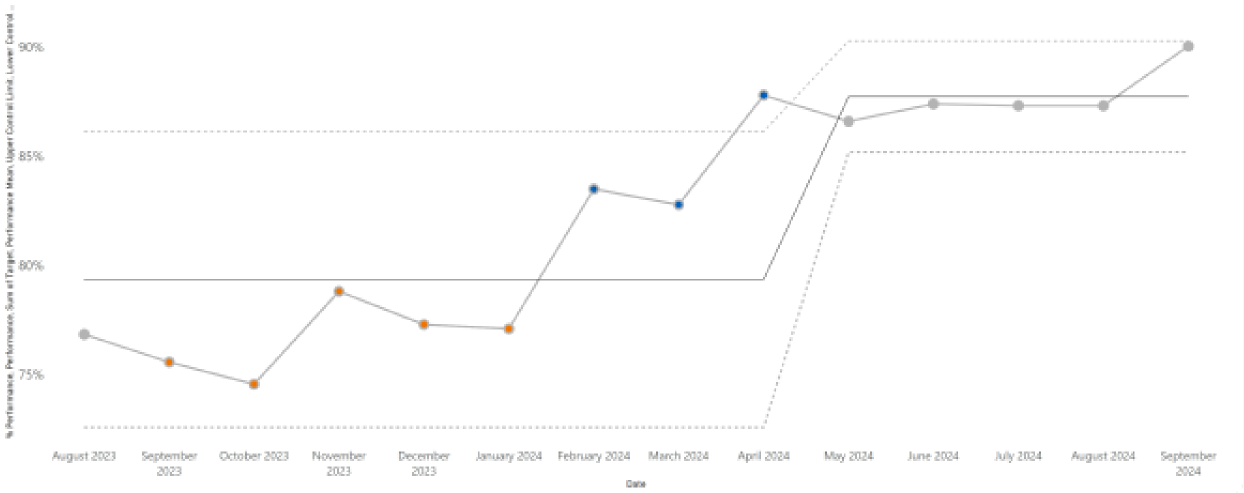
% of MEWS Scores within time -

Target	Target < or >	Performance	Assurance	Variation
	>=	57.68%		



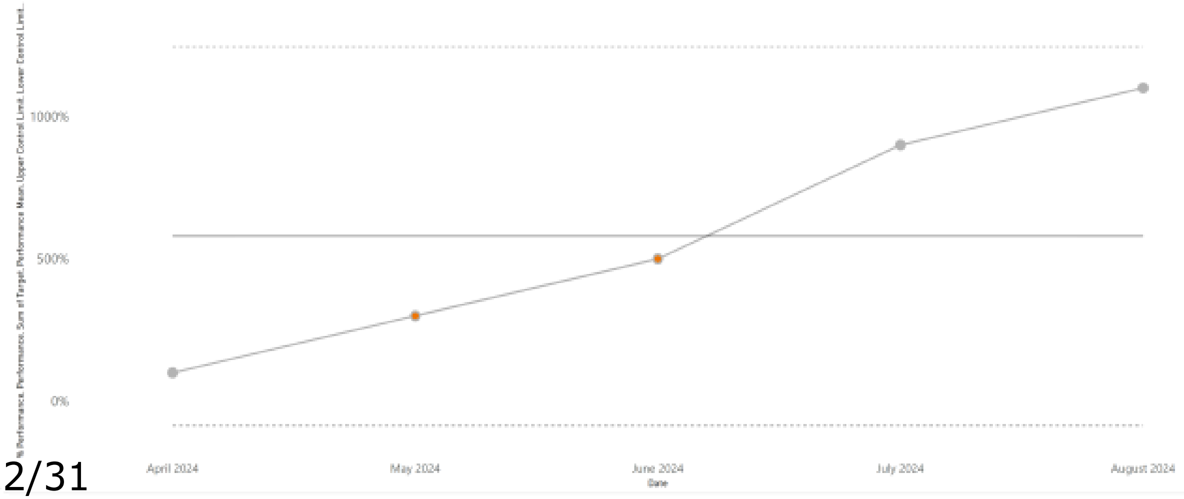
% of NEWS Scores within time -

Target	Target < or >	Performance	Assurance	Variation
	>=	90.04%		



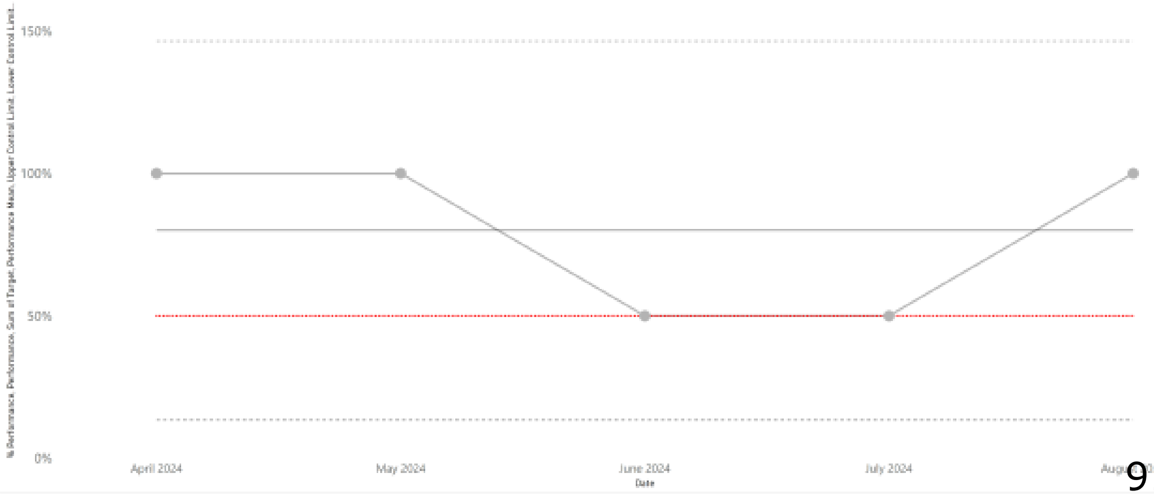
BBAS - Number of areas which have had an accreditation (rolling number each month) - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
	>=	11		



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

Target	Target < or >	Performance	Assurance	Variation
>= 50%	>=	100.00%		

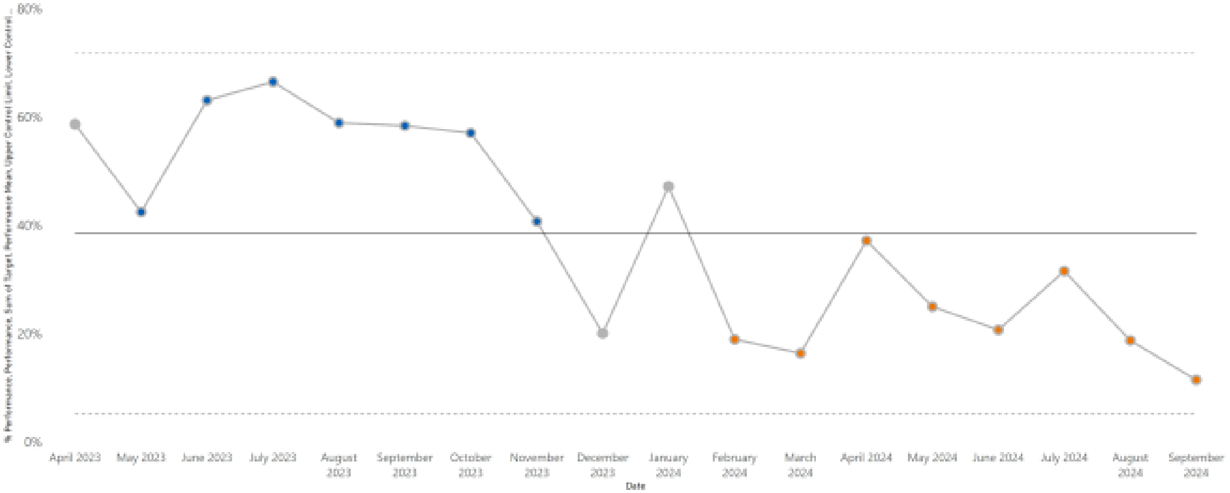


Clinical Effectiveness Benefits

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.

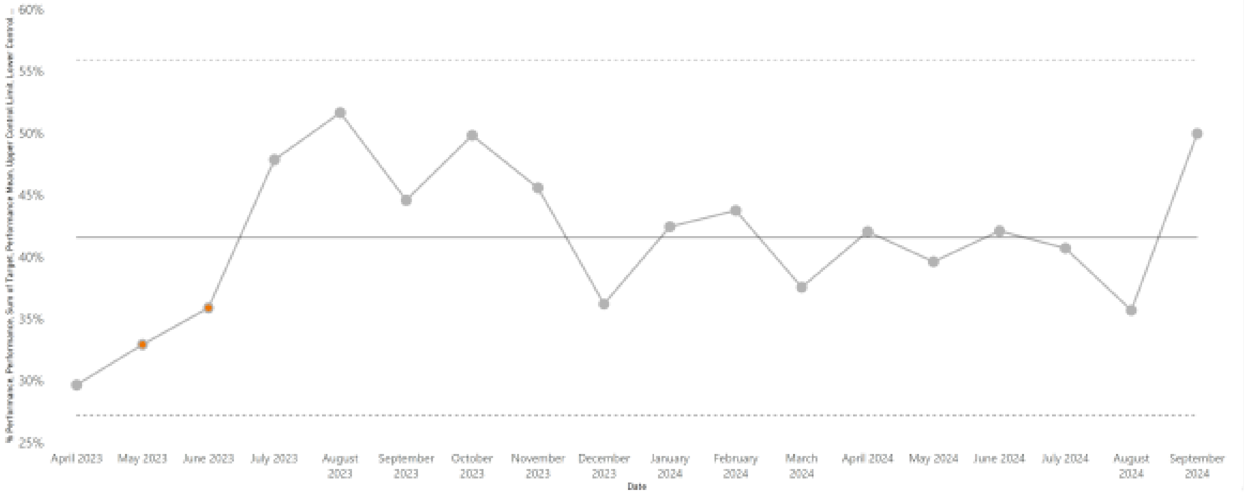
EPAU patients seen within 24 hours of referral -

Target	Target < or >	Performance	Assurance	Variation
	>=	11.46%	○	L



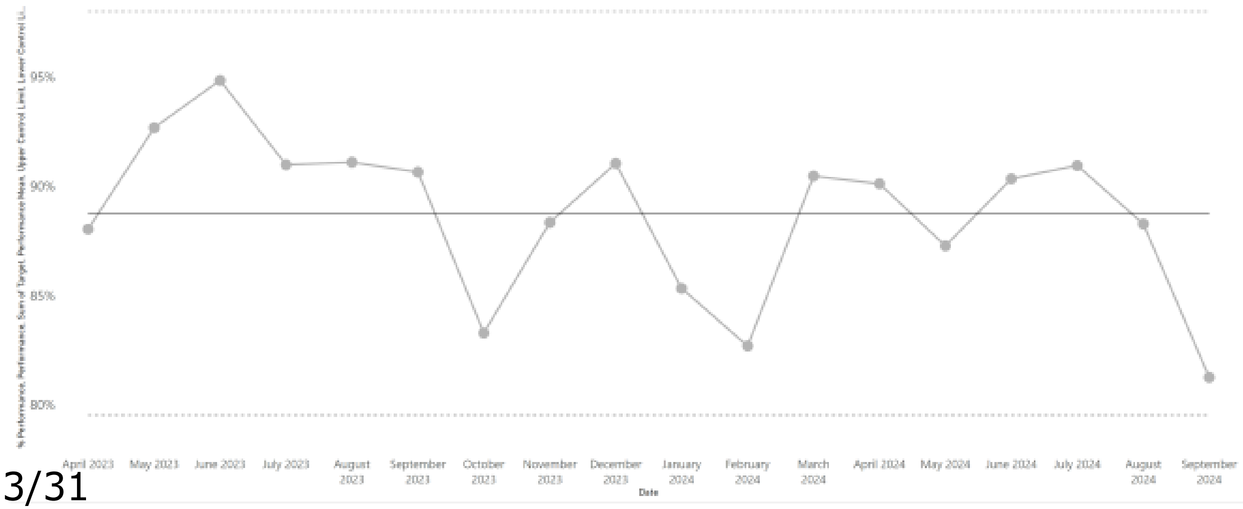
GED 15 Minutes to Triage -

Target	Target < or >	Performance	Assurance	Variation
	>=	49.96%	○	○



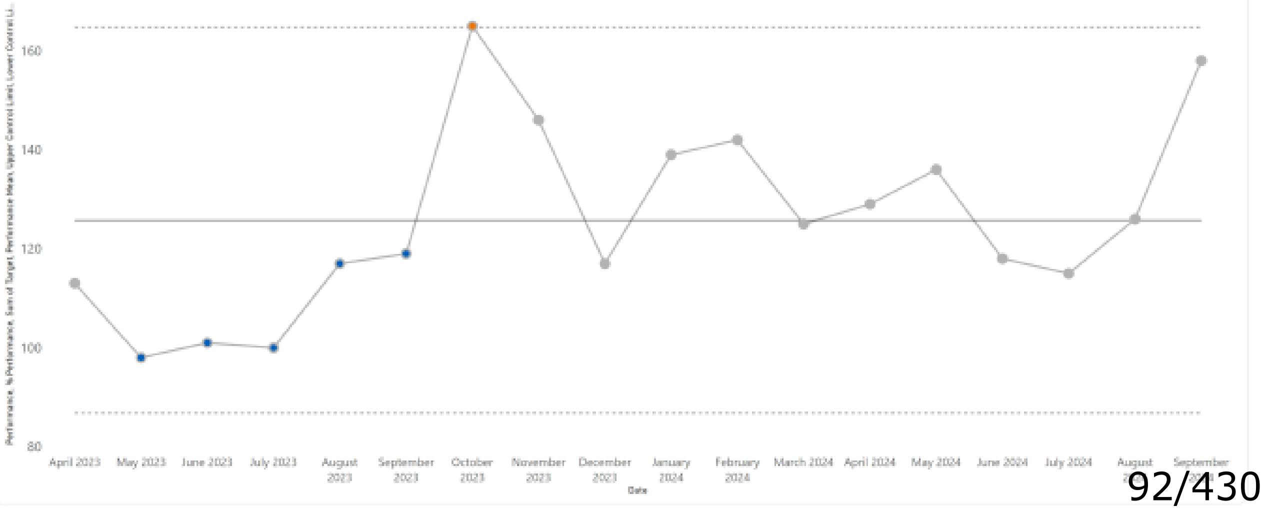
GED 4 hours from arrival to admission, transfer or discharge -

Target	Target < or >	Performance	Assurance	Variation
	>=	81.26%	○	○



GED Decrease in Time Taken to Treat -

Target	Target < or >	Performance	Assurance	Variation
	<=	158	○	○

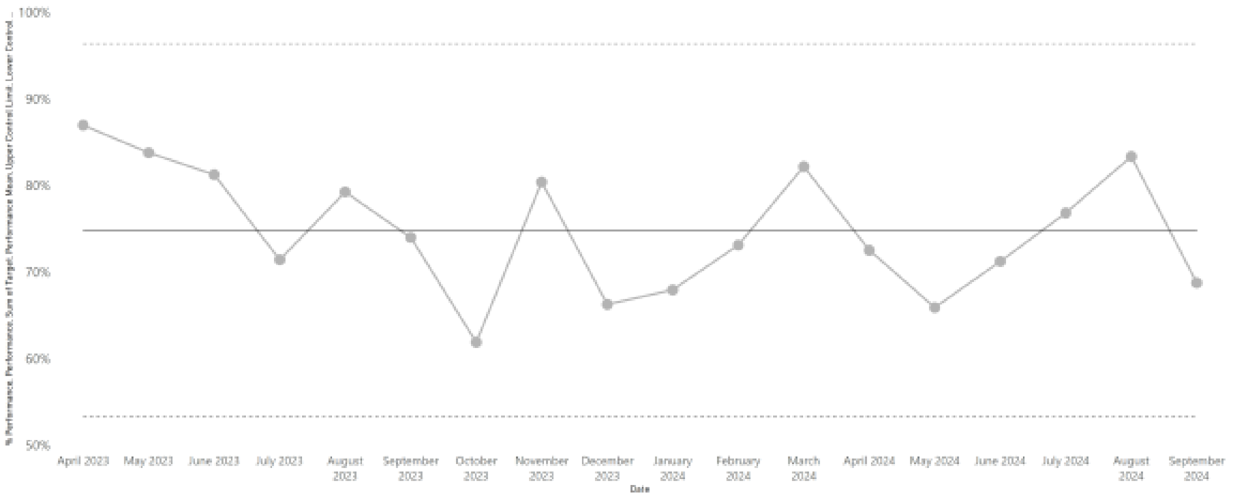


Clinical Effectiveness Benefits

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.

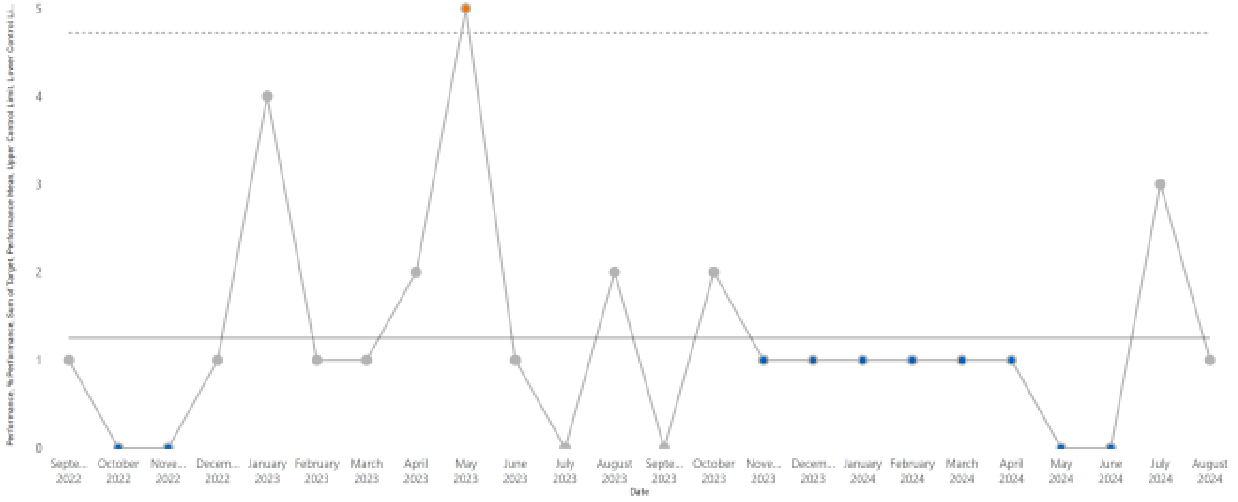
GED Increased patient satisfaction (Friends & Family Scores) -

Target	Target < or >	Performance	Assurance	Variation
	>=	68.75%		



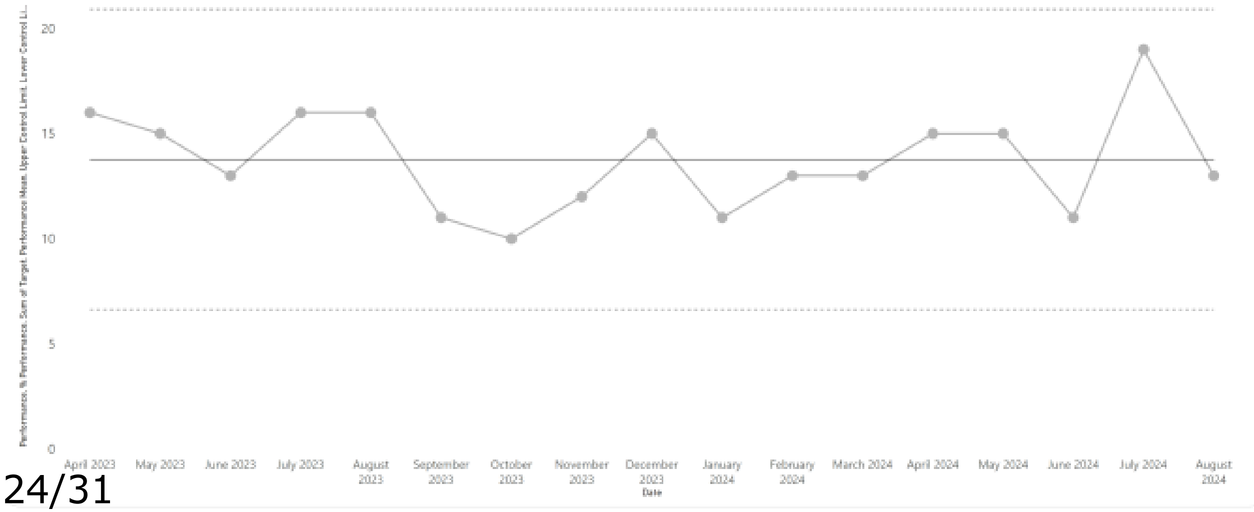
Hypoxic Encephalopathy (Grade 2,3) - Medical Director

Target	Target < or >	Performance	Assurance	Variation
TBA	<=	1		



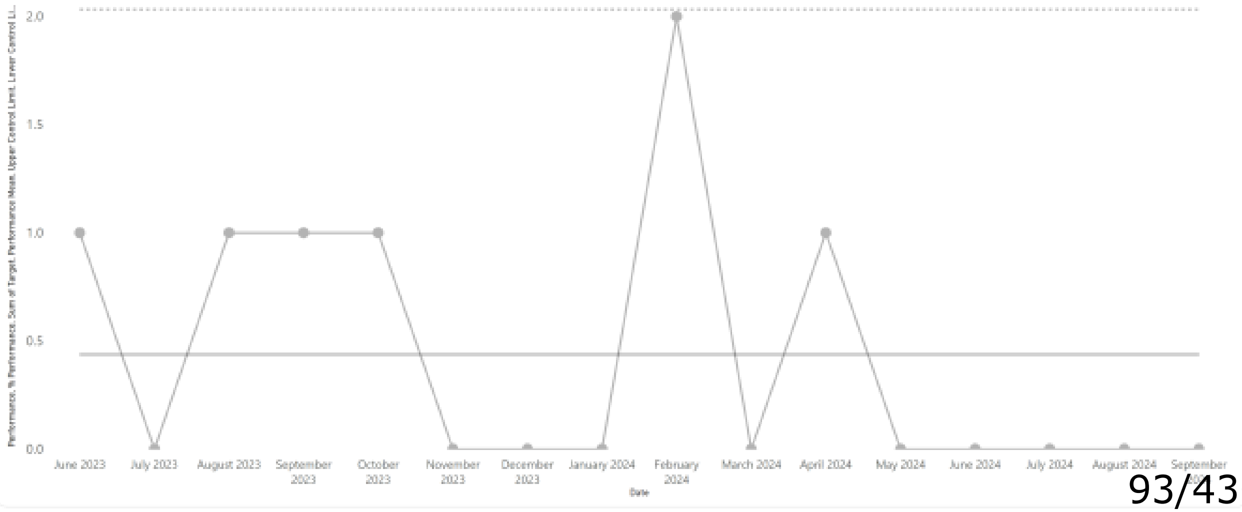
Number of emergency admissions from Matbase to NICU -

Target	Target < or >	Performance	Assurance	Variation
	>=	13		



Reduction in Obestetric Adverse Events on Delivery Suite -

Target	Target < or >	Performance	Assurance	Variation
	<=	0		

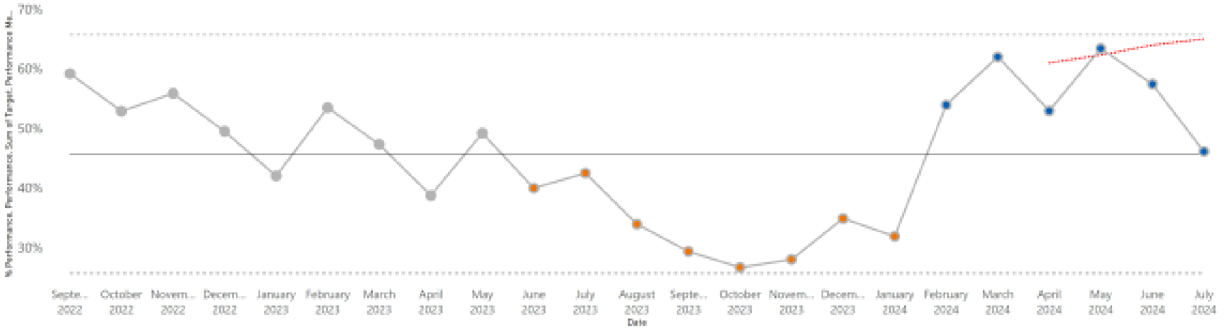


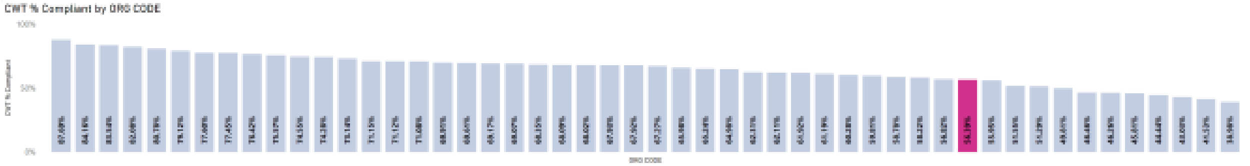
Operational Performance Benefits - Cancer

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

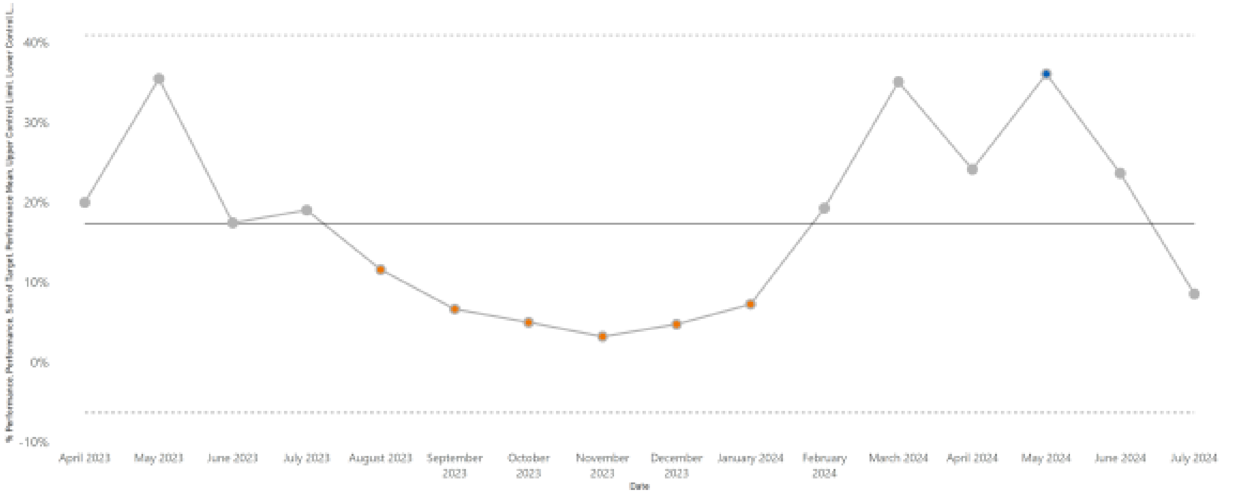
Target	Target < or >	Performance	Assurance	Variation
>= 75%	>=	46.11%	?	H





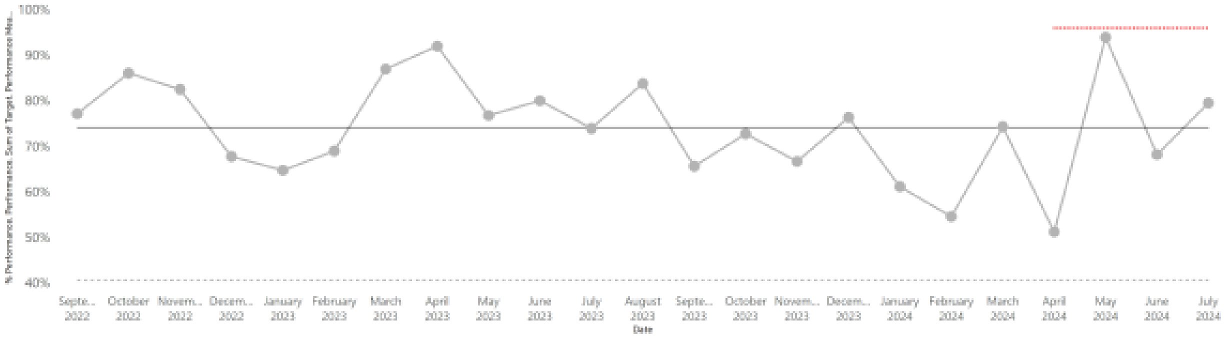
Cancer: 28 Day Faster Diagnosis Benchmarked Percentile -

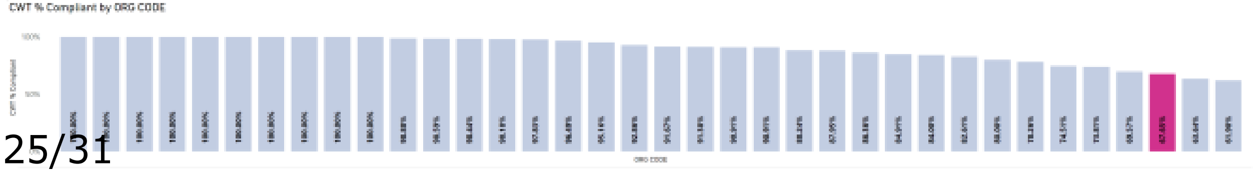
Target	Target < or >	Performance	Assurance	Variation
	>=	8.57%		



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

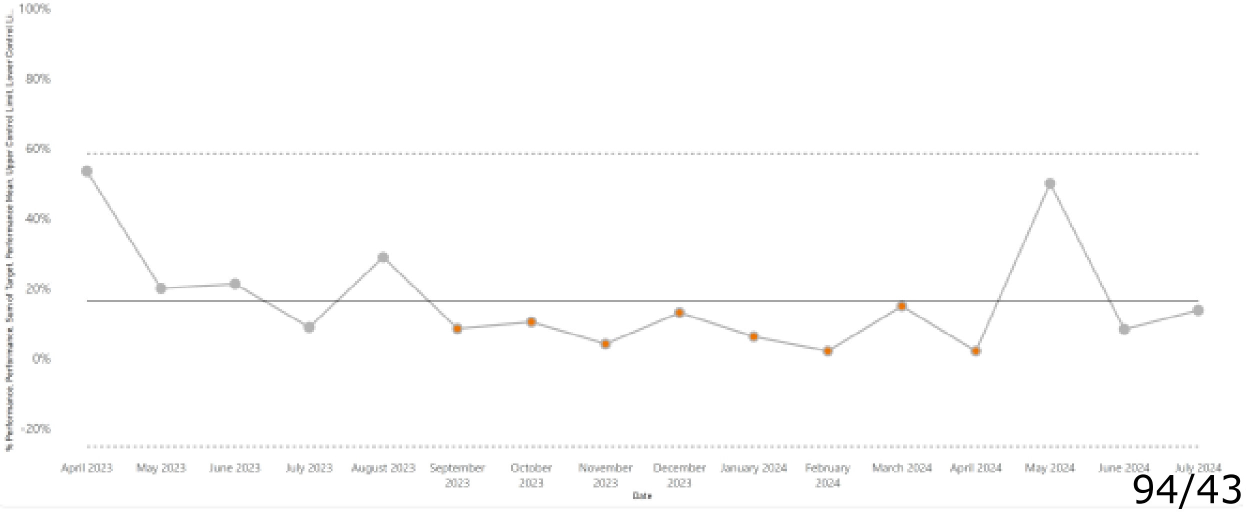
Target	Target < or >	Performance	Assurance	Variation
>=96%	>=	79.49%	?	





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

Target	Target < or >	Performance	Assurance	Variation
	>=	13.73%		

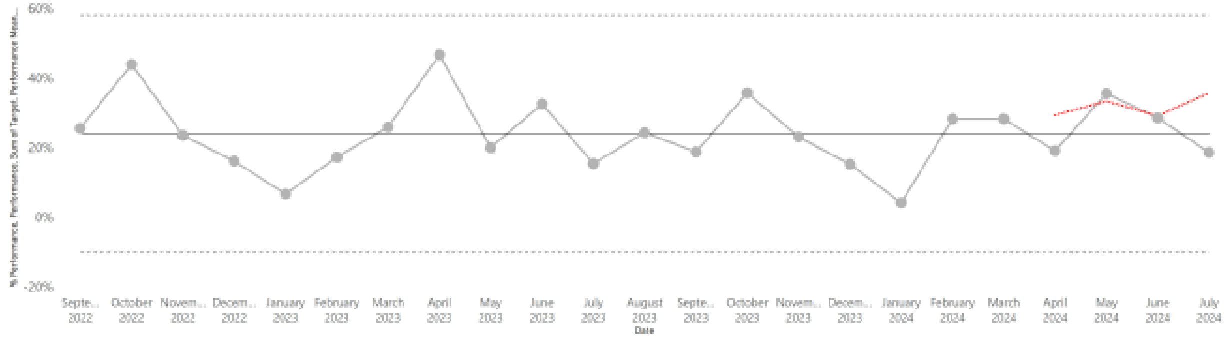


Operational Performance Benefits - Cancer

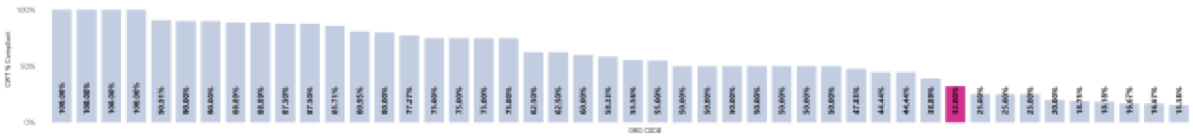
Improve the Trust's Elective & Cancer Performance to reduce the amount of time patients are waiting for diagnosis and treatment

Cancer: 62 Day referral to Treatment - Chief Operating Officer

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

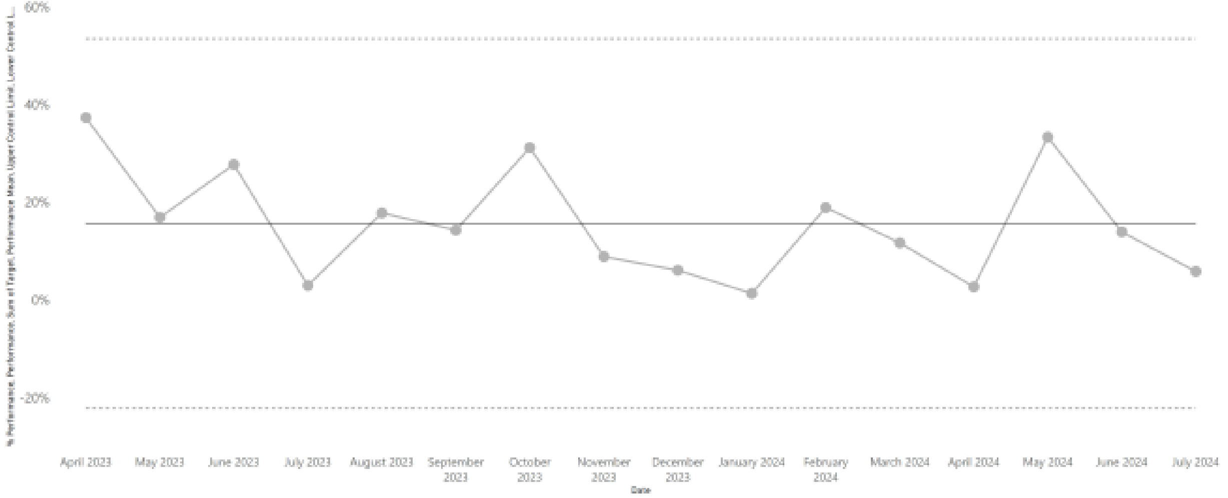


CWT % Compliant by ORG CODE



Cancer: 62 Day referral to Treatment Benchmarked Percentile -

Target	Target < or >	Performance	Assurance	Variation
	>=	5.81%		

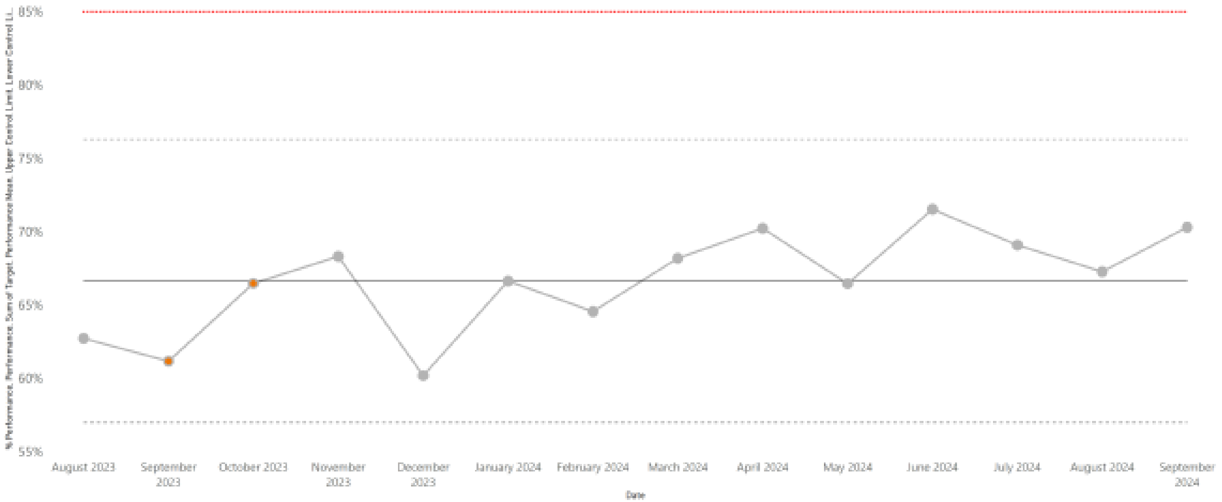


Operational Performance Benefits

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

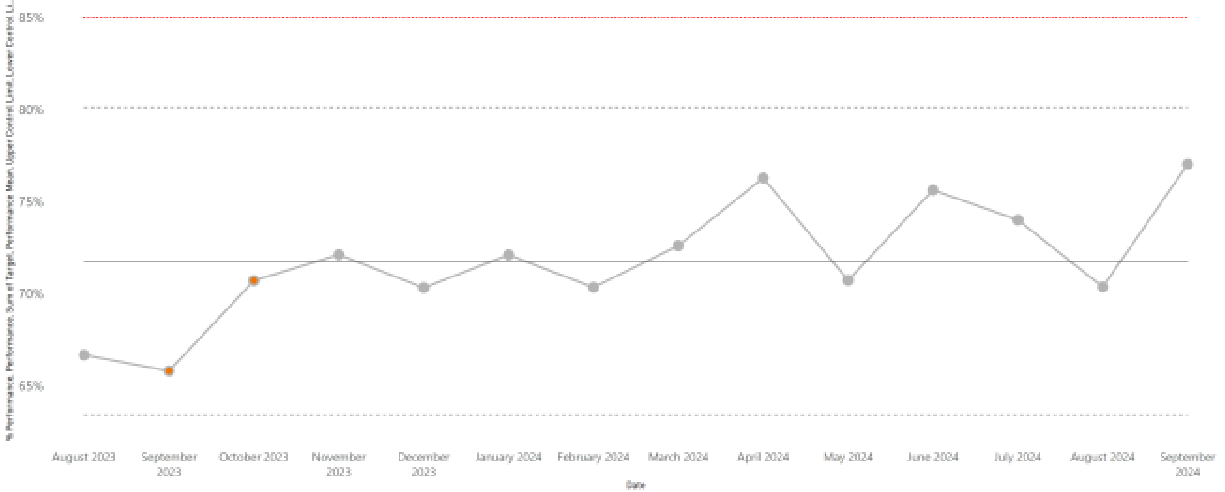
Capped Theatre Utilisation rate - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 85%	>=	70.30%	F	



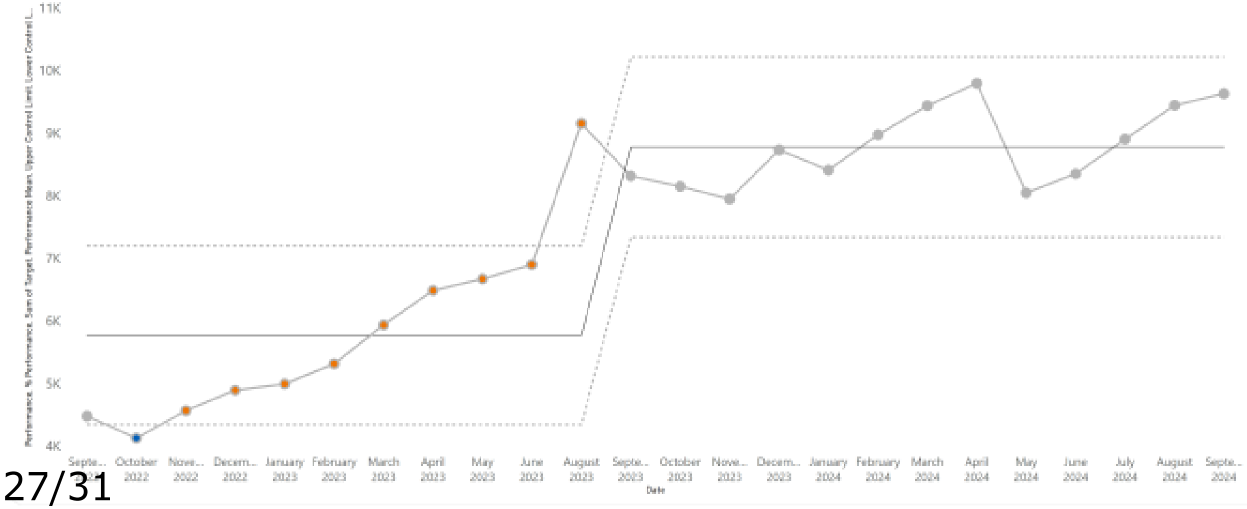
Uncapped Theatre Utilisation rate - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 85%	>=	77.04%	F	



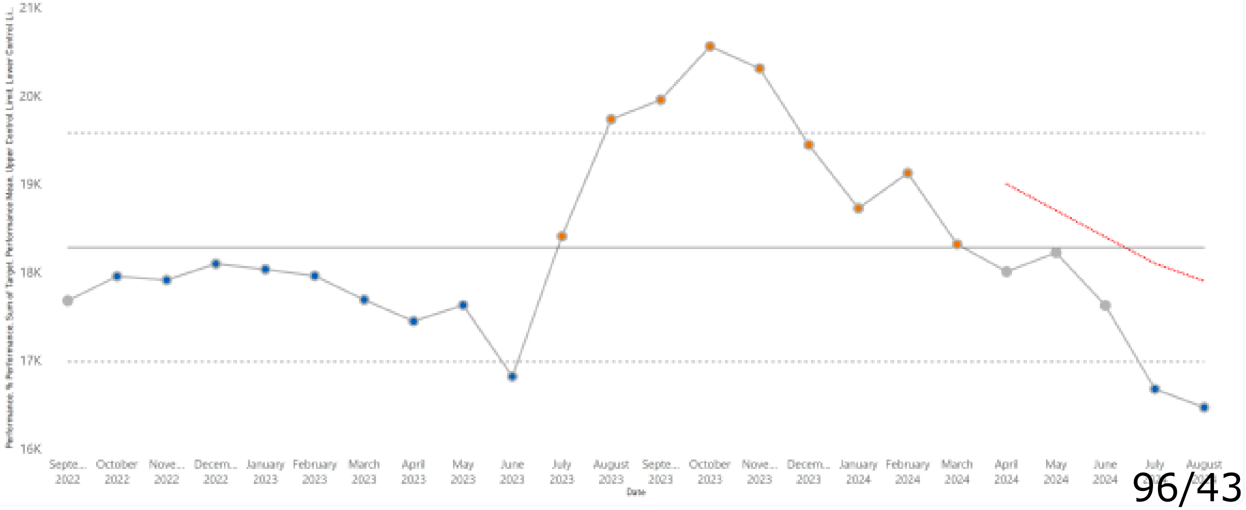
Number overdue follow up appointments - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
	<=	9631		



Overall size of active patient waiting list - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
<= 16500	<=	16466	?	L

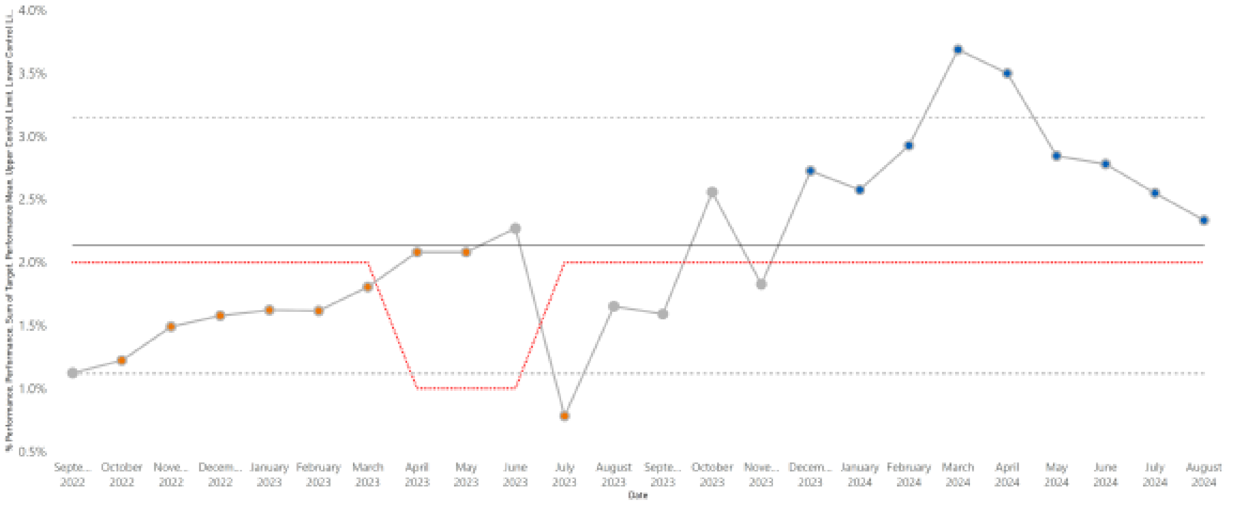


Operational Performance Benefits

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

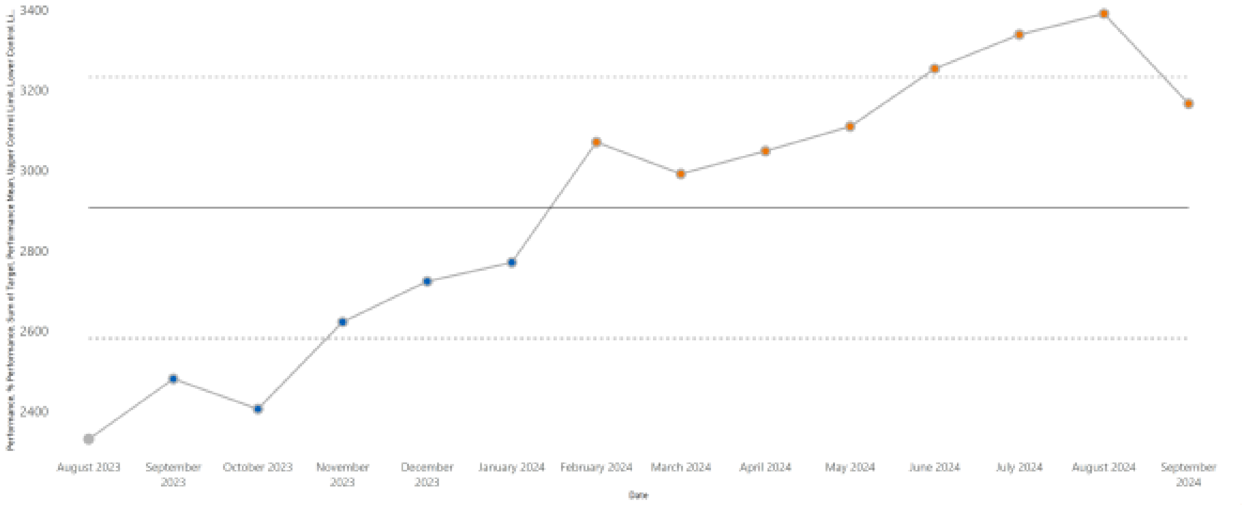
Moved or discharged outpatient attendances to PIFU pathways - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>=2%	>=	2.34%	P	H



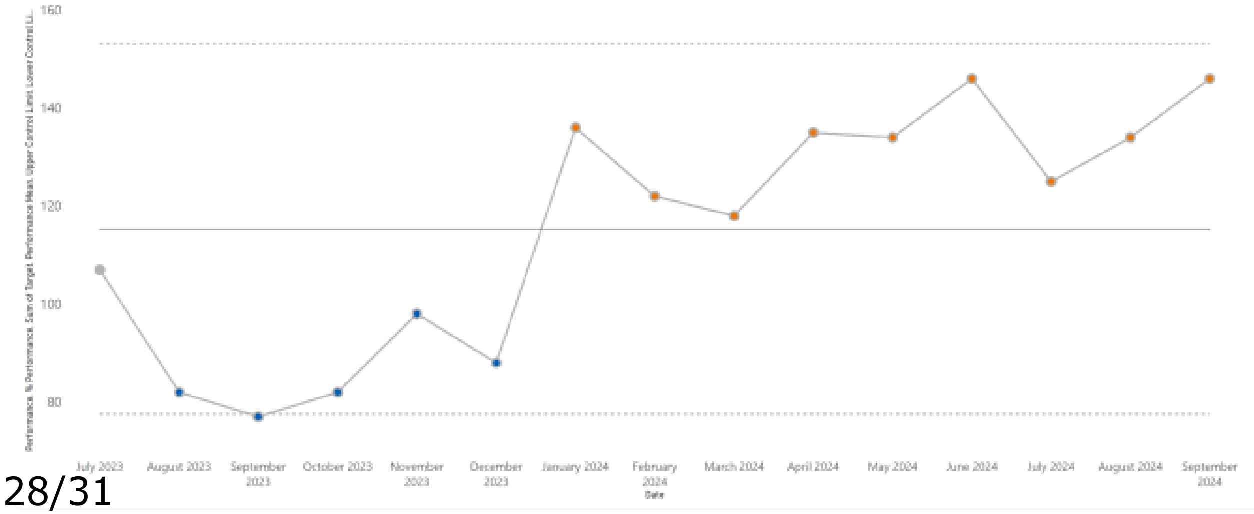
Overall size of the Inpatient Waiting List -

Target	Target < or >	Performance	Assurance	Variation
	<=	3167		H



1st Appointment Waiting Times -

Target	Target < or >	Performance	Assurance	Variation
	<=	146		H

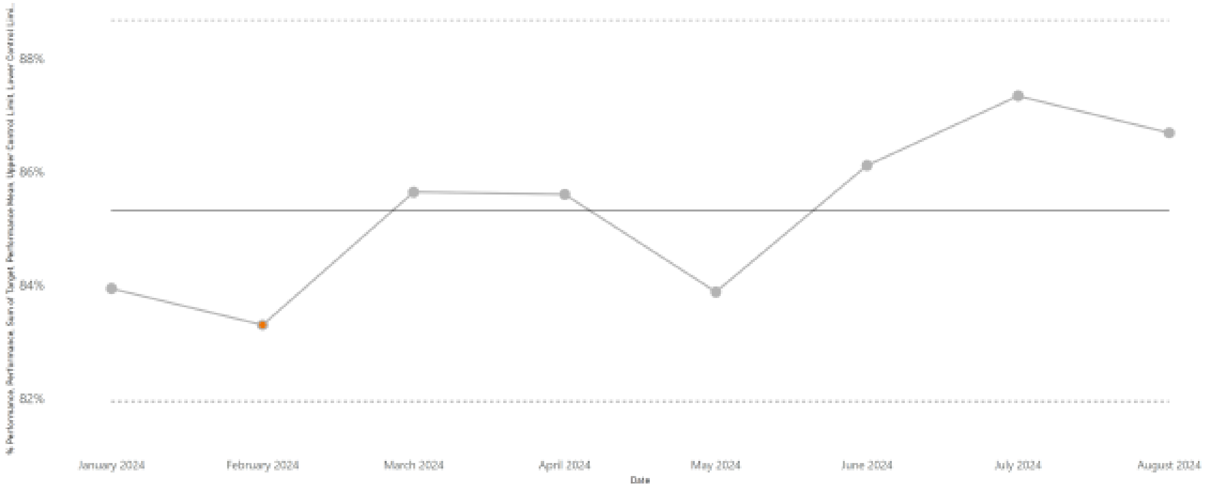


People & Culture Benefits

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.

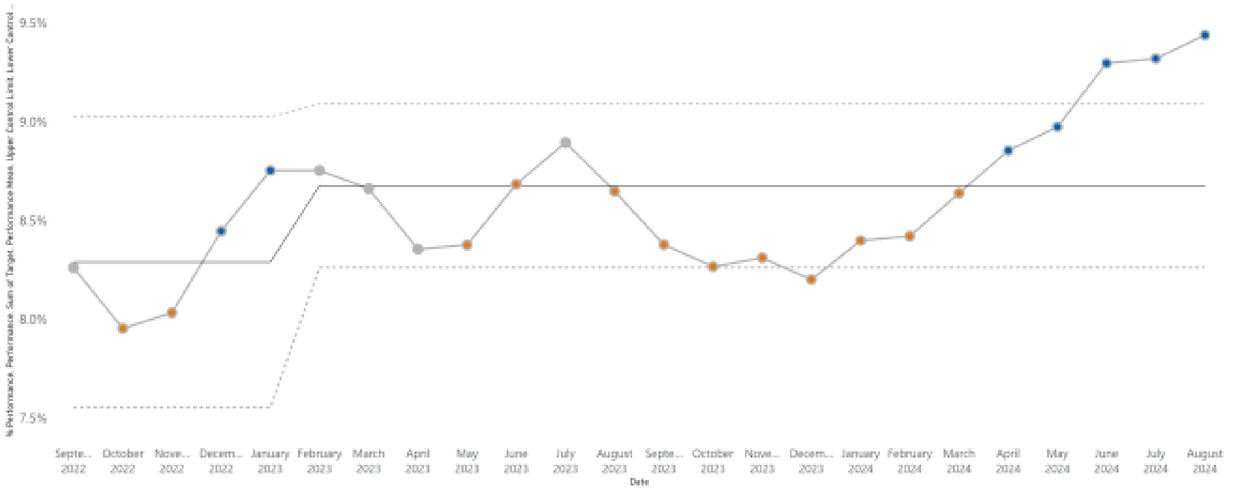
% of staff completing human factors training -

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



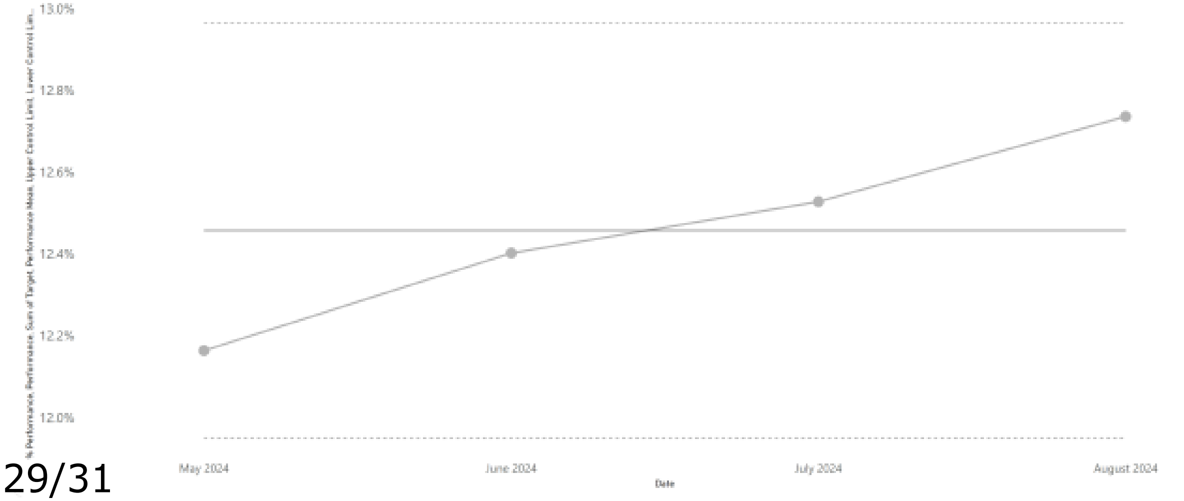
GM staff in leadership roles (B7 or above) - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
2% annual improvement	>=	9.44%		



Overall GM staff in workforce - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
5% annual improvement	N/A	12.74%		



Financial Improvement

Well Led

Quality & Safety

Clinical Effectiveness

Operational Performance

People & Culture

Appendix 2

RAYG Definitions

Appendix 1 - 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

Board of Directors

COVER SHEET

Meeting Date	Thursday, 10 October 2024	**Item Reference**	TB24/25_137
Report Title	Ambulatory Expansion Project		
Authors	Joe Downie, Deputy Chief Operating Officer Jennifer Huyton, Deputy Chief Finance Officer		
Responsible Director	Gary Price, Chief Operating Officer		
Purpose of Report	To provide an update on increased costs associated with the Ambulatory Expansion project and support recommendations made.		
Executive Summary	The Trust initially secured £5 million from the Targeted Investment Fund (TIF) to support the re-purposing of the Ambulatory unit. However, as the project has advanced, the revised capital requirement has increased to £5.8 million in 2024/25 with a further £0.2m required in 2028/29. This paper outlines the reasons for the change, options considered and proposal to mitigate increased costs within the 2024/25 Capital Programme.		
Key Areas of Concern	Impact to 2024/25 Capital Programme. Failure to proceed with additional costs would result in inability to carry on with expansion. Reputational damage to Trust if unable to complete programme within TIF timescales.		
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 the Board Assurance Framework	Risk 2 – Isolated Site	**12**
	Risk 4 – Financial Sustainability	**10**
	Risk 5 – Cancer Recovery	**10**
	Risk 6 – Waiting Times	**10**
	Risk 7 – Health Inequalities	**10**
Links to Corporate Risk Register (scoring 10+)	N/A	**-**

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

Action Required by the Board	The Board is asked to: • Note the content of the report. • Approve the recommendations made by FPBD Committee

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Finance, Performance & Business Development Committee	02.10.24	Gary Price, Chief Operating Officer	Supported recommendation to proceed with increased capital costs, with mitigations from reallocation of 24/25 Capital Programme

MAIN REPORT

1. INTRODUCTION

The Finance, Performance & Business Development Committee received an update on the Ambulatory Expansion Project which has been in progress since January 2024 when funding was approved by NHS England (NHSE).

In 2022/23 capital funding was released by NHSE over the course of three years to support the delivery of additional elective and cancer backlog through the Targeted Investment Fund (TIF). Through the Cheshire & Mersey Acute and Specialist Trust (CMAST) collaborative, bids were sought to address both admitted and non-admitted pathways. The Trust was successful in obtaining £5m in capital funding in January 2024 to expand Gynaecology Ambulatory services.

The initial business case for the project was completed in May 2023, with support from CMAST. However, there was a delay in the NHSE governance process to approve the case, by which time the case was only then considered in December 2023. The Trust bid was approved, and funding was released in January 2024.

GOVERNANCE ARRANGEMENTS

There is an Ambulatory Programme Board which meets monthly and has a number of workstreams.

The Ambulatory Programme board reports into Safe & Sustainable Environment (SSE) Group and provides a monthly paper/update on progress. SSE Group reports directly into Finance & Performance Executive Group (FPEG) and then into Executive Risk & Assurance Group (ERAG).

Key risks are escalated through the programme board and through to the appropriate groups based on the risk score. Key risks related to costs of the project were escalated through to FPEG.

KEY ISSUES/POINTS

An update of the project was provided to Finance, Performance & Business Development Committee on 2nd October. Key points/issues from the paper are outlined below:

- Programme is progressing well in terms of achievement of key milestones against the programme plan. Programme is expected to complete all building works by March 2025 in line with NHSE expectations, with a handover of the completed unit in April 2025 and commencement of clinical activity in May 2025.
- Significant increase in building/equipment costs identified following market testing and cost plan review undertaken in June 2024. A redesign of the original layout was completed resulting in a reduction in increased costs but still above initially allocated budget of £5m.
- Revised costs of an additional £0.8m for 24/25 and a further £0.2m required in 2028/29 to facilitate opening of 3rd treatment room, total of £6m now required.
- Following review of the options available, it was determined that the scheme was required to continue but mitigations for increased costs needed to be sought.
- Review of Capital Programme for 2024/25 means that a large proportion of the increased costs can be managed in year with a residual risk of £0.15m that may be mitigated at year end or would need to be supported by the 2025/26 Capital Programme.
- There is a small revenue impact as a result of the increased capital costs however the impact is immaterial in value and the overall revenue assumptions contains a 10% contingency.

The Committee raised concerns about the level of increased costs post original business case approval but agreed that at this stage, there is no option to stop or pause the project given the noted risks.

The Committee recommended that a lesson learnt exercise be undertaken as part of the Post Implementation Review into the project to ensure that appropriate levels of sensitivity are applied to initial costing estimates for any future projects.

RECOMMENDATION

The Board is asked to approve the recommendation made from Finance, Performance & Business Development Committee to proceed with the Ambulatory Expansion project noting the revised capital costs of the project from £5.0m to £6.0m

Ensure a lessons learnt exercise is undertaken as part of post implementation review to ensure any future projects reduce the risk of increased costs post business case approval.

Liverpool Women's
NHS Foundation Trust

Board of Directors

COVER SHEET

Meeting Date	Thursday, 10 October 2024	**Item Reference**	TB24/25_138
Report Title	Medical Appraisal and Revalidation Annual Report 2023/24		
Author	Janine Elson, Appraisal Lead Lynn Johnson, Revalidation Support Manager		
Responsible Director	Lynn Greenhalgh, Chief Medical Officer		

Purpose of Report	To provide the Medical Appraisal and Revalidation Annual report.
Executive Summary	Revalidation and Appraisal continues to work well within the Trust. Suggested areas for improvement are documented within the paper. • The Trust Board is asked to receive the report noting it will be shared with the Higher Level RO. • To approve the '2023 2024 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance compliance statement' confirming that the organisation, as a designated body, is in compliance with the regulations. (Section 4)
Key Areas of Concern	None
Trust Strategy and System Impact	Appraisal and Revalidation supports the health and wellbeing of medical staff and helps them with their career progression while providing assurance that their practice is current and fit for purpose. It drives quality of service provided by medical staff.

Links to Board Assurance Framework	Risk 1: Workforce	10
Links to Corporate Risk Register (scoring 10+)	N/A.	-

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

Action Required by the Board of Directors	The Board of Directors is asked to: 1. To receive the annual report and note that this will be shared with the higher Responsible Officer 2. Take assurance that there are effective medical appraisal and revalidation processes in place 3. To approve the statement of compliance in the 2023-2024 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance confirming that the organisation, as a designated body, is in compliance with the regulations and to note that this needs CEO signature and Board approval.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Putting People First Committee		**Lynn Greenhalgh**	

MAIN REPORT

Executive summary – 2023/24 Revalidation and Appraisal annual report and compliance statement.

Revalidation is the General Medical Council's (GMC) way of regulating licensed doctors that will give extra confidence to patients that doctors are up to date and fit to practice.

The GMC requires that the designated body has nominated or appointed a responsible officer in compliance with the Responsible Officer (RO) Regulations. The RO is a licensed doctor who has been licensed continuously for the previous five years and continues to be licensed throughout the time they hold the role of responsible officer.

During this revalidation year April 2023 to March 2024, the team supporting revalidation for the Trust was:
Dr Lynn Greenhalgh, Responsible Officer (RO),
Dr Janine Elson, Appraisal Lead,
Lynn Johnson Revalidation Support Manager and a team of trained appraisers who each will undertake between 4-7 appraisals/year. There are currently an adequate number of appraisers to appraise the doctors within the Trust.

Liverpool Women's NHS Foundation Trust as a designated body had 117 doctors with a prescribed connection in the revalidation year April 2023 to March 2024. All doctors but 1 were engaged with the process and all doctors were accounted for in terms of their participation.

For the time period of this report doctors were expected to have an appraisal and a conversation regarding wellbeing.

As part of the framework for quality assurance and for the purpose of revalidation, NHS England requests an Annual Report together with the compliance statement (Section 4 of the Annual report).

The Trust Board receives this paper for approval.

The Trust's 2023-2024 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance which includes the compliance statement has been completed and is attached as Appendix A.

This paper sets out the information usually submitted to the Trust Board within those papers to assure the Board that the Medical Appraisal and Revalidation processes continue to function well.

Revalidation recommendations:

23 doctors' revalidation date fell during this year. 17 received a positive recommendation.

6 recommendations were deferred due to the RO having insufficient evidence.

1 referral for none engaging with the appraisal and revalidation process was made and this doctor was supported to re-engage. and the process is now complete.

Governance and Quality Assurance:

The Responsible Officer has provided quarterly assurance paper to the Putting People First Committee and this annual report to NHS England to demonstrate compliance with the Framework of Quality assurance for Responsible Officers and Revalidation.

Appraisal update training

All new appraisers attend formal new appraiser training with update training being delivered twice yearly in house.

Internal quality assurance is performed by a peer review of a random sample of 10% of completed appraisals. For the year 2023/24 this was done using the NHSE SUPPORT tool. This provides not only feedback to individual appraisers but also a learning and discussion opportunity for the reviewing appraisers. All appraisers are expected to attend at least one peer review session a year.

All appraisees complete a feedback questionnaire about the quality of their appraisal; this is included in an annual report to the appraisers to be included and discussed at their own appraisal.

The Appraisal Lead observes the quality of the appraisers undertaking an appraisal, at least once every 5 years. This information is used to provide evidence to the RO and designated body about the quality of the appraisal and used for feedback to the appraiser.

The 2023-2024 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance has been reviewed at People Organisational development Executive Group before submission to Board.

Recommendations:

- The Trust Board is asked to receive the report noting it will be shared with the Higher Level RO.
- To approve the '2023 2024 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance compliance statement' confirming that the organisation, as a designated body, is in compliance with the regulations. (Section 4)

1. Purpose of the paper

As part of the framework for quality assurance and for the purpose of revalidation, NHS England requests an Annual Report together with the 2023-2024 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance compliance statement

The paper is intended to fulfil the above and provide assurance to the Trust Board that, in line with the self- and external assessments, the Trust is fulfilling all the requirements for revalidation.

2 Background

Revalidation was made statute on 3rd December 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving public safety and increasing public trust and confidence in the medical system. All doctors are allocated to a Designated Body through the GMC. Each Designated Body has a Responsible Officer, who is responsible for implementing appraisal and revalidation. Doctors in training are in the Deanery designated Body and therefore are not included in this report.

The GMC decides whether to revalidate a doctor based on the recommendation made to it by the Responsible Officer. A positive revalidation decision means the doctor's license to practice is extended for five years. Deferral is a neutral recommendation resulting in a new revalidation date being set. It does not impact on the doctor's license to practice. Non-engagement indicates a doctor's license is a risk of being withdrawn.

Liverpool Women's NHS Foundation Trust has a statutory duty to support the RO with sufficient funding and other resources necessary to enable them to discharge their duties under the Responsible Officer Regulations.

The RO oversees compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations;
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors; ensuring that accurate records are kept of all relevant information, actions and decisions
- Ensures that the organisation's medical revalidation policies and procedures are in accordance with equality and diversity legislation
- Making timely recommendations to the GMC about the fitness to practice of all doctors with a prescribed connection in accordance with the GMC requirements and the GMC Responsible Officer Protocol
- Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors

3 Governance Arrangements

The current Responsible Officer is Dr Lynn Greenhalgh. The Trust responsible Officer is appraised by an external appraiser nominated by NHS England. Her 2024 appraisal is booked on the 18th July 2024. She took over being RO in April 2021 after a period of 3 months acting as RO in an interim capacity.

The current Appraisal Lead is Dr Janine Elson. She is also currently appraised by an external appraiser nominated by NHS England. Dr Elson is leaving the Trust and a new Appraisal Lead Dr Astrid Weber has been appointed and will start in her new role in August 2024.

Lynn Johnson was appointed to the post of Revalidation Support Manager in 2017, with the remit to provide support and advice to the RO and doctors on matters relating to appraisal and revalidation.

The Trust's Responsible Officer, Appraisal Lead and Revalidation Support Manager attend regular external Responsible Officer/Appraisal Lead Network meetings with other ROs and representatives from GMC and NHS England

The RO, Appraisal lead and Revalidation Support Manager meet regularly as a team, several times a month. Revalidation Team meetings have been established and meet at least twice a year. The purpose of the meeting is to provide appraiser peer support and to discuss any issues arising relating to the appraisal systems/processes as well as cascading any information provided but the NHSE/I Responsible Officer and Appraisal Lead meetings.

The Medical Appraisal/Revalidation Team reports to the Putting People First Committee and the minutes are formally recorded and submitted. From April 2024 onward the reporting structures will change and will be to the People Organisational Development executive Group (PODEG)

NHS England requests an Annual Report together with the compliance statement (Section 4).

There is a process to support the appropriate transfer of information about a doctor's practice to and from the doctor's responsible officer. It is designed to be used to share information with the doctor's responsible officer in the following situations:

- When a doctor's prescribed connection changes
- When a concern arises about the doctor's practice in any place where the doctor is practising I

The Trust has an established team and system to record all incidents and complaints through the Risk and Safety Team.

The Trust also has a dedicated Audit team to assist the doctors and contribute to their clinical performance.

4 Quality Assurance

All appraisees complete a feedback questionnaire about the quality of their appraisal; this is included in an annual report to the appraisers to be included and discussed at their own appraisal.

Internal quality assurance is performed by a peer review of a random sample of 10% of completed appraisals. For the year 2023/24 this will be done using the NHSE SUPPORT tool. This provides not only feedback to individual appraisers but also a learning and discussion opportunity for the reviewing appraisers. All appraisers are expected to attend at least one peer review session a year.

All appraisees complete a feedback questionnaire about the quality of their appraisal; this is included in an annual report to the appraisers to be included and discussed at their own appraisal.

The Appraisal Lead observes the quality of the appraisers undertaking an appraisal, at least once every 5 years. This information is used to provide evidence to the RO and designated body about the quality of the appraisal and used for feedback to the appraiser.

5 Medical Appraisals

Appraisal and Revalidation Performance Data

The Revalidation Support Manager maintains a database of all appraisal dates. Doctors receive timely notification and reminder emails with the request to undertake an annual appraisal, in accordance with NHSE guidance.

The data on the appraisal is shown in the table below.

Total number of appraisals completed	102
Total number of appraisals approved missed	2
Total number of unapproved missed	13

Reasons for the incomplete/missed appraisal authorised were:

There were 13 approved late appraisals. 11 of these were new starters, one doctor was on sabbatical and the last doctor missed their appraisal and has now completed it

The overall rate of unauthorised missed/incomplete appraisal is just under 1% which is the same as the previous 2 years. This will be actively managed by the revalidation team.

The Revalidation team has a reminder letter system which now clarifies that discussion with the GMC liaison officer takes place regarding possible referral to the GMC as a consequence of unauthorised late appraisal.

6 Appraiser training

As part of the Revalidation process, every doctor will undergo a formal appraisal process each year facilitated by a trained appraiser.

The GMC recommends that each appraiser perform a maximum of 8 appraisals, minimum 6 appraisals per year. Due to our size our appraisers undertake between 4-7 appraisals a year.

All new appraisers attend formal new appraiser training with update training being delivered twice yearly in house.

7 Appraisee

Doctors upload documentation into a portfolio on RMS (Revalidation Management System) covering the GMC domains as outlined in Good Medical Practice. RMS requires the completion of pre-appraisal documentation by doctors regarding their own probity and health. Their PDP and Job plan are part of the portfolio. This portfolio is submitted to their appraiser prior to their appraisal meeting.

In each revalidation cycle, each doctor is obliged to gather patient and colleague feedback once. There is a system built into RMS to facilitate this, the feedback is discussed at appraisal, and feeds into the personal development plans.

Appraisees that are new to the Trust as supported by the Revalidation Manager and the Appraisal Lead with training on L2P and the expectations of the Trust with regards the supporting information necessary for appraisal submission.

8 Issues for Board consideration

- The number of doctors with a prescribed connection and requiring appraisal has remained the same as last year at 117 from 101 in 21/22, and 97 in 20/21.
- The Team have worked hard to maintain the appraiser numbers as trained experienced appraisers have left the Trust. This is tracked by the Revalidation team.
- Appraiser time is accounted for within job plans with a currency of 0.25 PA. The Appraisal lead currency is 0.5 PA.
- The Revalidation Support Manager, Appraisal Lead and Appraisers have managed to support doctors through the appraisal system..

11 Conclusions

Medical Revalidation is in its second cycle. The Trust has seen a significant improvement in managing doctors who do not seek approval for late/incomplete appraisals. This is thanks to the efforts of the team and is reflected in the performance data.

12. Recommendations

1. The Board of Directors is asked to receive the report noting it will be shared with the Higher Level RO.
2. To approve the ‘2023-2024 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance compliance statement’ confirming that the organisation, as a designated body, is in compliance with the regulations and to note that the ‘2022-2023 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance compliance statement’ needs CEO and Board approval. (Section 4)

Appendix A – 2023-2024 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance

NHS
England
North West
Medical Directorate
Professional Standards Team

2023-2024 Annual Submission to NHS England North West:

Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2024**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2023-2024 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Liverpool Womens NHS Foundation Trust
What type of services does your organisation provide?	Obstetric & Gynaecology, Reproductive Medicine, Neonatology and Genomic Medicine.

	Name	**Contact Information**
Responsible Officer	Lynn Greenhalgh	0151 702 4417
Medical Director	Lynn Greenhalgh	0151 702 4417
Medical Appraisal Lead	Janine Elson	0151 709 9988
Appraisal and Revalidation Manager	Lynn Johnson	0151 709 9988 ex 4268
Additional Useful Contacts		

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

No

Organisation:

Please describe arrangements for Responsible Officer to report to the Board:

This report will be presented to the Putting People First Committee and then to the Trust Board.

Date of last RO report to the Board: September

2023

Action for next year: Present the Annual

submission to Putting People First and to Trust

Board in a timely manner.

Annex A

Illustrative designated body annual board report and statement of compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance before completing.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 – Summary and
conclusion Section 4 – Statement
of compliance

Section 1: Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	To support the Deputy Medical Director once trained to take on some RO work.
Comments:	Deputy Medical Director has received Responsible Officer Training and NHSR Case Manager training.
Action for next year:	To enable the Deputy Medical Director to take on more Responsible Officer work.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes	
Action from last year:	None
Comments:	L2P is now embedded as the Trust’s Appraisal and Revalidation System. The Trust also employs a Revalidation Manager and allocated time for an appraisal lead. All Appraisers are given an allocation within their job plans.
Action for next year:	To maintain the efficiency and effectiveness of the team. The current appraisal lead will change during this year. So adequate training and handover for new staff needs to be adequate.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	None
Comments:	The revalidation manager completes this task which is held within the appraisal and revalidation system.
Action for next year:	The new Appraisal and Revalidation Officer will be trained to ensure records remain accurate.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	None
Comments:	
Action for next year:	The Medical Appraisal and Revalidation policy requires review in September 2024.

1A(v) A peer review has been undertaken (where possible) of our organisation’s appraisal and revalidation processes.

Action from last year:	
Comments:	At regional network level there is discussion around the smaller specialist Trusts supporting each other in peer review. It is hoped to progress this in 2024.
Action for next year:	To explore peer review of the organisations appraisal and revalidation processes with other specialist Trusts

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	
Comments:	Short term post graduate doctors who are not under going ARCP are treated the same as those in long term posts as regards appraisal and revalidation. The same governance structure applies. They are added and managed through the L2P appraisal/revalidation management system. Where this is not possible due to time constraints their Educational Supervisor is asked to perform an exit appraisal so that they have documentation to take forwards to their next placement and we have evidence of their work at LWH.
Action for next year	To continue with current processes that allow the Trust to support locum and short term placement doctors.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor’s whole practice for which they require a General Medical Council (GMC) licence to practise, which takes account of all relevant information relating to the doctor’s fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	
Comments:	The review of the full scope of practice of a doctor is reviewed at appraisal. A sample of appraisals are peer reviewed as quality assurance so that appraisers understand what information is required in a appraisees documentation. Information on complaints and significant events regarding the doctor is provided to them by the appraisal and revalidation manager prior to appraisal for ease of inclusion.
Action for next year:	To continue as above.

1B(ii) Where in question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	
Comments:	Appraisers review appraisal documentation prior to the appraisal and will ask for this data to be included in the current appraisal and will defer the appraisal if necessary to ensure documentation is complete and a high quality appraisal can take place. If inadequate documentation is pick up during quality assurance processes then this is brough to the attention of the appraiser and appraisee and the information requested in year, if crucial.
Action for next year:	To continue as above

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	
Comments:	There is a Medical Appraisal and Revalidation Policy in place.
Action for next year:	The Trust will review the Medical Appraisal and Revalidation Policy is in September 2024.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	
Comments:	The Trust does have adequate number of appraisers currently but will need more very soon.
Action for next year:	All appraisers complete 4-6 appraisals. As the consultant body increases in size the number of appraisers required also increases so there is a need to recruit more appraisers over the coming year.

---

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality assurance of medical appraisers or equivalent).

Action from last year:	Peer review of appraisal quality is embedded and provides good check and challenge and support for appraisers
Comments:	
Action for next year:	To ensure that these process continue as the individual in the role of appraisal lead changes.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	There are regular appraiser update meetings. The appraisal lead has set up a series of peer review sessions where appraisers review the quality of each others appraisals performance using the SUPPORT tool. In addition 1:1 sessions are given by the appraisal lead for any appraiser who is identified as needing additional training or support.
Comments:	
Action for next year:	To ensure that these process continue as the individual in the role of appraisal lead changes.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	
Comments:	Recommendations are made in a timely manner unless there are extenuating circumstances.

Action for next year:	Continue as above.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	
Comments:	The Responsible Officer e mails the doctor to let them know that they have been recommended for revalidation. If the doctor's revalidation is being deferred then the Responsible Officer will contact the doctor to see if that is what they would want as in most cases this is due to either the inability to complete their documentation for appraisal or the 360 degree assessment has not been completed. If the doctor agrees then a deferral will take place. If the doctor is not engaging with the appraisal process then there is an escalation process which includes letters from the Appraisal and Revalidation manager int eh first instance followed by contact from the appraisal lead and if engagement is still not forthcoming then the Responsible Officer will ask to meet with the doctor. If this does not get the required response then the Responsible Officer will inform the GMC that the doctor is not engaging with appraisal and revalidation. If the doctor is not able to meet with the RO then the reason for this will be recorded prior to referral to the GMC.
Action for next year:	To continue as above

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	
Comments:	The Trust creates and environment to deliver effective clinical governance for doctors by having the following systems in place. Concerns from patients can be raised through PALS or patient complaints or direct feedback. Concerns from colleagues can be made by speaking with the doctor's line manager, clinical director or directly to the

	Responsible Officer/Medical Director or Deputy Medical Director. Post Graduate doctors can raise concerns via their educational supervisor and medical students through their medical supervisor. Medical Students also give feedback via the University and Post Graduate doctors via the GMC trainees survey. The Trust has 2 Freedom to Speak up Guardians, one of whom is a doctor to help staff to raise concerns. The Trust uses the Ulysses system for incident reporting and this can be triangulated with complaints and serious incidents. Each practitioner is provided with a summary of complaints and serious incident prior to appraisal. The Trust manages any issues raised with compassion. The Trust has adopted a Fair and Just culture which supports a compassionate response. All practitioners, where a concern has been raised about their practice, are offered help and support from Occupational Health and psychological support from Staff Support Services. If appropriate they are offered a colleague for peer support. Significant concerns are discussed with PPA (Practitioner Performance Association) for independent advice and guidance. The Trust endeavours to learn from all clinical incidents in line with PSIRF which has been implemented in the Trust and is currently being review to assess its effectiveness.
Action for next year:	To continue as above.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	

Comments:	Concerns from patients can be raised through PALS or patient complaints or direct feedback. Concerns from colleagues can be made by speaking with the doctor’s line manager, clinical director or directly to the Responsible Officer/Medical Director or Deputy Medical Director. Post Graduate doctors can raised concerns via their educational supervisor and medical students through their medical supervisor. Medical Students also give feedback via the University and Post Graduate doctors via the GMC trainees survey. The Trust has 2 Freedom to Speak up Guardians, one of whom is a doctor to help staff to raise concerns. The Trust uses the Ulysses system for incident reporting and this can be triangulated with complaints and serious incidents. Each practitioner is provided with a summary of complaints and serious incident prior to appraisal.
Action for next year:	To continue as above

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	
Comments:	Each doctor is sent a Governance report with details of relevant complaints and compliments. They are also given details of research projects and audits they have been involved. Where performance indicators are available on an individual doctor these are also provided. Doctors are expected to provide some of their own information which may not be available to the Appraisal and Revalidation Team as not all evidence can be collected centrally. Where it can be that evidence is given to the doctor.
Action for next year:	

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	
Comments:	The Trust's Policy reflects the national Maintaining High Professional Standards in the NHS. The policy when reviewed this year will also incorporate recent changes to the GMC publication on Good Medical Practice.
Action for next year:	The Trusts Maintaining High Professional Standards Policy has a review date of September 2024 so will be reviewed accordingly.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	A quarterly Responsible Officer report is presented to Putting People First Committee which is a Board Committee. The above information was included in that report for 2022-23.

Comments:	
Action for next year:	This reporting will be continues for 2024-25.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	
Comments:	MPET forms are used for doctors transferring between hospitals. If concerns are raised regarding a doctor working at the Trust who works elsewhere then this is shared with the Responsible Officer of the other organization.
Action for next year:	To continue with this work.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (reference GMC governance handbook).

Action from last year:	
Comments:	The Trust has adopted a 'Fair and Just' culture with training for this being mandatory across the Trust. The principles of this are used in responding to concerns about practitioners. The Trust has a 'Maintaining High Professional Standards' Policy which clearly defines the governance process for responding to concerns about a doctors practice. The Trust has used either external practitioners with protected characteristics or colleagues within the Trust with protected characteristics to quality assure processes around responding to concerns about a practitioner. Significant concerns are discussed with PPA (Practitioner Performance Association) for independent advice and guidance. PPA are also reporting on the characteristics of those doctors where we have discussed concerns to them. This data will be reported to Putting People Fist Committee.

Action for next year:	To continue as above

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, for example, from national reviews, reports and enquiries, and integrate these into the organisation’s policies, procedures and culture (give example(s) where possible).

Action from last year:	
Comments:	All national safety alerts are circulated across the Trust. All newly issued NICE guidance is reviewed by the deputy medical director and those applicable to the Trust are applied and monitored. Within the maternity service Ockenden and East Kent requirements and learning is monitored and incorporated into service developments via the maternity transformation programme and wider within the Trust via the Safety and Effectiveness Sub committee. Learning and actions from the Cumerlegde report was also monitored via the Safety and Effectiveness Sub committee. The Trust has taken the opportunity offered to take part in the Safety and culture review as part of the national maternity safety program.
Action for next year:	To continue as above

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (reference Messenger review).

Action from last year:	N/A
Comments:	The Trust works closely with regulators engaging in informal dialogue where possible. The Trust shares good practice and adopts good practice where this is shared. The Trust strives to ensure consistency of understanding of organizational goals and values across all professions, for example, our leadership programmes are multidisciplinary.
Action for next year:	To engage with any national or regional learning that is shared regarding the Messenger Review.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	
Comments:	All recruitment undertaken either directly or via agencies is fully compliant with the NHS Pre-Employment Checks Standards. If all pre-employment checks are not complete at the date of commencement of a post then a formal written risk assessment will be completed by the HR Business partner and saved on file whilst the recruitment team complete the checks.
Action for next year:	To continue as above

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	
Comments:	The Trust has commenced a number of Trustwide improvement plans a number of which are addressing culture. For example a Trustwide 'Safety Culture' and Anti Racism plan. The Trust is also undertaking a Deteriorating patient Collaborative to drive higher standard of care and to understand the blockers to that. The Trust has signed the Sexual Safety Charter and has actively had workshops to understand how this will work in practice. The Trust has adopted and is embedding quality improvement methodology.
Action for next year:	To support the work as described above.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	
Comments:	The Trust monitors ED&I data pertaining to workforce primarily through the WRES data set which is reported to our People Committee and Board- medical staff are highlighted as a staff group within this report. The Trust also has in place a BAME staff network which is chaired by a clinician. The Trust has commenced a positive discrimination scheme whereby staff from BAME backgrounds will be automatically shortlisted if they meet the essential criteria of the role. The Trust has adopted and is embedding Fair and Just Culture methodology. The Trust has 2 Freedom to Speak Up Guardians one of which is a doctor.
Action for next year:	To continue as above

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	
Comments:	The Trust has adopted and is embedding a fair and Just Culture. This is embedded when concerns are raised about a doctors practice. The Trust also has 2 Freedom to Speak up Guardians including one doctor. The Guardians report to Putting People First on a regular basis. The Trust has a clear policy on raising concerns which includes whistleblowing. The Trust undertakes ‘The Big Conversation’ twice a year where senior leaders go to all areas of the Trust to seek feedback on there are of the Trust. What works well and what does not. The senior leaders tend to visit the same areas of the Trust each year and feedback on what happened to issues raised the previous visit.
Action for next year:	To continue with the above.

1F(iv) Mechanisms exist that support feedback about the organisation’ professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	
Comments:	All doctors that undergo a formal disciplinary process are assigned a non executive director to whom they can raise concerns.
Action for next year:	To seek feedback from all doctors that have undergone a formal disciplinary investigation over the last 3 years to help to improve the process.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	
Comments:	The Trust is working with NHSR to review its data on doctors where concerns regarding their practice has been raised as regards country of primary medical qualification and protected characteristics as defined by the equality act.
Action for next year:	This data will be presented to the Putting People First Committee.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	
Comments:	The Responsible Officer, Appraisal Lead and Appraisal and Revalidation manager all attend network meetings.
Action for next year:	To ensure attendance at Network meetings

Section 2 – metrics

Year covered by this report and statement: 1 April 2023 to 31 March 2024.

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	117

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	102
Total number of appraisals approved missed	2
Total number of unapproved missed	13 – 11 new starters One doctor on sabbatical One late appraisal who has now completed

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	23
Total number of late recommendations	2
Total number of positive recommendations	17
Total number of deferrals made	6
Total number of non-engagement referrals	1
Total number of doctors who did not revalidate	5

2D – Governance

Total number of trained case investigators	5
Total number of trained case managers	2
Total number of new concerns registered	4

Total number of concerns processes completed	3
Longest duration of concerns process of those open on 31 March	14 weeks (from instigation of investigation)

Median duration of concerns processes closed	24 weeks (from instigation of investigation until final resolution)
Total number of doctors excluded/suspended	0
Total number of doctors referred to GMC	0

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	23
Number of new employment checks completed before commencement of employment	22 (1 risk assessment prior to commencement of employment whilst awaiting final information)

2F – Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Good progress has been made and standards of appraisal have been maintained.
Actions still outstanding
Current issues
Change of personnel within the team is anticipated this year. There will need to be a focus on maintaining standards during handover to the new team.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1): *Only new actions are copied below*
1A (i) To enable the Deputy Medical Director to take on more Responsible Officer work. 1A (ii) To maintain the efficiency and effectiveness of the team. The current appraisal lead and Appraisal and Revalidation officer will change during this year. So adequate training and handover for new staff needs to be adequate. 1A (iv) The Medical Appraisal and Revalidation policy is require review in September 2024. 1A (v) To explore peer review of the organisations appraisal and revalidation processes with other specialist Trusts 1B (iii) The Trust will review the Medical Appraisal and Revalidation Policy is in September 2024. 1B (iv) All appraisers complete 4-6 appraisals. As the consultant body increases in size the

number of appraisers required also increases so there is a need to recruit more appraisers over the coming year. 1D (ix) To engage with any national or regional learning that is shared regarding the Messenger Review. 1F (iv) To seek feedback from all doctors that have undergone a formal disciplinary investigation over the last 3 years to help to improve the process. 1F (v) This data will be presented to the Putting People First Committee. 1G To ensure attendance at Network meetings
Overall concluding comments (consider setting these out in the context of the organisation’s achievements, challenges and aspirations for the coming year):

Section 4 – Statement of compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body	

Name:	
Role:	
Signed:	
Date:	

Liverpool Women's
NHS Foundation Trust

Self-Assessment Review Document Approval for Submission to NHSE

Author

Linda Watkins Director of Medical Education

Date 2nd October 2024 V2

Executive Summary

The Quality Framework identifies the standards that organisations are expected to have in place to provide a quality learning environment for the learners they have responsibility for. Every organisation is expected to have assessed which standards are fully or partially in place via the use of an annual **self-assessment review** (SAR). There is an expectation, via the **Education Funding Agreement** (EFA), that organisations will refresh their SAR every year as good practice.

NHS England (NHSE) expect the governance of clinical education and training to directly link to the Placement Provider Board given both the importance of ensuring all learners and educators are fully supported as well as the significant financial investment made by NHSE each year via the EFA.

The Director of Medical Education is requesting approval of the Board for submission to NHSE on 31st October 2024.

Report

SAR Report

In line with the previous Health Education England (HEE) national quality framework, all placement providers are required to complete an annual Self-Assessment Review (SAR).

16. Section 6.27

The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to knowledge and library specialists.

We have ongoing challenge by the university of Liverpool that we should provide a protected undergraduate rest area for medical students. In order to achieve the Medical School quality requirements for undergraduate medicine in the trust. The MEM and Undergraduate dean have again asked permission from the trust to convert one of our valuable training rooms into a Medical Students rest room. This will however put further pressure on rooms available for training. All students listed above also use either rest rooms in clinical areas or library and conservatory as rest areas.

Submission

The SAR is an online survey. For this to be approved by the Board, we have completed a word version of the survey for review and signature by the Medical Director our Board level representative for education.

Please see the report in its entirety presented with this document.

The board is asked to support the submission of the Self-Assessment Report to Health Education England.

Glossary of terms and abbreviations used in the SAR

Abbreviation	Term	Explanation
ACP	Advanced Care Practitioners	Learners from a nursing or Midwifery background who complete additional training to work to work at an advanced level
CPD	Continuing Professional Development	Ongoing learning for qualified staff in the NHS.
CMO	Chief Medical Officer	Head doctor at an NHS trust
DDON	Deputy Director of Nursing	Has portfolio responsibility for Nursing and Midwifery training in the trust on behalf of the Chief Nurse
DME	Director of Medical Education	Responsible for Education across the trust, with a focus on Medical Education. Chairs Education Governance Group
ED&I Lead	Equality Diversity and Inclusion	Lead person for ED&I in the trust
EFA	Education Funding Agreement	Funding to the trust to support educational activity from NHSE. Was previously Learning Development Agreement (LDA)
GMC	General Medical Council	Responsible for licensing and regulation of doctors, produce annual survey of training
HEE	Health Education England	Previous title of NHSE education section
ICB	Integrated Care Board	Local organisation responsible for Patient Care.
HEI	Higher Education Institution	Unusually a university overseeing training of students on placement at the trust
Lead for LO &D	Lead for Learning and Organisational Development	Leads Mandatory and Developmental training across the trust, manages Non-medical training budgets and Nursing and Midwifery CPD
LTFT	Less than full time training (or trainees)	Students who work or train part time
MDT	Multi Disciplinary Training	Training involving different professions who work together
MEM	Medical Education Manager	Supports undergraduate and postgraduate medical training, manages postgraduate

		study leave budget and Postgraduate Centre
NHS England WT&E quality team	**NHS England Workforce Training and Education Team**	**Oversee the EDA and SAR. Provide intelligence to NHS England regarding quality of training**
MUT	**Making Up Time**	**A term used locally to describe additional placement time to allow the student nurse or midwife to reach the mandated number of clinical hours usually lost due to sickness or childcare issues**
NETS	**National Education and Training Survey**	**Survey of all learners in the NHS produced by NHS England**
PA	**Practice Assessor**	**Qualified Nurse or Midwife who has been trained to assess students.**
PA	**Physicians Associate**	**Biomedical postgraduate who has completed a 2-year course and licensing exam to enable then to work along side the medical workforce. They must always be supervised by a consultant.**
PAD	**Practice Assessment Documents**	**A overarching Document used to record competency and training in Nursing**
PARE	**Practice Assessment Record and Evaluation**	**A record used to record training for most Nursing and Midwifery Students**
PODEG	**People and Organisational Development Executive Board**	**Liverpool Women's Workforce Committee**
PSW	**Professional Support and Wellbeing**	**Service provided by NHSE to help support learners with additional needs**
RAPP	**Reasonable Adjustment Placement plan**	**This is a plan which outlines adjustments which must be put into place in the placement to support the learner.**
Resident		**New (to the UK) term for doctors in training posts. Was previously Post Graduate Doctors in Training (PGDiT)**
SAR	**Self-Assessment Review**	**Annual review of quality of training submitted by all trusts to NHSE Also referred to as SA in the report**
SLEC- LWH	**Self Learning Environment Charter at Liverpool Women's Hospital**	**The Safe Learning Environment Charter supports the development of positive safety cultures and continuous learning across all learning environments in the NHS.**

NHS England Self-Assessment for Placement Providers 2024

1.

Introduction

The NHS England Self-Assessment (SA) for Placement Providers is a process by which providers carry out their own quality evaluation against a set of standards. Providers are asked to complete this online form indicating where they have or have not met the standards as set out in the SA. There is the opportunity under most questions to provide comments to support your answer.

Completing the Self-Assessment

- **Your region and trust name has been pre-populated - do not amend this**.
- The SA saves your progress at the end of each page - **click save** and next page button.
- **You can amend/change your responses any time prior to completing the final submission** box in section 12 (click save after any changes).
- Anyone completing any part of the SA can do so using the same link supplied by your regional NHS England WT&E quality team. **Only one person should use the link at any one time**. You must close the weblink for someone else to access the survey to avoid overwriting previous entries.
- **To print the SA**, prior to/after submission, skip through to the last page and use the print button. Only questions with responses will print.
- You can move around the SA without being forced to complete questions/sections before moving to another section. **Save each update even if only partially completed**.
- **All sections are mandatory**, please undertake a final check that every question has been completed prior to submission. If a question/section has not been answered after submission, the SA will be returned to you for completion.
- Where free text comments are available the word or character limits are shown within each question.

- The SA does not support the upload of attachments. If we require any evidence as part of your submission, we will contact you separately after submission.

****This submission should be completed for the whole organisation. It's important that those responsible for each section feed into and contribute to the response.****

Sections of the Self-Assessment

Section 1: Provide details of (up to) 3 challenges within education and training that you would like to share with us.

Section 2: Provide details of (up to) 3 achievements or good practice within education and training that you would like to share with us.

Section 3: Confirm your compliance with the obligations and key performance indicators of the NHS Education Funding Agreement (EFA). This should be completed once on behalf of the whole organisation.

Section 4: Confirm your compliance with the Quality, Library, Reporting Concerns, and Patient Safety training obligations and key performance indicators of the NHS Education Funding Agreement (EFA). This should be completed once on behalf of the whole organisation. It is important that those responsible for these areas feed into this section.

Section 5: Confirm your policies and processes in relation to Equality, Diversity and Inclusion. Should normally be completed by your placement provider EDI Lead.

Section 6 - 11: Self-assess your compliance against the Education Quality Framework and Standards. Each section must be completed once on behalf of the whole organisation. There are opportunities to share good practice examples. You are asked to confirm whether you meet the standard for all professions / learner groups or provide further details where you do not meet or partially meet the standard(s). Where you are reporting exceptions, you are asked to provide the professions impacted and a summary of the challenges you face in meeting the standard.

Section 12: Final sign-off.

Further Questions

If you have any queries regarding the completion of the SA, please review the FAQ document. If you still require further information, you can contact your regional NHS England WT&E quality team.

2 – 9 Region and Provider Selection – Do Not Amend

Please do not amend the region you have been allocated to. If you feel this is incorrect please continue to complete the SA and email your regional NHS England WT&E quality team.

☐ East of England
☐ London
☐ Midlands
☐ North East and Yorkshire
☑ North West
☐ South East
☐ South West

10. Training profession selection

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

2. Please select from the list below those professional groups your organisation currently train, please select all those which apply. Please select only one option for each row.

	Yes we train in this professional group	N/A we do NOT train in this professional group
Advanced Practice	☑	☐
Allied Health Professionals	☑	☐
Dental	☐	☑
Dental Undergraduate	☐	☑

	Yes we train in this professional group	N/A we do NOT train in this professional group
Healthcare Science	☑	☐
Medical Associate Professions	☑	☐
Medicine Postgraduate	☑	☐
Medicine Undergraduate	☑	☐
Midwifery	☑	☐
Nursing	☑	☐
Paramedicine	☑	☐
Pharmacy	☑	☐
Psychological Professions	☐	☑
Social Workers	☐	☑

11. Section 1 - Provider challenges

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to provide details of (up to) 3 challenges within education and training that you would like to share with us. Please consider whether there are any challenges which impact your ability to meet the education quality framework standards. Please select the category which best describes the challenge you are facing, along with a brief description/narrative of the challenge (*the character limit is set at 1000 characters*). In the event you cannot find an appropriate category select other and add the category at the start of your narrative.

3. Example 1: Please choose the most appropriate category for your challenge.

☐ Apprenticeships

☑ Burnout / Wellbeing

☑ COVID / Post COVID return to norms

☐ Culture

☐ Curricula / Training Standards

☐ Educational Governance & Strategy

☐ Funding - Requirements / Unpredictability / Timeliness

☑ HEI Issues/ Processes

☐ Increase in LTFT / Reasonable Adjustment Requests

☐ IT Systems

☐ NHS England Issues/ Processes

☐ Other

☐ Placement Management / Capacity

☐ Supervisors / Educators (investment)

☐ Supervisors / Educators (recruitment / retention)

☐ Supervisors / Educators (training)

☐ Training affected by service pressures (cannot release staff)

☐ Training Equipment / Systems

☐ Training Space / Facilities

☐ Trust Merger or Reconfiguration

☐ Workforce Challenges (recruitment / retention)

Please provide your narrative in the comments box

Students requiring additional support

Across both nursing students and post graduate doctors we have noted an increase in those who require increased support for training. For example there has been an increase in student RAPP's (6 last academic year to 14 this year), which most of the time state that the student cannot work nights. Some HEI's share an adequate amount of information so that we can best support the student when on placement, whilst other partners just state on their RAPP 'no nights' with no supporting evidence. Within Medical specialities we have seen an impact on Postgraduate Doctors who were in the final years of training or foundation roles during Covid require increased pastoral support at ST 2- 4 level. Triggers have included when Residents have been faced with working again in an acute area such as theatres or Neonatal ITU. Psychological support has been provided by the trusts in house psychology service as well as signposting to PSW type services.

We have also seen a recent increase in unprofessional behaviours on placement amongst both nursing and midwifery students, these range from lack of engagement with PARE documentation and assessment processes, inappropriate use of social media and general poor professional conduct when on shift (bad language, over familiarity with staff, vaping in clinical areas, uniform policy not adhered to). This leads to an increase in PEF workload and also future workforce challenges.

4. Example 2: Please choose the most appropriate category for your challenge.

☐ Apprenticeships
☐ Burnout / Wellbeing
☐ COVID / Post COVID return to norms
☐ Culture
☐ Curricula / Training Standards
☐ Educational Governance & Strategy
☐ Funding - Requirements / Unpredictability / Timeliness
☐ HEI Issues/ Processes
☑ Increase in LTFT / Reasonable Adjustment Requests
☐ IT Systems
☐ NHS England Issues/ Processes
☐ Other
☐ Placement Management / Capacity
☐ Supervisors / Educators (investment)
☐ Supervisors / Educators (recruitment / retention)
☐ Supervisors / Educators (training)
☑ Training affected by service pressures (cannot release staff)
☐ Training Equipment / Systems
☑ Training Space / Facilities
☐ Trust Merger or Reconfiguration
☐ Workforce Challenges (recruitment / retention)

Please provide your narrative in the comments box

Student practice hour deficits and Making Up Time (MUT) placement requests.

Attendance management-student absences from sickness and also booking holidays in placement blocks seem to be on the increase, this impacts capacity management and also the students assessments which then have to be managed accordingly. The number of midwifery students needing to add on months of placement at the end of 3rd year is on the increase, this then impacts the next academic years capacity. Within nursing we are seeing an increase in requests for MUT placements at the end of blocks, this are often not accompanied by any practice assessment documentation (PAD) which leads to students not maintaining professionalism as they then lack accountability.

5. Example 3: Please choose the most appropriate category for your challenge.

- ☐ Apprenticeships
- ☐ Burnout / Wellbeing
- ☑ COVID / Post COVID return to norms
- ☑ Culture
- ☑ Curricula / Training Standards
- ☑ Educational Governance & Strategy
- ☐ Funding - Requirements / Unpredictability / Timeliness
- ☐ HEI Issues/ Processes
- ☐ Increase in LTFT / Reasonable Adjustment Requests
- ☐ IT Systems
- ☐ NHS England Issues/ Processes
- ☐ Other
- ☐ Placement Management / Capacity
- ☐ Supervisors / Educators (investment)
- ☐ Supervisors / Educators (recruitment / retention)
- ☐ Supervisors / Educators (training)
- ☐ Training affected by service pressures (cannot release staff)

☐ Training Equipment / Systems

☐ Training Space / Facilities

☐ Trust Merger or Reconfiguration

☐ Workforce Challenges (recruitment / retention)

Please provide your narrative in the comments box

GMC Survey for GPs
The trust is disappointed with the negative feedback received from GP trainees from this years GMC survey. This is despite a number of actions being taken including taking them off nights. The nature of GP trainees means they may have had very limited experience of O&G prior to coming to LWH making the experience challenging. However, further feedback was given by trainees in post at that time and there have been further actions which have been implemented since August. This includes protected self-development time, an increase in in house educational teaching opportunities and renewing the mentor system. We also provided supported induction for a further week after formal induction. We are seeking feedback from the School of GP regarding how we can continue to work towards improving their experience. We will continue to monitor this with the NETS and GMC survey. The DME is also keen to look at whether a longer period of enhanced induction is needed for GP trainees.

12. Section 2 - Provider achievements and good practice

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to provide details of (up to) 3 achievements within education and training that you would like to share with us. Please select the category which best describes the achievement you wish to share, along with a brief description/narrative (*the word limit is set at 1000 characters*). In the event you cannot find an appropriate category select other and add the category at the start of your narrative.

6. Example 1: Please choose the most appropriate category for your achievement.

☑ Collaboration / Partnerships

☐ Covid - Response / Catch up

☐ CPD

☐ Culture

☐ Development of TEL Provision
☐ Improved Facilities
☐ Increased SIM for Training
☐ Innovative Training / Course Development
☐ Learner / Trainee Support or Wellbeing
☐ Multi-professional Initiatives
☐ New/Improved Strategy or Governance
☐ Other
☑ Placement Capacity / Expansion
☑ Quality - Improvement Initiatives, response to data, positive feedback
☐ Recruitment / Retention Initiatives
☐ Supervisors / Educators (investment)
☐ Supervisors / Educators (training)

Please provide your narrative in the comments box

A trust wide review of training capacity showed an increased number of Postgraduate Doctors in Training (Residents) were required to enable the trust to meet its requirement for training (both in house and local essential), mitigate the changes in service needs and the increase in less than full time working. The CMO was successful in getting permission from the ICB to increase spending on trust doctors. These posts are either joint with the University of Liverpool or include an element of specialist Out of programme experience. The majority of these posts are in place as of August 24. The trust has also been able to expand its ACP programme to increase capacity in the work force across both Maternity and Gynaecology.

We will monitor the impact of these using the staff survey/ NETS and GMC survey in the next 12 months.

7. Example 2: Please choose the most appropriate category for your achievement.

☑ Collaboration / Partnerships
☐ Covid - Response / Catch up
☐ CPD
☐ Culture

☐ Development of TEL Provision

☐ Improved Facilities

☐ Increased SIM for Training

☐ Innovative Training / Course Development

☐ Learner / Trainee Support or Wellbeing

☐ Multi-professional Initiatives

☐ New/Improved Strategy or Governance

☐ Other

☐ Placement Capacity / Expansion

☐ Quality - Improvement Initiatives, response to data, positive feedback

☑ Recruitment / Retention Initiatives

☑ Supervisors / Educators (investment)

☐ Supervisors / Educators (training)

Please provide your narrative in the comments box

We have increased both maternity and nursing capacity over the last few years, and this has led to new HEI partnerships with Chester (MW) and Liverpool University (nursing). This will promote LWH as a potential future employer and support workforce planning.

Over the last year at LWH we have secured a further PEF post which is funded by the increased student tariff as a result of increasing capacity. This will allow us to better support students out in practice and ensure quality of placements and exposures is maintained.

8. Example 3: Please choose the most appropriate category for your achievement.

☐ Collaboration / Partnerships

☐ Covid - Response / Catch up

☐ CPD

☑ Culture

☐ Development of TEL Provision

☐ Improved Facilities

☐ Increased SIM for Training

☑ Innovative Training / Course Development

☐ Learner / Trainee Support or Wellbeing

☑ Multi-professional Initiatives

☐ New/Improved Strategy or Governance

☐ Other

☐ Placement Capacity / Expansion

☑ Quality - Improvement Initiatives, response to data, positive feedback

☐ Recruitment / Retention Initiatives

☐ Supervisors / Educators (investment)

☐ Supervisors / Educators (training)

Please provide your narrative in the comments box

There are numerous projects at LWH that continue to run to support student wellbeing, enhance learning experiences and improve working culture.

SLEC- LWH are a pilot site for this NHSE project which aims to improve learning environment cultures.

Practice Assessor model within maternity- this allows continuity of assessments for students and is recognised as gold standard in the region as the small team allows the process to be quality assured. The quality and quantity of PS feedback has also improved over the last 12 months following staff training and this also supports students in recognising their own improvements and also areas needed for development. We also have a SOP to support this timely submission of feedback.

Yearlong shift templates- midwifery students are provided with their shifts for the whole academic year so they can plan work life balance/childcare etc. This have also been incorporated into nursing placements this year so that students have their whole block of shifts when at LWH.

MDT student teaching sessions- these are ran in house based on assessment feedback on topics that student's identify as requiring more exposure to. These sessions are delivered by the PEFs and also subject matter experts and are offered to all students at LWH.

13. Section 3 - Contracting and the NHS Education Funding Agreement

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to confirm your compliance with the obligations and key performance indicators set out in Schedule 3 of the **NHS Education Funding Agreement (2024-27)**. This should be completed once on behalf of the whole organisation. Please select only one option for each row. There is an option to provide additional comments to support your answer, this is restricted to 2000 characters.

9. Please confirm your compliance with the obligations and key performance indicators set out in Schedule 3 of the NHS Education Funding Agreement (EFA).
This should be completed once on behalf of the whole organisation.
Please select only one option for each row.

	Yes	No
There is board level engagement for education and training at this organisation.	☑	☐
The funding provided via the NHS Education Funding Agreement (EFA) to support and deliver education and training is used explicitly for this purpose.	☑	☐
We undertake activity in the NHS Education Funding Agreement which is being delivered through a third party provider.	☐	☑
The Provider or its sub-contractor did	☐	☑

	Yes	No
not have any breaches to report in relation to the requirement of the NHS Education Finding Agreement (EFA)		
We are compliant with all applicable requirements of the Data Protection Legislation and with the requirements of Schedule 5 of the NHE Education Funding Agreement.	☑	☐
The Provider did not have any health and safety breaches that involve a learner to report in the last 12 months.	☑	☐
The organisation facilitates a cross-system and collaborative approach, engaging the ICS for system learning.	☑	☐
We have collaborative relationships with our	☑	☐

	Yes	No
stakeholders (e.g. education providers) which provide robust mechanisms to deliver agreed services.		

If ‘yes’ please add comments to support your answer; if ‘no’ please provide further detail:

The trust at board level is active in collaborating with the ICBs review of women’s services across Liverpool. There has been a recent appointment of joint Chief executive with LUFT. While LWH remains a separate entity there has been a reorganisation of Board and Governance structure over the last 6 months within the trust to align with a more streamlined risk based approach to governance. As such the DME participates in the People Organisational Development Executive Board as does the LD&O lead. The board retains engagement and oversight of key documents and intelligence such as the SAR and reports on National surveys.

The funding provided via the NHS Education Funding Agreement (EFA) to support and deliver education and training is used explicitly for this purpose.

Overall the trust can demonstrate how educational resources are allocated and used. EFA monies are identified by finance and managed as a separate budget. Reports are received at Education Governance Group. While some monies can be clearly identified as direct use for education, such as postgraduate centre funding, Nursing and Midwifery CPD (sits in LD&O) and undergraduate Educational supervision. Others are allocated to the division supporting the learners to fund support for education such as postgraduate educational supervision or training lists. This spending can be less clear; however work is ongoing to improve transparency. The trust has increased its commitment to Educational supervision over the past year to align with neighbouring trusts and NHSE’s expectation of 0.25 per trainee and we hope this will be managed via the medical education budget in the future.

There is some income that has been held centrally from undergraduate nursing and midwifery. The DDON has ongoing meetings with finance to identify how this money will be spent.

10. Please provide the name and email address of the board named individual responsible for education and training.

Name	Lynn Greenhalgh Medical Director
Email Address	Lynn.greenhalgh@lwh.nhs.uk

11. Signature

☐ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Dr Linda Watkins

Linda.Watkins@lwh.nhs.uk

Director of Medical Education Liverpool Women’s NHSFT

NB Completed in conjunction with practice educator facilitators Laura Stoddart and Sarah Parnell.

14. Section 4 - Education Quality

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to confirm your compliance with the quality, library, reporting concerns and patient safety training obligations and key performance indicators of the **NHS Education Funding Agreement (EFA)**. This should be completed once on behalf of the whole organisation. It is important that those responsible for these areas are able to feed into this section. There is an option to provide additional comments to support your answer, this is restricted to 1000 characters.

12. Can you confirm as a provider that you...
Please select only one option for each row.

	Yes	No	N/A
We are aware of the requirements and process for an education quality intervention, including who is required to attend.	☑	☐	☐
We are reporting and engaging with the requirements and process to escalate issues, in line with NHS England’s	☑	☐	☐

	Yes	No	N/A
education concerns process.			
Have developed and implemented a service improvement plan to ensure progression through the Quality and Improvement Outcomes Framework for NHS Funded Knowledge and Library Services.	☑	☐	☐
Has the provider been actively promoting, to all learners, use of the national clinical decision support tool funded by NHS England?	☑	☐	☐
Have a Freedom to Speak Up Guardian and they actively promote the process for raising concerns through them to their learners.	☑	☐	☐
Have a Guardian of Safe Working (if postgraduate doctors in training are being trained), and they	☑	☐	☐

	Yes	No	N/A
actively promote the process for raising concerns through them to their learners.			
Are aware of the Safe Learning Environment Charter (SLEC)	☑	☐	☐
Are actively implementing and embedding the SLEC multi-professionally.	☑	☐	☐

If ‘yes’ please add comments to support your answer; if ‘no’ please provide further detail:

Quality and Improvement Outcomes Framework – Implementation Plan

The Librarian and his line manager have developed and implemented a service improvement plan. Key developments are: updated information on library services and resources available on the Trust’s new Intranet. Addition of a link to BMJ best Practice on the Trust’s Electronic Patient Record (Digicare)

BMJ Best Practice

We have a good supply of leaflets and flyers in the library on BMJ Best Practice. The librarian regularly attends induction sessions for new staff and students on placement and BMJ Best Practice is always promoted during these sessions. We also regularly promote BMJ Best Practice through our communications systems. SLEC- LWH are a pilot site for this NHSE project which aims to improve learning environment cultures.

We actively use feedback such as NETS, Staff survey and GMC survey as well as patient feedback to develop ways to improve learning environment and experience.

13. As an organisation, have you been referred to a regulator for education and training concerns in the last 12 months (with or without conditions) (e.g., GMC, GDC, HCPC, NMC, etc)

Note: we are not seeking information about the referral of an individual learner.

☑ **We have not** been referred to a regulator

☐ **We have** been referred to a regulator and the details are shared below.

If you have received conditions from a regulator please provide more details including the regulator, the profession involved and a brief description

14. Did you actively promote the National Education and Training Survey (NETS) to all healthcare learners?

☑ Yes

☐ No

Please briefly describe your process for encouraging responses including your organisations response rate for the 2023 NETS.

Reminder emails are sent to all learners along with messages on the Trainees Teams channel.

15. Have you reviewed, at Board Level, and where appropriate, taken action on the outcome of the results of the National Education and Training Survey (NETS).

☑ Yes

☐ No

Please provide a brief description of the action you have taken as a result; if 'no' please provide further details including your plans to use the NETS data for quality improvement activity in the future:

Reviewed the sexual safety charter and implemented information for learners and new staff at induction.

Increased numbers of Postgraduate doctors to enable more opportunities for non-service based learning.

Increased Educational supervision time for postgraduate medical training posts and appointed a new PEF for nursing to increase capacity in the Nursing and midwifery Practice facilitator team.

16. 2024's NETS will be open from 1 October 2024 until 26 November 2024. How will your organisation increase their NETS response rate for 2024?

We will continue to promote to all relevant learners. If NHSE are able to give us ID for non-responders we will contact them directly to encourage them to complete the survey if appropriate.

17. Patient Safety and the promotion of a Patient Safety culture is integral to the Education Quality Framework. Please provide the following information:

Name and email address of your Board representative for Patient Safety	Dianne Brown dianne.brown@lwh.nhs.uk
Name and email address of your non executive director representative for Patient Safety	Jackie Bird Jackie.bird@lwh.nhs.uk
Name and email address of your Patient Safety Specialist/s	Deborah Ward Deborah.ward@lwh.nhs.uk
What percentage of your staff have completed the patient safety training for level 1 within the organisation (%)	87.74% of all staff on 22nd Sept 24

18. Signature

☑ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Dr Linda Watkins

Linda.Watkins@lwh.nhs.uk

Director of Medical Education Liverpool Women's NHSFT

15. Section 5 - Equality, Diversity and Inclusion

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks about your policies and processes in relation to equality, diversity and inclusion and should normally be completed by your nominated EDI lead. There is an option to provide additional comments to support your answer, this is restricted to 1000 characters.

19. Please confirm whether your organisation has an Equality, Diversity and Inclusion Lead (or equivalent):

☑ Yes

☐ No

If 'yes' please add comments to support your answer sharing details of governance and links with education and training alonside the nominated name of your EDI lead for education and training; if 'no' please provide further detail

Lisa Shoko is the Trust's EDI and Anti-Racism Lead

Diane Martin is the Trust's Culture and Inclusion Lead

EDI reports are presented at the People and OD Executive Group. Lisa is also invited to attend the Education Governance Committee.

20. Please confirm that you liaise with your Equality, Diversity and Inclusion Lead (or equivalent) to...
Please select only one option for each row.

	Yes	No
Ensure reporting mechanisms and data collection take learners into account?	☑	☐

	Yes	No
Implement reasonable adjustments for learners with a disability?	☑	☐
Ensure policies and procedures do not negatively impact learners who may have a protected characteristic(s)?	☑	☐
Ensure International Graduates (including International Medical Graduates) receive a specific induction into your organisation?	☑	☐
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	☑	☐
Ensure a policy is in place to manage Sexual Harassment in the Workplace?	☑	☐
Do you have initiatives to support reporting of sexual harassment?	☑	☐
Has your organisation signed up to the NHS England Sexual Safety in	☑	☐

	Yes	No
Healthcare - Organisational Charter?		
Does your organisation have a designated sexual safety lead, such as a Domestic Abuse and Sexual Violence (DASV) lead?	☑	☐

If ‘yes’ please add comments to support your answer; if ‘no’ please provide further detail:

1. Learners are included as “staff”. We currently do not receive ED&I data for learners attending placements from external HEI’s.
2. Where we are aware of adjustments needed, they are implemented. Additionally, the Culture and Inclusion Lead is introducing a Reasonable Adjustments Passported for staff which will be added to the Trust’s onboarding process.
3. EIAs are carried out on all policies to the best of our ability.
4. Internationally educated staff/graduates receive an Induction and a period of shadowing and supernumerary work. We use the GMC and NHS England resources to support Internationally educated doctors.
5. FTSUG- Freedom to speak up allows anonymous reporting and we have an ongoing campaign in the organisation promoting FTSUG.
   We have a Ulysses reporting system to report all incidents.
   Staff are also encouraged to report incidents to their managers.
   ECI/HR support mechanisms are also in place.
6. We have a robust Equality and Human Rights Policy and EIAS.
7. LWH is signed up to the NHS England Sexual Safety in Healthcare-Organisational Charter and have a Domestic Abuse and Sexual Violence Lead – Deborah Ward
   Deborah.ward@lwh.nhs.uk

21. How does your organisation manage sexual harassment reports?

the trust has implemented a sexual safety referral form where any individual who has witnessed or been subjected to sexual misconduct can report this and seek support.

The trust is planning to adopt a New Sexual Safety Policy being developed by LUFT which will be in line with National Guidelines.

Reporters would be offered support in reporting their experience and referral on to external bodies (such as the police) as needed. They would also be supported in seeking relevant psychological support.

Allegations would be investigated by an appropriately trained person appointed by the trust.

If the allegation is against an employee of the trust then the most appropriate Senior Manager will manage the case with support of HR business partners.

Current relevant trust policies include Resolution policy (replaces Dignity at work and grievance policies), Health work and wellbeing, Maintaining High professional Standards, Trust disciplinary Policy and Procedure, Freedom to speak up and Whistle Blowing.

22. Postgraduate Deans and their teams are keen to consider responses and initiatives and share good practice. Please share details on EDI initiatives that are specific to or have an impact on education and training in your organisation and the email address for someone we can contact to discuss this further.

1. We have group Induction FTSUG and EDI are presented as part of the programmes.
2. EDI is mandatory, inclusive, and compassionate leadership is part of our managers training. Additionally, the Trust delivers 1:1 Anti-Racism Coaching and Action Learning Sets for Managers and Senior Leaders
3. We have regular ED&I lead Great Days (Trust teaching) these cover various themes including, Anti-Racism, Asylum Seekers, gender, mental health, maternity race and Best for Baby Too collaborative (refugees and the NHS).

Lisa.Shoko@lwh.nhs.uk

Anti.racism.hub@lwh.nhs.uk

23. For education and training, what are the main successes for EDI in your organisation?

1. Volunteers to careers a project to encourage members of the local community to work at Liverpool Women's NHS Foundation Trust
2. Patient & Staff lived experience stories used at board and sub board meetings to increase awareness of ED&I issues.
3. Supported Internship – a structures workplace study programme for 16-24 year olds with special educational needs or disability. To build confidence and self-esteem.
4. Diversity interview panels and plans for inclusive recruitment.
5. The Anti-Racism Hub deliver regular training and provide education and awareness across the Trust for anti-racism.
6. Delivered an actioned an accessible environment audit.

24. For education and training, what are the main challenges for EDI in your organisation?

1. Resourcing (i.e. purchasing specialised equipment)

   Accessible information standards for all our staff.

25. Signature

☑ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Lisa Shoko lisa.shoko@lwh.nhs.uk
EDI and Anti-Racism Lead

16. Section 6 - Assurance Reporting: learning environment and culture

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 2000 characters per text box. **This section should be completed once on behalf of the whole organisation,** however it is important that those responsible for these areas are able to feed into this section.

26. Thinking about the learning environment and culture of your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Safety Check in meetings are broadcast online weekly on Friday for 20 minutes highlighting lessons learned to all staff. Recordings are archived and can be accessed by all staff in the trust.

We have monthly Learning for All half day face to face learning sessions for all staff. Where practicable clinical sessions are reduced giving as many people as possible an opportunity to attend. The programmes contain research, audits, interesting cases, Schwartz rounds and morbidity and mortality reports, this has a multiprofessional approach where everyone across all specialties can take part.

We run Educational Supervision Workshops twice a year to keep our Education Supervisors updated annually.

There are numerous projects at LWH that continue to run to support student wellbeing, enhance learning experiences and improve working culture.

SLEC- LWH are a pilot site for this NHSE project which aims to improve learning environment cultures.

PA Assessor model within maternity- this allows continuity of assessments for students and is recognised as gold standard in the region as the small team allows the process to be quality assured. The quality and quantity of PS feedback has also improved over the last 12 months following staff training and this also supports students in recognising their own improvements and also areas needed for development. We also have a SOP to support this timely submission of feedback.

Yearlong shift templates- midwifery students are provided with their shifts for the whole academic year so they can plan work life balance/childcare etc. This have also been incorporated into nursing placements this year so that students have their whole block of shifts when at LWH.

MDT student teaching sessions- these are ran in house based on assessment feedback on topics that student's identify as requiring more exposure to. These sessions are delivered by the PEFs and also subject matter experts and are offered to all students at LWH.

Laura.Stoddart@lwh.nhs.uk

Kathy.Smith@lwh.nhs.uk

27. Quality Framework Domain 1 - Learning environment and culture Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
The learning environment is one in which	☑	☐

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
education and training is valued and championed.		
The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.	☑	☐
The organisational culture is one in which all staff, including learners, are treated fairly, with equity, consistency, dignity and respect.	☑	☐
There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.	☑	☐
Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for	☑	☐

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
patients and service users.		
The environment is one that ensures the safety of all staff, including learners on placement.	☑	☐
All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.	☑	☐
The environment is sensitive to both the diversity of learners and the population the organisation serves.	☑	☐
There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence led practice activities and research and innovation.	☑	☐

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.	☑	☐
The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to knowledge and library specialists.	☐	☑
The learning environment promotes multi-professional learning opportunities.	☑	☐
The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.	☑	☐

28. Areas of exception
<u>From the professional groups you train</u>, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

☐ **All professions**
☐ **Site specific**
☐ Dental Postgraduate
☐ Dental Undergraduate
☐ Medicine Postgraduate
☑ Nursing
☑ Midwifery
☑ Allied Health Professionals
☐ Pharmacy
☐ Paramedicine
☐ Medical Associate Professions
☐ Advanced Practice
☐ Psychological Professions
☐ Healthcare Science
☑ Medicine Undergraduate
☐ Social Workers

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

Midwifery students

Adult and child nursing students

ODP students

TNA

Paramedic spoke placements

Physio placements

Medical Undergraduate

29. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

We do have excellent library facilities and good access to PCs, with access to Edu roam. However we struggle for learning space for large group interactive learning. We have one main lecture theatre and a portacabin that can hold more than 30, being an acute trust we are required to provide face to face multi professional interactive training to satisfy national maternity guide lines which is requires to be delivered in a large venue in order to be compliant.

In order to achieve the Medical School quality requirements for undergraduate medicine in the trust. The MEM and Undergraduate dean have again asked permission from the trust to convert one of our valuable training rooms into a Medical Students rest room. This will however put further pressure on rooms available for training.

All students listed above also use either rest rooms in clinical areas or library and conservatory as rest areas.

30. Signature

☑ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Kathy Smith

Kathy.Smith@LWH.nhs.uk

Medical Education Manager

17. Section 7 - Assurance Reporting: educational governance and commitment to quality

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether the you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. **This section should be completed once on behalf of the whole organisation,** however it is important that those responsible for these areas are able to feed into this section.

31. Thinking about the educational governance and commitment to quality of your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you to would like share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Introduction of raising concerns SOP for staff with regards to learners- promote open and honest culture and ensure correct procedures are being followed. Also SOP about expectations of learners on practice and expectations of practice supervisors, this has been introduced following learner issues in seeking timely feedback.

MDT student teaching sessions- attended by student nurses, midwives, ODP's and medical students, "those whose work together should train together" topics included obstetric emergency management, medication management, scrubbing in theatre, pharmacy, Human Factors, PMHT, diabetes and Sepsis to name a few.

We provide all new Trainee doctors prior to joining the Trust access to our Doctors Induction Teams channel, this contains a virtual tour, training videos, trainees handbook, rota details. This gives them an opportunity to familiarise themselves with the Trust and our systems before they have their face to face induction. This channel is always there for them to go back and reflect on what has been delivered at Induction.

As a Trust we manage the Women and Children's Advanced Learning Platform, this is a virtual platform that contains all regional and weekly teaching recordings, for all trainees in the North West Region in O & G and Paediatrics. If a trainee misses teaching they can always view it after or during the session(live) on line. The platform records attendance providing evidence of training.

32. Quality Framework Domain 2 - Educational governance and commitment to quality

Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-	☑	☐

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
professional and, where appropriate, inter-professional approach to education and training.		
There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level.	☑	☐
The governance arrangements promote fairness in education and training and challenge discrimination.	☑	☐
Education and training issues are fed into, considered and represented at the most senior level of decision making.	☑	☐
The provider can demonstrate how educational resources (including financial) are allocated and used.	☑	☐

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Educational governance arrangements enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of education and training.	☑	☐
There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.	☑	☐
Consideration is given to the potential impact on education and training of service changes (i.e. service re-design / service reconfiguration), taking into account the views of	☑	☐

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
learners, supervisors and key stakeholders (including WT&E and Education Providers).		

33. Areas of exception

<u>From the professional groups you train</u>, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

☐ **All professions**
☐ Dental Undergraduate
☐ Midwifery
Paramedicine
☐ Psychological Professions
☐ Social Workers
☐ **Site specific**
☐ Medicine Postgraduate
☐ Allied Health Professionals
☐ Medical Associate Professions
Healthcare Science
☐ Dental Postgraduate
☐ Nursing
☐ Pharmacy
☐ Advanced Practice
Medicine Undergraduate

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

34. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are

impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

No exceptions

35. Signature

☑ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Linda Watkins

Linda.Watkins@lwh.nhs.uk

DME

18. Section 8 - Assurance Reporting: developing and supporting learners

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

36. Thinking about how you develop and support learners within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

We are introducing from September 2024 'preparation for practice weeks' for all 1st year cohorts. This week aims to introduce them to professional elements and specialist services that they will encounter during their training with the intention of them feeling more prepared for placement. For example topics that will be covered will include; governance, infection control, ED&I leads, PMHT, Freedom to Speak up, pharmacy, maternity education team (obstetric emergency management as 1st years), PMA, bladder care, safeguarding etc.

Introducing 1st year students on the PN ward to spend some time with HCA's so they understand their role and to promote team working. PEF's to deliver training during HCA training day so they feel confident to support students. This will have an impact on promoting positive working culture.

As above examples re team of practice assessors, MDT sessions.

Over recent years have introduced new placements such as leadership week, exposures to research team, 104 bleep holder, NIPE week, governance, urodyanmics, bereavement, screening, FMU, twin clinic. These exposures all help students achieve MORA proficiencies and become better prepared for practice.

In depth induction offered to all midwifery students for their yearlong placements and face to face inductions recently introduced to nursing students.

As stated above, Learning for All, Safety Check-ins, Trainees Induction Channel, Advanced Learning Platform.

Medical Student Whatsapp Group allowing us to communicate quickly to keep the students informed and allowing them a quick response network when required.

Ongoing work as to how best support GP trainees coming in to the trust. Amendments made during most recent induction.

Various actions already taken to improve out of hours support in acute areas. Increased presence in Anaesthetics, Ongoing work to implement resident consultant presence for obstetrics. Already implemented in Neonatology.

37. Quality Framework Domain 3 - Developing and supporting learners

Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.	☑	☐
The potential for differences in	☑	☐

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.		
Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.	☑	☐
Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.	☑	☐
Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning	☑	☐

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
outcomes required.		
Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional and regulatory standards, and learning outcomes.	☑	☐
Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.	☑	☐
Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.	☑	☐
Learners understand their role and the context of their placement in relation to care	☑	☐

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
pathways, journeys and expected outcomes of patients and service users.		
Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.	☑	☐
Learners are encouraged to access resources to support their physical and mental health and wellbeing as a critical foundation for effective learning.	☑	☐

38. Areas of exception

From the professional groups you train, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

☐ **All professions**
☐ **Site specific**
☐ Dental Undergraduate
☐ Dental Postgraduate
☐ Medicine Postgraduate
☐ Nursing
☐ Midwifery
☐ Allied Health Professionals
☐ Pharmacy

☐ Paramedicine

☐ Psychological Professions

☐ Social Workers

☐ Medical Associate Professions

☐ Healthcare Science

☐ Advanced Practice

☐ Medicine Undergraduate

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

39. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

No exceptions

40. Signature

☑ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Linda Watkins

Linda.Watkins@lwh.nhs.uk

DME

19. Section 9 - Assurance reporting: developing and supporting supervisors

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

41. Thinking about how you develop and support supervisors within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

As stated above we provide twice yearly Educational Supervisors Workshops to support the development of our Educational Supervisors.

The undergraduate dean hold a bimonthly drop in session for undergraduate educational supervisors.

All educational supervisors are invited to the bimonthly medical education faculty meeting where all issues relating to undergraduate and postgraduate training are discussed and monitored.

Below comments relate to Practice Supervisors who support learners at LWH.

At LWH we have continued with the annual supervision update for all staff, this is part of their mandatory training and is led by the PEF's. This is delivered on CCMT so combines RM's and RN's, AHP's also have updates.

Bi-Monthly drop in sessions for PEF support for supervisors.

6 hour Supervision workshop for all NQ staff in how to better support students on practice and raise concerns etc.

Trust leadership, coaching and Mentoring courses are also available to members of staff wishing to develop these skills.

42. Quality Framework Domain 4 - Developing and supporting supervisors

Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Formally recognised supervisors are appropriately supported, with allocated time in job plans/ job descriptions, to undertake their roles.	☑	☐
Those undertaking formal supervision roles are appropriately trained as defined by the relevant regulator and/or professional body and in line with any other standards and expectations of partner organisations (e.g. Education Provider, WT&E).	☑	☐
Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.	☑	☐

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Educational Supervisors are familiar with, understand and are up-to-date with the curricula of the learners they are supporting. They also understand their role in the context of learners' programmes and career pathways, enhancing their ability to support learners' progression.	☑	☐
Clinical supervisors are supported to understand the education, training and any other support needs of their learners.	☑	☐
Supervisor performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development	☑	☐

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
and role progression and/or when they may be experiencing difficulties and challenges.		
Supervisors can easily access resources to support their physical and mental health and wellbeing.	☑	☐

43. Areas of exception

<u>From the professional groups you train</u>, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

☐ **All professions**
☐ Dental Postgraduate
☐ Midwifery
☐ Paramedicine
☐ Psychological Professions
☐ Social Workers
☐ **Site specific**
☐ Medicine Postgraduate
☐ Allied Health Professionals
☐ Medical Associate Professions
☐ Healthcare Science
☐ Dental Undergraduate
☐ Nursing
☐ Pharmacy
☐ Advanced Practice
☐ Medicine Undergraduate

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

44. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

No exceptions

45. Thinking about the Educator Workforce Strategy, please confirm that your organisation

	Yes	No
Is aware of the Educator Workforce Strategy.	☑	☐
Ensures educators/supervisors undertake a skills gap / learning development needs analysis for this role.	☑	☐
Ensures educators/supervisors have formal development to undertake this role.	☑	☐
Considers the educator workforce in wider clinical workforce planning.	☑	☐

If ‘yes’ please add comments to support your answer; if ‘no’ please provide further detail:

All Practice Supervisors attend annual updates to ensure they are trained at appropriate level, as PEF’s we oversee placement capacity and utilisation and ensure this is maximised each year to meet future workforce needs.

Undergraduate and Postgraduate Medical educators have annual educational appraisal within their Annual appraisal as a separate section. Biannual educator update workshops are run by the trust although educators can also attend CPD held by the University of Liverpool, Medical Education Leaders UK and NHSENW.

Educational supervision funding is included in Trust Doctors and Physicians Associates posts and is also needed in ACP roles. Specific funding for this is not available for ACPS and has to be found from divisional budgets. There is an expectation that supervision should be from consultants for all these learner groups.

It should be borne in mind that there has been an increase in less than full time postgraduate doctors. The subsequent need to increase trust doctors roles also increases the amount of time that should be provided for educational supervision. New consultant posts almost all have educational supervision included, however demand for supervision currently exceeds supply as there is limited capacity and reduced willingness to take on additional programmed activities by consultants above 10 PA. As a small trust many consultants already have other additional roles.

46. Implementation of the Educator Workforce Strategy

☐ We have **fully implemented** the recommendations of the Educator Workforce Strategy.

☑ We have **partially implemented** the recommendations of the Educator Workforce Strategy.

☐ We have **not yet started** implementation of the recommendations of the Educator Workforce Strategy.

47. Signature

☑ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Linda Watkins

Linda.Watkins@lwh.nhs.uk

DME

20. Section 10 - Assurance reporting: delivering programmes and curricula

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

48. Thinking about how you deliver programmes and curricula to support training within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

For undergraduate midwifery learners we match the yearlong placement planners with the expectations laid out in the MORA document to ensure that students have the opportunity to meet the expectations of the programme when on practice. This includes placements such as NIPE, Leadership etc.

PEF’s sit on programme boards at universities to ensure we have some oversight of curriculum delivery within HEI’s and the timings of this across the 3 years. The O&G curriculum lead for UoL is a LWH Consultant and the Undergraduate team participate in curricula review and attend regular meetings.

Specialty tutors and educational supervisors attend a regular Med ED faculty meeting where issues such as curricular delivery are discussed.

See comments above regarding the significant increase in trust doctor roles within the trust to enable access to training opportunities and reduce impact of service provision. Business case can be provided on enquiry from Rachel.London@lwh.nhs.uk

49. Quality Framework Domain 5 - Delivering programmes and curricula Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to	☑	☐

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
training programmes.		
Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.	☑	☐
Placement providers collaborate with professional bodies, curriculum/ programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure their content is responsive to changes in treatments, technologies and care delivery models, as well as a focus on health promotion and disease prevention.	☑	☐
Placement providers proactively seek to develop new and innovative methods of	☑	☐

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
education delivery, including multi-professional approaches.		
The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.	☑	☐
Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.	☑	☐

50. Areas of exception
<u>From the professional groups you train</u>, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

☐ **All professions**
☐ Dental Undergraduate
☐ Midwifery
☐ Paramedicine
☐ **Site specific**
☐ Medicine Postgraduate
☐ Allied Health Professionals
☐ Medical Associate Professions
☐ Dental Postgraduate
☐ Nursing
☐ Pharmacy
☐ Advanced Practice

☐ Psychological Professions

☐ Healthcare Science

☐ Medicine Undergraduate

☐ Social Workers

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

51. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

No exceptions

52. Signature

☑ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Linda Watkins

Linda.Watkins@lwh.nhs.uk

DME

21. Section 11 - Assurance reporting: developing a sustainable workforce

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

53. Thinking about developing a sustainable workforce within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Increased PEF team from 2 to 2.6 WTE with recent addition of Associate PEF to support nursing and AHP students

Trust has a well-established preceptor team with a two week induction programme for Newly appointed Midwifes. They also provide a longer supernumerary period for International Graduates.

Link in with preceptorship team for final year students so they are supported when newly qualified

Laura.Stoddart@lwh.nhs.uk

We continue to offer taster weeks to foundation trainees interested in O&G as well as protected elective placements to Local Medical students.

Kathy.Smith@lwh.nhs.uk

54. Quality Framework Domain 6 - Developing a sustainable workforce Please select only one option for each row.

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	☑	☐
Does the provider provide opportunities for learners to	☑	☐

	We meet the standard for all professions / learner groups we train	**We have exceptions to report** and provided narrative below
receive appropriate careers advice from colleagues		
The provider engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	☑	☐
Transition from a healthcare education programme to employment and/or, where appropriate, career progression, is underpinned by a clear process of support developed and delivered in partnership with the learner.	☑	☐

55. Areas of exception

From the professional groups you train, please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

☐ **All professions**
☐ Dental Undergraduate
☐ Midwifery
☐ Paramedicine
☐ Psychological Professions
☐ Social Workers
☐ **Site specific**
☐ Medicine Postgraduate
☐ Allied Health Professionals
☐ Medical Associate Professions
☐ Healthcare Science
☐ Dental
☐ Nursing
☐ Pharmacy
☐ Advanced Practice
☐ Medicine Undergraduate

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

56. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

No exceptions

57. Signature

☑ I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Linda Watkins

Linda.Watkins@lwh.nhs.uk

DME

22. Section 12 - Final Submission

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

Before completing your final submission please ensure you have:
1. Completed all questions within the Self-Assessment (including the free text sections)
2. Received Board level sign off for your submission

58. Board level sign-off (Premises, Learning Environment, Facilities, and Equipment)

☐ I confirm that our premises, learning environments, facilities and equipment are: suitable for the performance of the Services; accessible, safe and secure; comply with any applicable Health and Safety Legislation, any other Applicable Law, Guidance, appropriate risk management clinical guidance, good healthcare practice and the requirements of any relevant Regulator; and are sufficient to enable the Services to be provided at all times and, in all respects, in accordance with the NHS Education Funding Agreement.

59. Board level sign-off

☐ I confirm that the responses in this SA have been signed off at board level

Name, email address and role of Board representative for education and training

60. Please confirm the date that board level sign off was received:

*

61. Final Submission (please only tick this box when you ready to submit your self-assessment)

☐ I confirm that all sections of this self-assessment have been completed and that this is the final version for submission

23. Thank you for your time

Thank you for your time on the NHS England Self-Assessment for Placement Providers

You can continue to update this self-assessment using the link supplied to your by your regional NHS England WT&E education quality team.

If you would like to print a version of your draft submission at any time, please use the print button on the next page (note that you will only print those sections currently completed)

Once you have completed all sections in full of this self-assessment please ensure that you complete section 12 final submission and tick the box Complete Submission. At which point your final response will be sent to your regional NHS England WT&E education quality team.

Board of Directors

COVER SHEET

Meeting Date	Thursday, 10 October 2024	**Item Reference**	TB24/25_140
Report Title	Bi-Annual staffing paper January 2024 – June 2024 (Q4 & Q1)		
Author	Nashaba Ellahi, Deputy Chief Nurse		
Responsible Director	Dianne Brown, Chief Nurse		

Purpose of Report	The Board of Directors is asked to note the contents of the paper and take assurance from the actions undertaken to effectively manage and provide safe staffing within Nursing, Midwifery and AHP to support the delivery of safe care.
Executive Summary	The bi-annual staffing paper triangulates information from evidence-based tools, Nurse sensitive indicators (such as complaints and clinical incidents) and professional judgement with the main areas of reporting between January 2024 – June 2024 summarised as: • Demand for Bank and Agency has reduced with agency fill rates decreasing significantly. • Maternity leave has reduced. • Sickness is above threshold yet reduced from previous reporting at 6.29% in June 2024. • Turnover is above threshold in HCA and AHP staff (June 2024); NMC below threshold • Age profile has marginally shifted due to continued recruitment activity in divisions. Staff who may retire now or in the next five years is within normal variation limits. • All areas saw a reduction in staffing related incidents except for Gynaecology who saw an increase. • There were 8 Patient Safety Incident Investigations, 3 Never Events and 1 reportable MNSI case. • Friends and Family Test – reduction in comments received on where 'we could have done better' relating to staffing numbers or staff shortages • Complaints – 35 formal complaints with no complaint category noting staffing as a specific issue.
Key Areas of Concern	The following areas are worthy of noting and monitoring closely to support discussions for improvement: • Vacancy rate (June 2024) has increased to 12.36% (137.51wte) largely due to Neonatal vacancies (62.22wte) which includes vacancies for the Liverpool Neonatal Partnership is a potential concern if active recruitment doesn't yield the desired volume of staff. • No staff group achieved PDR compliance for 6 months. June 2024 reflects no staff groups achieved LMT or CMT and MT achieved only by AHP staff group. • Red Flag events (268) were all reported from Maternity services and reflect an increase of 56 red flags, majority relating to delay of >12 hours during ongoing induction of labour (218).
Trust Strategy and System Impact	The report links to the requirement that NHS organisations have a responsibility to undertake an annual comprehensive Nursing and Midwifery skill mix review to ensure that there are safe care staffing levels to provide

	assurance to the Board of Directors and stakeholders that the organisation is safe to provide high quality care with the right staff, with the right skills, in the right place at the right time (National Quality Board (NQB), 2016) through effective staffing (NICE, 2014; NICE, 2015; NHSI, 2018). Furthermore, the paper and content support the 'triple aim' to improve quality and value and several of the Trusts Strategic aims including to 'deliver safe services' and 'deliver the best possible experience for patients and staff'. The bi-annual Nursing and Midwifery staffing report details the Trusts position against the requirements of NICE guidance for adult wards (2014); NICE Guidance for maternity settings (2015), NQB Safer Staffing Guidance (2016) and NHSI, Developing Workforce Safeguards (2018).

Links to Board Assurance Framework	**Risk 1 – Workforce** If the Trust is unable to address staffing challenges and EDI inequalities, it may fail to deliver safe, high-quality care, meet organisational objectives, and engage effectively with patients and staff. This can lead to reduced patient trust, lower staff morale, legal consequences, and failure to recruit, promote, and retain diverse talent.	10
Links to Corporate Risk Register (scoring 10+)	All the below risks relate to NMAHP staffing and are reported in detail through ERAG by division:	
	Pharmacy: Staffing for Safe service delivery (**12**). Gap analysis undertaken and in line with Trust priorities an external review of service is underway.	12
	Imaging: Workforce (**10**). Focus on management of sickness, Use of Bank and Agency for shortfalls, active recruitment, use of student sonographers where possible, offering retention premium.	10
	Maternity Base: BR+ assessment for PN care potential under-provision of staff on PN ward (combined within Estates related risk, score **10**). Mitigation for staffing in place with increased daily shift assignment count for the area. Ward manager appointed, Matron secondment covering substantive Matron and 2 deputy ward managers recruited.	10

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

Action Required by the Board of Directors	The Board of Directors is asked to receive assurance that NMAHP staffing is well managed through a series of actions, escalations, and mitigations to support safe patient care.

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The bi-annual Nursing, Midwifery and Allied Health Professional (AHP) staffing report is provided to the Board of Directors through the Putting People First (PPF) Committee. The report sets out the Liverpool Women's NHS Foundation Trust (LWH) position in the context of the National Nursing, Midwifery and AHP workforce challenges. This report covers the period from January 2024 to June 2024 (Quarter 4 and Quarter 1). The report provides assurance that there are robust systems and processes in place throughout the year to monitor and manage Nursing, Midwifery and AHP staffing requirements. The report will demonstrate the adoption of a triangulated approach to the bi-annual staffing report and therefore includes discussion of evidence-based tools, professional judgement, and outcomes (e.g., complaints, incidents) to support understanding.

Adoption of principles within National Quality Board (2016), NICE Guidance (2014;2015) and Delivering Workforce Safeguards (2018) to support workforce planning, care hours per patient per day (CHPPD) requirements and the operational oversight of staffing and acuity-based care is embedded in the Trust.

The report presented highlights the following areas for discussion and noting (January 2024 – June 2024).

- Demand for Bank and Agency has reduced by 12% throughout Q4/Q1 2024 with demand for the six-month period compared to year on year decreasing by 14% which is likely due to substantive staff in post and lower sickness rates than seen in previous reporting period and good roster management. Bank fill rates have increased by 8% year on year with agency fill rates decreasing significantly (97% reduction year on year) due to tighter controls in place and overall lower maternity leave rates.
- Vacancy rate (June 2024) has increased to 12.36% (137.51wte) largely due to Neonatal vacancies (62.22wte) that are those for the Liverpool Neonatal Partnership.
- Maternity leave in June 2024 is 36.61wte across all NMAHP staff groups which reflects 3.72% of total NMAHP staff and a reduction from previously reported period where December 2024 saw 49.12wte on maternity leave.
- Sickness has been above target of 4.5% with a combined NMAHP sickness position of 6.29% in June 2024. This is above threshold, however, is an improvement from previous reporting period where sickness for NMAHP groups in December 2023 was at 8.64%.
- Long-term sickness (LTS) rates (28 calendar days or more) continue to remain the greatest challenge with high levels of LTS noted across all staff groups, however it must be noted that AHPS are a smaller cohort, therefore the LTS appears disproportionately elevated. June 2024 LTS reflects NMC, 55.39%; HCA, 63.41% and AHP, 62.28%.
- Turnover in June 2024 for NMAHP staff groups reflects NMC group remains under the Trust threshold of 13% however, HCA turnover is 16.25% and AHP turnover is 13.65%.
- Age profile has marginally shifted due to continued recruitment activity in divisions. There remains a risk in Nursing and Midwifery (NMC/HCA) to those who may retire now or in the next five years, however this is within normal variation limits.
- Staff Training and Personal Development Review performance measures have fluctuated over the reporting period with no staff group achieving PDR compliance at any point within the 6-month reporting period. In June 2024 MT was only achieved by AHP staff group and no staff groups achieved LMT or CMT in June 2024.
- 244 clinical incidents related to staffing or staff sickness were noted compared to 245 in previous reporting period, with highest seen in Maternity Services (113) closely followed by Gynaecology including Hewitt Fertility Centre (111), CSS (17) and Neonatal (3). All areas saw a reduction in staffing related incidents except for Gynaecology who saw an increase.
- Red Flag events (268) were all reported from Maternity services and reflect an increase of 56 red flags, majority relating to delay of >12 hours during ongoing induction of labour (218).
- There were 8 Patient Safety Incident Investigations, 3 Never Events and 1 reportable MNSI case.
- Friends and Family Test – 8 comments received from 443 where patients noted being 'displeased'. 21 comments (from 5162) related to the Trust question "please tell us anything we could have done better" also related to staffing numbers or staff shortages, which is a reduction from previous report (27 comments from 4027). Most of the comments related to Gynaecology services (17), followed by Maternity (4).
- Complaints – 35 formal complaints received highlighting a reduction of 1 from previous reporting period, with no complaint category noting staffing as a specific issue. 35 PALS+ recorded with none noting

staffing in the issue raised and no PALS cases noted staff shortages in issues raised. 44 Compliments were received, which reflect a decrease of 7 from previous reporting.

- Staff experience – 26 reported violence and aggression incidents (previously 29), all relating to non-physical violence or aggression towards staff. No themes or trends identified across incidents.
- Recruitment and Retention – ongoing recruitment across the Trust continued with successful recruitment and commencement of staff. No further International Recruitment (IR) required. People Promise Manager in post and working on an accelerator programme as part of a wider retention strategy.

All Divisions receive locally owned data which is reported as divisional staffing papers through Divisional Boards and are therefore no longer reported directly through PPF or Trust Board.

MAIN REPORT

1.0 Introduction

To provide the Board of Directors with a six-monthly update of the 2024/2025 staffing establishment reviews in relation to the Nursing, Midwifery and Allied Health Professional (AHP) workforce requirements. To report against the workforce requirements identified in 2024/2025 to achieve safe staffing across services within the Trust.

2.0 Background

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

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

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

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

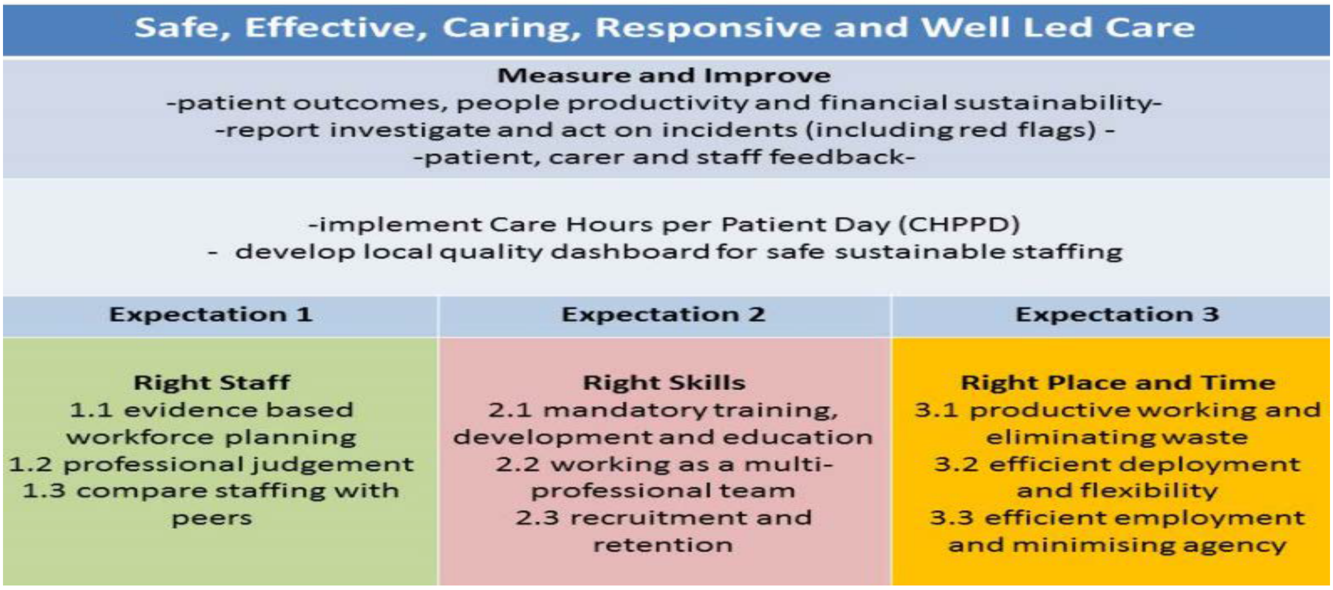
The Trust Board via the Putting People First Committee receives twice-yearly staffing review papers; one which confirms a complete Nursing and Midwifery establishment review was undertaken reported through Divisional overviews (reported into Divisional Boards) and a further comprehensive staffing report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

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

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

Developing Workforce Safeguards (NHSI, 2018) additionally recommends:

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



Safe, Effective, Caring, Responsive and Well Led Care

Measure and Improve
-patient outcomes, people productivity and financial sustainability-
-report investigate and act on incidents (including red flags) -
-patient, carer and staff feedback-

-implement Care Hours per Patient Day (CHPPD)
- develop local quality dashboard for safe sustainable staffing

Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Table 1: National Quality Board (2016)

3.0 Workforce planning - Setting evidenced based establishments

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

The Safer Nursing Care Tool within Gynaecology in-patient areas is adopted for use. After LWH contributed to beta-testing the revised SNCT: Adult Inpatient Wards in Acute Hospitals during 2023. The revised tool including refreshed levels of care has since been adopted and in use. In May 2024 a repeat audit was undertaken in Gynaecology using the revised SNCT (2023) over a 4-week period (30 days) with the results reflecting that ward level care was mostly level 0 (recognising patients require hospitalisation and ward level care). Over 2024/25 the Trust priorities includes a Task and Finish group leading a review of the HDU requirements of the Trust with support of the Critical Care Network and partners from LUHFT. All SNCT reviews for HDU in Gynaecology will be considered alongside other data to inform the model of HDU care across Gynaecology and Maternity in the future.

National guidance (Intensive Care Society, 2019) supports staffing recommendations in Level 2 care facilities (High Dependency Units) as a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care, therefore supporting the need for a thorough diagnostic and recommendations with the critical care network involvement and support, before any decisions of a proposed model of care is supported by Executive Directors.

Maternity Services are assessed using Birthrate Plus®. The Birthrate Plus® methodology is based on an assessment of clinical risk and the needs of women and their babies during labour, delivery, and the immediate post-delivery period. Birthrate Plus® utilises the accepted standards of one midwife to one woman to determine the total midwife hours and therefore the staffing required to deliver midwifery care to women across the whole maternity pathway using NICE guidance (2015) and acknowledged best practice (RCM, 2018). A Birthrate Plus® refresh audit was completed in April 2023 with report received in May 2023 and reflected that the Maternity budgeted establishment in 2023/24 was 5.35wte below the audit recommendation which Maternity addressed and are now fully compliant with current Birthrate Plus® establishment. The Birth Rate plus ward acuity tool has been introduced into maternity services and is completed 6 hourly and calculates the care hours required in the next 6-hour period. In the updated tool, babies are assigned a separate category using a care needs matrix, whilst the care needs of the birthing person are determined using either an antenatal or postnatal care matrix. Compliance in use of the tool in June 2024 is at 36.61%

and slowly improving, with an aim to achieve 80% consistently. Oversight to ensure improvements divisionally is in place.

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

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

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

From April 2016, following the Carter Review all Trusts were required to publish staffing fill rates of RN/RM and Care Staff by hours and percentages (Actual versus Planned) and CHPPD via the Strategic Data Collection Service (SDCS), run by NHS Digital. A summary of the submission is uploaded onto the Trust website each month. Appendix 1 highlights data submitted from January 2024 – 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 nurses/ midwives and nursing assistants and dividing this by the number of patients occupying a bed at midnight. The data is aggregated each day over the month. In maternity mothers and babies are included in the census.

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

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

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

Trustwide CHPPD in Q4 and Q1 (Appendix 1) has shown overall higher rates when compared to that in Q2 and Q3, and when triangulated against fill rates and professional judgement does not raise a cause for concern. When CHPPD is reviewed on Model Hospital (June 2024 latest published data) it reflects LWH provider value is 9.5 (Quartile 4), and most likely reflects effective rosters and productive wards, however if much higher could reflect the reverse. When LWH CHPPD is compared, it highlights that it is higher than ‘My Region’ peer median of 8.7 (Quartile 3). When compared further to Birmingham Womens and Children’s NHS Foundation Trust (My Peer) it highlights that LWH CHPPD value of 9.5 is lower than ‘My Peer’ with Birmingham Womens and Children’s having a peer median of 13.0 (Quartile 4). Although it can be worthwhile comparing data on Model Hospital as very high rates of CHPPD may suggest an organisation has several unproductive wards or inefficient staff rostering processes, it is important to be mindful of comparing different types of wards and Trusts.

4.0 Operational oversight of staffing and acuity-based care

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

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

4.1 Temporary Staffing

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

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

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

NHSP continue to focus efforts on Bank recruitment. The following is a summary of activity during Q4/Q1:

- Weekly updates on agency spend provided to directorates/divisions.
- Weekly engagement ward walks from NHSP local team and weekly drop-in sessions in alternate departments across the trust to support substantive sign up and queries.
- National campaigns to engage and reward bank- Share the love hamper winner, Easter hamper winner, and a GEM (going the extra mile) award winner. In addition, the local team reach out and celebrate Bank members who book consistently or receive feedback from managers/ colleagues.
- Attendance at university jobs fairs with LMJU to promote the Bank and Trust
- Weekly/monthly engagement meetings with each ward to drill down on fill figures and booking practices.
- Monthly manager newsletter with review of previous month and key dates for the future
- Continued support with health roster compliance – 99%
- Continued within Northwest region to promote LWH to current bank staff registered with NHSP.

- Bank adverts out for key roles and ad hoc for roles as requested, shared with trust communications for further reach.
- Central team providing support to fill AHP placements.
- Review of payrates to ensure in line with AFC and bench marking across the C&M region.
- Monitoring bank member compliance in line with MIAA instruction- ID badge verification quarterly spot checks

All new starters broken down by role and recruitment type from January – June 2024 are noted in Table 2. The figures reflect the new starters in the reporting period who have joined the bank, which equates to 79 new bank staff, of which 38 are substantive staff in LWH (multi-post holders) and 41 are bank only or bank exclusive (so may have joined for another Trust but added LWH as a place to work OR joined primarily to work at LWH).

Roles	Bank	Multi-post Holder (MPH)	Total
HCAs Band 2&3	21	6	27
Midwives	1	29	30
Nurses	5	9	14
Theatres	1	4	5
Sonographer	0	1	1
Embryologist	1	0	1
Pharmacist	1	0	1
Total	**30**	**49**	**79**

Table 2: Number of individuals added new to NHSP Bank between January-June 2024

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

The graphs (Appendix 2, Trustwide graph) reflect that overall demand has decreased throughout Q4/1 by 12% from Jan 2024 – June 2024. Demand for the 6-month period compared to year on year has decreased by 14% (16,336 hours).

Bank fill year on year has increased by 8%. This has led to an average bank fill for Q4/Q1 of 77.3% compared to 61.5% for the same period in the previous year (2023). Agency fill has reduced significantly by 97% year on year with average usage at 0.1% for the Q4/1 period (a cost saving of £95,757).

5.0 Trustwide Nursing, Midwifery and AHP Workforce Measures (January 2024-June 2024 data; Q4 & Q1 position)

5.1 Vacancy position

The data highlights the vacancy position in June 2024 (Table 3) for Nursing, Midwifery and AHP of 137.51wte, an increase from the previous reporting period (50.67wte in December 2023). This demonstrates a vacancy rate of 12.36%. The increase in vacancy rate is primarily due to the large number of vacancies within the Family Health Division, specifically the neonatal workforce required for the Liverpool Neonatal Partnership and recruited through LWH.

Of the 137.51wte vacancies, the largest is in Family Health Division with 84.30wte (Neonatal, 62.22wte and Maternity, 22.08wte), followed by CSS Division with 34.93wte and Gynaecology Division including Hewitt Fertility Centre 18.28wte.

All divisions are actively recruiting to their vacancy positions.

Sum of Wte Budget	Sum of Wte Contracted	Sum of Vacancy
1111.67	**974.16**	**137.51**

Table 3: December 2023 Trustwide NMAHP vacancy position

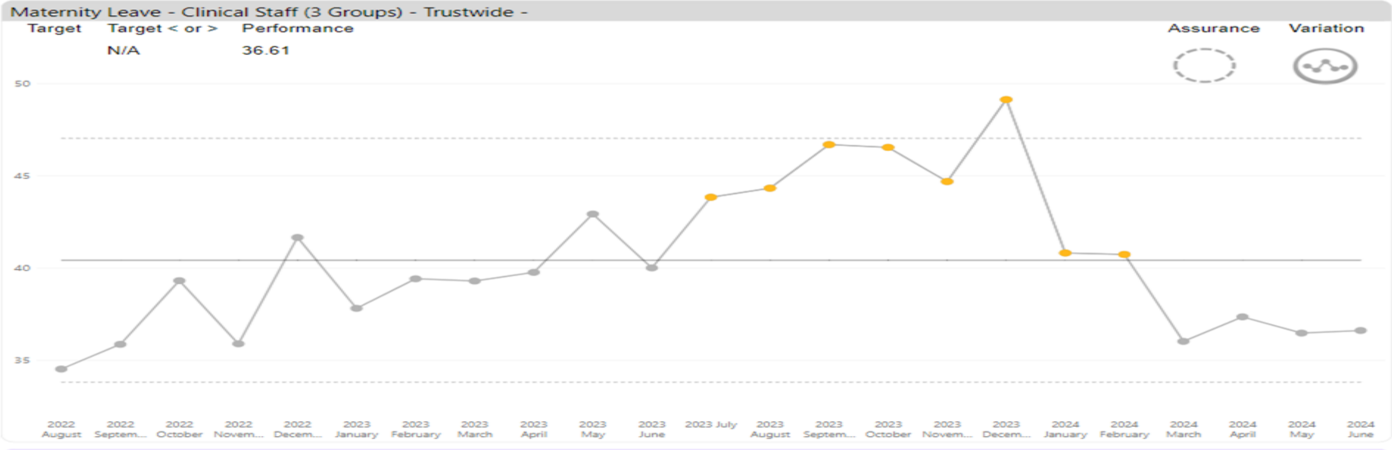
5.2 Maternity Leave

Table 4 highlights the rolling position of staff on maternity leave across each staff group and Trustwide. The group of staff with the largest maternity leave are those who are registered midwifes or nurses. HCA group remains relatively static, AHP group has no staff on maternity leave since April 2024. Overall, within this reporting period less staff are currently on maternity leave than previous reporting period. When directly comparing June 2024 (36.61wte) with December 2023 (49.12wte) it is a difference of 12.51wte. The 36.61wte combined across all NMAHP staff groups reflects 3.72% of staff (December 20023 was 5.03%).

	Jan-24			Feb-24			Mar-24			Apr-24			May-24			Jun-24		
Figures based on 3 staff groups within clinical areas	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Overall Maternity of All 3 Staff Group WTE	7.77	30.84	2.20	7.77	30.76	2.20	7.77	27.65	0.60	8.16	29.19	0.00	7.16	29.31	0.00	7.92	28.69	0.00
		40.81			40.73			36.02			37.35			36.47			36.61	

Table 4: Maternity leave

When looking at maternity leave through a statistical process chart (SPC), Chart 1, it reflects that maternity leave sits within normal variation in this reporting period, whereas the previous reporting period highlighted maternity leave was outside of the normal process limits.



Statistical Process Chart 1: Maternity Leave

5.3 Sickness absence

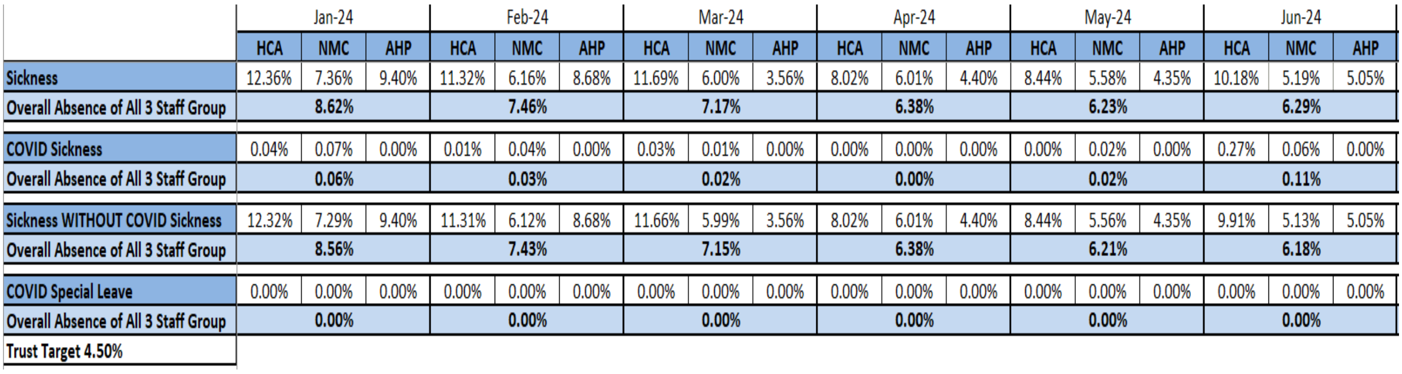
The combined sickness absence of NMAHP staff groups over the reported six-month period (Table 5) has remained high and above the Trust threshold of 4.50%, currently at 6.29% in June 2024, which is a reduction from previous sickness reported at 8.64% in December 2023.

The lowest combined overall sickness rate was seen in May 2024 (6.23%) in the last six months, which is below the lowest reported period of sickness in the previous reporting period of 6.66%.

Covid-19 related sickness remains at less than 1% and as expected.

The overall percentage of sickness across the 3 staff groups June 2024 is 6.29% with further breakdown of this illustrating the following:

- 6.18% was all non-covid related sickness.
- 0.11% was covid-19 related sickness.
- 0% was covid -19 special leave (this is not calculated in the sickness recorded).



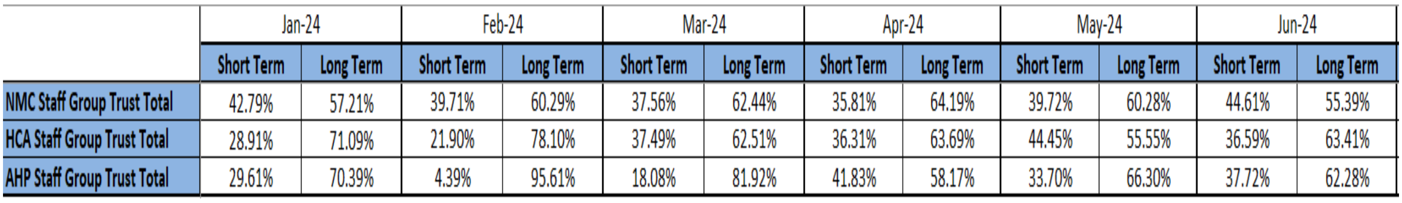
	Jan-24			Feb-24			Mar-24			Apr-24			May-24			Jun-24		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Sickness	12.36%	7.36%	9.40%	11.32%	6.16%	8.68%	11.69%	6.00%	3.56%	8.02%	6.01%	4.40%	8.44%	5.58%	4.35%	10.18%	5.19%	5.05%
Overall Absence of All 3 Staff Group	**8.62%**			**7.46%**			**7.17%**			**6.38%**			**6.23%**			**6.29%**		
COVID Sickness	0.04%	0.07%	0.00%	0.01%	0.04%	0.00%	0.03%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.00%	0.27%	0.06%	0.00%
Overall Absence of All 3 Staff Group	**0.06%**			**0.03%**			**0.02%**			**0.00%**			**0.02%**			**0.11%**		
Sickness WITHOUT COVID Sickness	12.32%	7.29%	9.40%	11.31%	6.12%	8.68%	11.66%	5.99%	3.56%	8.02%	6.01%	4.40%	8.44%	5.56%	4.35%	9.91%	5.13%	5.05%
Overall Absence of All 3 Staff Group	**8.56%**			**7.43%**			**7.15%**			**6.38%**			**6.21%**			**6.18%**		
COVID Special Leave	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Overall Absence of All 3 Staff Group	**0.00%**			**0.00%**			**0.00%**			**0.00%**			**0.00%**			**0.00%**		
Trust Target 4.50%																		

Table 5: All sickness absence

5.4 Long-term and short-term sickness

Sickness over the reporting period reflects that long-term sickness (LTS) continues to remain the greatest challenge across all staff groups and has been for over 12 months, with one exception in July 2023 in the NMC staff group, when LTS was at 49.68%. The data (Table 6) reflects June 2024 has the lowest long-term sickness rate at 55.39% for NMC staff group with April 2024 reflecting the highest levels of long-term sickness at 64.19%. The HCA group reflects the lowest long-term sickness recorded in May 2024 at 55.55% with the highest rate recorded at 78.10% in February 2024. AHPs generally reflect significantly higher levels of long-term sickness when compared to other professional groups which is reflective of AHP's being a relatively small cohort of staff, which skews the data to appear disproportionately elevated when reviewing. February 2024 saw long-term sickness at its highest in the reporting period at 95.61%, this is significantly higher than the highest long-term sickness reported in the previous six months (88.35% in December 2023).

The Divisions all undertake long term sickness review meetings with HR Business Partners, Managers and Matrons with oversight from Heads of NMAHP to ensure actions are in line with policy and appetite for alternative considerations to support earlier returns is considered.

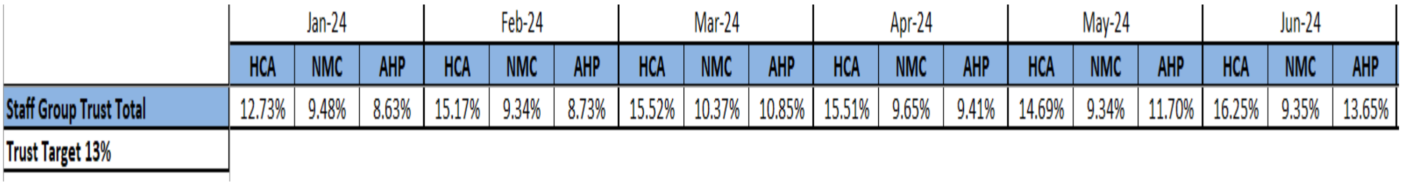


	Jan-24		Feb-24		Mar-24		Apr-24		May-24		Jun-24	
	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
NMC Staff Group Trust Total	42.79%	57.21%	39.71%	60.29%	37.56%	62.44%	35.81%	64.19%	39.72%	60.28%	44.61%	55.39%
HCA Staff Group Trust Total	28.91%	71.09%	21.90%	78.10%	37.49%	62.51%	36.31%	63.69%	44.45%	55.55%	36.59%	63.41%
AHP Staff Group Trust Total	29.61%	70.39%	4.39%	95.61%	18.08%	81.92%	41.83%	58.17%	33.70%	66.30%	37.72%	62.28%

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

5.5 Turnover

The Trust turnover threshold is 13%. The position over the last six months (Table 7) reflects that NMC group has remained under the Trust threshold, AHP groups have remained under threshold except for June 2024 when turnover for AHPs was 13.65%. However, the HCA staff group has been above threshold for five out of six months during the reporting period.



	Jan-24			Feb-24			Mar-24			Apr-24			May-24			Jun-24		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Staff Group Trust Total	12.73%	9.48%	8.63%	15.17%	9.34%	8.73%	15.52%	10.37%	10.85%	15.51%	9.65%	9.41%	14.69%	9.34%	11.70%	16.25%	9.35%	13.65%
Trust Target 13%																		

Table 7: Turnover

5.6 Age profile

Table 8 reflects the position overall across all NMAHP staff groups. The age profile in the staff groups overall have marginally shifted over most of the age bands, with recruitment having seen an increase in NMC filled posts within 21-25 and 26-30 age bands. There remains a risk in Nursing and Midwifery (NMC/HCA) to those who may retire now or in the next five years. As a percentage of the NMAHP workforce this is represented as 9.46% within 56-60 age bands and 5.96% within 61-65 age bands in June 2024.

Headcount	Jan-24			Feb-24			Mar-24			Apr-24			May-24			Jun-24		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
<=20 Years	4	0	0	4	0	0	4	0	0	4	0	0	4	0	0	4	0	0
21-25	27	76	3	27	85	3	27	85	2	28	85	1	26	85	1	23	83	1
26-30	31	104	8	31	105	8	29	102	8	30	111	7	30	108	7	31	109	5
31-35	25	144	17	26	142	16	24	146	16	25	147	15	27	148	14	28	142	14
36-40	31	90	7	31	94	7	32	96	7	35	101	7	36	104	7	35	111	9
41-45	34	101	11	34	100	10	33	99	8	34	97	10	34	97	10	33	98	10
46-50	23	69	8	23	67	8	23	67	8	23	68	8	22	68	7	22	68	7
51-55	30	77	10	30	77	10	32	75	11	34	73	11	32	73	11	32	74	11
56-60	26	76	3	27	76	3	27	76	3	27	76	3	29	77	3	29	76	3
61-65	24	43	3	24	43	3	22	42	3	22	43	3	21	43	3	21	44	3
66-70	9	4	0	9	4	0	8	5	0	8	5	0	9	5	0	8	5	0
>=71 Years	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
Total	**265**	**785**	**70**	**267**	**794**	**68**	**262**	**794**	**66**	**271**	**807**	**65**	**271**	**809**	**63**	**267**	**811**	**63**
Total of all 3 Staff Groups	**1120**			**1129**			**1122**			**1143**			**1143**			**1141**		

Table 8: NMAHP age profile data

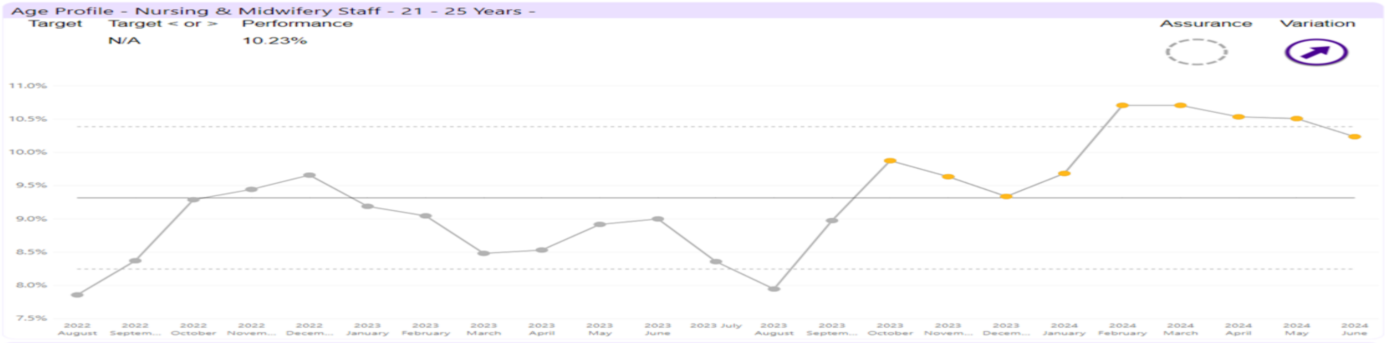
When reviewing the age profiles through Statistical Process Charts (SPC 2-5) this helps to further understand the variation and if the information is reflecting an improvement, concern or normal variation. The below charts reflect the following:

SPC 2 – reflects the active recruitment of newly qualified staff (age 21-25 years) across a variety of roles, but mostly midwifery and where there have been larger historical vacancies. It shows since September 2023 recruitment has been improving and outside of normal variation which is a positive shift and continued expected variance.

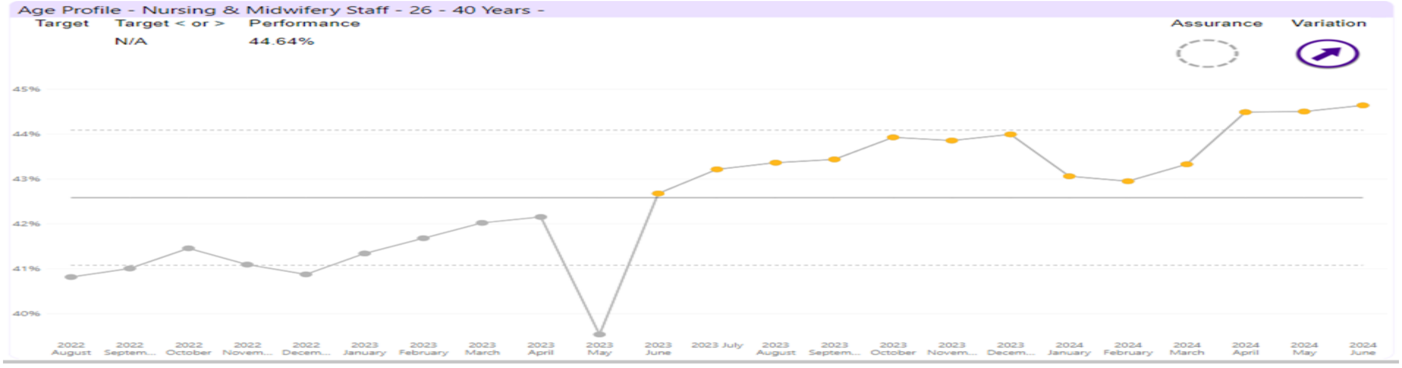
SPC 3 – reflects ages 26-40 years and the active recruitment and retention across divisions to reduce vacancies with the increased variance reflecting a positive shift above upper control limit as this age group may also reflect longer NHS employment and experience.

SPC 4 – is reflective of a downward shift which is expected given the active recruitment across other age bands and remains within normal variation.

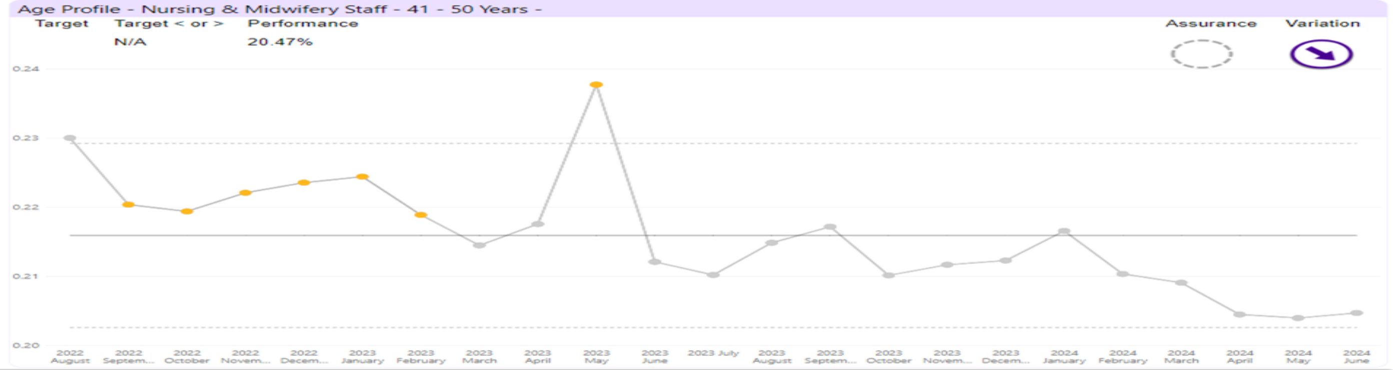
SPC 5 - positive decreasing position which reflects that staff who can retire now or in the next 5 years are within the normal variation limits.



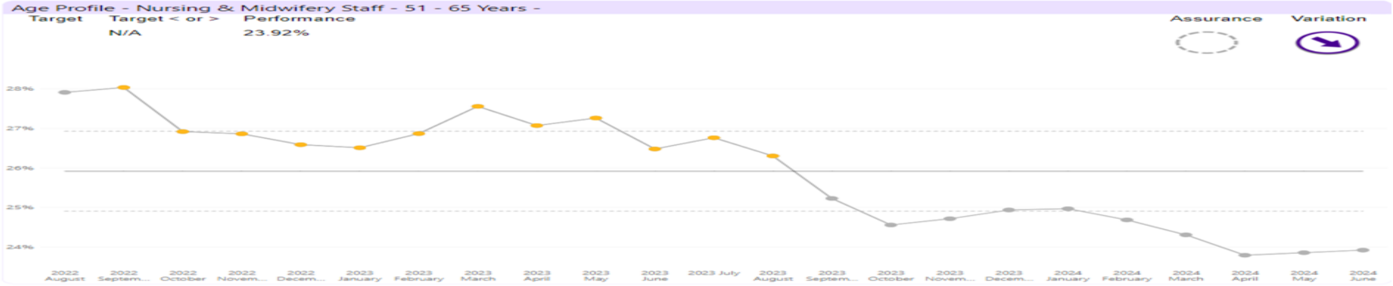
Statistical Process Chart 2: Age profile 21-25 years



Statistical Process Chart 3: Age profile 26-40 years



Statistical Process Chart 4: Age profile 41-50 years



Statistical Process Chart 5: Age profile 51-65 years

6.0 Trustwide Nursing, Midwifery and AHP Training and Personal Development Review (January 2024-June 2024)

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

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

Over the reporting period it is evident that compliance has not been achieved in CMT, LMT, however AHPs achieved compliance in MT across the full reporting period. HCAs met MT compliance in January 2024 only and NMC staff groups have remained under target for MT for full reporting period. No staff groups achieved PDR target.

In June 2024 the following indicator has been achieved:

- MT – in AHP staff group, (also achieved across the whole reporting period)

When comparing June 2024 position across all four indicators and across all staff groups with previous reporting position (December 2023) the below is established:

- 1 area of compliance (as above)
- 4 individual indicators have improved since December 2023, although not achieving target
- 6 indicators are performing worse than December 2023, across all staff groups, however one indicator did meet target, although this reduced from the previous reporting position.

The below data does not reflect where small teams in divisions may have met all targets within the reported periods. Divisional updates reported through staffing papers presented at Divisional Boards reflect compliance within division and continued actions being taken to support a focus on improvement.

	Jan-24				Feb-24				Mar-24				Apr-24				May-24				Jun-24			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
NMC Staff Group Trust Total	90.21%	91.92%	93.14%	89.53%	89.33%	91.31%	92.72%	89.74%	90.53%	90.68%	93.21%	87.80%	91.08%	91.22%	93.21%	84.27%	90.38%	91.35%	93.05%	85.87%	85.75%	91.63%	93.75%	85.54%
HCA Staff Group Trust Total	91.10%	90.75%	95.50%	86.46%	90.63%	89.84%	94.24%	83.64%	91.80%	89.99%	94.47%	80.18%	90.54%	91.33%	94.84%	83.54%	91.85%	89.86%	94.87%	79.39%	89.38%	88.32%	94.12%	87.16%
AHP Staff Group Trust Total	90.45%	91.34%	95.94%	86.21%	88.76%	89.91%	96.89%	74.55%	93.23%	90.83%	97.67%	80.70%	93.50%	88.89%	96.55%	83.61%	93.12%	90.99%	96.89%	77.19%	89.08%	81.95%	95.50%	88.60%
PDR Trust Target 90%																								
OtherTraining Trust Target 95%																								

Table 9: Training and PDR data

7.0 Measurement of Quality of Care

7.1 Clinical Incident Reporting

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

The number of Trustwide clinical incidents reported within the last six months (January 2024 - June 2024) can be seen in Table 10. The data highlights the incidents related to staffing levels and/or staff sickness affecting staffing levels and is drawn from the overall incidents reported within the timeframe.

Since previous reporting period (July 2023 – December 2023) a static position of clinical incidents related to staffing is noted with 244 incidents reported across in this reporting period across divisions compared to 245 previously.

Of the total clinical incidents related to staffing across divisions, Family Health Division had the largest volume of 116; (Maternity, 113; Neonatal, 3), Clinical Support Services (CSS) Division reported 17 and Gynaecology Division reported 111. All areas have seen a reduction in staffing related clinical incidents except for Gynaecology who have seen an increase from previous reporting period.

Reporting Period January 2024 – June 2024
Total clinical incidents reported = 3568 (previous reporting period = 4718)
Total staffing levels/staff sickness incidents reported related to clinical incidents (combined divisions) = 244 (previous reporting period = 245)

Table 10**:** Trustwide overview of incidents

7.2 Red Flag Events

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

There were no nursing red flags reported in the reporting period, therefore all red flags reported are midwifery red flags within Maternity services. Table 11 reflects the 6-month position of midwifery red flags highlighting those that contribute to the overall midwifery red flags. There were 268 red flags reported between January 2024–June 2024 which is an increase of 56 from previous reporting period (July 2023 – December 2023) where 212 red flags were reported.

On closer analysis of reported red flags in Maternity between January 2024 – June 2024, the 3 highest reported red flags following appropriate review and validation are related to delay of >12 hours during ongoing induction of labour (218, previously 195), >2 hour delay in admission to induction of labour (36, previously 30) and delay of 30 minutes or more between presentation and triage (7, which has reduced from previous reporting of 12).

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

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

Midwifery Red Flags	Jan	Feb	Mar	Apr	May	Jun	Grand Total
Any Occasion When 1 Midwife Is Not Able To Provide Continuous 1-1 Care				1	2		3
Delay Of 2 Hours Or More Between Admission For Induction & Beginning		9	11	11	5		36
Delay Of 30 Mins Or More Between Presentation And Triage	5		1		1		7
Delay Over 12 Hours During Ongoing Induction Of Labour	4	48	54	47	34	31	218
Missed Or Delayed Care (Eg Delay 60mins Or More In Washing & Suturing)		1	1		1	1	4
Grand Total	**9**	**58**	**67**	**59**	**43**	**32**	**268**

Table 11: Midwifery Red Flags

7.3 Serious Incidents/Patient Safety Incident Investigations

From September 2023 the Trust launched the Patient Safety Incident Response Framework (PSIRF) under the NHS Standard Contract. As part of the NHS Patient Safety Strategy (NHSE/I, 2019) the Trust is now seeing PSIRF replace the previous Serious Incident Framework (NHSE, 2015).

There was a total of eight Patient Safety Incident Investigations (PSII) reported in the Trust and an additional three Never Events and one MNSI case between January 2024 - June 2024. This is a reduction from the previous reporting period where the Trust had twenty-three combined SIs and PSIIs, one Never Event and two HSIB (now MNSI) cases. The reduction in PSIIs is likely a reflection of the increased PSIRF criteria knowledge in staff and Trust appetite in triggering a PSII. Of the overall incidents PSIIs, the following is the breakdown:

Maternity services with one PSII; one Never Event (retained Tampon) and one MNSI case (cooled baby). Neonates had one PSII, and one Never Event (insertion of a longline and guidewire left in place). Gynaecology Division had five PSIIs related to clinical care, clinical practice, and delayed treatment. CSS division had one PSII reported and one Never Events (retained Tampon post procedure).

Actions from all PSIIs will be implemented and shared for lessons learned when completed.

7.4 Patient Experience - Friends and Family Test (FFT)

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

A total of **7192** "Overall Experience" comments were received during the period January 2024 to June 2024 from the overall **7737** FFT responses received.

Of these **443** (6%) comments were received by patients noting themselves as "displeased". Of these displeased comments 4 in Maternity and 4 in Gynaecology/Hewitt Fertility Centre mentioned staffing numbers/shortages in their description of their experience. The common theme of these continues to be a lack of support on the ward or areas which the patients attributed to being understaffed.

The FFT asks patients "please tell us anything we could have done better". In the period from January 2024 to June 2024, **5162** comments were left in this section covering both Pleased and Displeased results. Of these **21** (0.4%) identified staffing numbers/shortages as something that needed to be improved, this is a reduced volume to that reported in the previous reporting period. The majority of these related to Gynaecology services (17), followed by Maternity (4).

Main Gynaecology themes were:

- Waiting times in GED

Maternity and Gynaecology have Quality Improvement projects underway from previous reporting period to support the improvement work to address the themes noted now and previously.

7.5 Complaints, Concerns and Compliments

There were **35** formal complaints received in the Trust during January 2024 – June 2024 which was a decrease of one from previous six months (36). The breakdown reflects: Gynaecology 23 (14 of these were Hewitt), Family Health 11 (Maternity 10 and Neonatal 1) and CSS (Theatres and Anaesthetic) 1.

These contained 158 individual categories of concerns that required investigation within these 35 complaints, a decrease of 60 individual concerns from the previous reporting period. An average of 5 categories of concerns raised per complaint (previously 5). Response rates for complaints answered in timeframe agreed with the complainants during this reporting period reflects 100% compliance (previously 100%). There was no complaint category where staffing levels was raised specifically.

There were **35** PALS+ recorded during the reporting timeframe (the same number as the last reporting period) with no cases noting staffing in the issue raised. There were **1162** PALS cases noted within January 2024-

June 2024 which is a decrease from the previous reporting period (1364 reported). There were no PALS cases noted where shortages of staff were highlighted as the issue raised (0 in previous reporting period).

There was a total of **44** compliments Trustwide received (via PALS) within the timeframe which broadly covered general satisfaction of the service provided, which includes staff groups and individuals. Compared to the previous reporting period this is a decrease of 7 compliments. Of the 44 compliments the clinical divisions breakdown is: Gynaecology, 23; Maternity, 14; Neonatal, 1; and CSS, 1; Patient Experience, 3 and Patient Administration Service 2. All compliments, where possible when individuals are identified, are shared with the individual and their manager/leaders.

7.6 Staff Experience

We recognise safe staffing is the single most important determinant of employee morale, closely followed by supportive line management. Improving staff wellbeing and experience remains a key priority. Key actions taken over the reporting period include:

Health and Wellbeing – The LWH Staff Support Service led by a Consultant Psychologist, and supported by a psychologist and wellbeing coach continues to receive an average of 25 referrals per month. Prevention of PTSD is a key focus of the service, and this training is being rolled out to clinical staff in acute areas, with shift leaders and medical staff training having taken place. Closer working and supervision between the Staff Support team, PMAs, PNAs and Mental health first aiders has been established. Wellbeing conversation training is being refreshed and rolled out to managers, recognising the value of a good quality wellbeing conversation. Physical health will be a focus for the next 12 months, with the health and wellbeing coach offering tailored programmes to staff to support weight management and nutrition and physiotherapy colleague providing tailored MSK interventions.

Leadership and Management - Every NMAHP leader (alongside other professionals) are invited to undertake one of 3 programmes, which are accredited by the Chartered Management Institute. Over 200 staff have either completed or are currently engaged on a programme.

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

People Promise - The People Promise Manager has started in post and is working with colleagues in Nursing & Midwifery to deliver 3 key projects:

- Launch of a career development and enrichment programme for ‘mid-career’ nurses, midwives and AHPS
- Further rolling out flexible working for clinical staff, noting the beneficial impact of ‘unlimited roster requests’ within maternity
- Empowering managers to have meaningful conversations about retention.

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

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

Breaks Audits - Breaks continue to be closely monitored, with a programme of ongoing audits and feedback on progress at Professional Forum.

7.7 Staff reported incidents (Violence and Aggression)

During January 2024 – June 2024 the number of reported incidents related to verbal or physical acts of violence or aggression against NMAHP staff is recorded as **26** (previously 29 reported). This is broken down further as Maternity 14, Neonatal 1 and Gynaecology 9 and CSS 2. Several incidents of visitor verbal abuse towards staff are attributed to the smoking rules denying visitors readmission to the Maternity Base after 2200 hours should they leave for the purpose of smoking; overall verbal assault towards staff from visitors to Maternity Base in this period totalled 10.

Not included in the data are 2 incidents of physical assault linked to post operative confusion. These incidents, whilst reported as violence and aggression, are non-intentional, therefore, we would not pursue as violence towards a member of staff. Assurance is given that the staff members involved received appropriate support and no injuries were sustained.

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

8.0 Attraction, Recruitment and Retention

The Learning and Development Facilitator in the Trust supports the Trust attraction, recruitment, and retention plans. They do this through Widening Participation, Acorns and Cadets, Work Experience, Apprenticeships, Recruitment Fairs and Careers Events. In June 2024 the Trust participated in the NHSE week-long career event aimed at Year 10 students who cannot do work experience in the clinical areas due to their age. At this event professionals attended to showcase the variety of professions in the NHS at Hope University where approximately 270 pupils from Liverpool attended. A particular focus on Midwifery and Neonatal Nursing careers was facilitated.

The Trust also engages through wider teams an ambition to increasing diversity of new entrants across roles and salary bands as a priority. LWH has recently introduced a positive recruitment scheme based on race. It has been agreed that volunteers identified as part of a talent pool will be guaranteed interviews for support worker roles within clinical services. NHS Professionals, now emulate this scheme.

Three volunteers from the Volunteers to Careers (VtC) programme have gained employment in support roles within Neonatal, Gynae and Maternity Services, a further two have been offered MSW posts. HR are integrating volunteering in recruitment campaigns and into workforce and people plans and providing career support to volunteers signposted by the volunteer service.

LWH has completed its International Theatre Nurse recruitment, through Cheshire International Recruitment Collaborative (CIRC). A total of 22 Internationally educated recruits arrived to LWH since recruitment commenced (11 in Theatre, with one leaver; 11 in Midwifery, with one leaver). The current position reflects that during January 2024 – June 2024, the final midwife arrived and commenced in the Trust, 17th February 2024, with nurse vacancies successfully recruited and completed as of September 2023.

The Trust continued to provide pastoral support to new international recruits from the moment they onboarded, including access to an applicant landing page, which enabled them access to training and pastoral support materials, prior to their UK Arrival. On arrival to LWH all International Recruits received a full onboarding programme and take part in an internal Mentoring and Coaching programme, as part of a development initiative.

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

9.0 Actions and recommendations:

The following actions are proposed during next six months (July 2024-December 2024):

- Succession planning across all divisions in line with business planning cycle.
- Continued focus to recruiting to vacancy position.
- Divisions to continue to review trajectories of improvement in Training and PDRs to be reviewed through monthly Divisional Performance Reviews
- Continued focus on the nursing and midwifery self-assessment tool/retention improvement and action plan.
- Focus on accelerator career development programme for staff in conjunction with the People Promise Manager
- Following a successful joint bid with LUHFT for the NHSE Global Majority Pilot Programme, plan to recruit 3 participants from LWH and LUHFT and provide individuals with an agreed pathway of development, coaching and support, access to Elevate programme and mock applications and interviews to enable them to gain confidence to apply and gain future roles.

10.0 Conclusions

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

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

Furthermore, the Board of Directors are requested to gain assurance that the divisional level staffing reviews are written and received in Divisional Board and that this further supports divisional level oversight, actions to address areas of challenge and responsibilities to ensure safe staffing. In addition, noting that Maternity services report staffing twice yearly directly to Trust Board to fulfil requirements as outlined by The Maternity Incentive Scheme (MIS) Year 6, Safety Action 5. Neonatal services provide Board of Directors with a yearly Clinical Negligence Scheme for Trusts (CNST) compliance report.

Appendix 1 – CHPPD and Actual versus Planned Fill Rates

The NHS Digital Return via Strategic Data Collection Service (SDCS) - Safe Staffing Fill Rate each month are noted as per below from January 2024–June 2024. The data is presented monthly to Trust Board via the Integrated Performance Report, supported by a detailed narrative and triangulation of information from the Heads of Nursing and Midwifery.

January 2024

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	85%	70%	147%	89%
Induction & Delivery Suites	88%	81%	77%	58%
Maternity & Jeffcoate	80%	97%	87%	98%
MLU	90%	79%	77%	90%
Neonates (ExTC)	91%	79%	90%	85%
Transitional Care	42%	119%	68%	87%

February 2024

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	84%	77%	148%	98%
Induction & Delivery Suites	80%	83%	84%	97%
Maternity & Jeffcoate	80%	106%	84%	97%
MLU	80%	79%	82%	76%
Neonates (ExTC)	91%	81%	88%	95%
Transitional Care	52%	131%	62%	117%

March 2024

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	86%	80%	92%	103%
Induction & Delivery Suites	85%	84%	82%	94%
Maternity & Jeffcoate	80%	106%	84%	91%
MLU	79%	97%	73%	77%
Neonates (ExTC)	93%	100%	94%	102%
Transitional Care	32%	135%	68%	100%

April 2024

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	85%	88%	91%	100%
Induction & Delivery Suites	88%	88%	81%	80%
Maternity & Jeffcoate	92%	109%	87%	104%
MLU	86%	77%	82%	83%
Neonates (ExTC)	95%	92%	97%	90%
Transitional Care	47%	77%	43%	77%

May 2024

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	88%	88%	95%	100%
Induction & Delivery Suites	91%	84%	80%	77%
Maternity & Jeffcoate	83%	114%	83%	96%
MLU	71%	87%	62%	84%
Neonates (ExTC)	90%	108%	91%	100%
Transitional Care	35%	94%	65%	35%

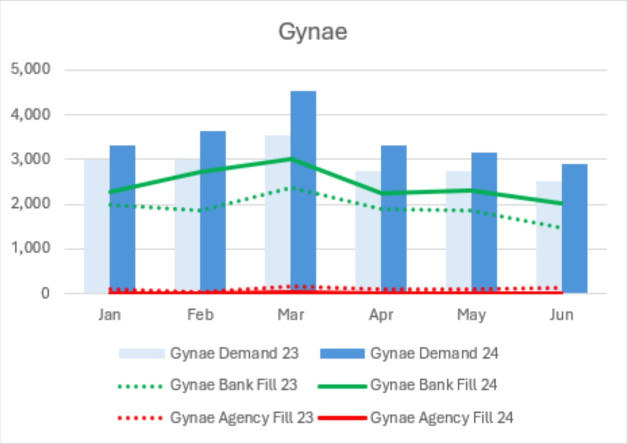
June 2024

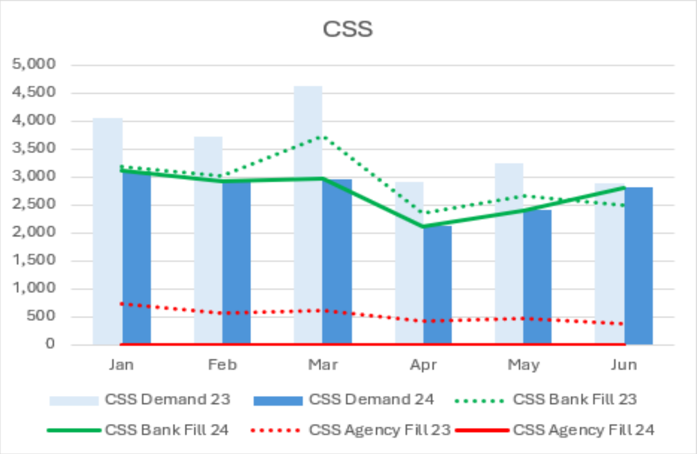
WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	85%	78%	96%	100%
Induction & Delivery Suites	90%	82%	87%	93%
Maternity & Jeffcoate	87%	106%	89%	102%
MLU	68%	83%	60%	97%
Neonates (ExTC)	89%	103%	86%	88%
Transitional Care	50%	70%	60%	47%

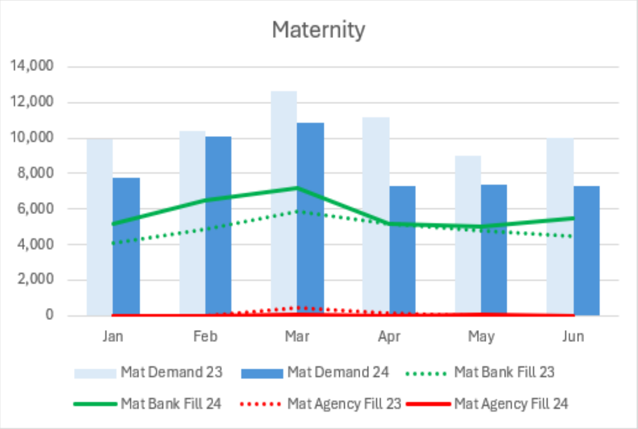
Trustwide CHPPD

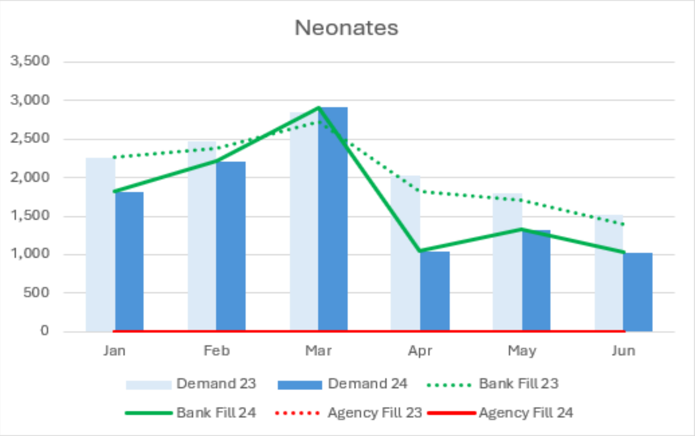
CHPPD	Jan 24	Feb 24	March 24	April 24	May 24	June 24
Trust wide	9.3	8.6	8.7	9.2	8.9	9.5

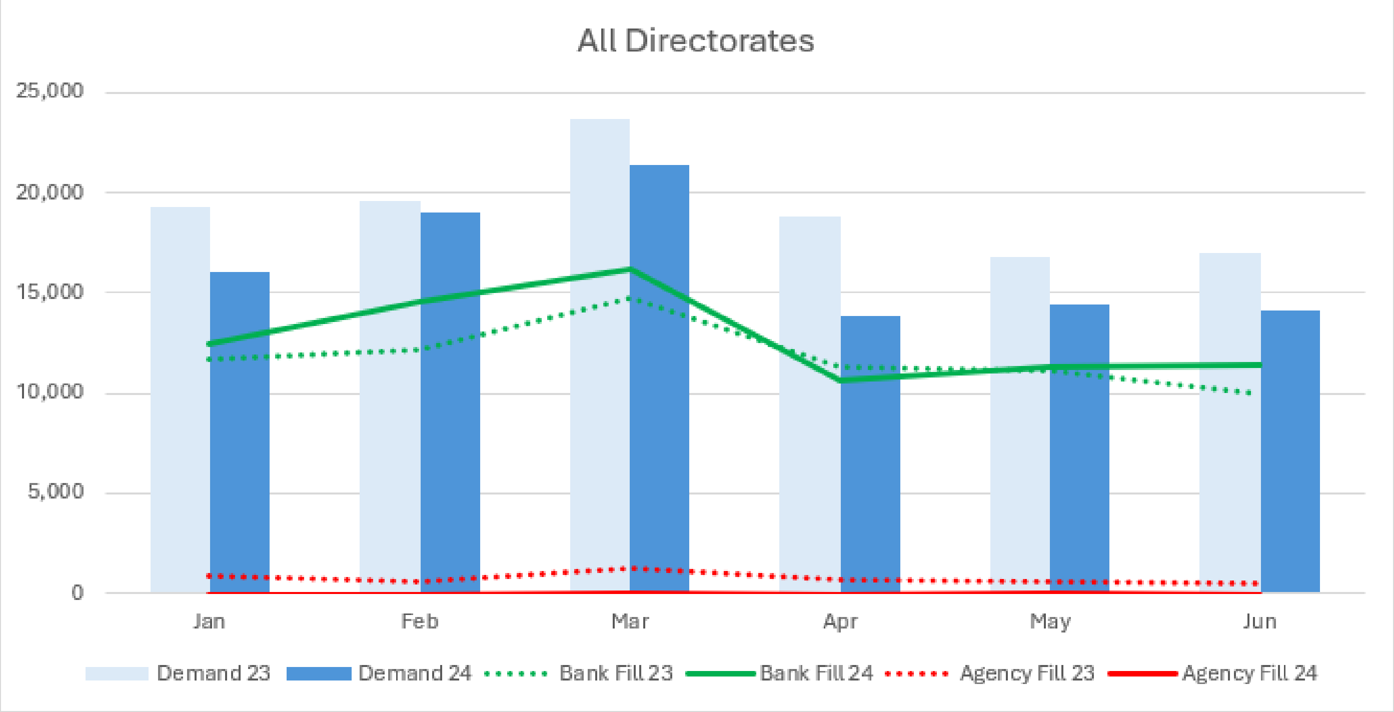
Appendix 2: NHSP January 2024- June 2024 Bank and Agency demand and fill rates by Division and Trustwide











Appendix 3: NICE Guidance on Red Flag Events

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

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

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

Other midwifery red flags may be agreed locally.

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

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

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

nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).

- Less than 2 registered nurses present on a ward during any shift.

Other nursing red flag events may be agreed locally.

Board of Directors

COVER SHEET

Meeting Date	Thursday, 10 October 2024	**Item Reference**	TB24/25_141
Report Title	Maternity Incentive Scheme Year 6 – Sept/October 2024 Compliance Update		
Author	Angela Winstanley – Quality & Safety Matron Maternity Yana Richens – Director of Midwifery		
Responsible Director	Dianne Brown – 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 also provides a position statement for all 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	Update on previously identified risk: The previously identified risk in relation to deliverance and attendance at PROMPT training has been resolved since the announcement that no further medical industrial action is planned.
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	-
Links to Corporate Risk Register (scoring 10+)	NA	-

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

Action Required by the Board of Directors	The Board of Directors is asked to: • Note the current position in relation to the recently published Maternity Incentive Scheme Year 6. • Take assurance that the Family Health Division has clear oversight and management of the scheme requirements.

	- Note the compliance with the requirements for the Neonatal Nursing Staffing Review, the Board is asked that this is noted in the Board Minutes.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Divisional CNST Oversight Committee	Twice Monthly	Director of Midwifery	Weekly progress updates from scheme safety action leads.
Family Health Divisional Board	September 2024	Clinical Director for Family Health	Accepted and approved for submission to October 2024 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 (Appendix 3). 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:

Table 1 Current Position MIS for Year 6 – September 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.

<table>
<tr><th>Safety Action Point & Description</th><th>Required Standard</th><th>Status and Actions Required.</th></tr>
<tr><td><b>SA.1</b> Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?</td><td>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.</td><td><b>Sept 2024 - This standard is on target to be achieved.</b>
<b>100%</b> Compliance – 32 Deaths eligible for notification, at this time, all reported within the time frame required.</td></tr>
<tr><td></td><td>B. <b>95%</b> 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 – 100%</td><td><b>Sept 2024 - This standard is on target to be achieved.</b>
<b>100%</b> Compliance – Of 32 cases reported, that are eligible for full PMRT review, all 32 families have been informed and perspectives of care sought.</td></tr>
<tr><td></td><td>C. For deaths of babies who were <b>born and died</b> in your Trust multi-disciplinary reviews using the PMRT should be carried out from 08.12.2023.

a) <b>95%</b> of reviews should be started within two months of the death.
- 100% Cases started within two months – 32 Cases all have had PMRT Reviews commenced.

<b>b)</b> <b>60%</b> of multi-disciplinary reviews should be completed and published within six months.
16 Cases - Fully published within six months –100% Compliance</td><td><b>Sept 2024 – This standard is on target to be achieved</b>
-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.</td></tr>
<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><td>Quarter</td><td>Received by Quality Committee</td><td>Received by Trust Board</td></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><b>Sept 2024 - This standard is on target to be achieved.</b>
Learning from Deaths Reports are scheduled for Quality Committee throughout the forthcoming scheme period.</td></tr>
</table>

Safety Action Point & Description	**Required Standard**	**Status and Actions Required.**
SA.2 Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 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)	**Sept 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.
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?	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.	**Sept 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.
	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.	**Sept 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.

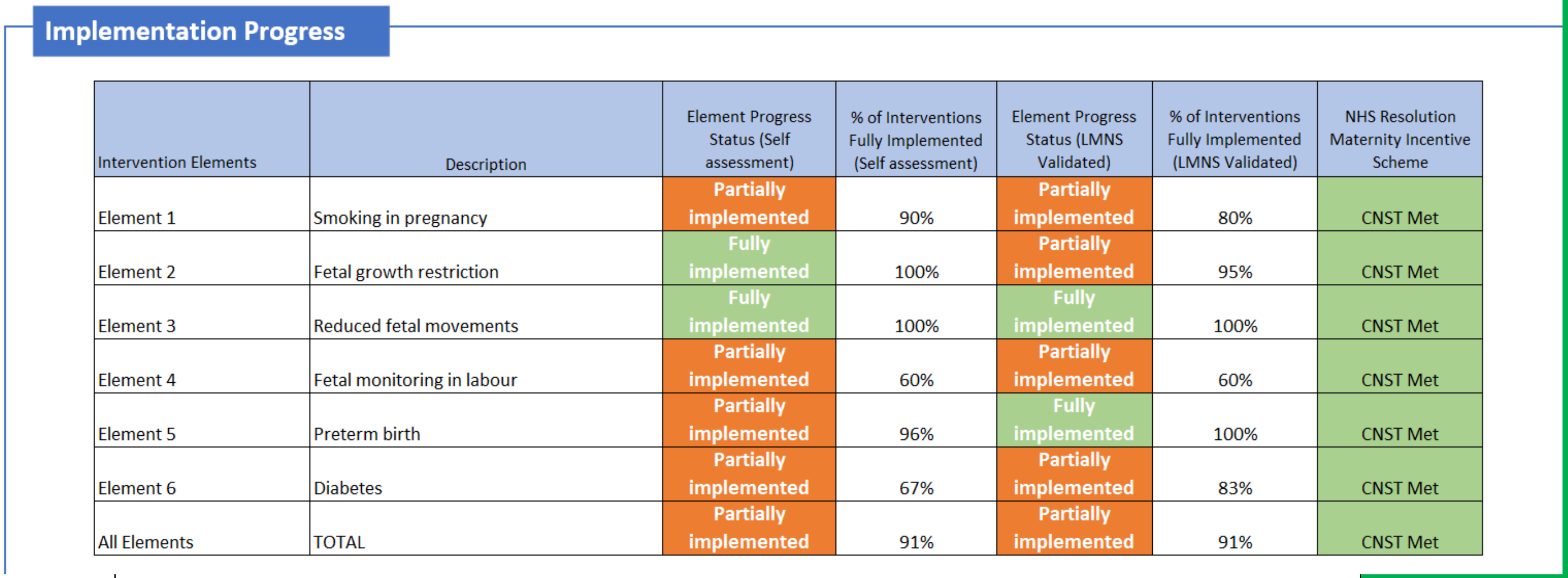
Safety Action Point & Description	**Required Standard**	**Status and Actions Required.**
SA.4 Can demonstrate an effective system of clinical workforce planning to the required standard?	**Obstetric Medical Workforce** 1. NHS Trusts/organisations should ensure that the following criteria are met for 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.	**Sept 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	**Sept 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	**Sept 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

Safety Action Point & Description	Required Standard	Status and Actions Required.
	4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations 27 listed in the RCOG workforce document: *'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'* into their service when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. **Evidence Required**: Trust positions with the requirements should be shared with the Trust Board, the Board-level safety champions as well as the LMNS.	**Sept 2024 - This standard is on target to be achieved.** 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. Jan to June 2024 – TBC
	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.	**Sept 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.

Safety Action Point & Description	**Required Standard**	**Status and Actions Required.**
		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.	**Sept 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).	**Sept 2024 – This standard is achieved.** The Family Health Divisional Board have received the Neonatal Nursing Workforce Review Paper, prepared by the Head of Neonatal Nursing, which can be found in the Appendix to this report. This staffing report demonstrates that neonatal staffing in the neonatal unit meets expected the BAPM standards and this should be reflected within the Trust Board Minutes. This paper will also be submitted to PPF.
SA.5 Can demonstrate an effective system of midwifery workforce planning to the	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	**Sept 2024 – This standard is 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

Safety Action Point & Description	**Required Standard**	**Status and Actions Required.**
required standard?	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. 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 was presented to Trust Board on 12th 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.	**Sept 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 September 2024, the FHD reviewed their Q2 position in relation to SBLCBV3 and have uploaded all evidence and audits to support a continued strong position of compliance. The Trust have simce received the validated Q2 position in relation to SBLCBv3 Implementation and can report a 91% compliance with the intervention requirements (see table 1) .

Safety Action Point & Description	Required Standard	Status and Actions Required.



Implementation Progress

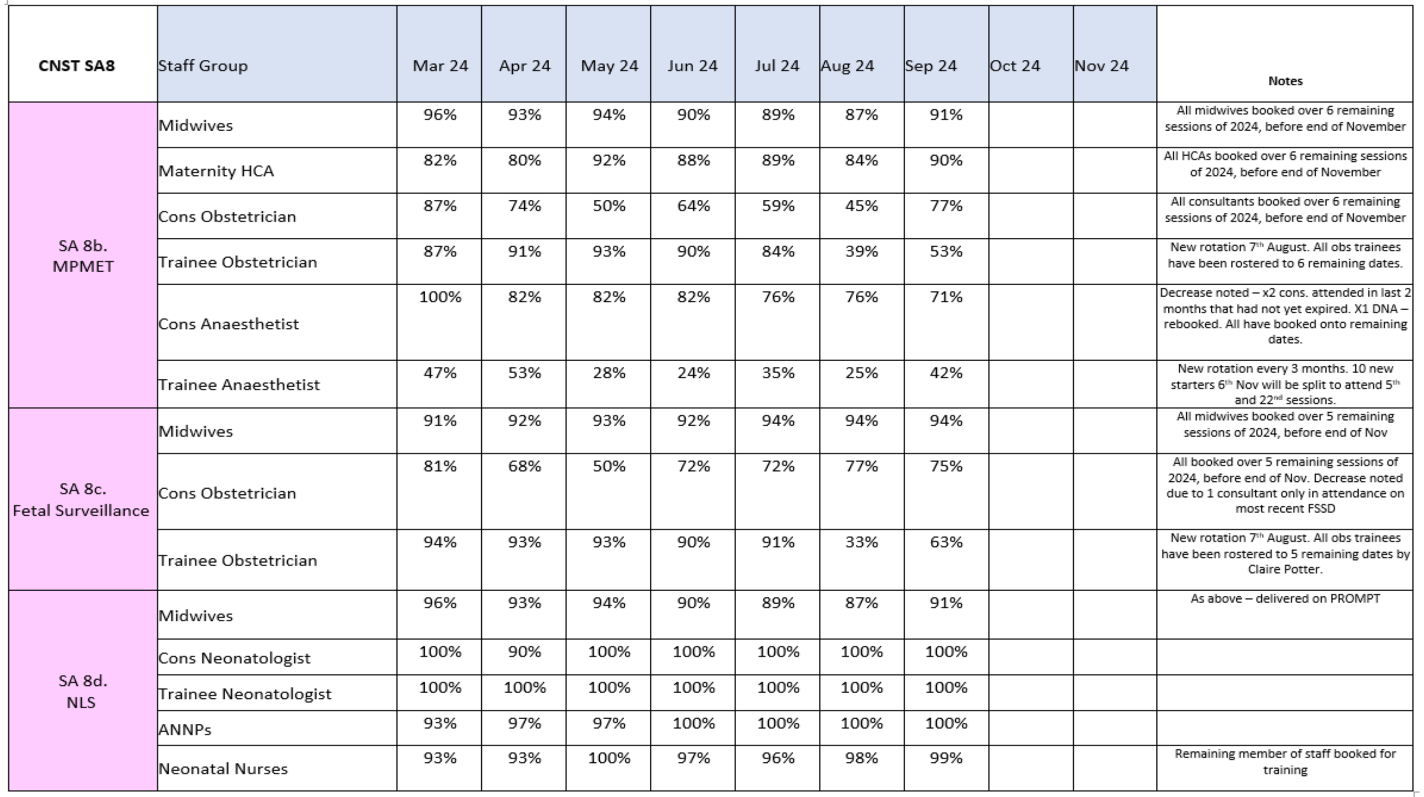
Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	80%	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	60%	Partially implemented	60%	CNST Met
Element 5	Preterm birth	Partially implemented	96%	Fully implemented	100%	CNST Met
Element 6	Diabetes	Partially implemented	67%	Partially implemented	83%	CNST Met
All Elements	TOTAL	Partially implemented	91%	Partially implemented	91%	CNST Met

Table 1: September 2024: Compliance with SBLCBV3 position as per LMNS validation. Next compliance position will be available in November/December 2024 update.

Safety Action Point & Description	**Required Standard**	**Status and Actions Required.**
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.	**Sept 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 has been 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. meeting a co-produced action plan has been developed with the MNVP. This has been shared with the LMNS through the Future NHS LMNS MIS Oversight site. 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.

Safety Action Point & Description	**Required Standard**	**Status and Actions Required.**
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	**Sept 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 01.10.2024 with MPMET, Fetal Surveillance Day and New-born Life support. The Anaesthetic attendance and compliance have been escalated to the CSS Divisional Manager. CSS Division have planned and assured that all new anaesthetic medical starters to the Trust in November will be scheduled to attend MPMET. This action will remain amber until such time the scheme period ends and all evidence collated and validated.

Safety Action Point & Description	Required Standard	Status and Actions Required.



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%	91%			All midwives booked over 6 remaining sessions of 2024, before end of November
	Maternity HCA	82%	80%	92%	88%	89%	84%	90%			All HCAs booked over 6 remaining sessions of 2024, before end of November
	Cons Obstetrician	87%	74%	50%	64%	59%	45%	77%			All consultants booked over 6 remaining sessions of 2024, before end of November
	Trainee Obstetrician	87%	91%	93%	90%	84%	39%	53%			New rotation 7th August. All obs trainees have been rostered to 6 remaining dates.
	Cons Anaesthetist	100%	82%	82%	82%	76%	76%	71%			Decrease noted – x2 cons. attended in last 2 months that had not yet expired. X1 DNA – rebooked. All have booked onto remaining dates.
	Trainee Anaesthetist	47%	53%	28%	24%	35%	25%	42%			New rotation every 3 months. 10 new starters 6th Nov will be split to attend 5th and 22nd sessions.
SA 8c. Fetal Surveillance	Midwives	91%	92%	93%	92%	94%	94%	94%			All midwives booked over 5 remaining sessions of 2024, before end of Nov
	Cons Obstetrician	81%	68%	50%	72%	72%	77%	75%			All booked over 5 remaining sessions of 2024, before end of Nov. Decrease noted due to 1 consultant only in attendance on most recent FSSD
	Trainee Obstetrician	94%	93%	93%	90%	91%	33%	63%			New rotation 7th August. All obs trainees have been rostered to 5 remaining dates by Claire Potter.
SA 8d. NLS	Midwives	96%	93%	94%	90%	89%	87%	91%			As above – delivered on PROMPT
	Cons Neonatologist	100%	90%	100%	100%	100%	100%	100%			
	Trainee Neonatologist	100%	100%	100%	100%	100%	100%	100%			
	ANNPs	93%	97%	97%	100%	100%	100%	100%			
	Neonatal Nurses	93%	93%	100%	97%	96%	98%	99%			Remaining member of staff booked for training

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

Monitoring of attendance at each of the three training days using local held records or ESR.

SA.9 Can you demonstrate that there are robust processes in place to provide	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;	**Sept 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,

Safety Action Point & Description	Required Standard	Status and Actions Required.
assurance to the Board on Maternity and neonatal safety and quality issues?	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 BSC to develop trusting relationships between staff, the frontline maternity, neonatal and obstetric safety champions, the 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.	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. 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.

Safety Action Point & Description	Required Standard	Status and Actions Required.
		The Quality & Safety Matron is developing a report that will outline the key trust level principles of the PQSM, with embedded evidence to assure that the Trust and Division are meeting the requirements. This will be tabled at FHDB in October 2024 with onwards sharing where required.
	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.	**Sept 2024** - The HoM and DM, 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.	**Sept 2024 - The FH Division needs to undertake additional actions to achieve this standard.** There have five 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.

Safety Action Point & Description	Required Standard	Status and Actions Required.
		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 of Directors is asked to:

- Note the current position in relation to the recently published Maternity Incentive Scheme Year 6.
- Take assurance that the Family Health Division has clear oversight and management of the scheme requirements.
- Note the compliance with the requirements for the Neonatal Nursing Staffing Review, the Board is asked that this is noted in the Board Minutes.

SUPPORTING DOCUMENTS

- Neonatal Staffing Paper

Liverpool Women's
NHS Foundation Trust

Board of Directors

COVER SHEET

Meeting Date	Thursday, 10 October 2024	**Item Reference**	TB24/25_141
Report Title	Perinatal Quality Surveillance & Safety Dashboard		
Author	Clare-Louise Murray, Lead Governance Manager Family Health Division 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	N/A	**-**
Links to Corporate Risk Register (scoring 10+)	-	**-**

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

Action Required by the Board of Directors	The Board of Directors is asked to 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 August 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**	**Aug-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%	100.00%
	Stillbirth Number >24 weeks (Adjusted)	Actual Number	2	1	1	0	2	3	2	2	1
	Stillbirth Adjusted % per 1,000 Birth		5.10%	5.20%	1.72%	3.40%	3.40%	0.00%	4.63%	3.24%	1.65%
	Apgar <7 @ 5 Minutes (>37wks)	<1.6%	1.30%	1.53%	1.48%	1.32%	1.06%	1.21%	1.54%	2.01%	0.54%
	Term Admission to NICU	<6%	5.11%	4.66%	4.87%	6.25%	3.90%	5.55%	4.62%	6.93%	4.14%
	Women in receipt of COC	No standard	18.80%	16.96%	20.92%	19.52%	19.57%	17.06%	22.87%	17.45%	20.35%
	BAME in receipt of COC	No standard	39.60%	32.22%	43.68%	37.00%	33.70%	37.62%	42.57%	27.50%	35.21%
	Social Depravation of CoC	No standard	20.62%	18.69%	20.92%	22.06%	24.32%	17.36%	22.87%	20.12%	21.74%
	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%	96.80%
	Coroner Reg 28 Made to Trust	Actual Number	0	0	0	0	0	0	0	0	0
	MNSI Referals Accepted	Actual Number	1	0	0	1	0	0	0	2	0
Workforce	MNSI Completed Reports Returned	Actual Number	0	2	1	0	1	0	0	2	0
	Supernumary Shift Leader	100% CNST	100%	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%	7.10%
	Midwifery Vacancy	% of Workforce	2.20%	0.00%	0%	0%	0%	0%	0%	0%	3%
Feedback	Rostered Cons Hrs on DS	>60	106.5	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	0
	Number of Maternity Incidents over 30 days	Actual Number	26	26	45	28	43	43	43	43	52
	Number of PALS/PALS +	Actual Number	43	43	36	29	0	36	36	38	38

Perinatal Quality Surveillance & Safety Narrative – August 2024.

Midwifery Red Flags:

34 red flags were reported during August 2024, a significant decrease from the 94 reported in July 2024. The delays pertain to three specific categories:

Reason	**Number**
IOL>12 hours	31
30-minute triage	1
IOL >2 hours of arrival	1

The Midwifery red flags reported in August were the lowest numbers of reported delays seen this year. No harm was reported for each of the delays.

March	April	May	June	July	August
Total IOL= 190 (46 delays >12 hrs) Approximately 24%	Total IOL =190 (46 delays >12 hrs) Approximately 24%	Total IOL= 178 (58 delays >12 hrs) Approximately 33%	Total IOL = 178 (20 delays > 12 hrs) Approximately 11 %	Total IOL = 235 (70 delays > 12 hrs) Approximately 29.78%	Total IOL = 231 (31 delays > 12 hrs) Approximately 5.19%

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.

The remaining red flag was in relation to a delay in suturing.

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:

There were no cases which required external reporting to MNSI throughout August 2024.

Five cases are currently under investigation by MNSI. All cases are on track and progressing within the allotted timeframes set out by MNSI.

Maternity Serious Safety Incidents	There were no PSIIs declared in August 2024 for the Maternity Division. There are 52 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 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 August 2024: 1 Number of Neonatal Perinatal Deaths in August 2024: 7 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 45 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.

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 include 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. Capacity and demand of elective caesarean sections within the Trust was discussed at August's meeting, which included the risks with the rising demand for caesarean sections rising by 50% from 2019-2024. It was noted that the results had caused an overspill of resources including out of hours cover, theatre staffing and anaesthetist time. Two risks were submitted to the risk register for out of hours on call support and delays in transfer to obstetric theatres. Mitigating the risk had included CSS and Family Health recommending three controls which included: • Introduce all day Sunday theatre list. • Create an intelligible, criteria for out of hours emergency caesarean section. • Improve productivity through the Theatre Workstream as part of the Improvement Plan by March 2025. It was noted that the overall births in the Trust had decreased but the co-morbidities of woman had increased. Concluding that the Trust did not have the staff capacity or bed capacity on Maternity Base for a third theatre if introduced, and the overall analysis was down to Estates, Time, and Cost. After a deep dive of the data into category three caesarean sections, it was noted that some out of hours deliveries were done due to capacity and not emergency.
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.
Workforce **Midwifery Sickness**	Sickness across the division increased slightly from 6.9% in July to 7.1% in August. There was an increasing trend across all clinical areas of the trust. The weighting of short term and long term in remained the same at 44% short term to 55% long term. For Neonates absence remained increased by 0.5% and there was a further shift towards long term at 75% and short term at 24%. The HR team are working closely with line managers to support staff back from long term absence Reasons for absence remained the same in maternity. For Neonates there is a prevalence of absence for musculoskeletal.

Midwifery Vacancies	Return to work compliance in Maternity remained static at 45% a deep dive of compliance was conducted in August and there is assurance that return to work meetings are taking place but there is a lag in the recording of the meeting. This has been addressed with line managers to ensure timely recording. Compliance for return to works for Neonates increased to 83%. Sickness in the Obstetric Medical Teams remained at 2.7% No absence to report in the neonatal medical team. Vacancies at 2.8%, 21 WTE Newly Qualified Midwives are starting 7 October 2024. Temporary contracts have been provided to ensure backfill for maternity leave, which currently stands at 12.37 WTE.
Saving Babies Lives	The SBCBv3 Team have received a validated Q2 2024-2025 implementation compliance status from the LMNS. Current compliance sits at 91% overall, with every element achieving >90% completion, post validation of all evidence submitted to support our positive position. Further work will be carried out within the Division to improve diabetic clinic provision at ACWH, ensuring women with pre-existing diabetes and gestational diabetes are seen separately, fetal surveillance competency testing and obstetric training in relation to smoking in pregnancy also will be subject to improvement measures. The Implementation Tool info graph can be found in the MIS Year 6 Update paper.

RECOMMENDATION

The Board of Directors is asked to receive this paper and seek assurance of ongoing compliance and progress with the implementation of a perinatal quality dashboard and framework.

Board of Directors

COVER SHEET

Meeting Date	Thursday, 10 October 2024	**Item Reference**	TB24/25_141
Report Title	Bi-annual Neonatal Staffing paper update, January – June (Q1-Q2) 2024		
Author	Susan O'Neill DHoN		
Responsible Director	Dianne Brown – Chief Nurse		

Purpose of Report	To provide an overview of Neonatal Services workforce from January to June 2024.
Executive Summary	The Board of Directors is asked to note the contents of the paper and take assurance of the actions undertaken to effectively manage and provide safe staffing within Nursing, Midwifery and AHP to support the delivery of safe care.
Key Areas of Concern	N/A
Trust Strategy and System Impact	• To deliver safe services • To deliver the best possible experience for patients and staff

Links to Board Assurance Framework	None	-
Links to Corporate Risk Register (scoring 10+)	N/A	-

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

Action Required by the Board of Directors	The Board of Directors is asked to: • Note the contents of the report.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

MAIN REPORT

1. Introduction

This paper is to provide assurance to the Board of Directors that the Neonatal Services workforce is safe and sustainable and is capable of delivering services now and into the future.The paper will provide assurance that nursing within NICU meets safer standards of nursing (BAPM) with an action in place to address any gaps in compliance and that NWNODN and specialist's commissioner are aware of increased intensive care activity and the impact this has on nursing standards.

2. Background

2.1 Nursing

The workforce with the Neonatal Intensive Care Unit (NICU) comprises of both registered and non-registered nurses. The registered staff are made up of Advanced Neonatal Nurse Practitioners (ANNP) and Nurses from a background Adult, Children, and midwifery training. Over 70% of the nurses on the unit have completed a speciality course in the care the preterm and sick babies this allows them to be registered as nurses who are qualified in speciality (QIS).

Currently, we have a small number of non-registered staff who work within the low dependency (LD) nursery and the transitional care unit (TC). They are responsible for most of the delivery of care to the babies within these areas with the only limitation being the inability to give certain medications. LWH has a standalone TC with its own budget and staffing.

Neonatal Community Outreach is also supported by the TC team. This is provided 7 days a week for babies from both the Neonatal Unit and Transitional Care, this allows for earlier and a smooth and confident transition home. This service is supported by the LD team in addition to the funded establishment due to demand on the service.

At LWH we continue to be very successful in the recruitment of staff .The age profile of the unit has reduced year on year, and we have had great success with internal recruitment embedding our talent pool into our recruitment process (internal candidates). Turnover increased in 2023/24 compared to previous years, with the recruitment of staff into newly created posts required for the opening of the new Neonatal Surgical Intensive Care unit at Alder Hey Hospital leading to vacancy on both Alder Hey and LWH sites. Rolling annual turnover at the end of Q1 Reduced to 11.51 %.

Newly qualified staff or those appointed without previous neonatal experience yare enrolled on the Neonatal Induction Programme, this is run jointly with NWNODN. Following a 12-month consolidation period, staff are then progressed on to the Neonatal Qualification in Speciality course (QIS) to enhance their knowledge and skills. This is run at LWH and validated by Liverpool John Moore's University at Level 6, and it is a requirement that at least 70% of our staff hold this qualification. (DoH, 2009, Toolkit for High Quality Neonatal Services).

Nurses on NICU are also responsible for the delivery of the IV antibiotics and BCG immunisations for all eligible babies born at Liverpool Women's.

47 Nurses at band 5,6 and 7 have been recruited to date to work on the new surgical intensive care unit at Alder Hey as part of the Liverpool Neontal Partnership . These posts were funded fom commissioned funding for the LNP and are not part of LWH or AH establishment.They currently work across both LWH and Alder Hey sites to gain the necessary skills and experience required to care for infants who require intensive care for a surgical condition. A training and education programme has been developed for these staff requiring them to be able to work on both sites and to facilitate the staff on the Alder Hey site to rotate to LWH for ITU upskilling experience which is required on a supernumerary basis.

2.2 Advanced Clinical Practice (ACP)

The role of the ANNP is an integral part of safe and effective care delivery at LWH.

Currently there are 27.96 wte ANNPs. Funding for posts is from LWH and the LNP. The team is well established with levels of experience within the existing team of ANNPs ranging from new to post to 26 years post qualification. The team has been led by a Team of 8b Lead ANNP's. Seven 8b lead ANNPs (6.28 WTE), with the Nurse Consultant undertaking the Deputy Head of Nursing post. This reflects the ambition of the new national framework for ACP.

Recruitment to vacancy of trained ANNPs has been challenging in the last 6-12 months, with more options now available at higher banding elsewhere. There has been a slight drift in retention. ANNPs working at tier 2 level across the northwest neonatal operational delivery network are being paid at band 8b, at LWH they are at 8a.

Therefore to remain competitive and attractive to external applicants , some band 8a vacancy was converted to band 8b. This was an integral piece of work to ensure safer staffing at ANNP level and to ensure the safe practice and care of neonates across the partnership.

Two internal candidates were successful in being recruited to these vacancies. The remaining vacancy was advertised to senior registrars, 4 of whom were successfully recruited as clinical fellowes The remaining 2 vacancies were advertised and appointed to with clinical fellowes . The remaining vacancy of 4.0 WTE is to be advertised in September 2024.

The British Association of Perinatal Medicine acknowledges that ANNPS work at both Tier 1 and Tier 2 level. Tier 2 ANNPs work at registrar level (ST 3-8) undertaking senior responsibilities both day and night. Tier 1 ANNPs work at ST 1-3 level, working under direct supervision of a tier 2 ANNP or doctor.

The current ANNP team at LWH comprises.

Band 8b – 8.48 wte (LWH Funded Posts 11.6 WTE funded)

Band 8a – 15.64wte (5.8 Funded LWH 10 funded LNP)

Band 7 – 3.84wte (LNP Funded) Will increase to band 8a upon completion of competency assessment after 12 months post qualification probationary experience.)

The team have been awarded HEE funding for a further 4 trainee ANNP funding for course to start in Jan 2025. These posts are funded from LNP commissioned funding for the medical staffing model, but will work across both LWH and Alder Hey sites.

British Association of Perinatal Medicine (BAPM) acknowledges that ANNPS work at both Tier 1 and Tier 2 level. Tier 2 ANNPs work at registrar level (ST 3-8) undertaking senior responsibilities both day and night. Tier 1 ANNPs work at ST 1-3 level, working under direct supervision of a tier 2 ANNP or doctor.

Transport

ANNPS currently provide medical cover (1.0 WTE) for out of hours emergency transport for connect NW the northwest ODN Neonatal Transport team. The service went off site in May 2024 to a large new base in Warrington, due to the large footprint coverage of the team requirements. This has been agreed through the network and commissioners, therefore LWH is supporting this service through 1wte Tier 1 ANP on a rotational basis for 6 month blocks.

3. Workforce planning - Setting evidenced based establishments

Neonatal Nursing has become one of the most prescribed areas of nursing over the last years. In line with other intensive care specialities BAPM has set clear standards around the minimum number of nurses required to care for our client group. This is set in the national specification for neonatal care and is clearly defined by the specialist commissioners in hospital contracts. BAPM standards can be reviewed in the link below;

http://www.bapm.org/publications/documents/guidelines/BAPM_Standards_Final_Aug2010.pdf

Neonatal Units have also seen the introduction of the safer staffing guidance for Neonatal services, this reflects the requirements of the BAPM guidance but also addresses ways in which professional judgement should be used to ensure safer staffing on units. This way of working has been in use on the NICU since early 2017 and has helped ensure we maintain safe and appropriate levels of staffing.

https://improvement.nhs.uk/resources/safe-staffing-neonatal-care-and-children-and-young-peoples-services/

There is also a requirement to have quality roles extra to the establishment; these include education, breast feeding, infection control, development care. BAPM recommends that nurses are Identified to be champions for the quality of practice within each unit and should have protected time and responsibility in the following areas:

- Infant feeding

- Family care.
- Developmental care.
- QI in perinatal optimisation.
- Safeguarding children.
- Bereavement support and palliative care.
- Discharge planning and outreach nursing.
- Risk, governance and patient safety.
- Infection control.
- Education and practice development

The above requirements were highlighted with some provision in the Neonatal staffing budgets for 23/24, however have not been approved as roles within the budgeted establishment. They will form part of budget setting for 24/25 budgets. At LWH Budgets are rota based and time is allocated from the nursing rotas to support these roles as reviewed and agreed by the Head of Neonates and the Deputy Chief Nurse.

3.1 Staffing Tool

The CRG Workforce Calculator (2020) is used by commissioners to define staffing establishments in line with activity for NICU across England. It is intended to support neonatal nurse managers and their colleagues by providing a consistent method for the calculation of nursing establishment requirements which meet national standards i.e. NHSI (2018); NHSE Neonatal Service Specification e08 (2015); DH (2009); BAPM (2010); NICE (2010). There is a mandatory annual review by the NWNODN and it is a requirement of CNST that the CRG tool is used. Below are the figures for this period of reporting.

CRG calculator calculations have identified the following in relation to the Neonatal Service at LWH for the last 6 months. (Jan- June)

Table 1 CRG Neonatal Workforce tool Calculator Jan-June 2024

Activity (HRG 2016)							
	Activity	*For calculations*		Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	3,778	*12.9*	*6.07*	12	86.26%	13	-1
HRG 2	3,538	*12.1*	*3.04*	12	80.78%	13	-1
HRG 3	6,924	*23.7*	*1.52*	20	94.85%	23	-3
Total	**14,240**			**44**	**88.67%**	**49**	**-5**

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 145.68, of which 101.98 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	154.32	119.61	157.36	-3.04	-37.75
Total reg nurses	134.00	103.88	146.57	-12.57	-42.69
Total QIS	98.00	79.54	121.38	-23.38	-41.84
Total non-QIS	36.00	24.34	25.19	10.81	-0.85
Total non-reg	20.32	15.73	10.80	9.52	4.93
Reg nurses as % nursing staff	86.8%	86.8%	93.1%		
QIS as % reg nurses	73.1%	76.6%	82.8%		

Based on the activity and acuity over the 6 month period

- 86.8 % of our workforce are registered nurses, this needs to increase to 93.1%
- 76.6 % are Qualified in speciality needs to increase to 81.4%.
- The tool does not highlight, the need for quality roles within the service. Therefore, often to support some of the quality roles cotside nurses are used when acuity and occupancy allow. This includes bereavement, FiCare, ROP, infant feeding etc. It is also not reflective of Transitional care or neonatal community outreach activity.

LWH activity over the last 2 years and appears to be constant, to date this activity has been supported with increased use of bank staff. There has been no agency staff used. The NWNODN and specialist commissioners have recognised this activity in year and have supported this financially. While the NWNODN and specialist commissioners did not believe that this increase in activity would continue in long term, what we can see now is that this higher level of intensive care continued for a prolonged period through to May 2024 with a slight drop in June 2024.

The team have reviewed quality roles and agreed that within these roles there are some essential roles and should be removed from cotside numbers, these include FICare, ROP screening, breast feeding, clinic support. The team had hoped to fund a palliative care nurse through either operational planning or national critical care monies; however, this was not supported, and can currently only be supported by 15 hrs a week from nursing establishment. Funding was obtained for one year for a full time Band 6 palliative care nurse in 2022. This role had a huge impact on families and staff and they led on family support, staff support and agency liaison. The role helped support nursing staff in end of life and bereavement training and delivered the national Bereavement Care pathway. They supported staff in the delivery of high quality end of life care and supported parents during difficult conversations with consultants when end of life care was being discussed. Consultants felt that the role added to the communication in difficult circumstances as it was the only point of consistency. The role contributed practically to the PMRT process and helped support parents though this process. The role led to agency involvement with the three different Childrens hospices that serve our parents and acted as a conduit for each of them. Since the role has gone from a full time role to one of 15 hours we have noticed a difference in our family support and consistency of information delivery. Medical (consultants) and nursing staff have commented on how much they miss the full time role.

A proportion of the families supported were on the unit for over 4 months and many are discharged on to other areas of care with ongoing complex needs. 40 of these families had a baby who died in our care/shortly after transfer to home or hospice for end if life care.

When the post was in full time hours the role supported 113 families and had amazing feedback from families post bereavement All quality roles are 0.2wte or less 0.5wte.

An ask in operational planning was requested for 3 band 7 roles to support palliative care, FiCare and education.

Funding toward governance nurse and education (1.5wte) had been awarded through the NCCR and these posts are now filled. It is anticipated that there will be input from the neonatal network to support supernumerary time for nurses working in the ROP clinics at some point in the future.

For the 2024/25 rota / establishment review, the team have highlighted that the priority is to recruit to the quality roles in order to free up band 6 clinical nursing time to provide a supernumerary shift leader on each side of the neonatal unit. Currently 1 shift leader oversees both sides of the unit covering 8 rooms and up to 44 babies on each shift. Feedback from staff has been included in the planning for these roles, the staff have identified that there are times when the shift leader is pulled in too many directions and unable to provide support to all areas.

Staff also identified that the band 4 role in the low dependency area in the last 2 years has been a welcome addition to the team. 2 additional band 4 staff were added to the establishment in 2023. Band 4 staff including 2 TNAs are able to care for babies requiring a higher level of care that includes caring for babies on non invasive respiratory support and IV fluids by band 4 support staff which will free up the registered staff who are caring for the babies requiring this category of care currently.

Staff feedback is welcomed and a significant number of queries and has come from PNA sessions provided by 6 nurses who have trained as PNAs over the last 2 years. Developing the PNA team is a key priority particularly in light of the after effects of the Lucy Letby case, and the ongoing enquiry requiring our staff to be interviewed by police. The team plans to prepare a business plan to fund a lead for PNA at band 7.

Establishment is reviewed and discussed with network throughout the year. Recruitment and training plans are in place to continue to develop and support all roles within the Liverpool neonatal partnership.

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

CHPPD hours are recorded monthly as per national requirements and are used as a tool to help ensure safer staffing. This numbers have been consistent and review monthly throughout the year. They are reflective of the occupancy and acuity of the unit.

4. Operational oversight of staffing and acuity-based care

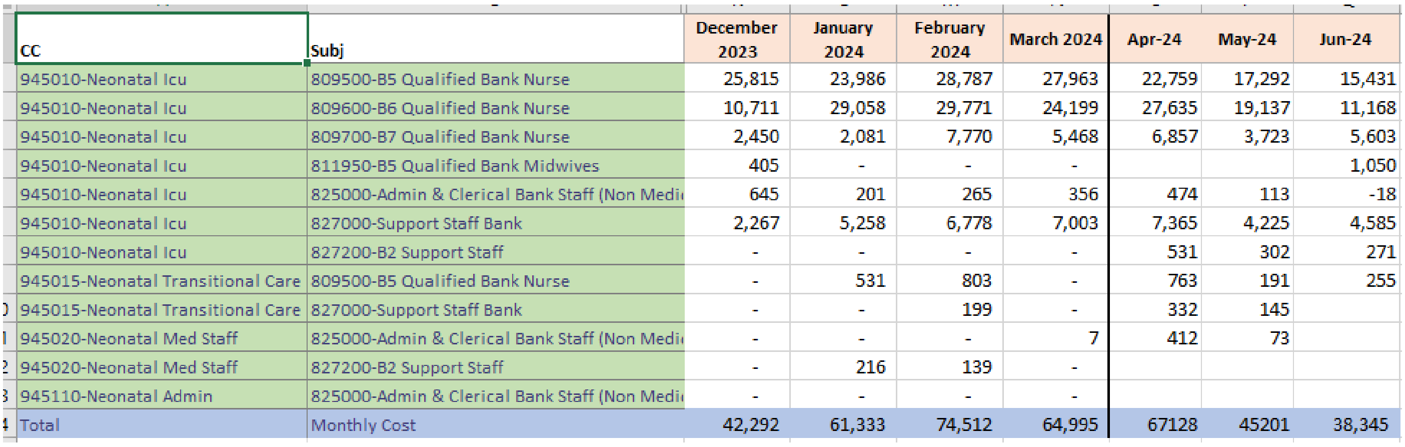
A series of actions are taken on a yearly, monthly, weekly, and daily basis to manage safe and effective staffing and optimise care for women, babies across services and divisions. This is captured as:

- Yearly oversight by the Northwest Neonatal Operational Deliver Network (NWNODN) using the CRG Nursing calculator
- Monthly rosters sign off meetings undertaken by the Head of Nursing/Deputy Head of Nursing across all rotas where roster effectiveness is challenged against roster compliance KPIs. Final roster approvals are signed off by Heads of Nursing (HoN).
- Weekly forward view of staffing overseen by Matron and Ward Manager.
- Neonatal services provide information for staffing on a weekly basis to NHS Gold command.
- Staffing reported to Bronze (staffing meetings) twice daily (Mon-Fri) and recorded on Power BI (RAG rated). Any identification of risk is addressed and where not resolved escalated to Silver (daily huddle) for resolution. First on call manage staffing at weekends and bank holidays.
- RAG rated staffing matrix in place for NICU. Acuity and activity review is undertaken at 10am/10pm and 12am/12pm each day with MDT jointly in NNU and Maternity; focusing on staffing, activity, dependency, and ability to take women and babies recorded.
- Neonatal services adhere to national reporting to Cot Bureau three times daily
- Silver (daily huddle) informed of staffing forecasts position as they arise, into the following shift and ahead of a weekend.

4.1 Temporary Staffing

The neonatal service use NHSP for any shifts that have not been filled due to vacancy, sickness, maternity leave and special leave. Due to increased vacancy from recruitment to LNP and an increase in sickness, activity and acuity we can see below the levels of bank staff required to ensure safer staffing. All shifts were covered by staff on substantive contract or staff who were previously employed on the unit. No agency staff were used. Specialised commissioners recognised the increased activity in 2023 and £1.3 was added to support those extra costs. The specialised commissioners are fully aware of the continued increase in acuity and activity and the relevant business partners are discussing how those financial needs are met.

Table 2. Bank requirements

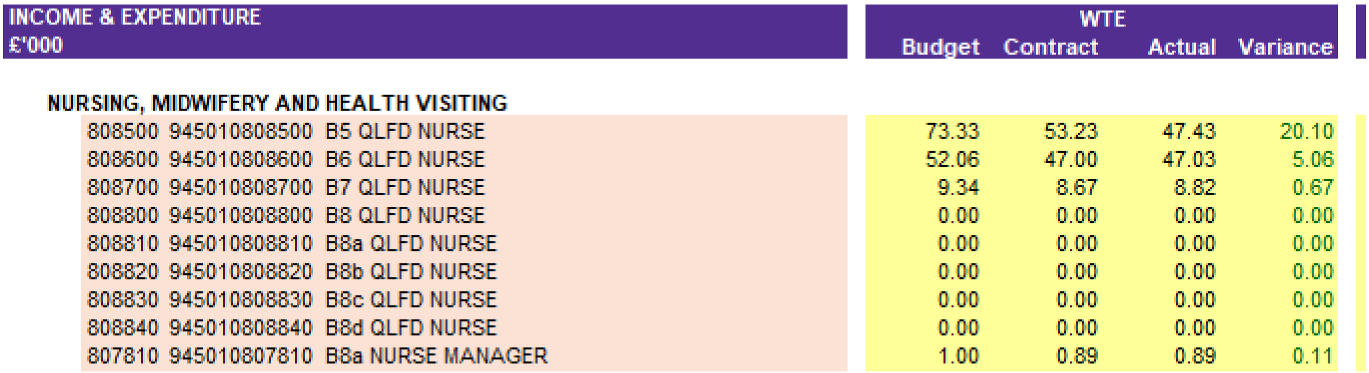


CC	Subj	December 2023	January 2024	February 2024	March 2024	Apr-24	May-24	Jun-24
945010-Neonatal Icu	809500-B5 Qualified Bank Nurse	25,815	23,986	28,787	27,963	22,759	17,292	15,431
945010-Neonatal Icu	809600-B6 Qualified Bank Nurse	10,711	29,058	29,771	24,199	27,635	19,137	11,168
945010-Neonatal Icu	809700-B7 Qualified Bank Nurse	2,450	2,081	7,770	5,468	6,857	3,723	5,603
945010-Neonatal Icu	811950-B5 Qualified Bank Midwives	405	-	-	-			1,050
945010-Neonatal Icu	825000-Admin & Clerical Bank Staff (Non Medi	645	201	265	356	474	113	-18
945010-Neonatal Icu	827000-Support Staff Bank	2,267	5,258	6,778	7,003	7,365	4,225	4,585
945010-Neonatal Icu	827200-B2 Support Staff	-	-	-	-	531	302	271
945015-Neonatal Transitional Care	809500-B5 Qualified Bank Nurse	-	531	803	-	763	191	255
945015-Neonatal Transitional Care	827000-Support Staff Bank	-	-	199	-	332	145	
945020-Neonatal Med Staff	825000-Admin & Clerical Bank Staff (Non Medi	-	-	-	7	412	73	
945020-Neonatal Med Staff	827200-B2 Support Staff	-	216	139	-			
945110-Neonatal Admin	825000-Admin & Clerical Bank Staff (Non Medi	-	-	-	-			
Total	Monthly Cost	42,292	61,333	74,512	64,995	67128	45201	38,345

5. Neonatal Nuring Workforce Measures Dec 23- June 24

5.1 Vacancy position

Table 3. Neonatal Vacancies at end of Q2 2024

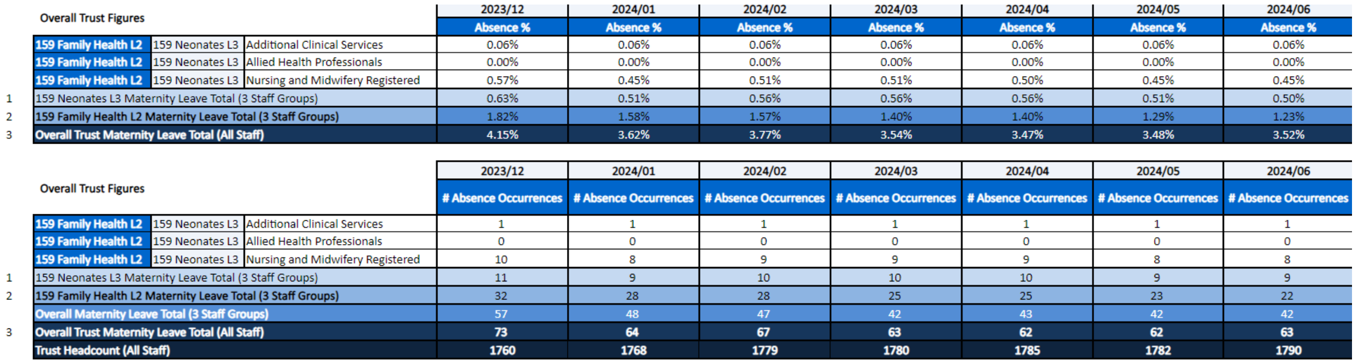


INCOME & EXPENDITURE £'000	WTE Budget	Contract	Actual	Variance
NURSING, MIDWIFERY AND HEALTH VISITING				
808500 945010808500 B5 QLFD NURSE	73.33	53.23	47.43	20.10
808600 945010808600 B6 QLFD NURSE	52.06	47.00	47.03	5.06
808700 945010808700 B7 QLFD NURSE	9.34	8.67	8.82	0.67
808800 945010808800 B8 QLFD NURSE	0.00	0.00	0.00	0.00
808810 945010808810 B8a QLFD NURSE	0.00	0.00	0.00	0.00
808820 945010808820 B8b QLFD NURSE	0.00	0.00	0.00	0.00
808830 945010808830 B8c QLFD NURSE	0.00	0.00	0.00	0.00
808840 945010808840 B8d QLFD NURSE	0.00	0.00	0.00	0.00
807810 945010807810 B8a NURSE MANAGER	1.00	0.89	0.89	0.11

The data highlights the vacacy position (Table 2) for Nursing with a total of 25.88 wte (19%) total vacancy for registered nursing staff at the end of Q2 2024.The vacancy majority of vacancies are because we have internally recruited to 18 new posts in the Liverpool Neonatal Partnership. Creating vacancy at band 5, and 6. There are 11 band 5 nurses with start dates in September 2024 and a further 5 posts have been advertised for recruitment in October 2024 also. The band 6 vacancies will be advertised in October 2024 .
The remaining vacancy at band 7 is planned to e used to uplift the digital nnurse to a band 7 from band 6 to align with the digital midwife role following job matching.

5.2 Maternity Leave

Table 4 Maternity Leave



	Overall Trust Figures			2023/12	2024/01	2024/02	2024/03	2024/04	2024/05	2024/06
				Absence %	Absence %	Absence %	Absence %	Absence %	Absence %	Absence %
	159 Family Health L2	159 Neonates L3	Additional Clinical Services	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%
	159 Family Health L2	159 Neonates L3	Allied Health Professionals	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	159 Family Health L2	159 Neonates L3	Nursing and Midwifery Registered	0.57%	0.45%	0.51%	0.51%	0.50%	0.45%	0.45%
1	159 Neonates L3 Maternity Leave Total (3 Staff Groups)			0.63%	0.51%	0.56%	0.56%	0.56%	0.51%	0.50%
2	159 Family Health L2 Maternity Leave Total (3 Staff Groups)			1.82%	1.58%	1.57%	1.40%	1.40%	1.29%	1.23%
3	**Overall Trust Maternity Leave Total (All Staff)**			4.15%	3.62%	3.77%	3.54%	3.47%	3.48%	3.52%

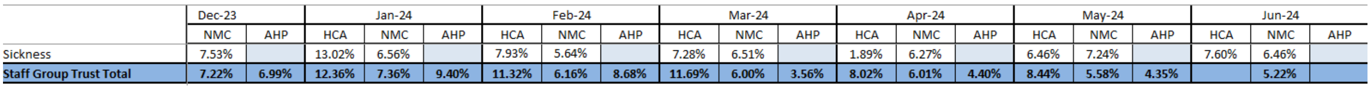
	Overall Trust Figures			2023/12	2024/01	2024/02	2024/03	2024/04	2024/05	2024/06
				# Absence Occurrences	# Absence Occurrences	# Absence Occurrences	# Absence Occurrences	# Absence Occurrences	# Absence Occurrences	# Absence Occurrences
	159 Family Health L2	159 Neonates L3	Additional Clinical Services	1	1	1	1	1	1	1
	159 Family Health L2	159 Neonates L3	Allied Health Professionals	0	0	0	0	0	0	0
	159 Family Health L2	159 Neonates L3	Nursing and Midwifery Registered	10	8	9	9	9	8	8
1	159 Neonates L3 Maternity Leave Total (3 Staff Groups)			11	9	10	10	10	9	9
2	159 Family Health L2 Maternity Leave Total (3 Staff Groups)			32	28	28	25	25	23	22
	Overall Maternity Leave Total (3 Staff Groups)			57	48	47	42	43	42	42
3	**Overall Trust Maternity Leave Total (All Staff)**			**73**	**64**	**67**	**63**	**62**	**62**	**63**
	Trust Headcount (All Staff)			**1760**	**1768**	**1779**	**1780**	**1785**	**1782**	**1790**

Table 4 shows a reduction in maternity leave on the neonatal unit from 2023 data equating to approximately 6 wte each month. This is a picture reflective of the age profile of our registered nurses.

5.3 Sickness absence

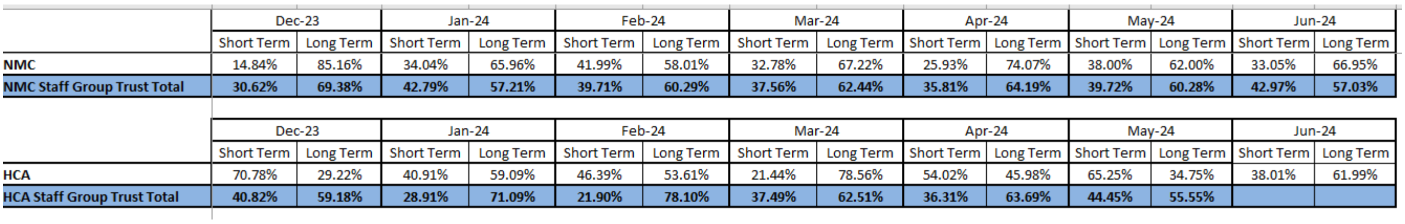
Sickness absence (Table 5) has remained between 5.64 % to 7.53% in the 6 month reporting period.Covid sickness is still accounting for less than 1% each month. Log term sickness (tale 6) has made up between 58.01% to 85.16% in qualified staff with higher levels of short tem sickness seen in the non-registered staff group.Teams Leaders have managed sickness according to policy and with direct support from the HR Business partners, all those on long term sickness have a plan in place.

Table 5: Sickness absence



	Dec-23		Jan-24			Feb-24			Mar-24			Apr-24			May-24			Jun-24		
	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Sickness	7.53%		13.02%	6.56%		7.93%	5.64%		7.28%	6.51%		1.89%	6.27%		6.46%	7.24%		7.60%	6.46%	
Staff Group Trust Total	**7.22%**	**6.99%**	**12.36%**	**7.36%**	**9.40%**	**11.32%**	**6.16%**	**8.68%**	**11.69%**	**6.00%**	**3.56%**	**8.02%**	**6.01%**	**4.40%**	**8.44%**	**5.58%**	**4.35%**		**5.22%**	

Table 6: Long Term v Short Term Sickness



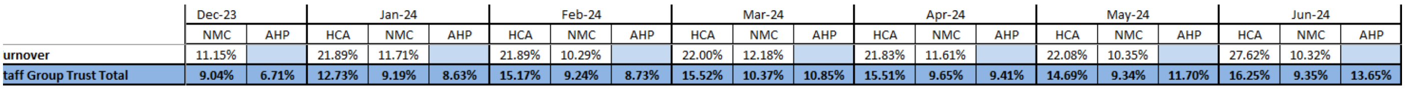
	Dec-23		Jan-24		Feb-24		Mar-24		Apr-24		May-24		Jun-24	
	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
NMC	14.84%	85.16%	34.04%	65.96%	41.99%	58.01%	32.78%	67.22%	25.93%	74.07%	38.00%	62.00%	33.05%	66.95%
NMC Staff Group Trust Total	**30.62%**	**69.38%**	**42.79%**	**57.21%**	**39.71%**	**60.29%**	**37.56%**	**62.44%**	**35.81%**	**64.19%**	**39.72%**	**60.28%**	**42.97%**	**57.03%**

	Dec-23		Jan-24		Feb-24		Mar-24		Apr-24		May-24		Jun-24	
	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
HCA	70.78%	29.22%	40.91%	59.09%	46.39%	53.61%	21.44%	78.56%	54.02%	45.98%	65.25%	34.75%	38.01%	61.99%
HCA Staff Group Trust Total	**40.82%**	**59.18%**	**28.91%**	**71.09%**	**21.90%**	**78.10%**	**37.49%**	**62.51%**	**36.31%**	**63.69%**	**44.45%**	**55.55%**		

5.4 Turnover

The Trust Turnover threshold is 13%, however, the turnover rate on the neonatal unit sits consistently below the Trust threshold in a range of 8.48-11.1% in registered staff and 10.6-24.7% in Support staff. Much of the movement in support staff has been around retirements and internal promotion.

Table 7: Turnover

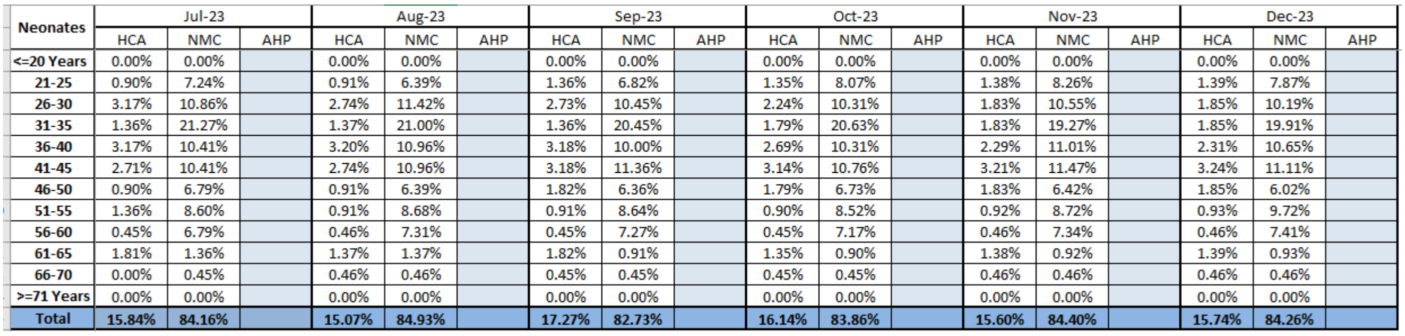


	Dec-23		Jan-24			Feb-24			Mar-24			Apr-24			May-24			Jun-24		
	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
urnover	11.15%		21.89%	11.71%		21.89%	10.29%		22.00%	12.18%		21.83%	11.61%		22.08%	10.35%		27.62%	10.32%	
taff Group Trust Total	**9.04%**	**6.71%**	**12.73%**	**9.19%**	**8.63%**	**15.17%**	**9.24%**	**8.73%**	**15.52%**	**10.37%**	**10.85%**	**15.51%**	**9.65%**	**9.41%**	**14.69%**	**9.34%**	**11.70%**	**16.25%**	**9.35%**	**13.65%**

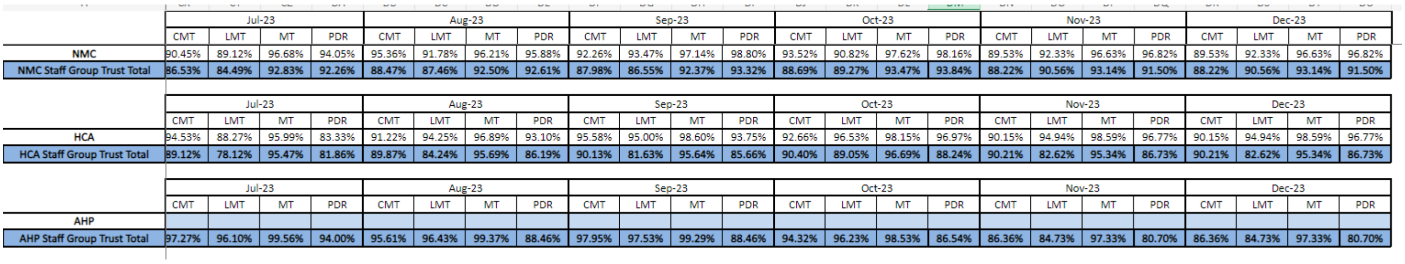
5.5 Age profile

The age profile of the staff on the neonatal unit has remained static over the last six months. Most of the registered staff are 50 years or under.

Table 8: Age profile data



Neonates	Jul-23			Aug-23			Sep-23			Oct-23			Nov-23			Dec-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
<=20 Years	0.00%	0.00%		0.00%	0.00%		0.00%	0.00%		0.00%	0.00%		0.00%	0.00%		0.00%	0.00%	
21-25	0.90%	7.24%		0.91%	6.39%		1.36%	6.82%		1.35%	8.07%		1.38%	8.26%		1.39%	7.87%	
26-30	3.17%	10.86%		2.74%	11.42%		2.73%	10.45%		2.24%	10.31%		1.83%	10.55%		1.85%	10.19%	
31-35	1.36%	21.27%		1.37%	21.00%		1.36%	20.45%		1.79%	20.63%		1.83%	19.27%		1.85%	19.91%	
36-40	3.17%	10.41%		3.20%	10.96%		3.18%	10.00%		2.69%	10.31%		2.29%	11.01%		2.31%	10.65%	
41-45	2.71%	10.41%		2.74%	10.96%		3.18%	11.36%		3.14%	10.76%		3.21%	11.47%		3.24%	11.11%	
46-50	0.90%	6.79%		0.91%	6.39%		1.82%	6.36%		1.79%	6.73%		1.83%	6.42%		1.85%	6.02%	
51-55	1.36%	8.60%		0.91%	8.68%		0.91%	8.64%		0.90%	8.52%		0.92%	8.72%		0.93%	9.72%	
56-60	0.45%	6.79%		0.46%	7.31%		0.45%	7.27%		0.45%	7.17%		0.46%	7.34%		0.46%	7.41%	
61-65	1.81%	1.36%		1.37%	1.37%		1.82%	0.91%		1.35%	0.90%		1.38%	0.92%		1.39%	0.93%	
66-70	0.00%	0.45%		0.46%	0.46%		0.45%	0.45%		0.45%	0.45%		0.46%	0.46%		0.46%	0.46%	
>=71 Years	0.00%	0.00%		0.00%	0.00%		0.00%	0.00%		0.00%	0.00%		0.00%	0.00%		0.00%	0.00%	
Total	**15.84%**	**84.16%**		**15.07%**	**84.93%**		**17.27%**	**82.73%**		**16.14%**	**83.86%**		**15.60%**	**84.40%**		**15.74%**	**84.26%**	



	Jul-23				Aug-23				Sep-23				Oct-23				Nov-23				Dec-23			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
NMC	90.45%	89.12%	96.68%	94.05%	95.36%	91.78%	96.21%	95.88%	92.26%	93.47%	97.14%	98.80%	93.52%	90.82%	97.62%	98.16%	89.53%	92.33%	96.63%	96.82%	89.53%	92.33%	96.63%	96.82%
NMC Staff Group Trust Total	**86.53%**	**84.49%**	**92.83%**	**92.26%**	**88.47%**	**87.46%**	**92.50%**	**92.61%**	**87.98%**	**86.55%**	**92.37%**	**93.32%**	**88.69%**	**89.27%**	**93.47%**	**93.84%**	**88.22%**	**90.56%**	**93.14%**	**91.50%**	**88.22%**	**90.56%**	**93.14%**	**91.50%**

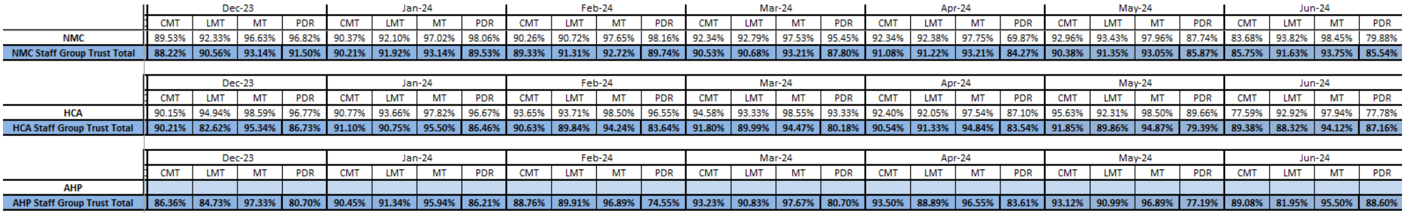
	Jul-23				Aug-23				Sep-23				Oct-23				Nov-23				Dec-23			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
HCA	94.53%	88.27%	95.99%	83.33%	91.22%	94.25%	96.89%	93.10%	95.58%	95.00%	98.60%	93.75%	92.66%	96.53%	98.15%	96.97%	90.15%	94.94%	98.59%	96.77%	90.15%	94.94%	98.59%	96.77%
HCA Staff Group Trust Total	**89.12%**	**78.12%**	**95.47%**	**81.86%**	**89.87%**	**84.24%**	**95.69%**	**86.19%**	**90.13%**	**81.63%**	**95.64%**	**85.66%**	**90.40%**	**89.05%**	**96.69%**	**88.24%**	**90.21%**	**82.62%**	**95.34%**	**86.73%**	**90.21%**	**82.62%**	**95.34%**	**86.73%**

	Jul-23				Aug-23				Sep-23				Oct-23				Nov-23				Dec-23			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
AHP																								
AHP Staff Group Trust Total	**97.27%**	**96.10%**	**99.56%**	**94.00%**	**95.61%**	**96.43%**	**99.37%**	**88.46%**	**97.95%**	**97.53%**	**99.29%**	**88.46%**	**94.32%**	**96.23%**	**98.53%**	**86.54%**	**86.36%**	**84.73%**	**97.33%**	**80.70%**	**86.36%**	**84.73%**	**97.33%**	**80.70%**

Training

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

Table 9 Training Compliance



	Dec-23				Jan-24				Feb-24				Mar-24				Apr-24				May-24				Jun-24			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
NMC	89.53%	92.33%	96.63%	96.82%	90.37%	92.10%	97.02%	98.06%	90.26%	90.72%	97.65%	98.16%	92.34%	92.79%	97.53%	95.45%	92.34%	92.38%	97.75%	69.87%	92.96%	93.43%	97.96%	87.74%	83.68%	93.82%	98.45%	79.88%
NMC Staff Group Trust Total	**88.22%**	**90.56%**	**93.14%**	**91.50%**	**90.21%**	**91.92%**	**93.14%**	**89.53%**	**89.33%**	**91.31%**	**92.72%**	**89.74%**	**90.53%**	**90.68%**	**93.21%**	**87.80%**	**91.08%**	**91.22%**	**93.21%**	**84.27%**	**90.38%**	**91.35%**	**93.05%**	**85.87%**	**85.75%**	**91.63%**	**93.75%**	**85.54%**

	Dec-23				Jan-24				Feb-24				Mar-24				Apr-24				May-24				Jun-24			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
HCA	90.15%	94.94%	98.59%	96.77%	90.77%	93.66%	97.82%	96.67%	93.65%	93.71%	98.50%	96.55%	94.58%	93.33%	98.55%	93.33%	92.40%	92.05%	97.54%	87.10%	95.63%	92.31%	98.50%	89.66%	77.59%	92.92%	97.94%	77.78%
HCA Staff Group Trust Total	**90.21%**	**82.62%**	**95.34%**	**86.73%**	**91.10%**	**90.75%**	**95.50%**	**86.46%**	**90.63%**	**89.84%**	**94.24%**	**83.64%**	**91.80%**	**89.99%**	**94.47%**	**80.18%**	**90.54%**	**91.33%**	**94.84%**	**83.54%**	**91.85%**	**89.86%**	**94.87%**	**79.39%**	**89.38%**	**88.32%**	**94.12%**	**87.16%**

	Dec-23				Jan-24				Feb-24				Mar-24				Apr-24				May-24				Jun-24			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
AHP																												
AHP Staff Group Trust Total	**86.36%**	**84.73%**	**97.33%**	**80.70%**	**90.45%**	**91.34%**	**95.94%**	**86.21%**	**88.76%**	**89.91%**	**96.89%**	**74.55%**	**93.23%**	**90.83%**	**97.67%**	**80.70%**	**93.50%**	**88.89%**	**96.55%**	**83.61%**	**93.12%**	**90.99%**	**96.89%**	**77.19%**	**89.08%**	**81.95%**	**95.50%**	**88.60%**

Trust targets for indicators are as follows:

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

PDR compliance dipped in the first quarter of the year, due to the volume of PDRs due within the first 3 months. More of the senior staff have attending PDR trainer courses and the PDR compliance is anticipated to increase and remain above the trust target for the remainder of the year. New paperwork and group PDR sessions will help in mainting compliance.

In the last 6 months teams have met the requirement for core, local and mandatory training Compliance on mandatory training has been met by all groups and is above trust staff group totals for qualified nurses. There has been atargeted focus to improve compliance in the non registered group of staff.

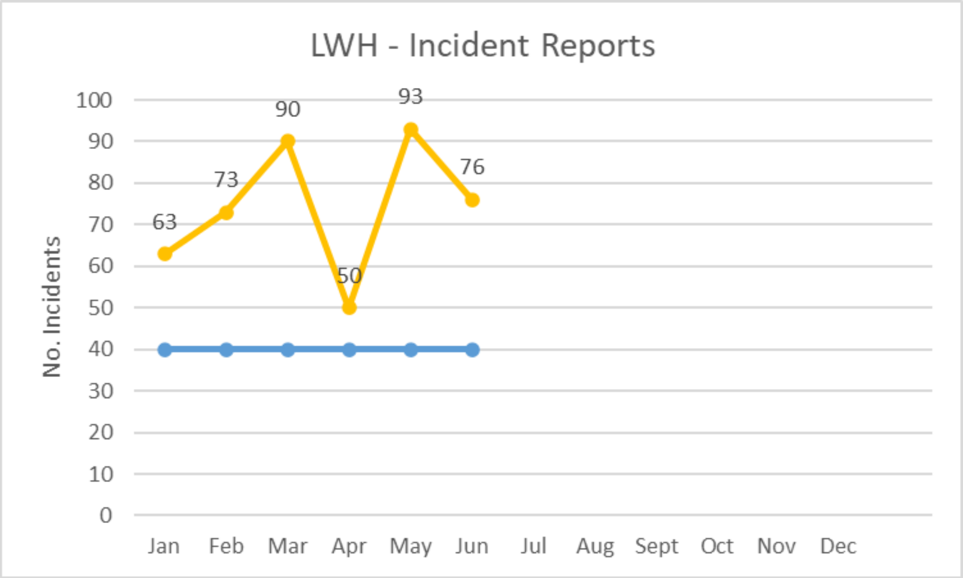
Blockbuster days have been reinvigorated, a cleanse of the training profile has been undertaken and all staff are reminded about outstanding training required, receiving email reminders from team leaders and matron about areas of non-compliance.

7 Measurement of Quality of Care

5.3 Clinical Incident Reporting

There has been a total of 427 incident reported over the last 6 months this has increased from the previous 6 months from 329, this is a 23% increase. The expect incident reporting rate on a NICU is 4% of the admission rate. The graph below (Table 9) shows the NICU has an above expected reporting rate. This is consistent with a good reporting culture.

Table 10: Incident reporting



The top 5 cause group has changed slightly over the last 6 months. Table 11 shows that medication errors continue to be our top incident. There are robust processes in place and the team review all incidents regularly with pharmacy and consultant team. Medicine errors are a mixture of prescribing and administration, including near misses.

There have been increased incidents around equipment and this is being address with procurement team and will be added to risk register around the appropriateness of alternative stock. The reporting of injuries has increased as this now included skin injuries which previously had been reported under invasive procedures.

Investigations included blood sampling and we have seen significant improvement over the previous 6 months

Table 11 Overview top 5 Incidents over 12 months

2023/4	**Jul- Dec**	**Jan-Jun**
Total clinical incident	329	427
Total clinical incident relating to staffing	2	3
Top 5 Incidents		
	Medication -84	Medication 81
	Investigation - 47	Equipment 68
	Equipment - 41	Injury 62

	Invasive procedure - 33	Admission / Discharge / Transfer 45
	Clinical management - 23	Clinical Management 29

There were 3 incidents relating to staffing. These incidents were all due to an increase in NCOT activity with a risk of home visits to babies with ongoing additional needs not being met. To mitigate the risk patients were brough to clinics at LWH and phone consultations made.

All incidents are reviewed by the Matron and Safety Lead with a report formulated and presented to the Liverpool Neonatal Risk Meeting monthly. The report is also submitted to the LNP Integrated Governance Meeting each month which reports into the LNP Board, Family Health Divisional Board and Alder Hey Surgical Divisional Board.

Lessons learnt are shared in a variety of ways, including:

- Lesson of the week
- Governance boards
- What you need to know board
- 7@7 safety huddles
- My Paediatrics App
- Room communication folders
- Closed Facebook group (where appropriate)

5.4 Red flag events

There are no national reportable red flags for Neonates

5.5 Serious Incidents PSII Reviews

There were 3 PSIIs during the previous 6 months, these included 2 invasive medical procedure that were carried out by the medical team one being a never event of a retained guide wire. The third was a drug error involving a potassium infusion incorrectly reprecribed and conitued over a period of 4 hours. All 3 PSIIs were completed as per trust guidance for PSIRF. Action plans and learning from the incidents is up to date at the time of the report

5.6 Patient/Family Experience

The parent discharge survey is a way for the neonatal team to gain feedback which can be used to improve and develop our model of care on the neonatal unit. Gaining feedback from families who have experienced every aspect of the neonatal journey provides us with direct feedback as part of the parent voice. We will continue to collect feedback and provide reports quarterly to continue to develop and improve the parent experience.

It is important to highlight how good the feedback was for the neonatal unit and care, and that is testament to the caring nature of the staff on the unit, excellent teamworking and leadership that is demonstrated on the neonatal unit.

However, there are always areas to develop and refine and from this survey, it is clear that we need to prioritise certain aspects of a family's experience on the neonatal unit to include:

1. Improved promotion of the discharge survey on the Neonatal Unit and Transitional care. We must also work to ensure we gain feedback from families whose babies are discharged back to postnatal ward following admission (short stay admissions).
2. Gaining feedback from both parents, rather than the mother only as each parent may have different experiences and comments to provide.
3. We need to ensure increased accessibility to non-English speaking families and this is something we are working hard to develop through use of translated surveys for individuals to complete. We have implemented V-Create, a secure video messaging service for families which has the facility to translate text into different languages and all surveys will be uploaded onto this platform for families to access and complete to ensure inclusion of all families. A reminder messages can be sent through the vCreate platform to families to ask them to complete the surveys which may assist in promoting completion. The discharge survey has now been uploaded onto vCreate for use from January 2024 and therefor will enable us to reach out to families whose primary language is not English. We can work with the vCreate team to ensure all languages required are available.
4. There needs to be a big drive to ensure survey completion in the acute setting when babies discharged from acute setting back to postnatal ward or to local/other hospital as currently this is an area where we are not gaining a true representative sample of feedback from. This will be highlighted to all staff and senior leadership team to help promote and support completion. We are also going to utilise peer supporters and volunteers on the unit to help promote feedback survey completion.
5. There was feedback again this quarter highlighting that some felt they did not receive enough support prior to birth. The action is to try and identify through feedback what support they would like, and feedback to antenatal team members any suggestions for development. A key action that needs to be continued is to offer families the opportunity to visit the unit antenatally as this is a theme that is often fed back. Feedback mentioned having information pre-admission available and the action from this is to create a leaflet for families that can be provided before admission with all this information included. Leaflet is currently being drafted and reviewed by FiCare unit team
6. Hospitality provision is an area that needs to be improved and developed, and a business case is currently being created to provide a hot meal to all parents on the neonatal unit per day, especially as catering facilities are very limited within the trust, especially overnight and at the weekend. Having a baby on the neonatal unit can cause great financial difficulty to families, and we are therefore keen to try and assist families with this in some way. This has been escalated to Senior leadership team for review. We have also been in contact with

different food banks and charities to identify resources available in the area. Social prescribing team as part of citizens advice bureau are now attending LWH once weekly to provide individual support to families, and promotion of early help has also improved on the neonatal unit.

7. Further work to be undertaken to ensure delivery room cuddles are facilitated at delivery (unless criteria for exclusion). This is essential work as the FiCare model and journey should commence antenatally and delivery room cuddles enable empowerment to families prior to admission to the neonatal unit. This will be captured in thermoregulation QI project that is ongoing and if challenges identified, these will be reviewed, and solutions provided to ensure all families receive family integrated care from delivery.
8. Regular parental updates have been highlighted this quarter and we must ensure parents/carers are provided with these regularly. This will be fed back through senior leadership team.
9. Improved review of discharge letter by parents prior to discharge needs to be undertaken to ensure all information understood by parents/carers that is included and to ensure it is accurate. This data is captured on badgernet discharge checklist, and a consultant should also ensure the letter has been checked prior to parental review.
10. Translation of all resources needs to be a focus and priority. This will be escalated to patient experience team and senior leadership team to help support ways to do this.
11. All staff must ensure the FiCare model is integrated and embedded onto the unit as part of routine practice.
12. Preparing for discharge needs to be an area of focus this quarter following feedback received. We will work with the discharge coordinator and Lead ANNP to ensure families feel ready for discharge. There is a discharge checklist to be completed on badgernet by nursing and medical staff and this will help to ensure families empowered ready for discharge.
13. Parent feedback requested provision of sanitary products in bathrooms on NICU which we can organise.

7.5 Complaints, Concerns and Compliments

There were no formal complaints received in the Neonates from January to June 2024
There were **6** PALS queries and 1 compliment noted within timeframe none of the queries were around shortage of staffing. They were all requests for information that did not require review or escalation.

7.6 Staff Experience

There has been a real focus on staff well-being over the last year, with dedicated time each week focused on well-being, well-being Wednesday, feel good Friday. Staff have been listened too and these events have happened at different times of day and night and over weekends. Staff well-being conversations, questionnaire have been used frequently.
This has been a very busy period for the unit, and we have had increased acuity, with this we have seen some attitudes and behaviours from parents and families that is not acceptable towards staff members. This has been addressed at the time by the Consultant on service and followed up by the

HoN/DHoN and Lead Clinician with a face-to-face conversation with parents. We have discussed with staff 1:1 and at unit meeting. We have also enlisted the help of the psychologist to support parents and also help team understand how to support families who are going through a trauma.

The PNA has been developed and embedded on the unit. We have 2 qualified PNA's with a further 5 in training. The PNA's are providing 1:1 and group session support. This is proving very successful, and feedback has been really positive. We will need approximately 20 PNA's within NICU.

There has been 1 freedom to speak up complaint submitted from a staff member in this reporting period, relating to attitudes and behaviours of staff members to one another.

6. Attraction, Recruitment and Retention

As a tertiary centre and working in partnership with Alder Hey Children's hospital this makes the service at LWH a really great place to work to allow for experience and development, hence we attract the best students and staff in the region. To maintain our staff, we offer great opportunities for training, development, and progression. We also offer flexible working opportunities and career breaks.

We have supported the development of a further 5 Professional Nurse Advocates (PNA), 4 neonatal Nurse Practitioners, education roles, FiCare role, Palliative Care Nurse, and governance nurse. We have also supported secondments to Connect NW transport service and the NWNODN ROP team. We are in the process of developing specialist neonatal tissue viability nurses.

10.0 Actions and Recommendations:

The following actions are proposed during the next six months (July 2024- Dec 2024):

- Development of the quality roles to support the cotside to deliver outstanding care to include substantive palliative care nurse hours, FiCAre nurse and Education posts to be requested in operational planning.
- Introduction of a band 6 shift lead to support the current shift lead. This would be achievable if the above posts were approved.
- PNA team to support staff during the Letby trials and Thirlwall inquiry. This will need business case approval. Training and non-clinical time required.
- Continue to development the training and recruitment plans to support new nurses that will join the LNP nursing team over the next 12 months.
- Continue to develop our ANNP team and to ensure recruitment and retention . Re-advertise vacancy and recruit to clinical fellow posts in absence of ANNP applicants.
- Continue to meet the flexible needs of our staff where possible.
- Compliance with PDR and mandatory training within the NICU service.

- Continue to develop our Neonatal Community Outreach team and supporting dietetic service that supports it. Develop a business case to submit to specialist commissioners to review NCOT activity and staffing requirements.

- Work with the Northwest Neonatal ODN to develop Network approach to ROP service delivery.

- Development of a digital nurse team with Uplift of Digital Nurse from Band 6 to band 7

- Work with parents and families to ensure they feel we are communicating in a way that they feel heard and understood.

- Work with maternity colleagues and MNVP lead to ensure there is a collaborative approach to how families of babies receiving transitional care and requiring support from the neonatal team on the maternity ward feel they are heard and understood.

10.0 Conclusions

The Board of Directors are asked to gain assurance from the Neonatal report that the staffing levels and delivery of nursing care on the neonatal unit is meeting the expected standards and the service is delivering good family experience. Additionally, the Board of Directors is asked to take assurance that there is sufficient oversight in Neonatal services of where improvements can be made with plans in place to action those changes. The staffing review undertaken has not highlighted any risks when complaints, incidents, training, and staffing have been triangulated, however, it has been noted that the team could do more around effective communication with parents and families. The continued high acuity and occupancy will continue to challenge the NICU service but adequately trained and appropriate numbers of staff it is felt this challenge can be met.

Liverpool Women's
NHS Foundation Trust

Board of Directors

COVER SHEET

Meeting Date	Thursday, 10 October 2024	**Item Reference**	TB24/25_142
Report Title	University Hospitals of Liverpool (UHL) Group Board Governance Arrangements		
Author	Hollie Holding, Associate Director of Corporate Governance		
Responsible Director	Tim Gold, Chief Transformation Officer Daniel Scheffer, Director of Corporate Affairs including Company Secretary		

Purpose of Report	The purpose of this report is to set out the arrangements for the establishment of the University Hospitals of Liverpool Group Board (the "Group Board") between Liverpool University Hospitals NHS Foundation Trust (LUHFT) and Liverpool Women's NHS Foundation Trust (LWH), approving the establishment of a Joint Committee arrangement.
Executive Summary	The adult and specialist Trusts in Liverpool have a strong record of working together to benefit patients and their families across the city, and the region. As the next step in this work, NHS Cheshire and Merseyside Integrated Care Board (ICB) has asked that Trusts put arrangements in place that find solutions and have a simpler way of making decisions about the things that involve patients and their families, members of the public and NHS staff in the system. As such, a Joint Committee for the five Adult Acute and Specialist Hospitals has been established, as explained further within this report. As part of this work, LUHFT and LWH continue to build upon the existing arrangements and Joint Board appointments. The paper sets out details for the establishment Group Board to be named NHS University Hospitals of Liverpool (UHL) Group. The proposals were presented for review and approval by the LWH Board of Directors and LUHFT Board of Directors in September 2024 with agreement that ULH will come into effect from 1 November 2024. The new Group Board committees will be formally constituted as committees of the statutory LUHFT and LWH Boards. The Committees will act under delegated authority from, and at all times remain accountable to, their respective 'parent' Trust Boards. All business conducted by each Committee will be conducted in the name of the respective Trust. Full details of the Group Governance and Assurance Framework are set out within the paper. The paper also sets out the practical arrangements and logistics governing how the Group Board will operate in practice. It was presented to the LWH Board of Directors on 12 September 2024, and LUHFT Board of Directors on 25 September 2024, at which time each Board reviewed and approved the following:

	- The establishment of the NHS University Hospitals of Liverpool Group Board. - The Provider Collaborative Agreement (PCA). - The Joint Board Terms of Reference. - The proposed amendments to the Trust Constitution.

Links to Board Assurance Framework	Links to all risks on the Board Assurance Framework	Various

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	**Date**	**Lead**	**Outcome**
Shared at Joint Board Workshop	10.10.24	Various	Update noted in support of wider presentations.
LWH Board of Directors	12.09.24	Various	The Board of Directors reviewed and approved the supporting documents.
LUHFT Board of Directors	25.09.2024	Various	The Board of Directors reviewed and approved the supporting documents.

MAIN REPORT

1. Introduction

The purpose of this report is to set out the arrangements for the establishment of the University Hospitals of Liverpool (UHL) Group Board (the "Group Board") between Liverpool University Hospitals NHS Foundation Trust (LUHFT) and Liverpool Women's NHS Foundation Trust (LWH), by establishing a Joint Committee arrangement.

The paper sets out the context, legal and regulatory requirements, practical arrangements and logistics governing how the NHS University Hospitals of Liverpool Group Board of Directors will operate in practice. It was presented to and reviewed by the LWH Board of Directors on 12 September 2024, and LUHFT Board of Directors on 25 September 2024, at which time each Board reviewed and approved the following:

- The establishment of the NHS University Hospitals of Liverpool Group Board.
- The Provider Collaborative Agreement (PCA).
- The Joint Board Terms of Reference.
- The proposed amendments to the Trust Constitution.

2. Liverpool Adult Acute and Specialist Providers (LAASP)

The adult and specialist Trusts in Liverpool have a strong record of working together to benefit patients and their families across the city, and the region. As the next step in this work, NHS Cheshire and Merseyside Integrated Care Board (ICB) has asked the five adult acute and specialist Trusts in Liverpool to establish a joint committee (see below). Its purpose is to create sustainable healthcare systems for the future with a clear focus on improving patient care and outcomes.

The ICB has asked that Trusts put arrangements in place that find solutions and have a simpler way of making decisions about the things that involve patients and their families, members of the public and NHS staff in the system. As such, a Joint Committee for the five Adult Acute and Specialist Hospitals is being established.

3. LAASP Joint Committee

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. The focus of the LAASP Joint Committee will include:

- Transformation: Defining and implementing our five-year blueprint and roadmap (UHL), for delivering adult acute and specialist care in Liverpool.

- Collective Accountability: Defining and implementing controls and collaboration across LAASP where it is beneficial to operate at scale, with consistency and shared responsibility, e.g. financial management, capital planning and managing our workforce.

- Governance: Establishing shared leadership, governance and decision-making across the five Liverpool adult acute and specialist providers in order to develop and implement the University Hospitals of Liverpool (UHL) Group Model.

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. The Joint Committee approved the Terms of Reference and Joint Working Agreement on 19 September 2024, which were presented to the Board of Directors for each Trust for information.

The Board of Directors will be kept fully updated on developments.

4. NHS University Hospitals of Liverpool Group – Shared Board of Directors

As a first step towards establishing shared governance for LAASP, LUHFT and LWH continue to build upon their existing arrangements and Joint Board appointments and will establish the UHL Group Board as a Joint Committee for their respective Boards of Directors. These new governance arrangements will support the delivery of services at the respective hospital sites.

By working collaboratively and aligning governance arrangements, the trusts will be:

- Able to address the coordination of treatment and care, across care pathways.
- Positioned to tackle endemic health issues and inequalities across the city by working together on solutions.
- Aligned to focus on service quality and deliver a more consistent experience for patients and their families.
- Positioned to offer more robust service resilience.
- Able to make the best use of the collective workforce and enhance the career prospects and learning for staff.
- Positioned to grow and strengthen our research capacity and capabilities.
- Supporting clinical services delivery with a more efficient and resilient corporate service offer, which in turn supports those staff with career development opportunities.

An Executive Managing Director has been appointed to lead LWH, who will sit as a voting member of this Group Board of Directors. This will ensure equity with other sites, retaining the LWH identity, and voice and influence at board level.

5. Potential Governance Models

A range of models exist to allow trusts to integrate governance and decision-making and no one size fits all. Sections 65Z5 and 65Z6 of the NHS Act 2006 provide the power for trusts to exercise functions jointly (Joint Functions) and to appoint a joint committee (Group Board) to exercise these but also to reserve functions to individual trusts for standalone decision-making. A Task and Finish Group was established to consider a number of models to do this, including:

- Meetings in Common
- Advisory Committees
- Shared/Joint Leadership
- Joint Committee
- Acquisition

Initial exploration was undertaken which evaluated the above options. The evaluation took into account the ability to improve patient pathways and make better use of resources, alignment with national guidance, timescale to deliver and complexity to implement, and support from NHS England/Cheshire &

Merseyside ICB. Work has been ongoing throughout with legal advice received via Browne Jacobson LLP who helped the Trusts understand legal aspects and constraints at each stage. Opportunities to enable further change, together with the impact of changes made at this stage on the wider Liverpool Adult Acute and Specialist Services Programme were also taken into consideration.

6. Proposed Model – Joint Committee

NHS England describes a Joint Committee within guidance Arrangements for Delegation and Joint Exercise of Statutory Functions. It describes a Joint Committee as a *'statutory basis for a group of NHS organisations to take collective responsibility for one or more of their statutory functions – enabling joint decision-making approaches (including to financial management) if they so choose while creating more transparency and clarity of accountability when organisations work together as systems'.* It goes on to describe that the constituent organisations of a joint committee agree to abide by the decisions made jointly on a range of issues. These constituent organisations will determine the committee's scope of work and governance arrangements – including setting out criteria, standards, principles or success measures to which the committee operates; and deciding how and when they will review the committee's performance in respect of these.

A Joint Committee has been selected as the preferred model for the NHS University Hospitals of Liverpool Group Board as it is felt to have several benefits including:

- A Joint Committee has decision-making powers within the scope of delegation, as set out in each Trust's Constitution, Standing Orders, Scheme of Delegation and Standing Financial Instructions.
- It can be established without the need for organisational and structural changes.
- Less complications and time implications for implementation.
- Allows trusts to exercise functions jointly but remain separate corporate bodies (retained sovereignty and independence).
- Alignment of strategic objectives and decision-making.
- Streamlined corporate governance.
- Reduction of Board and Committee meetings.
- Allows for joint appointments – Non-Executive and Executive Directors.
- The model can be 'scaled up' so additional trusts can join the underpinning agreement.

Clear governance arrangements for making decisions, differentiating between those individuals who should be involved in the final, formal decision-making and those who contribute to committee discussions will need to be adopted. The Joint Committee Model is set out for approval as required by the respective Boards of Directors together with the establishment of a Provider Collaboration Agreement (PCA). (Appendix A).

7. Legal and Regulatory Considerations

The establishment of the Group Board must be consistent with the provisions of the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and the Health and Social Care Act 2022. Relevant provisions of the Health and Social Care Act 2008 also apply in terms of matters that need consideration by the Trust Board of Directors.

Statutory guidance exists that needs to be considered as part of implementing any model – there is however a high degree of flexibility based on interpretation. The key legislation is within Section 47A of the 2022 Act which introduced a new power for Foundation Trusts to enter into arrangements for the carrying out of any of its functions jointly by a Joint Committee. The changes in the 2022 Act are crucial in that these powers allow trusts to establish joint committees that can exercise functions on behalf of participating trusts and make binding decisions – shared objectives and shared decision-making operating within shared governance arrangements.

In practical terms, the move to Joint Group arrangements for LUHFT and LWH will involve:

- Each Board establishes a new Committee of the Trust Board of Directors, which is known as University Hospitals of Liverpool Group Board.
- The University Hospitals of Liverpool Group Board has a Terms of Reference as agreed by the LUHFT and LWH Board of Directors, set out in the PCA.
- LUHFT and LWH to authorise functions to be delegated to the University Hospitals of Liverpool Group Board.
- LUHFT and LWH revise their respective Schemes of Delegation to provide for these new delegations to the University Hospitals of Liverpool Group Board.

The legal framework within which each Trust was established will continue to operate as set out in the respective Trust Constitution and Provider License.

The Trust sought legal advice on its proposals for establishing the University Hospitals of Liverpool Group Board and this advice has confirmed that the proposals set out in this paper are consistent with the current statutory and regulatory framework. NHS England published new statutory guidance on Arrangements for delegation and joint exercise of statutory functions: Guidance for integrated care boards, NHS trusts and foundation trusts on 27 March 2023.

The proposals set out in this paper are consistent with this guidance, specifically, Sections 65Z5 and 65Z6 Joint Exercise Arrangements; two or more NHS organisations within the scope of Section 65Z5 can choose to come together (including via a Joint Committee) to make legally binding decisions and pool funds across agreed functions. Any constraints on how these arrangements are made and which functions can be part of them are set out in the 2022 Regulations and Annex E and G of the NHS England Statutory Guidance.

It is noted that Local Authorities and Council Authorities can be part of the arrangements, but they cannot include their own functions in decision-making using these mechanisms.

8. Reserved Functions

Reserved Functions are any Functions of the Trust that cannot lawfully be delegated or jointly exercised or otherwise are Functions that NHS England has categorised as not ‘Open to Joint Exercise of Functions’ in Arrangements for delegation and joint exercise of statutory functions. Reserved Functions include:

- Standing Orders, Standing Financial Instructions and Scheme of Delegation
- Care Quality Commission (CQC) Registration
- NHS Provider Licence
- Information Commissioners Office (ICO) Registration
- NHS Resolution (NHSR) Schemes Membership
- Remuneration Committee
- Audit Committee
- Charitable Funds Committee
- Meetings that the Trusts’ Boards to approve Annual Accounts and Annual Reports
- Council of Governors – Statutory Duties

The table below proposes a management approach for each of the Reserved Functions.

Reserved Function	Management Approach	Executive Lead
Audit Committee	Structured as a Committee in Common from 2025/26 e.g. with the same membership, shared meetings and cycle of business	Group CFO & Group Corporate Affairs Officer
Remuneration Committee	Structured as a Committee in Common from 2024/25 e.g. with the same membership, shared meetings and cycle of business	Group Corporate Affairs Officer
Charitable Funds Committee	Structured as a Committee in Common from 2025/26 e.g. with the same membership, shared meetings and cycle of business)	Group Corporate Affairs Officer / Group Chief Communications Officer
Approval of Annual Accounts and Annual Reports	Each trust would have a separate board meeting for approval purposes Meetings can be aligned to take place on the same day / in common	Group CFO & Group Corporate Affairs Officer
Council of Governors	Councils of Governors cannot delegate their functions or decision-making. It is not possible to share governors but an individual can stand for election in each trust. The Council of Governors can be structured as a Committee in Common e.g. with the same membership, shared meetings and cycle of business	Group Corporate Affairs Officer
Membership	Each Council of Governors is accountable to each Trust's Membership. There are opportunities to deliver engagement and events collaboratively between the Trusts, however, it should be noted that each membership remains individual	Group Corporate Affairs Officer
Standing Orders, Standing Financial Instructions and Scheme of Delegation	Standalone but aligned documents to ensure consistency in terms of authorisation.	Group Chief Finance Officer
CQC Registration	Each trust would have a separate CQC registration and associated annual fee. Engagement and processes to be undertaken through Quality Governance.	Group Chief Nursing Officer
NHS Provider Licence	Each trust would have a separate NHSE Provider Licence. Engagement and processes to be undertaken through Corporate Governance and Finance.	Group Corporate Affairs Officer
ICO Registration	Each trust would have separate ICO registration and associated annual fee. Engagement and reporting to be undertaken through Digital and aligned DPO functions.	Group Digital & Information Officer / Group Corporate Affairs Officer
NHSR Schemes Membership	Each trust would have separate NHSR insurance policies. Engagement and reporting to be undertaken through the Liverpool Legal Services Collaborative.	Group Corporate Affairs Officer

9. Composition of the NHS University Hospitals of Liverpool Group Board

The NHS Act 2006, NHS England Code of Governance for Provider Trusts and each Trust Constitution describes the key rules trusts should follow when establishing their Board of Directors. These are summarised below:

- The board of directors and its committees should have a diversity of skills, experience and knowledge.
- The board should be of sufficient size for the requirements of its duties but should not be so large as to be unwieldy.
- Consideration should be given to the length of service of the board of directors as a whole and membership regularly refreshed.
- At least half the Board of Directors, excluding the Chair, shall comprise Non-Executive Directors. This only affects the number of voting Executive Directors

i. Composition

For Executive Directors:

- One of the Executive Directors shall be the Chief Executive and Accounting Officer.
- One of the Executive Directors shall be the Chief Finance Officer
- One of the Executive Directors is to be a registered medical practitioner (or a registered dentist (within the meaning of the Dentists Act 1984).
- One of the Executive Directors is to be a registered nurse or a registered midwife.

For Non-Executive Directors:

- The board of directors should satisfy itself that at least one Non-Executive Director has recent and relevant financial experience.

The composition of the Joint Board is proposed as follows:

<table>
<tr><th colspan="2">Executive Voting Members</th><th>Executive Non-Voting Members</th></tr>
<tr><td colspan="2">Group Chief Executive Officer</td><td>Group Chief Strategy & Partnerships Officer</td></tr>
<tr><td colspan="2">Group Chief Finance Officer</td><td>Group Chief Transformation Officer</td></tr>
<tr><td colspan="2">Group Chief Medical Officer</td><td>Group Chief Digital & Information Officer</td></tr>
<tr><td colspan="2">Group Chief Nursing Officer</td><td>Group Chief Quality Improvement Officer</td></tr>
<tr><td colspan="2">Group Chief People Officer</td><td>Group Chief Communications & Marketing Officer</td></tr>
<tr><td colspan="2">Group Chief Delivery Officer</td><td>Group Chief Corporate Affairs Officer/Company Secretary</td></tr>
<tr><td colspan="2">Royal Managing Director</td><td rowspan="3"></td></tr>
<tr><td colspan="2">Aintree Managing Director</td></tr>
<tr><td colspan="2">Liverpool Women’s Managing Director</td></tr>
<tr><th colspan="3">Non-Executive Directors</th></tr>
<tr><td colspan="3">Group Chair
+ 9 Voting Non-Executive Directors</td></tr>
<tr><th colspan="3">Total Board Size & Membership</th></tr>
<tr><td>25</td><td colspan="2">10 Non-Executive Directors (Chair + Voting NEDs)
15 Executives (9 Voting)</td></tr>
</table>

ii. Amendments to the Constitution

Each Trust has a Constitution, which is the governing document for each Trust and sets out the legal framework, fundamental principles, and processes by which a Trust is governed. It provides the provisions and Standing Orders for the practice and procedure for both the Board of Directors and the Council of Governors. In order for the above Executive and Non-Executive Members to be appointed to the Group, an amendment will need to be made to the LUHFT and LWH Constitution respectively to include updates to:

- The composition of the Board of Directors.
- The explicit ability to work more collaboratively via joint committees/committees in common.

As such, the Corporate Governance Team has undertaken a review of each Constitution, with approved amendments detailed in the briefing paper attached at Appendix B. Following approval by each Board, the amendments have been presented to the respective Council of Governors for approval.

iii. Approval of Group Executive Directors

A Board Nomination and Remuneration Committee took place on 25 September 2024 for each Trust, at which time approval to the appointment of the Executive Members identified to the Group Board was outlined. As part of that, an Executive Managing Director has been appointed to lead LWH, who will sit as a voting member of this joint Board of Directors. This will ensure equity with other sites, retaining the LWH identity, and voice and influence at board level.

iv. Approval of Group Non-Executive Directors

Following review and recommendation by the Council of Governors Joint Nomination and Remuneration Committee, the Council of Governors approved the below Non-Executive Directors to joint roles on 21 August 2024 (LWH) and 22 August 2024 (LUHFT).

DAVID FLORY
Joint Chair

MIKE EASTWOOD
Joint Non-Executive Director
Deputy Chair

GEOFFREY APPLETON
Joint Non-Executive Director
Senior Independent Director

JACKIE BIRD
Joint Non-Executive Director

ZIA CHAUDHRY
Joint Non-Executive Director

SARAH WALKER
Joint Non-Executive Director

TOM WALLEY
Joint Non-Executive Director

TRACY ELLERY
Joint Non-Executive Director

DAVID GILBURT
Joint Non-Executive Director

VACANCY
Joint Non-Executive Director

The Term of Office dates for each of the above Joint Non-Executive Directors is detailed below:

Non-Executive Director	Term of Office Dates	Term of Office
David Flory – Chair	1 March 2024 – 28 February 2027	First term
Mike Eastwood – Deputy Chair	1 September 2024 – 31 March 2026	Second Term
Geoffrey Appleton	1 September 2024 – 31 August 2027	First Term
Jackie Bird	1 September 2024 – 31 March 2025	First Term
Zia Chaudry	1 December 2021 – 30 November 2024	First Term
Sarah Walker	1 September 2024 – 31 August 2027	Second Term
Thomas Walley	1 September 2024 – 30 June 2026	Second Term
Tracy Ellery – Deputy Chair	1 September 2024 to 30 June 2025	Second Term
David Gilburt	1 September 2024 – 30 November 2025	First Term
Vacancy	NA	NA

The recruitment process for the vacant role and NEDs with an imminent end of Term of Office is in review.

v. Enhancing Board Oversight / NED Champion Roles

NHS England sets out in guidance 'Enhancing Board Oversight' in December 2021 that board oversight would be enhanced through a change from previously established NED champion roles to committee discharge. Both LUHFT and LWH Board of Directors have identified Non-Executive Directors assigned to the five recommended Champion Roles. The below table sets out the proposition for Joint Non-Executive Directors to be allocated to the Champion Roles identified in the guidance.

Maternity Board Safety Champion	Wellbeing Guardian	Freedom to Speak Up	Doctors Disciplinary	Security Management
Jackie Bird	Sarah Walker	Zia Chaudhry	Thomas Walley	Mike Eastwood

vi. Schedule of Business

The Schedule of Business informs the Board of Directors agenda, acting as a guide to schedule items to ensure meetings take place at the appropriate frequency and are of a manageable length. Mandatory items for Board of Directors to receive are detailed by NHS England, NHS Resolution, NHS Employers the Health and Social are Act 2008, the National Institute for Health and Care Excellence and the Health and Safety Executive.

A draft Schedule of Business for the Group Board has been prepared taking account of services provided by the Group (Appendix C).

10. Statutory and Mandatory Roles

There are several roles that NHS Foundation Trusts must ensure are in place as part of guidance, legislation or regulation. These cover a wide range of portfolios, including:

- Emergency preparedness
- Medicines management
- Finance
- Information management / governance
- Health and safety

- Infection control
- Safeguarding
- Freedom of information
- Freedom to Speak Up
- Quality / patient safety
- Sustainability
- Equality and diversity
- Wellbeing
- Maternity
- Security management

To ensure compliance with all relevant legislation and guidance, a review was undertaken with Executive leads to confirm that the most up-to-date guidance and legislation is referenced, and all relevant roles are understood. The full list of statutory roles can be found in Appendix D.

11. The Group Governance and Assurance Framework

i. Overarching Governance Framework

Key features of the Group Governance and Assurance Framework of the model include:

- Streamlined governance arrangements, reducing duplication in meeting attendance and reporting.
- Ensures that decisions are made in the right place and that risks and issues can be escalated and managed effectively from line of sight (ward) to the Board.
- The availability of data to be presented in a timelier manner.

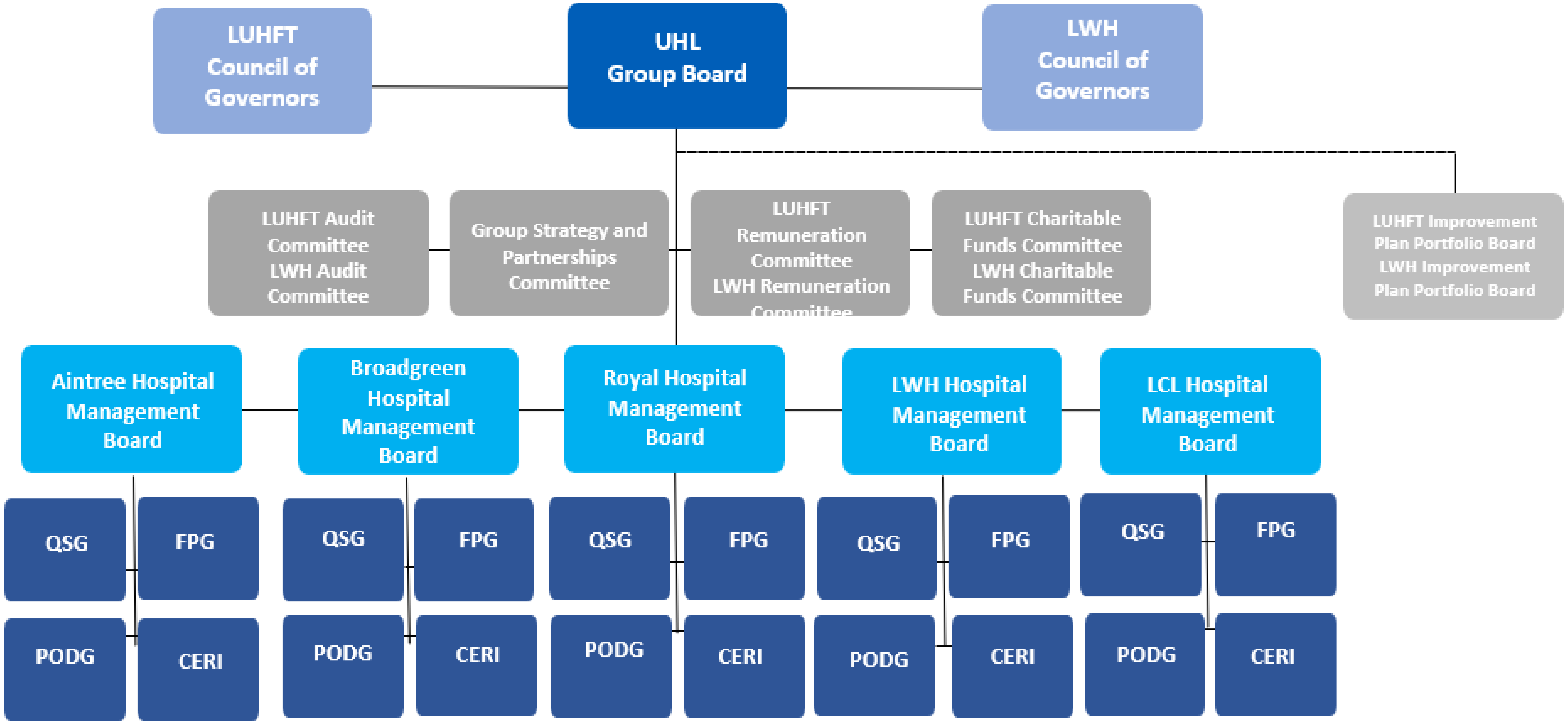
Full details of the Group Governance and Assurance Framework are detailed in the Group Corporate Governance Manual, which sets out the control framework within which the Group and each Trust's objectives are delivered. The legal framework within which each Trust was established and continues to operate is set out in the respective Trust's Constitution and Provider License.

The Group Corporate Governance Manual will be presented to the first Group Board meeting in November 2024.

The proposed Governance and Assurance Framework for the University Hospitals of Liverpool Group is set out below.

Governance and Assurance Framework
University Hospitals of Liverpool Group

The Governance Framework – Site Based Governance



LUHFT Council of Governors

UHL Group Board

LWH Council of Governors

LUHFT Audit Committee
LWH Audit Committee

Group Strategy and Partnerships Committee

LUHFT Remuneration Committee
LWH Remuneration Committee

LUHFT Charitable Funds Committee
LWH Charitable Funds Committee

LUHFT Improvement Plan Portfolio Board
LWH Improvement Plan Portfolio Board

Aintree Hospital Management Board

Broadgreen Hospital Management Board

Royal Hospital Management Board

LWH Hospital Management Board

LCL Hospital Management Board

QSG FPG PODG CERI

QSG FPG PODG CERI

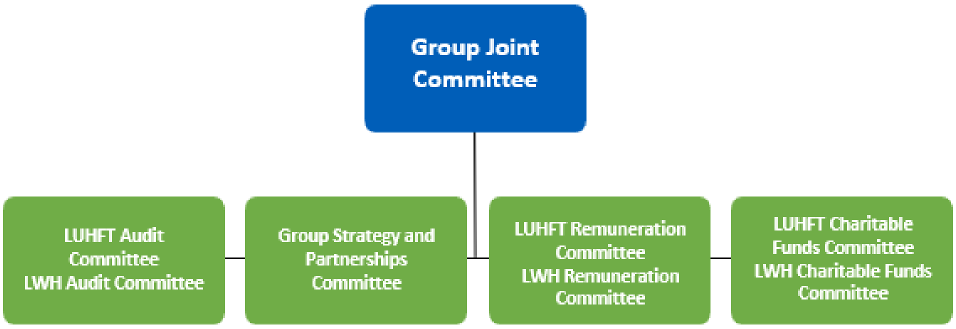
QSG FPG PODG CERI

QSG FPG PODG CERI

QSG FPG PODG CERI

ii. Sub-Committee Arrangements

The new Group Board committees are formally constituted as committees of the LUHFT and LWH Boards. The Committees will act under delegated authority from, and at all times remain accountable to, their respective 'parent' Trust Boards. All business conducted by each Committee will be conducted in the name of the respective Trust. Full details of the Group Governance and Assurance Framework are set out within the paper. Arrangements for the Group Joint Board Sub-Committees will be established and put in place by the Corporate Governance Team, as set out in the diagram below:


Group Joint Committee
LUHFT Audit Committee
LWH Audit Committee
Group Strategy and Partnerships Committee
LUHFT Remuneration Committee
LWH Remuneration Committee
LUHFT Charitable Funds Committee
LWH Charitable Funds Committee

Committee	Arrangements
Remuneration Committee	Committee in Common. Terms of Reference revised and aligned in September 2024.
Audit Committee	Individual Arrangements for each Trust Working with the Trust's Internal and External Auditors plans to establish a Committee-in-Common approach be undertaken for consideration by the Audit Committee of each Trust from April 2025/26.
Charitable Funds Committee	Plans to establish a Committee-in-Common approach be undertaken for consideration by the Charitable Funds Committee of each Trust from April 2025/26.
Strategy and Partnerships Committee	Joint Committee from November 2024.

Committees-in-Common create a framework for aligned decision-making and promote consistent decisions about the exercise of functions by all participant organisations, though those decisions are separately taken. A Committee-in-Common approach is often taken where a Trust is required to have a reserved function, however a Joint Board membership is in place.

To create a Committee-in-Common, each Trust will delegate decision-making for a particular function to an internal committee of that organisation. The committees of each of the organisations may have common membership, either entirely or in part hence the name 'committees in common'. Individual committees then make decisions for each Trust, essentially simultaneously and following arrangements that maximise the chances of aligned decision-making.

iii. Site Based Governance

The introduction of Hospital Management Boards and a focus on site-based governance gives each site greater autonomy and increased oversight of their opportunities, risks and issues. These changes ensure that we have a clear vision of where we want to be, and the leadership capacity, capability and appropriate governance to get us there.

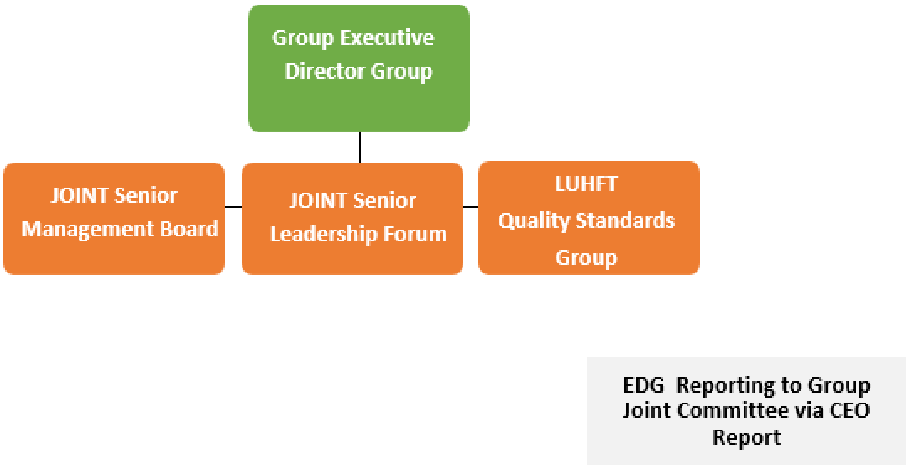
The governance arrangements provide strengthened control and corporate services support, with decisions made at a site level to increase responsiveness. The Executive Managing Directors of each Hospital Management Board are voting members of the Trust Board, which maintains the connectivity between the Board and site levels. Hospital Management Boards have delegated authority to make decisions affecting their sites, with a limited number of areas that will require Group-wide consultation and agreement, which are:

1. Change group-wide policies at site level
2. Operate outside of delegated limits
3. Change assurance or governance structure
4. Independently change digital or information systems
5. Agree different direction to the agreed strategy.

iv. <u>Group-wide Governance</u>

Whilst arrangements are developed to bring a focus on decision-making at the most appropriate site level, the Trusts will continue to operate within the delegated authorities and retained functions as individual organisations, each shares the same vision and values, as does each site within the model. The Group Executive Team will have oversight and make decisions that impact both LUHFT and LWH at a Trust level, and Hospital Management Boards have devolved control of aspects that impact their effective running and ability to respond.

The Joint Executive Directors Group has oversight and makes decisions that impact all sites across the Group. It is the approval forum for all issues that cannot be delegated to site-based decisions. It triages key issues to (and from) the Joint Senior Management Board and Quality Standards Group. Key issues from EDG are reported to the Board through the Board Chief Executive's report. Arrangements for the Group and Trust-wide decisions are detailed below:


Group Executive Director Group
JOINT Senior Management Board
JOINT Senior Leadership Forum
LUHFT Quality Standards Group
EDG Reporting to Group Joint Committee via CEO Report

12. Recommendation

The Board of Directors is asked to note the update.

Date 25 September 2024

LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

and

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

Provider Collaboration Agreement for the purpose of NHS University Hospitals of Liverpool Group Joint Working Arrangements and Appointment of a Joint Committee to Exercise Joint Functions as a Group Board

Version control

Date	Version	Author
07.08.2024	V001-1	Browne Jacobson LLP
26.08.2024	V001-2	LUHFT
03.09.2024	V001-3	Browne Jacobson LLP
06.09.2024	V001-4	LUHFT
09.09.2024	V001-5	LUHFT
11.09.2024	V001-6	LUHFT
18.09.2024	V001-7	LUHFT/LWH

This Agreement is made between the Parties on 25 September 2024

PART A – PARTIES

The Parties to this Agreement are

(1) **Liverpool University Hospitals NHS Foundation Trust** of Royal Liverpool University Hospital, Mount Vernon St, Liverpool L7 8YE (LUHFT) and

(2) **Liverpool Women's NHS Foundation Trust** of Crown St, Liverpool L8 7SS (LWH)

Each a Trust and together the Trusts

PART B – BACKGROUND

A. The Background to this Agreement (including acronyms and capitalised words that are used in it) shall be interpreted in accordance with the definitions and rules of interpretation set out in Schedule 1

B. LUHFT is constituted as an NHS foundation trust in accordance with its constitution dated August 2024.

C. LWH is constituted as an NHS foundation trust in accordance with its constitution dated August 2024.

D. Both Trusts must exercise their Functions in accordance with their respective Governance and having regard to Guidance.

E. The Trusts share all executive and non-executive directors including a shared Chair and Chief Executive Officer.

F. The Trusts have agreed to exercise their powers under sections 65Z5 and 65Z6 of the NHSA to establish and implement joint working and delegation arrangements as set out in this Agreement and to establish a joint committee to be known as the Group Board to exercise Joint Functions

G. The Trusts have agreed to data sharing, access to records and mutual operation of all Joint Functions including human resources and joint line management arrangements to facilitate the exercise of Joint Functions.

H. The Trusts have agreed that the Group Board will exercise Joint Functions but will not exercise Reserved Functions.

PART C – OPERATIVE PROVISIONS

1. Definitions and interpretation

This Agreement (including acronyms and capitalised words that are used in it) shall be interpreted in accordance with the definitions and rules of interpretation set out in Schedule 1.

2. Actions taken prior to the Commencement Date

2.1. Both Trusts shall have satisfied or agreed in writing to waive the conditions set out in Clause 2.2 on or prior to the Commencement Date.

2.2. The conditions referred to in Clause 2.1 are:

2.2.1. The Trusts shall have exchanged duly executed copies of this Agreement.

2.2.2. The Trusts shall have constituted the Group Board and approved the Group Board Terms of Reference (ToR).

2.2.3. The Trusts shall have updated and adopted Standing Orders that are mutually compatible.

2.2.4. Such other conditions that either Trust may have specified in writing before the Commencement Date.

3. Commencement and duration

3.1. The Agreement shall take effect from the Commencement Date and will continue in full force and effect until terminated in accordance with the terms of this Agreement and, in particular, but without limitation, in accordance with Clause 18.

3.2. Subject to Clause **Error! Reference source not found.**, no termination of the Agreement by either Trust shall take effect prior to 31 March 2026.

4. No merger, acquisition or dissolution

4.1. LUHFT and LWH agree to establish provider collaboration arrangements between them in accordance with this Agreement to be known as NHS University of Hospitals Liverpool Group or UHL.

4.2. Both Trusts shall remain independent, sovereign organisations constituted in accordance with the NHSA and their respective Constitutions.

4.3. Nothing in this Agreement commits the Trusts or is intended to commit them to undertake or apply for merger, acquisition or dissolution or any other transaction whose outcome would be the establishment of a single organisation as successor to one or both of them.

4.4. Each of the Trusts shall continue at all times to maintain its own individual governance, registrations, licences, memberships, committees and other arrangements that it may be required to maintain or hold by Law, Direction or Guidance including:

4.4.1. Constitution, Standing Orders, Standing Financial Instructions and Scheme of Delegation

4.4.2. CQC registration

4.4.3. NHS provider licence

4.4.4. ICO registration

4.4.5. NHSR Schemes membership

4.4.6. Nominations & Remuneration Committee

4.4.7. Audit Committee

4.4.8. Meetings that the Trusts' Boards must each hold as set out in Clause 8 of this Agreement.

5. Trust Board Appointments

5.1. Voting NEDs of each Trust shall continue to be appointed by its CoG in accordance with its Constitution.

5.2. The Trusts acting by their respective Nomination & Remuneration Committees:

5.2.1. Shall appoint Voting Executive Directors (EDs) in accordance with the scheme set out in Schedule 7, and

5.2.2. May additionally appoint Non-Voting NEDs and Non-Voting EDs in accordance with the scheme set out in Schedule 7.

5.3. Each Trust shall (in compliance with its Constitution) maintain a functioning Board comprising Voting NEDs (including the Chair) and Voting EDs whose numbers will be neither less nor more than the number of Voting NEDs and Voting EDs prescribed by its Constitution.

5.4. Each Trust's Voting EDs must include the Chief Executive Officer (CEO), Chief Finance Officer (CFO), Chief Medical Officer (CMO), and Chief Nursing Officer (CNO).

5.5. The number of each Trust's Voting NEDs shall at all times be greater than the number of its Voting EDs.

6. Appointment of Group Board

6.1. The Trusts agree to establish a Joint Committee to be known as the 'Group Board'.

6.2. The Group Board shall be fully and equally accountable to both Trusts.

6.3. The Group Board ToR and its membership must be agreed by both Trusts and must include the provisions set out in Clause 6.4.

6.4. The provisions referred to in Clause 6.3 are:

6.4.1. All the Voting Directors of both Trusts shall be voting members of the Group Board during their terms of office.

6.4.2. Voting Directors of both Trusts are outlined in each Trust Constitution and the Group Corporate Governance Manual.

6.4.3. The Trusts may appoint Non-Voting Directors and/or other individuals to be voting or non-voting members of the Group Board.

6.4.4. The Trusts and Group Board shall have Committees in accordance with Clause 11.

6.4.5. The Group Board shall exercise the Joint Functions.

6.4.6. Subject to Clause 6.4.7, meetings of the Group Board shall be held in public.

6.4.7. The Group Board may, by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings; and where such a resolution is passed, this Agreement shall not require the meeting to be open to the public during proceedings to which the resolution applies.

6.4.8. The proceedings of the Group Board shall not be invalidated by any vacancy in its membership or by any defect in the appointment of a member of the Group Board.

6.5. The Group Board ToR as at the Commencement Date are as set out in Schedule 4 of this Agreement.

6.6. The Trusts may agree to amend the Group Board ToR but only by Variation in accordance with Clause 17 of this Agreement.

7. Joint Exercise of Functions

7.1. Subject to Clause 7.2 the Trusts agree that from the Commencement Date:

7.1.1. They shall jointly exercise their Joint Functions.

7.1.2. The Group Board shall exercise for them all their Joint Functions.

7.1.3. If the Group Board appoints a Committee in accordance with Clause 11, then the Group Board may authorise the Committee to exercise Joint Functions that the Group Board expressly subdelegates to the Committee in its ToR.

7.1.4. The Group Board may authorise one of the Trusts to contract with a third party on behalf of itself alone or both Trusts jointly and/or severally subject to compliance with the Trusts' standing orders and standing financial instructions.

7.2. Subject to Clause 6.4.8, the Trusts agree that they, the Group Board and their Committees, directors and officers must always comply with this Agreement and with each of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation when they are exercising Joint Functions.

8. Meetings of the Trusts' Boards

8.1. Subject to Clause 8.2, the Trusts intend that as far as possible meetings and business of the Trusts' Boards will be undertaken by the Group Board on their behalf.

8.2. In accordance with paragraph 18E of Schedule 7 the Board of each Trust must continue to hold any meetings that it is required to hold including

8.2.1. An annual meeting to approve the Trust’s annual audited accounts and annual report

8.2.2. Any other meeting at which must be presented the documents referred to in Clause 8.3:

8.3. The documents referred to in Clause 8.2.2 are:

8.3.1. The Trust’s audited accounts and annual report,

8.3.2. Any report on the Trust’s accounts made pursuant to paragraph 24 of Schedule 7 and Schedule 10 to the NHSA, and

8.3.3. Any other documents as may be prescribed.

9. Workforce

9.1. Both Trusts shall continue to employ their own workforces.

9.2. Both Trusts agree that in the exercise of their joint working arrangements, members of either Trust’s or both Trusts’ workforce may be line managed by duly authorised officers of either Trust or both Trusts.

10. Exercise of Reserved Functions

10.1. Both Trusts shall continue to exercise separately their Reserved Functions.

10.2. The Trusts agree that the Group Board shall not at any time exercise their Reserved Functions.

11. Appointment of Committees and Committees in Common

11.1. The Group Board shall have the following Committees:

- Group Strategy & Partnerships Committee
- Aintree Hospital Management Board
- Broadgreen Hospital Management Board
- Royal Hospital Management Board
- LCL Hospital Management Board
- LWH Management Board

11.2. For the purpose of assisting the exercise of Joint Functions the Group Board may appoint one or more Committees additional to those set out in Clause 11.1.

11.3. The voting members of a Committee of the Group Board may comprise or include individuals who are or are not voting members of the Group Board.

11.4. For the purpose of assisting the exercise of their Reserved Functions the Trusts may appoint Committees in Common.

11.5. Without prejudice to the generality of Clause 11.4, the Boards of each of the Trusts (acting as independent, sovereign bodies) shall consider and (if agreed by both Boards) arrange for:

11.5.1. Their Audit Committees to operate together as Committees in Common

11.5.2. Their Nomination & Remuneration Committees to operate together as Committees in Common and

11.5.3. Their Charitable Funds Committees to operate together as Committees in Common.

11.6. In operating as Committees in Common:

11.6.1. Each Trust's Audit Committee, Nomination & Remuneration Committee and Charitable Funds Committees shall continue at all times to be directly accountable to its respective Trust Board but shall routinely report to the Group Board; and

11.6.2. Each Trust shall ensure that the members of its Audit Committee, Nomination & Remuneration Committee and Charitable Funds Committees at all times satisfy the independence requirements set out in NHS England's *Code of governance for NHS provider trusts* (2022).

11.7. For illustrative purposes an organogram of the Trusts' Committees structure as at the Commencement Date is set out in Schedule 5.

12. Operating Principles

12.1. The Trusts shall exercise their Functions having regard to the operating principles set out in Clause 12.2.

12.2. The operating principles referred to in Clause 12.1 are:

12.2.1. LWH and LUHFT will operate within the Group Governance and Assurance Framework as set out in the UHL Group Corporate Governance Manual;

12.2.2. Improve access to safe high-quality care across the Trusts' respective clinical and non-clinical areas including shared areas of clinical co-operation;

12.2.3. Deliver improved outcomes for all patients – minimising unwarranted variation and reducing inequity in access and outcomes;

12.2.4. Support and encourage staff to make best use of shared professional development and research opportunities;

12.2.5. Combine the Trusts' employer power to benefit employment opportunities in their local economies as anchor institutions;

12.2.6. Standardised quality and corporate governance processes in line with best practice and minimise bureaucracy, such as additional structures and meetings;

12.2.7. Be sensitive to local needs and differences to ensure the populations the Trusts serve are at the heart of their decision making;

12.2.8. Agree mutually beneficial areas to plan, agree and deliver change across both Trusts including joint strategy, aims and objectives.

13. Benefits

13.1. The Trusts shall exercise their Functions having regard to unlocking benefits set out in Clause 13.2.

13.2. The benefits referred to in Clause 13.1 are:

13.2.1. Extended opportunities for clinical partnerships leading to an increase in clinical knowledge and expertise;

13.2.2. Improved access to essential services for patients;

13.2.3. Increased standardisation, reduced duplication leading to operational and financial efficiencies;

13.2.4. Improved staff experience working to a single organisational structure, vision and values;

13.2.5. Improved clinical skills from access to a larger cohort and a broader range of opportunities across a larger organisation;

13.2.6. Setting the conditions for future service transformation;

13.2.7. Transition of the Trusts towards Segment 2 of the NHS National Oversight Framework and removal from NHS England tiering arrangements;

13.2.8. Strong partnership engagement through LAASP Joint Committee to contribute to the development of the LAASP Strategic Case (5 Year Plan for Liverpool)

14. Mobilisation

14.1. The Trusts shall establish a Mobilisation Delivery Group led by the Chief Transformation Officer and consisting of representatives from both Trusts. The Mobilisation Delivery Group shall work on behalf of the executive teams of both Trusts on the following matters:

14.1.1. Defining and implementing the Group governance and assurance model;

14.1.2. Engaging and communicating with staff and partners throughout the transition process;

14.1.3. Defining the Group brand and usage guidelines;

14.1.4. Putting in place the day one digital requirements so that work can be managed effectively across the Group and sites;

14.1.5. Effective management of any required Executive recruitment and workforce change management processes; and

14.1.6. Designing and planning the longer term Group Operating Model

15. Resourcing the Group Board

Both Trusts shall be jointly and equally responsible for resourcing the Group Board.

16. Pooled Fund

16.1. The Trusts may enter into arrangements for the Trusts themselves or the Group Board to establish and maintain a Pooled Fund.

16.2. Arrangements for any Pooled Fund must be on terms set out in a Pooled Fund Agreement.

17. Variation

17.1. Except as set out in Clause 17.2 or otherwise in this Agreement, any Variation of this Agreement, including the introduction of any additional terms and conditions, shall only be binding when agreed by written resolutions of both Trusts' Boards.

17.2. The Scheme for Trust Board Appointments set out in Schedule 7 and the Governance Organogram for the Trusts' Appointment of Committees as at the Commencement Date set out in Schedule 5 are intended to be illustrative only and may be updated by resolution of the Group Board without the requirement for Variation set out in Clause 17.1.

18. Termination

18.1. The Trusts acknowledge and confirm that, save in accordance with this Clause 18, neither of them shall be entitled to terminate this Agreement.

18.2. The Trusts acknowledge and confirm that neither of them shall be entitled to terminate this Agreement in consequence of any breach (whether material or otherwise) of any provision of this Agreement by the other.

18.3. Both Trusts acknowledge and confirm that they have considered and understood the position set out at Clause 18.2 above and that the provisions of Clauses 3.2 (and Clause 22 in relation to the Dispute Resolution Procedure) shall apply in the event of any breach of this Agreement.

18.4. Subject to Clauses 3.2 and **Error! Reference source not found.** , a Trust may only terminate this Agreement by giving Notice of Termination specifying a minimum notice period that expires on the next 31 March if notice is given prior to 6 months of that date, or if later, expires 12 months from the date the notice of termination is served. The notice period may be shorter where agreed in writing by the other Trust.

18.5. The initial duration of this Agreement shall be for a minimum period from the date of signing until 31 March 2026.

19. Consequences of termination

19.1. On or pending expiry or termination of this Agreement, the Parties will agree an Exit Plan to ensure that the services provided by either Trust are not destabilised.

19.2. For a reasonable period before and after termination or expiry of this Agreement the Trusts shall co-operate fully with one another and ensure that the Exit Plan provides for continuity of services and a smooth transition of Trust Boards whilst avoiding any inconvenience or risk to the health and safety of the Trusts' service users, employees or members of the public.

19.3. This clause 19 shall continue in full force and effect on or after termination or expiry of this Agreement.

20. Data sharing and confidentiality

Each Trust undertakes that it shall not at any time during the period for which this Agreement applies, and for a period of five years after termination of this Agreement, disclose to any person any Confidential Information concerning or in connection with the other Trust or this Agreement except as permitted by Schedule 6.

21. No partnership

Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between the Trusts, constitute either Trust the agent of the other Trust, nor authorise a Trust to make or enter any commitments for or on behalf of the other Trust except as expressly provided in this Agreement.

22. Notices

22.1. A notice given under this Agreement:

22.1.1. Will be in writing in the English language

22.1.2. Will be sent to the intended recipient by email to the following address or such other address as the Party has notified for the purposes of this clause:

22.1.2.1. for LUHFT, the Chief Executive Officer of LUHFT in post at the time of the notice

22.1.2.2. for LWH, the Chief Executive Officer of LWH in post at the time of the notice

22.2. Any notice or other communication given to a Trust under or in connection with the Agreement shall be in writing, addressed to the authorised representatives at the Trust's principal place of business or such other address as that Trust may have specified to the other Trust in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery, commercial courier or email.

22.3. A notice or other communication shall be deemed to have been received:

22.3.1. If delivered personally, when left at the address referred to in Clause 22.2; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Business Day after posting; if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed; or, if sent by fax, one (1) Business Day after transmission.

22.3.2. If delivered by email, immediately on sending provided it is correctly addressed or if deemed receipt is not within business hours (meaning prior to 5.30 pm and excluding weekends and public holidays in England), then it will be deemed to have been received at 9.00 am on the next day that is not a weekend or a public holiday in England.

22.4. The provisions of this Clause 22 shall not apply to the service of any proceedings or other documents in any legal action.

23. Dispute Resolution

23.1. In accordance with Clauses 3.2, 3.3 and 18 regarding termination of the Agreement, both Trusts agree to this dispute resolution process.

23.2. In the case of dispute, the Group Chief Transformation Officer and Audit Committee Chairs shall review any dispute referred to them via the Group Company Secretary and Joint Chair in writing with 28 days of receipt, and provide a resolution.

23.3. In the case of the resolution being rejected, the matter will be referred to the Senior Independent Director (SID) who will provide a final and binding determination and resolution.

23.4. In the case of dispute between the Boards leading to consideration of termination, Clauses 3.2 and 3.3 determine the timescale and Clause 18 in respect of notification of termination.

24. Other general provisions

24.1. Each Trust shall (at its own expense) promptly execute and deliver such documents, perform such acts and do such things as the other Trust may reasonably require from time to time for the purpose of giving full effect to this Agreement.

24.2. Each Trust will bear its own costs of negotiating and entering into this Agreement.

24.3. This Agreement is personal to the Trusts and neither Trust shall assign, transfer, mortgage, charge, declare a trust of, or deal in any other manner with any of its rights and obligations under this Agreement without the prior written consent of the other Trust.

24.4. This Agreement (together with the documents referred to in it) constitutes the entire agreement between the Trusts and supersedes and extinguishes all previous discussions, correspondence, negotiations, drafts, agreements, promises, assurances, warranties, representations and understandings between them, whether written or oral, relating to its subject matter.

24.5. No failure or delay by a Trust to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy. A waiver of any right or remedy under this Agreement or by law is only effective if it is in writing.

24.6. Except as expressly provided in this Agreement, the rights and remedies provided under this Agreement are in addition to, and not exclusive of, any rights or remedies provided by law.

24.7. If any provision or part-provision of this Agreement is or becomes invalid, illegal or unenforceable, it shall be deemed modified to the minimum extent necessary to make it valid, legal and enforceable. If such modification is not possible, the relevant provision or part-provision shall be deemed deleted. Any modification to or deletion of a provision or part-provision under this Clause shall not affect the validity and enforceability of the rest of this Agreement.

24.8. This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all the counterparts shall together constitute the one agreement.

24.9. No one other than a party to this Agreement shall have any right to enforce any of its terms.

24.10. This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales.

24.11. Each Trust irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this Agreement or its subject matter or formation (including non-contractual disputes or claims).

The Trusts have executed this Agreement as set out below on the date stated at the beginning of it

PART D – SCHEDULES

Schedule 1 – Definitions and Interpretation

1 In this Agreement capitalised words and expressions shall have the meanings given to them as follows:

Word or expression	**Meaning**
Agreement	This collaboration agreement (including its Schedules) which sets out arrangements of the Trusts to exercise their Functions jointly
Arrangements for delegation and joint exercise of statutory functions	NHS England Guidance *Arrangements for delegation and joint exercise of statutory functions – Guidance for integrated care boards, NHS trusts and foundation trusts* dated 24 March 2024 (Publication approval reference: PRN0152)
Audit Committee	A Committee that each of the Trusts must appoint in accordance with NHS England's *Code of governance for NHS provider trusts* (2022) to ensure that it operates effectively and meets its statutory and strategic objectives, and to provide it with assurance that this is the case
CEO	A Voting ED who is the Chief Executive Officer of one or both of the Trusts
Chair	A Voting NED who is the Chair of one or both of the Trusts
Commencement Date	1 November 2024
Committee	A committee or subcommittee of one of the Trusts or a subcommittee of a Joint Committee (including the Group Board)
CiC or Committees in Common	Arrangements between the Trusts to appoint like for like Committees with the same or equivalent terms of reference and memberships so that they may meet simultaneously with shared agenda and minutes
CoG	Council of Governors

Word or expression	**Meaning**
CQC	Care Quality Commission
Constitution	The constitution of an NHSFT that has been approved by its Board of Directors and CoG and is in force at the relevant time of their respective decision-making and exercise of functions
Direction	A direction to an NHST or NHSFT trust that the Secretary of State or NHS England may issue in the exercise of their respective functions under Legislation
Director	A NED or an ED of one or both of the Trusts
ED or Executive Director	an executive director who may be Voting ED or a Non-Voting ED
EIR	Environmental Information Requests
Exit Plan	A plan for the transition of any affected services and required changes to the Trust Boards on the expiry or termination of this Agreement to include: (i) details of the affected services; (ii) details of service users and/or user groups affected; (iii) the joint working arrangements and jointly exercised functions that will need to continue to ensure continuity of services and how these will be transitioned into separate arrangements for each Trust; (iv) the intended timescales for the Exit Plan
FoIA	Freedom of Information Act 2000
Functions	All the duties and/or powers of the Trusts under the NHSA or any other legislation or otherwise conferred by any other source whatsoever
Governance	In the case of an NHSFT means its Constitution, Standing Orders and Schedule 7 of the NHSA

<u>**Word or expression**</u>	<u>**Meaning**</u>
Group Board	A Joint Committee that the Trusts have agreed to establish to exercise Joint Functions in accordance with the Group Board ToR
Group Board ToR	ToR of the Group Board
Guidance	Any statutory guidance of the Secretary of State or NHS England to NHS bodies comprising or including NHSFTs (for example *Arrangements for delegation and joint exercise of statutory functions*) or other non-statutory guidance that the Trusts must have regard to in accordance with their NHS provider licence
Joint Committee	A joint committee that the Trusts agree to establish under section 65Z6 of the NHSA
Joint Functions	Any Functions set out in Schedule 2 which the Trusts agree are jointly exercisable by them
LCL	Liverpool Clinical Laboratories
Legislation	An Act of Parliament (for example the NHSA) or statutory instrument
LUHFT	Liverpool University Hospitals NHS Foundation Trust
LWH	Liverpool Women's NHS Foundation Trust
LAASP	Liverpool Adult Acute and Specialist Providers
NED or Non-Executive Director	A non-executive director who may be Voting NED or a Non-Voting NED
NHSA	National Health Service Act 2006
NHSFT	NHS foundation trust within the meaning of section 30 of the NHSA

Word or expression	**Meaning**
NHSR Schemes	The indemnity schemes known as the Clinical Negligence Scheme for Trusts, Liabilities to Third Parties Scheme and Property Expenses Scheme which the Secretary of State has established under the NHSA and which are managed on their behalf by NHS Resolution
Nominations & Remuneration Committee	A Committee that each Trust must appoint whose responsibilities include functions under Schedule 7: • (The CEO not being a member of it) to appoint the Trust's CEO and advise the Board about their remuneration and terms of service and (The CEO being a member of it) to appoint other executive directors and advise the Board about their remuneration and terms of service
Non-Voting Director	a Non-Voting ED or Non-Voting NED
Non-Voting ED	An Executive Director who is not a Voting Director
Non-Voting NED	A Non-Executive Director who is not a Voting Director
Notice of Termination	Notice in writing from one Trust to the other Trust to terminate this Agreement in accordance with Clause 18
Pooled Fund	A fund to be made up of payments received in accordance with arrangements between the Parties that must be set out in a Pooled Fund Agreement and out of which payments may be made in accordance with the arrangements towards expenditure incurred in the exercise of Joint Functions
Pooled Fund Agreement	An agreement in writing between the Trusts for the establishment of a Pooled Fund in accordance with section 65Z6 of the NHSA

<u>**Word or expression**</u>	<u>**Meaning**</u>
Reserved Functions	Any Functions set out in Schedule 3 which the Trusts agree are not Joint Functions
Schedule 7	Schedule 7 of the NHSA unless it is intended to refer to Schedule 7 of this Agreement
Secretary of State	Secretary of State for Health and Social Care
Standing Orders	In the case of an NHSFT means the standing orders of its board of directors and/or the standing orders of its CoG that the NHSFT is required to adopt by its Constitution for the regulation of their proceedings and business
ToR	Terms of reference
University Hospitals of Liverpool or UHL	The name of the provider collaboration between LUHFT and LWH established in accordance with this Agreement
UK GDPR	Has the meaning given to it in section 3(10) (as supplemented by section 205(4)) of the Data Protection Act 2018.
Variation	A variation of this Agreement in accordance with Clause 17
Voting Director	A Voting ED or a Voting NED
Voting ED	In the case of an NHSFT means a Director who is an executive director within the meaning of paragraph 16 of Schedule 7 and has been appointed by the NEDs and (except for the CEO's appointment) the CEO in accordance with the NHSFT's Constitution
Voting NED	In the case of an NHSFT means a Director within the meaning of paragraph 16 of Schedule 7 and has been appointed by the NHSFT's CoG in accordance with its Constitution

2. Any reference to the exercise by the Trusts of Joint Functions shall be interpreted to include any exercise of Joint Functions by the Group Board or a Committee of it on behalf of the Trusts.

Schedule 2 – Joint Functions

1. Joint Functions are any Functions of the Trusts which are not Reserved Functions

2. Joint Functions include but are not limited to:

   2.1. Each of the Trust's Functions to provide goods and services, namely hospital accommodation and services and community health services, for the purposes of the health service in accordance with the NHSA

   2.2. All the Trusts' Functions that NHS England has categorised as 'Open to Joint Exercise of Functions' in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in Paragraph 3 below (excluding references to legislation that is applicable to or in force in Wales only).

3. The table referred to in paragraph 2(2) is as follows:

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 43 NHS Act 2006	(2) An NHS foundation trust may provide goods and services for any purposes related to— (a) the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and (b) the promotion and protection of public health. (2A) An NHS foundation trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes. (3) An NHS foundation trust may also carry on activities other than those mentioned in subsection (2) for	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	the purpose of making additional income available in order better to carry on its principal purpose.		
Section 44 NHS Act 2006	(6) According to the nature of its functions, an NHS foundation trust may, in the case of patients being provided with goods and services for the purposes of the health service, make accommodation or further services available for patients who give undertakings (or for whom undertakings are given) to pay any charges imposed by the NHS foundation trust in respect of the accommodation or services. (7) An NHS foundation trust may exercise the power conferred by subsection (6) only to the extent that its exercise does not to any significant extent interfere with the performance by the NHS foundation trust of its functions.	COMMISSIONING	Yes
Section 47 NHS Act 2006	(1) An NHS foundation trust may do anything which appears to it to be necessary or expedient for the purpose of or in connection with its functions. (2) In particular it may– (a) acquire and dispose of property, (b) enter into contracts, (c) accept gifts of property (including property to be held on trust for the purposes of the NHS foundation trust or for any purposes relating to the health service), (d) employ staff. (3) Any power of the NHS foundation trust to pay remuneration and allowances to any person includes power to make arrangements for providing, or securing	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	the provision of, pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay). (4) "The purposes of the NHS foundation trust" means the general or any specific purposes of the trust (including the purposes of any specific hospital at or from which services are provided by the trust).		
Section 47A NHS Act 2006 as inserted by section 64 of the Health and Care Act 2022	Joint exercise of functions An NHS foundation trust may enter into arrangements for the carrying out, on such terms as the NHS foundation trust considers appropriate, of any of its functions jointly with any other person.	CORPORATE	Yes
Section 56 NHS Act 2006	(1) An application may be made jointly by– (a) an NHS foundation trust, and (b) another NHS foundation trust or an NHS trust established under section 25, to the regulator for the dissolution of the trusts and the establishment of a new NHS foundation trust. (1A) An application under this section may be made only with the approval of more than half of the members of the council of governors of each applicant (that is an NHS foundation trust). (2) The application must– (a) be supported by the Secretary of State if one of the parties to it is an NHS trust, (b) specify the property and liabilities proposed to be transferred to the new NHS foundation trust, and (d) be accompanied by a copy of the proposed	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	constitution of the new trust (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the dissolution of the trusts and the establishment of the proposed new trust have been taken. (11) On the grant of the application, the proposed constitution of the NHS foundation trust has effect, but the directors of the applicants may exercise the functions of the trust on its behalf until a board of directors is appointed in accordance with the constitution.		
Section 56A NHS Act 2006	56A Acquisitions (1) An application may be made jointly by— (a) an NHS foundation trust (A), and (b) another NHS foundation trust or an NHS trust established under section 25 (B), to the regulator for the acquisition by A of B. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of each applicant (that is an NHS foundation trust). (3) The application must— (a) be supported by the Secretary of State if B is an NHS trust, and (b) be accompanied by a copy of the proposed constitution of A, amended on the assumption that A acquires B. (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the acquisition have been taken.	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(4A) Where the regulator proposes to grant the application, it may by order make provision for the transfer of employees of B to A on the grant of the application. (5) On the grant of the application, the proposed constitution has effect, but where a person who is specified as a director of A in the constitution has yet to be appointed as such, the directors of A may exercise that person's functions under the constitution.		
Section 63 NHS Act 2006	An NHS foundation trust must exercise its functions effectively, efficiently and economically.	ANCILLARY FUNCTION	Yes
Section 63A NHS Act 2006	(1) In making a decision about the exercise of its functions, an NHS foundation trust must have regard to all likely effects of the decision in relation to— (a) the health and well-being of the people of England; (b) the quality of services provided to individuals— (i) by relevant bodies, or (ii) in pursuance of arrangements made by relevant bodies, for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England; (c) efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.	ANCILLARY FUNCTION	Yes
Section 65Z5 NHS Act 2006 as inserted by Section 71 of the Health and Care Act 2022	Joint working and delegation arrangements (1) A relevant body may arrange for any functions exercisable by it to be exercised by or jointly with any one	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	or more of the following— (a) a relevant body (b) a local authority (within the meaning of section 2B); (c) a combined authority. (2) In this section “relevant body” means— (a) NHS England, (b) an integrated care board, (c) an NHS trust established under section 25, (d) an NHS foundation trust, or (e) such other body as may be prescribed.		
Section 65Z6 NHS Act 2006 as inserted by Section 71 of the Health and Care Act 2022	Joint committees and pooled funds (1) This section applies where a function is exercisable jointly (by virtue of section 65Z5 or otherwise) by a relevant body and any one or more of the following— (a) a relevant body; (b) a local authority (within the meaning of section 2B); (c) a combined authority. (2) The bodies by whom the function is exercisable jointly may— (a) arrange for the function to be exercised by a joint committee of theirs; (b) arrange for one or more of the bodies, or a joint committee of the bodies, to establish and maintain a pooled fund.	CORPORATE	Yes
Section 72 NHS Act 2006	(1) It is the duty of NHS bodies to co-operate with each other in exercising their functions.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 82 NHS Act 2006	In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.	ANCILLARY FUNCTION	Yes
Section 223L NHS Act 2006	(1) NHS England may set joint financial objectives for integrated care boards and their partner NHS trusts and NHS foundation trusts. (2) An integrated care board and its partner NHS trusts and NHS foundation trusts must seek to achieve any financial objectives set under this section.	CORPORATE	Yes
Section 223LA NHS Act 2006	(1) An integrated care board and its partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that their expenditure in a financial year (taken together) does not exceed the aggregate of any sums received by them in the year.	CORPORATE/ ANCILLARY	Yes
Section 223M NHS Act 2006	(1) Each integrated care board and its partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that, in respect of each financial year— (a) local capital resource use does not exceed the limit specified in a direction by NHS England; (b) local revenue resource use does not exceed the limit specified in a direction by NHS England.	CORPORATE/ ANCILLARY	Yes
Section 242 NHS Act 2006	(1B) Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services,	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in– (a) the planning of the provision of those services, (b) the development and consideration of proposals for changes in the way those services are provided, and (c) decisions to be made by that body affecting the operation of those services.		
Section 249 NHS Act 2006	(1) In exercising their respective functions, NHS bodies (on the one hand) and the prison service (on the other) must co-operate with one another with a view to improving the way in which those functions are exercised in relation to securing and maintaining the health of prisoners.	ANCILLARY FUNCTION	Yes
Criminal Justice Act 2003, Section 325(3)	In establishing those arrangements for the purpose of assessing and managing risks posed by relevant sexual and violent offenders &c, the responsible authority i.e. the chief officer of police, the local probation board for that area or (if there is no local probation board for that area) a relevant provider of probation services and the Minister of the Crown exercising functions in relation to prisons, acting jointly must act in co-operation with the persons specified in subsection (6); and it is the duty of those persons to co-operate in the establishment by the responsible authority of those arrangements, to the extent that such co-operation is compatible with the exercise by	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	those persons of their relevant functions. NHS trusts are included among persons in sub-s (6)(h).		
Mental Health (Care and Treatment) (Scotland) Act 2003, Section 31	(1) Where it appears to a local authority that the assistance of a Health Board, a Special Health Board or a National Health Service trust– (a) is necessary to enable the authority to perform any of their duties under section 25 or 26 of this Act i.e. relating to provision of care and support services and services designed to promote well-being and independence; or (b) would help the authority to perform any of those duties, the authority may request the Health Board, Special Health Board or National Health Service trust to co-operate by providing the assistance specified in the request. (2) A Health Board, a Special Health Board or a National Health Service trust receiving a request under subsection (1) above shall, if complying with the request– (a) would be compatible with the discharge of its own functions (whether under any enactment or otherwise); and (b) would not prejudice unduly the discharge by it of any of those functions, comply with the request.	ANCILLARY FUNCTION	Yes
National Health Service Trust (Scrutiny of Deaths) (England) Order 2021, article 3	(1) An NHS trust in England may scrutinise the death of any person who has died in England where— (a) a senior coroner is not under a duty to investigate the death under section 1 of the Coroners and Justice Act 2009, or	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(b) it is unclear whether the death is one which a registered medical practitioner would be required to notify to the relevant senior coroner under the Notification of Deaths Regulations 2019.		
Social Workers Regulations 2018, reg 7	(1) The persons specified for the purposes of section 53(1)(d) of the Act i.e the Children and Social Work Act 2017, which requires Social Work England ("the regulator") to cooperate with, among others, any person specified in regulations made by the Secretary of State are— (d) any NHS trust established under section 25 of the National Health Service Act 2006,	ANCILLARY FUNCTION	Yes
Children Act 2014, s11(2); (4)	(2) Each person and body to whom this section applies which includes NHS Trusts by ss(1) must make arrangements for ensuring that– (a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and (b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need. (4) Each person and body to whom this section applies must in discharging their duty under this section have regard to any guidance given to them for the purpose by the Secretary of State.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Children Act 2014, Section 25(5) [Applicable in Wales only]	(1) Each local authority in Wales must make arrangements to promote co-operation between– (a) the authority; (b) each of the authority's relevant partners which includes NHS Trusts by ss(4)(e); and (c) such other persons or bodies as the authority consider appropriate, being persons or bodies of any nature who exercise functions or are engaged in activities in relation to children in the authority's area. (2) The arrangements under subsections (1) and (1A) not reproduced here are to be made with a view to— (a) improving the well-being of children within the authority's area, in particular those with needs for care and support; (b) improving the quality of care and support for children provided in the authority's area (including the outcomes that are achieved from such provision); (c) protecting children who are experiencing, or are at risk of, abuse, neglect or other kinds of harm (within the meaning of the Children Act 1989). (5) The relevant partners of a local authority in Wales must co-operate with the authority in the making of arrangements under this section.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 25(6) [Applicable in Wales only]	(6) A local authority in Wales and any of their relevant partners may for the purposes of arrangements under this section– (a) provide staff, goods, services, accommodation or other resources;	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(b) establish and maintain a pooled fund as defined by ss(7).		
Children Act 2014, Section 25(8) [Applicable in Wales only]	(8) A local authority in Wales and each of their relevant partners must in exercising their functions under this section have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 27(3) [Applicable in Wales only]	(3) An NHS trust to which section 25 see lines above applies must– (a) appoint an executive director, to be known as the trust's "lead executive director for children and young people's services", for the purposes of the trust's functions under that section; and (b) designate one of the trust's non-executive directors as its "lead non-executive director for children and young people's services" to have the discharge of those functions as his special care.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 28(2) [Applicable in Wales only]	(2) Each person and body to whom this section applies including an NHS trust all or most of whose hospitals, establishments and facilities are situated in Wales, by ss(1)(c) must make arrangements for ensuring that– (a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and (b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Children Act 2014, Section 28(4) [Applicable in Wales only]	(4) The persons and bodies referred to in subsection (1)(a) to (c) and (i) must in discharging their duty under this section have regard to any guidance given to them for the purpose by the Assembly.	ANCILLARY FUNCTION	Yes
Domestic Violence, Crime and Victims Act 2004, Section 9(2), (3)	(3) It is the duty of any person or body within subsection (4) establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s2(1) [Not in force]	(1) A relevant health organisation which includes NHS trusts by s13 that operates a mental health unit must appoint a responsible person for that unit for the purposes of this Act.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s3(1) [Not in force]	(1) The responsible person for each mental health unit must publish a policy regarding the use of force by staff who work in that unit.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s11(2) [Not in force]	(2) In exercising functions under this Act, responsible persons and relevant health organisations which includes NHS Trusts by s13 must have regard to guidance published by the SoS by ss(1) under this section.	ANCILLARY FUNCTION	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s4(3) [In force in Wales only]	(3) The following persons must, when exercising functions under this Part, have regard to any relevant guidance contained in the code on additional learning	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	needs issued by the Welsh Ministers by ss(1)]— (h) an NHS trust;		
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s20 [In force in Wales only]	(4) If a matter is referred to an NHS body which includes an NHS Trust by s99(1) under this section, the NHS body must consider whether there is a relevant treatment or service as defined by ss(6) that is likely to be of benefit in addressing the child's or young person's additional learning needs. (5) If the NHS body identifies such a treatment or service, it must— (a) secure the treatment or service for the child or young person, (b) decide whether the treatment or service should be provided to the child or young person in Welsh, and (c) if it decides that the treatment or service should be provided to the child or young person in Welsh, take all reasonable steps to secure that the treatment or service is provided in Welsh.	COMMISSIONING	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s21 [In force in Wales only]	Various duties (not set out in full here) consequent on the NHS body identifying (or not identifying) a relevant treatment or service per s20	COMMISSIONING	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s64 [In force in Wales only]	(1) This section applies where a health body mentioned in subsection (2) which includes an NHS Trust, in the course of exercising its functions in relation to a child who is under compulsory school age and for whom a local authority is responsible, forms the opinion that the child has, or probably has, additional learning needs.	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(3) The health body must inform the child's parent of its opinion and of its duty in subsection (4). (4) After giving the parent an opportunity to discuss the health body's opinion with an officer of the body, the health body must bring it to the attention of the local authority that is responsible for the child or, if the child is looked after, to the attention of the local authority that looks after the child, if the health body is satisfied that doing so would be in the best interests of the child. (5) If the health body is of the opinion that a particular voluntary organisation is likely to be able to give the parent advice or other assistance in connection with any additional learning needs that the child may have, it must inform the parent accordingly.		
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s65 [In force in Wales only]	(1) Subsection (2) applies if a local authority requests a person mentioned in subsection (4) [which includes NHS Trusts] to exercise the person's functions to provide the authority with information or other help, which it requires for the purpose of exercising its functions under this Part. (2) The person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person that decides not to comply with a request under subsection (1) must give the local authority that made the request written reasons for the decision.	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s76 [In force in Wales only]	(1) The Education Tribunal for Wales may, in relation to an appeal under this Part,— (a) exercise its functions to require an NHS body to give evidence about the exercise of the body's functions; (b) make recommendations to an NHS body about the exercise of the body's functions. (3) An NHS body to whom a recommendation has been made by the Tribunal must make a report to the Tribunal before the end of any prescribed period beginning with the date on which the recommendation is made. ss(4) specifies the contents of the report.	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(2) A regulatory body i.e. the Welsh Ministers and SCW, by s176(1) must, in the exercise of its relevant functions, seek to co-operate with a relevant authority which includes, by s177(1)(e) an NHS Trust if the regulatory body thinks such co-operation— (a) will have a positive effect on the manner in which the body exercises its functions, or (b) will assist the body in achieving its general objectives.	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(3) Where a regulatory body requests the co-operation of a relevant authority under subsection (2) the authority must comply with the request unless the authority— (a) is prevented from co-operating in the manner requested by any enactment or other rule of law, (b) thinks that such co-operation would otherwise be incompatible with its own functions, or	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(c) thinks that such co-operation would have an adverse effect on its functions.		
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(4) If a relevant authority requests the co-operation of a regulatory body, the body must comply with that request unless the body— (a) is prevented from co-operating in the manner requested by any enactment (including this Act) or other rule of law, (b) thinks that such co-operation would otherwise be incompatible with the regulatory body's own functions, or (c) thinks that such co-operation would have an adverse effect— (i) on the body's functions, or (ii) on achieving the body's general objectives.	REGULATORY	Yes
Well-being of Future Generations (Wales) Act 2015, Parts 2 and 3	Not reproduced in full here, the Act confers various duties on public bodies to do things in pursuit of the economic, social, environmental and cultural well-being of Wales in a way that accords with the sustainable development principle and to require public bodies to report on such action. "Public bodies", by section 6, includes NHS Trusts.	REGULATORY	Yes
Counter-terrorism and Security Act 2016, s26	(1) A specified authority which includes, by Schedule 6, and NHS Trust must, in the exercise of its functions, have due regard to the need to prevent people from being drawn into terrorism.	ANCILLARY FUNCTION	Yes
Counter-terrorism and Security Act 2016, s38	(1) The partners which include NHS Trusts by Schedule 7 of a panel i.e. a panel established by a LA by s36 must,	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	so far as appropriate and reasonably practicable, act in co-operation with— (a) the panel in the carrying out of its functions; (b) the police and local authorities in the carrying out of their functions in connection with section 36.		
Counter-terrorism and Security Act 2016, s38	By ss(3) the duty of a partner of a panel to act in co-operation with the panel includes the giving of information (subject to ss(4)) and extends only so far as the co-operation is compatible with the exercise of the partner's functions under any other enactment or rule of law.	CORPORATE	Yes
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 4(1)	(1) Each public authority listed in Schedule 2 which includes NHS Trusts to these Regulations must publish information to demonstrate its compliance with the duty imposed by section 149(1) of the Act i.e. the public sector equality duty of the Equality Act 2010. See further regs 4(2) onwards and reg 6 for requirements as to publication and exemption for authorities with fewer than 150 employees	REGULATORY	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 6(1)	(1) Where an NHS trust or an NHS foundation trust supplies a drug or appliance to a patient for the purpose of treatment, the NHS trust or the NHS foundation trust (as the case may be) must, subject to paragraphs (3) to (6), make and recover from the patient for the supply of continues as to charges to be made in respect of particular items See further reg 6 for exemptions	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 7(1)	(1) Where drugs or appliances are supplied to a patient, including during the out of hours period, for the purpose of treating that patient, by a prescriber at a walk-in centre, the NHS trust, NHS foundation trust or other person responsible for the management of the centre, must, subject to paragraphs (3) to (5), make and recover from that patient for the supply of continues as to charges to be made in respect of particular items See further reg 7 for exemptions	COMMISSIONING	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 10(1)	(9) Where a claim to an exemption has been made but is not substantiated, and in consequence of the claim a charge has not been recovered, if— (b) the drugs or appliances were supplied by an NHS trust or an NHS foundation trust as mentioned in regulation 6, then that NHS trust or NHS foundation trust must recover that charge from the person concerned	COMMISSIONING	Yes
National Health Service (Charges to Overseas Visitors) Regulations 2015	The Regulations place various duties (not set out in full here) on "relevant bodies" (which includes NHS Trusts, by reg 2) to make and recover charges for the provision of relevant services to overseas visitors. Further, NHS Trusts, in meeting their obligations to make and recover charges from overseas visitors, must (by reg 3A) enter certain specified information against record against the overseas visitor’s consistent identifier.	COMMISSIONING	Yes
National Health Service (Optical Charges and Payments) Regulations 2013, reg 2(2)	(2) Where a charge is payable by virtue of paragraph (1) a charge for such amount for glasses and contact lenses as determined by the SoS, the NHS trust or NHS	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	foundation trust, or other person on its behalf, that supplies or is to supply the glasses or contact lenses must– (a) on arranging to supply the glasses or contact lenses, make the charge, and (b) on supplying the glasses or contact lenses or having them available for supply, recover the charge from the person supplied or to be supplied (if the charge has not previously been paid).		
National Health Service (Optical Charges and Payments) Regulations 2013, reg 10(1)	(1) An NHS trust or NHS foundation trust which, following a sight test, issues a prescription for an optical appliance to a person who— (a) has indicated that they are an eligible person; or (b) is an eligible person by virtue of regulation 8(5), must issue to that person a voucher relating to the optical appliance prescribed. See further reg 10(2) for requirements on issuing a voucher	COMMISSIONING	Yes
Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218, reg 23	This provision imposes consultation duties (not set out in full here) on a "responsible person" ("R") (which may be a "service provider", a definition which by reg 23(14) includes an NHS Trust) where R has under consideration any proposal for a substantial development of the health service. This is subject to reg 23(12) which sets out the circumstances in which the functions in reg 23 are to be carried out by a responsible commissioner in the place of a service provider.	ANCILLARY FUNCTIONS	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012, reg 4	(1) This regulation applies where a clinical commissioning group, NHS trust or NHS foundation trust and a local authority propose to designate a body as a Care Trust under section 77(1) of the 2006 Act, or propose to revoke such designation. (2) Where this regulation applies, the body and the local authority must, before designating or revoking the designation, as the case may be, consult jointly such persons as appear to them to be affected by the proposed designation or revocation.	REGULATORY	Yes
Care Act 2014, s6	(1) A local authority must co-operate with each of its relevant partners which, by ss(7) includes each NHS body in the authority's area, defined in turn by ss(8) as NHS trust or NHS foundation trust which provides services in the authority's area, and each relevant partner must co-operate with the authority, in the exercise of— (a) their respective functions relating to adults with needs for care and support, (b) their respective functions relating to carers, and (c) functions of theirs the exercise of which is relevant to functions referred to in paragraph (a) or (b).	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s17	(5) A Local Health Board or an NHS Trust providing services in the area of a local authority must, for the purposes of this section which imposes a duty on Welsh LAs to secure the provision of information, advice and assistance, provide that local authority with information	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	about the care and support it provides in the local authority's area.		
Social Services and Well-being (Wales) Act 2014, s118	(2) Where a child who is accommodated in Wales— (g) in any accommodation provided by or on behalf of an NHS Trust or by or on behalf of an NHS Foundation Trust, ceases to be so accommodated after reaching the age of 16, the person by whom or on whose behalf the child was accommodated or who carries on or manages the home or hospital (as the case may be) must inform the local authority or local authority in England within whose area the child proposes to live. subject to ss(3) which provides that the duty if the accommodation has been provided for a consecutive period of at least three months.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s120	(1) Subsection (2) applies where a child is provided with accommodation in Wales by a Local Health Board, an NHS Trust or a local authority in the exercise of education functions ("the accommodating authority")— (a) for a consecutive period of at least 3 months, or (b) with the intention, on the part of that authority, of accommodating the child for such a period. (2) The accommodating authority must notify the appropriate officer as defined by ss(4) of the responsible authority as defined by ss(3)— (a) that it is accommodating the child, and (b) when it ceases to accommodate the child.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Social Services and Well-being (Wales) Act 2014, s134	Not reproduced in full here, this section makes provision for "Safeguarding Boards" and regulations governing them. By ss(2)(d) an NHS Trust is designated as a partner of a Safeguarding Board.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s161B	(1) The Welsh Ministers may require a person falling within subsection (2) which includes an NHS Trust to provide them with— (a) any documents, records (including medical or other personal records) or other information— (i) which relate to the exercise of a social services function of a local authority, and (ii) which the Welsh Ministers consider it necessary or expedient to have for the purposes of a review under section 149A or 149B; (b) an explanation of the content of— (i) any documents, records or other information provided under paragraph (a), or (ii) any documents or records provided to an inspector conducting an inspection of premises under section 161 in connection with a review under section 149B. Subject to ss(3) which provides that a person is not required to provide documents, records or other information under subsection (1) if the person is prohibited from providing them by any enactment or other rule of law.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s162(6)	(1) A local authority must make arrangements with a view to promoting the matters specified in ss(3) to promote co-operation between—	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(a) the local authority, (b) each of the authority’s relevant partners including, by ss(4)(f) an NHS Trust providing services in the area of the authority in the exercise of— (i) their functions relating to adults (ii) their other functions the exercise of which is relevant to the functions referred to in sub-paragraph (i), and (c) such other persons or bodies as the authority considers appropriate, being persons or bodies of any nature who or which exercise functions or are engaged in activities in relation to— (i) adults within the authority’s area with needs for care and support, or (ii) adults within the authority’s area who are carers. (6) The relevant partners of a local authority must co-operate with the authority in the making of arrangements under this section.		
Social Services and Well-being (Wales) Act 2014, s162(7); (9)	(7) A local authority and any of its relevant partners may for the purposes of arrangements under this section— (a) provide staff, goods, services, accommodation or other resources; (b) establish and maintain a pooled fund defined at ss(7); (c) share information with each other.	COMMISSIONING	Yes
Social Services and Well-being (Wales) Act 2014, s162(7); (9)	(9) A local authority and each of its relevant partners including, by ss(4)(f) an NHS Trust providing services in the area of the authority must, in exercising their	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	functions under this section, have regard to any guidance given to them for the purpose by the Welsh Ministers.		
Social Services and Well-being (Wales) Act 2014, s164(1), (3)	(1) If a local authority requests the co-operation of a person mentioned in subsection (4) includes an NHS Trust in the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164(2); (3)	(2) If a local authority requests that a person mentioned in subsection (4) includes an NHS Trust provides it with information it requires for the purpose of the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164(5)	(5) A local authority and each of those persons mentioned in subsection (4) includes an NHS Trust must	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	in exercising their functions under this section have regard to any guidance given to them for the purpose by the Welsh Ministers.		
Social Services and Well-being (Wales) Act 2014, s164A(1), (3)	(1) If a local authority requests the co-operation of a person mentioned in subsection (4) includes NHS Trusts in the exercise of its functions mentioned in subsection (5) relating to functions under Children Act 1989 &c, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164A(2), (3)	(2) If a local authority requests that a person mentioned in subsection (4) includes NHS Trusts provides it with information it requires for the purpose of the exercise of any of its functions mentioned in subsection (5) relating to functions under Children Act 1989 &c, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.		
Children and Families Act 2014, s28	(1) A local authority in England must co-operate with each of its local partners which includes, by ss(2)(m), an NHS Trust or NHS Foundation Trust which provides services in the authority's area, or which exercises functions in relation to children or young people for whom the authority is responsible, and each local partner must co-operate with the authority, in the exercise of the authority's functions under this Part.	ANCILLARY FUNCTIONS	Yes
Children and Families Act 2014, s31	(1) This section applies where a local authority in England requests the cooperation of any of the following persons and bodies in the exercise of a function under this Part— (g) an NHS trust or NHS foundation trust. (2) The person or body must comply with the request, unless the person or body considers that doing so would— (a) be incompatible with the duties of the person or body, or (b) otherwise have an adverse effect on the exercise of the functions of the person or body. (3) A person or body that decides not to comply with a request under subsection (1) must give the authority that made the request written reasons for the decision.	ANCILLARY FUNCTIONS	Yes
Children and Families Act 2014, s77	(4) The persons listed in subsection (1) including at ss(1)(l) NHS Trusts must have regard to the Code of	ANCILLARY FUNCTIONS	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	Practice issued by the SoS pursuant to ss(1) in exercising their functions under this Part.		
Equality Act 2010 c. 15	Refers to all functions under this Act	CORPORATE	Yes
Health Act 2009 c. 21	Refers to entire Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	All duties of an NHS Trust under this Act	REGULATORY	Yes
Local Government and Public Involvement in Health Act 2007 c. 28	All duties of an NHS Trust under this Act	REGULATORY	Yes
Health Act 2006 c. 28	Refers to entire Act.	REGULATORY	Yes
Health and Social Care (Community Health and Standards) Act 2003 c. 43	Refers to entire Act.	REGULATORY	Yes
Mental Capacity Act 2005 c. 9	Refers to entire Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	All functions of a Trust under this Act.	REGULATORY	Yes
Local Audit and Accountability Act 2014 c. 2	Refers to entire Act.	REGULATORY	Yes

Schedule 3 Reserved Functions

1. Reserved Functions are any Functions of the Trusts that they cannot lawfully delegate or jointly exercise or otherwise are Functions that NHS England has categorised as not ‘Open to Joint Exercise of Functions’ in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in paragraph 2 below.
2. The table referred to in paragraph 1 is as follows:

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 27A NHS Act 2006	(1) A public benefit corporation must hold an annual meeting of its members. (2) The meeting must be open to members of the public. (3) At least one member of the board of directors of the corporation must attend the meeting and present the following documents to the members at the meeting— (a) the annual accounts, (b) any report of the auditor on them, (c) the annual report. (4) Where an amendment is made to the constitution in relation to the powers or duties of the council of governors of a public benefit corporation (or otherwise with respect to the role that the council has as part of the corporation)— (a) at least one member of the council of governors must attend the next meeting to be held under this paragraph and present the amendment, and (b) the corporation must give the members an opportunity to vote on whether they approve the amendment. (5) If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the corporation must take such steps as are necessary as a result.	CORPORATE	**No**
Section 37 NHS Act 2006	(1) An NHS foundation trust may make amendments of its constitution only if— (a) more than half of the members of the council of governors of the trust voting approve the amendments, and (b) more than half of the members of the board of directors of the trust voting approve the amendments.	CORPORATE	**No**
Section 42B (6) NHS Act 2006 as inserted by section 62 of the Health and Care Act 2022	Limits on capital expenditure (6) A trust that is the subject of an order under this section must not exceed the capital expenditure limit imposed by the order during the financial year to which it relates.	CORPORATE / REGULATORY	**No**
Section 43 NHS Act 2006	(1) The principal purpose of an NHS foundation trust is the provision of goods and services for the purposes of the health service in England.	CORPORATE	**No**

Section 43 NHS Act 2006	(3D) An NHS foundation trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the council of governors of the trust voting approve its implementation.	CORPORATE	**No**
Section 46 NHS Act 2006	(1) An NHS foundation trust may borrow money for the purposes of or in connection with its functions. (4) An NHS foundation trust may invest money (other than money held by it as trustee) for the purposes of or in connection with its functions. (5) The investment may include investment by– (a) forming, or participating in forming, bodies corporate, (b) otherwise acquiring membership of bodies corporate. (6) An NHS foundation trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.	CORPORATE / ANCILLARY	**No**
Section 50 NHS Act 2006	An NHS foundation trust must pay to the regulator such fee as the regulator may determine in respect of its exercise of functions under— (a) section 39; (b) section 39A.	REGULATORY	**No**
Section 51A NHS Act 2006	(1) An NHS foundation trust may enter into a significant transaction only if more than half of the members of the council of governors of the trust voting approve entering into the transaction. (2) “Significant transaction” means a transaction or arrangement of such description as may be specified in the trust's constitution. (3) If an NHS foundation trust does not wish to specify any descriptions of transaction or arrangement for the purposes of subsection (2), the constitution of the trust must specify that it contains no such descriptions.	CORPORATE	**No**

Section 56B NHS Act 2006	(1) An application may be made to the regulator by an NHS foundation trust for the dissolution of the trust and the establishment of two or more new NHS foundation trusts. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of the applicant. (3) The application must, by reference to each of the proposed new trusts— (a) specify the property and liabilities proposed to be transferred to it; (b) be accompanied by a copy of its proposed constitution. (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the dissolution of the trust and the establishment of each of the proposed new trusts have been taken. (5) On the grant of the application, the proposed constitution of each of the new trusts has effect but, in the case of each of the new trusts, the proposed directors may exercise the functions of the trust on its behalf until a board of directors is appointed in accordance with the constitution.	CORPORATE	**No**
Section 57A NHS Act 2006	57A Dissolution (1) An application may be made by an NHS foundation trust to the regulator for dissolution. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of the applicant.	CORPORATE	**No**
Section 61 NHS Act 2006	(1) An NHS foundation trust must take steps to secure that (taken as a whole) the actual membership of any public constituency and (if there is one) of the patients' constituency is representative of those eligible for such membership.	CORPORATE	**No**
Chapter 5A NHS Act 2006	Trusts Special Administration.	REGULATORY	**No**
Domestic Violence, Crime and Victims Act 2004, Section 9(2), (3)	(2) The Secretary of State may in a particular case direct a specified person or body within subsection (4) including NHS trusts established under section 25 of the National Health Service Act 2006 or section 18 of the National Health Service (Wales) Act 2006 by ss(4)(a) to establish, or to participate in, a domestic homicide review as defined by ss(1).	ANCILLARY FUNCTION	**No**

Charities Act 2011, ss149; 152	Various provisions as to the audit/examination of the accounts of an "English NHS charity" (which would include a charitable trust, the trustees of which are an NHS Trust), including requirements as to the auditor/independent examiner and the giving of guidance by the Charities Commission	REGULATORY	**No**
Policing and Crime Act 2017, s1	(1) A collaboration agreement as defined by ss(3) may be made by— (a) one or more persons within a paragraph of subsection (2), and (b) one or more persons within another paragraph of that subsection. (2) Those persons are— (a) an ambulance trust in England, (b) a fire and rescue body in England, and (c) a police body in England. See further sections 3 and 4 regarding collaboration agreements	CORPORATE	**No**
Investigatory Powers Act 2016, Part 3	Not reproduced in full here, this part of the Act contains provision for applications by "relevant public authorities" to the Investigatory Powers Commissioner for authorisations to obtain communications, and the granting of authorisations by a designated officer in a relevant public authority in specific circumstances. "Relevant public authority" includes (by Schedule 4) ambulance trusts.	REGULATORY	**No**
Immigration Act 1999, s20A	Not reproduced in full here, this provision confers a duty on NHS Trusts to supply a "nationality document" at the direction of the SoS, if the SoS has reasonable grounds for believing is lawfully in the possession of an NHS Trust.	REGULATORY	**No**
Network and Information Systems Regulations 2018	Not reproduced in full here, the regulations make provision for the identification of "operators of essential services" (OES) (where they provide an essential service as specified in Schedule 2 of the regs and where they (a) rely on network and information systems; and (b) satisfy a threshold requirement described for that kind of essential service. NHS Trusts are specified in Schedule 2. An OES is subject to duties relating to notification of their status to a designated competent authority and take appropriate and proportionate technical and organisational measures to manage risks posed to the security of the network and information systems on which their essential service relies.	CORPORATE	**No**

Housing Act 1996, s213B	NHS Trusts are included among the public authorities specified by Homelessness (Review Procedure etc) Regulations 2018 (see reg 10 and Schedule) for the purposes of this provision: (1) This section applies if a specified public authority considers that a person in England in relation to whom the authority exercises functions is or may be homeless or threatened with homelessness. (2) The specified public authority must ask the person to agree to the authority notifying a local housing authority in England of— (a) the opinion mentioned in subsection (1), and (b) how the person may be contacted by the local housing authority. (3) If the person— (a) agrees to the specified public authority making the notification, and (b) identifies a local housing authority in England to which the person would like the notification to be made, the specified public authority must notify that local housing authority of the matters mentioned in subsection (2)(a) and (b).	REGULATORY	**No**
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 5(1)	(1) Each public authority listed in Schedule 2 which includes NHS Trusts to these Regulations must prepare and publish one or more objectives it thinks it should achieve to do any of the things mentioned in paragraphs (a) to (c) of section 149(1) of the Act. See further regs 5(2) onwards and reg 6 for requirements as to publication.	CORPORATE	**No**
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, Schedule 1(2)	Not reproduced in full here, a relevant public authority is subject to a duty to publish annual information relating to gender pay gap information relating to employees.	CORPORATE	**No**
Controlled Drugs (Supervision of Management and Use) Regulations 2013	The Regulations place various duties (not set out in full here) on "designated bodies" (which includes NHS Trusts, by reg 7) in relation to the supervision, management and use of controlled drugs	REGULATORY	**No**

Children and Families Act 2014, s23	(1) This section applies where, in the course of exercising functions in relation to a child who is under compulsory school age, a clinical commissioning group, NHS trust or NHS foundation trust form the opinion that the child has (or probably has) special educational needs or a disability. (2) The group or trust must— (a) inform the child's parent of their opinion and of their duty under subsection (3), and (b) give the child's parent an opportunity to discuss their opinion with an officer of the group or trust. (3) The group or trust must then bring their opinion to the attention of the appropriate local authority in England. (4) If the group or trust think a particular voluntary organisation is likely to be able to give the parent advice or assistance in connection with any special educational needs or disability the child may have, they must inform the parent of that.	ANCILLARY FUNCTIONS	**No**
Mental Health Act 1983	Refers to entire Act.	REGULATORY	**No**
Mental Capacity Act 2005	Refers to entire Act.	REGULATORY	**No**
Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008/1858	Refers to entire Regulations.	REGULATORY	**No**
Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008/1184	Refers to entire Regulations.	REGULATORY	**No**

Schedule 4 Group Board Terms of Reference (ToR)

1 Introduction

1.1 The Group Board is a statutory joint committee of the boards of Liverpool University Hospitals NHS Foundation Trust and Liverpool Women's NHS Foundation Trust who have established it to exercise Joint Functions in accordance with the Provider Collaboration Agreement dated 1 November 2024 (the PCA).

1.2 In these terms of reference 'Joint Functions' mean all the Trusts' functions that the Trusts have agreed in the PCA to exercise jointly subject to any variation of the PCA that the Trusts have agreed in accordance with it.

2 Authority & Accountabilities

2.1 The Group Board is authorised by the Boards to exercise the Joint Functions.

2.2 The Group Board shall be fully and equally accountable to both Trust Boards for the exercise of the Joint Functions and shall at all times comply with the PCA and NHS England guidance when exercising Joint Functions.

2.3 The Group Board may authorise one of the Trusts to contract with a third party on behalf of itself alone or both Trusts jointly and severally subject to compliance with the Trusts' standing orders and standing financial instructions.

2.4 The Group Board is authorised by the Boards to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.5 The Group Board shall transact all business in accordance with the policies of the Trusts on openness and conformity with the Nolan principles and values of the Public Services.

3 Reporting Arrangements

3.1 The minutes of Group Board meetings shall be formally recorded and submitted to each Trust's Board.

3.2 The Group Board shall provide to each Trust's Board an Annual Report of the activities of the Group Board.

4 Membership

4.1 The voting members of the Group Board shall include all the Voting Directors of both Trusts during their terms of office.

4.2 Additionally the Trusts may appoint Non-Voting Directors of the Trusts to be voting or non-voting members of the Group Board.

4.3 The proceedings of the Group Board shall not be invalidated by any vacancy in its membership or by any defect in the appointment of a member of the Group Board.

4.4 In line with both Trusts' Standing Orders, members of the Group Board must attend at least 75% the Group Board's meetings annually, subject to Annual Review and Appraisal process.

5 Attendance

5.1 The Group Company Secretary will attend as required to ensure that the Group Board business is transacted as per this Terms of Reference, the PCA, the Trusts' Standing Orders and documents referred to in them.

6 Chair

6.1 The Joint Chair of the Trusts, if present, shall preside at any meeting of the Group Board or, if the Joint Chair is absent, the Joint Vice Chair of the Trusts shall preside. If the Joint Vice Chair is presiding at a meeting instead of the Chair, then references in this Terms of Reference to the Joint Chair shall be construed as the Joint Vice Chair.

7 Quorum

7.1 No business shall be transacted at a meeting of the Group Board unless:

7.1.1 At least half the voting members of the Group Board are present

7.1.2 At least half of the voting members present are Voting NEDs of one or both of the Trusts

7.1.3 The voting members present include (in addition to the Joint Chair) at least one Voting ED of LUHFT and one Voting ED of LWH (who in the case of a joint director may be the same person) and at least one Voting NED of LUHFT and one Voting NED of LWH (who in the case of a joint director may be the same person).

8 Decision making

8.1 The Group Board will generally operate on the basis of forming a consensus on all issues considered, taking account of the views expressed by all members. The Joint Chair will seek to ensure that any lack of consensus is resolved amongst members.

8.2 If the Group Board is unable to reach a consensus on an issue, the Joint Chair may put the issue to a vote. The vote will be carried if:

8.2.1 A majority of voting members present and voting are in favour (and in the event of a tied vote the Joint Chair shall have a casting vote), and

8.2.2 The voting members in favour include not less than half the LUHFT Voting Directors present and not less than half the LWH Voting Directors present.

9 Admission of the public to meetings

9.1 Meetings of the Group Board shall be held in public.

9.2 But the Group Board may, by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings.

10 Managing Conflicts of Interest

10.1 Each member of the Group Board must abide by all policies of the Trust of which she or he is a director or officer in relation to conflicts of interest.

10.2 Where any Group Board member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Joint Chair (in her or his discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate in meetings (or parts of meetings) in which the relevant matter is discussed.

11 Administrative Support

11.1 The Group Company Secretary's Office shall provide administrative support to the Group Board.

12 Annual Workplan

12.1 The Group Board will agree an Annual Workplan and cycle of business prior to the beginning of each financial year. The reporting cycle will then form part of the agenda alongside the standing agenda items.

13 Frequency of Meetings

13.1 Meetings of the Group Board shall be held not less than six times a year.

13.2 Extraordinary meetings may be called for a specific purpose at the discretion of the Joint Chair. Where possible, a minimum of seven working days' notice will be given when calling any extraordinary meeting.

14 Papers Publication

14.1 All papers will be published using the available electronic Board paper system. A progress report of outstanding/pending Group Board actions will be presented to each meeting of the Group Board.

15 Standards

15.1 The Group Board shall comply with the following standards:

15.1.1 NHSE Code of Governance for NHS provider trusts

15.1.2 NHSE Risk Assessment Framework

15.1.3 NHSE Annual Planning Guidance

15.1.4 The Health NHS Board – Principles of Good Governance

15.1.5 Corporate Governance – Principles of Public Life (GP01)

16 Standard Agenda

16.1 Agendas will be built around the Group Board annual workplan, and most of the following will appear on each agenda, while some will appear only once or twice each year:

16.1.1 Declarations of interest,

16.1.2 Minutes of previous meeting,

16.1.3 Action list

16.1.4 Reports of committees of the Group Board

16.1.5 Reports of committees of both Trusts including Audit Committees, Nominations & Remuneration Committees and Charitable Funds Committees

16.1.6 Self-assessment of the Group Board's effectiveness

16.1.7 Review of the Group Board's terms of reference

16.1.8 Annual Report of Group Board

16.1.9 Other items as per agreed cycle of business

17 Committees

17.1 The Group Board shall have the following committees:

17.1.1 Group Strategy & Partnerships Committee

17.1.2 Aintree Hospital Management Board

17.1.3 Broadgreen Hospital Management Board

17.1.4 Royal Hospital Management Board

17.1.5 LCL Hospital Management Board

17.1.6 LWH Hospital Management Board

17.2 For the purpose of assisting the exercise of Joint Functions the Group Board may appoint one or more additional committees.

17.3 The voting members of a committee of the Group Board may only be individuals who are voting members of the Group Board.

17.4 The Group Board may authorise a committee to exercise Joint Functions that the Group Board expressly subdelegates to the committee in its ToR.

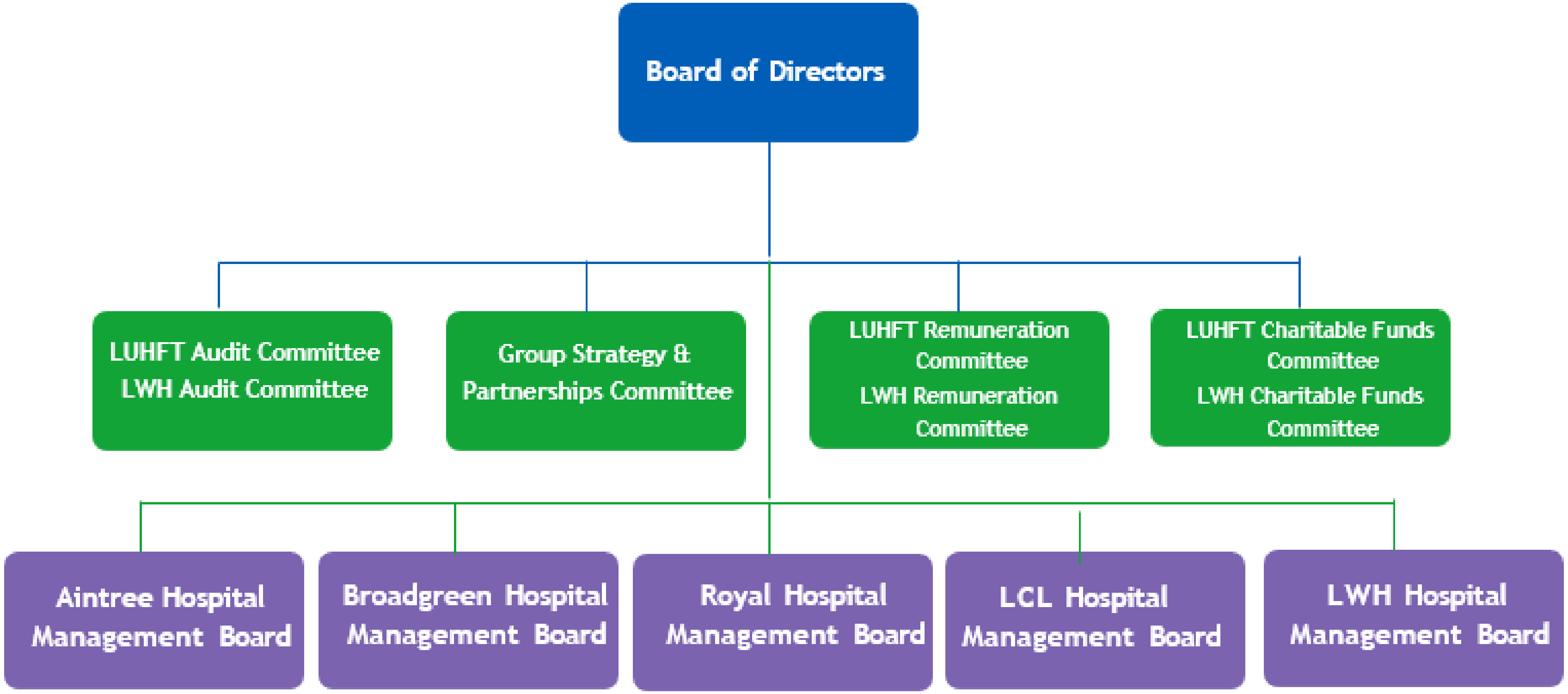
18 Amendment

18.1 These terms of reference may only be amended by variation in accordance with Clause 17 of the PCA.

Date approved: 25 September 2024

Date of review: September 2025

Schedule 5 Governance Organogram for the Trusts’ Appointment of Committees as at the Commencement Date



Board of Directors

LUHFT Audit Committee
LWH Audit Committee

Group Strategy & Partnerships Committee

LUHFT Remuneration Committee
LWH Remuneration Committee

LUHFT Charitable Funds Committee
LWH Charitable Funds Committee

Aintree Hospital Management Board

Broadgreen Hospital Management Board

Royal Hospital Management Board

LCL Hospital Management Board

LWH Hospital Management Board

Schedule 6 Data sharing and confidentiality

1. In this Schedule “Confidential Information” means: all information, whether written or oral (however recorded), provided by one Trust (the Disclosing Trust) to the other Trust (Receiving Trust) and which (i) is known by the Receiving Trust to be confidential; (ii) is marked as or stated to be confidential; or (iii) ought reasonably to be considered by the Receiving Trust to be confidential.

2. The Trusts may disclose Confidential Information:

    2.1. to their employees, agents or consultants who need to know such information for the purpose of discharging their obligations under this Agreement if they ensure that their employees, agents, or consultants to whom they disclose Confidential Information comply with this Schedule 6 and

    2.2. as may be required by law, a court of competent jurisdiction or any governmental or regulatory authority.

3. The Trusts will not use each other’s Confidential Information for any purpose other than to comply with this Agreement.

4. The Trusts acknowledge that they are subject to legal duties under the FOIA and EIR which may require them to disclose, on request, information relating to this Agreement and that they are also subject to the Code of Practice on Openness in the NHS (4 August 2003).

5. If a Trust receives a Request for Information (as defined in FOIA) or a request under regulation 5(1) of EIR (each, a Request) about their collaboration arrangements or the Group Board, prior to any disclosure of information to which an exemption to FOIA or EIR (as the case may be) may apply (Potentially Exempt Information) and recognising fully that the decision whether and what to disclose is for the Trust receiving the Request:

    5.1. Notify the other Trust of such Request

    5.2. Consider any representations made by the other Trust in relation to the Request and any possible exemptions and

    5.3. Consult with the other Trust in relation to any proposed disclosure as to whether any further explanatory material or advice should also be disclosed with the information in question

6. Each Trust agrees that it will promptly inform the other Trust of any media enquiries which it receives in relation to the collaboration arrangements. The Trusts will work co-operatively to agree a joint response to any media enquiries received in relation to the collaboration arrangements.

7. The Trusts will work co-operatively together in relation to the use of personal data and the requirements of the UK GDPR and Data Protection Act 2018 including ensuring that appropriate technical and organisational security measures are taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.

Schedule 7 Scheme for Trust Board Appointments

Chair (Voting)

Non-Executive Directors x 9 (Voting)

Chief Executive Officer (Voting)

Chief Finance Officer (Voting)

Chief Medical Officer (Voting)

Chief Nursing Officer (Voting)

Chief People Officer (Voting)

Chief Delivery Officer (Voting)

Managing Director – Aintree (Voting)

Managing Director – Royal (Voting)

Managing Director – Liverpool Womens' (Voting)

Chief Strategy & Partnerships Officer (Non-Voting)

Chief Transformation Officer (Non-Voting)

Chief Quality Improvement Officer (Non-Voting)

Chief Digital & Information Officer (Non-Voting)

Chief Communications & Marketing Officer (Non-Voting)

Chief Corporate Affairs Officer & Company Secretary (Non-Voting)

Appendix 1

Changes to Constitution August 2024

Page No.	Reference	Change	Rationale
Throughout	-	Updated page numbers following changes.	For easy readability.
4	Introduction	Included an introduction highlighting the move to a group model with Liverpool University Hospitals NHS Foundation Trust.	To provide context for the reader on the group model and the changes to the Board of Directors.
11	Powers: 4.1	Included reference to the Health and Social Care Act 2012 and the Health and Care Act 2022.	To highlight the specific legislation that governs the Trust.
19	Board of Directors - Composition: 23	Change to the minimum and maximum number of Non-Executive Directors (23.2.2) and Executive Directors (23.2.3) to read: 23.2 The Board of Directors is to Comprise: 23.2.1 a Non-Executive Chair 23.2.2 no less than four and no more than 11 other Non-Executive Directors; and 23.2.3 no less than four and no more than 11 Executive Directors	Updated to reflect the move to a Board in Common with Liverpool University Hospitals NHS Foundation Trust.
129	Annex 8: 25 – Composition	Change to the minimum and maximum number of Non-Executive Directors (25.2.2) and Executive Directors (25.2.3). 25.2 The Board of Directors is to Comprise: 25.2.1 a Non-Executive Chair 25.2.2 no less than four and no more than 11 other Non-Executive Directors; and 25.2.3 no less than four and no more than 11 Executive Directors	Updated to reflect the composition within the Board of Directors under paragraph 23 of the Constitution.
140	Annex 8: Delegation to Committees	New paragraph added to highlight committees established by the Board may meet in common with a Committee of another NHS Foundation Trust.	To allow for wider collaboration across the system via joint committees, without a requirement to alter the Constitution.

Liverpool University Hospitals Group Joint Committee Board of Directors 2024/25 - Cycle of Business

Item	Reporting (Joint / Individual)	Action	National Requirement to report to Board (Y/N)	Item Purpose	Outline Areas to be considered within the report	Lead	Report Authors/ (Personal Assistant)	Assurance / Oversight Committee or Group	April	May	June	July	August	September	October	November	December	January	February	March	April
CONTEXT																					
Intoduction, Apologies & Declaration of Interest	Joint	For Noting	N/A	To note an introduction, apologies and declarations of interest pertaining to any agenda items.	N/A	Chair	N/A	N/A		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Story	Joint	For Noting	N/A	To provide the Trust Board with a story that outlines the experience of one of the Trust's Patients.	N/A	Chief Nursing Officer	N/A	N/A						✓		✓					
Staff Story	Joint	For Noting	N/A	To provide the Trust Board with a story that outlines the experience of one of the Trust's Staff Members / Volunteers.	N/A	Chief People Officer	N/A	N/A		✓		✓						✓		✓	
Minutes of the Previous Meeting	Joint	For Approval	N/A	To review and approve the minutes of the previous meeting as a true and accurate record.	N/A	Chair	Deputy Company Secretary	N/A		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rolling Action Tracker	Joint	For Noting	N/A	To monitor progress and completion of actions of the Board of Directors.	N/A	Chair	Deputy Company Secretary	N/A		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Urgent Matters Arising	Joint	For Noting	N/A	To review any urgent matters not included in the agenda requiring the Board's attention.	N/A	Chair	N/A	N/A		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ASSURANCE AND RISK																					
Hospital Management Board Assurance Reports (Aintree, Broadgreen, LCL, Liverpool Women's, Royal)	N/A	For Assurance	N/A	To highlight risks of significance to the Board for awareness or support	Site risks scored at 12+, and new risks of 10+ Mitigating actions Requests for support (where applicable)	Executive Managing Director (Pete Turkington) Executive Managing Director (Natalie Hudson) Executive Chair (Healther Barnett) Executive Chair (Rob Forster) Liverpool Women's Executive Chair (TBC)	Corporate Governance Lead	N/A				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Trust and Site Integrated Performance Reports	Joint	For Assurance	N/A	To receive an analysis of Trust and Site's performance on a monthly basis. Appended to the CEO Report to enable triangulation.	• Quality and Safety • Clinical Effectiveness •People •Operational • Financial Duty •Research & Innovation	Executive Leads	Executive Leads	Sub Groups (Performance & Finance, Quality & Safety, Clinical Effectiveness, Workforce)		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Board Assurance Framework	Joint	For Decision	N/A	To update the Board on all the Trust's strategic risks to the delivery of the objectives underpinning the strategic priority 'Great Care, Great People, Great Ambitions and Great Research and Innovation'	To provide the Board with the latest version of the BAF for which contained details of the 14 principal risks to the achievement of the Trust's strategic objectives.	Director of Corporate Affairs/Company Secretary	Deputy Company Secretary	Executive Director Group		✓		✓			✓			✓			✓
Risk Appetite Statement	Joint	For Approval	Y	To ratify the Risk Appetite Statement	To define the Trust appetite statement for risk in relation to the Trust strategic objectives	Director of Corporate Affairs / Company Secretary	Corporate Governance	Audit Committee							✓						
OPERATIONAL PERFORMANCE																					
Chief Executive's Report	Joint	For noting	N/A	To provide key updates on Trust activities, issues and risks via the CEO.	•To include CMAST and ICB updates • To include details of the Chair's commitments on a monthly basis •Highlight success stories and significant achievements •Areas of escalation from the Executive Director Group (LUHFT SMB/QSG inc) •To include Trust Wide 12+ risks	Chief Executive Officer	Deputy Company Secretary / Director of Quality Governance (Risks 12+)	N/A		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Improvement Plan	Individual	For Assurance	N/A	To receive assurance on delivery of phase 2 of the Trust's Improvement Plan.	•Overall delivery status •Risk and issues profile •Benefits realisation summary	Chief Transformation Officer	Head of Improvement Plan Delivery Unit	Improvement Plan Portfolio Board		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Winter Plan	Individual	For Assurance	Y	To provide assurance that a resilient winter plan has been developed based on clear evidence and adequate risk identification	• Governance, assurance and finance • Winter Programme Oversight (including delivery, performance and implemented schemes • Key risks	Executive Managing Directors	Executive Managing Directors	N/A								✓					
Emergency Preparedness, Resilience & Response Annual Report (EPRR)	Individual	For Approval	Y	To review and approve the Trust EPRR on an annual basis,	Annual overview of the Trust Performance with EPRR and any associated risks	Chief Delivery Officer	Director of Operational Planning and Integration, Aintree	Audit Committee								✓					
Emergency Preparedness, Resilience & Response (EPRR) Core Standards	Individual	For Approval	Y	https://www.england.nhs.uk/wp-content/uploads/2022/07/PRN00235-emergency-preparedness-resilience-and-response-eprr-annual-assurance-process-for-2023-24-letter-may-2.pdf	To receive an overview of the Trust's compliance with NHSE EPRR Core Standards annual assurance process and any associated risks to non-compliance and mitigations	Chief Delivery Officer	Director of Operational Planning and Integration, Aintree	Audit Committee								✓					
QUALITY AND SAFETY																					
Quality Account	Individual	For Approval	Y	To consider and if deemed appropriate approve the Quality Account.	Not Applicable - Report prescribed	Chief Nursing Officer	Programme Lead - Anchor and Health Inequalities	LUHFT Quality Standards Group		✓											
Complaints Annual Report	Individual	For Assurance	Y	To provide an overview of the management of complaints by the Trust during on an annual basis. The report also identifies key themes and trends raised by those who use our services, providing assurance that changes to practice have been implemented as a result.	Identify the key themes and trends raised by those who use our services, providing assurance that changes to practice have been implemented as a result.	Chief Nursing Officer	Deputy Director of Quality Governance	LUHFT Quality Standards Group				✓									
Infection Prevention and Control Annual Report	Individual	For Assurance	Y	To provide an overview of measures undertaken to reduce and control the risk of healthcare associated infections in the Trust for patients, staff and visitors. Detailed within the Health and Social Care Act (2008): Code of Practice for the NHS on prevention and control of healthcare related guidance.	• Governance and Monitoring • IPC Team • Surveillance • COVID-19 • Policies and guidelines • Education and training • IPC Audit • Hospital cleanliness • Decontamination • Water safety • Antibiotic stewardship • Forward Plan	Chief Nursing Officer	Director of Infection, Prevention and Control / Deputy Director of Infection, Prevention and Control	LUHFT Quality Standards Group		✓											

Item	Reporting (Joint / Individual)	Action	National Requirement to report to Board (Y/N)	Item Purpose	Outline Areas to be considered within the report	Lead	Report Authors/ (Personal Assistant)	Assurance / Oversight Committee or Group	April	May	June	July	August	September	October	November	December	January	February	March	April
Volunteer Services Annual Report	Individual	For Assurance	Y	To receive an overview of the work undertaken by volunteer services to include successes and challenges.	An overview of the work undertaken by volunteer services to include successes and challenges	Chief Nursing Officer	Deputy Chief Nurse / Head of Patient and Family Experience	LUHFT Quality Standards Group				✓									
Learning from Deaths Quarterly Report	Joint	For Assurance	Y	To provide an overview of the learning from deaths in line with meeting learning candour and accountability requirements.	•To provide an overview of the learning from deaths in line with meeting learning candour and accountability requirements. This report should incorporate information regarding unexpected deaths escalated to a serious incident and complaints. • To receive assurance from the Hospital Leadership Teams on the learning from deaths • Receive assurance on the Learning from Deaths review process and champion quality improvement that leads to actions that improve patient safety. Further, receive assurance that information is published on the organisation's approach, achievements and challenges	Chief Medical Officer	Director of Patient Safety / Deputy Director of Patient Safety	LUHFT Quality Standards Group		✓		✓				✓		✓			
7 Day Services Board Assurance Self Assessment	Joint	For Assurance	Y	This new measurement system replaces the previous self-assessment survey and consists of a standard measurement and reporting template, which all providers of acute services will complete with self-assessments of their delivery of the 7DS clinical standards.	To provide information on the latest NHSE seven day service standards and assurance that the Trust is meeting the four priorities (access to consultant-directed assessment - clinical standard 2, diagnostics - clinical standard 5, interventions - clinical standard 6 and ongoing review - clinical standard 8.	Chief Medical Officer	Deputy Chief Medical Officer	LUHFT Quality Standards Group				✓									
Controlled Drugs Accountable Officer Annual Report	Individual	For Assurance	Y	To receive the annual report for assurance	A summary of controlled drugs and associated risks / actions	Chief Medical Officer	Chief Pharmacist	LUHFT Quality Standards Group							✓						
Medicine's Management Annual Report	Joint	For Assurance	Y	The purpose of this report is to submit, for the Board's information, the annual report for medicines management within the Trust for the period April 2016 to March 2017 and to provide the report of the Accountable Officer for Controlled Drugs for the same period.	TBC	Chief Medical Officer	Chief Pharmacist	LUHFT Quality Standards Group						✓							
Flu Vaccination Annual Report	Individual	For Assurance	Y	To provide assurance the Trust is doing everything as possible as an employer to protect patients and staff from seasonal flu	Self assessment against the best practice management checklist for health care worker vaccination	Chief Nursing Officer	Associate Director of People (Occupational Health and Wellbeing)	Corporate Group						✓							
Safe Staffing - Six Monthly Report	Joint	For Assurance	Y	To receive an overview of nurse staffing capacity in line with the in line with the National Institute for Clinical Excellence (NICE) safe staffing and National Quality Board (NQB) standards.	To identify risks, provide assurance on mitigations and track / monitor improvement.	Chief Nursing Officer	Deputy Chief Nurse	LUHFT Quality Standards Group				✓				✓				✓	
Safeguarding Annual Report	Individual	For Assurance	Y	To provide an annual summary of the progress made against the previous year's forward plan and highlighting any key on-going risks.	Assurance on key matters discussed at reporting groups, providing a mechanism by which to escalate any concerns. Annual reports to provide progress to achieve plans and mitigate risks.	Chief Nursing Officer	Divisional Director of Nursing (Safeguarding) / Deputy Chief Nurse	LUHFT Quality Standards Group						✓							
Health and Safety Annual Report	Individual	For Assurance	Y	To provide an annual summary of the progress made against the previous year's forward plan and highlighting any key on-going risks.	Assurance on key matters discussed at reporting groups, providing a mechanism by which to escalate any concerns. Annual reports to provide progress to achieve plans and mitigate risks.	Director of Estates and Facilities	Director of Estates and Facilities	LUHFT Quality Standards Group						✓							
Fire Safety Annual Report	Individual	For Assurance	Y	To confirm that adequate fire safety management arrangements are in place to manage and monitored LUHFT's legal obligations, and associated fire safety risk. In addition, that adequate provisions are in place to proactively identify any deficiency in arrangements to enable appropriate and proportionate resolution in a timely manner.	To provide an annual overview of incident data, unwanted fire alarm signals, actual fires and a forward plan	Director of Estates and Facilities	Associate Director of Health and Safety	Senior Management Board						✓							
Liverpool Quality Assessment (LQA) (bi-annual update)	Joint	For Noting	N	To provide assurance on LQA progress.	To provide assurance on progress to improve falls and pressure ulcer prevention, nutrition and hydration, LQA progress (including changes to ward ratings) and learning.	Chief Nursing Officer	Assistant Director of Corporate Nursing	LUHFT Quality Standards Group						✓						✓	
Dementia Strategy Assurance Report	Individual	For Assurance	N	To provide assurance on progress to deliver the dementia strategy.	Assurance that the Trust is on track to achieve the actions and milestones noted within the Dementia Strategy.	Chief Nursing Officer	Deputy Chief Nurse / Director of Corporate Nursing) / Dementia Team	Strategy & Partnerships Committee		✓						✓					
Maternal Medicine Network Update	Individual	TBC	TBC	TBC	TBC	TBC	TBC	TBC						✓							
Maternity Staffing Report																					
CNST: Maternity Incentive Scheme Updates	Individual	For Assurance	TBC	TBC	MIS Year 6 Scheme Update Perinatal Quality Surveillance Dashboard into Integrated Performance REport	Chief Nursing Officer	TBC	TBC									✓	✓	✓		

Item	Reporting (Joint / Individual)	Action	National Requirement to report to Board (Y/N)	Item Purpose	Outline Areas to be considered within the report	Lead	Report Authors/ (Personal Assistant)	Assurance / Oversight Committee or Group	April	May	June	July	August	September	October	November	December	January	February	March	April
PEOPLE EXPERIENCE																					
Equality and Diversity WRES Plan / WDES Plan	Individual	For Assurance	Y	To provide an update regarding the annual report and actions taken.	• EDI WRES/WDES Plan • Monitoring and delivery of Plan • Priorities	Chief People Officer	Associate Director of EDI	N/A						✓							
Equality & Diverstiy Annual Report	Individual	For Assurance	Y	To provide the Board with an update.	Workforce Proile Patient profile Equality Delivery System (EDS) Assessment EDI Delivery plan outcomes (from previous operational year) Progress monitoring of EDI Strategy	Chief People Officer	Associate Director of EDI	N/A						✓						✓	
Health and Wellbeing Framework Progress	Joint	For Assurance	Y	To provide assurance on the progress of delivery of actions identify using the framework diagnostic tool. To be presented alongisde the FTSU Report to triangulate key areas and issues.	Assurance on the delivery of Health and Wellbeing actions that support the transformation in the delivery of holistic Health and Wellbeing agenda, sighted on NHS People Plan and recommendations from NHSE/I and NICE guidelines on mental wellbeing in the workplace.	Chief People Officer	Associate Director of People (Occupational Health and Wellbeing)	N/A						✓						✓	
National Staff Survey Report	Joint	For Assurance	Y	To provide the Board with a report on the National staff opinion survey report.	• A 6 monthly high level progress update report to be presented to the Board. • Hospital Leadership Teams • Trust progress report	Chief People Officer	Associate Director of Organisational Development	HLT Management Board												✓	
Guardian of Safe Working	Joint	For Assurance	Y	To receive assurance on junior doctor working practices on a quarterly basis with an aggregate annual report	• Immediate Safety Concerns • High Level Data across sites • Locum bookings • Summary and actions taken	Chief Medical Officer	Guardians of Safe Working - Philip Weston / Shahed Ahmed	HLT People and OD Group		✓ Q4 to include aggregated annual report		✓ Q1			✓ Q2			✓ Q3			✓ Q4 to include aggregated annual report
Freedom to Speak Up Guardian Reporting	Joint	For Assurance	Y	To receive an update on the FTSU process	• FTSU service utilization • Summary of activity • September report to include benchmark of the Trust against national picture for the previous year. • March Group report and April Board report to include 1/2 way progress on the FTSU Board self assessment actions. • Data pertaining to the last full quarter available • Key themes for the incomplete quarter within which a report is delivered.	Freedom to Speak Up Guardian	Freedom to Speak Up Guardian	HLT People and OD Group						✓						✓	
Medical Annual Appraisal & Revalidation Annual Report	Joint	For Assurance	Y	To outline the Trust's position with regards to compliance with revalidation requirements.	•Annual apparaisal data and compliance for medical and dental staff •Annual revalidation data for medical and dental staff •Overview of governance processes	Chief Medical Officer	Professional Standards Team Manager	Senior Manaagement Board						✓							
Gender Pay Gap Report	Joint	For Approval	Y	To receive assurance of compliance with reporting requirments for Gender Pay Gap as set out in the Equality Act 2010.	•Compliance •Key findings and reasons resulting from pay gap calculations •Actions required to address pay gap	Chief People Officer	Associate Director of ED and I	Senior Management Board												✓	
Violence Prevention and Reduction Standards (6 monthly)	Joint	For Assurance	Y	*To oversee, review and ensure appropriate security management within the Trust in line with the NHS Violence Prevention and Reduction Standard 2020*. To review their status against the Violence Prevention and Reduction Standard, providing Board level assurance that the standard has been achieved at a minimum of six monthly intervals as part of the NHS Standard Contract with the assurance published on the website.	Governance Compliance Recommendations Standards tracker	Chief Nursing Officer	Assocaite Director of Health and Safety / Head of Shared Services	Health and Safety Group		✓						✓					
Sexual Safety Charter	Joint	For Assurance	N	To provide assurance that the Trust have implemented all ten commitments laid our in the NHS Sexual Safety Charter launched on 3 September 2023.	•Compliance with the ten commitments •Assurance on process undertaken including engagement •Actions required to mitigate any key concerns	Chief People Officer	Associate Director of ED and I	EDI Executive Led Group				✓									
Culture Update	Joint	For Assurance	N	To receive an update on progress of Culture and Staff Engagement.	TBC	Chief People Officer	TBC	TBC								✓					✓
FINANCE																					
Financial Plan Budget	Individual	For Approval	Y	Approval of the annual budget.	• Process undertaken to develop the budget and operating plan • Financial and strategic context • Proposed revenue and capital budgets for the year for recommendation to the Trust Board	Chief Finance Officer	Chief Finance Officer / Deputy Chief Finance Officer	Finance and Performance HLT Group		✓											✓
3-Year Financial Plan	Joint	For Approval	Y	To consider and if deemed appropriate approve the budget and updated LTFM.	To provide the 3-year financial plan for approval.	Chief Finance Offcer	Deputy Chief Finance Officer	**TBC**		✓											
National Cost Collections (NCC)	Joint	For Approval	Y	Approval of the costing process that supports the mandated National Cost Collection for PLICS	To provide assurance on compliance with required national costings standards and guidance	Chief Finance Officer	Chief Finance Officer / Deputy Chief Finance Officer	Corporate Group								✓					

Item	Reporting (Joint / Individual)	Action	National Requirement to report to Board (Y/N)	Item Purpose	Outline Areas to be considered within the report	Lead	Report Authors/ (Personal Assistant)	Assurance / Oversight Committee or Group	April	May	June	July	August	September	October	November	December	January	February	March	April
Patient Level Information and Costing Systems	Individual	For Asssurance	Y		Update on use of PLICS information to provide a better understanding of cost drivers and support the achievement of the Trust's strategic, clinical and financial goals.	Chief Finance Officer	Chief Finance Officer / Deputy Chief Finance Officer	Corporate Group				✓									
ESTATES AND DIGITAL																					
NHS Premises Assurance Model (PAM)	Joint	For Approval	Y	NHSE/I mandated self-assessment to improve oversight of the management of estate related risk.	• Self assessment against five domains • 12 month action plan	Chief Finance Officer / Director of Estates & Facilities	Director of Estates and Facilities	Quality and Safety Sub Group						✓							
Estates Return Information Collection (ERIC)	Joint	For noting	Y	Annual submission to NHSE/I of estates and facilities data which is also used to populate the Trust's Model Hospital data set.	Outline of approach taken and key finding from data around finance costs, income, EBME, grounds & maintenance, hard & soft FM, waste, energy	Chief Finance Officer / Director of Estates & Facilities	Director of Estates and Facilities	Corporate Group				✓									
Sustainable Development Management Plan (SDMP)	Joint	For Decision	Y	To consider if deemed appropriate to approve the Annual SDMP.	Publication of the NHS Carbon Reduction Strategy for England in January 2009 set a mandatory framework for NHS organisations. This included Sustainable Development Management Plan. Forms part of the Annual Report and Accounts.	Chief Finance Officer / Director of Estates & Facilities	Director of Estates and Facilities	TBC		✓											
Information Governance / Cyber Security Annual Report	Joint	For Assurance	Y	To provide assurance on Cyber security, Information Governance, and the annual submission of the DSP Toolkit.	Data Security and Protection Tool Kit	Chief Digital and Information Officer	Chief Information Officer / Information Governance Team	Audit Committee				✓									
STRATEGY AND PARTNERSHIPS																					
Trust Strategy Quarterly Updates (TBC with Strategy & Partnerships)	Joint	For Assurance	N	Approval of the Trust Strategy and quarterly updates (TBC)	• Governance arrangements • Strategic aims and objectives • Delivery plan • Key risks and mitigations, including timelines and expected outcomes • High level road map	Executive Director of Strategy and Partnerships	Deputy Director of Strategy and Partnerships	N/A		✓											
Risk Management Strategy (Bi-anually 2023 & 2025)	Individual	For Assurance	Y	Monitoring of the Risk Management Strategy	• Governance arrangements • Strategic aims and objectives • Delivery plan • Key risks and mitigations, including timelines and expected outcomes • High level road map	Executive Director of Strategy and Partnerships	Chief Nursing Officer / Director of Quality Governance / Deputy Director of Quality Governance	Audit Committee													
GOVERNANCE																					
Code of Conduct	Joint	For Assurance	Y	To provide assurance to the Board on the use and effectiveness of the Trust's Code of Conduct arrangements	Introduction Current arrangements Analysis Recommendation	Director of Corporate Affairs / Company Secretary	Corporate Governance	Audit Committee								✓					
Code of Governance Compliance (to be submitted as part of the Annual Report)	Individual	For Assurance	Y	To provide assurance to the Board on the management of conflicts of Interest in LUHFT.	Introduction Disclosure Requirements Recommendations	Director of Corporate Affairs / Company Secretary	Deputy Company Secretary	Audit Committee		✓											
Risk Management Policy	Individual	For Assurance	Y	To provide assurance to the Board on the Risk Manegement Policy in place.	Introduction Review of Standing Orders Proposed changes Compliance	Chief Nursing Officer	Director of Quality Governance	Audit Committee										✓			
New NHS Guidance or Mandated Requirement	Joint	For Decision	Y	To review and approved new NHS Guidance or mandated requirement	Outline the purpose Outline any changes that has been made to existing guidance Outline the process for implementation Outline the anticipated impact (if any) and mitigations to resolve	Ad-hoc	Ad-hoc	Assurance and Risk Committee		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Regulatory Issues or Compliance Reports	Joint	For Decision	N/A	To review and receive regulatory issues or compliance reports	Outline the issue / background Outline the process for resolving the issue, mitigations and timescales for completion	Ad-hoc	Ad-hoc	Assurance and Risk Committee		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Committee Assurance Reports	Joint	For Assurance	N	To receive assurance / escalation of risks and mitigations from the Committees	• Audit Committee • Charitable Funds Committee • Nominations and Remunerations Committee • Strategic & Partnerships Committee	Executive Directors / Non Executive Directors	Corporate Governance	N/A		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Board and Committee Effectiveness Reviews	Joint	For Assurance	N	To report the outcome of the evaluation of the Board and its committees and determine what changes are necessary to ensure that the Board and its committees deliver their objectives.	• Joint Partnership Board - LUHFT and Mersey Care NHS Foundation Trust	Director of Corporate Affairs / Company Secretary	Corporate Governance	NA				✓									
Committee's Terms of Reference Review	Joint	For Assurance	N	To ensure the Committee Terms of Reference are appropriate and any changes have Trust Board approval.	• Liverpool Women's NHS Programme Board	Director of Corporate Affairs / Company Secretary	Corporate Governance	N/A		✓		✓									
Use of the Trust Seal	Individual	For Assurance	Y																		✓
Decleration of Interest	Joint	For Assurance	N	To disclose the Board's declartions of interest	Declaration of Interest register	Director of Corporate Affairs / Company Secretary	Head of Corporate Information Compliance	Audit Committee		✓							✓				

Item	Reporting (Joint / Individual)	Action	National Requirement to report to Board (Y/N)	Item Purpose	Outline Areas to be considered within the report	Lead	Report Authors/ (Personal Assistant)	Assurance / Oversight Committee or Group	April	May	June	July	August	September	October	November	December	January	February	March	April
Review of Corporate Governance Manual	Joint	For Approval	N	To review and approve any amendments to the Corporate Governance Manual.	Analysis Overview of changes made within the reporting period Recommendations	Director of Corporate Affairs / Company Secretary	Corporate Governance	Audit Committee						✓							
Constitution (Ad-hoc)	Joint	For Decision	Y	To review and approve any changes alongside presentation to the Council of Governors prior to submission to NHS England.	To outline changes made to the Trust Constitution and rationale.	Director of Corporate Affairs / Company Secretary	Corporate Governance	N/A													
Board Champions (ad-hoc)	Joint	For Decision				Director of Corporate Affairs / Company Secretary	Corporate Governance	N/A								✓					
Annual Report (including Annual Governance Statement)	Individual	For Approval	Y	To consider and if deemed appropriate approve the Annual Report / AGS.	Auditor's Opinion Audit Findings letter to Trustees Letter of Representation External Auditors Annual Report (Value for Money)	Chief Finance Officer / Director of Corporate Affairs/Company Secretary	Corporate Governance	Audit Committee			✓										
Annual Accounts and Annual Report (to include Compliance with Code of Governance)	Individual	For Approval	Y	To consider and if deemed appropriate approve the Annual Accounts and Annual Report.	Reports to be prepared in line with the Group Accounting Manual and Annual Reporting Manual as issued by NHSE	Chief Finance Officer	Deputy Chief Finance Officer	Audit Committee			✓										
Charitable Funds Governing Document	Individual	For Approval	Y	To consider and if deemed appropriate approve the Charitable Funds Governing Document	Risks identified Mitigating actions Requests for support (where applicable)	Director of Communications	Charity Senior Programme Manager	Charitable Funds Committee				✓									
Charitable Funds Annual Reports and Accounts	Individual	For Approval	Y	To consider and if deemed appropriate approve the Charitable Funds Accounts	Audited charity annual report and accounts Auditor's Engagement Pack Audit Findings letter to Trustees Letter of Representation	Director of Communications	Finance Manager - Charitable Accounts	Charitable Funds Committee								✓					
Well Led Governance Review	Joint	For Assurance	N	To provide an update following well-led governance review completion.	To include Analysis, Performance and Reccomendations.	Director of Corporate Affairs / Company Secretary	TBC	N/A													
CONCLUDING BUSINESS																					
Key Messages and Risks for Risk Register and Reflections on the Meeting	Joint	For Noting	N/A	N/A	N/A	Chair	N/A	N/A	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Mandatory and Statutory Roles in NHS Trusts

Portfolio	Role	Legislation / Requirement
Overall Responsibility for the Trust	Chairman Accountable Officer	NHS Act 2006 NHS Act 2006
Emergency Preparedness	Accountable Officer for Emergency Preparedness	Emergency Preparedness Resilience and Response (EPRR), NHS England 2009
Medicines Management	Accountable Officer for the Destruction of Controlled Drugs	Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (SI (2013/373)
	Accountable Officer for Controlled Drugs	Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (SI (2013/373) think 1 and 2 fall under the CDAO responsibilities
	Medicines Safety Officer	Patient Safety Alert NHS/PSA/D/2014/005
	Non-Medical Prescribing Lead	NMC Code of Conduct/Standards
	Chief Pharmacist. Director of Pharmacy	CQC (part of well led and responsible for systems and processes for medicines management
	Chief Pharmacist	The Pharmacy (Preparation and Dispensing Errors – Hospital and Other Pharmacy Services) Order 2022 (allows the Trust to benefit from the dispensing error defences)
	Hospital Pharmacy and Medicines Optimisation Executive Lead	NHSI, Carter Project
	Hospital Pharmacy and Medicines Optimisation Lead	NHSI, Carter Project
Finance	Accounting Officer	NHS Act 2006
	Counter Fraud Board Lead (Executive)	Directions to NHS Bodies on Counter Fraud 2004
	Local Counter Fraud Specialist	Directions to NHS Bodies on Counter Fraud 2004
	Security Management Director	Secretary of State Directions March 2005
	Local Security Management Specialist	Secretary of State Directions March 2005
	Senior Compliance Officer	Bribery Act 2010
Information Management/Governance	Caldicott Guardian	HSC1999/012
	Senior Information Risk Officer (SIRO)	Information Governance Toolkit
	Information Governance Lead	NHS Standard Contract

	Chief Clinical Information Officer	NHS Information Strategy
	Data Protection Officer	Data Protection Act and General Data Protection Regulations
	Executive Board member for data and cyber security	Data Protection Act and General Data Protection Regulations
Health & Safety	Trust Board Lead (Executive)	As below
	Health and Safety Assistance	Reg 7: Health and Safety Assistance. The Management of Health and Safety at Work Regulations 1999
	Responsible Person (Fire)	Part 2 Fire Safety Duties. The Regulatory Reform (Fire Safety) Order 2005
	Safety Assistance (Fire)	Reg 18: Safety Assistance. The Regulatory Reform (Fire Safety) Order 2005
	Board Level Director (Fire)	Firecode – fire safety in the NHS Health Technical Memorandum 05-01: Managing healthcare fire safety
	Fire Safety Manager	Firecode – fire safety in the NHS Health Technical Memorandum 05-01: Managing healthcare fire safety
	Expert Advice	Reg 14: Expert Advice. The Ionising Radiation (Medical Exposure) Regulations 2017
	Radiation protection Adviser	Reg 14: Radiation Protection Adviser. The Ionising Radiations Regulations 2017
	Dangerous Goods Adviser	1.8.3: SAFETY ADVISER. ADR 2023 - Agreement concerning the International Carriage of Dangerous Goods by Road
	Designated Duty Holder (Medical Pipelines, ventilation, water, Electrical)	Health Technical Memorandum 00: Policies and principles of healthcare engineering
	Designated Person (Medical Pipelines, ventilation, water, Electrical	Health Technical Memorandum 00: Policies and principles of healthcare engineering
	Senior Operational Manager (Medical Pipelines, ventilation, water, Electrical)	Health Technical Memorandum 00: Policies and principles of healthcare engineering
Infection Control	Director of Infection Prevention & Control (DIPC)	Health & Social Care Act 2008 Code of Practice on Control of Infection

	Decontamination Lead	Health & Social Care Act 2008 Code of Practice on Control of Infection
Safeguarding	Safeguarding Executive Lead	Safeguarding Accountability Assurance Framework NHS Standard Contract
	Lead Professional for Safeguarding	Safeguarding Accountability Assurance Framework
	Designated Doctor for Child Protection	Safeguarding Accountability Assurance Framework
	Designated Doctor for Safeguarding Adults	Safeguarding Accountability Assurance Framework
	Named Nurse for Safeguarding Adults	Safeguarding Accountability Assurance Framework
	Designated Midwife for Safeguarding	Safeguarding Accountability Assurance Framework
	Deprivation of Liberty & Safeguarding (DoLS) Lead	Mental Capacity Act 2005
	Mental Health Act Administrator	Mental Capacity Act 2005
	Prevent Lead	Counter-Terrorism and Security Act 2015 NHS Standard Contract
Freedom of Information Act	Freedom of Information Act Lead	Freedom of Information Act
	Qualified Person for FOIA	Freedom of Information Act
Freedom to Speak Up	Freedom to Speak Up Guardian	NHSE Requirement & requirement of NHS Standard Contract
	NED Champion for Freedom to Speak Up	NHS England – Enhancing Board Oversight, A New Approach to NED Champion Roles.
Quality/Patient Safety	Quality Executive Lead	Francis Inquiry
	Executive Lead for End of Life Care	More Care, Less Care Report 2013
	Responsible Person for Compliance with Complaints Regulations	NHS Complaints Regulations
	Complaints Manager	NHS Complaints Regulations
	Guardian of Safe Working Hours	NHS Employers
	Medicines Devices Safety Officer	Patient Safety Alert NHS/PSA/D/2014/006
	Central Alerting System (CAS) Liaison Officer	NHS England – Introduction to the National Patient Safety Alerting System
	Responsible Officer for Revalidation	General Medical Council

	Quality Review Service Lead	NHS England
	Patient Safety Specialist	NHS Patient Safety Strategy
	NED Champion for Doctors Disciplinary	NHS England – Enhancing Board Oversight, A New Approach to NED Champion Roles. Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors Dentists in the NHS Directions on Disciplinary Procedures 2005
Human Tissue Authority	Designated Individual	Human Tissue Act
Human Fertility & Embryology	Responsible Person	Human Fertility & Embryology Act
Care Quality Commission	CQC Nominated Individual	Health & Social Care Act 2014
Sustainability	Trust Board Lead (Executive)	NHS Carbon Reduction Strategy 2009
	Designated Person (Sustainability)	NHS Carbon Reduction Strategy 2009
	Senior Operational Manager (Sustainability)	NHS Carbon Reduction Strategy 2009
Equality & Diversity	Board Executive Lead	Equality Act 2010
Wellbeing	NED Champion for Wellbeing	NHS England – Enhancing Board Oversight, A New Approach to NED Champion Roles. We are the NHS People Plan for 2020-21-action for us all.
Maternity	NED Champion for Maternity	NHS England – Enhancing Board Oversight, A New Approach to NED Champion Roles. Ockenden Review 2020.
Security Management	NED Champion for Security Management	NHS England – Enhancing Board Oversight, A New Approach to NED Champion Roles. Directions to NHS Bodies on Security Management Measures 2004.

Liverpool Trusts
Shadow Joint Committee

Paper No: TB24/25_143

Title of paper:

Liverpool Adult Acute and Specialist Trusts (LAASP) Joint Working Agreement and Shadow Joint Committee

Purpose:
To provide a framework for the Liverpool adult acute and specialist trusts (the Trusts) to work together and to define arrangements for developing delegation of functions and development or enactment of a case for change to a joint committee by April 2025.

Thereafter to support recommendation of arrangements to the Trust Boards.

Summary:
The Trusts have identified a need to work together to

1. Manage financial planning, resources and risk as one
2. Deliver efficient and effective Corporate and Support Services
3. Strategically think as one to develop the LAASP Strategic Case
4. Leading as one to make shared decisions to implement the LAASP Strategic Case

In doing so the Trusts recognise there is a need to work together to develop and define this agenda including the delegations that are likely to be necessary to enable and enact the city decision making envisaged.

Developing and defining this scope will necessarily take time and require a work plan. It is therefore proposed that the Trusts consider and endorse:

1. A joint working agreement which will describe and scope the nature of these discussions and the timetable for codifying this (April 2025)
2. A terms of reference that govern an anticipated period of shadow joint working through to April 2025

In developing these proposals the draft content has been developed and come from joint working between the Trusts through the emerging LAASP Programme Board, the Trust cosecs and engagement with Browne Jacobson who were identified having recently advised on comparable activity within the city.

Trust objectives met or risks addressed: N/A

Financial implications: n/a. Collaboration is expected to be more efficient and should result in a more pragmatic response to any financial challenges within C&M

Stakeholders: All C&M Acute and Specialist Trusts and C&M ICB.

Recommendation(s):

1. To consider and agree the proposed Trusts' JWA
2. To consider and agree the proposed Trusts' shadow committee terms of reference
3. To note the reliance and interplay between the afore mentioned documents and the committee work plan under system discussion. It is also expected that the Trusts may form a joint committee by April 2025 by which time detailed work on scope will have been completed including definition of any required delegations.

Presenting officer: Daniel Scheffer

Date of meeting: 25 September 2024

Browne Jacobson

Date **2024**

(1) Liverpool Heart and Chest NHS Foundation Trust

(2) Liverpool University Hospitals NHS Foundation Trust

(3) Liverpool Women's NHS Foundation Trust

(4) The Clatterbridge Cancer Centre NHS Foundation Trust (CCC)

(5) The Walton Centre NHS Foundation Trust (TWCFT) of

JOINT WORKING AGREEMENT

for the purpose of joint working arrangements between Liverpool Adult Acute and Specialist Trusts including the appointment of a joint committee

Version control

Date	**Version**	**Author**
11 Sep 2024	001	Browne Jacobson - CD
12 Sep 2024	002	BV – local edits
12 Sep 2024	003	Browne Jacobson - CD
17 Sep 2024	004	Browne Jacobson - CD

PART A – DATE OF AGREEMENT

This Agreement is made between the Parties on the day of September 2024

PART B – PARTIES

The Parties to this Agreement are

(1) Liverpool Heart and Chest NHS Foundation Trust (**LHCH**) of Thomas Drive, Liverpool L14 3PE

(2) Liverpool University Hospitals NHS Foundation Trust (**LUHFT**) of Royal Liverpool University Hospital, Mount Vernon St, Liverpool L7 8YE

(3) Liverpool Women's NHS Foundation Trust (**LWFT**) of Crown St, Liverpool L8 7SS

(4) The Clatterbridge Cancer Centre NHS Foundation Trust (**CCC**) of Clatterbridge Road, Bebington, Wirral, CH63 4JY, and

(5) The Walton Centre NHS Foundation Trust (**TWCFT**) of Lower Lane, Fazakerley, Liverpool, L9 7LJ

Each a Trust who together are the Trusts and accordingly any reference in this Agreement to the Trusts shall mean all of the Trusts unless otherwise indicated.

PART C – BACKGROUND

A. The Background to this Agreement (including acronyms and capitalised words that are used in it) shall be interpreted in accordance with the definitions and rules of interpretation set out in Schedule 1

B. The Trusts comprise Liverpool Adult Acute and Specialist Providers (LAASP)

C. Each of the Trusts is constituted as an NHSFT in accordance with its respective constitution

D. The Trusts must exercise their Functions individually and (insofar as they agree joint working arrangements) collaboratively in accordance with their respective Governance and having regard to Guidance.

E. In 2022 the LCSR was commissioned to realise opportunities for greater collaboration between LAASP, to optimise acute care clinical pathways in Liverpool and beyond. The Trusts agree their joint working arrangements should not only consolidate these LCSR ambitions but also move beyond them.

F. On 08 July 2024 the ICB wrote to the Trusts to request in summary that they should work jointly to:

- Design, develop and implement decision making arrangements that enable the 5 Trusts to “act as one” so that benefits can be maximised and delivered faster. These arrangements must be in place in shadow form September 2024, with full delegation in place from April 2025.
- Develop a plan to meet the additional financial targets as a pooled challenge.
- Put in place arrangements to maximise economies of scale in senior management and administration across the 5 organisations, including but not limited to the management of vacancy control and where possible joint appointments..
- Put in place arrangements to manage finances collectively.
- Collaboratively establish the Strategic Case (and associated integration programme) for a Liverpool Five Year Plan that will develop the roadmap for implementing clinical and financial opportunities outlined in both the Clinical Services Review and the Cheshire and Merseyside financial review. The Case must include definition of the care model and associated clinical and patient benefits, activity and financial model, workforce plan, estates and digital requirements and implementation plan.
- Continue to work within the Liverpool place partnership to further enhance place wide collaboration with Mersey Care, Alder Hey and Local Authorities

G. The Trusts have accordingly agreed to exercise their powers under section 65Z5 of the NHSA to establish and implement joint working and delegation arrangements as set out in this Agreement and to appoint a shadow joint committee to be known as the Liverpool Adult Acute and Specialist Trusts Joint Committee or LJC

H. In due course the Trusts intend to exercise their powers further under sections 65Z5 and 65Z6 of the NHSA to enhance and implement joint working and delegation arrangements and to constitute LJC as a substantive joint committee to exercise Joint Functions.

PART D – OPERATIVE PROVISIONS

1. Definitions and interpretation

This Agreement (including acronyms and capitalised words that are used in it) shall be interpreted in accordance with the definitions and rules of interpretation set out in Schedule 1.

2. Actions taken prior to the Commencement Date

2.1. All the Trusts shall have satisfied or agreed in writing to waive the conditions set out in Clause 2.2 on or prior to the Commencement Date.

2.2. The conditions referred to in Clause 2.1 are:

2.2.1. The Trusts shall have exchanged duly executed copies of this Agreement

2.2.2. The Trusts shall have constituted the shadow LJC and approved the LJC ToR

2.2.3. Such other conditions that all the Trusts may have specified in writing before the Commencement Date.

3. Commencement and duration

3.1. The Agreement shall take effect from the Commencement Date and will continue in full force and effect until terminated in accordance with the terms of this Agreement and, in particular but without limitation, in accordance with Clause 9.

3.2. Subject to Clause**Error! Reference source not found.** 9, no termination of the Agreement by either Trust shall take effect prior to 12 months after the Commencement Date.

4. Appointment of LJC

4.1. The Trusts agree to appoint the LJC to operate as a shadow joint committee with effect from the Commencement Date until they constitute it as a statutory joint committee.

4.2. The LJC must operate in accordance with the LJC ToR.

4.3. The LJC ToR and its membership must be agreed by all the Trusts and must include the provisions set out in Clause 4.4.

4.4. The provisions referred to in Clause 4.3 are:

4.4.1. Membership

4.4.2. Chair

4.4.3. Deputies

4.4.4. Attendees

4.4.5. Quoracy

4.4.6. Frequency of meetings

4.4.7. Declaration of interests

4.4.8. Decision-making

4.4.9. Authority of the LJC

4.4.10. Conduct of the LJC

4.4.11. Accountability to Trust Boards

4.4.12. Reporting to Trust Boards

4.4.13. Support to the LJC

4.4.14. Amendment of LJC ToR

4.5. The LJC ToR as at the Commencement Date are as set out in **Error! Reference source not found.** of this Agreement.

4.6. Each of the Trusts warrants that their respective Members of the LJC shall have been authorised to exercise any decision-making powers that they may exercise in accordance with the ToR.

4.7. Subject to Clause 4.8 the Trusts shall use all reasonable endeavours to agree to amend the LJC ToR to constitute the LJC as a substantive joint committee under s65Z6 of the NHSA to exercise Joint Functions for the purpose of their Joint Working Arrangements with effect from 01 April 2025.

4.8. The Trusts may agree to amend the LJC ToR but only by Variation in accordance with Clause 8 of this Agreement.

5. Purpose

5.1. This Clause sets out the Purpose of the Joint Working Arrangements that the Trusts shall authorise the LJC to undertake for them.

5.2. The LJC shall begin and consolidate the process for the Trusts to act as one on strategic activities spanning the Trusts as the LAASP.

5.3. The Trusts' objective is to constitute the LJC as a statutory joint committee with delegated responsibilities and accountabilities by no later than April 2025.

5.4. Prior to constituting the LJC as a statutory joint committee the Trusts agree that the LJC will operate as a shadow joint committee focused on the Scope.

5.5. In particular the Trusts agree the LJC will establish the way and means by which to:

5.5.1. Manage financial planning, resources and risk as one

5.5.2. Deliver efficient and effective Corporate and Support Services

5.5.3. Strategically think as one to develop the LAASP Strategic Case

5.5.4. Leading as one to make shared decisions to implement the LAASP Strategic Case

6. Scope

6.1. This Clause sets out the Scope of the Joint Working Arrangements that the Trusts shall authorise the LJC to undertake for them.

6.2. The LJC shall identify the projects and areas it will work on to achieve the Purpose in and through its Work Plan.

6.3. The LJC may add and remove projects and areas from the Work Plan from time to time provided that they are linked to the LJC's Purpose.

6.4. The LJC shall lead development in the areas set out in Schedule 3.

6.5. Work and project plans will be developed and defined as resourced.

6.6. Engagement with professional groups to scope delivery will be required and progressed as required.

6.7. The LAASP Programme Board has been established which will act as a delivery vehicle for the LJC, catalysing and commissioning actions on behalf of the committee, led by SROs and including cross Trust representation.

7. Principles

7.1. This Clause sets out the Principles that the Trusts agree will inform the Purpose and Scope of their Joint Working Arrangements.

7.2. The Trusts and the LJC shall:

7.2.1. Ensure that proposals are underpinned by demand and capacity analysis

7.2.2. Ensure that clinicians are at the forefront of the development of the envisaged approach, with appropriate clinical leadership from each organisation to shape and develop the work and facilitate involvement from the clinical community

7.2.3. Ensure engagement with system partners who may be impacted or have the potential to mitigate the impact of any proposed pathway changes including the ICB, neighbouring Places, CMAST, NHS Commissioning: Specialist Services, and the MHLDC Collaborative

7.2.4. Ensure engagement with partners in relevant care pathways, including General Practice, community and mental health providers and North West Ambulance Service NHS Trust

7.2.5. Ensure that programmes of work are resourced to deliver, securing a dedicated team from relevant Trusts to support the LJC to develop and implement the operating model for each site, undertaking design work and modelling for operational and proposed service transformation.

7.2.6. Ensure that the Work Plan complies with statutory duties and best practice standards in delivering service change

7.2.7. Ensure that any need for patients, public and stakeholders' involvement are identified as a core part of the Work Plan and form part of a planned engagement approach with patients, public and stakeholders

7.2.8. Ensure no detriment to patients within a wider geography than Liverpool.

8. Variation

8.1. Any Variation of this Agreement, including the introduction of any additional terms and conditions, shall only be binding when agreed by written resolutions of the Trusts' Boards.

9. Termination

9.1. The Trusts acknowledge and confirm that none of them shall be entitled to terminate this Agreement within 12 months of the Commencement Date.

9.2. Subject to Clauses 9.1 and 9.3, a Trust may only terminate this Agreement by giving Notice of Termination specifying a minimum notice period of three months that expires on the next 31 March .

9.3. The Trusts may agree in writing to abridge or otherwise vary the notice period under Clause 9.2.

10. Data sharing and confidentiality

Each Trust undertakes that it shall not at any time during the period for which this Agreement applies, and for a period of five years after termination of this Agreement, disclose to any person any Confidential Information concerning or in connection with the other Trust or this Agreement except as permitted by Schedule 4.

11. No partnership

Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between the Trusts, constitute either Trust the agent of the other Trust, nor authorise a Trust to make or enter any commitments for or on behalf of the other Trust except as expressly provided in this Agreement.

12. Notices

12.1. A notice given under this Agreement:

12.1.1. Will be in writing in the English language

12.1.2. Will be sent by email addressed to the Chief Executive of the Trust that is the intended recipient:

12.1.3. A notice or other communication shall be deemed to have been received by email immediately on sending provided it is correctly addressed or if deemed receipt is not within business hours (meaning prior to 5.30 pm and excluding weekends and public holidays in England), then it will be deemed to have been received at 9.00 am on the next day that is not a weekend or a public holiday in England.

12.2. The provisions of this Clause 12 shall not apply to the service of any proceedings or other documents in any legal action.

13. Dispute Resolution

13.1. Any Trust in dispute about this Agreement including its validity, meaning, effect and operation, shall use all reasonable endeavours to resolve its dispute in accordance with Stages 1-3 of the following dispute resolution process:

13.1.1. Stage 1: a named officer for each Trust in dispute will meet to try to resolve the dispute. If they cannot resolve the dispute then they will escalate it to Stage 2.

13.1.2. Stage 2: the Chief Executives of each Trust in dispute will meet to try to resolve the dispute. If they cannot resolve the dispute then they will escalate it to Stage 3.

13.1.3. Stage 3: the Chair of the LJC shall meet with Chairs of other Trusts and make a recommendation for dispute resolution.

14. Other general provisions

14.1. Each Trust shall (at its own expense) promptly execute and deliver such documents, perform such acts and do such things as the other Trust may reasonably require from time to time for the purpose of giving full effect to this Agreement.

14.2. Each Trust will bear its own costs of negotiating and entering into this Agreement.

14.3. This Agreement is personal to the Trusts and neither Trust shall assign, transfer, mortgage, charge, declare a trust of, or deal in any other manner with any of its rights and obligations under this Agreement without the prior written consent of the other Trust.

14.4. This Agreement (together with the documents referred to in it) constitutes the entire agreement between the Trusts and supersedes and extinguishes all previous discussions, correspondence, negotiations, drafts, agreements, promises, assurances, warranties, representations and understandings between them, whether written or oral, relating to its subject matter.

14.5. No failure or delay by a Trust to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy. A waiver of any right or remedy under this Agreement or by law is only effective if it is in writing.

14.6. Except as expressly provided in this Agreement, the rights and remedies provided under this Agreement are in addition to, and not exclusive of, any rights or remedies provided by law.

14.7. If any provision or part-provision of this Agreement is or becomes invalid, illegal or unenforceable, it shall be deemed modified to the minimum extent necessary to make it valid, legal and enforceable. If such modification is not possible, the relevant provision or part-provision shall be deemed deleted. Any modification to or deletion of a provision or part-provision under this Clause shall not affect the validity and enforceability of the rest of this Agreement.

14.8. This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all the counterparts shall together constitute the one agreement.

14.9. No one other than a party to this Agreement shall have any right to enforce any of its terms.

14.10. This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales.

14.11. Each Trust irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this Agreement or its subject matter or formation (including non-contractual disputes or claims).

This Agreement is signed by Chief Executive Officers on behalf of the Trusts on the date stated above as follows

By:	**On behalf of:**
.... Liz Bishop, Chief Executive Officer	Liverpool Heart and Chest NHS Foundation Trust
.... James Sumner, Chief Executive Officer	Liverpool University Hospitals NHS Foundation Trust
.... James Sumner, Chief Executive Officer	Liverpool Women’s Hospital NHS Foundation Trust
.... Liz Bishop, Chief Executive Officer	The Clatterbridge Cancer Centre NHS Foundation Trust
.... Jan Ross, Chief Executive Officer	The Walton Centre NHS Foundation Trust

PART E – SCHEDULES

Schedule 1 – Definitions and Interpretation

1 In this Agreement capitalised words and expressions shall have the meanings given to them as follows unless the context otherwise requires:

Word or expression	**Meaning**
2006 Act or NHSA	the National Health Service Act 2006 (as amended);
Agreement or **JWA**	this Agreement including its Schedules
Chair	the chair of the LJC;
CMAST	Cheshire and Merseyside Acute and Specialist Trusts Collaborative;
Delegation	the terms of any delegation to the LJC including any associated delegation agreement as agreed by the relevant board(s) and appended to these Terms of Reference at Schedule 2 and 'Delegated' shall be construed accordingly;
ICB	NHS Cheshire and Merseyside Integrated Care Board, including any individual, organisation or committee to which its powers or responsibilities are delegated;
Joint Functions	functions that the Trusts agree to exercise jointly in accordance with their Joint Working Arrangements
Joint Working Arrangements	the joint working arrangements that the Trusts have agreed in accordance with s65Z5 of the NHSA as set out in this Agreement including but not limited to the Purpose, Scope and Principles
LAASP	Liverpool Adult Acute and Specialist Providers
LCSR	Liverpool Clinical Services Review
LJC	Liverpool Adult Acute and Specialist Trusts Joint Committee;
Member	a member of the LJC listed in the ToR;

MHLDC	The Cheshire and Merseyside mental health, learning disability and community services collaborative
Principles	the principles of the Joint Working Arrangements as set out in Clause 0
Purpose	the purpose of the Joint Working Arrangements as set out in Clause 5;
Schedule or **Schedules**	one or more of the Schedules to this Agreement
Scope	the scope of Joint Working Arrangements as set out in Clause 6 and Schedule 3
SRO	Senior Responsible Officer – for delivering the work programme, a programme workstream or project
ToR	the terms of reference of the LJC initially as set out in Schedule 2 but subject to amendment as the Trusts may agree to vary them in accordance with this Agreement
Trusts	Liverpool Heart and Chest NHS Foundation Trust (LHCH); Liverpool University Hospitals NHS Foundation Trust (LUHFT); Liverpool Women's NHS Foundation Trust (LWFT); The Clatterbridge Cancer Centre NHS Foundation Trust (CCC); and The Walton Centre NHS Foundation Trust (TWCFT); and
Work Plan	the rolling plan of work to be adopted and carried out by the LJC over a 12-month period (or such longer period as may be agreed by the Trusts) in accordance with its ToR.

2 All references to legislation are to that legislation as updated from time to time.

3 Any reference to the exercise by the Trusts of Joint Functions shall be interpreted to include any exercise of Joint Functions by the LJC or a subcommittee of it on behalf of the Trusts.

Schedule 2 Liverpool Adult Acute Trusts Joint Committee Terms of Reference

1. Background

1.1. Liverpool Adult Acute Trusts Joint Committee (LJC) is a shadow joint committee of Liverpool Heart and Chest NHS Foundation Trust (LHCH); Liverpool University Hospitals NHS Foundation Trust (LUHFT); Liverpool Women's NHS Foundation Trust (LWFT); The Clatterbridge Cancer Centre NHS Foundation Trust (CCC); and The Walton Centre NHS Foundation Trust (TWCFT) who are referred to individually as a Trust and together as the Trusts.

1.2. The Trusts exercised their powers under s65Z5 of the NHSA to enter a Joint Working Agreement (JWA) dated September 2024 and to appoint the LJC to act for them as a shadow joint committee in accordance with these Terms of Reference (ToR) subject to any amendment of them that the Trusts may agree to make.

1.3. These ToR are subject to and must be interpreted in accordance with the JWA.

1.4. As a shadow joint committee the LJC does not have and is not intended to have delegated functions and/or joint decision-making powers.

1.5. The Trusts intend to amend these ToR in due course as set out in the JWA to constitute the LJC as a statutory joint committee under s65Z6 of the NHSA with delegated functions and joint decision-making powers.

2. Membership

2.1. The Members of the LJC are:

- Chair of CCC
- Chief Executive of CCC
- Chair of LHCH
- Chief Executive of LHCH
- Chair of LUHFT
- Chief Executive of LUHFT
- Chair of LWH

- Chief Executive LWH
- Chair of TWCFT
- Chief Executive of TWCFT

3. Chair

3.1. The Chair of LJC (the Chair) shall be the Chair of LUHFT who will remain in this position unless otherwise agreed by a majority of the remaining Members.

3.2. Meetings of the LJC will be run by the Chair. The decision of the Chair on any point regarding the conduct of the LJC (including interpretation and applications of these ToR) shall be final.

3.3. The Deputy Chair of LJC shall be agreed by a majority of the Members when and as the need arises.

3.4. If the Chair is not in attendance at a meeting then the Deputy Chair shall deputise for the Chair and any reference to Chair in these Terms of Reference shall include the Deputy Chair.

4. Deputies

4.1. With the permission of the Chair, Members may nominate in writing a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf and count in the quorum. The decision of the Chair regarding authorisation of a deputy is final. Should permission not be granted, the Chair will provide details of the rationale to the respective organisation. Such nominations should usually be received five working days before the date of the meetings and should always include a short explanation as to why the nomination of a deputy is necessary.

4.2. The deputy must ensure that they understand the extent to which they are able to take decisions on behalf of their Trust.

4.3. Where the context requires, any reference to a Member in these ToR shall be interpreted to include a deputy who attends a meeting on behalf of a Member.

5. Attendees

5.1. The Chair of the LJC may invite such attendees to LJC meetings to provide information or be involved in discussion as the Chair considers appropriate.

5.2. The Trusts shall make any of their officers who are involved in delivery of the Work Plan available to attend the LJC as requested.

6. Quoracy

6.1. As a minimum one Member from each Trust or their deputy must be in attendance for the LJC to be quorate.

6.2. If any Member of the LJC has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

6.3. Members shall attend meetings in person but alternatively may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting provided all Members are able to hear and speak to one another.

7. Frequency of meetings

7.1. The LJC will meet at least monthly in private.

7.2. As far a possible, LJC meetings will be scheduled to ensure that they do not conflict with Trust Board meetings and are synchronised so that Members may properly engage their Boards ahead of LJC meetings. The process of engagement with Trust Boards will be supported by a clear operational framework that the LJC will approve.

7.3. The Chair may call an additional meeting, at any time, by giving not less than 10 calendar days' notice in writing to Members.

7.4. Three of the Members may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all Members specifying the matters to be considered at the meeting.

7.5. In emergency situations the Chair may call a meeting with two working days' notice by setting out the reason for the urgency and the decision to be taken.

8. Declaration of interests

8.1. If any of the Members has an interest, financial or otherwise, in any matter and is due to be present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the NHS England guidance on managing conflicts of interest in the NHS as applicable from time to time.

8.2. The Chair of the meeting will determine how a conflict of interest should be managed. The Chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

9. Decision-making

9.1. Where these ToR provide for a decision to be made by a majority the Members, then each Member shall have one vote for each position they hold as a Chair or Chief Executive of a Trust. For example, if a Member is the Chair of two Trusts, then they will have two votes out of 10 possible votes.

9.2. All other decision-making shall be as set out in Clauses 9.3 and 9.4 below.

9.3. As a shadow joint committee the LJC's decision-making shall be as follows:

9.3.1. Where a Chief Executive has delegated authority from their Trust to take decisions, they are able to take decisions on behalf of their Trust. Other members of the LJC cannot require a Chief Executive to exercise their delegated authority in a particular way.

9.3.2. The Trusts will work towards having consistency in the levels of delegated authority held by each of the Chief Executives.

9.3.3. Where the Chief Executive does not have delegated authority from their Trust to take a decision which the Trusts wish to take in the LJC (outside of the formal delegations to the LJC) then that decision will need to be referred back to the relevant Trust board for determination.

9.3.4. For the avoidance of doubt the LJC as a shadow joint committee does not have and is not intended to have delegated functions and/or joint decision-making powers.

9.4. When the Trusts constitute the LJC as a statutory joint committee, then the Trusts intend its decision-making will be as follows:

9.4.1. The Trusts may formally delegate decision-making to the LJC in relation to particular projects or workstreams within the Work Plan. Such delegations will be in accordance with the guidance given by NHS England. Delegations will be appended to these Terms of Reference and must be delivered in accordance with these Terms of Reference and the Delegation. If there is any conflict between these Terms of Reference and a Delegation, the Delegation will prevail. Where functions of the Trusts have been delegated, the LJC acts as a joint committee of the relevant Trusts.

9.4.2. The LJC shall aim to make decisions by consensus of all Members, with the Chair and Chief Executive Members from each Trust seeking to make consensus decisions on behalf of their own Trust. If consensus cannot be reached between all Members, the matter will be referred to the Trust boards for further consideration.

10. Purpose, Scope and Authority of the LJC

10.1. The Trusts authorise the LJC to establish and implement a Work Plan to undertake and achieve their Joint Working Arrangements.

10.2. The LJC is authorised to investigate any activity within its Terms of Reference.

10.3. The LJC is authorised to seek any information it requires within its remit, from any officer of a Trust. The Trusts shall ensure that their officers co-operate fully and promptly with any such request made by the LJC.

10.4. The LJC is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations provided it ensures that full funding is available to meet the associated costs.

10.5. The LJC is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary provided it ensures that full funding is available to meet the associated costs.

10.6. As a shadow joint committee, the LJC is authorised to create working groups as are necessary to achieve its Purpose. The LJC is accountable for the work of any such group.

10.7. When the LJC is constituted as a statutory joint committee, then the Trusts intend that the LJC may appoint and delegate decision-making to LJC Sub-Committees in relation to particular projects or workstreams. Such delegations will be in accordance with the guidance given by NHS England and will be appended to the relevant Sub-Committee Terms of Reference.

11. Conduct of the LJC

11.1. Members must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

11.2. Members of the LJC will abide by the ‘Principles of Public Life’ (The Nolan Principles) and the NHS Code of Conduct.

12. Accountability to Trust Boards

12.1. The LJC is accountable to each Trust board and will report on progress within its scope accordingly.

13. Reporting to Trust Boards

13.1. The Members from each Trust shall be responsible for ensuring that appropriate reporting is made to their Trust board and their Trust’s Council of Governors and that feedback from their Trust is fed through to the LJC.

13.2. The LJC shall submit a summary of the minutes from the LJC Chair to each Trust board meeting in public. The LJC shall ensure that the work of the LJC Sub-Committees is reflected in its own minutes.

13.3. The LJC shall provide regular reports on its work to the ICB.

13.4. The LJC shall provide an annual report on the outputs of its work.

14. Support to the LJC

14.1. The lead officer coordinating support to the LJC is the LUHFT and LWH Chief Transformation Officer who is responsible for managing LJC agendas and the Work Plan including linking with and drawing upon relevant expertise within Trusts.

14.2. LUHFT shall provide meeting administration support to the LJC which shall include:

- Seeking agenda items from Members two weeks in advance of each meeting; development and agreement of the agenda with the Chair in consultation with the Lead Officer;

- Sending out agendas and supporting papers to Members at least five working days before the meeting.
- Liaising with attendees invited to LJC meetings under paragraph 10
- Drafting minutes including an updated version of the Work Plan for approval by the Chair within five working days of any LJC meeting.
- Distributing approved minutes (including updated Work Plan) to all attendees following within 10 working days of Chair's approval.
- Maintaining an on-going list of actions, specifying which Members are responsible, due dates and keeping track of these actions.
- Publicising LJC meetings, minutes and associated documents as appropriate
- Providing such other support as the Chair requests, for example advice on the handling of conflicts of interest.

15. Amendment of LJC ToR

15.1. The Trusts may agree to amend these ToR but only in accordance with the JWA.

16. Annual review

16.1. The LJC shall undertake an annual self-assessment of its own performance against the Work Plan and these Terms of Reference. This self-assessment shall form the basis of the annual report from the LJC to the Trusts and the ICB Board.

Schedule 3 Scope

The LJC shall lead development in the following areas:

1. Manage financial planning, resources and risk as one by:

- Development of an integrated 25/26 planning process
- Delivery of 24/25 CIP stretch target
- Developing effective arrangements for the management of a LAASP control total, CIP programme, balance sheet, cash position and capital programme
- Shared ownership of LAASP financial risks

2. Efficient and effective Corporate and Support Services through:

- Transformation Plans in place to achieve identified average cost for Corporate and Support Services across LAASP
- Transformation or efficiency plans in place to achieve economies of scale in infrastructure, estates and facilities

3. Strategically thinking as one to develop the LAASP Strategic Case through:

- Development of LAASP strategic principles for acting as one
    - Underpinned by a consistent and aligned approach to our strategy development and deployment, digital, research and innovation, commercial and contractual levers and opportunities
- Development of a strategic case, agreed by LAASP JC, ICB and LAASP Boards (*5) that:
    - Develops the LAASP strategic principles for acting as one
    - Identifies the case for change, including definition of key clinical risks, opportunities and inequalities in the current model
    - Develops the future LAASP model of care, including alignment with integrated care and population health models in the city
    - Defines the workforce, estates and digital models to deliver the care model

    - Develops the business case that summarises the financial and activity impacts of the new care model
    - Defines the roadmap and programme structure required to support delivery.

4. Leading as one to make shared decisions to implement the LAASP Strategic Case through the establishment of the LJC which will:

- Establish a roadmap that delivers on the on next steps towards a LAASP way of working
- Contributing to Liverpool Place imperatives to address health inequalities and inequity from the LCSR report
- Connecting with partners and through CMAST and wider (where relevant to pathway) to ensure all patient needs are considered and any implications identified and mitigated
- Leading and coordinating the provider response and contribution with the ICB for delegated adult specialised commissioning functions

Schedule 4 Data sharing and confidentiality

1. In this Schedule “Confidential Information” means: all information, whether written or oral (however recorded), provided by one Trust (the Disclosing Trust) to the other Trust (Receiving Trust) and which (i) is known by the Receiving Trust to be confidential; (ii) is marked as or stated to be confidential; or (iii) ought reasonably to be considered by the Receiving Trust to be confidential.

2. The Trusts may disclose Confidential Information:

   2.1. to their employees, agents or consultants who need to know such information for the purpose of discharging their obligations under this Agreement if they ensure that their employees, agents, or consultants to whom they disclose Confidential Information comply with this Schedule 4 and

   2.2. as may be required by law, a court of competent jurisdiction or any governmental or regulatory authority.

3. The Trusts will not use each other’s Confidential Information for any purpose other than to comply with this Agreement.

4. The Trusts acknowledge that they are subject to legal duties under the FOIA and EIR which may require them to disclose, on request, information relating to this Agreement and that they are also subject to the Code of Practice on Openness in the NHS (4 August 2003).

5. If a Trust receives a Request for Information (as defined in FOIA) or a request under regulation 5(1) of EIR (each, a Request) about their collaboration arrangements or the Group Board, prior to any disclosure of information to which an exemption to FOIA or EIR (as the case may be) may apply (Potentially Exempt Information) and recognising fully that the decision whether and what to disclose is for the Trust receiving the Request:

   5.1. Notify the other Trust of such Request

   5.2. Consider any representations made by the other Trust in relation to the Request and any possible exemptions and

   5.3. Consult with the other Trust in relation to any proposed disclosure as to whether any further explanatory material or advice should also be disclosed with the information in question

6. Each Trust agrees that it will promptly inform the other Trust of any media enquiries which it receives in relation to the collaboration arrangements. The Trusts will work co-operatively to agree a joint response to any media enquiries received in relation to the collaboration arrangements.
7. The Trusts will work co-operatively together in relation to the use of personal data and the requirements of the UK GDPR and Data Protection Act 2018 including ensuring that appropriate technical and organisational security measures are taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.

Board of Directors

COVER SHEET

Meeting Date	Thursday, 10 October 2024	**Item Reference**	TB24/25_144
Report Title	Amendments to the Nominations and Remuneration Committee Terms of Reference		
Author	Michelle Carlton, Senior Corporate Governance Officer Hollie Holding, Deputy Company Secretary		
Responsible Director	Daniel Scheffer, Director of Corporate Affairs/Company Secretary		

Purpose of Report	The Nominations and Remuneration Committee Terms of Reference are presented for the Board of Directors to review and approve following approval by the Committee.
Executive Summary	Following the announcement in July 2024 that NHS Cheshire and Merseyside had asked the five adult acute and specialist Trusts in Liverpool to establish a Joint Committee to create a sustainable healthcare system for the future with a clear focus on improving patient care and outcomes, both Liverpool University Hospitals NHS Foundation Trust (LUHFT) and Liverpool Women's NHS Foundation Trust (LWH) are building upon the existing joint Board appointments and developing a shared Board of Directors, which will support LWH's long-standing ambition to be aligned with a larger acute Trust to support the management of identified clinical risks. It was proposed that the Nominations and Remuneration Committees therefore meet in common going forward, requiring a review and subsequent amendments to the Terms of Reference for the Committee at both Trusts to be aligned and allow for the Committees to meet in common.
Key Areas of Concern	There are no key areas of concern to bring to the attention of the Board of Directors.

Links to Board Assurance Framework	Risk 9: Well Led	9
Links to Corporate Risk Register (scoring 10+)	N/A	-

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

Action Required by the Board of Directors	The Board of Directors is asked to review and ratify the Nominations and Remuneration Committee Terms of Reference.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Nominations and Remuneration Committee	25.09.24	Daniel Scheffer	Approved.

MAIN REPORT

1. Introduction

In 2023/24, NHS Cheshire and Merseyside Integrated Care System (ICS) confirmed their preferred future direction of travel, namely a closer collaboration with a large acute provider of services to support the long-term sustainability of services for the benefit of women, babies, and others who access their services. With this in mind, a Joint Chief Executive Officer and a Joint Chair were appointed between Liverpool University Hospitals NHS Foundation Trust (LUHFT) and Liverpool Women's NHS Foundation Trust (LWH).

Following a further announcement in July 2024 that NHS Cheshire and Merseyside had asked the five adult acute and specialist Trusts in Liverpool to establish a Joint Committee to create a sustainable healthcare system for the future with a clear focus on improving patient care and outcomes, both LUHFT and LWH are building upon the existing joint Board appointments and developing a shared Board of Directors, which will support LWH's long-standing ambition to be aligned with a larger acute Trust to support the management of identified clinical risks.

As a result, there was a requirement for the Nominations and Remuneration Committee Terms of Reference for both Trusts to be reviewed and amended to align them and allow for the Committees to meet in common.

2. What is a Committee in Common?

Committees-in-Common create a framework for aligned decision-making and promote consistent decisions about the exercise of functions by all participant organisations, though those decisions are separately taken. A Committee-in-Common approach is often taken where a Trust is required to have a reserved function, however a Joint Board membership is in place.

To create a Committee-in-Common, each Trust will delegate decision-making for a particular function to an internal committee of that organisation. The committees of each of the organisations may have common membership, either entirely or in part hence the name 'committees in common'. Individual committees then make decisions for each Trust, essentially simultaneously and following arrangements that maximise the chances of aligned decision-making.

3. Review Process

The starting point for an effective Committee is its Terms of Reference (TOR). These are ultimately set by the Board of Directors, and they set out the role, the duties, the scope and limits of its responsibilities and membership. To allow for the LUHFT and LWH Committees to meet in common, a review of both sets of TOR was undertaken.

A tracked change version of the amended LWH TOR can be found at Appendix A.

The Committee is required to review the ToR at intervals (not exceeding two years) however, it is good practice to undertake an annual review. It is the intention that, as the Group model progresses, the ToR be reviewed to ensure that they are fit for purpose within the landscape in which the Committee is operating. Any amendments will be approved by the Committee before being presented to the Board for review and ratification.

4. Recommendation

The Board of Directors is asked to review and ratify the Nominations and Remuneration Committee Terms of Reference.

NHS
Liverpool Women's
NHS Foundation Trust

NOMINATION & REMUNERATION COMMITTEE

TERMS OF REFERENCE

Introduction

Liverpool Women's NHS Foundation Trust and Liverpool University Hospitals NHS Foundation Trust approved arrangements to establish a group model to support increased joint working and collaboration between the two organisations and the wider system, in line with the powers set out in the Health and Care Act 2022 and with approval from NHS England and the Cheshire and Merseyside Integrated Care Board.

To support the joint working, a joint Chair and a joint Chief Executive have been appointed, together with joint Non-Executive Directors and Joint Executive Directors. In line with current legislation, both Trusts remain as individual statutory organisations with individual Constitutions.

Authority / Constitution

1. The Committee is constituted as a standing Committee of the Trust's~~established by the~~ Board of Directors and will be known as the Nomination and Remuneration Committee (the Committee). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings. The Nomination & Remuneration Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

~~1.~~2. While LWH remains an individual statutory organisation within the Group model, the Committee may meet in common with an Audit Committee of another Trust within the Liverpool University Hospitals Group.

~~2.~~3. The Committee is authorised by the Board to investigate any activity within its Terms of Reference. All members of staff are directed to co-operate with any request made by the Committee.

4. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

~~3.~~5. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

Purpose

6. The Nomination & Remuneration Committee's primary responsibilities include overseeing the processes for recruiting and appointing senior leadership positions

within the Trust, ensuring there is a transparent and merit-based selection process. Additionally, the committee is tasked with developing and reviewing policies related to the remuneration, incentives, and terms of service for the executive directors and senior management, ensuring these are fair, competitive, and capable of attracting and retaining the high-calibre talent necessary for the Trust's success.

~~4.~~7. Committee will recommend and monitor the structure of remuneration including setting pay ranges and receiving relevant reports (at least annually) for the layer of management under Executive Director not covered under Agenda for Change (AfC).

Duties

8. In order to fulfill its role effectively, ~~T~~the Committee ~~is responsible for~~will:

- Act in accordance with the terms of the Trust's Constitution and Standing Orders, taking relevant provisions of the NHS Foundation Trust Code of Governance into consideration.

a. Appointments to the Executive Team

- Determine a remuneration policy for the Chief Executive Officer (CEO), Executive Directors and the Trust Secretary.
- Approve the remuneration and terms of office for each vacant CEO and Executive Director post prior to the post being advertised.
- Evaluate the skills, knowledge and experience on the Board and prepare a description of the role and capabilities required for the appointment of a CEO/Executive Director.
- ~~Overseeing~~Participate in the recruitment and selection process for the posts of CEO~~Chief Executive[1]~~ and Executive Director and ratify appointments.~~s~~
- Review~~ing~~ the structure, size and composition of the ~~Executive Director composition of the~~ Board ~~of Directors~~ and make recommendations where necessary.
- In the event of the Board agreeing to an Executive Director being appointed as a Non-Executive Director of another organisation, determine whether the individual should retain any associated remuneration.
- It is for the Non-Executive Directors to appoint and remove the CEO. The appointment of a CEO requires the approval of the Council of Governors.
- Both the appointment and removal of the Company Secretary should be a matter for the whole Board of Directors. The Committee will support the CEO in making the appointment prior to presentation to the Board for approval.

~~a.~~b. Remuneration

- Subject to receipt of a report on the annual performance of the CEO (from the Chair of the Board of Directors), and taking account of such national pay determinants, comparative data and other matters considered appropriate by the Committee, review the remuneration of the CEO on an annual basis.
- Subject to receipt of a report on the annual performance of individual Executive Directors (from the CEO of the Board of Directors), and taking account of such national

---

~~[1] Note that Chief Executive appointments are subject to approval by the Council of Governors~~

pay determinants, comparative data and other matters considered appropriate by the Committee, review the remuneration of the individual Executive Directors on an annual basis.

- Taking account of value for money requirements for the organisation, ensure that remuneration is sufficient to recruit, retain and motivate the CEO and Executive Directors with the level of skills appropriate for proper and robust management of the organisation.
- Ensure that the contractual terms of severance payments on termination of office for the CEO/Executive Directors are fair to the individual/organisation and in line with associated national guidance. Severance payments should not reward failure and, where appropriate, should reflect the director's duty to mitigate losses.
- Ensure that the contractual terms of severance payments on termination of office for staff at Very Senior Manager (VSM) level and above are fair to the individual/organisation and in line with associated national guidance. Severance payments should not reward failure and, where appropriate, should reflect the staff member's duty to mitigate losses. This also applies to equivalent medical staff grade cases and any other cases where the severance payment exceeds £100,000 Monitor levels of remuneration across the organisation, particularly in relation to those at VSM level.
- Ensure compliance by the Trust with the requirements for disclosure of the CEO and Executive Directors' remuneration in the annual report and accounts.
- Recommend and monitor the level and structure of remuneration for senior managers operating at and below Board level.

c. Succession Planning

~~Preparing a description of the role and capabilities required for the Chief Executive and Executive Director posts to reflect the balance of skills, knowledge and experience required~~

- Give full consideration to ~~S~~succession planning, ~~Executive appointments~~ taking into account the challenges, risks and opportunities facing the Trust and the skills and expertise required on the Board to meet them.

~~Reviewing the structure, size and composition of the Executive Director composition of the Board of Directors~~

~~b. Reviewing Executive Directors' performance.~~

~~c. Determining the remuneration and terms of service of the Chief Executive and the Executive Management Team~~

~~d. Determining the annual cost of living award for senior managers (excluding those paid under Agenda for Change arrangements)~~

~~e. Succession planning for Executive Director appointments~~

~~f. Overseeing agreement of appropriate contractual arrangements relating to the Chief Executive and Executive Management Team~~

~~g. Scrutinising any termination payments relating to the Chief Executive or the Executive Management Team, ensuring that they have been properly calculated and take account of any relevant guidance~~

~~h. To be responsible for any disciplinary issue relating to the Chief Executive or member of the Executive Management Team which may result in their dismissal. The Committee will not be responsible for any disciplinary issue which is short of dismissal~~

~~i. Such other duties as the Board of Directors may delegate.~~

Membership

9. ~~The Committee membership will be appointed by the Board of Directors and will consist of:~~The members of the Committee shall be:

- Trust Chair
- All Non-Executive Directors

~~5. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum.~~

10. The Chair of the Board of Directors will be the Chair of the Committee. The Deputy~~Vice~~ Chair of the Board will Chair the Committee if the Chair is not present. ~~be the Vice Chair of the Committee from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent.~~

11. The following are required to attend and participate in the meetings of the Committee in a non-voting capacity except on those occasions when discussions or decisions related to their own remuneration or terms of office:

- Group Chief Executive Officer
- Group Chief People Officer
- Group Director of Corporate Affairs / Company Secretary

~~6.~~12. A quorum shall be three members including the Chair or Deputy~~Vice~~ Chair. Where quorum cannot be established, the Committee will continue to meet but will be uale to confirm any documentation or take decisions. ~~and at least two Non-Executive Directors.~~

Voting

~~7.~~13. Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.

Requirements of Membership

Members

14. Members will be required to attend a minimum of 75% of all meetings each financial year but should aim to attend all scheduled meetings.

~~8.~~15. Attendance at the Committee will be recorded and monitored.~~.~~

~~Officers~~

~~9. The Chief Executive and Chief People Officer (or equivalent executive lead for the Trust with responsibility for the human resources functions of the Trust) will be in attendance at its meetings, as and when appropriate and necessary.~~

~~10. The Trust Secretary will act as Secretary to the Committee.~~

Equality Diversity & Inclusion

~~11.~~16. In conducting its business, members must demonstrably consider the equality and diversity implications of decisions they make and consider whether in the management of risk control, the Trust achieves positive change around inclusion, equality and diversity.

Conflicts of Interest

~~12.~~17. If any of the Members has an interest, financial or otherwise, in any matter and is due to be present at the meeting at which the matter is under discussion, ~~he/she~~they will declare that interest as early as possible and act in accordance with the Trust's Conflicts of Interests Policy. The Chair of the meeting will determine how a conflict of interest should be managed. The Chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

Reporting

~~13. The Nomination and Remuneration Committee will be accountable to the Board of Directors.~~

18. The minutes of the Nomination & Remuneration Committee will be formally recorded and submitted to the ~~Board of Directors~~next meeting for approval. ~~The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it or require executive action~~ An assurance report shall be available to the Board of Directors on request.

~~14.~~19. Identified risk are to b escalated to the Board of Directors in accordance with the agreed assurance and escalation procedure.

~~15. Summary minutes will also be circulated to members of the Audit Committee.~~

~~16.~~20. A summary of all CEO/Executive Director appointments and annual remuneration shall be reported in the Trust's annual report. ~~The Committee will report to the Board annually on its work and performance in the preceding year.~~

~~17.~~21. ~~Trust standing orders and standing financial instructions apply to the operation of the Remuneration and Nomination Committee.~~The Committee will report annually to the Bard of Directors in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its performance according to a standardised framework and process.

Administration of Meetings

~~18.~~22. Meetings shall be held at least once per year or as required to fill Executive Director vacancies. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.

~~19.~~23. The Director of Corporate Affairs~~Secretary~~ will plan to ensure that Board is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chair and members.

~~20.~~24. Agendas and papers will be circulated at least four~~five~~ working days (or three working days plus a weekend) in advance of the meeting. ~~.~~

~~21.~~25. Minutes will be circulated to members as soon as is reasonably practicable.

Review

~~22.~~26. The Terms of Reference of the Committee shall be reviewed and submitted for approval to the Board of Directors at least annually.

Version Control Schedule

Date	Version no	Main changes proposed	Date approved by Nomination & Remuneration Committee	Date ratified by Board of Directors (thereby come into force)
March 2024	1	Development of the Terms of Reference – alignment with updated template		
September 2024	2	Addition of an introduction to highlight the move to a Group model with Liverpool Women's NHS Foundation Trust.		

		Authority / Constitution – addition of a paragraph outlining the ability of the Committee to meet in common with other Committees within the Group model. General alignment of wording and paragraphs throughout to the TOR for the LUHFT Nominations and Remuneration Committee to allow for working together as a committee in common.		

Liverpool Women's
NHS Foundation Trust

Board of Directors

COVER SHEET

Meeting Date	Thursday, 10 October 2024	**Item Reference**	TB24/25_145
Report Title	Committee Chair's Reports		
Author	Helen Garnett, Senior Corporate Governance Officer		
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 September 2024
Executive Summary	The Chair reports for the following Board committees are included in this report and attached at Appendix 1. Finance, Performance and Business Development Committee • 2 October 2024 – Chaired by Tracy Elery
Key Areas of Concern	N/A
Trust Strategy and System Impact	N/A

Links to Board Assurance Framework	None	**-**
Links to Corporate Risk Register (scoring 10+)	None	**-**

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 Committee Chair's Reports.

REPORT DEVELOPMENT:

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

Finance, Performance and Business Development Committee Assurance Report

Report to	Board of Directors
Date	10 October 2024
Meeting Name	Finance, Performance and Business Development Committee
Date of Meeting	2 October 2024
Chair's Name & Title	Tracy Ellery, Joint Non-Executive Director

Agenda Items

The Committee discussed the following agenda items:

- Emergency Preparedness, Resilience and Response NHS England Core Standards Annual Assurance Annual Report - **(Moderate Assurance)**
- Ambulatory Update - **(Substantial Assurance)**
- Finance, Performance & Business Development Committee Closure Report – **(Substantial Assurance)**
- Integrated Performance Report – **(Moderate Assurance)**
- Finance Performance Report - **(Substantial Assurance)**

Matters for Escalation

Emergency Preparedness, Resilience and Response NHS England Core Standards Annual Assurance Annual Report – the Committee received the report which summarised the Core Standards Annual Assurance process outcome for 2024/25. For 2024/25, 45 were fully compliant (19 in 2023/24), 14 were partially compliant (38 in 2023/24), and zero were non-compliant (one in 2023/24). The Trust would be submitting an improved position from non-compliant to partially compliant (77%), forming the work plan. The Committee sought assurance on the work being undertaken in the remainder of the year to move from partially compliant to fully compliant. With the work plan, it was anticipated between now and December 2024, the Trust would rate at 85% or above, and it was agreed that this would be referenced in the report to the Trust Board to provide assurance.

Key Issues

(i) Ambulatory Update

The Committee received an update on the re-purposing of the Ambulatory Unit and associated costs. The Trust had initially secured £5m from the Targeted Investment Fund to support the re-purposing of the Ambulatory Unit; however, as the project advanced, the revised capital requirement increased to £5.8m in 2024/25 with a further £0.2m required in 2024/25 following a market testing and cost plan review undertaken in June 2024.

To address this, the Project Group revised the original expansion plan and reduced the overall costs without compromising the scope or objectives outlined in the business case. Despite this, there remained a pressure of £0.8m for 2024/25 and £0.2 for 2028/29 for the third treatment room, requiring a total of £6m to be committed until 2028/29. The capital allocation for 2024/25 could be covered in a year. However, this would leave a residual financial risk.

The Committee noted that the project needed to continue (supported by the Finance and Performance Executive Group and Executive Risk and Assurance Group) pending approval by the Trust Board.

(ii) Finance, Performance & Business Development Committee Closure Report

The existing governance arrangements must be formally closed to establish the University Hospitals of Liverpool Group Board (the Group Board) between Liverpool University Hospitals NHS Foundation Trust (LUHFT) and Liverpool Women's Hospital (LWH) in November 2024. The first Group Board meeting would occur at the end of November 2024, and LWH would move into the new governance arrangements in November 2024.

The new reporting arrangements would have a HLT Quality and Safety Group, a Clinical Effectiveness, Research and Innovation Group, a Finance and Performance Group and a People and Organisational Development Group, which report to the Hospital Management Board and, ultimately, the Trust Board (in line with the current LUHFT governance arrangements) from November 2024. The Trust Board would continue to receive the integrated performance report and the finance report and would receive full sight of the site's significant scoring risks (scoring 12+) and any emerging risks.

The report set out the transition into the new governance arrangements. It included the draft HLT Finance and Performance Group terms of reference and cycle of business for approval at the first meeting for onward approval at the Hospital Management Board. Items from the current Finance, Performance & Business Development Committee cycle of business had been mapped into the HLT Finance and Performance Group and Group Strategy and Partnership Committee.

The Committee approved the FPFB Committee Closure Report.

Decisions Made

- The Committee approved the EPRR Core Standards Annual Assurance Annual Report for onward submission to the Trust Board for final approval.
- The Committee approved the FPFB Committee Closure Report.

Recommendation

The Trust Board is asked to note the report.

Board of Directors

COVER SHEET

Meeting Date	Thursday, 10 October 2024	**Item Reference**	TB24/25_146
Report Title	Emergency Preparedness, Resilience and Response Core Standards Annual Submission		
Author	Gary Price Chief Operating Officer		
Responsible Director	Gary Price Chief Operating Officer		

Purpose of Report	The purpose of the report is to update the committee on NHSE Emergency Planning, Response and Resilience core standards.
Executive Summary	The report has been considered by FPBD. This report provides a summary outcome of the NHSE EPRR Core Standards annual assurance process for 2024/25. This report shows the improvement the Trust has made since last year and plans for continual improvement with remaining actions.
Key Areas of Concern	45 out of 59 actions are assessed as compliant. There 14 actions that are assessed as partially compliant. There are no actions assessed as non-compliant. This is a significant improvement on last year and gives an overall compliance of 77% (partially compliant). An action plan has been developed to continue to (85%) substantively compliant by December 2024.

Action Required by the Board of Directors	The Board of Directors is asked to note the improvement in the EPRR core standards submission from the previous year. The action plan for continual improvement for the remaining partially compliant actions will be overseen by the Safe and Sustainable Environment Group and Reported into Finance Performance and Executive Group.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Safe and Sustainable Environment Group	27/9/24	Steve Dobie, EPRR Lead	Recommend to FPBD
FPBD	2/10/24	Gary Price COO	Recommend to Trust Board for Approval

MAIN REPORT

INTRODUCTION

The new approach to EPRR core standards submission requires commissioners and providers of NHS commissioned care to submit evidence, assessed through a formal review and subsequent check and challenge.

NHS England recognise that the change in approach to assessment is challenging and will increase the resource required to demonstrate compliance. However, it is important to note that this does not signal a material change or deterioration in preparedness but should be considered as a revised and more rigorous baseline in which to improve plans for preparedness, response and recovery for the future.

ANALYSIS

For 23/24 the Trust was assessed against the revised standards and approach which required substantial evidence to be uploaded for external assessment.

The final ‘check and challenge’ assurance score was received by the Trust mid-November 23, which assessed LWH’s EPRR assurance as non-compliant. This was the same outcome for all Trusts in Cheshire and Mersey.

The Trust has made significant progress on improvements through 24/25 and will be submitting an improved position from 23/24 of partially compliant (77%). There is an action plan in place for those areas to improve to substantially compliant (85%) by December 24. Appendix 1 details the standards however they are summarised below.

	23/24	24/25
Fully compliant	19	45
Partially Compliant	38	14
Non Compliant	1	0

RECOMMENDATION

The EPRR core standards process required a submission to Trust Board on compliance levels with the annual standards and where partially or non-compliance an action plan is in place. Significant improvement has been made in compliance in 24/25 and the action plan for the partially compliant standards will be overseen via FPEG and reported to Trust Board in the annual EPRR report.

SUPPORTING DOCUMENTS

Appendix 1: 24/25 EPRR core standards summary
Appendix 2: 24/25 EPRR core standards action plan

Ref	Domain	Standard name	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
Domain 1 - Governance				
1	Governance	Senior Leadership	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Fully compliant
2	Governance	EPRR Policy Statement	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Fully compliant
3	Governance	EPRR board reports	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	Fully compliant
4	Governance	EPRR work programme	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Fully compliant
5	Governance	EPRR Resource	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Partially compliant
6	Governance	Continuous improvement	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Fully compliant

Ref	Domain	Standard name	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
Domain 2 - Duty to risk assess				
7	Duty to risk assess	Risk assessment	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Fully compliant
8	Duty to risk assess	Risk Management	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Fully compliant
Domain 3 - Duty to maintain				
9	Duty to maintain plans	Collaborative planning	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Fully compliant
10	Duty to maintain plans	Incident Response	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant
11	Duty to maintain plans	Adverse Weather	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	Fully compliant

Ref	Domain	Standard name	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
12	Duty to maintain plans	Infectious disease	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	Fully compliant
13	Duty to maintain plans	New and emerging pandemics	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant
14	Duty to maintain plans	Countermeasures	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Fully compliant

Ref	Domain	Standard name	Supporting Information - including examples of evidence	**Self assessment RAG** Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
15	Duty to maintain plans	Mass Casualty	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Fully compliant
16	Duty to maintain plans	Evacuation and shelter	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant
17	Duty to maintain plans	Lockdown	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant
18	Duty to maintain plans	Protected individuals	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant
19	Duty to maintain plans	Excess fatalities	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant

Ref	Domain	Standard name	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
Domain 4 - Command and				
20	Command and control	On-call mechanism	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	Fully compliant
21	Command and control	Trained on-call staff	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	Fully compliant
Domain 5 - Training and				
22	Training and exercising	EPRR Training	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Partially compliant
23	Training and exercising	EPRR exercising and testing programme	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Fully compliant
24	Training and exercising	Responder training	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Partially compliant

Ref	Domain	Standard name	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
25	Training and exercising	Staff Awareness & Training	As part of mandatory training Exercise and Training attendance records reported to Board	Partially compliant
Domain 6 -				
26	Response	Incident Co-ordination Centre (ICC)	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	Partially compliant
27	Response	Access to planning arrangements	Planning arrangements are easily accessible - both electronically and local copies	Fully compliant
28	Response	Management of business continuity incidents	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Fully compliant
29	Response	Decision Logging	• Documented processes for accessing and utilising loggists • Training records	Partially compliant
30	Response	Situation Reports	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Fully compliant
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Guidance is available to appropriate staff either electronically or hard copies	Fully compliant
Domain 7 - Warning and				
33	Warning and informing	Warning and informing	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	Fully compliant

Ref	Domain	Standard name	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
34	Warning and informing	Incident Communication Plan	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Fully compliant
35	Warning and informing	Communication with partners and stakeholders	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Fully compliant
36	Warning and informing	Media strategy	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Fully compliant
Domain 8 - Cooperation				
37	Cooperation	LHRP Engagement	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	Fully compliant
38	Cooperation	LRF / BRF Engagement	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	Fully compliant

Ref	Domain	Standard name	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
39	Cooperation	Mutual aid arrangements	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Fully compliant
43	Cooperation	Information sharing	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Fully compliant
Domain 9 - Business				
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	Fully compliant
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	Fully compliant

Ref	Domain	Standard name	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	Fully compliant
47	Business Continuity	Business Continuity Plans (BCP)	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Fully compliant
48	Business Continuity	Testing and Exercising	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	Fully compliant

Ref	Domain	Standard name	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
49	Business Continuity	Data Protection and Security Toolkit	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	Fully compliant
50	Business Continuity	BCMS monitoring and evaluation	• Business continuity policy • BCMS • performance reporting • Board papers	Fully compliant
51	Business Continuity	BC audit	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Partially compliant
52	Business Continuity	BCMS continuous improvement process	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Partially compliant
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Partially compliant
Domain 10 -				

Ref	Domain	Standard name	Supporting Information - including examples of evidence	**Self assessment RAG** Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
55	Hazmat/CBRN	Governance	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Fully compliant
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Partially compliant
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Fully compliant
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	Partially compliant

Ref	Domain	Standard name	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
60	Hazmat/CBRN	Equipment and supplies	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	Fully compliant
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	Fully compliant
63	Hazmat/CBRN	Hazmat/CBRN training resource	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	Partially compliant
64	Hazmat/CBRN	Staff training - recognition and decontamination	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Partially compliant

Ref	Domain	Standard name	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
65	Hazmat/CBRN	PPE Access	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	Fully compliant
66	Hazmat/CBRN	Exercising	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Partially compliant

Overall self assesment rating:

Ref	Domain	Standard name	**Self assessment RAG** Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
Domain 1 - Governance						
5	Governance	EPRR Resource	Partially compliant	EPRR Resouce Requirement LWH is a single site with limited EPRR resource, Trust working with LUHFT to develop an EPRR function - schedulded for Q4 24/25 - Lead COO	COO	Q4
Domain 2 - Duty to risk assess						
Domain 3 - Duty to maintain Plans						
Domain 4 - Command and control						
Domain 5 - Training and exercising						
22	Training and exercising	EPRR Training	Partially compliant	TNA Required to be completed Q3 24/25 - EPRR Lead	EPRR Lead	Q3 24/25
24	Training and exercising	Responder training	Partially compliant	As part of TNA more robust training records to be established for individual staff members.	EPRR Lead	Q3 24/25
25	Training and exercising	Staff Awareness & Training	Partially compliant	TNA to be completed and presented through Trust committees for oversights.	EPRR Lead	Q3 24/25
Domain 6 - Response						
26	Response	Incident Co-ordination Centre (ICC)	Partially compliant	As part of TNA would include testing of setting up an ICC for key staff.	EPRR Lead	Q3 24/25
29	Response	Decision Logging	Partially compliant	TNA to also include loggists and record keeping	EPRR Lead	Q3 24/25
Domain 7 - Warning and informing						
Domain 8 - Cooperation						
Domain 9 - Business Continuity						
51	Business Continuity	BC audit	Partially compliant	25/26 to include BCP review as part of Trust audit programme	Deputy COO	Q2 25/26
52	Business Continuity	BCMS continuous improvement process	Partially compliant	25/26 to include BCP review as part of Trust audit programme Increase frequency of BCP tabletop exercises i.e. 4 per year	EPRR Lead	Q1 25/26
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	Partially compliant	Trust has a process for BCPs on file however, some not all within date or require a review.	COO/EPRR Lead	Q4 24/25
Domain 10 - CBRN						
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Partially compliant	Risk assessment requires to be refreshed Q4.	H&S Lead	Q3 24/25
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	Partially compliant	Risk assessment requires to be refreshed Q4.	H&S Lead	Q4 24/25

Ref	Domain	Standard name	**Self assessment RAG** Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
63	Hazmat/CBRN	Hazmat/CBRN training resource	Partially compliant	Train the trainer completed Trust staff training plan to be developed.	EPRR Lead	Q4 24/25
64	Hazmat/CBRN	Staff training - recognition and decontamination	Partially compliant	Train the trainer completed Trust staff training plan to commence	EPRR Lead	Q1 25/26
66	Hazmat/CBRN	Exercising	Partially compliant	CBRN exercise to be unertaken Q1 25/26	EPRR Lead	Q1 25/26

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 detail 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